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OF SEXUALITY

Updated, with More Countries

2004

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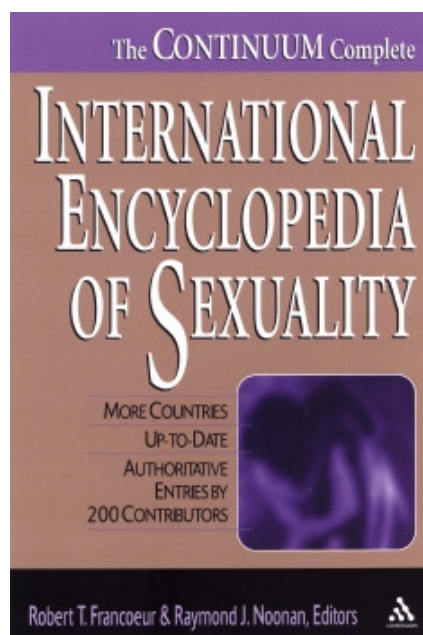
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" . . . a landmark effort to cross-reference vast amounts of information about human sexual behaviors, customs, and cultural attitudes existing in the world. Never before has such a comprehensive undertaking been even remotely available to researchers, scholars, educators, and clinicians active in the field of human sexuality."—Sandra Cole, Professor of Physical Medicine and Rehabilitation, University of Michigan Medical Center

2. The International Encyclopedia of Sexuality, Vol. 4 (Francoeur & Noonan, 2001)

" . . . a masterpiece of organization. The feat of successfully compiling so much information about so many countries into such a coherent and readable format defies significant negative criticism."—*Sexuality and Culture*, Paul Fedoroff, M.D., Co-Director, Sexual Behaviors Clinic Forensic Program, The Royal Ottawa Hospital, Ottawa, Canada

3. The Continuum Complete International Encyclopedia of Sexuality (Francoeur & Noonan, 2004)

" . . . [a] treasure trove. . . . This unique compilation of specialized knowledge is recommended for research collections in the social sciences . . . as well as a secondary source for cross-cultural research."—*Library Journal*, March 15, 2004, p. 64

" . . . a book that is truly historic, and in many ways comparable to the great sexological surveys of Havelock Ellis and Alfred Kinsey. . . . Many works of undeniable importance are intended to speak about human sexuality. But in this encyclopedia we hear the voices of a multitude of nations and cultures. With coverage of more than a quarter of the countries in the world, . . . not only will the *Continuum Complete International Encyclopedia of Sexuality* remain a standard reference work for years to come, but it has raised the bar of sexological scholarship to a rigorous new level."—John Heidenry, editor, *The Week*, and author of *What Wild Ecstasy: The Rise and Fall of the Sexual Revolution*

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8. Significant Unconventional Sexual Behaviors

DAVID L. WEIS

In this section, we consider a group of "other" sexual behaviors. These include sexual coercion (rape, sexual harassment, and child sexual abuse), prostitution, pornography, paraphilias, and fetishes. As a general rule, Americans tend to view heterosexual relations between consenting adults in an ongoing relationship, such as marriage, as the norm. It is true that such sexual relations are the modal pattern in the U.S.A. (Laumann et al. 1994), as is true of every culture. However, the earlier reviews of extramarital sex, alternative lifestyles, homosexuality, and bisexuality all serve to illustrate that sizable percentages of Americans engage in sexual behavior that departs from this assumed norm. American sexologists have struggled for some time to develop acceptable terminology to describe other sexual practices. The concept of sexual orientation has allowed us to view homosexuality and bisexuality as variations in orientation. Similarly, the concepts of gender transposition and gender diversity have provided terminology for examining cross-gender behaviors.

Typically, nonmarital sexual practices have been labeled as sexual deviance or sexual variance. There are, however, at least two problems with such terms. First, no matter what the proper sociological conceptualization, these terms inevitably convey a sense of pathology, dysfunction, or abnormality to behaviors which are situationally defined. For example, consider the act of exhibitionism, exposing one's genitals to another. When practiced in the streets, the act is defined as a crime and is quite rare. When practiced in certain business establishments, the practitioner is paid for the act and clients pay to see it; and when practiced in the privacy of one's home with an intimate partner, it is seen as normal and healthy sexual interaction. Second, some of these behaviors are, in fact, quite common. Muehlenhard reviews evidence that shows many women are victims of sexual coercion. Several recent surveys provide evidence that nearly one quarter of Americans view pornographic videotapes each year (Davis 1990; Laumann et al. 1994). It appears that relatively small percentages of Americans participate in any one of the various fetish groups reviewed below. However, taken together and added to the forms of nonmarital sexual expression we have already reviewed, it seems clear that rather large percentages of Americans do participate in some "other" form of sexual practice.

A. Coercive Sex

Sexual Assault and Rape

CHARLENE L. MUEHLENHARD and BARRIE J. HIGHBY
[Updated by C. L. Muehlenhard]

Basic Concepts. The conceptualization of rape and the treatment of rapists and rape victims in the United States have changed substantially since the 1970s, largely because of the work of feminists. The situation is complex, however; there are many perspectives on these issues. Even the terminology related to rape is at issue. Some people use the term *sexual assault* instead of *rape* to emphasize the violent nature of the act and to place greater emphasis on the behavior of the perpetrator; recent reforms in the criminal codes of some states no longer speak of rape, but of varying degrees of sexual assault (Estrich 1987; Koss 1993a). Others, however, prefer to retain the term *rape* "to signify the outrage of this crime" (Koss 1993a, 199). Some regard rape as different and more serious than assault and contend that "to label rape as a form of assault . . . may obscure its unique indignity" (Estrich 1987, 81). There is no clear consensus in

the law, the popular media, research literature, or feminist writings. We will use the term *rape*.

Similarly, some people use the term *rape survivor* instead of *rape victim*. Each term has advantages. The term *victim* highlights the harm that rape causes. The term *survivor* has more optimistic connotations and, thus, may empower someone who has been raped; it also highlights similarities between people who have survived rape and people who have survived other life-threatening events. The term *survivor*, however, may perpetuate the stereotype that only rapes that are life-threatening—that is, that involve a great deal of extrinsic violence—are worthy of being regarded as "real rape." Thus, we will use the term *rape victim*.

Definitions. Rape can generally be defined as one person's forcing another to engage in nonconsensual sex. This general definition, however, leaves many questions unanswered (Muehlenhard et al. 1992b). What behaviors count as sex? Whom do these definitions cover? What counts as force? What counts as consent? In the United States, thinking about each of these questions has changed since the 1970s, and controversy remains.

Defining rape is complicated by the fact that there are many types of definitions. In the legal domain, the federal government and all 50 states each have their own definition. Legal definitions are written by legislatures, which are composed primarily of men; thus, these definitions are likely to be written from men's perspectives (Estrich 1987). The definitions held by the general public are influenced by the law, the media, folk wisdom, jokes, and so forth. Some researchers base their definitions on legal definitions, which makes them subject to the same biases as legal definitions; others make conscious decisions to deviate from legal definitions, which they find biased or inadequate. Finally, there are political definitions, written by activists wanting to make various political points. For example, MacKinnon (1987, 82) wrote,

Politically, I call it rape whenever a woman has sex and feels violated. You might think that's too broad. I'm not talking about sending all of you men to jail for that. I'm talking about attempting to change the nature of the relations between women and men by having women ask ourselves, "Did I feel violated?"

Persons who regard legal definitions as the most valid criticize such political definitions as being too broad (e.g., Farrell 1993). Based on the assumption that language is power, however, political activists have resisted the status quo by challenging widely held definitions and encouraging people to think about the assumptions behind these definitions.

Prior to the 1970s, definitions of rape often included only penile-vaginal sexual intercourse. This definition has been criticized as too phallocentric, promoting the ideas that an act must involve a man's penis and must have the potential for reproduction to count as "real sex" (Muehlenhard et al. 1992b; Rotkin 1972/1986). Currently, most definitions of rape use a broader conceptualization of sex, including many kinds of sexual penetration (e.g., penile-vaginal intercourse, fellatio, cunnilingus, anal intercourse, or penetration of the genitals or rectum by an object). Some definitions are even broader, including behaviors such as touching someone's genitals, breasts, or buttocks (Estrich 1987; Koss 1993a).

Another contentious question involves whom these definitions cover. If rape is defined as forced penile-vaginal intercourse, then by definition, an act of rape must involve a woman and a man; this definition would exclude coercive sex between two individuals of the same gender. Defini-

tions that are limited to situations in which the perpetrator penetrates the victim exclude situations in which a woman forces a man to engage in penile-vaginal intercourse, because such situations would involve the victim penetrating the perpetrator (Koss 1993a). Some definitions of rape include only the experiences of adolescents and adults (e.g., Koss et al. 1987), whereas others also include the experiences of children (e.g., Russell 1984).

Prior to the 1970s, rape laws in the U.S. included a "marital exclusion," exempting husbands from being charged with raping their wives. By the mid-1990s, this marital exclusion had been removed from the laws of all 50 states, as well as from federal law (X 1994). In some states, however, laws still define rape between spouses more narrowly than rape between nonspouses, giving married women less legal protection than unmarried women. Furthermore, some state laws still treat rape less seriously if it occurs between two people who have previously engaged in consensual sex (X 1994).

Yet another contentious question involves what counts as force. Most definitions include physical force and threats of physical force. Many also include sex with someone who is unable to consent because of being intoxicated, asleep, or otherwise unable to consent. There is disagreement, however, regarding how intoxicated one needs to be, whether the alcohol or drugs need to be administered to the victim by the perpetrator, what happens if both persons are intoxicated, and so forth. This is particularly relevant in cases of date or acquaintance rape (Muehlenhard et al. 1992b).

Even regarding threats of physical force, there is disagreement about how direct such threats need to be. For example, in some court cases, appellate judges have written that a woman's acquiescing to sex with a man because she is afraid that he will harm her (e.g., because he has harmed her in the past, or because they are in an isolated location and he is behaving in a way she regards as threatening) is not sufficient to define the incident as rape. Instead, as Estrich commented, these judges interpreted the law to mean that a woman should not cry and give in; she should fight like a "real man" (1987, 65).

Conceptualizations of Rape and Rapists. Prior to the changes initiated by feminists in the 1970s, rape was commonly conceptualized as a sexual act in which a man responded to a woman's sexual provocations. Rapists were often assumed to be either black men who raped white women or else men who were lower class or crazy and who were provoked by women who dressed or behaved too provocatively (Davis 1981; Donat & D'Emilio 1992; Gise & Paddison 1988; LaFree 1982; Mio & Foster 1991). Amir (1971, 273), for example, discussed "victim precipitated rape," which he conceptualized as rape incited by female victims who spoke, dressed, or behaved too provocatively (e.g., who went to a man's residence or who attended "a picnic where alcohol is present"). MacDonald (1971, 311) wrote that

the woman who accepts a ride home from a stranger, picks up a hitchhiker, sunbathes alone or works in the garden in a two-piece bathing suit which exposes rather than conceals her anatomy invites rape. The woman who by immodest dress, suggestive remarks or behavior flaunts her sexuality should not be surprised if she is attacked sexually. These ladies are referred to as "rape bait" by police officers.

Female victims were often thought to have desired or enjoyed the experience (Gise & Paddison 1988; Griffin 1971; Mio & Foster 1991; Muehlenhard et al. 1992a). For example, Wille (1961, 19) wrote about the typical rape victim's "unconscious desires to be the victim of a sexual as-

sault." Husbands, in effect, "owned" their wives and were entitled to their sexuality; thus, the concept of marital rape was nonexistent (Clark & Lewis 1977; Donat & D'Emilio 1992). Sexual acts that occurred between acquaintances or on dates were often assumed to be sexual encounters that the woman had let get out of hand (e.g., Amir 1971).

In the 1970s, feminist writers began to conceptualize rape as violence (e.g., Brownmiller 1975; Griffin 1971). In a classic article, Griffin (1971, 312) wrote that

rape is an act of aggression in which the victim is denied her self-determination. It is an act of violence which, if not actually followed by beatings or murder, nevertheless always carries with it the threat of death. And finally, rape is a form of mass terrorism, for the victims of rape are chosen indiscriminately.

Griffin also emphasized that the fear of rape limits women's freedom, and as such, rape functions as do other forms of violence. Conceptualizing rape as violence has numerous advantages: acknowledging the serious consequences of rape; highlighting the similarities between the effects of rape and the effects of other kinds of violence; taking the emphasis of rape prevention off restricting women's sexual behavior; and acknowledging that rape affects all women, even those who have not actually been raped, by instilling fear and, thus, restricting women's freedom.

Currently, in the United States, it is common to hear people say, "Rape isn't sex; it's violence." Nevertheless, many writers, including both feminist political activists and researchers, have found value in conceptualizing rape as having elements of sex as well as violence (Muehlenhard et al. 1996). Feminists have discussed similarities between rape and other sexual situations which may also be coercive:

So long as we say that [rape involves] *abuses of violence, not sex*, we fail to criticize what has been made of sex, what has been done to us through sex, because we leave the line between rape and intercourse . . . right where it is. (MacKinnon 1987, 87, emphasis in original)

Our understanding of rapists has been enhanced by investigating both the sexual and the violent aspects of their behavior and attitudes. Rapists are more likely than nonrapists to become sexually aroused by depictions of sexual violence, as well as to feel hostile toward women, to accept rape myths and violence against women, and to view heterosexual relationships as adversarial. They drink more heavily and are more likely to have drinking problems, which may serve as a release or an excuse for sexually violent behavior. They are also more likely to have witnessed parental abuse or to have been physically or sexually abused in their childhoods. They begin having sexual experiences, either consensual or nonconsensual, earlier than nonrapists (Berkowitz 1992; Burt 1991; Koss & Dinero 1988; Finkelhor & Yllo 1985; Malamuth 1986; Russell 1982/1990).

[Update 2003: Recent research has supported and extended knowledge about sexually aggressive men. Analyzing a sample of U.S. college men, Abbey et al. (2001) found that 33% reported engaging in some form of sexual assault. Compared with other men, those who had engaged in sexual assault had more-hostile attitudes toward women, were more accepting of verbally pressuring a woman to have sex, described their friends as more approving of forced sex, and had greater expectancies that alcohol increased men's sex drive. There were also differences in their descriptions of their consensual sexual experiences: Compared with other men, the sexually assaultive men reported having had sex at a younger age, having had more partners, and drinking more prior to sex. Numerous other studies have also found

high levels of alcohol use among sexually aggressive men (Testa 2002).

[A meta-analysis by Murnen et al. (2002) found support linking men's sexual aggression to their masculine ideology. The two largest effect sizes were for Malamuth's construct of "hostile masculinity" (which includes a desire to dominate and control women and a distrustful, defensive, and insecure orientation toward women; Malamuth et al. 1991), and for Mosher's construct of "hypermasculinity" (in which men regard violence as manly, consider danger to be exciting, and have calloused attitudes toward women; Mosher & Sirkin 1984). (*End of update by C. L. Muehlenhard*)]

Research has also dispelled myths about rape. Rapists represent all ethnic groups and social classes (Russell 1984, 1990), and the overwhelming majority of rapes occur between acquaintances (Kilpatrick et al. 1987; Koss et al. 1988; Russell 1984) and between members of the same race or ethnicity (Amir 1971; O'Brien 1987). Research shows that men can be raped and women can be rapists (Brand & Kidd 1986; Muehlenhard 1998; Muehlenhard & Cook 1988; Sarrel & Masters 1982; Struckman-Johnson et al. 2003; Waterman et al. 1989). Still, because rape and the fear of rape affects women more than men, and because of the differences in how women's and men's sexuality is conceptualized in the United States, some claim it would be a mistake to treat rape as a gender-neutral phenomenon (MacKinnon 1990; Rush 1990). Finally, "thanks to the feminist movement, no one any longer defends the dangerous claim that rape is a sexually arousing or sought-after experience on the part of the victim" (Palmer 1988, 514).

Prevalence. How prevalent is rape? Estimates of prevalence depend not only on how rape is defined, but also on the methodology used. Conducting interviews in the presence of family members yields lower prevalence estimates than conducting interviews in private or using anonymous surveys, which is understandable given that many rape victims do not tell their families about having been raped, and some rape victims have been raped by family members (Koss 1993a; Koss et al. 1988; Russell 1984). Asking respondents if they have been "raped" yields lower prevalence estimates than asking if they have had an experience that meets the researchers' definition of rape, because many rape victims do not label their experience as "rape" (Kahn & Andreoli Mathie 2000; Peterson & Muehlenhard 2003). Asking respondents a single question about their experiences generally yields lower estimates than does asking multiple questions, perhaps because asking only one such question fails to elicit memories of rapes that may have occurred in numerous contexts (e.g., with strangers, casual acquaintances, dates, or family members, obtained by force or threats of force or when the victim was unable to consent, and so forth; Koss 1993a). (*Updates added by C. L. Muehlenhard, 2003*)

Until recently, statistical reports on the prevalence of rape published by the U.S. government were inadequate: The *Uniform Crime Reports*, published by the Federal Bureau of Investigation (FBI 1993), include only rapes that were reported to the police—a small minority of all rapes (Russell 1984). The *National Crime Victimization Surveys* (NCVS), conducted by the government's Bureau of Justice Statistics (BJS), also have serious methodological flaws (BJS 1993; Koss 1992; Russell 1984). [*Update 2003*: Some of these flaws have subsequently been addressed (e.g., in the past, NCVS reports concluded that rape was rare, despite the fact that respondents had been asked no questions about rape; see Russell 1984). Other flaws remain, however (e.g., the interviews are not necessarily confidential, and family

members and others are sometimes present during the interviews; Tjaden & Thoennes 2000).

[Recently, the National Violence Against Women (NVAW) Survey, cosponsored by the National Institute of Justice and the Centers for Disease Control and Prevention, has corrected many of these problems (Tjaden & Thoennes 2000). The data from this national telephone survey came from 8,000 women and 8,000 men, selected from the 50 U.S. states and the District of Columbia by random-digit dialing. The NVAW included questions about forcible rape, physical assault, and stalking. Rape was defined as "forced vaginal, oral, and anal sex" (Tjaden & Thoennes 2000, 13). Respondents were asked multiple questions about experiences they had had that met the researchers' definition of rape. Respondents were asked about both completed and attempted rape (in this summary of the NVAW data, the term *rape* refers to both completed and attempted rape).

[NVAW results showed that of the women surveyed, 17.6% reported having been raped (14.8% reported completed rape and an additional 2.8% reported attempted rape). Of the men surveyed, 3.0% reported having been raped (2.1% reported completed rape and an additional 0.9% reported attempted rape). Many of the rape victims reported being raped more than once (Tjaden & Thoennes 2000).

[Among those who reported being raped, 21.6% of the women and 48.0% of the men experienced their first rape before age 12, and 32.4% of the women and 23.0% of the men experienced their first rape between ages 12 and 17. Therefore, 54.0% of the female rape victims and 71.0% of the male rape victims experienced their first rape when they were children or adolescents. Among all respondents, 9.6% of the women and 0.9% of the men reported having been raped as adults (Tjaden & Thoennes 2000).

[In the NVAW Survey, more American Indian/Alaska Native women (34.1%) than white women (17.7%), African-American women (18.8%), and mixed-race women (24.4%) reported having been raped. More non-Hispanic women (18.4%) than Hispanic women (14.6%) reported having been raped. (Statistical comparisons among racial and ethnic groups did not include men or Asian/Pacific Islander women because of limitations with the data.)

[Consistent with previous findings, the NVAW Survey revealed that women are especially at risk from current and former intimate partners; 7.7% of the women and 0.3% of the men in the sample reported having been raped by a current or former intimate partner (spouse, cohabiting partner, boyfriend/girlfriend, or date). The rape victims were asked about their most recent rape: Among the female rape victims, 61.9% were raped by a current or former intimate partner; 6.5% were raped by a relative; 21.3% were raped by another acquaintance; and 16.7% were raped by a stranger. (Data for male rape victims were insufficient to calculate reliable percentages.) (*End of update by C. L. Muehlenhard*)]

Consequences for Rape Victims. Research in the U.S. on the consequences of rape has improved dramatically in the past several decades. Prior to the 1970s, studies of rape victims consisted of occasional case studies of victims who sought psychotherapy, a biased sample because most rape victims do not seek therapy, and those who do are likely to be atypical (e.g., to be in greater distress, to be of higher socioeconomic status, etc.). The next generation of studies involved assessing rape victims who reported the rapes to police or emergency-room personnel; this practice allowed longitudinal assessment of the aftermath of rape, but the samples were still biased because most rapes are never reported. Currently, the consequences of rape are often studied by surveying random samples of people; this practice allows

comparisons of rape victims with nonvictims, regardless of whether the rape victims had reported the rapes to authorities or had labeled their experiences as rape. Some researchers even conduct prospective studies, in which members of a high-risk group (e.g., first-year college students) are assessed annually; if someone in the sample is raped during the time span of the study, their pre- and postrape adjustment can be compared (e.g., Humphrey & White 2000).

Research shows that most rape victims experience psychological, physical, and sexual problems after being raped. It is important to remember, however, that not all rape victims experience all of these consequences; some experience many consequences, whereas others experience relatively few consequences.

The psychological consequences of rape can include depression; fear; anxiety; anger; problems with self-esteem and social adjustment; feeling betrayed, humiliated, or guilty; and experiencing problems with trust (Lystad 1982; Muehlenhard et al. 1991; Resick 1993; Resick & Nishith 1997). Recently, some of these psychological consequences have been conceptualized as post-traumatic stress disorder (PTSD) (American Psychiatric Association 1994). This symptom constellation includes reexperiencing the rape (such as in dreams or flashbacks), feeling numb and avoiding reminders of the rape, and experiencing hyperarousal (such as insomnia, difficulty concentrating, outbursts of anger, or an exaggerated startle response; see Herman 1992; Resnick et al. 1993).

[Update 2003: Although it is likely that being raped causes these psychological problems, it is possible that in some cases these psychological problems increase individuals' vulnerability to rape. For example, in a longitudinal study of college women's experiences with sexual coercion, women who reported being verbally sexually coerced during the semester had lower self-esteem scores than did other women at the beginning of the semester, suggesting that low self-esteem left the women vulnerable to verbal sexual coercion (Jones & Muehlenhard 1994). Thus, research that finds differences between rape victims and nonvictims must be interpreted cautiously. (End of update by C. L. Muehlenhard)]

Sexual problems resulting from rape can include avoidance of sex, decreased sexual satisfaction, sexual dysfunctions, and flashbacks to the rape during sex (Kilpatrick et al. 1987; Lystad 1982; Warshaw 1988). Some rape victims engage in sex indiscriminately in ways that they do not feel good about, perhaps because the rape made them feel devalued, as if "they now have nothing left that's worth protecting" (Warshaw 1988, 74).

[Update 2003: Paradoxically, one consequence of sexual victimization seems to be further sexual victimization. Numerous studies have shown evidence that women who experienced child sexual abuse are more likely than others to be sexually victimized as adolescents or adults (see Muehlenhard et al. 1998 for a review). Some studies have also found this for men (Brenner & Muehlenhard 1995). NVAW data replicated this pattern: Among women who reported having been raped before age 18, 18.3% reported having been raped again as an adult; among women who did not report having been raped before age 18, only 8.7% reported having been raped as an adult (Tjaden & Thoennes 2000). In a longitudinal study of U.S. college women, Humphrey and White (2000) found that sexual victimization during childhood (before age 14) predicted an increased risk of sexual victimization as an adolescent (from age 14 until the beginning of the college); in turn, sexual victimization during adolescence predicted an increased risk of sexual victimization during college. As with studies comparing the psychological

characteristics of rape victims and nonvictims, studies comparing the subsequent victimization rates of these groups must also be interpreted cautiously: It could be the case that earlier victimization increases the risk of later victimization, but it could also be the case that personality, family, or environmental factors increase some individuals' risk as a child, as an adolescent, and as an adult.

[Numerous studies suggest that being raped leads to behavior changes. For example, as mentioned above, after being raped, some rape victims avoid sex, and others engage in sex indiscriminately. Brener et al. (1999) found that women who had been raped were significantly more likely than other women to engage in numerous health-risk behaviors. Analyzing data from a nationally representative sample of U.S. college students, they found that 20% of the women and 4% of the men reported having been raped, defined as having been forced to engage in sexual intercourse against their will. Multivariate analyses, controlling for age, parents' education, race, and sorority membership, found that women who had been raped were more likely than other women to report having thought seriously about suicide during the prior year; fighting physically with a boyfriend or spouse during the prior year; smoking cigarettes, drinking heavily, driving after drinking alcohol, and using marijuana during the prior month; having had two or more sexual partners during the prior three months; having used alcohol or drugs during their last sexual intercourse; and having had sexual intercourse before age 15. It could be the case that being raped increases the likelihood that women will engage in these health-risk behaviors; however, it could also be the case that engaging in these behaviors increases women's vulnerability to rape or that other factors increase the likelihood of these behaviors and of rape. (End of update by C. L. Muehlenhard)]

The physical consequences of rape can include physical injuries (including injuries from weapons or fists, as well as vaginal or anal injuries), sexually transmitted diseases, pregnancy, reproductive problems causing infertility, and psychosomatic problems (Koss 1993b; Resick 1993; Resick & Nishith 1997; Warshaw 1988).

[Update 2003: In the NVAW study (Tjaden & Thoennes 2000), among those who reported having been raped as an adult (age 18 and older), 31.5% of the female rape victims and 16.1% of the male rape victims reported having been physically injured during their most recent rape. These injuries ranged from bruises and sore muscles to broken bones, chipped teeth, and knife wounds. Of the women injured during a rape, 35.6% reported receiving medical treatment for their injuries. (End of update by C. L. Muehlenhard)]

Divulging the rape to someone else may result in various problems: feeling embarrassed or uncomfortable; reliving aspects of the experience; being disbelieved or blamed; and being questioned about one's behavior and dress, which might lead victims to feel as if they are "on trial," and needing to prove their innocence to others. When rape victims report the rape to the police, their report may be disbelieved or trivialized, although police attitudes and sensitivity have improved during the last several decades. Should the case go to trial, recent "rape shield laws" generally prohibit defense attorneys from inquiring about the victim's sexual past; nevertheless, defense attorneys typically try to discredit victims (Allison & Wrightsman 1993; Estrich 1987; Gelles 1977; Griffin 1971; Roth & Lebowitz 1988).

Contrary to stereotypes, acquaintance or date rape is as traumatic as stranger rape. Victims of acquaintance rape are as likely as victims of stranger rape to experience depression, anxiety, problems with relationships, problems with sex, and thoughts of suicide (Koss et al. 1988). Women who are raped by acquaintances they had trusted may doubt their

ability to evaluate the character of others and may be reluctant to trust others. Women raped by acquaintances are less likely than women raped by strangers to be believed and supported by others. If the victim and rapist have mutual friends, the friends may be reluctant to believe that a friend of theirs could be a rapist; they may thus be reluctant to take the victim's side against the perpetrator, and the victim may feel unsupported. If the rapist goes to the same school, workplace, or social functions as the victim, the victim may feel uncomfortable and withdraw from these activities (Kilpatrick et al. 1987; Koss et al. 1988; Russell 1982/1990; Stacy et al. 1992; Warshaw 1988).

[Update 2003: NVAW data (Tjaden & Thoennes 2000) revealed that rape by current or former intimate partners was especially dangerous for women: 36.2% of women raped by intimates, compared with 23.6% of women raped by nonintimates, were physically injured. In a multivariate analysis, in which other explanatory variables were held constant, women raped by intimates were 2.2 times more likely to be injured than women raped by nonintimates. (End of update by C. L. Muehlenhard)]

People raped by their spouses or cohabiting partners may experience consequences that other rape victims do not experience. Whereas stranger rape is typically a one-time occurrence, the rape of wives and other partners is likely to occur repeatedly and may last for years (Russell 1982/1990). Many also experience other forms of domestic violence. Victims raped by a spouse or cohabiting partner must decide either to live with the perpetrator and risk subsequent rapes or to divorce or separate, which requires many lifestyle adjustments, and which does not guarantee that they will not be raped by their ex-spouse or ex-partner (Koss et al. 1988; Lystad 1982; Russell 1982/1990). The consequences may also extend to children living in the household (Mio & Foster 1991). Children may be aware of the problem and may even witness the rapes. They may fear the parent or stepparent who is the perpetrator and may develop negative views of sex and relationships.

Boys and men who have been raped experience many of the same consequences that girls and women do, although being a male victim may result in additional consequences that female victims do not encounter. Being forced into submission is incongruous with the male sex-role stereotype that espouses control and dominance. Males raped by females often confront beliefs that they must have desired and enjoyed the act and that male victims are less traumatized than are female victims. Males raped by other males, regardless of their sexual orientation, often confront homophobic attitudes. Males also confront the myth—held by others and sometimes by the victims themselves—that if they had an erection, they must have wanted sex (Groth & Burgess 1980; Russell 1984; Sarrel & Masters 1982; Smith et al. 1988; Warshaw 1988).

Lesbian and gay rape victims may encounter difficulty in attempting to obtain services from crisis-intervention and social-service centers, as many of these agencies are not prepared to serve lesbian and gay clients (Renzetti 1996; Waterman et al. 1989). Obtaining services may require that gay or lesbian rape victims “come out,” revealing their sexual orientation and risking possible discrimination, possibly even losing their jobs, housing, or children should others find out (legal protection of lesbians and gays in the United States varies from city to city and state to state; in most of the U.S., there is no such protection). If rape occurs in a lesbian or gay relationship in which the perpetrator is the biological parent of the children, if the victimized partner leaves the relationship, she or he will probably have to leave the children with the perpetrator. Furthermore, the

gay and lesbian community is often tight-knit, so lesbian or gay rape victims may be reluctant to tell mutual friends or to participate in the community's social functions (Grover 1990; Muehlenhard et al. 1991).

Punishment of Rapists. The typical punishment for rapists is no penalty, given that most rapes are not reported to the police (Koss et al. 1988; Russell 1984). Even those that are reported rarely result in arrest and conviction (Allison & Wrightsman 1993). Among those who are convicted of rape, punishment varies from merely being placed on parole to life in prison.

Until the 1970s, the penalty for rape included the death penalty; 89% of the men executed for rape in the United States from 1930 to 1967 were African-American (Estrich 1987, 107). In 1977, the U.S. Supreme Court found the death penalty for rape to be unconstitutional (*Coker v. Georgia*, 433 U.S. 584, 1977; see Estrich 1987). Studies of actual sentences given to convicted rapists reveal that the harshest penalties for rape are still imposed on African-American men convicted of raping white women (Estrich 1987; LaFree 1980). There is also a bias against convicting affluent, successful men and men who rape women they know or who rape women who do not conform to cultural expectations of how a “good woman” should behave (Estrich 1987; LaFree et al. 1985).

Prevention. Prior to the 1970s, rape prevention was generally regarded as women's responsibility. Because rape was regarded as an act of sex incited by provocative women, rape prevention consisted largely of expecting women to restrict their behavior (expecting women not to talk or dress provocatively, not to go out at night, etc.).

Currently, a variety of prevention strategies are common in the U.S. (Muehlenhard et al. 1992a). Some people still urge women to restrict their behavior, and research shows that women do indeed restrict their behavior because of the fear of rape: Women report avoiding going outside alone at night, not talking to strangers, wearing bulky clothing, having unlisted phone numbers, and so on (Gordon & Riger 1989; Hickman & Muehlenhard 1997). These precautions limit women's freedom and diminish women's quality of life. [Update 2003: Furthermore, this approach focuses on stranger rape; paradoxically, although stranger rape accounts for a minority of all rapes (Tjaden & Thoennes 2000), women fear stranger rape more than acquaintance rape and take more precautions to avoid stranger rape than acquaintance rape (Hickman & Muehlenhard 1997; Pain 1997; Poirier & Muehlenhard 2000). (End of update by C. L. Muehlenhard)]

There are other prevention strategies that are not predicated on women's restricting their behavior. For instance, many universities have installed extra lighting and emergency telephones (often marked by blue lights) to help women feel safer. These strategies are aimed primarily at preventing stranger rape, however, and will not help women who are raped indoors by husbands, partners, dates, or other acquaintances. To address these problems, many universities have initiated lectures and workshops presented to college dormitory residents, fraternities, sororities, and athletic groups; some high schools and even junior high schools have also initiated such programs, although they sometimes meet resistance from parents and school boards (Donat & D'Emilio 1992). There is evidence that such programs can lead to attitude change (Jones & Muehlenhard 1990), although the effectiveness of these strategies in actually preventing rape is unknown.

Some women take self-defense classes. For example, Model Mugging programs teach women self-defense strate-

gies that utilize women's physical strengths, such as lower-body strength (Allison & Wrightsman 1993). Research shows that active-resistance strategies (e.g., physically fighting, screaming, and running away) are generally more effective than the passive-resistance strategies (e.g., pleading, crying, reasoning, or doing nothing), and active strategies do not increase the risk of physical harm (Bart & O'Brien 1984; Ullman 1997; Ullman & Knight 1992; Zoucha-Jensen & Coyne 1993). Unfortunately, no strategy is effective all of the time or for all people, and even experiencing an attempted rape can be traumatic. Furthermore, many feminist theorists have argued that, because most rapists are men, it is unfair to place the burden of rape prevention on women (Berkowitz 1992; Koss 1993b).

The most important strategies for preventing rape involve working for broader social change: changing men's and women's attitudes about rape, sex, and gender roles; working toward gender equality; discouraging violence as a problem-solving technique; and emphasizing that coercive sex in any context, whether with a stranger or acquaintance, is never acceptable.

[*Sexual Rape in the Military* ROBERT T. FRANCOEUR

[Update 2003: In the early 1990s, Americans became very aware of "sexual harassment" when several women charged Senator Bob Packwood with sexual harassment; when, in Congressional hearings to confirm Clarence Thomas as an associate justice of the U.S. Supreme Court, Anita Hill claimed that she had been a victim of repeated sexual harassment by Thomas; and when women officers attending the annual Tailhook Convention of the U.S. Navy made public charges of sexual harassment and assault against male officers. Three admirals were issued letters of censure, but as one woman officer later reported, "not a single Naval officer who took part in Tailhook got anything more than a slap on the wrist."

[The Tailhook scandal eventually left the headlines, but it erupted again in 2003 at the Air Force Academy in Colorado Springs, when women cadets took their charges to the press and television news reporters, finally forcing a Congressional hearing and three independent military investigations of the top command at the Academy. With close to 800 women in the 4,200-member Cadet Corp, the command admitted to processing 56 cases of rape in the previous 10 years, and expelling only eight male cadets and court marshalling only one cadet, who was acquitted. As one female cadet commented: "They tell you to expect getting raped, and if it doesn't happen to you, you're one of the rare ones. They say if you want a chance to stay here, if you want to graduate, you don't tell. You just deal with it."

[Attempts of the Pentagon to deal with the emerging scandal failed in mid 2003 when the General appointed in 1991 to solve the problem was forced to resign along with the four top officers in March 2003. Congressional hearings and three independent military investigations were initiated, with reports that rapists had routinely used the General's disciplinary crackdown on minor infractions as a shield to intimidate victims and thwart their efforts to seek prosecution. In effect, the commander set a tone to blame the victim, which in turn discouraged women cadets from lodging formal complaints for fear of retribution against themselves or classmates who could serve as witnesses. It was soon documented that claims of sexual assault were rarely investigated or seldom severely punished.

[In August 2003, the Air Force general counsel issued a report based on her five-month investigation that substantiated many of claims made in a 1996 report to the Air Force, the inspector general, and the Senate Armed Services Com-

mittee. Air Force records showed at least 30 sexual assaults were reported to Academy officials since the report was given to the Air Force Chief of Staff in 1996 and passed on in 2000 to the Senate Armed Forces committee. The 2003 report confirmed allegations that were known to the highest-level officials in the Pentagon and Congress, namely that:

- The Air Force Academy maintained "a culture of silence and intimidation" that stigmatized women who came forward. This culture, filtered down from the highest levels of command, placed the institution and peers above personal integrity.
- The reporting consisted of a fractured composite of agencies, functioning separately, but there was no formal program to help victims.
- No one had ultimate responsibility for investigating and dealing with incidents.
- Sixteen cases of assault spanning several years included one woman so traumatized she slept with a weapon; another woman raped at the Academy's prep school, who was so ostracized for reporting the attack, she didn't report a subsequent gang rape; another who suffered a cut vagina in an attack but didn't report it until she experienced "noticeable" blood loss; and others who were left to "suffer silently in shame."
- The school "reflects institutional/cultural dysfunction" that officials should confront.

[On August 28, the office of the Department of Defense inspector general released the results of a survey of female cadets that showed that the problem in the Air Force Academy has been much more common than originally suspected, with 12%, one-in-six female cadets, reporting being raped or the victim of an attempted rape. Since 10% of the female cadets declined to answer the survey, the inspector general concluded that the true extent of the problem is probably much higher than 12% (Janofsky 2003; Moss 2003; Schemo 2003a, 2003b; Zubeck 2003). (*End of update by R. T. Francoeur*)]

Child Sexual Abuse and Incest

DIANE BAKER and SHARON E. KING

Knowledge of child sexual abuse (CSA) has undergone cycles of awareness and suppression, as both professionals and the general public have struggled to come to terms with its existence since child sexual abuse first gained widespread attention in the 1890s, when Freud proposed that it was at the root of hysterical neurosis. Although modern clinical work tends to confirm the link between child sexual abuse and various neuroses, Freud quietly abandoned his early belief in response to the strong opposition from Victorian attitudes of that era. Linking neuroses with repressed childhood sexual conflict, Freud's Oedipal and Electra complexes, was revolutionary, but at least much more acceptable than admitting the reality and prevalence of child sexual abuse.

During the past 20 years, child sexual abuse has received renewed attention from American clinicians, researchers, and the general public. Recently, child sexual abuse has been the focus of a substantial amount of American research that has, in turn, led to broader recognition of the initial and long-term problems associated with child sexual abuse.

Definitions. The definition presented by the National Center on Child Abuse and Neglect is "Contact and interactions between a child and an adult when the child is being used for the sexual stimulation of the perpetrator or another person." This definition is problematic, however, in that it leaves key

terms open to question. For example, in considering who is a child, researchers have employed cutoff ages anywhere between 12 and 17 years for victims of child sexual abuse. In deciding who is an adult, some researchers have required perpetrators to be at least 16 years of age; others have required age differences between victim and perpetrator of five years or ten years; still others have not required any age difference at all if force or coercion was used. In determining what is sexual stimulation, some authors include non-contact experiences, such as exhibitionism or propositioning, whereas others require manual contact, and still others, genital contact. In a 1987 study designed to determine the effect of varying the operational definition of child sexual abuse on its prevalence, the percentage of college men identified as victims ranged from 24% to 4% based on how restrictive the criteria used were. The parameters defining child sexual abuse, therefore, will have strong implications for how widespread a problem society considers it.

A second major issue is determining, in the absence of physical injury, what has been damaged. This issue is complicated by a consistently identified minority of victims who report such experiences as having been positive. Some authors have pointed to this subset and wondered whether the abuse was against the individual or societal values, and further, whether in defining child sexual abuse, consideration should be given to the victim's view of the experience as negative or positive. Yet, a victim's view of a child sexual abuse experience as positive does not preclude the possibility that it was a harmful or damaging one.

A cogent argument against using the victim's assessment of the experience as positive or negative in defining abuse is that the inequalities of knowledge, sophistication, and power inherent in any child-adult relationship prevent the child from giving informed consent to engage in sexual behavior. From this perspective, it is the emotional and intellectual immaturity of the child that causes the developmentally inappropriate exposure to adult sexuality to be harmful and abusive.

These issues of definition influence the composition of the groups studied by researchers and, thereby, the results obtained. As yet, there has been no completely satisfactory way to define child sexual abuse to ensure that the research results are relevant and helpful to the greatest number of people. Currently, the most widely used set of criteria for defining child sexual abuse are contact experiences between a child aged 12 or younger with an individual five or more years older, or between a child aged 13 to 16 with an individual ten or more years older. These criteria emphasize the differences in developmental maturity between the victim and perpetrator, while minimizing the inclusion of age-appropriate sexual exploration between peers as sexual abuse.

Prevalence of Child Sexual Abuse. Accurate estimates of the prevalence of child sexual abuse in either the general population or clinical populations have been difficult to obtain, in part because of the differences in operational definitions discussed above, in part to the sensitive nature of the topic, and in part to differing methods of assessment (e.g., questionnaire, face-to-face interview, or telephone interview). Estimates of the percentage of adult women who have experienced child sexual abuse vary from 6% to 62% and of adult men from 3% to 31%. In general, percentages are higher among clinical samples than among community-based samples. Additionally, more people disclose abuse histories when information is gathered via an interview rather than by questionnaire, when specific questions about childhood sexual experiences are asked, and when such

terms as "sexual abuse" and "molestation" are avoided (see also Prendergast 1993).

More confidence can be placed in the accuracy of prevalence rates when the samples used are large, random, and community-based. In a 1990 random sample of over 2,000 adults across the United States, 27% of women and 16% of men reported having experienced such abuse as children. In other large-scale studies, about 25% of women and 17% of college men have been identified as having histories of child sexual abuse. The majority of child sexual abuse cases are perpetrated by a nonrelative, generally an acquaintance or family friend; about 30% of girls are abused by a relative (with about 4% involving father-daughter incest), whereas about 10% of boys are abused by a relative. Finally, the prevalence of child sexual abuse does not seem to vary with social class or ethnicity (Hunter 1990).

Theories Explaining Child Sexual Abuse. Upon hearing of child sexual abuse, people generally react strongly, wondering how such abuse could occur. Originally, professionals held a simplistic view of child sexual abuse, considering it to be the result of the isolated actions of a depraved and flawed perpetrator. In the past several decades, however, two more-complicated theories of child sexual abuse have dominated the field.

Family systems theory posits that families function as integrated systems and that irregularities in the system are displayed through symptomatic behavior in one or more family members. From this perspective, the occurrence of incest reflects a distortion in the family system, specifically in the marital subsystem, that is being expressed through a parent's (usually the father's) sexual behavior with a child. This model proposes, then, that child sexual abuse occurs as a misguided attempt to cope with problems in the family. Treatment, therefore, involves recognition of the underlying problems and the institution of changes by all family members rather than through removal of the perpetrator.

Although less simplistic than earlier proposals, this model has been criticized for seeming to blame the victims for the abuse and by removing responsibility from the perpetrator. Additionally, the model is relevant only to incest, which is a relatively small fraction of the child sexual abuse cases.

In order to address these concerns, Finkelhor proposed a four-factor model of child sexual abuse incorporating some aspects of the family systems' perspective, but shifting responsibility for the abuse back to the perpetrator. He conceptualized child sexual abuse as resulting from an interaction between environmental circumstances and the personality of the perpetrator, rather than simply as inherent in the perpetrator or in the family system.

In this model, four preconditions must be met for child sexual abuse to occur. First, the offender must have some motivation to abuse sexually; thus, child sexual abuse satisfies some emotional or sexual need in the perpetrator that is not readily satisfied in other ways. Second, the offender must overcome his or her inhibitions against child sexual abuse. Inhibitions may be overcome in a variety of ways, such as substance use, rationalization, the influence of stressors, or personality factors (e.g., impulsivity). Third, environmental impediments to the abuse must be removed; the offender must have private access to a child. Therefore, she or he may target children who are without consistent adult supervision or obtain employment that provides contact with children. Fourth, the offender capitalizes on the lowered resistance of the child; children who are insecure, needy, uneducated about sexuality, and/or have a trusting relationship with the offender have lowered resistance.

These children are less likely to be assertive in refusing abusive overtures or to disclose immediately that the abuse took place. All of these factors, working in concert, allow child sexual abuse to occur.

Some people remain uncomfortable with the third and fourth preconditions of this model, because they appear to place some responsibility for the child sexual abuse outside the perpetrator and onto the child and his or her non-offending parent(s). Finkelhor stresses, however, that without the first and second preconditions, qualities, and behaviors of the offender alone, child sexual abuse would never occur. These preconditions place responsibility for the act squarely with the perpetrator.

Who Is at Risk for Child Sexual Abuse? The environmental circumstances in which boys are sexually abused versus those in which girls are sexually abused differ in some important ways. Some of these differences were highlighted by Tzeng and Schwarzin (1987), who compared the demographic characteristics of boys and girls in over 15,000 substantiated cases of sexual abuse in Illinois. They found that girls who had been sexually abused tended to live in homes that did not differ from those of the general population in the numbers and kinds of parents/caretakers present, whereas boys who had been sexually abused were significantly more likely to come from single-parent homes and/or from families with either new or many children/dependents. On the other hand, the girls' families tended to display significantly more dysfunction, and caretakers were more physically and/or mentally impaired than caretakers in the boys' families. These results are similar to those of Finkelhor, who found the risk of child sexual abuse among girls increased approximately twofold when a mother was absent from the home. These findings point to an increased risk of sexual abuse when parents are absent, impaired, or overworked (see also Prendergast 1993).

Some differences in the perpetrators of abuse of boys versus girls have also been identified. Tzeng and Schwarzin (1987) and others reported that sexual abuse of boys is more likely to be perpetrated by a stranger, whereas abuse of girls is more likely to be perpetrated by a relative. Further, when boys are abused by a relative, these relatives are more likely to be within five years of age of the boys, whereas relatives who abuse girls are more likely to be ten or more years older than the girls. Although the vast majority of perpetrators of both boys and girls are men, boys are more likely to be abused by women than are girls (17% versus 2%). Thus, for boys, child sexual abuse experiences tend to occur outside the home and to be perpetrated by a nonfamily member or, if inside the home and perpetrated by a relative, the relative is less likely to be a parent-figure or to have adult status. Girls are more likely to be abused within the home by a relative ten or more years older. Risk to girls is increased by sevenfold for girls with a stepfather. A general consensus among researchers is that more boys are somewhat more likely to experience severe abuse (actual intercourse) than are girls.

These differences suggest boys and girls may be experiencing child sexual abuse situations that require differing coping skills. Girls may, more typically, need to adjust to the notion that an adult in a position of trust has been abusive, and boys may, more typically, need to adjust to the notion that the world outside the home is not safe and may need to react to a more-severe physical experience. It should be stressed that all of these differences are generalizations, and there is substantial overlap in the nature of the child sexual abuse experiences of boys and girls.

Initial Effects of Child Sexual Abuse. Although researchers have identified a wide array of problems occurring among

children who have been sexually abused, most have failed to find any substantial differences in symptomatology between male and female victims. When studying these initial effects, researchers have recently begun to divide subjects into three groups based on their stage of development: preschool (ages 3 to 6), school age (ages 7 to 12), and adolescent (ages 13 to 17). By using these groupings, the presence and frequency of various behaviors and symptoms can be compared to those considered developmentally appropriate for the stage.

Among both preschool boys and girls, the most frequent behavioral symptom associated with child sexual abuse experiences is an increase in sexualized behaviors (Beitchman et al. 1991). This increase has been noted in a number of studies using a variety of methodologies, including chart review, parent rating, observed play with anatomically correct dolls, and human-figure drawing. However, the prevalence of this behavior varies widely depending on the context, from 10% of the sample in the case of human-figure drawing to 90% of the sample in play with anatomically correct dolls; still, this finding is among the most robust in the literature. [Comment 1997: These studies do not make comparisons to groups of "normal" children and their rate of sexual behavior. (End of comment by D. L. Weis)]

Emotionally, preschool children are likely to respond to sexual abuse with anxiety, signs of post-traumatic stress (e.g., nightmares, vigilance, or bed wetting), and depression (Kendall-Tackett et al. 1993). These children are also likely to exhibit greater immaturity than nonabused controls, showing increases in both dependency and impulsivity relative to physically abused and nonabused age peers.

Among school-age children, researchers have focused on behavioral problems that interfere with academic and social success. Sexually abused children have been assessed by their teachers as significantly less able than their non-abused peers to learn in the school environment. This difficulty may be a function of the wide range of behavioral and emotional problems they display. For example, approximately half of the school-age girls with histories of child sexual abuse show high levels of immaturity and aggression (Kendall-Tacketts et al. 1993). Similarly, both parents and teachers rated sexually abused children as more emotionally disturbed and neurotic than their classmates, displaying both depression and a wide range of fears (Beitchman et al. 1991; Browne & Finkelhor 1986; Kendall-Tackett et al. 1993). Additionally, like preschool children, the sexually abused school-age boys and girls display clear-cut increases in sexualized behaviors, including such problems as excessive and inappropriate masturbation and sexual aggression (Browne & Finkelhor 1986; Kendall-Tackett et al. 1993). All of these symptoms would be expected to lead to problems in school for children, regardless of their intelligence.

A somewhat different presentation has been observed among adolescents with a history of sexual abuse. Although acting-out behaviors, such as running away, substance use, and sexual promiscuity were more common in these adolescents than their nonabused peers, they were less common than among clinical groups of adolescents (Beitchman et al. 1991). The predominant finding among sexually abused adolescents is an increase in depressive symptomatology, such as low self-esteem and suicidal ideation. This depression may be expressed through self-injurious behaviors, as exhibited by more than two thirds of sexually abused adolescents (Kendall-Tackett et al. 1993), or through suicide attempts made by a third of these adolescents in a clinical sample.

Although there is an extensive list of symptoms and problems associated with the initial effects of sexual abuse, it should be noted that not all children display such effects.

Indeed, 20% to 40% of sexually abused children have been found to be asymptomatic at the time of initial assessment (Kendall-Tackett et al. 1993). Unfortunately, some of these children have become symptomatic by the time of later assessments. There is fairly consistent evidence that from a third to a half of sexually abused children show improvement in symptom presentation 12 to 18 months after the abuse, although another quarter to a third show deterioration in function.

Long-Term Effects of Child Sexual Abuse. Although the long-term effects of child sexual abuse experiences have been studied in both men and women, the majority of the work has been done with women. Reviews of this research have been conducted by Browne and Finkelhor (1986) and Beitchman et al. (1992). The results vary somewhat, depending on whether the samples were community-based or clinically based; still, there is substantial overlap across the two populations.

In both clinical and community-based surveys of women with histories of child sexual abuse, the most common long-term effect is depression. Depression is particularly striking among the community-based samples of victims, in which significantly more women with a history of child sexual abuse report both more-severe and more-frequent episodes of depression compared to those without such experiences. Almost one in five college women reporting a history of child sexual abuse had been hospitalized for depression compared to one in 25 women who had not been abused. In a community-based study of the Los Angeles area, researchers found that a history of child sexual abuse was associated with a fourfold increase in the lifetime prevalence rate for major depression among women. Other prominent depression-related symptoms include problems with self-esteem, which appear to intensify as time elapses from the abuse, and an increased risk for self-injurious or destructive behaviors (Browne & Finkelhor 1986).

Increases in problems with anxiety occur among some women with sexual abuse histories. Problems with anxiety are more prominent among clinical samples than community samples (Beitchman et al. 1992; Brown & Finkelhor 1986). Anxiety seems to be particularly prevalent among women sexually abused by a family member and in cases in which force was used during the abuse.

Relationship difficulties are more common among women with histories of child sexual abuse compared to nonabused women. Abused women are more likely to fear intimacy and to have sexual dysfunctions, particularly when the abuse was more severe and/or was perpetrated by a father or stepfather (Beitchman et al. 1992). A history of child sexual abuse in women is also associated with an increased risk of further revictimization in the forms of rape and domestic violence.

Much less research has been conducted on the long-term effects of sexual abuse in men; much of the information available has been based on clinical case studies or extrapolated from studies with some adult male victims, but in which the majority of the subjects were women. Therefore, conclusions are much more tentative. Several community-based surveys found that men who reported child sexual abuse experiences exhibited a higher rate of psychopathology (e.g., depression, anxiety, or symptoms of post-traumatic stress) than those who did not report such experiences. Men who have been sexually abused have reported significant problems with poor self-esteem and self-concept. Men may respond to such feelings by self-medicating with alcohol and drugs, as indicated by the large degree of substance abuse and dependence among male victims; sex-

ually abused women, on the other hand, report greater levels of depression and anxiety.

Clinicians suggest that intense anger, sexual dysfunction, problems with intimacy, gender-identity confusion, and substance abuse are prominent symptoms for males with a history of child sexual abuse seeking therapy. Additionally, disclosure of sexual abuse is particularly difficult for men. Issues related to disclosure include fears of not being believed (particularly if the perpetrator was female), fears others will consider them homosexual, concerns that they are homosexual because they have been abused by a man, and issues related to masculine identity.

Correlates of More-Severe Effects. Although the preceding paragraphs present a grim picture of the aftereffects of child sexual abuse, not all individuals suffer such severe effects. In fact, in a given sample of abuse survivors, a quarter to a third of the individuals can be expected to appear symptom-free on the chosen assessment instruments (Kendall-Tackett et al. 1993). About one third of these asymptomatic individuals may become symptomatic at later assessments. Still, these differences in outcome have led researchers to examine variables associated with more-severe effects.

One variable consistently associated with more-severe effects is the use of force (Beitchman et al. 1992; Browne & Finkelhor 1986; Kendall-Tackett et al. 1993). This finding has been most robust in studies of the initial effects of child sexual abuse among children (Kendall-Tackett et al. 1993). A number of researchers also have identified an association between the use of force and victims' reports of the degree of trauma experienced among adult survivors as well (Beitchman et al. 1992; Browne & Finkelhor 1986). There is also some evidence that family-background variables, such as high levels of conflict and low levels of support, are related to more-severe effects. The situation is further complicated in that, for some individuals, the use of force has been associated with a decrease in self-blame, thereby reducing the severity of effects.

The relationship of the perpetrator to the victim has also been examined. Among children, the initial effects of abuse are more severe when the perpetrator has a closer relationship to the child (Kendall-Tackett et al. 1993). The situation is less clear for the long-term effects among adults. In general, whether the perpetrator was a family member has little impact on later outcome among adults (Beitchman et al. 1992; Browne & Finkelhor 1986) with one important caveat: Trauma and psychopathology effects are more severe if the abuse was perpetrated by a father or stepfather (Beitchman et al. 1992; Browne & Finkelhor 1986). This difference may represent a greater degree of family dysfunction and a more significant breach of trust when a father perpetrated the abuse (Beitchman et al. 1992). The lack of a general effect of intrafamilial versus extrafamilial abuse among adults may be a reflection that it was the quality of the relationship with the abuser (i.e., how much he was trusted) that influenced outcome rather than whether he was a relative. Finkelhor has extended this notion by proposing that the important variable is the degree to which the child was seduced and persuaded by the perpetrator, whether or not the child had a prior relationship with the perpetrator.

A third major variable examined to determine its relationship to long-term effects has been the duration of the abuse. This variable has been difficult to assess for a number of reasons. First, the criterion for child sexual abuse of long duration varies among researchers, from abuse that occurred for more than six months to abuse that occurred for more than five years. Second, as noted by Beitchman et al. (1992), researchers have tended to use very different mea-

tures, some assessing a subjective sense of harm, and others assessing a more objective degree of psychopathology. There is some evidence, however, that child sexual abuse of longer duration leads to an increase in psychopathology in community-based samples. The two major reviewers of long-term effects of child sexual abuse (Beitchman et al. 1992; Browne & Finkelhor 1986) have both concluded that more research must be conducted before firm conclusions can be drawn, whereas reviewers of initial effects have suggested that longer duration is associated with a worse outcome (Kendall-Tackett et al. 1993).

The severity of the child sexual abuse experience has also been examined in relation to psychopathology and harm in adulthood; here again, the results are mixed. There is general agreement that increased trauma and maladjustment are associated with contact abuse versus noncontact abuse, both initially and in the long term. Further, abuse involving genital contact, whether manual, oral, or invasive, is associated with more-serious outcomes than kissing or clothed contact. Researchers differ, however, in whether invasive contact as compared to manual contact is associated with increased trauma in the long term. Initially, invasive contact is associated with a worse outcome (Kendall-Tackett et al. 1993). Further research is necessary to determine the long-term effects of invasive contact.

One nonabuse-related variable, family support, has also been consistently identified as contributing significantly to both the initial and long-term effects of child sexual abuse. Kendall-Tackett et al. (1993) reviewed three studies examining the relationship of maternal support to symptom outcome in children who had been sexually abused. All three studies concluded that children whose mothers were low in support exhibited worse outcomes following the abuse. This conclusion was supported by the findings of other researchers who examined long-term coping among college women with histories of child sexual abuse.

Theories about the Nature of the Effects. Researchers have cataloged a multitude of symptoms associated with child sexual abuse that therapists have, in turn, attempted to address in treatment. Therapeutic treatment of any type is greatly facilitated by a theory or framework to organize and to approach symptoms. Many clinicians note that it is an impaired trust in self and others that underlies many of the symptoms associated with child sexual abuse.

This difficulty with trust has led some researchers and therapists to conceptualize the symptoms associated with child sexual abuse as a function of post-traumatic stress disorder (PTSD). This disorder encompasses some of the more-troubling symptoms experienced by sexual abuse survivors, such as depression, nightmares, and affective numbing. All of the PTSD conceptualizations of sexual abuse incorporate the idea that exposure to the abuse is experienced by the victim as overwhelming, because of intense fear and/or to extreme violations of beliefs about the way the world operates. When confronted with the abuse then, the child is unable to cope, given his or her current level of internal resources, and so must distort cognitions and/or affect in an effort to adjust to the experience. These distortions are, then, the basis for the symptoms that appear following the abuse.

However, there are some limitations to the application of PTSD to sexual abuse symptomatology. Among the most compelling of these limitations is the fact that the symptoms of PTSD do not encompass all of the problems associated with child sexual abuse. Also, many survivors do not meet the criteria for PTSD. In one group of survivors, only 10% could be diagnosed with PTSD at the time of the survey, and

only 36% could have ever been diagnosed with the disorder. Clearly, more work is needed in the conceptualization of the symptoms associated with a history of child sexual abuse.

Toward this end, Finkelhor has proposed a theory of child sexual abuse symptomatology, the Traumatic Dynamic Model of Child Sexual Abuse (TD), which attempts to address the empirical findings more fully. The TD model emphasizes that the trauma associated with child sexual abuse may be because of the stress of the ongoing nature of the abuse situation, rather than an isolated event that is overwhelming and far removed from usual human experience (as described by the PTSD criteria in the *Diagnostic and Statistical Manual III Revised (DSM III-R)*). This differentiation does not suggest that one type of trauma is more harmful than another; it simply highlights a qualitative difference in events that may lead to different coping responses and/or symptomatology.

The TD model includes four dynamics that occur to varying degrees in any child sexual abuse situation and that are postulated to contribute to the symptoms identified in the research literature. These dynamics include: (a) Traumatic Sexualization, which occurs when the child is taught distortions about his or her sexuality, and may lead to the increase in sexual dysfunctions observed among adult survivors; (b) Betrayal, which occurs in two ways, either when the child finds that an adult she or he trusted has hurt him or her or when the child discloses the abuse to an adult who refuses to believe or help the child. Finkelhor characterized the increased depression and revictimization seen among survivors as a result of the lost trust and unmet dependency needs. It can also lead to increased anger and hostility as a mechanism of keeping others at a distance; (c) Powerlessness, which occurs in a variety of ways in the child sexual abuse situation, for example, when the child finds himself or herself incapable of physically warding off the perpetrator. Powerlessness is further manifest when the child is unable to extricate himself or herself from the abuse situation or unable to do so in a satisfactory way (e.g., without being removed from the home). This powerlessness dynamic leads to anxiety and fear in adult survivors as well as a decreased coping ability; (d) Stigmatization, which occurs either directly through the labeling of the child by others as bad or dirty following disclosure of the abuse or indirectly through the sneaking behavior of the perpetrator and the admonitions that the abuse be kept secret. Stigmatization may be associated with the low self-esteem and the self-destructive behaviors, such as substance abuse and suicide attempts, observed among survivors.

However the effects are conceptualized, recent evidence has demonstrated that child sexual abuse is prevalent and commonly results in harmful effects. Finkelhor and others have attempted to make sense of a confusing array of symptoms presented by many, but not all victims of child sexual abuse. More-sophisticated research designs (e.g., involving structural equation modeling) are required before the relationship between various experiences of child sexual abuse and outcomes become more clear.

Clergy Sexual Abuse

SHARON E. KING

In the past ten years, sexual abuse of minors by clergy has become a major public scandal and crisis for all the churches, although the public attention is often focused on the Catholic clergy because of their requirement of celibacy. Until recently, charges of sexual abuse by clergy were treated as an internal problem within Church jurisdiction and not reported to police. The main issue for Church officials was to control damage to their institution's image. That silence exploded with national media coverage of the

case of James Porter, a Massachusetts priest, who victimized, often sadistically, over 200 minors in several states between 1960 and 1972, and a similar case in Louisiana. Media coverage triggered a flood of new charges of abuse. Ten of 97 priests in a southwestern diocese, nine of 110 in a midwestern diocese, seven of 91 in a southern diocese, and 15 of 220 and 40 of 279 in the eastern United States were charged in civil and criminal suits. In December 1993, 12 of 44 priests in a California minor seminary were charged with having been sexually active with 11- to 17-year-old boys between 1964 and 1987. Between 1984 and 1994, an estimated 5,000 survivors reported their abuse to Church authorities. By early 1995, over 600 cases were pending (Sipe 1995, 26-28). Meanwhile, the Catholic dioceses of Santa Fe and Chicago admitted being in danger of bankruptcy; between 1984 and 1994, Catholic officials admitted to paying out over a half billion dollars in damages to survivors (Rossetti 1991).

Sipe (1995, 26-27) estimates that, at any one time, 6% of Catholic clergy are sexually involved with minors; the situation does not appear to be as serious in Protestant and Jewish circles. One third of the cases of abuse by priests can be classified as true pedophiles, with a three-to-one preference for boys. Two thirds of the abusive priests are involved with adolescents with a more even gender distribution. Four times as many priests are involved with adult women as with minors.

"The crisis of image has been compounded by church authorities who were slow, defensive, and even duplicitous in their public response as abuse by clergy became public and other indications of trouble mounted" (Sipe 1995, 8). Even as late as 1992, fully two thirds of the American Catholic bishops were confused or unconvinced that there is a problem of sexual abuse by the clergy, although even the Pope has acknowledged the crisis.

Civil authorities have responded by extending the statutes of limitations on reporting such abuse. New laws in all states require any professional to report suspected sexual abuse of a minor; in many states, any person is required to report suspected abuse. However, such laws are often vague in defining "reasonable suspicion."

The year 1990 was a watershed as confused Church authorities began losing their damage-control efforts to the rising tide of victims' voices expressed in civil and criminal lawsuits against priests, dioceses, and religious orders. Support groups for survivors spread across the nation: Victims of Clergy Abuse LINKUP, Survivors Connections, American Coalition for Abused Awareness, and Survivors Network of Those Abused by Priests (SNAP).

In 1992, the Catholic Archdiocese of Chicago adopted a model plan for processing allegations of clergy abuse; unfortunately, it remains incompletely and unevenly implemented. In 1993, St. John's (Benedictine) Abbey and University in Collegeville, Minnesota, established an ecumenical Interfaith Institute to study this problem.

How survivors are treated by a religious community varies greatly, and survivors should be reminded that, when they set out to seek legal action against anyone, the course may be extremely difficult. Far too often, survivors feel that they are revictimized by a system that protects the abuser, rather than one that is sensitive to the trauma of the victim.

[Clergy Sexual Abuse—A 2003 Update

WILLIAM PRENDERGAST

[Update 2003: In discussing the present, media-sustained uproar over sexual molestation by religious personnel, which first came to the attention of investigative reporters in the 1980s, the twofold emphasis has been on Catholic

priests and cases of molestation of children. The problem of clerical abuse is far greater and includes religious personnel from all religions: Catholic priests and brothers, Protestant ministers of many denominations, Jewish rabbis, and recently, Muslim imams. It also encompasses the sexual molestation of adult women and men, the fathering of children who are then abandoned, and even drug-involved sexual molestation.

[An extremely important element found in a majority of these cases is a religious one. Quite often the molester informs the victim that God has given him permission to use the body of the victim in any way he pleases and, secondly, that God will protect him from all harm should the victim tell his parents, the police, and so on. The element of "threat(s)" made by these molesters includes personal threats to the victim, as well as threats against his or her family members and religious threats ("God will punish you if you tell!"). Since this group of molesters, like the pedophile or hebophile groups in other molestations, carefully chooses inadequate, timid, easily impressed, and passive types to molest, these pronouncements are believed and contribute to long-lasting guilt in the victims that is especially difficult to treat. Parents and other adults in their close-to-idolization of religious personnel contribute to the damage done to these victims by not believing anything the victim reports, proving the "protection" dictate of the offender. For all of the above reasons, a very high percentage of victims of molestation by clerical abusers never tell anyone of their experience(s).

[As early as the mid-1960s, psychologists were already treating both priests and their victims, but none of the victims at that time was willing to be exposed by reporting. Many abused in childhood or adolescence only began to confront their abuse years later when they were adults, often married and successful in business. All of them were badly traumatized by their molestations (some of which lasted for years!) and their lives were a confused shamble of problems and failures (Prendergast 1996, 2003; Sipe 1995, 1999).

[Several times in the 1970s and 1980s, reports in the media, including pioneering investigations by the *National Catholic Reporter*, focused on allegations of sexual abuse by clergy in Boston, Rhode Island, and Louisiana. Bishops in these dioceses managed to ignore the allegations, often transferring the priests from parish to parish without informing the pastor in the new parish of the potential for continued abuse. Finally, in 2002, investigative reporters for the *Boston Globe* documented a massive coverup by Church authorities that forced the Vatican and the Pope to recognize the scandal, and forced the resignation of Bernard Law, the Cardinal Archbishop of Boston, and of other bishops in Florida, Milwaukee, and Phoenix. The media took the lead in publishing these reports on their front pages in large, bold figures. In reality, these molestations have been going on for hundreds of years and have been kept secret and protected by the superiors involved in their denominations. While an improvement has recently occurred, much of the same secrecy and protection continues in the form of transferring accused personnel from one place to another without informing the supervisors at the new assignment of the accusations made. In cases today, many of these cases are hidden from the congregations, go unreported to the authorities, and never reach the light of day (Cozzens 2002; Sipe 1995, 1999).

[The Catholic Church, at the present time, is the primary focus of these investigations. In late 2002 and early 2003, the Archdiocese of Boston, Massachusetts, was a major press focus. Cardinal Law, its appointed leader, followed traditional methods in dealing with accusations against priests and transferred them to other assignments. What

made Boston so striking an example of the problem was the outrage and public denouncement by the lay Catholics, the public, law officials, and even the priests under Cardinal Law's jurisdiction. In a historic "first," the Boston priests sent a petition demanding Law's replacement. In late 2002, Law quietly flew to the Vatican and received permission to resign his post.

[As of early 2003, there were more than 400 pending lawsuits in Boston, with subpoenas for depositions in the Cardinal's handling of these cases. There is a real possibility that the Boston Archdiocese and several other dioceses will have to file bankruptcy because of the staggering amounts demanded by these lawsuits.

[An extensive *New York Times* survey of documented cases of sexual abuse by priests through December 21, 2002, turned up the following findings:

- By the end of 2002, 1,200 priests in 161 of the 177 Latin Rite dioceses in the U.S. were accused of sexual abuse.
- By mid-2003, six bishops and archbishops had been forced to resign because of their involvement in sexual abuse or their complicity in reassigning known sexual abusers.
- Nationwide, 1.8% of all priests ordained from 1955 to 2001 have been charged with abuse.
- Eighty percent of the accused priests were accused of molesting boys. For laypeople accused, 80% of the victims are girls.
- Over half of the accused priests, 57%, were involved only with teenagers; the remaining 43% were accused of molesting children 12 years or younger (Goodstein 2003).
- Most priests accused were ordained between the mid-1950s and the 1970s, a period of great upheaval in the Church, when the Vatican II Council "opened the windows of the church to the world."
- The number of priests accused of abuse declined sharply by the 1990s. Some claim the decline is because of the victims' very slow recognition of their trauma and their delay in reporting the abuse for years.

[In attempting to find a solution to the problem and greatly concerned about the hundreds and even thousands of millions of dollars being awarded in lawsuits, the Catholic Bishops made this subject the focus of their annual meeting in Dallas on June 13-15, 2002. After debates, arguments, and many disagreements, the group came up with a proposed charter for the protection of children (not adults) that was sent to the Vatican in Rome for consideration. The Charter basically contained 13 Articles, as follows:

1. It bars priests who commit sexual abuse from any parish work and all public ministry in the future, and recommends to the Vatican that they be laicized.
2. Any priest who has sexually abused minors more than once in the past will be recommended for laicization.
3. A priest who abused only once in the past will be governed by strict rules determining if he can be returned to ministry after treatment. Victims will have a say in the process.
4. It allows bishops, acting on the advice of an advisory board composed mainly of laypeople (Diocesan Response Team) to decide whether to remove (laicize) abusive clergy from the priesthood.
5. It requires bishops to report all allegations of abuse of minors to civil authorities.
6. It says bishops should no longer make confidentiality agreements in settlement of civil lawsuits over sex abuse unless the victim insists.

7. It requires background checks for all diocesan and parish workers who have contact with children.
8. It requires bishops to provide an "accurate and complete" description of a priest's personnel record if the cleric seeks to transfer to another diocese.
9. It creates a commission to research how the U.S. Church has responded to sex abuse by priests.
10. It creates a national Office of Child and Youth Protection in the U.S. The Conference of Catholic Bishops is to implement "safe environment" programs and take other actions to protect children from abuse.
11. It creates a review board, including parents, to work with the Child Protection Office to annually examine how the bishops are responding to abuse.
12. It has dioceses establish an immediate outreach program to support victims of priestly sexual abuse (*The Sunday Star Ledger* 2002).

[Problems emerged immediately, especially with the second and third articles, which appeared to allow at least one molestation to go unpunished. The Articles were signed by a majority of the Bishops (249 to 2) and forwarded to Rome for Vatican approval. There were many doubts that the Vatican would accept the Dallas recommendations.

[On October 29-30, 2002, the Vatican decision came. Changes were made and, in essence, the Vatican would not accept this tougher policy (U.S. Conference of Catholic Bishops 2002). The following changes were made:

1. The deletion of the reporting requirement was the biggest surprise. Bishops "should comply with all applicable civil laws," said the Vatican. This meant that only about half of the states would be reporting.
2. Priests accused of misconduct would not be removed from functioning as priests until "a preliminary investigation in harmony with canon law is completed."
3. The Vatican insisted that: "all appropriate steps shall be taken to *protect* the reputation of the accused during the investigation." In this circumstance, the parish would not be informed that its priest is under suspicion of sexually abusing children.
4. The new charter also reduces the role and input of diocesan review boards made up of laypeople. The priests could appeal any penalty in secret Church courts run by clerics.
5. The new norms eliminated the requirement to keep victims apprised of the status of the case against a priest.
6. The most problematic change was the apparent elimination of the zero-tolerance provision. The Vatican reinstated the statute of limitations. This requires a victim to report his or her abuse within 10 years of turning 18, or by age 28. There is continued debate over this requirement (Goodstein 2002).

[The Bishops, however, concluded that their document "remained essentially intact" and that their promise to protect children remained strong.

[One thing that must be stated in all of this is that priests do not become sex molesters and perverts, but perverts and sex molesters become priests. The importance of this factor lies in the fact that it makes it possible to perform pre-screening testing by qualified sexologists and sex therapists in order to identify potential problems and make recommendations regarding suitability or treatment to the referring agency (the Bishops). This would eliminate 75% to 80% of the pedophiles and hebephiles from the priesthood and prevent damaging young, impressionable children and adolescents.

[A second factor that must be addressed is the common confusion regarding homosexuality and these pedophilic molestations. There is no connection! Mature adult homosexuals are not interested in children or adolescents. Here again, these molesters were already pedophiles or hebephiles *prior* to becoming priests. Continuing cases of homosexual behavior and molestation in the seminaries confirms this hypothesis. Again, the urgent need for qualified screening and testing prior to acceptance, and even during training, becomes a paramount prevention need (Prendergast 1996, 2003).

[In July 2003, as this *Encyclopedia* went to press, the attorney general for the State of Massachusetts released his report of a 16-month investigation of the Roman Catholic Archdiocese of Boston that involved 30,000 pages of Church documents and 100 hours of grand jury testimony. According to this 76-page official report, 789 children were known to have been sexually abused by 250 priests and other church workers in the Roman Catholic Archdiocese of Boston between 1940 and the present. However, the attorney general clearly stated that he had "absolutely no doubt that the number [of abusers] is far greater." No criminal charges would be filed against Church authorities, because the laws in effect at the time did not require clergy to report suspected cases of sexual abuse of minors. However, civil charges are likely to be filed by the victims, in suits that could easily force individual Church entities into bankruptcy. Summing up this report, the attorney general blamed the scandal on "a massive, inexcusable failure of leadership by the Archdiocese of Boston" and on "an institutional culture" of secrecy that prompted Church leaders to protect the Church and "sacrifice the children for many, many years." (*End of update by W. Prendergast*)]

[*Comment 2003*: A factor that appears not to have been publicly recognized is the fact that a significant number of Catholics have strong internal conflicts surrounding sexuality, probably as a result of their Catholic indoctrination. This is especially true, it seems, for boys who might feel some attraction for males as they approach and enter adolescence. Thus, although a majority might enter the priesthood because of true spiritual involvement with Catholicism, it appears that a certain number of boys do so in an attempt to resolve these conflicts between their internalized Catholic beliefs and their troubling sexuality. This is based on the belief, promoted by Catholic theology like many other theologies, that spiritual devotion will negate the "temptations of the flesh," a totally unrealistic and untrue belief rooted in the antisexualism of both Catholic and other religious and cultural belief systems. Hence, we find some observers arguing for allowing priests to marry, which continues to not be an option for the Church. (It is interesting to note further, that one major factor for why priests were originally forbidden to marry was not because of any spiritual basis, but because the Church wanted to stem the flow of the large sums of money as inheritances that went to the wives of priests and bishops when they died, which otherwise would have remained with the Church.) Thus, the task of reforming the Church's attitudes toward sexuality as a whole remains a complex issue that could be accelerated by the current sexual-abuse crisis involving priests. Nevertheless, it is important to point out that the vast majority of priests do *not* sexually molest anyone, although they still often teach many of the sexually unhealthy doctrines of the Church. (*End of comment by R. J. Noonan*)]

Satanic Ritual Abuse

SHARON E. KING

"Satanic" ritual abuse is another area of recent concern. As the 1989 report by the ritual abuse task force by the Los

Angeles County Commission for Women shows, it is a controversial area that requires careful and serious attention. Books and groups dealing with cult and ritual abuse continue to expose this alarming and controversial topic. Unfortunately, it often takes on the atmosphere of a circus and witchhunt. There is no scientific evidence that this type of child sexual abuse is widespread or common.

Recovered Memories and False Memory Syndrome

DIANE BAKER and SHARON E. KING

Of great concern recently are a number of cases involving children in daycare centers reporting that they were sexually abused by their caretakers. Although some investigations have led to convictions, other cases have been found to lack any substance at all. In one case, a middle-aged male retracted his charge that a prominent Catholic cardinal archbishop had sexually abused him when he was in the seminary, claiming that his lawyer had probably prompted or influenced his "recovered memory" of being abused.

Concern over false reporting is not limited to young children. Teachers all over the country report that they no longer touch their students as they once did. Hugging a child, allowing a young child to sit on one's lap, or being alone in a room with a child are just some of the things that teachers must now monitor. Cases in which children have projected sexual abuse that was happening at home onto a teacher, and the false reporting of sexual abuse by a teacher in order to get back at the teacher are now issues that mental-health workers and the legal system must unravel in some of the more unusual cases placed before the courts.

Better questioning of young victims by mental-health and legal workers is one area that continues to improve. As with any inquiry, it has become evident that the invitation to tell what happened cannot, in any way, be colored by suggestive questioning on the part of the interviewer.

Increasing numbers of adult women and men have begun to disclose incidents of sexual abuse that happened to them when they were children. Their sexual abuse occurred during a time when it was not safe for children to disclose such information and when the support systems of the state and therapeutic communities were not in place.

In some incidents where adults disclose what happened to them as children, they have always known what happened to them, but they have never before spoken out or sought help. In some instances, however, adults report "remembering" or retrieving lost memories of childhood sexual abuse. Remembering and dealing with unresolved issues of childhood sexual abuse can often explain to a victim how and why his or her life has been affected by the abuse. Weight problems, depression, sleep disturbances, intimacy and sexual disorders, unexplained fears, compulsive behaviors, self-esteem issues, and psychosomatic disorders are just a few of the symptoms that can be resolved when an adult finally confronts the repressed and unresolved trauma of childhood sexual abuse.

In a response to their own daughter's accusation of being sexually abused by her father, the Freyds' of Philadelphia started an organization that examines the False Memory Syndrome. Dr. Pamela Freyd and her husband have been most public in their denial of their daughter's accusations, basing their response on a belief that her "memories" were suggested by her therapist. After a period of silence on her part, Dr. Jennifer Freyd publicly countered her parents' denial of what happened to her, citing her mother's public debate as yet another example of her intrusiveness. Whatever the struggle between the members of the Freyd family, this small organization has brought forth a concern about the authenticity and reliability of retrieved memories.

Sexual Harassment

ROBERT T. FRANCOEUR

Public awareness of sexual harassment is also a recent phenomenon in American culture, even though sexual discrimination was prohibited by federal law over 30 years ago by Title VII of the 1964 Civil Rights Act. In 1979, Stanford University Law School professor Catharine MacKinnon broadly defined sexual harassment as “the unwanted imposition of sexual requirements in the context of a relationship of unequal power.” More-recent definitions include unwanted sexual advances, touches, and actions between peers and coworkers. Sexual harassment can also occur when a subordinate offers sexual favors in return for a promotion, better evaluation, or grade.

A 1976 *Redbook* magazine survey reported that 88% of the more than 9,000 women responding reported having experienced overt sexual harassment and regarded it as a serious work-related problem. A 1988 *Men's Health* survey reported 57% of the magazine's male readers stated they had been sexually propositioned at work, and 58% admitted they had at least occasional sexual fantasies about coworkers.

In a broad survey of over 20,000 federal government workers, 42% of the women and 15% of the men reported having been sexually harassed at work in the preceding two years. Most of the harassers, 78%, were male. Both women and men victims reported that the harassment had negative effects on their emotional and physical condition, their ability to work with others on the job, and their feelings about work. Women were considerably more likely than men to have been harassed by a supervisor, 37% versus 14% (Levinson et al. 1988).

A random-sample survey of undergraduate women at the Berkeley campus of the University of California found that 30% had received unwanted sexual attention from at least one male instructor during their undergraduate years. Examples of harassment included: verbal advances and explicit sexual propositions; invitations to date or to one's apartment; touches, kisses, and fondling; leering or standing too close; writing emotional letters; being too helpful; and offering grades in exchange for sexual favors (see Table 16).

It took over 15 years for the government to identify the sexual-harassment implications of the 1964 Civil Rights Act, and even longer for business corporations to understand the law. In a 1981 *Redbook-Harvard Business Review* survey, 63% of the top-level managers and 52% of middle managers believed that “the amount of sexual harassment at work is greatly exaggerated.” Although the amount of sexual harassment in the workplace has probably decreased because of the growing awareness of its risks, *Working Woman* reported that at least some business managers believe that “More than 95% of our complaints have merit” (Gutek 1985).

Although most research on sexual harassment has focused on its occurrence in the workplace and academia, sexual harassment has also been studied in the relationship be-

tween psychologists or psychotherapists and their clients, and between physicians and other healthcare workers and their patients.

In 1991, televised hearings of Supreme Court nominee Clarence Thomas and Anita Hill captured the nation's attention and sparked considerable debate and a growing awareness of sexual harassment. About the same time, the United States Navy became the focus of congressional investigations and media headlines when close to 100 male pilots and officers at an annual Tailhook convention were charged with blatant examples of sexual harassment. Sexual harassment was also the subject of *Disclosure*, a popular and powerful 1994 film dealing with a female executive sexually harassing a male employee. As a result, practically every American corporation, professional organization, and educational institution has been forced to develop and adopt a statement defining the nature of sexual harassment and its policies for responding to it.

The “interim guidelines” issued by the Equal Employment Opportunity Commission in 1980, established that “unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment” when

1. submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment,
2. submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual, or when
3. such conduct has the purpose or effect of substantially interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.

In 1985, sociologist Barbara Gutek explained the occurrence of sexual harassment in the workplace in terms of a gender-role spillover model. She defined a work role as “a set of shared expectations about behavior in a job,” and a gender role as “a set of shared expectations about the behavior of women and men.” Gender-role spillover occurs when gender roles are carried into the workplace, often in inappropriate ways, for example, when the woman in a work group is expected to make coffee or take notes at the meeting. Despite many attitudinal changes in American society, women are still often seen as subservient and sex objects. When these aspects of gender roles spill over into the workplace, sexual harassment can easily occur, despite its negative effects on the employees and organization (Gutek 1985, 17).

[False Accusations of Sexual Harassment and Rape]

RAYMOND J. NOONAN

[Comment 2003: Troubling news reports occasionally surface about false accusations of both rape and sexual harassment, as well as child sexual abuse, domestic violence, and other sexual assaults, that threaten to undermine the effectiveness of efforts to prevent these crimes. At the same time, false reports can destroy the lives and livelihoods of those falsely accused in ways similar to the victims of actual occurrences of these crimes. At one level, it trivializes the experiences of true victims and makes it more difficult for some of them to come forward. Yet, false accusations are typically not taken as seriously by many people, including the legal system, the media, and the general public, much as awareness of the true crimes were often brushed aside in the past. Statistics from Canada suggest that at least 5% of rape allegations are untrue; other reports from the U.S. suggest levels of false accusations as high as 50% or more. Little re-

Table 16**Varieties of Sexual Harassment in the Workplace**

Type of Harassment	% of Males Reporting	% of Females Reporting
Uninvited sexual attention	20	50
Touching	16	45
Suggestive invitations, talk, and joking	15	42
Harassed by same sex	12	7

Based on De Witt 1991; U.S. Merit Systems Board 1981, 1988; and other sources.

search is being done, generally, on why they occur or what the true incidence is, although some information can be obtained at some men's rights websites. Financial and political gain, personal revenge, morning-after regrets, and ammunition in divorce and custody battles appear to be some of the motivations. Nevertheless, it is likely that the levels are currently underestimated, with the problems associated with them affecting both men, women, families, and children, although the brunt of false accusations are typically directed at men. Young (1999), Patai (1998), and others have begun to document these hidden statistics, including the near-equal levels of domestic abuse by both men and women against each other. Certainly, these are issues that need further investigation to find out the true extent of the problems and ways to combat them—at the same time that effective measures are sought to stop the true instances of sex crimes and to help victims on both sides of the coin. (*End of comment by R. J. Noonan*)

B. Prostitution/Sex Workers

ROBERT T. FRANCOEUR and
PATRICIA BARTHALOW KOCH

Historical Perspective

In the American colonies and early days of the United States, prostitution did not thrive in the sparse rural population. Despite a shortage of women, there were still women on the financial fringe in the small cities—recent immigrants and unattached, single women with few skills—for whom prostitution provided a way of survival and, at times, a way to find a husband or other male supporter. Female servants, apprentices, and slaves were not allowed to marry—a custom that encouraged prostitution. In contrast, indentured male servants were apprentices and could earn money to support themselves and their families, although they received no salary. Until the end of the American Civil War, African and Caribbean women brought to the United States in the slave trade were frequently and regularly exploited sexually by their owners (Barry 1984).

In the 19th century, the Industrial Revolution in New England and the Middle Atlantic cities precipitated a massive influx of women from rural areas and from abroad looking for work and other opportunities. For example, women preferred the freedom that textile-mill work gave them to the tightly regulated life of a domestic servant, even though the wages were lower. There was little, if any, social life available after work hours for these single persons living apart from their families. Since they often shared a boarding house room with six to eight women, sometimes sleeping three to a bed, they frequently found their only relief at the local tavern. With men moving to the western frontier and a surplus of women, some women turned to prostitution for escape or affection. Too often they found that only sex work offered them a living wage (D'Emilio & Freedman 1988).

Throughout the mid-1800s, waves of immigration created a surplus of males who left their wives and families in Europe. In each new wave of immigration, some of the unattached immigrant women turned to prostitution in an effort to survive; some were already involved in "the trade." Males far outnumbered women in the western frontier towns and mining camps. Thousands of women were imported from Mexico, Chile, Peru, the South Pacific, and China to work in the flourishing brothels. After the Civil War, American cities followed the European practice of segregating prostitutes to certain areas of the city, which came to be known as "red-light" districts, and requiring them to register or be licensed. Regular physical examinations were required of all sex workers.

Between 1880 and 1920, prostitution was commonplace and legal. Since few prostitutes bothered to register, licens-

ing was not effective in controlling disease. Police supervision only spawned crime and corruption via bribes for protection or "looking the other way." In 1910, Congress passed the Mann Act, which forbade the transportation of women across state lines for "immoral" purposes. In the decade before World War I, the Social Hygiene Movement, Women's Christian Temperance Union, Young Men's Christian Association, and other "purity" organizations worked for the criminalization of prostitution. By the end of World War I, these efforts were successful in ending politicians' tolerance of prostitution. "Legal brothels were destroyed and prostitutes were dispersed from stable homes in red-light districts to the city at large where they were less likely to be self-employed or work for other women and more likely to be controlled by exploitive men including pimps, gangsters, slum landlords, unscrupulous club owners, and corrupt politicians" (McCormick 1994, 91).

Currently, prostitution is illegal in all states except Nevada, where a 1971 court decision allowed counties with a sparse population the discretion of legalizing and licensing prostitution. State legal codes forbid making money from the provision of sexual services, including prostitution, keeping a brothel, and pandering, procuring, transporting, or detaining women for "immoral" purposes. Patronizing a prostitute is illegal in some states; a convicted offender may face a fine of \$500 or more and a year or more in jail. In some states, pimps may be sentenced to 10 to 20 years in jail and fined \$2,000 or more.

The Spectrum of Sex Workers and Their Clients

Sex workers vary greatly in status, income, and working conditions, as well as in the services they offer—oral sex being the most common sexual practice offered. The vast majority of sex workers are females with male customers. Most prostitutes view their work as temporary, often on a part-time basis to supplement their traditionally female, poorly paid employment, and to support themselves and their families (McCormick 1994). The average prostitute's career lasts five years, since youthful attractiveness is valued by customers. The sexual orientation of female sex workers reflects that of the larger population, and includes heterosexual, lesbian, and bisexual women. While sex workers are predominantly female, the "managers," at all levels, are predominantly male. Pimps—those who live off the earnings of a sex worker—often exploit the workers' romantic feelings, emotional needs, or fear of violence, and often come from disenfranchised groups themselves.

On the one hand, many believe that females turn to prostitution because of dysfunctional families and individual psychopathology. The belief that female prostitutes are more likely than other women to be depressed, alienated, emotionally volatile, or engage in criminal activities and excessive use of alcohol and street drugs are often based on small, specialized samples (McCormick 1994). Research is also inconclusive as to the proportion of sex workers who abuse alcohol and other drugs. At least one study has indicated that call girls were as well adjusted as a control group of nonsex-worker peers who were matched for age and educational level (McCormick 1994). Yet, for many juveniles, sexual and physical abuse seems to be related, at least indirectly, to their becoming involved with prostitution.

On the other hand, economic survival, not psychopathology, may be the most important contributing factor to engaging in prostitution. Poor and disadvantaged women may engage in sex work because it is the best-paying or only job available. More-advantaged women may also engage in sex work because of the often unparalleled economic rewards, coupled with the flexibility in working

hours, and the sense of control over clients. Although non-commercial sex is described as more satisfying by most sex workers, many report achieving satisfaction and orgasm through their work (Savitz & Rosen 1988).

On the lowest rung of female and male sex workers are those who solicit on the street; above them are those working in bars and hotel lobbies. Their limited overhead is matched by their low fees. Streetworkers, usually from the lower socioeconomic class or runaway teenagers, face high risks of violence, robbery, and exploitation, as well as drug addiction, STDs, and HIV infections. Approximately 35% of streetwalkers have been physically abused and 30 to 70% raped while on the job (Delacoste & Alexander 1987). In addition, because of their visibility, streetworkers are the most vulnerable to harassment and arrest by law enforcement agents. While 10% to 20% of sex workers are streetwalkers, they constitute 90% of sex-worker arrests. Prostitution is the only crime in America in which the majority of offenders are female. In dealing with prostitutes, the courts often become a "revolving door system," with the sex worker posting bail and back on the street shortly after being arrested. Paradoxically, she is often fined, making it financially important for her to turn again to sex work to survive.

Government estimates suggest that half of the five million teenagers who run away from their homes each year spend at least some time as sex workers. Poor self-images, rejection by peers, few friends, unsupervised homes, and emotional, if not sexual, abuse in the home make them susceptible to the lure of big-city glamour where their survival needs force them to find work on the streets.

Houses of prostitution are less common today than they were in the past. The famous houses of the Storyville area of New Orleans or San Francisco's Barbary Coast were often very luxurious, and women both lived and worked in the same brothel for many years. Because of legal problems, most brothels today are rundown and in disrepair. If tolerated by the local police, they may be better maintained. In many places, regular, "go-go," and "topless" bars and massage parlors double as "fast-service" brothels. Brothels sometimes advertise their services in "underground" newspapers or in the "free press."

Escorts and call girls are at the upper level of sex workers. Young, slender, attractive, middle- and upper-class white women command the highest fees and the best working conditions among sex workers. Call girls typically see a small number of regular, scheduled clients. For them, sex work provides a much higher income than they would earn in almost any other profession, plus better control over their working hours.

The typical customer of a female sex worker, a "john," appears indistinguishable from the average American male. They are often involved in sexual relationships with another woman and report that they purchase sex by choice—perhaps for the adventurous, dangerous, or forbidden aspects of sex with a prostitute. Some frequent prostitutes because their usual sexual partners are unwilling to participate in certain sexual behaviors (like oral or anal sex). Other men frequent prostitutes because they have difficulty in establishing an ongoing sexual relationship because of lack of opportunity or physical or emotional barriers.

Most heterosexual male prostitutes are not street hustlers, but have steady customers or relationships that are ongoing and similar to those of a high-priced call girl. Their clients are often wealthy older women. Much more common are males who sell their sexual services to other males. In fact, most male prostitutes identify themselves as homosexual or bisexual. In large cities, gay male prostitutes

cruise gay bars, gay bathhouses, public toilets, bus and train stations, and other areas known to local clients.

Sex work also includes a variety of erotic entertainment jobs, including erotic dancing, live pornography or "peep shows," and acting in pornographic films and videos. Female burlesque shows have long been part of the American scene. However, the professional burlesque queens of the past have been replaced by amateur, poorly paid "table dancers." Feminists Barbara Ehrenreich, Gloria Hass, and Elizabeth Jacobs (1987) maintain that male go-go dancers play a role in advancing the rights of women and in breaking down patriarchal biases, because their female viewers treat them as sex objects and reduce their phallic power to impotence within bikini shorts.

The incidence of HIV infection and AIDS varies among sex workers and is increased by IV-drug use, untreated STDs, and unsafe-sex practices. In general, it is high among female and gay male sex workers on the street, and lowest among high-priced call girls and heterosexual male prostitutes.

Economic Factors

In the early 1990s, there were an estimated 450,000 female prostitutes working in the United States, a profession lacking job security and fringe benefits, such as health insurance and social security. Most working outside the high-class escort services do not pay taxes. Nor are taxes paid on any of the monies that are exchanged in the underground economy associated with prostitution, such as: the monies that pass between prostitutes and their pimps; the hotel, motel, massage parlor, or bar owners and clerks; or the recruiters like cab drivers and doormen who make prostitution possible.

A 1985 survey of the cost of enforcing antiprostitution laws in the 16 largest cities of the U.S. estimated police enforcement costs at \$53,155,688, court costs at \$35,627,496, and correction costs at \$31,770,211, for a total 1985 cost of \$119,553,395. In 1985, Dallas, Texas, police made only 2,665 arrests for the 15,000 violent crimes reported. They made 7,280 prostitution arrests at a cost of over \$10 million and almost 800,000 hours of police work. In 1986, Boston, Cleveland, and Houston police arrested twice as many people for prostitution as they did for all homicides, rapes, robberies, and assaults combined. Meanwhile, 90% of perpetrators of violent crimes evaded arrest. Between 1976 and 1985, violent crimes in the 16 largest cities rose by 32% while arrests for violent crimes rose only 3.7%, and arrests for robbery and homicide actually dropped by 15%. Equally important, the 16 largest cities continue to spend more on enforcing prostitution laws than they do on either education or public welfare (Pearl 1987).

Working in pairs, police spend an average of 21 hours to obtain a solicitation, make an arrest, transport the prostitute to the detention center, process her papers, write up a report, and testify in court. Undercover police cruising the street looking to get a solicitation need frequent changes of disguises and rented cars. Making an arrest of a call girl is even more difficult, requiring greater expense for false identification and credit cards, hotel room, luggage, and other paraphernalia to convince the call girl this is a legitimate customer and not a policeman. The hotel room is usually wiretapped and the solicitation videotaped.

Arrests of prostitutes working in massage parlors present their own difficulties. It usually takes half an hour for an undercover policeman to undress, shower, and get into the massage before an illegal service is offered. For a while, Houston police ran their own parlor. When that was declared entrapment by the courts, teams of 10 undercover of-

ficers began working existing modeling studios as customers. "Ten officers at a time, at \$60 each, with no guarantee that we'd get solicited. . . . We could spend \$3000 or \$4000 and not make a case" (Pearl 1987).

Current and Future Status

Historically, sex workers have been blamed for the spread of sexually transmissible diseases (STDs). However, recent research has indicated that sex workers are much more likely to practice safer sex than the "average teenager" (McCormick 1994). While prostitutes are being blamed for transmitting HIV to their clients, data from the Centers for Disease Control indicate that only a small proportion of persons with AIDS contracted HIV from a prostitute. However, rates of HIV infection are quite high—up to 80%—among sex workers who also use intravenous drugs. Unfortunately, sex workers are usually at higher risk of contracting an STD, including HIV, from their lovers with whom they do not use a condom than from their clients with whom they use a condom.

Today in the United States, religious and political conservatives and radical feminists continue to oppose prostitution through such groups as WHISPER (Women Hurt in Systems of Prostitution Engaged in Revolt), an organization devoted to rescuing women and children from sex work. On the other hand, sex workers have begun to organize and advocate better working conditions and treatment through such groups as COYOTE (Call Off Your Old Tired Ethics), Scapegoat, and U.S. PROStitutes. These groups lobby for the decriminalization and legalization of prostitution, inform the public about the realities of prostitution, and offer various services to sex workers. In addition, liberal feminists inside and outside of the sex industry have founded the International Committee for Prostitutes' Rights (ICPR) in order to preserve their rights to life, liberty, and security.

In spite of continued economic inequities in the United States, some observers believe prostitution will decline because of the availability of effective contraceptives, a continued liberalization of sexual attitudes and divorce, a decline in the double standard in employment and sexual expression between the genders, and the risk of AIDS. In the Kinsey study of male sexuality in the late 1940s, 69% of white males reported having had at least one experience with a prostitute. The recent national study of 18- to 59-year-olds, *Sex in America*, found that only 16% of the men ever paid for sex (Gagnon, Laumann, & Kolata 1994). Yet, it seems that prostitution will continue to exist in some form or another. Although some people support the decriminalization of sexual activity between consenting adults, whether or not money is exchanged, this is not likely to happen in the United States.

C. Pornography and Erotica

ROBERT T. FRANCOEUR

The Legal Context

A landmark legal definition of obscenity was established by the Supreme Court in the 1957 *Roth v. the United States* decision. For a book, movie, magazine, or picture to be legally obscene,

- the dominant theme of the work, as a whole, must appeal to a prurient interest in sex;
- the work must be patently offensive by contemporary community standards; and
- the work must be devoid of serious literary, artistic, political, or scientific value.

This ruling permitted the publication in the U.S.A., for the first time, of such works as D. H. Lawrence's *Lady Chatterley's Lover*, James Joyce's *Ulysses*, and works by

Henry Miller. However, this definition left the meaning of the term "community standards" unclear.

In the 1973 *Miller v. the United States* decision, the Supreme Court attempted to tighten the restrictions on obscene material by requiring that defenders of an alleged obscene work prove that it has "serious literary, artistic, or scientific merit." Despite this clarification, the courts still faced the near-impossible task of determining what has "literary, artistic, or scientific merit," who represents the "average community member," and what the "community" is. In 1987, the Supreme Court attempted to refine the *Roth* and *Miller* decisions by saying "a reasonable person," not "an ordinary member of the community," could decide whether some allegedly obscene material has any serious literary, artistic, political, or scientific value. Justice Potter Stewart further confused the situation when he remarked that "You know it when you see it."

In 1969, the Supreme Court ruled that private possession of obscene material was not a crime and is not subject to legal regulation. However, federal laws continue to prohibit obscene material from being broadcast on radio and television, mailed, imported, or carried across state lines. In recent years, pornographic material of any kind involving underaged children has been the target of repeated federal "sting" operations, raising issues of police entrapment.

Research Models

For at least two decades, there has been often-heated debate among the public, among feminists groups, and among scientists regarding the social and psychological impact of pornography, particularly materials that link sex with the objectification of women and with violence. A psychological research theory, the catharsis model, assumes that pornography and other sexually explicit materials provide a "safety valve" in a sexually repressive society. This model views pornography and other sexually explicit materials as "not so good, perhaps disgusting, but still useful" in diverting tensions that otherwise might trigger aggressive antisocial behavior. A different hypothesis suggests an imitation model in which sexually explicit books, pictures, and movies provide powerful role models that can, by conditioning and scripting, promote antisocial, sexually aggressive behavior. A third model of pornography addresses the personal and societal uses of pornography in different cultures, as a product designed as an alternative source of sexual arousal gratification and a way of enhancing masturbation. There are also models of pornography based on communication, Marxist, psychoanalytic, feminist, and religious theories (Francoeur 1991, 637).

Commission Studies

A 1970 White House Commission funded research by experts in the field and concluded that neither hardcore nor softcore pornography leads to antisocial behavior and recommended that all obscenity laws except those protecting minors be abolished. The majority of the commission concluded that pornography provides a useful safety valve in an otherwise sexually repressive culture. President Richard Nixon refused to officially accept the commission's report.

A 1986 investigation by then-Attorney General Edwin Meese did not sponsor any new research and took a different approach in reaching its conclusion. This commission reexamined the alleged connection between pornography and child abuse, incest, and rape by inviting anyone interested in speaking to the issue. The commission was widely criticized for having a preset agenda, for appointing biased commission members, and for relying on "the totality of evidence," which gave equal weight to the testimony of fundamentalist

ministers, police officers, antipornography activists, and putative victims of pornography. This allowed the commission to conclude there is a "proven" causal connection between violent pornography and sexual assaults. This commission concluded that there is a causal connection between viewing sexually explicit materials, especially violent pornography, and the commission of rape and other sexual assaults. The commission recommended stricter penalties to regulate the pornography traffic, enactment of laws to keep hardcore pornography off home cable television and home telephone services, more vigorous prosecution of obscenity cases, and encouraged private citizens to use protests and boycotts to discourage the marketing of pornography. Among the many criticisms of the Meese Commission, Robert Staples, a black sociologist, pointed out that in the black community, pornography is a trivial issue. It is "a peculiar kind of white man's problem," because blacks see the depiction of heterosexual intercourse and nudity, not as a sexist debasement of women, but as a celebration of the equal rights of women and men to enjoy sexual stimuli and pleasure (Nobile & Nadler 1986).

Concurrent with the *Meese Commission Report*, the 1986 *Report of the U.S. Surgeon General* concluded that we still know little about the patterns of use or the power of attitudes in precipitating sexually aggressive behavior. Much research is still needed in order to demonstrate that the present knowledge of laboratory studies has significant real-world implications for predicting behavior. This report did not call for censorship, boycotts, and other tactics advocated by the Meese Commission. Rather, it recommended development of "street-based, innovative approaches" to educate the public about the different types of sexually explicit material and their possible effects.

Local Efforts at Regulation

In 1985, Andrea Dworkin, Catherine MacKinnon, and Women Against Pornography joined forces with local citizens' groups in Minneapolis, Minnesota, and Long Island, New York, to promote a new kind of pornography legislation. Using a civil rights argument, the proposed legislation stated that

Pornography is sex discrimination. [Where it exists, it poses] a substantial threat to the health, safety, peace, welfare, and equality of citizens in the community . . . Pornography is a systematic practice of exploitation and subordination based on sex that differentially harms women. The harm of pornography includes dehumanization, sexual exploitation, forced sex, forced prostitution, physical injury, and social and sexual terrorism and inferiority presented as entertainment.

The proposed legislation would have made producing, selling, or exhibiting pornography an act of sex discrimination. Women forced to participate in pornographic films, exposed by force of circumstances to view pornography in any place of employment, education, home, or public place, or assaulted by a male inspired by pornography could sue in civil court for damages based on sex discrimination. The American Civil Liberties Union (ACLU), Feminist Anti-Censorship Taskforce (FACT), and others challenged this kind of legislation. After considerable nationwide debate about civil rights, sex discrimination, and the constitutional right to free speech, these legislative efforts were abandoned.

Contemporary Aspects

The availability of sexually explicit, X-rated videocassette rentals and sales has become a major factor in American home entertainment. In the past decade, feminist softcore pornography or erotica has made its mark in the popular me-

dia by portraying women as persons who enjoy sexual pleasure as much as men. This material appears in the pages of such mainstream women's magazines as *Cosmopolitan*. It is promoted by sex boutiques, with names like Eve's Garden, Adam and Eve, and Good Vibrations, catering to women. Another growing phenomenon is a variation on the Tupperware and Mary Kay Cosmetics home parties that bring women the opportunity to examine and, of course, purchase sex toys, love lotions, and lingerie in the privacy of their homes, surrounded by other women with whom they are friends. Exotic lingerie is also available in specialty stores in major shopping malls and by mail order from Victoria's Secret and Frederick's of Hollywood. Since 1992, Feminists for Free Expression, opposed to censorship and supported by such notables as Betty Friedan, Erica Jong, and Nancy Friday, has countered the efforts of some feminists to suppress pornography with an alternative view for the feminist community.

Erotic romance novels have become an acceptable form of softcore pornography for women. Far outselling gothic novels, science fiction, self-help, and other books aimed at women, erotic romances often center around a traditional rape myth, a story in which the woman is at first unwilling, but finally yields in a sensual rapture to a man. In nonsexual characteristics, women who read erotic romantic novels are very much like women who do not. However, they appear to enjoy sex more and have a richer sexual fantasy life (Coles & Shamp 1984; Lawrence & Herold 1988).

Researchers and theorists, both feminist and nonfeminist, have almost completely ignored the existence of gay pornography. Lesbian pornography tends towards two extremes, about evenly divided in popularity, with little middle ground. Small independent presses publish softcore pornography or erotica. Erotica on audiocassettes are very popular among lesbians. On the other side is a hardcore lesbian literature with a strong SM character that makes some feminists uncomfortable. *On Our Backs*, a tabloid magazine, is the largest publication of this type. *Eidos*, another tabloid, carries numerous ads for lesbians who desire bondage and dominance or sadomasochistic relations.

Considerably more pornography designed for homosexual men is available. Most of this genre is hardcore pornography with an emphasis on leather, SM, and younger males. At the same time, gay videos have pioneered in eroticizing the condom, nonoxynol-9, and safer-sex practices.

Dial-a-porn, or telephone sex, is a multimillion-dollar-a-year business producing massive profits for telephone companies and the companies providing phone-in services. In one year, dial-in services, including dial-a-porn, earned Pacific Bell \$24.5 million and the phone-in companies \$47.2 million. Because of constitutional concerns, the Public Utilities Commission and Federal Communications Commission (FCC) do not allow telephone companies to censor telephone messages or to discriminate among dial-for-a-message 1-900 services on the basis of content. Telephone companies cannot legally deny telephone lines to adults willing to pay the bill, although at least one court has ruled that it is not unlawful discrimination for a telephone company to refuse to provide services for dial-a-porn services. The FCC does require dial-a-porn services to screen out calls by minors by supplying their customers with special access numbers or having them pay by credit card. Concerned parents may pay a one-time fee to block all phones in a residence from access to dial-a-porn.

D. Paraphilias and Unusual Sexual Practices

BRENDA LOVE

In 1990, a Los Angeles man named Jeff Vilencia formed a group called Squish Productions. Through magazine arti-

cles, television appearances, and radio interviews, Vilencia had attracted more than 300 members to his group by 1995, all of whom shared the fetish of becoming aroused by the sight of others stepping on small living things such as snails and insects.

Although the fetish shared by Vilencia and his fellow members in Squish Productions may seem—and may in fact be—novel, paraphilias are nothing new. Paraphilias and fetishes have most likely been in existence in the U.S. for as long as there have been inhabitants on the Western continents. Although while a few immigrants may have brought sexual preferences, such as autoerotic asphyxiation, sadomasochism (SM), foot fetishes, and bestiality with them, other paraphilias have unquestionably developed here. In the world of paraphilias and fetishes, there is always something new. And thanks to increased awareness of and access to information about unorthodox sexual practices and their practitioners, interest in paraphilias appears to be growing in the United States.

Definitions

“Fetish,” as defined for the American health professional by the *Diagnostic and Statistical Manual of Mental Disorders III (DSM III)*, “is the use of nonliving objects (fetishes) as a repeatedly preferred or exclusive method of achieving sexual excitement.” Such objects “tend to be articles of clothing, such as female undergarments, shoes, and boots, or, more rarely, parts of the human body, such as hair or nails” (American Psychiatric Association 1980).

The manual also states that the fetish object “is often associated with someone with whom the individual was intimately involved during childhood, most often a caretaker. . . . Usually the disorder begins by adolescence, although the fetish may have been endowed with special significance earlier, in childhood. Once established, the disorder tends to be chronic” (American Psychiatric Association 1980).

“Paraphilias,” on the other hand, are defined by *DSM III* as recurrent, fixed, compulsive, sexually motivated thoughts or actions by a personally or socially maladjusted individual that interfere with the individual’s capacity for reciprocal affection. It is important to note that a paraphilia is not merely an activity that may appear strange or disgusting to an observer; rather, the activity or compulsion must meet all of the above criteria to be considered a problem requiring therapy.

It is also important to note in the area of paraphilias that many patients mention their unusual sexual interest simply to receive validation. The therapist can do much for the mental health of a patient by mentioning a support group or club for people with the interest, or by giving the patient the clinical name for the practice, stressing that the term *paraphilia* only applies when the above *DSM III* criteria apply. This can be followed by therapy to improve the person’s self-esteem, communication, and social skills. The confession of activities involving minors or nonconsensual activities, however, of course requires immediate intervention by health professionals.

Background on Fetishes and Paraphilias in the U.S.A.

Fetishes change according to current fashions and customs. A hundred years ago, fetishists were aroused by such things as handkerchiefs, gloves, black rubber aprons, garters, corsets, enemas, seeing females wring the necks of chickens, or whipping horses. Today many of these stimuli have been replaced by pantyhose, high heels, tennis shoes, cigarettes, escalators, latex, or phone sex.

In addition, today’s technology adds to the variety of ways a fetishist can pursue his or her predilection. In the

past, one had either to create one’s own drawings, or hope to catch a glimpse of an arousing person, object, or situation. Today, the fetishist has access to television, photographs, Internet newsgroups, clubs, videos, and magazines. Membership in fetish groups has increased during the last decade. And as computer technology has decreased the cost of publishing, groups or individuals have been increasingly able to print their own sex magazines, books, and newsletters, thereby avoiding the censorship imposed by mainstream publications.

At the same time, even the more straitlaced mainstream media have helped to increase the information available about fetishes and paraphilias. Unfortunately, many national television talk shows have “cashed in” on fetishes and victims of sexual trauma by sensationalizing their lives, rather than trying to educate the public. Hollywood also sensationalizes the issue, portraying erotic asphyxia, lust murder, sadomasochism, and nipple piercing. An example of the media’s exploitation and sensationalization of unusual sex practices was the hundreds of hours of air time devoted to keeping the public informed of the status of John Wayne Bobbit, the circumstances leading to his castration at the hands of his wife, the subsequent surgical reattachment of his penis, and his appearance in an X-rated video.

Perhaps the most important development in the growth of interest in paraphilias and fetishes has been the Internet, the worldwide computer network through which up to 500,000 “lurkers” a month enter the “alt.sex” newsgroups. Users of these newsgroups, which offer uncensored forums devoted to a wide variety of sexual interests, can exchange or download photos and information, including what would normally be considered illegal in the United States, with other Internet users.

While the Internet has played an increasing role in the lives of fetishists in recent years, it would not be correct to attribute the growing popularity of fetishism and other unorthodox forms of sexuality to the Internet alone, as those in Washington who seek to censor the Internet seem to believe. The role of the Internet is more modest according to Robin Roberts, an Internet guru in California and founder of Backdrop, one of America’s oldest fantasy and bondage clubs. Established in 1965, Backdrop promoted itself with discreet ads in the *Berkeley Barb* with post office boxes or mail-drop services as the method of contact. Today, Backdrop has about 5,700 members, but Roberts does not attribute the club’s growth to exposure on the Internet.

Roberts explains that Internet lurkers rarely participate in dialog and tend not to join sex clubs. They are typically readers of *Forum* magazine or “Letters to the Editor” columns. For those users who do participate in sex online, computers provide anonymity, and a way to explore taboos in a safe, nonthreatening environment. Roberts does note, however, that for those who are active participants in computer sex, rather than just lurkers, the Internet provides 24-hour access to other users, an equal chance to express one’s opinions, and an unlimited number of fantasies. At the same time, Roberts does not feel computer sex will replace fetish clubs, because of the simple fact that electronic mail does not provide touch, intonation of the voice, nuances of speech, or visual impressions.

The Growing Popularity of Fetishes and Paraphilias

Not everyone who accesses information about paraphilias and fetishes through these new technological avenues is a fetishist. Many are among the growing number of experimenters who, even though they do not have a fetish, will join groups or purchase sex toys and SM paraphernalia.

Such experimentation seems to be on the increase; a 1994 survey conducted in two San Francisco sex boutiques indicated that approximately 55% of their customers had at least experimented with SM (Love 1994).

Ann Grogan, owner of San Francisco's Romantasy boutique, has seen an increase in such experimentation among the customers who frequent her sex-accessory establishment, one of two operating in San Francisco in 1995 geared toward women customers.

"Gender play is becoming more and more popular among customers of all ages, primarily ages 30-50 years," Grogan says. "Couples now buy matching corsets and wrist restraints." During the last five years, females in increasing numbers have shown an interest in transgender play, assuming the dominant role in the sexual relationship. Many men are also expressing an interest in anal sexuality, measured in part by the purchase of dildoes and harnesses to be used on men by the women. And a growing number of recently divorced female customers in their 50s have shown a curiosity about safe sex and pleasuring themselves.

Grogan can also testify to the increasing influence of the Internet:

The latest trend seems to be the appearance of couples who have met on the Internet. They appear together at Romantasy after only one or two meetings, because in previous communications they have gotten far beyond the awkward preliminary dialog about each other's sexual preferences and have jumped into a willingness to act out each other's fantasies. Meeting on the Internet seems to be a "fast track to intimacy." (Grogan 1995)

Ted McIlvenna, president of the Institute for the Advanced Study of Human Sexuality, expects that interest and participation in paraphilias and fetishes will continue to grow. "In the next five years," McIlvenna believes,

we will see a group of people seeking information and support groups for their sex interests which, in the past, people have considered excessive or compulsive. This is not an evil path; instead it is remedial sex education. Because of the massive number of people involved—in the U.S. the estimate is forty million people—I have labeled this the "sexual accessories movement." Mental health professionals, including sexual health professionals, must monitor and study but leave this movement alone; their sexuality belongs to them. We can expect people to buy more, join more, and experiment more, and we can only hope that out of this will emerge societal control methods that will enable people to have better and more fulfilling sex lives. (McIlvenna 1995)

Given the recent and anticipated growth of many of the fetish clubs described below, it is important to ask about what causes paraphilias. Although there has been much scientific interest in this question, science has not yet discovered the etiology of fetishes or "paraphilic lovemaps," according to John Money (1988), the leading expert on paraphilias. It does appear, however, that, as is the case with substance abuse and addiction, a small percentage of the population seems more predisposed toward the development of paraphilias, often because of childhood trauma. Money says,

The retrospective biographies of adolescent and adult paraphiles point to the years of childhood sexual rehearsal play as the vulnerable developmental period. . . . The harsh truth is that as a society we do not want our children to be lustfully normal. If they are timorous enough to be discovered engaging their lust in normal sexual rehearsal

play or in masturbation, they become, in countless numbers, the victims of humiliation and abusive violence. (Money 1988)

Money has explained how these early traumas can lead to paraphilias:

They [adults who subject sexually curious children to abuse] do not know that what they destroy, or vandalize, is the incorporation of lust into the normal development of the lovemap. The expression of lust is diverted or de-toured from its normal route. Thus, to illustrate: those adults who humiliate and punish a small boy for strutting around with an erected penis, boasting to the girls who watch him, do not know that they are thereby exposing the boy to risk of developing a lovemap of paraphilic exhibitionism. (Money 1988)

Fetish and Paraphilia Clubs

The United States is probably home to more fetish clubs than any other country. As Brenda Love (1992) wrote in *The Encyclopedia of Unusual Sex Practices*, which catalogs over 700 sexual practices,

international advertising is fairly inexpensive and computerized printing of newsletters has made it simpler to form clubs. People with fetishes as obscure as large penises, big balls, hairy bodies, mud wrestlers, shaving, cigars, used condoms, genital modification, and throwing pies have been able to find others with similar interests willing to form clubs.

Sadomasochist (SM) clubs are probably the most prevalent type of fetish clubs in the U.S.A. today, although very few of the members could be defined as having a true SM fetish or paraphilia.

SM has become an umbrella term for many sexual activities, and because of its accouterments and role-playing, people wanting to experiment with or improve their sexuality join these groups. "It was only in the late fifteenth century that the first unambiguous case report of SM was reported, and then as a medical curiosity rather than a problem" (H. Ellis 1936a). William Simon has eloquently described the allure of SM:

The sadomasochistic script plays upon the potential absolutism of hierarchy, not merely to experience hierarchy with the relief accompanying the elimination of its ambiguities but to experience the dangerous emotions that invariably accompany acknowledgment of its exercise, the rage and fear of rage in both the other and ourselves. (Simon 1994)

Charles Moser (1988) estimates that approximately 10% of the adult population are SM practitioners. This estimate is based on Kinsey's report that approximately 50% reported some erotic response to being bitten (Kinsey 1953). However, there is no direct empirical evidence verifying this estimate. Moser divides SM behaviors

into two types, physical and psychological. . . . Physical behaviors may be further subdivided into the following categories: bondage, physical discipline, intense stimulation, sensory deprivation, and body alteration. . . . Psychological pain is induced by feelings of humiliation, degradation, uncertainty, apprehension, powerlessness, anxiety, and fear. . . . Both physical and psychological behaviors are devised to emphasize the transfer of power from the submissive to the dominant partner. SM practitioners often report it is this consensual exchange of power that is erotic to them and the pain is just a method of achieving this power exchange. (Moser 1988)

Moser lists the common types of clinical problems presented by SM practitioners to their therapists as: "1) Am I normal? 2) Can you make these desires go away? 3) SM is destroying our relationship; 4) I cannot lead this double life anymore; 5) I cannot find a partner; and 6) Is it violence or SM?" (Moser 1988). All but the last question are also the concern of most fetishists.

Foot-fetish club members have a more focused interest than do SM practitioners. Weinberg et al. (1994) conducted a survey of 262 members of a gay foot-fetishist group called the Foot Fraternity that had approximately 1,000 members in 1990, but had grown to over 4,000 by 1995. These sexologists also compared the ratio of self-masturbation during sexual encounters to that of oral-genital activity and to anal intercourse. Fetishists tended to masturbate to orgasm while engaging in foot play rather than experiencing orgasm as a result of some type of penetrative sex with a partner. Furthermore, the researchers discovered that 76% responded that they masturbated themselves to orgasm frequently, whereas 48.1% performed oral-genital activity, and only 9.55% performed anal intercourse.

Weinberg et al. (1994) reported that their research highlighted the psychological importance a support group or club has for fetishists.

Despite the lack of a widespread fetish subculture, the Foot Fraternity itself can be considered an embryonic subculture. Almost 70 percent of the respondents said membership in the Foot Fraternity allowed them to pursue their fetish interests more easily. Some 66 percent said membership increased their interest in feet and footwear, and over 40 percent said that they learned new ways of expressing their sexuality. Thus, the organization helped to sustain, as well as expand, its members' unconventional sexual interest. Almost 70 percent said the Foot Fraternity got them to correspond with others with similar interests, 50 percent that it got them to meet others with similar interests, and 40 percent that this led them to engage in foot play with another member. Finally, over 40 percent said that membership in the Foot Fraternity helped remove confusion about their interest in feet and footwear and almost 60 percent that it increased their self-acceptance. (Weinberg et al. 1994)

These statistics regarding benefits of membership can most likely be applied to other sexual interest groups as well.

Doug Gaines, founder of this Cleveland-based club, estimates that 15% of the U.S. population has a foot or related fetish, an opinion based on the fact that he has received 80,000 requests for club information. He promotes the group in magazines, radio interviews, and a foot-fetish Internet newsgroup.

Interestingly, Gaines seconded the findings of researchers on the genesis of fetishes by identifying childhood experiences, such as being tickled, riding on the foot of a parent ("playing horsey"), or seeing a parent's foot immediately prior to being picked up and nurtured, as predominant memories of most of his members. The Foot Fraternity offers a newsletter, glossy magazine, and videos of men modeling their feet. The selection of photos is determined by a detailed membership questionnaire which asks what type of shoe, sock, or foot the new member finds erotic.

The activities in which foot enthusiasts participate include masturbation while looking at photos of feet, slipping off a partner's shoes in order to smell the stockings and foot, or placing oneself underneath the foot in a submissive posture. The foot is massaged and licked completely (toes, between toes, bottom, etc.). SM dominance and submission scenes, for example, where a partner takes on the role of a policeman and the fetishist must kiss his boot to get out of being given a traffic ticket, are popular.

Another common scene consists of acting out the roles of principal and student. Foot fetishists rarely use pain in their dominance/submission; rather, these scenes simply serve as an excuse for foot worship. A few foot fetishists attend auctions where they are able to purchase shoes once belonging to their favorite sports figures or movie stars hoping that the "scent" of the person remains in the shoe.

Squish Productions, mentioned earlier, can also be viewed as a foot-fetish club. Unlike the Foot Fraternity, Squish has yet to be the subject of any in-depth survey by sexologists. Even so, the genesis of the Squish fetish appears to be similar to that found in other fetishes, as evidenced by Squish founder Jeff Vilencia's recollections of his childhood. Identifying what he considers to be his childhood trigger point in the development of his fetish, Vilencia recalled that, as the younger of two children, he was the "victim" of an older sister who enjoyed kicking and stepping on him. Upon reaching puberty, he discovered feeling aroused when seeing females step on bugs. The bug apparently only serves as a projection of himself, because his fantasy involves taking the bug's place under the woman's foot.

Cross-dressing and other forms of transgender activity are found in many countries. The new *DSM IV* no longer lists this activity as a paraphilia, but rather as "gender dysphoria." Clubs such as ETVC in San Francisco have an extensive library for members, social outings, support-group hotline, newsletter, makeup classes, and lingerie modeling. Membership in ETVC increased from 329 in 1988 to a total of 433 in 1995.

Another group, Texas Tea Party, sponsors an annual party that, after eight years of existence, drew about 400 people in 1995. Estimates on the percentage of the population who have ever cross-dressed range from 1.5 to 10%. Groups attract new members with newspaper and magazine advertisements, appearances on television and radio, magazine articles on the subject, and by staffing a booth at the annual San Francisco Lesbian and Gay Freedom Day Parade and Celebration.

A recent survey of 942 transgenderists by Linda and Cynthia Phillips indicates that most members experienced cross-dressing in puberty, although one member did not begin cross-dressing until the age of 72. The average transgenderist did not seek out a transgender club until his early 40s. Sexual arousal while cross-dressing is also more common during adolescence, and appears to diminish as the boy grows older. Therefore, an adult male transgenderist dresses to feel "feminine," whereas an underwear fetishist uses the lingerie for sexual arousal. (Females who cross-dress do not tend to experience arousal while cross-dressing) (Phillips 1994).

No one knows how many cross-dressers or clubs exist in the U.S., but it is known that many people purchase special-interest cross-dressing magazines. One of these, *Tapestry*, had a 1995 quarterly distribution of 10,000 issues compared to 2,000 five years earlier. And a fairly new magazine, *Transformation*, had an international distribution of 50,000 in 1995.

Infantilism is fairly unique to the U.S. and growing in popularity. Its practitioners take on the persona of infants or young children. They may wear diapers under their business suits, drink from a baby bottle, use an assortment of toys and baby furniture, and, if they have a partner, they may participate by reading bedtime stories, diapering, spanking, or using other forms of affection or punishment.

One practitioner, who asked to be identified only as Tommy, is the founder of Diaper Pail Friends. Inside his home in a prestigious San Francisco suburb, a visitor will

find an adult-sized high chair, bibs, and numerous baby bottles in the kitchen. Downstairs, Tommy's bedroom features a large crib with a view of the Bay area, a collection of adult-sized baby clothes, and a trail of toys leading to a train set that fills the center of an adjacent room.

Diaper Pail Friends is about 15 years old, and grew from about 1,000 members in 1990 to more than 3,000 in 1995. Most of the members discovered the group through articles in magazines or books, television talk shows, or an Internet newsgroup. The club publishes a newsletter, short stories, videos, and distributes adult-sized baby paraphernalia.

A group of sexologists conducted an extensive survey of the Diaper Pail Friends, but had not yet published their findings as of 1995. Tommy, however, concluded from an informal survey of the group's members that

Even a casual review of infantilists in the DPF Rosters show that there are tremendous differences between one infantilist and another. In fact, there would seem to be as many personal, individual variations as there are people. Nevertheless, certain patterns do seem to become evident, patterns that seem to encompass a very large percentage of the environmental and inborn factors that are involved with the creation of Infantilism in human personality. These patterns are [in order of prevalence] (1) deficient early nurturing, (2) rejection of Softness, (3) childhood sexual abuse [primarily in female members], and (4) bed wetting. Every infantilist probably has one or more of these patterns in their history, and each infantilist combines them in varying degrees. The variations are limitless. (Tommy 1992)

A Chicago-based national acrotomophile club (people aroused by seeing amputees) has a membership of about 300. They sponsor an annual conference during the first week of June and have spawned local chapters that also hold meetings. Quarterly pamphlets are sent to members and a couple of Internet newsgroups exist. New membership is not aggressively recruited, but the number of self-identified acrotomophiles has increased since the 1989 publication of Grant Riddle's book, *Amputees and Devotees*, which examines the psychological basis of this phenomenon.

According to Riddle, many "devotees" are aware of this preference as a child, but there seems to be a wide variety of reasons for its development. One of these is being overly criticized by parents and wishing to be like a handicapped neighbor, assuming this would relieve some of the pressure. Another cause is being taught that sex is dirty, and from there, having to rationalize that if one cares for someone handicapped, one can justifiably ask for sex in return. Activities of acrotomophiles include having a healthy partner pretend to limp or use crutches; most acrotomophiles, however, content themselves with viewing photos (mostly of clothed females) or possibly catching a glimpse of an amputee on the street (Riddle 1989).

Autoerotic asphyxia (self-strangulation) seems originally to have been carried to Europe by French Foreign Legionnaires returning from war in Indochina (Michalidimitrakis 1986). Erotic asphyxia involves using a pillow, gag, gas mask, latex or leather hood, plastic bag, or other object to block oxygen intake. It may also involve strangulation by a partner's hands, or with a scarf or Velcro blood-pressure cuff. Corseting of the waist is another less obvious method of impeding oxygen intake.

This practice takes the lives of an estimated 250 to 1,000 Americans each year. It is believed that many more people experiment with asphyxia safely alone and/or with a partner, but because this act carries great legal liability if things go wrong, it is impossible to estimate the number of people

who engage in it. During the early 1990s, a Seattle man made an effort, through workshops and lectures, to teach safety techniques to practitioners. Although he found many interested parties, he had to limit his public appearances and advice because of legal concerns.

Although there is little information available about the asphyxiphile's childhood, John Money has described one case in his book, *Breathless Orgasm*. This subject recalled first becoming interested in asphyxia when his childhood sweetheart drowned. He began by thinking of her drowning experience and soon discovered he was becoming aroused by visualizing her nude body under water and thinking about her suffocating (Money et al. 1991).

Another asphyxiphile, who related his experience to the audience at a San Francisco lecture on the subject, described being raised as a Jehovah's Witness and taught that masturbation was a sin. This did not deter him from engaging in masturbation, but rather made it much more exciting, because he felt he could be "struck by lightning." After giving up his religious practice in his late teens, he immediately discovered that masturbation lost its intensity. He then found that by putting himself in a life-or-death situation, i.e., asphyxia, he could recover this lost intensity.

Most data on asphyxiphiles have been collected from the death scene of the victims. Ray Blanchard and Stephen J. Hucker have collected a vast data bank of coroner's reports and other materials on the subject. In their study of 117 incidents, they discovered that older men

were more likely to have been simultaneously engaged in bondage or transvestitism, suggesting elaboration of the masturbatory ritual over time. The greatest degree of transvestitism was associated with intermediate rather than high levels of bondage, suggesting that response competition from bondage may limit asphyxiators' involvement in a third paraphilia like transvestitism. (Blanchard et al. 1991).

Sexual asphyxia is rarely depicted in print media, but has been shown in a few films, such as the 1993 movie, *The Rising Sun*, and also in the 1976 French-Japanese movie, *In the Realm of the Senses*.

Chubby Chasers, a San Francisco club of men attracted to the obese, almost doubled in membership between 1990 and 1995 and grew to include 50 different international groups. This club was involved on the Internet early and recruited many of its members there. This club also staffs a booth at the annual San Francisco Lesbian and Gay Freedom Day Parade. Membership in the organization includes a newsletter and invitation to many social activities. Many, but not all, "chasers" had a parent or close relative who was very obese, and recall having a preference for "chubbies" when they were as young as 4 or 5. For those with this interest, there are full-color commercial magazines depicting obese nude females, sometimes with a slender male partner, available in adult book stores.

There are a number of food fetishists or "piesexuals," a word coined by a well-known pie enthusiast, Mike Brown, who began his affair with pies at age 13. Mr. Brown produces pie videos and also hosts annual "bring your own pie" throwing parties, where couples undress and hit each other with pies. There is an Internet newsgroup and also several clubs catering to this interest. *Splosh* magazine, although not sexual, features attractive females smeared with an assortment of food and mud, another messy fetish.

Other more obscure fetish/paraphilia organizations include WES (We Enjoy Shaving) of Reno, Nevada; the Wisconsin STEAM journal for agoraphiles, who enjoy engaging in sex in public; and Hot Ash, a New York club for peo-

ple aroused by partners who smoke. Hot Ash publishes a newsletter and sells videos for those with this interest.

New York is also the home of a vampire sex club whose members make small cuts on others and rub or lick the blood off. Blood sports are also common among some SM practitioners in the forms of caning, cutting, or piercing. San Francisco had coprophilia (feces) and urophilia (urine) clubs before the AIDS epidemic. Some of the newest groups include Fire Play, whose members drip hot wax on their partners, rub lit cigarettes on their bodies, and/or use chemical irritants. Some with this interest rub a small part of the body with diluted alcohol and ignite it.

In another new paraphilic activity, some men catch bees and use them to sting the penis. The venom not only doubles the size of the penis for a few days, but also seems to bring about a change in the neural system that enhances the arousal stage.

The foregoing are but a few of the many unorthodox sexual practices now being pursued in the United States. Many more exist, and new ones are being invented all the time. And thanks to technology, including the Internet, advances in the quality and availability of home-based desktop publishing, and the rise of sensationalist television talk shows, interest and participation in these activities is on the increase.

In the coming years, the continuing growth of fetish/paraphilia sex groups will require therapists to learn to make clear determinations among people who experiment with various activities, those who self-report to have a fetish but five years later become bored with it, and the few clinically defined paraphiles who truly need some type of intervention or treatment.

9. Contraception, Abortion, and Population Planning

PATRICIA BARTHALOW KOCH

[*Comment 1997*: In the final sections of this review of sexuality in American culture, we consider several areas which are concerned with health and/or technology. The areas of contraception, abortion, and sexually transmitted disease each have rather obvious health implications, but each is also influenced by growing medical technology and illustrates a relationship between sexual conduct and technological advances. We would note that the question of effective social policy in each of these areas remains a matter of considerable social conflict within the U.S.A. The identification and treatment of sexual "dysfunctions" reflect these same concerns. In fact, the growing recognition that various sexual conditions can be diagnosed and treated, and the growing public acceptance of the legitimacy of such treatment, may be one of the more profound, if subtle, changes in American sexuality in the last century. In no small way, this process has served to fuel the growth of an array of sexual professions, with a corresponding need to provide graduate education for such professionals and the emergence of professional organizations. We provide a brief review of each of these professional developments. Finally, we close with a series of reviews on American popular culture, each enabled to some degree by technological developments, which both reflect and influence sexual information and communication about American sexuality. Some mention of this was already made earlier in the section on fetishes and paraphilias (see Section 8D, Significant Unconventional Sexual Behaviors). As always seems to be the case with sexual issues within the U.S.A., they all have generated a fair amount of political activity and social conflict. (*End of comment by D. L. Weis*)

A. Contraception

PATRICIA BARTHALOW KOCH

A Brief History

"The struggle for reproductive self-determination is one of the oldest projects of humanity; one of our earliest collective attempts to alter the biological limits of our existence" (Gordon 1976, 403). Throughout U.S. history, as elsewhere, many have been desperate to learn safe and effective ways to prevent conception and induce abortion, while others have believed artificial contraception is unacceptable because it interferes with the course of nature.

Brodie (1994) conducted a historical analysis of efforts for reproductive control in colonial and 19th-century America. New England fertility rates in colonial times were higher than those in most of Europe. Colonists had little real ability, and perhaps little will, to intervene in their reproduction. It has been estimated that one third of the brides of this time were pregnant. Although the Puritans viewed marriage with children as the highest form of life, the prevalence of premarital pregnancy was not viewed as a threat to this value, because virtually all such pregnancies led to marriage (Reiss 1980).

On the other hand, Native Americans seemed to possess knowledge and cultural practices—breastfeeding, periodic abstinence, abortion, and infanticide—specific to their particular tribes, enabling them to maintain small families. Fertility among the African and Caribbean women brought as slaves varied widely, depending on the region of the United States—in some places, fecundity reaching human capacity and in other places, fertility rates decreasing. According to Brodie (1994, 53): "Fecundity assured slave women that they were valuable to the master and offered some hope against being sold. Yet preventing the birth of new slaves for the master could be a form of resistance to slavery."

The three most common forms of birth control during this time were coitus interruptus (withdrawal), breastfeeding, and abortion. The effectiveness of breastfeeding in preventing another pregnancy depended on how long the woman breastfed, on when her menstruation resumed after childbirth, and on how long and how often the infant suckled. However, by the 19th century, the option of bottle-feeding infants was becoming more available and popular.

Abortion methods included violent exercises, uterine insertions, and the use of drugs. These methods may have been no more dangerous than the pregnancy and childbirth complications of the time, but it has been suggested that these methods were also a common cause of death for women. American folk medicine was evolving from the knowledge and indigenous practices of the Native Americans, European settlers, and African/Caribbean slaves. Many abortifacients were made from plants, such as pennyroyal, tansy, aloe, cohosh, and squaw root. Such "remedies" were often passed down through family Bibles and cookbooks. Over 1,500 medical almanacs, many containing herbal remedies to "bring on a woman's courses," were circulated before the American Revolution. Yet there was little public discussion of birth control and no laws or statutes governing information or practice.

Brodie documents that reproductive control during most of the 19th century in America was neither rare nor taboo. Information was available about withdrawal, douching (the "water cure"), rhythm (although the information was not very accurate), condoms, spermicides, abortion-inducing drugs, and early varieties of the diaphragm. When other contraceptive options were available, couples seemed to prefer them over withdrawal; sexual abstinence was not one of the chief means of controlling birthrates. Abortion was not illegal until "quickening" (movement of the fetus).

Beginning in the 1830s, reproductive control became a commercial enterprise in the expanding American market economy. Douches and syringes, vaginal sponges, condoms, diaphragms (or "womb veils"), cervical caps, and pessaries (intra vaginal and intrauterine devices) began to be widely advertised through a burgeoning literature on the subjects of sexuality and reproductive control, euphemistically called "feminine hygiene." Education through this means was made possible by the technological improvements in printing and the increased basic literacy of the American public.

The self-help literature instructed readers on how to make contraceptive and abortion agents at home from products readily available in the household or garden. Douching was the most frequent method for reproductive control used by middle- and upper-class women. The invention of the vulcanization process for rubber by Goodyear in the 1840s enabled condoms to be made more cheaply. In addition, the appearance of the mail-order catalog allowed the public to "shop" for contraceptive devices confidentially.

The birthrate of white native-born married women was reduced almost by half between 1800 and 1900, coinciding with the major social upheaval of industrialization and urbanization. Many American couples wanted fewer children and greater spacing between them. This became possible with the evolving availability of information about and access to more-effective contraceptive techniques.

By the mid-1800s, the abortion rate among the white middle class increased sharply with greater access to diverse sources of information about abortion, abortion drugs and instruments, and persons offering abortion services. There was little outcry about abortion being "immoral" until the American Medical Association launched a campaign to curb it at mid century. Historians have debated whether the new opposition to abortion by male physicians was more because of the threat of competition from female midwives or to a concern about the dangers of unsafe abortion.

As reproductive control became commercialized after 1850, and as some women became increasingly able to assert a degree of independent control over their fertility through contraception and abortion, the deep ambivalences with which many Americans regarded such changes came increasingly into play. In the second half of the 19th century, diverse groups emerged to try to restore

American "social purity," and one of the issues they focused on was restricting sexual freedom and control of reproduction. . . . All branches of government were their allies; their goals were won through enactments of federal and state legislation and sustained by judicial decisions that criminalized contraception and abortion, both of which had in earlier decades been legal. (Brodie 1994, 253)

Laws began to alter 200 years of American custom and public policy towards contraception and abortion. Federal and state laws made it a felony to mail products or information about contraception and abortion. Such materials were then labeled "obscene." In 1873, Congress passed "The Act for the Suppression of Trade in, and Circulation of Obscene Literature and Articles of Immoral Use," which tightened the loopholes on interstate trade and importation of birth-control materials from abroad. This law was better known as the Comstock Law, named after Anthony Comstock, a leading "social purity" proponent and crusader against "obscenity." Comstock was even appointed a special agent of the U.S. Post Office and allowed to inspect and seize such "illegal" material until his death in 1915.

The combined force of the social purity legions and of overwhelming public acquiescence overrode a generation

of commercialization and growing public discourse and drove reproductive control, if not totally back underground, at least into a netherworld of back-fence gossip and back-alley abortion. (Brodie 1994, 288)

The Comstock Law would stand until a federal appeals court would overturn its anticontraceptive provisions in 1936 (*United States v. One Package*) on the grounds that the weight of authority of the medical world concerning the safety and reliability of contraception was not available when the law was originally passed. (The anti-obscenity provisions of the Comstock Law remained intact for several more decades.)

What is referred to as "the birth-control movement" was begun in the United States shortly before World War I, primarily by socialists and sexual liberals as both a political and moral issue. Margaret Sanger's leadership, in the early 1900s, was responsible for gaining support from mainstream America and centralizing the cause through her American Birth Control League. Sanger attributed her indomitable dedication to making birth-control information and methods available to American women, particularly of the working class, to her nursing experiences with poor women during which they would beg her to tell them the "secrets" of the rich for limiting children.

In 1915, she began publishing *Woman Rebel*, a monthly magazine advocating birth control. She was indicted for violating the Comstock Law, but the case was dropped and she continued dispensing birth-control information through lectures and publications. In 1916, she was arrested again for opening the first birth-control clinic in the United States in a poor slum in Brooklyn, New York. She served 30 days in jail; however, the testimonials of her poor birth-control clients at the trial helped to fuel the birth-control movement.

Gordon (1976) documents the birth-control movement throughout the 20th century in the United States. In the early 1920s, most doctors were opposed to contraception. However, through the efforts of Margaret Sanger and Dr. Robert Latou Dickenson, contraception was scientifically studied and became accepted as a health issue, not simply a moral one. Clergy, particularly of the Protestant and Jewish faiths, also began to view contraceptive choice as an individual moral decision when it affected the health of a family. To this day, however, the Catholic Church has remained staunch in its opposition to "artificial birth control." Yet, this opposition has not deterred Catholic women in the United States from using birth-control methods as frequently as women of other or no faiths.

The Great Depression of the 1930s forced many more Americans into accepting and practicing birth-control measures. Social workers, based on their interactions with many poor and struggling families, became proponents in support of better education about, and access to, birth control for all women, not just the middle class and wealthy. The manufacturing of condoms became a large industry. In the 1930s, with the formation of the American Birth Control League, over 300 clinics throughout the United States were providing contraceptive information and services; this increased to more than 800 clinics by 1942.

Yet, despite the fact that a 1937 poll indicated that 79% of American women supported the use of birth control, those who did not have access to private doctors were limited in their access to birth-control information and devices. However, judges, doctors, government officials, entrepreneurs, and others were beginning to respond to grassroots pressure. For example, in 1927, the American Medical Association officially recognized birth control as part of medical practice. In 1942, Planned Parenthood Federation of America

(PPFA) was founded with a commitment to helping women better plan family size and child spacing. PPFA was greatly responsible for making birth control more accessible to women of various backgrounds, particularly those of lower socioeconomic levels, throughout the United States.

Development of the Oral Contraceptive Pill and IUD

During the 1950s, research was progressing in the United States that would transform contraceptive technology and practice worldwide. Asbell (1995) details the biography of the “drug that changed the world.” The quest for a female contraceptive that could be “swallowed like an aspirin” began when Margaret Sanger and Katherine McCormick, a wealthy American woman dedicated to the birth-control movement, enlisted Gregory Pincus, an accomplished reproductive scientist, to develop a contraceptive pill. Applying the basic research findings of others, particularly Russel Marker, who produced a chemical imitation of progesterone from the roots of Mexican yam trees, Pincus developed just such a pill combining synthetic estrogen and progesterone.

With the help of John Rock, a noted Harvard gynecologist and researcher, the oral contraceptive was initially given to 50 Massachusetts volunteers, and then field tested with approximately 200 women in Puerto Rico in 1956, where it was believed opposition to such a drug would be less than in the United States. However, the pill was heartily condemned by the Catholic Church, leaving Puerto Rican women to face the dilemma of choosing to be in the trials (and committing a mortal sin) or bearing more children that they could not adequately support. In addition, the standards for informed consent for research subjects were not as strict as they are today, so that participants in these trials were not thoroughly informed as to the experimental procedures being used and the potential risks involved (which were generally unknown).

In 1957, the pill was first approved by the Food and Drug Administration (FDA) for treatment of menstrual disorders. At this time, it was observed that many women who had never before experienced menstrual disorders suddenly developed this problem and sought treatment with the pill. By 1960, the pill was formally approved by the FDA as a contraceptive following double-blind clinical trials with 897 Puerto Rican women. Such a procedure would well be considered ethically questionable today.

The pill was extremely attractive to many potential users because of its convenience and efficacy. Women now had the option of engaging in intercourse with minimal threat of pregnancy. This method separated the act of coitus from the action taken to restrict fertility (ingestion of the pill). In addition, the woman was in sole charge of this method of birth control and did not need any cooperation from her male partner. Many believed this innovation in birth control was responsible for a “sexual revolution” in which women were to become more “sexually active,” displaying patterns of sexual attitudes and behaviors more like men, although there is little scientific evidence to support this claim. As Ira Reiss explained the evolutionary changes taking place in American sexual expression:

Sexual standards and behavior seem more closely related to social structure and cultural and religious values than to the availability of contraceptive techniques . . . [increased premarital sexuality] was promoted by a courtship system that had been evolving for a hundred years in the United States permitting young people to choose their own marriage partners, and which therefore encouraged choice of when as well as with whom to share sex. (Asbell 1995, 201)

By 1967, the Population Council estimated that 6.5 million women were using the birth-control pill in the U.S., while 6.3 million women were using it in other parts of the world. Some were concerned as to whether millions of women were serving as guinea pigs in a massive experiment, since careful large-scale studies of its safety had not been conducted before it was marketed (Seaman 1969). Disturbing side effects, including deep-vein thrombosis, heart disease and attacks, elevated blood pressure, strokes, gallbladder disease, liver tumors, and depression, were being reported. In the first few years of use in the U.S., more than 100 court claims were filed against its manufacturer. Some countries, including Norway and the Soviet Union, banned the pill. Some American women mobilized to create a women’s health movement, spearheaded by the National Women’s Health Network, to help the public become better informed about the benefits and risks of pill use, as well as other medical procedures and drugs. Yet, accurate information about the benefits and risks of pill use was often unavailable, difficult to access, and distorted and sensationalized. In the 1970s, pill sales dropped 20%.

Twenty-five years later, oral contraception has become one of the most extensively studied medications ever prescribed. Today, pills with less than 50 micrograms of estrogen are associated with a significantly lower risk of serious negative effects and are as effective in preventing pregnancy as the higher-dose pills of the past (Hatcher et al. 1994).

The intrauterine device (IUD) also became popular in the United States as the “perfect” alternative to the pill because of its effectiveness and convenience. However, the Dalkon Shield, which was marketed from 1971 to 1975, was implicated in a number of cases of pelvic inflammatory disease and spontaneous septic abortions resulting in the deaths of at least 20 women. In 1974, the Shield was taken off the U.S. market, although it was still distributed abroad. Currently, there are only two IUDs for sale in the United States, the TCu-380A (ParaGard) and the Progesterone T device (Progestasert).

Government Policy and Legal Issues

While research was expanding birth-control options, the 1950s and 1960s saw the development and implementation of federal policies supporting population control programs designed to deal with overpopulation throughout the world. Birth control was offered as a “tool” for economic development to Third World countries. The 1960 budget of \$2 million for family-planning programs grew to \$250 million in 1972 (Asbell 1995). However, American goals were often in conflict with the cultural beliefs of the people in various countries. Reproductive options cannot be separated from the economic options and social mores of a culture.

Governmental policies on birth control were also changing at home. In 1964, President Lyndon B. Johnson, over strong political opposition, provided federal funds to support birth-control clinics for the American poor. These efforts were continued by President Richard M. Nixon, who in 1970 declared “a new national goal: adequate family-planning services within the next five years for all those who want them but cannot afford them” (Asbell 1995).

Important legal changes were also occurring in the U.S. during this time. In 1965, the Supreme Court decided, in *Griswold v. Connecticut*, that laws prohibiting the sale of contraceptives to married couples violated a constitutional “right of privacy.” Writing the majority opinion, Justice William O. Douglas declared:

we deal with a right of privacy older than the Bill of Rights—older than our political parties, older than our

school system. Marriage is a coming together for better or worse, hopefully enduring and intimate to the degree of being sacred. (Asbell 1995, 241)

The court asked, "Would we allow the police to search the sacred precincts of marital bedrooms for telltale signs of the use of contraceptives?" The judges responded, "The very idea is repulsive to the notions of privacy surrounding the marital relationship."

In 1972, the Supreme Court extended this "right to privacy" for contraceptive use to unmarried people (*Eisenstadt v. Baird*) on the basis that a legal prohibition would violate the equal protection clause of the 14th Amendment. A 1977 Supreme Court decision (*Carey v. Population Services*) struck down laws prohibiting the sale of contraception to minors, the selling of contraception by others besides pharmacists, and advertisements for or displays of contraceptives.

Recent Developments in Birth Control

More-recent developments in contraceptive technology receive tougher scrutiny than in the past before winning FDA approval. For example, Norplant was developed by the international nonprofit Population Council, which began clinical trials including half a million women in 46 countries, not including the U.S.

However, Norplant was not approved for use in the United States by the Food and Drug Administration (FDA) until 1990. This approval was opposed by the National Women's Health Network because the long-term safety of Norplant had not been established. Wyeth-Ayerst, the U.S. distributor, is required by law to report any unusual events associated with Norplant use to the FDA, while an internationally coordinated surveillance of Norplant use and its effects is being conducted by the World Health Organization and others in eight developing countries. Currently, a class-action suit is being formulated by a group of Norplant users in the U.S., primarily because of the difficulties they experienced in having the Norplant rods removed. Such complications are a serious impediment keeping American pharmaceutical companies from researching and developing new contraceptives.

Depo-Provera (Depo-medroxyprogesterone acetate or DMPA) is the most commonly employed injectable progestin used in over 90 countries worldwide. However, it was not approved for use in the U.S. by the FDA until 1992. Women's health activists, organized by the National Women's Health Network, had opposed its approval in the absence of more long-term studies of its safety.

In 1993, the FDA approved the first female condom, called Reality, for over-the-counter sale in the United States. The female condom, or vaginal pouch, is a polyurethane lubricated sheath that lines the vagina and partially covers the perineum. Although the method failure rate of the female condom (5%) is similar to that of the male condom (3%), it has a higher failure rate with typical use (21%) than does the male condom (12%) (Hatcher et al. 1994). This may reflect the "newness" of this female method and inexperience with its use. Yet, in a study of 360 women using female condoms, only 2 discontinued its use.

Although a combination of RU-486 (mifepristone) and prostaglandin has been tested in over a dozen countries, particularly in France, it has generated controversy in the U.S. and was only approved for use here in 1996. Because RU-486, when combined with a prostaglandin, is an effective early abortifacient, its use has been opposed by anti-abortion proponents, even for research purposes or its potential use in the treatment of breast cancer, Cushing's syndrome, endometriosis, and brain tumors. Because it was so politically controversial, RU-486 had not been expected to be ap-

proved for any use in the United States, which turned out not to be the case.

What is the future for the development of new birth-control methods in the United States? Contraceptive-vaccine researchers acknowledge that a new form of birth control for men is badly needed. Yet, it is believed that immunizing men against their own sperm would risk destroying the testes. However, researchers in the U.S. are talking with the FDA to test a vaccine with women that induces the woman's immune system to attack sperm. Previously, such vaccines have been tested on mice, rabbits, and baboons with an effectiveness rate of 75 to 80%.

In the past, Federal agencies have shied away from supporting such work because "right-to-lifer" advocates view such a vaccine as abortive and, therefore, unacceptable. In addition to the possibility of medical liability, American pharmaceutical companies are unlikely to market such a vaccine because of the protests and boycotts that "right-to-life" groups threaten to organize. Because of the threat of boycotts from adversarial groups and lawsuits from persons claiming to be harmed by new contraceptive technologies, only one American company remains active in contraceptive research and development. In the late 1960s, nine American drug companies were competing to find new and better birth-control methods.

Current Contraceptive Behavior

Between 1988 and 1990, the proportion of women in the United States, from the age of 15 to 44, who had never had vaginal-penile intercourse declined from 12% to 9%. (Data used in this section are based on the 1982 and 1988 *National Survey of Family Growth (NSFG)* and the 1990 *NSFG Telephone Reinterview*) (Peterson 1995). The proportion of 15- to 44-year-olds who were at risk for unintended pregnancy but were not contracepting increased from 7% to 12%. This increase was most pronounced among 15- to 44-year-olds (8% to 22%), never-married women (11% to 20%), and non-Hispanic white women (5% to 11%).

In 1990, 34.5 million women, or 59% of those aged 15 to 44, in the United States were using some type of contraception—with almost three quarters (70.7%) of married women using contraception; see Table 17. There is little difference in contraceptive use based on religious background between Catholic, Protestant, and Jewish women. The leading methods used by contraceptors were female sterilization (29.5%), the contraceptive pill (28.5%), and the male condom (17.7%). (Information on the use of three newer methods—Norplant, the female condom, and Depo-Provera—was not available at the time of the surveys). Overall, the use of female and male sterilization, the condom, and periodic abstinence had increased from 1988, whereas the use of the pill, IUD, and diaphragm had decreased.

Female sterilization is most widely used among older and less-educated women who have completed their childbearing, with over one half (52.0%) of female contraceptors age 40 to 44 having been sterilized. Anglo-American women are much more likely to have male partners with a vasectomy (15.5%) than are African-American women (1.3%). The aging of the baby-boom generation in the United States portends a continued rise in female sterilization rates throughout the next decade and a rise in vasectomies among the better educated.

The increased use of the condom was most pronounced among young (aged 15 to 44), African-American, never-married, childless, or less-educated women, and those living below the poverty level. For example, condom use among never-married women tripled between 1982 and 1990 (4% to 13%). The percentage of adolescents using

Table 17

Number of Women 15-44 Years of Age, Percent Using Any Method of Contraception, and Percent Distribution of Contraceptors by Method, According to Age, Race and Origin, and Marital Status, 1988 and 1990

Age, Race, and Marital Status	Number of Women Using a Method (in Thousands)	Percent Using Any Method	Female Sterilization	Male Sterilization	Pill	IUD	Diaphragm	Condom	Periodic Abstinence ¹	Other
1990²										
All women	34,516	59.3	29.5	12.6	28.5	1.4	2.8	17.7	2.7	4.8
Age										
15-19	2,623	31.5	0.0	0.0	52.0	0.0	0.0	44.0	1.0	3.0
15-17	1,165	24.3	0.0	0.0	41.1	0.0	0.0	51.9	2.2	4.7
18-19	1,458	41.2	0.0	0.0	60.7	0.0	0.0	37.6	0.0	1.7
20-24	5,065	55.3	8.0	1.8	55.4	0.8	0.6	25.3	2.8	5.3
25-29	6,385	60.0	17.4	5.0	47.3	0.4	2.3	19.0	2.7	5.9
30-34	7,344	66.2	32.7	13.0	23.9	0.9	4.7	15.9	3.5	5.4
35-39	7,138	70.6	44.2	19.8	10.6	3.3	3.3	10.3	3.4	5.2
40-44	5,962	66.9	52.0	26.5	2.2	1.8	3.8	9.2	1.6	2.9
Race and Origin										
Hispanic	2,856	52.2	33.1	6.4	31.4	1.9	1.5	17.1	3.7	5.1
White non-Hispanic	25,928	60.5	27.3	15.5	28.5	1.3	3.0	17.0	2.7	4.7
Black non-Hispanic	4,412	58.7	41.0	1.3	28.5	1.4	1.6	19.4	1.2	5.6
Marital Status										
Currently married	21,608	70.7	33.5	33.5	19.2	20.6	1.4	14.0	3.5	3.8
Divorced, separated, widowed	4,026	57.3	52.1	2.8	22.4	2.5	0.9	9.7	0.6	9.0
Never married	8,882	43.0	9.6	1.1	50.5	0.8	0.6	30.1	1.8	5.5
1988										
All women	34,912	60.3	27.5	11.7	30.7	2.0	5.7	14.6	2.3	5.4
Age										
15-19	2,950	32.1	1.5	0.2	58.8	0.0	1.0	32.8	0.8	4.8
15-17	1,076	19.9	0.0	0.0	53.3	0.0	0.7	40.4	0.9	4.7
18-19	1,874	49.6	2.4	0.4	61.9	0.0	1.2	28.4	0.8	4.9
20-24	5,550	59.0	4.6	1.8	68.2	0.3	3.7	14.5	1.7	5.2
25-29	6,967	64.5	17.0	6.0	44.5	1.3	5.5	15.6	2.4	7.6
30-34	7,437	68.0	32.5	14.0	21.5	2.9	8.9	12.0	2.7	5.5
35-39	6,726	70.2	44.9	19.7	5.2	2.7	7.7	11.8	3.0	5.1
40-44	5,282	66.0	51.1	22.2	3.2	3.7	3.9	10.5	2.2	3.2
Race and Origin										
Hispanic	2,799	50.4	31.7	4.3	33.4	5.0	2.4	13.6	2.5	7.1
White non-Hispanic	25,799	62.9	25.6	14.3	29.5	1.5	6.6	15.2	2.3	5.0
Black non-Hispanic	4,208	56.8	37.8	0.9	38.1	3.2	2.0	10.1	2.1	5.9
Marital Status										
Currently married	21,657	74.3	31.4	17.3	20.4	2.0	6.2	14.3	2.8	5.6
Divorced, separated, widowed	4,429	57.6	50.7	3.6	25.3	3.6	5.3	5.9	1.9	3.8
Never married	8,826	41.9	6.4	1.8	59.0	1.3	4.9	19.6	1.3	5.7

¹Includes natural family planning and other types of periodic abstinence.

²Percentages for 1990 were calculated excluding cases for whom contraceptive status was not ascertained. Overall, contraceptive status was not ascertained for 0.3% of U.S. women in 1990.

Source: Peterson, L. S. (1995, February). "Contraceptive Use in the United States: 1982-1990." From *Vital and Health Statistics. Advanced Data No. 260*, Hyattsville, MD: National Center for Health Statistics.

condoms rose from 33% to 44% between 1988 and 1990. Almost all contracepting teenagers used either the pill (52%) or condom (44%) in 1990. However, it must be kept in mind that only 56% of condom users report using them consistently every time they have intercourse.

The use of contraception at first intercourse by adolescents has increased significantly since the early 1980s. For example, during 1980-1982, 53% of unmarried women aged 15 to 19 used contraception during their first intercourse experience. By 1988-1990, this percentage rose to 71%, mainly attributable to rising condom use (from 28% to 55%). The increase in condom use was particularly striking among Hispanic teens, with a threefold increase from 1980 to 1990 (17% to 58%).

Table 18 depicts the latest estimates of pregnancy prevention with typical use (indicating user failure) and perfect use (indicating method failure) among the contraceptive methods currently available in the United States (Hatcher et al. 1994). The most effective methods are Norplant, the oral

contraceptive pill, male and female sterilization, Depo-Provera, and IUDs.

[*A Contraceptive Revolution?* WILLIAM TAVERNER

[Update 2003: In the seven years since Patricia Barthallow Koch prepared the above status report, major advances have been made in the availability of new contraceptive methods in the United States. From 2001 to 2002 alone, the U.S. Food and Drug Administration (FDA) approved six new contraceptive methods. Some have celebrated the new options as indicative of a "contraceptive revolution"; others have questioned how "new" the methods really are. Andrea Tone, for instance, comments that, rather than being truly innovative, many of the "new" methods are little more than repackaging of old technologies (Tone 2002-2003). For example, the widely advertised contraceptive patch uses the same fundamental hormonal technology as "the pill," "the shot," or any other mode of entry to the body.

[New methods introduced to the American public since 1997 include:

- *Essure*, a new type of female sterilization without incision. A "micro-insert" is placed in each fallopian tube, facilitating local tissue growth that serves as a barrier (Conceptus).
- *Lea's Shield*, a cup-shaped cervical cap designed to cover the cervix without being held in place by the cervix (U.S. Food & Drug Administration).
- *Lunelle*, a monthly hormonal shot, and an alternative to Depo Provera, an injection given every three months (Hatcher et al. 2003).
- *Male polyurethane condoms* became commercially available in 1997 (Brick & Taverner 2001). Two male polyurethane condoms are marketed in the United States, Avanti by Durex and Supra by Trojan, providing a condom alternative for people with latex allergies.
- *Mirena*, a hormonal intrauterine device effective for 10 years (Hatcher et al. 2003).
- *NuvaRing*, a hormonal vaginal ring, inserted in the vagina for three weeks, and removed the week of menstruation (Hatcher et al. 2003).
- *Ortho Evra*, a transdermal hormonal patch usually worn on the lower abdomen or buttocks for one week, for each of three weeks, and not worn the week of menstruation (Hatcher et al. 2003).

[*Comings and Goings*. Other notable changes in contraceptive availability during the last several years involve the contraceptive sponge, implants, and spermicides. In 1995, the contraceptive sponge was removed from the market when the manufacturer decided to stop production, rather than make government-ordered changes to the manufacturing plant. The sponge regained popularity when an episode of the television sitcom, *Seinfeld*, featured a character who dealt with the impending loss of her favorite method by hoarding many boxes of the sponge, and then determining whether each potential sexual partner was "sponge-worthy." In 1998, a pharmaceutical company purchased the rights to the sponge and anticipated FDA approval some time in 2003.

[Norplant, a six-rod hormonal implant system, was sold in the United States from 1991 until 2000. The method was FDA-approved for five years, but is possibly effective for up to seven years (Hatcher et al. 2003). Although Norplant is not available to new users, some women continue to use their previously implanted method; other women look forward to the

Table 18

Percentage of Women Experiencing a Birth Control Failure During the First Year of Typical Use and the First Year of Perfect Use and the Percentage Continuing Use at the End of the First Year

Method	% of Women Experiencing an Accidental Pregnancy Within the First Year of Use		% of Women Continuing Use at One Year
	Typical Use	Perfect Use	
Chance	85	85	
Spermicide	21	6	43
Periodic Abstinence	20		67
Calendar		9	
Ovulation Method		3	
Sympto-Thermal		2	
Post-Ovulation		1	
Withdrawal	19	4	
Cap (with spermicide)			
Parous Women	36	24	45
Nulliparous Women	18	9	58
Sponge			
Parous Women	36	20	45
Nulliparous Women	18	9	58
Diaphragm (with spermicide)	18	6	58
Condom			
Female (Reality)	21	5	56
Male	12	3	63
Pill	3		
Progestin Only		0.5	N.A.
Combined		0.1	N.A.
IUD			
Progesterone T	2.0	1.5	81
Copper T 380A	0.8	0.6	78
Depo-Provera	0.3	0.3	70
Norplant (6 Capsules)	0.09	0.09	85
Female Sterilization	0.4	0.4	100
Male Sterilization	0.15	0.10	100

Source: Hatcher et al. (1994, 13)

eventual marketing and availability of Jadelle, a two-rod implant system that received FDA approval in 1996 (Schwartz & Gabelnick 2002), and Implanon, a single implant effective for three years and currently available in several European countries (Hatcher et al. 2003).

[Research on nonoxynol-9, a spermicide found in contraceptive film, foam, jelly, sponges, and suppositories, has had many United States health organizations rethinking the extent to which they endorse such products. While nonoxynol-9 products continue to work with moderately high effectiveness as contraceptive methods, they may also exacerbate individuals' risk of HIV infection. Nonoxynol-9 may irritate the vaginal walls, causing lesions that could facilitate the transmission of HIV (Schwartz & Gabelnick 2002).

[Research has also clarified the effectiveness of coitus interruptus (withdrawal), a method whose failure has been traditionally overstated by American educators. Tests of its effectiveness show that it has a "perfect use" failure rate of 4% and a typical use failure rate of 27% (Hatcher et al. 2003). Still, its efficacy remains highly user-dependent, as effectiveness relies on the male's ability to predict ejaculation and withdraw in time.

[*For Emergency Use Only.* New forms of emergency contraception became available in the late 1990s, including the "Yuzpe Regimen" and "Plan B," a progestin-only method. Although they are sometimes confused with abortifacients, all methods of emergency contraception actually prevent pregnancy before it begins, and will not disturb an implanted pregnancy (Hatcher et al. 2003; Brick & Taverner 2003). Plan B is more effective and has fewer side effects (Brick & Taverner 2003). For several years, it was recommended that use of emergency contraception begin within 72 hours of unprotected vaginal intercourse; in 2002, the period was extended to 120 hours. However, the earlier the regimen is begun, the more effective it is. Recognizing that timing is of the essence, and that increased access to emergency contraception could greatly reduce the number of unplanned pregnancies every year, five states have enacted laws permitting the dispensing of emergency contraception without a prescription. These states include Alaska, California, Hawaii, New Mexico, and Washington (Alan Guttmacher Institute 2003). The 45 other American states still require a woman to visit a doctor or reproductive health center before emergency contraception may be dispensed.

[*A New Gag Rule.* Despite all the reliable, safe contraceptive methods available for sexually active teens, the United States government has championed abstinence as the contraceptive method of choice since 1996. Federal funding in excess of \$100 million supports "abstinence-only" education programs that forbid any discussion of the effectiveness of other methods. No research has indicated that such programs are effective in reducing teen sexual activity, or delaying the initiation of sexual intercourse (Kirby 2001). Nevertheless, in government-funded abstinence-only programs, American educators are unable to provide basic contraceptive information to teens, at least three quarters of whom have had intercourse by their late teens (Alan Guttmacher Institute 2002). Perhaps consequently, U.S. teens continue to experience pregnancy, birth, and abortion at rates much higher than most other industrialized nations (Moss 2003; Singh & Darroch 2000), despite similar levels of sexual activity between U.S. teens and teens in other developed nations.

[*Limited Coverage.* Half of American health insurance companies do not cover any reversible methods of contraception. Plans that do cover contraceptive methods often do

not cover all FDA-approved options. Twenty states require insurance companies to provide full contraceptive coverage, but 10 of these states allow employers offering health insurance not to offer contraceptive coverage for religious reasons. The other 30 states have no laws requiring that contraceptives be covered by insurers (Planned Parenthood Federation).

[*Who Is Using What?* Sixty million American women are in their reproductive years, age 15 to 44. Sixty-four percent of these women practice some method of contraception. Among women of reproductive age who use contraception, 61% use reversible methods, such as oral contraception and condoms, while the remaining 39% rely on male and female sterilization. Half of American women aged 40 to 44 have been sterilized, and an additional 20% have a partner who has had a vasectomy (Alan Guttmacher Institute 1999).

[Among younger Americans, condoms are becoming increasingly popular for their *first* act of intercourse. More than two thirds of teens use a condom at first intercourse; however, condom use fades among both men and women as they become older (Alan Guttmacher Institute 2002). By their late 20s, almost half of men and women rely on female methods (Alan Guttmacher Institute *Facts in Brief* 1999). Among teen females and women in their 20s, the most popular contraceptive method is the pill (Alan Guttmacher Institute 1999).

[Perhaps because of the political climate described earlier, the mindset of protection against *both* unplanned pregnancy and sexually transmitted infections has not caught on in the United States as it has in other developed nations. A "trade-off" is evident in American contraceptive decision-making, where individuals decide to focus exclusively on one aspect of protection, but not on both (Ott et al. 2002; Taverner 2003). Consequently, one in four sexually active U.S. teens has a sexually transmitted infection (STI/STD), and scores of millions of Americans are infected with a viral STI (SIECUS; CDC). (*End of update by W. Taverner*)

B. Childbirth and Single Women

PATRICIA BARTHALOW KOCH

Each year, one million American teenage girls become pregnant, a per-thousand rate twice that of Canada, England, and Sweden, and ten times that of the Netherlands. A similar disproportionately high rate is reported for teenage abortions (Jones et al. 1986).

The birthrate for unmarried American women has surged since 1980, with the rate for white women nearly doubling, and the rate for teenagers dropping from 53% of the unwed births in 1973, to 41% in 1980, and 30% in 1992. One out of every four American babies in 1992 was born to an unmarried woman. The unwed birthrate rose sharply for women 20 years and older. The highest rates were among women ages 20 to 24 (68.5 births per 1,000), followed by 18- and 19-year olds (67.3 per 1,000) and 25- to 29-year-olds (56.5 per 1,000). Overall, according to a 1995 report from the National Center for Health Statistics, the unmarried birthrate rose 54% between 1980 and 1992, from 29.4 births per 1,000 unmarried women ages 15 to 44 in 1980 to 45.2 births per 1,000 in both 1991 and 1992 (Holmes 1996a).

In 1970, the birthrate for unmarried black women was seven times the rate for white women, and four times the rate for white women in 1980. Since 1980, the white unmarried birthrate has risen by 94% while the rate for blacks rose only 7%. By 1992, the birthrate for single black women was just 2.5 times the rate for white women. In 1992, the out-of-wedlock birthrates were 95.3 for Hispanic women, 86.5 for black women, and 35.2 for white women (Holmes 1996a).

Commenting on the social implications of these statistics, Charles F. Westoff, a Princeton University demogra-

pher, said they “reflect the declining significance of marriage as a social obligation or a social necessity for reproduction.” Poorly educated, low-income teenage mothers and their children are overwhelmingly likely to experience long-term negative consequences of early childbearing as single parents (Associated Press News Release, June 7, 1995). A 1996 study, sponsored by the charitable Robin Hood Foundation, estimated the public cost of unwed teenage pregnancy at \$7 billion. The study looked at the consequences for teenage mothers, their children, and the fathers of the babies, compared with people from the same social background when pregnancy was delayed until the woman was 20 or 21. The breakdown of annual costs included \$2.2 billion in welfare and food-stamp benefits, \$1.5 billion in medical-care costs, \$900 million in increased foster-care expenses, \$1 billion for additional prison construction, and \$1.3 billion in lost tax revenue from the reduced productivity of teenage women who bear children (Holmes 1996a).

At the present rate, something like 50% or more of America’s children will spend at least part of their childhood in a single-parent family. About half of this number will be the result of divorce or separation; the rest will be born to a mother who has never been married (Luker 1996).

In any given year, roughly 12% of American infants are born to teenage mothers. However, the vast majority of these teenage mothers are 18 or 19 years old, and thus only technically teenagers. American teenagers have been producing children at about the same rate for most of the 20th century. Fewer than a third of all single mothers are teenagers, even when we include the 18- to 19-year-olds. And this proportion is declining. What is different in recent decades is that increasing numbers of teenage mothers are unmarried when they give birth. In 1970, only 30% of teenage mothers had never been married; by 1995, 70% of teenage mothers had never been married (Luker 1996).

While there is no good reason to suppose that the teenage birthrate is going up in any significant way—it was, in fact, higher in the 1950s—one must admit that the rate of single parenting is going up. In 1947, virtually all single mothers were widows, or living apart from their mate after separation or divorce. In 1947, fewer than one in 100 had never been married. Today, overall, never-married single mothers account for one in three, and the percentage is rising. The number of single teenage mothers is going up at a rapid rate, but so is the number of single mothers at every age.

These data suggest that we are participants in, or at least witness to, an important shift in the nature of American family life that is echoing throughout the industrialized world. According to Luker (1996), the last years of the 20th century may turn out to be the beginning of a time when the very notions of childrearing on the one hand and family life on the other are increasingly disconnected. While the rate of out-of-wedlock births is clearly on the way up, the rate of marriage may be declining, and the age of first marriage is clearly being delayed. In 1995, 60% of American families were headed by a single parent, half of them never-married. Luker (1996) suggests two possible outcomes. The present situation may prove to be only a temporary deviation from a stable pattern of long standing. Or it may mark the first hesitant appearance of an important new pattern.

If the latter interpretation turns out to have substance, one can ask why this is happening. Luker cites several influential shifts in social attitudes and behavior. First, “illegitimacy” has lost its moral sting. Second, many women are realizing that they do not need to put up with the abuse, domination, and other burdens they associate with married life. This has special resonance for women in poverty, who ask why they should live with a male who is unreliable and has

no skills or job. Third, although welfare benefits are declining throughout the industrialized world, teenage pregnancies are on the rise regardless of the level of welfare benefits. Finally, the vast majority of teenage pregnancies are unintended and not linked with the availability of welfare aid.

So long as teenagers are sexually active, the most effective way to reduce the incidence of childbearing is to assure that they have access to contraception before the fact, and abortion, if needed, after the fact. The many Americans who oppose sexuality and contraceptive education in the schools, distribution of contraceptives in schools, and abortion can only hope that someone discovers a way to reduce teenage sexual activity itself. That seems unlikely, given the decreasing age of puberty among American youth, the declining age of first sexual intercourse, and the clear trend to delay marriage well into the 20s or even 30s. Admonitions to “Just say ‘No’” are scarcely going to suffice as a workable national policy. In analyzing the politics of teenage pregnancy and single mothers in the United States, Kristin Luker (1996) concluded that:

Americans have every right to be concerned about early childbearing and to place the issue high on the national agenda. But they should think of it as a *measure*, not a cause, of poverty and other social ills. A teenager who has a baby usually adds but a slight burden to her life, which is already profoundly disadvantaged. . . . Early childbearing may make a bad situation worse, but the real causes of poverty lie elsewhere.

[Factors in a Falling Birth Rate]

ROBERT T. FRANCOEUR

[Update 2003: America’s birthrate fell to a record low in 2002 as teenagers and women in their prime childbearing years had fewer babies, according to June 25, 2003, statistics from the Health and Human Services Department. The birthrate was 13.9 per 1,000 people in 2002, compared with 14.1 for 2001. This most recent figure is the lowest in government records that go back to the turn of the 20th century. A major factor in the decline has been the reduction in births by teenagers; other factors in this decline include the aging of the population, the fact that women in their prime childbearing years have been choosing to have fewer children, and the fact that, as the population ages, there are fewer women in their 20s and 30s.

[However, the percentages of premature and low-birth-weight babies continued to rise, as they did throughout the last decade of the 20th century. Twelve percent of births in 2002 were premature, compared with 11.9% in 2001. In addition, 7.8% were listed as low-birthweight, the highest level in 30 years. These increases came despite greater access to prenatal care. In 2002, 83.8% of women began receiving care in the first trimester of pregnancy, compared with 83.4% in 2001 and 75.8% in 1990. The birthrate for unmarried women declined, but this group still accounted for more than one third of all births. (End of update by R. T. Francoeur)]

[C. Condom Distribution in the Schools]

ROBERT T. FRANCOEUR

[Update 1998: Seventy-two percent of American high school seniors, on average, have engaged in sexual intercourse, although the percentage is higher for teenagers in large cities and their suburbs. At the same time, American teenagers have the highest rate of teenage pregnancy and abortion in North America and Europe. They are also rapidly becoming the highest risk group for HIV/AIDS infec-

tion in the United States. American parents, educators, and healthcare professionals are consequently struggling to decide on ways to deal with this reality. Typical of the conflicted, schizophrenic American approach to sexual issues, religious conservatives call for teaching abstinence-only education and saying nothing about contraceptives and other ways of reducing the risk of contracting sexually transmissible diseases and HIV infections. At the same time, others advocate educating and counseling: "You don't have to be sexually active, but if you are, this is what you can do to protect yourself." However, the problem is so serious in New York, Baltimore, Chicago, Los Angeles, San Francisco, Philadelphia, Miami, and other large cities, that school boards in these cities now allow school nurses and school-based health clinics to distribute free condoms to students, usually without requiring parental notification or permission (Guttmacher 1997; Richardson 1997).

[Typical of the opposition is Dr. Alma Rose George, president of the National Medical Association, who opposes schools giving condoms to teens without their parents knowing about it: "When you give condoms out to teens, you are promoting sexual activity. It's saying that it's all right. We shouldn't make it so easy for them." Faye Wattleton, former president of the Planned Parenthood Federation of America, approves of schools distributing condoms, and maintains that "mandatory parental consent would be counterproductive and meaningless." Some critics claim that condom distribution programs are inherently racist and a form of genocide because the decisions are mostly made by a white majority for predominantly black schools.

[Recently, a study comparing the sexual activity and condom use of 7,000 students in New York City high schools, and 4,000 similar high school students in Chicago, supported the effectiveness of school condom distribution (Guttmacher 1997). The New York schools combined HIV/AIDS education with free condoms, while the Chicago schools had similar HIV/AIDS education but no condom distribution. In both cities, 60% of the students were sexually active regardless of whether or not their schools distributed condoms. However, students in schools that distributed condoms were significantly more likely to have used a condom in their last intercourse than teens in schools that did not distribute condoms. Regardless of the data available on the ineffectiveness of abstinence-only education and the effectiveness of condom distribution, this debate will continue. (End of update by R. T. Francoeur)]

D. Abortion PATRICIA BARTHALOW KOCH

In America today, it seems that two camps are at war over the abortion issue. "Pro-choice" supporters advocate the right of the individual woman to decide whether or not to continue a pregnancy. They contend that the rights of a woman must take precedence over the "assumed" rights of a fertilized human egg or fetus. They believe that a woman can never be free unless she has reproductive control over her own body. Pro-choice advocates in the United States include various Protestant and Jewish organizations, Catholics for Free Choice, Planned Parenthood, the National Organization for Women (NOW), National Abortion Rights Action League (NARAL), and the American Civil Liberties Union (ACLU), among others.

Anti-abortion groups have politically identified themselves as "pro-life" supporters of "the right to life" for the unborn. This coalition involves such constituents as Eastern Orthodox, charismatic and conservative Roman Catholics, fundamentalist Protestants, and Orthodox Jews in influential groups like Operation Rescue, Focus on the Family, and the Christian Coalition. These groups use various methods

in order to prevent women from being able to have abortions, including, in some cases, personal intimidation of abortion providers and clients and political action.

The basic motivation of the protection of human life of those in the anti-abortion movement has, however, been questioned. For example, an analysis of the voting records of U.S. senators who are anti-abortion advocates indicates that they had the lowest scores on votes for family-support issues, bills for school-lunch programs, and for aid to the elderly (Prescott & Wallace 1978).

[Abortion—The 25th Anniversary of the

Roe v. Wade Decision PATRICIA BARTHALOW KOCH

[Update 1998: A 1998 report on the status of abortion rights in the United States documents that there are more obstacles today for women seeking their constitutional right to abortion than ever before since the Supreme Court's *Roe v. Wade* decision in 1973 (NARAL 1998). The report documents the increasing risk of unintended pregnancy, with concomitant increasing difficulties in obtaining abortions, resulting in increased risks to women's health and well-being. The factors contributing to this include increased anti-abortion legislation enacted at the state and federal levels, an acute shortage of medical providers being trained in abortion procedures in medical schools, a parallel shortage of medical providers willing to contend with constant harassment from anti-choice activists, lack of sexuality education, and denial of insurance coverage for contraception. As Chief Justice William Renquist stated in the Supreme Court's *Planned Parenthood v. Casey* decision, "Roe continues to exist but only in the way a storefront on a western movie exists: a mere facade to give the illusion of reality" (*Planned Parenthood of Southeastern PA v. Casey* 1992).

[In 1998, states were enforcing an unprecedented number of abortion restrictions, including: mandatory waiting periods, Medicaid funding bans, parental notification and consent laws, bans on the use of public facilities for abortion, prohibitions on the participation of public employees in providing abortion services, bans on actual abortion procedures (e.g., "partial-birth" abortions), and prohibitions on the use of public funds to counsel women about or provide referrals for abortion services. In 1998, for example, 17 states were enforcing three or more abortion restrictions, a 467% increase from 1992. Over half the states enacted some restriction on access to abortion in 1997. An anti-abortion bill introduced into a state legislature in 1997 was more than twice as likely to be enacted than in 1996. Efforts to ban "partial-birth" or "late-term" abortions dominated legislative debate at both the federal and state levels in 1997. This resulted in 16 states banning this rare procedure and the U.S. Congress passing a bill to ban it. The bill was not signed by President Clinton, because it contained no provision to protect the mother's health or life.

[There is also diminishing access to abortion providers because of increased harassment and violence by anti-abortion groups and a shortage of physicians trained and willing to provide abortion services. Between 1982 and 1992, the number of abortion providers nationwide decreased by 18%. Many residency programs have eliminated abortion instruction from the curriculum altogether or have relegated it to an elective course. Currently, there are no abortion providers in 84% of the counties in the United States. The American Medical Association has concluded that the shortage of abortion providers has "the potential to threaten the safety of induced abortion" (AMA 1992).

[Private insurance companies, often with the blessing of state legislatures, are cutting back on coverage for contra-

ceptive services. Almost half—49%—of the typical large insurance plans exclude coverage for prescription contraception, although for women this often constitutes their major medication expenses. Illinois, North Dakota, and Texas have even enacted state legislation allowing health-care institutions or insurers to refuse to provide or counsel patients for healthcare services that violate their “organizational conscience,” including family planning, infertility services, vasectomy, female sterilization, and abortion procedures.

[These increasing obstacles to obtaining legal abortions demonstrate the successes of the anti-abortion groups, particularly in electing supporters into state and federal legislatures. It seems likely that the trend to erode access to abortion services will continue, at least in the short term. (*End of update by P. B. Koch*)]

A Brief Legal History PATRICIA BARTHALOW KOCH

As documented by Brodie (1994), early American common law accepted abortion up until “quickening” (movement of the fetus). Not until the early 1800s did individual states begin to outlaw abortion at any stage of pregnancy. By 1880, most abortions were illegal in the United States, except those “necessary to save the life of the woman.” However, since the right and practice of early abortion had already taken root in American society, abortionists openly continued to practice with public support and little legal enforcement. In the 1890s, doctors estimated that there were approximately two million abortions performed each year in the U.S. (Brodie 1994).

Before 1970, legal abortion was not available in the United States (Gordon 1976). In the 1950s, about one million illegal abortions were performed a year, with more than 1,000 women dying each year as a result. Three quarters of the women who died from abortions in 1969 were women of color. Middle- and upper-class women, often with difficulty and great expense, could get “therapeutic abortions” from private physicians. By 1966, four fifths of all abortions were estimated to be for married women, and the ratio of legal to illegal abortions was one to 110.

In 1970, New York State passed legislation that allowed abortion on demand through the 24th week if it was done in a medical facility by a physician. However, on January 22, 1973, the U.S. Supreme Court decided a landmark case on abortion—*Roe v. Wade*. The Court stated the “right of privacy . . . founded in the Fourteenth Amendment’s concept of personal liberty . . . is broad enough to encompass a woman’s decision whether or not to terminate her pregnancy” (Tribe 1992). The major points of this decision were:

1. An abortion decision and procedure must be left up to the pregnant woman and her physician during the first trimester of pregnancy.
2. In the second trimester, the state may choose to regulate the abortion procedure in order to promote its interest in the health of the pregnant woman.
3. Once viability occurs, the state may promote its interest in the potentiality of human life by regulating and even prohibiting abortion except when judged medically necessary for the preservation of the health or life of the pregnant woman.

Although induced abortion is the most commonly performed surgical procedure in the United States, various restrictions continue to be placed upon the accessibility of abortion for certain groups of women. For example, in 1976, the Hyde Amendment, implemented through the United States Congress, prohibited federal Medicaid funds from being used to pay for abortions for women with

low incomes. This is believed to contribute to the fact that low-income women of color are more likely to have second-trimester abortions, rather than first-trimester ones, since it takes time for them to save enough money for the procedure.

In addition, the Supreme Court has upheld various state laws that have been instituted to restrict abortions. In 1989, a Missouri law prohibiting the use of “public facilities” and “public employees” from being used to perform or assist abortions not necessary to save the life of the pregnant woman was upheld (*Webster v. Reproductive Health Services*). The court also upheld one of the strictest parental notification laws in the country in 1990 (*Hodgson v. Minnesota*). This law required notification of both of a minor’s parents before she could have an abortion, even if she had never lived with them. Along with this restriction came a “waiting period” provision. A court decision in *Rust v. Sullivan* (1991) upheld a “gag rule” that prohibited counselors and physicians in federally funded family-planning clinics from providing information and making referrals about abortion. In 1992, the court upheld many restrictions set forth in a Pennsylvania law (*Planned Parenthood v. Casey*). These restrictions included requiring physicians to provide women seeking abortions with pro-childbirth information, followed by a 24-hour “waiting period,” and parental notification for minors (Tribe 1992).

Nineteen years after the *Roe* decision, the *Casey* decision demonstrated that the Supreme Court was divided more sharply than ever over abortion. While a minority of justices wanted to overturn the *Roe* decision outright, the majority did not allow a complete ban of abortion. However, by enacting the “undue burden” standard, they did lower the standard by which abortion laws are to be judged unconstitutional. This standard places the burden of proof on those challenging an abortion restriction to establish that it is a “substantial obstacle” to their constitutional rights.

The various state laws now restricting abortion are particularly burdensome for younger and poorer women, and open the way for the creation of increasing obstacles to women’s access to abortion. Currently, only 13 states provide funding for poor women for abortions, and 35 states enforce parent-notification/consent laws for minors seeking abortions. At the same time, the Supreme Court has upheld the right to abortion in many cases.

The recent murders of physicians and staff at abortion clinics, arson and bombing of abortion clinics, and the blocking of abortion clinics by anti-abortion protesters have contributed to women’s difficulty in receiving this still-legal medical procedure. Over 80% of all abortion providers have been picketed, and many have experienced other forms of harassment, including bomb threats, blockades, invasions of facilities, property destruction, assault of staff and patients, and death threats.

In 1988, Operation Rescue, the term adopted by anti-abortion groups, brought thousands of protesters to Atlanta to blockade the abortion clinics. Using an 1871 statute enacted to protect African-Americans from the Ku Klux Klan, the federal courts invoked injunctions against the protesters. However, in 1993, this decision was overturned, leading to Operation Rescue blockades of abortion clinics in ten more U.S. cities. The federal government moved to apply the Racketeer Influenced and Corrupt Organization (RICO) Act against such blockades on the grounds that it was a form of extortion and part of a nationwide conspiracy. This application of the RICO Act was upheld unanimously by the Supreme Court in 1994. Despite this protection, there has nevertheless been a serious decline in the number of facilities and physicians willing to perform abortions.

Current Abortion Practice

PATRICIA BARTHALOW KOCH

Legally induced abortion has become the most commonly performed surgical procedure in the United States. In 1988, 6 million pregnancies and 1.5 million legal abortions were reported. One in five women (21%) of women of reproductive age have had an abortion (Hatcher et al. 1994). If current abortion rates continue, nearly half of all American women will have at least one abortion during their lifetime.

Women having abortions in the United States come from every background and walk of life (Koch 1995). Abortion rates are highest among 18- to 19-year-old women, with almost 60% being less than 25 years old. One in eight (12%) are minors, aged 17 or younger. Of these minors, over 98% are unmarried and in school or college, with fewer than one tenth having had any previous children.

The vast majority (80%) of adult women having abortions are separated, divorced, or never married, with 20% currently married. One third of American women seeking abortions are poor. Almost half are currently mothers, with most of them already having two or more children. Half of the women seeking abortions were using a form of birth control during the month in which they conceived. About one third of abortion clients are employed, one third attend public school or college, and the other third are unemployed. The majority of women (69%) getting abortions are Anglo-American. Latinas are 60% more likely than Anglos to terminate an unintended pregnancy, but are less likely to do so than are African-American women.

Women with a more-liberal religious or humanist commitment are four times more likely to get an abortion than those adhering to conservative religious beliefs, according to Alan Guttmacher Institute surveys in 1991 and 1996. Catholic women are just as likely as other women to get abortions. Catholic women, who constitute 31% of the female population, had 31% of the abortions in 1996. In 1991, one sixth of abortion clients in the U.S. were born-again or evangelical Christians (Alan Guttmacher Institute 1991). In a similar 1996 survey, evangelical or born-again Christians, who account for almost half the American population, had 18% of the abortions.

Women give multiple reasons for their decision to have an abortion, the most important reasons being financial inability to support the child and inability to handle all the responsibilities of parenting. Three quarters of abortion clients believe that having a baby would interfere with work, school, or their other family responsibilities. Over half are concerned about being single parents and believe that the relationship with the father will be ending soon. Adolescent women, in particular, usually believe that they are not mature enough to have a child. One fifth of the women seeking an abortion are

concerned that either the fetus or they, themselves, have a serious health problem which necessitates an abortion. One in 100 abortion clients are rape or incest survivors. Most abortion clients (70%) want to have children in the future.

Half of the abortions in the U.S. are performed before the eighth week of gestation and five out of six are performed before the 13th week (Hatcher et al. 1994). The safest and easiest time for the procedure is within the first three months. Most (97%) women receiving abortions during this time have no complications or postabortion complaints. Vacuum curettage is the most widely used abortion procedure in the United States, accounting for 97% of abortions in 1989. Intra-amniotic infusion is the rarest form of abortion performed, accounting for only 1% of abortions in 1989.

The weight of research evidence indicates that legal abortion, particularly in the first trimester, does not create short or long-term physical or psychological risks for women, including impairment of future fertility (Russo & Zierk 1992). In 1985, the maternal death rate for legal abortions was 0.5 per 100,000 for suction methods, 4.0 for induced labor, and one in 10,000 for childbirth (Hatcher et al. 1994).

Attitudes Toward Abortion

PATRICIA BARTHALOW KOCH

The National Opinion Research Center has been documenting attitudes toward abortion since 1972 (Smith 1996). Throughout this time period, public support for abortion under various circumstances has increased (see Table 19). The vast majority of Americans approve of abortion if a pregnancy seriously endangers the health of the mother, if the fetus has a serious defect, or if the pregnancy resulted from a rape or incest. Approximately half of the American public approves of abortion if the woman does not want to marry the father or if the parents cannot afford a child or do not want any more children. Close to half of Americans approve of abortion if the woman wants it for any reason. Level of education has the strongest effect on people's attitudes, with college-educated people being significantly more approving than those who are less educated. Catholics, fundamentalist Protestants, and Mormons who have a strong religious commitment are the most likely to disapprove of abortion. Anglo-Americans are somewhat more approving than African-Americans; men and adults under 30 are slightly more approving than women and adults over 65. In general, approval of legal abortion and the right of women to control their reproductive ability is associated with a broad commitment to basic civil liberties.

America is at a crossroads in terms of protecting the access of all women to abortion (Tribe 1992, 6). (See comments on efforts of the Christian Coalition to enact laws that restrict and limit access to abortion and abortion informa-

Table 19

Percentage of U.S.A. Adults Approving of Legal Abortion for Various Reasons (Updated to 2000)

Reason for Abortion	1972	1980	1990	1994	1996	1998	2000
Pregnancy poses serious health danger for woman	86.9%	90.1%	91.8%	90.6%	91.6%	87.9%	88.5%
Strong chance of serious defect of fetus	78.6	83.1	81.2	82.3	81.8	78.6	78.7
Pregnancy resulted from rape	79.1	83.4	84.8	83.6	84.3	80.1	80.6
Parent(s) low income—cannot afford a child	48.8	51.7	48.1	50.4	46.6	44.3	42.2
Unmarried woman who does not want to marry father	43.5	48.4	45.3	47.6	44.9	42.3	39.1
Married woman who does not want more children	39.7	47.1	45.1	48.3	46.7	42.3	40.7
Woman wants an abortion for any reason	NA*	41.1	43.4	46.3	45.0	40.9	39.9

*NA = Not asked

Source: *General Social Surveys*. Chicago: National Opinion Research Center (NORC).

tion in Section 2A, Religious, Ethnic, and Gender Factors Affecting Sexuality, Sources and Character of Religious Values). The era of absolute judicial protection of legal abortion rights that began with the Supreme Court's 1973 decision in *Roe v. Wade* ended with that Court's 1989 decision upholding certain state regulations of abortion in the case of *Webster v. Reproductive Health Services*. Thus, a woman's right to decide whether to terminate a pregnancy was placed in the arena of rough-and-tumble politics, subject to regulation, and possibly even prohibition, by federal and state elected representatives. The range of abortion rights that many Americans have taken for granted are now in jeopardy. Even as the public agenda is stretched to address such new questions as the right to die, the use of aborted fetal tissue in treating disease, and the ethics and legal consequences of reproductive technologies, no issue threatens to divide Americans politically in quite as powerful a way as the abortion issue still does.

[Abortion Update 2003

SUSAN DUDLEY

[Update 2003: Social conflict about abortion in the United States remains passionate on both sides, and is played out on several fronts: by both peaceful and violent demonstrators at public rallies and at abortion-clinic entrances, by politicians and their supporters in the state and federal legislatures, and by lawyers and advocates in the courts.

[The true motivation of anti-abortion activists who claim that their concern is protection of human life has been further questioned by correlational research that suggests that states with the most-restrictive laws and regulations on abortion tend to have fewer safeguards for maternal and infant health and safety than states where abortion laws are less restrictive (Schroedel 2000).

[When mainstream medical associations take a position on abortion, it is usually with the recognition that the provision of legal and medically safe abortion is a public health necessity that prevents the mortality and morbidity that invariably accompany illegal black-market abortion practices.

[Several of the more prominent advocacy organizations on both sides of the abortion debate have changed their names in recent years. The National Abortion Rights Action League (NARAL) became the National Abortion and Reproductive Rights Action League, and then more recently changed its name to NARAL Prochoice America. Operation Rescue also uses the name Operation Save America.

[The incidence of illegal and violent action taken by anti-abortion protestors has been high. Since 1977, the National Abortion Federation has documented at least 7 murders, 17 attempted murders, 353 death threats, 3 kidnappings, 41 bombings, 570 bomb threats, 166 arsons, 372 clinic invasions, 100 butyric acid attacks, receipt of 545 anthrax threat letters, 123 cases of assault and battery, 71 burglaries, 444 stalking incidents, and 686 clinic blockades.

[Enactment of the federal Freedom of Access to Clinic Entrances (FACE) Act in 1994 has helped to curb the incidence of illegal anti-abortion activities in recent years. This law forbids the use of "force, threat of force or physical obstruction" to prevent someone from providing or receiving reproductive health services. Nevertheless, 56% of clinics experienced anti-abortion harassment in 2000 (Henshaw & Finer 2001).

[The U.S. Supreme Court has issued several important rulings in response to challenges against laws passed to ban specific abortion procedures or to limit the availability of abortion in the U.S. For example, *Stenberg v. Carhart* in 2000 resulted in overturning abortion-procedure bans that had been enacted in a number of states. In the same year, *Hill v. Colorado* established that protestors coming closer

than eight feet from clinic patrons could be found guilty of harassment. In 2003, *Planned Parenthood v. American Coalition of Life Advocates* asserted that protestors are not free to make threats against the life and safety of abortion providers or their patients.

[In 2003, 17 states provide some funding for poor women for abortion, and 32 states enforce parent-notification/consent laws for minors seeking abortions (Alan Guttmacher Institute 2003).

[In 2000, 1.31 million abortions took place in the U.S., and it remains one of the most common procedures. Mifepristone was approved for induction of medical abortion in the U.S. in 2000, and approximately 6% of women who had abortions that year opted for this method instead of surgical abortions (Finer & Henshaw 2003).

[Each year, 2 out of every 100 women of reproductive age have an abortion, and 48% of them have had at least one previous abortion (Alan Guttmacher Institute 2003). At the current rate, it is estimated that 43% of American women will have an abortion in their lifetimes.

[Fifty-two percent of U.S. women who get abortions each year are younger than 25. Teenagers account for 19% of all abortions, and women 20 to 24 account for the other 33% (Alan Guttmacher Institute 2003).

[Fifty-four percent of women having abortions report that they used a contraceptive method during the month they became pregnant, and 8% report that they have never used a birth-control method (Alan Guttmacher Institute 2003).

[Unintended pregnancies are more than 3 times as likely to be terminated by abortion by black women and 2½ times as likely by Hispanic women as by white women in America (Alan Guttmacher Institute 2003).

[Also in 2003, application of RICO (organized racketeering) statutes in the prosecution of illegal anti-abortion activities was limited in a ruling on *Scheidler v. National Organization for Women*. (End of update by S. Dudley)]

[Update 2003: In early February 2003, President Bush announced a commitment of \$15 billion over the next five years to fight AIDS in the 15 African and Caribbean nations with the highest rates of AIDS infection. This allocation immediately raised the question of how distribution of the money could be managed without violating the so-called Mexico City policy barring American foreign aid to groups that consider abortion to be a valid family-planning option. One of the President's first acts in office in 2000 was to reinstate this ban, which was first imposed by President Ronald Reagan and later suspended by the Clinton administration.

[Faced with a clash between two goals—disseminating the AIDS money widely and holding to the anti-abortion position, the President adopted a compromise that would allow groups to receive the money to fight AIDS through the State Department's foreign assistance program as long as none of the money went to any family-planning activities that encourage or perform abortions.

[The policy would allow an organization that conducted family-planning activities that included abortion in one country to qualify for the AIDS money in another country. It would prohibit sending the money to an organization that ran integrated health clinics that included both AIDS treatment and abortion or abortion counseling, but would allow it if the AIDS treatment program and the family-planning activities were conducted and financed completely separately.

[Some groups that work on health and family-planning issues in poor countries said the administration's policy was likely to prove too restrictive by forcing them to choose between providing a full range of health services, including family planning, and taking the AIDS treatment money from the United States. (End of update by R. T. Francoeur)]

[Update 2003: The first indication of the social and medical impact of the legalization of mifepristone (RU-486) came in mid-January 2003 from an Alan Guttmacher Institute report. In a survey of American women ages 15 to 44 in the first six months of 2001, Finer and Henshaw reported that the U.S. abortion rate was continuing to decline and had reached its lowest point since the 1970s, 21.3 abortions per 1,000 women ages 15 to 44. The number of providers also declined in the first half of 2001. However, physicians used mifepristone to perform more than 37,000 nonsurgical abortions, about 6% of all abortions induced in the first six months after the controversial drug became available to American women. (*End of update by R. T. Francoeur*)]

[E. Other Reproductive and Sexual Health Issues]

[Infertility and Assisted Pregnancy]

ROBERT T. FRANCOEUR

[Update 1998: America's romance with assisted reproductive technology began a hundred years ago when J. Marion Sims made 55 attempts at "ethereal copulation," as artificial insemination with donor semen (AID) was then known. His success rate at Jefferson Medical School in Philadelphia was only 4%, because insemination was performed just before or after menstruation, which was wrongly believed at the time to be a woman's most fertile period. In 1960, Bunge and Sherman experimented with artificial insemination using frozen donor semen at the State University of Iowa, whereas Behrman and associates at the University of Michigan reported 29 successful pregnancies using frozen semen. By 1974, America had 28 private and public sperm banks, with approximately 20,000 pregnancies a year from artificial insemination, double the mid-1960s' rate (Francoeur 1977).

[In 1981, reproductive specialists at Eastern Virginia Medical Center produced American's first *in-vitro* fertilized (IVF) baby, three years after the world's first IVF baby in Cambridge, England. Some American feminists organized a Feminist International Network on the Reproductive Technologies to protest "female slavery and exploitation by male infertility specialists and patriarchal husbands" (Ardetti, Klein, & Minder 1984).

[Other forms of assisted reproductive technology have followed, including embryo transplants, surrogate motherhood, embryo lavage for harvesting ova from donors, epididymal aspiration of sperm, and microinsemination of ova with single sperm. Social complications quickly followed. The court fight of Mary Beth Whitehead, a New Jersey surrogate mother, to retain custody of "Baby M," whom she had contracted to carry for an infertile couple, made national news. In the aftermath, several states outlawed surrogate-mother contracts and prohibited payment. In 1990, when a divorcing couple fought over custody of seven frozen embryos remaining from fertility treatments, the court declared the frozen embryos "human life from the moment of conception," and awarded custody to the mother (Holmes, Hoskins, & Gross 1981; Corea 1985). The 1990s have witnessed a flood of new technologies, including insertion of sperm and zygotes into the fallopian tube (GIFT and ZIFT), postmenopausal pregnancies, and frozen eggs.

[Three major psychological, social, and ethical controversies have emerged from these technologies. The first involves "designer and discount designer embryos." Several American infertility clinics now offer infertile couples the option of paying \$20,000 or more to select donor sperm and egg from a select list of designer donors. After IVF, several designer zygotes are implanted in the adoptive woman's uterus. If any embryos are left in cryogenic storage after a

successful pregnancy, they may be sold at a discount to other infertile couples.

[The high risk of multiple births is a second issue. England, Australia, and most European countries have laws prohibiting transfer of more than two or three embryos in each pregnancy attempt. These clinics have a success rate about 20% lower than American clinics, which are not subject to any limit on the number of embryos they transfer. American clinics typically transfer four or five embryos per attempt, but some clinics transfer as many as ten. The result is a high risk of multiple pregnancies that are themselves dangerous to both mother and offspring. In a survey of 281 American infertility clinics in 1995, 37% of all births were multiple births, contrasted with 2% in the general population. Woman under age 35 experienced a 17% pregnancy rate and a 3% multiple-pregnancy risk when two embryos were transferred. Transfer of four embryos gave a 34% pregnancy rate, but a multiple-pregnancy risk of 15%. Transferring more than four embryos does not improve the fertility rate, but it does increase the multiple births. In 1997, infertility treatment resulted in the survival of the McCaughey septuplets, the world's second set of surviving septuplets, the first being in Saudi Arabia.

[Some clinics transfer multiple embryos in the hope of raising their fertility rate, in order to attract more clients. A clinic that reduces the risk of multiple pregnancy faces a lower fertility rate and may not survive in the competition for clients. The present practice is not pleasant for infertile couples who have to decide whether to let a multiple pregnancy go to full term and risk losing all or some of the offspring, or to resort to "selective reduction," which aborts several of the multiple embryos early in pregnancy. Selective reduction improves the survival of the one or two remaining embryos, but it may also trigger a miscarriage of all the embryos.

[Finally, there is the issue of payment for donor eggs. When egg donation was first introduced, donors were paid a few hundred dollars. More recently, the standard fee has been \$2,500. In early 1998, a major New Jersey hospital offered donors \$5,000, because their clients were being forced to wait up to a year for an egg. The shortage of donor eggs has brought private egg brokers into the market, with some brokers offering \$35,000 for a suitable donor. (*End of update by R. T. Francoeur*)]

10. Sexually Transmitted Diseases and HIV/AIDS

A. Sexually Transmitted Diseases

ROBERT T. FRANCOEUR

It is impossible to obtain reliable statistics about the incidence of STDs, because American physicians are only required by law to report cases of HIV and syphilis to the Centers for Disease Control and Prevention (CDC). Public clinics keep fairly reliable statistics, but many private physicians record syphilis and other STDs as urinary infections and do not report them to the CDC. A second, equally important factor leading to the lack of data is the number of persons infected with various STDs who are without symptoms and do not know they are infectious. This "silent epidemic" includes most males infected with candidiasis, 10% of males and 60 to 80% of females infected with chlamydia, 5 to 20% of males and up to 80% of females with gonorrhea, and many males and females with hemophilus, NGU, and trichomonas infections.

In 1995, the nation's three most commonly reported infections were sexually transmitted, according to statistics from the federal Centers for Disease Control and Preven-

tion released in October 1996. Chlamydia, tracked for the first time in 1995, topped the list with 477,638 cases. Gonorrhea, the most commonly reported infectious disease in 1994 with 418,068 cases dropped to second in 1995 with 392,848 cases. AIDS dropped from second place in 1994 (78,279 cases) to third place in 1995 (71,547 cases). In 1995, five sexually transmitted diseases, chlamydia, gonorrhea, AIDS, syphilis, and hepatitis B, accounted for 87% of the total number of infectious cases caused by the top ten maladies. Chlamydia was more commonly reported among women, striking 383,956 in 1995; gonorrhea and AIDS were more common with men, with 203,563 and 58,007 cases, respectively.

The latest data suggest that the national incidence of gonorrhea and syphilis has continued to decline (U.S. Department of Health and Human Services 1994). Reported cases of gonorrhea peaked at a million cases in 1978 and declined to about 700,000 cases in 1990. With a realistic estimate suggesting two million new cases annually, gonorrhea is one of the most commonly encountered STDs, especially among the young. About 50,000 new cases of syphilis are reported annually; an estimated 125,000 new cases occur annually. Syphilis is primarily an adult disease, mostly concentrated in larger cities, and one of the least common STDs. The incidence of syphilis rose sharply between the late 1980s and the early 1990s, and then continued its more long-term decline. Congenital syphilis rates have decreased in parallel to declining rates of syphilis among women. Infants most at risk were born to unmarried, African-American women who receive little or no prenatal care. Syphilis and gonorrhea have consistently been more common in the southern states. Reasons for this are not well understood, but may include differences in racial and ethnic distribution of the population, poverty, and the availability and quality of healthcare services.

Chlamydia is the most prevalent bacterial STD in the United States, with four million adults and possibly 10% of all college students infected. It is more common in higher socioeconomic groups and among university students. Prevention and control programs were begun in 1994, and are a high priority because of the potential impact on pelvic inflammatory disease (PID) and its sequelae, infertility and ectopic pregnancy. Twenty to 40% of women infected with chlamydia develop PID. Many states have implemented reporting procedures and begun collecting case data for chlamydia.

Three million new cases of trichomonas are reported annually, but probably another six million harbor the protozoan without symptoms. Fifteen million Americans have had at least one bout of genital herpes. About a million new cases of genital warts are reported annually.

STD rates continue to be much higher for African-Americans and other minorities than for white Americans, sixtyfold higher for blacks and fivefold higher for Latinos. About 81% of the total reported cases of gonorrhea occur among African-Americans, with the risk for 15- to 19-year-old blacks more than twentyfold higher than for white adolescents. Similarly, the general gonorrhea rate is fortyfold higher for blacks and threefold higher for Latinos than it is for white Americans. There are no known biologic reasons to explain these differences. Rather, race and ethnicity in the United States are risk markers that correlate with poverty, access to quality healthcare, healthcare-seeking behavior, illicit drug use, and living in communities with a high prevalence of STDs.

[*Recent Developments* PATRICIA BARTHALOW KOCH

[*Update 1998:* In 1997, a Committee on Prevention and Control of Sexually Transmitted Diseases issued an im-

portant analysis of the epidemiology of STDs (except for HIV) and effectiveness of public health strategies to prevent and control them in the United States (Eng & Butler 1997).

[The Committee, sponsored by the Institute of Medicine, an adviser to the federal government, concluded that STDs are hidden epidemics of enormous health and economic consequence in the United States. The incidence rates of curable STDs in the United States are the highest in the developed world, with rates that are 50 to 100 times higher than other industrialized nations. For example, the reported incidence of gonorrhea in 1995 was 150 cases per 100,000 persons in the United States versus three cases per 100,000 in Sweden. STDs continue to have a disproportionate impact on women, infants, young people, and racial/ethnic minorities. The estimated overall costs from STDs in the United States was nearly \$17 billion in 1994.

[Updates concerning the epidemiology and consequences of STDs in the United States are provided by the Centers for Disease Control and Prevention (CDC 1998). Chlamydia (an estimated 4,000,000 new cases each year) and gonorrhea (800,000 new cases each year) are a major cause of pelvic inflammatory disease (PID). Among American women with PID, 20% will become infertile, and 9% will have an ectopic pregnancy, which is the leading cause of first-trimester pregnancy-related deaths in American women. The ectopic pregnancy rate could be reduced by as much as 50% with early detection and treatment of STDs. In addition, fetal or neonatal death occurs in up to 40% of pregnant women who have untreated syphilis. There are an estimated 101,000 new cases of syphilis each year, with 3,400 infants born with congenital syphilis.

[Genital herpes may now be the most common STD in the United States, with perhaps more than 45 million Americans, including 18% of whites and 46% of blacks, carrying the herpes virus. Despite an emphasis on safe sex to prevent HIV/AIDS, the Centers for Disease Control reported that genital herpes had increased fivefold since the late 1970s among white teenagers and doubled among whites in their 20s. In all, about one in five Americans is infected with genital herpes. There are an estimated 200,000 to 500,000 new symptomatic cases each year. In addition, it is likely that more than 24 million Americans are infected with human papilloma virus (HPV), with an estimated 500,000 to a million new infections each year. Sexually transmitted HPV is the most important risk factor for cervical cancer, which was responsible for about 5,000 deaths in 1995.

[To deal with this silent epidemic in the United States, the Institute of Medicine Committee made a strong advocacy statement in support of establishing an effective national system for STD prevention. To accomplish this, four major strategies were recommended for implementation by public- and private-sector policymakers at the local, state, and national levels:

1. Overcome barriers to adoption of healthy sexual behaviors, particularly through a nationally organized mass-media campaign;
2. Develop strong leadership, strengthen investment, and improve information systems for STD prevention;
3. Design and implement essential STD-related services in innovative ways for adolescents and underserved populations; and
4. Ensure access to and quality of essential clinical services for STDs.

[The report concluded that the veil of enforced secrecy about sexual health must be lifted, public awareness raised, and bold national leadership must come from the highest

levels in order to overcome the public health shame of STD epidemics. However, it is unlikely that these recommendations will be put into action, and Americans will needlessly continue to suffer the physical, emotional, social, and financial consequences of these preventable diseases. (*End of update by P. B. Koch*)

[*Update 2002*: For the first time in over a decade, the Centers for Disease Control reported an increase in cases of syphilis, largely because of outbreaks among gay and bisexual men in several U.S. cities. After dropping every year since 1990, the syphilis rate increased from 2.1 cases per 100,000 people in 2000 to 2.2 cases per 100,000 in 2001. Syphilis among women actually dropped 17.6% in 2001. More than two thirds of the new syphilis patients were men. Between 1997 and 2001, syphilis outbreaks erupted in New York City, Seattle, Chicago, San Francisco, and Miami, with a major contribution from men having sex with men (Yee 2002). (*End of update by R. T. Francoeur*)]

[*Status as of 2003*

KAREN ALLYN GORDON

[*Update 2003*: While obtaining accurate and current data on sexually transmitted diseases (STD) and sexually transmitted infections (STI) in the United States is difficult, the availability of public health data has greatly improved over the last decade because of changes in case identification, expanded reporting, surveillance systems, and epidemiological investigations. For some diseases, such as chlamydia, increased cases may be attributed to increased screening efforts and better identification through use of more-sensitive screening tests. Underestimating and reporting of STDs may also be influenced by reluctance to seek treatment in a public clinic, lack of reporting from private practitioners, access to quality services, fear of discrimination, cost, stigma, and stresses of daily life. Much remains to be investigated beyond clinical concerns in terms of the social level of infection and disease patterns in geographic regions and population subgroups as identified by age, race, ethnicity, socioeconomic level, and sexual-practice patterns.

[More is known about the trends of some STDs because of long-term surveillance. Over a 40-year period, 1950 to 2000, data are available on syphilis, gonorrhea, and chancroid through reporting by state health departments. Hepatitis B was added as of 1970 and chlamydia as of 1990. As of 2000, all 50 states and the District of Columbia require reporting of chlamydia cases to the Centers for Disease Control and Prevention (CDC).

[For nationally notifiable diseases for 2002, virus-based conditions include human immunodeficiency virus (HIV infection), acquired immunodeficiency syndrome (AIDS), and hepatitis B, while bacterial conditions include gonorrhea, chlamydia, and syphilis.

[In all, about 25 diseases or infections occur from or are associated with sexual intercourse, for which only estimated data on incidence and prevalence are available on herpes, human papilloma virus (HPV), trichomoniasis, and bacterial vaginosis. The rates for notifiable STDs for 2000 exceed the national health objectives proposed in *Healthy People 2010*.

[Among the most common STDs in the United States, trends show a decline in cases of gonorrhea from 445.10 per 100,00 in 1980 to 128.3 per 100,00 in 2001, as well as syphilis from 20.34 of primary and secondary cases per 100,00 in 1990 to 2.1 cases of primary and secondary cases in 2001. Outbreaks in certain geographic areas and among men who have sex with men, for example, reflect the persistence of the disease and difficulty in eradication (Fox et al. 2001). During 2001, a 2% increase (2.17 cases per 100,000) re-

flected a 15.4% increase among men, but a 17.7% decrease among women, across all ethnic and racial groups. Rates are disproportionately high in certain cities or geographic regions such as the South. Chancroid reflected a decline from 0.3 cases per 100,000 in 1980 to 0.01 cases per 100,000 in 2001.

[By comparison, *Chlamydia trachomatis* (a notifiable disease in 1995) increased from 190.42 cases per 100,000 in 1990 to 278.3 cases per 100,000 in 2001. Regional data suggest that declines in prevalence of chlamydia may be related to increased use of screening programs through family planning clinics.

[In 2000, rates of chlamydia and gonorrhea were higher for female 15- to 19-year-olds and in male 20- to 24-year-olds. In 2001, the rate for females was 435.19 cases per 100,000. Disproportionately higher rates of chlamydia occurred among blacks and American Indian and Alaskan Natives, showing a similar pattern for gonorrhea and syphilis, both primary and secondary.

[Estimates of human papilloma virus prevalence suggest that up to 20 million people are infected, with the prevalence of HPV-16 being at least twice as high among women as among men. Based on data from the *National Health and Examination Survey (NHANES)* of 1999, estimated prevalence of herpes in the general U.S. population ages 14 to 49 was 19%, suggesting an increase in prevalence among teens over the last two decades.

[Consequences of STDs place women at risk for more-serious medical complications. Pelvic inflammatory disease (PID) is a serious consequence associated with gonorrhea and chlamydia, which can lead to infertility, chronic pelvic pain, and ectopic pregnancy. The consequences of reactivation or reinfection of certain types of HPV, with its increased risk for dysplasia and cervical cancer in women, make this an especially serious STD. Herpes, hepatitis B, and HIV infection can be passed from an infected woman to a fetus or infant.

[In the United States, state and federally funded programs for reporting, control, and prevention underscore the need for heightened awareness of the magnitude of epidemics associated with sexual activity. Despite the decline of STDs such as syphilis, the patterns of increase of HIV in selected subpopulations and viral STDs, such as genital herpes and HPV across all socioeconomic levels and among teens, call for new behavioral surveillance and relevant interventions related to sexual practices and relationships (Cates et al. 1999; CDC 2000, 2001, 2002, 2003; Gross 2003; National Center for Health Statistics 2002). (*End of update by K. A. Gordon*)]

[*Human Papilloma Virus and Cervical Cancer*

PEGGY CLARKE

[*Update 2003*: Worldwide, cervical cancer is the second most common cancer in women. In the United States, cervical cancer accounts for over 12,000 new cases and over 4,400 deaths each year. Detected early, this cancer is preventable in virtually all cases. In recent years, the direct link between cervical cancer and human papilloma virus (HPV), which is a sexually acquired infection, has been confirmed.

[There are over 70 different strains of HPV, only a small number of which are linked to cervical cancer. Other strains, of significantly lower health risk and non-cancer causing, can appear as visible genital warts. As many as 20 million Americans may be infected with one or several strains of HPV, some of which pass out of the body undetected. Most HPV infections are transient and the majority of those infected are unaware of the infection and shed the virus with no ill effects. In most cases, the HPV virus is harmless and

carries no symptoms; however, an HPV infection that causes changes in the cervical cells can, if left untreated, lead to cervical cancer.

[While anyone who has ever been sexually active may have acquired an HPV infection, only rare cases will lead to cervical cancer. However, cervical cancer is fully preventable, if early pre-cancerous cells can be detected and treated early. The PAP test detects changes in the cervix, showing that a person may be at risk for cervical cancer. This test involves collecting a small sample of cells from the cervix, with subsequent examination under a microscope for the presence of abnormal cells.

[In addition to the PAP test, there now exists a test to detect the presence of specific cancer-related types of HPV. This test is performed by collecting cells from the cervix and is then sent to a lab for evaluation. Testing for HPV infection, in combination with a PAP test, has been approved for routine screening of women who are 30 years and older. (The combination test is called DNA with PAP test.) A negative test result means the patient has little or no risk of having cervical cancer, providing added confidence in the screening for infection. A positive test result indicates the presence of cancer-related HPV. A positive HPV test result with a normal PAP result does not mean the patient has or will develop cervical cancer; however, following screening guidelines, the positive result indicates the need for close medical monitoring. (*End of update by P. Clarke*)]

B. HIV/AIDS

A National Perspective, 1997 ANDREW D. FORSYTH

In a single decade, human immunodeficiency virus (HIV), the agent that causes acquired immunodeficiency syndrome (AIDS), has become one of the greatest threats to public health in the United States. By 1992, AIDS surpassed heart disease, cancer, suicide, and homicide to become the leading cause of death among men between ages 25 and 54 (CDC 1993a). Similarly, AIDS became the fourth leading cause of death among women between ages 25 to 44 in 1992 and the eighth leading cause of death among all United States citizens. Over one million people are estimated to be infected with HIV in the United States—approximately 1 in 250—and over 441,528 cases of AIDS have been diagnosed, 62% of which have already resulted in death (CDC 1994a).

Trends suggest that AIDS will continue to have a significant impact in the United States in coming years. Throughout the 1980s and early 1990s, there was a steady increase in the number of documented AIDS cases. However, between 1993 and 1994, the number of AIDS cases reported to public health departments nationwide dramatically increased because of the implementation of an expanded surveillance definition of AIDS, which included cases of severe immunosuppression manifesting in earlier stages of HIV infection. Although the number of AIDS cases declined in 1994 relative to the previous year, it still represents a considerable increase over cases reported in 1992 (CDC 1995a).

Consistent with previous years, the most severely affected segment of the U.S. population in 1994 was men who have sex with men. Although men constitute 82% of all AIDS cases reported among adults and adolescents (13 years or older), men who have sex with men represent the single largest at-risk group, constituting 44% of all nonpediatric AIDS cases (CDC 1994a). Young men who have sex with men (between ages 20 and 24) constitute a particularly salient at-risk group for HIV infection, representing 60% of AIDS cases among all men of that same age. In contrast, 53% of all men with AIDS occur in men who have sex with men.

Even so, the number of AIDS cases reported among men who have sex with men decreased by 1.1% for the second

consecutive year in 1992, suggesting that infection rates among this segment of the population may be leveling off (CDC 1993a). The same cannot be said for heterosexual men who inject drugs and men who inject drugs and have sex with men; they represent the second and third largest at-risk groups among men, explaining 24% and 6% of AIDS cases, respectively (CDC 1994b). Newly reported AIDS cases for these groups continue to increase sharply. Although only 4% of all men diagnosed with AIDS by 1994 were infected via sexual contact with an infected woman, they had the largest proportionate increase in AIDS cases among all men in recent years (CDC 1994a).

The proportion of AIDS cases reported among women has more than doubled since the mid-1980s (CDC 1994b). In 1994, 58,448 cumulative cases of AIDS were documented among women, comprising 13% of all adults and adolescents (13 years or older) diagnosed with AIDS in the United States (CDC 1994a). Although they represent a minority of all AIDS cases, the incidence of AIDS among women has increased more rapidly than have rates for men, with over 24% of all cases of AIDS among women reported in the last year alone (CDC 1994b). The impact of the CDC's implementation of the expanded case definition for AIDS is particularly salient for incidence rates among women: In 1994, 59% of cases of women with AIDS were reported based on the revised surveillance definitions. Correspondingly, the incidence of AIDS opportunistic illness (AIDS-OI) has increased more rapidly among women than it has for men. Overall, the modes of HIV transmission for women also differ considerably from those for men: Women are most likely to be infected via intravenous drug use (41%) or sex with infected men (38%). Although 19% of women with AIDS reported no risk of exposure to HIV, follow-up data from local public health departments suggested an inverse trend. Most of those with previously unidentified risk exposure were infected via heterosexual contact (66%) or intravenous drug use (27%) (CDC 1994b).

Because women of childbearing age (i.e., 15 to 44 years old) represent 84% of AIDS cases among women, perinatal transmission of HIV presents itself as a serious problem (CDC 1994b). In comparison with the statistics for HIV transmission for all women cited above, the most frequently reported modes of HIV transmission for seropositive new mothers were by heterosexual contact with infected male partners (36%) and injection drug use (30%) (CDC 1994a). However, it is often impossible to separate these two avenues of infection, because women may be having sex with of an infected male while also using IV drugs, both before and during pregnancy. According to recent trends, approximately 7,000 HIV-infected women gave birth to infants in the United States in 1993; about 30% of these infants may have contracted HIV perinatally (Gwinn et al. 1991). In 1994, 1,017 cases of AIDS were documented among children less than 13 years of age, an increase of 8% from 1993. In 92% of these cases, children contracted HIV perinatally (CDC 1994a). Demographically, there were no apparent differences in perinatal transmission rates between boys and girls; however, most newly reported cases of pediatric AIDS occurred among African-American (62%) and Hispanic (23%) children (CDC 1995a). By December 1994, a cumulative total of 6,209 AIDS cases were documented among children 13 years or younger (CDC 1994a).

In any discussion of incidence, etiology, and the avenues of infection for HIV/AIDS, the official CDC statistics are quite misleading, especially when comparing figures for different years. The clinical definition of the AIDS syndrome has been expanded several times, making the incidence seem comparatively lower in earlier years. In addi-

tion, the CDC has not been consistent in studying modes of infection, especially for women. The intake interview questions asked of men and women seeking HIV testing have changed significantly over the years; they also differ significantly for men and women, with several possible avenues of infection left out in the questions for women. In the 1980s, being born in a developing country could be listed as an avenue for men and women testing HIV-positive; women, but not men, were asked if they had had sex with a person from a developing nation. Also, the criteria for assignment to the "unidentified risk" category has changed back and forth, which in turn raises or lowers the number of infected individuals in other categories.

Clearly, adolescents and young adults are at-risk for HIV infection as well, although modes of transmission for them vary considerably. In 1994, there was a cumulative total of 1,965 cases of AIDS among adolescents between ages 13 and 19 years (CDC 1994a). For this age group, males represented 66% of AIDS cases and most frequently contracted HIV through receipt of infected blood products (44%), through sex with men (32%), or through injection drug use (7%). In contrast, females between the ages of 13 and 19 most frequently contracted HIV through sexual contact with infected men (52%) or injection drug use (18%); 22% of these young women failed to identify an exposure category. For young adults between the ages of 20 and 24, men represented 77% of AIDS cases, most of whom contracted HIV through sex with men (63%), injection drug use (13%), or sex with men and injection drug use (11%). Young women in this group were most likely to be infected with HIV through sexual contact with infected men (50%) or injection drug use (33%). Another 14% of women in this age group failed to identify an exposure category, although it is possible that the most frequent mode of transmission for them and their younger peers parallels that of older women who initially failed to report an exposure category, most of whom were infected via sexual contact with infected men (CDC 1994a).

The impact of the AIDS epidemic has been especially devastating in communities of color in the United States, largely because of a number of socioeconomic factors that disproportionately affect racial and ethnic minorities (CDC 1993b). Although they represent only 21% of the population, racial and ethnic minorities presently constitute 47% of cumulative AIDS cases among adult and adolescent men, 76% of cases among adult and adolescent women, and 81% of all pediatric AIDS cases (CDC 1994a). In 1994, African-Americans and Hispanics alone represented 58% of the 80,691 reported AIDS cases for that year, and they had the highest rates of infection per 100,000 people (100.8 and 51.0, respectively). In contrast, Asian/Pacific Islanders and American Indians/Alaska Natives comprised 577 (0.007%) and 227 (0.003%) of AIDS cases, respectively, reported in 1994 and had the lowest rates of infection per 100,000 people (6.4 and 12.0%, respectively). Whites comprised 33,193 (41%) of AIDS cases reported in 1994 and had the third highest infection rate per 100,000 people (17.2%).

The disproportionate effects of AIDS on racial minorities in the U.S. are most salient among women and children. In 1994, infection rates among African-American and Hispanic adult and adolescent women (i.e., 13 years and older) were 16.5 and 6.8 times higher than were rates for white women of the same ages, respectively (CDC 1994a). Likewise, infection rates among African-American and Hispanic children (i.e., less than 13 years old) were 21 and 7.5 times higher than were rates for white children, respectively. Although racial and ethnic status do not themselves confer risk for HIV/AIDS, a number of sociocultural factors

inherent to many communities of color increase the risk of HIV infection, including chronic underemployment, poverty, lack of access to health-education services, and inadequate healthcare (CDC 1993b).

Clearly, AIDS has quickly emerged as a leading threat to public health facing United States citizens. Although there appear to be trends indicating that the impact of AIDS is leveling off in some risk groups (e.g., men who have sex with men), it is increasing steadily in others (e.g., African-American and Hispanic women and children). Furthermore, it is possible that additional segments of the population are currently "at risk" for HIV infection, including the severely mentally ill, older adults, and women who have sex with women. AIDS cases among them may constitute a third wave in the AIDS epidemic.

Because there is no cure for AIDS, behavioral change that reduces risk of exposure to HIV (e.g., unprotected sex and sharing of needles while injecting drugs) is paramount. Interventions focusing on AIDS education, self-protective behavioral change, and utilization of existing medical and testing services together represent the most promising course of action in the prevention of HIV infection and AIDS in the United States.

The clinical definition of AIDS has been revised twice by the Centers for Disease Control, first in 1987 and then in 1993, when new female symptoms for invasive cervical (stage 4) and other disease were added, along with a revision in the T4 (helper) cell count. These redefinitions need to be considered when interpreting statistics on the rates of AIDS infection.

Confidential testing for HIV status is available nationwide, with a free or sliding-scale fee and counselors available to assist in informing partners of HIV-positive persons. Several states have won the right to test all prospective employees for HIV and share this information with related agencies. The American Civil Liberties Union has won a court decision denying mandatory testing. Legal and ethical challenges posed by HIV/AIDS are far-reaching, and it may be another decade before consistent, reasonable, and effective guidelines emerge.

Although African-Americans constitute 12% of the population, they represent 27% of the reported AIDS cases (CDC 1992), these infections being more because of heterosexual intercourse and IV-drug use than to gay and bisexual men. Hispanics are also overrepresented, with 16% of reported cases. Consequently, there is an urgent need for development of the education and prevention programs in the African-American and Latino communities.

College students pose a particular problem. Changes in college-student behaviors between 1982 and 1988 were not encouraging. In a comparison of student behavior among 363 unmarried students in 1982 (when the term AIDS was coined and few articles were published on the subject) and 273 students in 1988, the number of students having intercourse, the number of partners, and the lifetime incidence of intercourse all increased. In 1988, 72% of men and 83% of women had received oral sex, and 69% of males and 76% of females had given oral sex; 14 and 17%, respectively, had engaged in anal sex. Twenty percent of males and 12% of females in 1988 had four or more partners. Students with multiple or casual partners were less likely to use condoms; there also was no increase in condom use from the first to the most recent intercourse (Bishop & Lipsitz 1991).

Despite the need and proven effectiveness of sterile needle-exchange programs for IV-drug users and the free distribution of condoms in high schools, both programs have met considerable opposition from conservative groups and the religious right. At the same time, the need for safer-

sex education for all segments of the population has allowed educators to make considerable progress in general sexuality education that might not have been possible if AIDS did not pose such a major public health problem.

[Emerging Trends Prior to 2000]

PATRICIA BARTHALOW KOCH

[Update 1998: A major development in the course of the AIDS epidemic in the United States was heralded in 1996. For the first time, there was a marked decrease in deaths among people with AIDS (PWAs)—12% less during the first two quarters of 1996 as compared to 1995 (CDC 1996). This decline in deaths is likely because of two factors:

1. The slowing of the epidemic overall, in part because of the effectiveness of prevention efforts, with an increase in people diagnosed with AIDS of only 2% in 1995; and
2. Improved treatments, including the use of protease inhibitors, which lengthen the lifespan of PWAs.

[Yet, it must be noted that AIDS deaths are not declining among all groups. For example, deaths declined among men by 15% but increased among women by 3%. Deaths declined among men who have sex with men by 18%, among injecting-drug users by 6%, but increased among people contracting AIDS through heterosexual contact by 3%. The death rate is also not decreasing equally among various racial/ethnic groups. Declines were greater among whites (21%) than among Hispanics (10%) or blacks (2%).

[The cumulative number of AIDS cases reported to the CDC through June 30, 1997, was 612,078. Adult and adolescent cases totaled 604,176, with 511,934 (85%) cases in males and 92,242 (15%) cases in females. An additional 7,902 cases were reported in children under age 13. Racial/ethnic minorities continued to be disproportionately affected by AIDS, as illustrated by the breakdown of AIDS cases by race/ethnicity: white, not Hispanic—279,072 (46%); black, not Hispanic—216,980 (36%); Hispanic—109,252 (18%); Asian/Pacific Islander—4,370 (7%); American Indian/Alaskan Native—1,677 (3%).

[With the increasing number of people living with HIV and AIDS, additional resources will be needed for services, treatment, and care. A major breakthrough in the treatment of HIV disease has been the use of “drug cocktail” therapy, which combines the use of multiple drugs, usually a protease inhibitor with one or two reverse transcriptase inhibitors. Research has shown that this combination-drug therapy can dramatically prolong survival and slow disease progression in people with advanced AIDS, as well as holding the virus for many months below minimum detectable blood levels (Smart 1996). In fact, AIDS deaths in the United States declined 44% between 1996 and 1997. As of mid-1998, the long-term effectiveness of these treatments is unknown, with concern over the development of resistance leading to more virulent strains of HIV. Also, the expense of these drugs (approximately \$20,000 or more per year) prohibits large segments of HIV-infected people, often from minority groups, from receiving treatment. Prevention efforts must still be emphasized, since they remain the best and most cost-effective strategies for containing HIV and saving lives. (End of update by P. B. Koch)]

[Update 2002: UNAIDS Epidemiological Assessment: The current status of the epidemic and recent trends in the U.S. include the following:

- Women account for an increasing proportion of people with HIV and AIDS, but men still account for the largest proportion.

- Racial/ethnic disparities among people with HIV and AIDS continue to increase. Among men with AIDS recently diagnosed, 62% were non-Hispanic black or Hispanic; among women, 81% were non-Hispanic black or Hispanic.
- The impact of HIV among adolescents and young adults (ages 13 to 24 years) is not apparent from AIDS case surveillance data alone. In 25 states with HIV reporting, adolescents and young adults accounted for 13% of recent HIV diagnoses compared with 3% of AIDS diagnoses. HIV surveillance data suggest steady HIV transmission among people in this age group.
- HIV surveillance data indicate an epidemic with higher proportions of women, blacks, and heterosexually acquired infections than indicated by AIDS case data alone.
- Male-to-male sexual contact, still the predominant mode of HIV exposure, accounted for 41% of all recent AIDS diagnoses, and 54% of cases recently diagnosed among men.
- The proportion of AIDS cases attributed to heterosexual contact has continued to increase, and accounted for 22% of recently diagnosed cases (11% of cases among men, and 59% of cases among women).
- Injection drug use accounted for 30% of all recently diagnosed AIDS cases (27% of cases among men, and 38% of cases among women).
- Perinatally acquired AIDS has declined significantly, primarily because of the use of zidovudine to prevent HIV transmission.
- Regional trends: In all regions of the United States, most AIDS cases, cumulative and recent, have been diagnosed among persons from larger metropolitan areas. In each region, rates (cases reported per 100,000 population) were highest in the large metropolitan areas, intermediate in smaller metropolitan areas, and lowest in rural areas. Large metropolitan-area rates were highest in the Northeast; smaller metropolitan-area rates were highest in the Northeast and South; and rural-area rates were highest in the South.

[The estimated number of adults and children living with HIV/AIDS on January 1, 2002, were:

Adults ages 15-49:	890,000	(rate: 0.6%)
Women ages 15-49:	180,000	
Children ages 0-15:	10,000	

[An estimated 15,000 adults and children died of AIDS during 2001.

[No estimate is available for the number of American children who had lost one or both parents to AIDS and were under age 15 at the end of 2001. (End of update by the Editors)]

[A 2003 HIV/AIDS Update ROBERT T. FRANCOEUR]

[Update 2003: In 2002, for the first time in a decade, the number of newly diagnosed cases of AIDS rose in the United States, a disturbing turnaround that health officials warn reflects growing complacency about the dangers of HIV.

[For gays and bisexual men, HIV diagnoses rose for the third straight year. HIV diagnoses among gay and bisexual men rose 7.1% in 2002 in 25 states with long-standing HIV reporting procedures, according to the Centers for Disease Control and Prevention. The number represented an increase of nearly 18% since 1999, disturbing because the number of newly diagnosed HIV cases per year fell steadily throughout the 1990s, even among gay men. For the country as a whole, the CDC reported 42,136 AIDS diagnoses in 2002, a 2.2% increase from the previous year, and the first rise since 1993.

[The increase in HIV cases can be blamed on a younger generation that does not remember the devastation of the AIDS epidemic, lack of concern because of the advent of life-extending AIDS-treatment drugs, and burnout from years of safe-sex warnings. Other reasons for the increase include persons at risk are not diagnosed early enough and pass the infection to others before they know they have HIV, and the difficulty of HIV+ persons adhering to complex HIV drug regimens. There were 16,371 AIDS deaths in 2002—a 5.9% decline from 2001.

[These statistics indicate the need for more prevention efforts aimed at gay and bisexual men. One strategy announced by the CDC involves providing money to community groups in large cities that have had outbreaks of sexually transmitted diseases, such as syphilis and AIDS (July 29, 2003: <http://www.cdc.gov>). (*End of update by R. T. Francoeur*)]

[HIV/AIDS among Latinos and Latinas

MIGUEL A. PÉREZ and HELDA L. PINZÓN-PÉREZ

[*Update 2003:* According to the CDC, the proportional distribution of AIDS cases in the United States has shifted among U.S. ethnic groups. Gender, cultural factors, perceptions of HIV/AIDS and/or stigma associated with AIDS, perceptions of the quality and availability of services, among other factors, have a tremendous impact on behaviors that put Latinos at risk for infection.

[While the rates have decreased among whites, the number of cases among Latinos has increased accordingly. In 1996, Latinos accounted for 17.3% of all male AIDS cases in the United States; that figure had increased to 19% by 2000 (CDC 1996; CDC 2002). As of June 1998, Latino men accounted for 18%, and Latinas 20%, of the cumulative AIDS cases, respectively (CDC 1998). Table 20 shows the proportion of AIDS cases among ethnic groups in the U.S. and contrasts that to the proportion of the population they represent.

[Latinos in their reproductive years seem to be at a great risk for HIV infection. In addition to the known risk factors for HIV infection (see Table 21), risk factors for Latinos include poverty, lack of access to healthcare, sexual roles,

and socioeconomic factors (Blasini-Caceres & Cook 1997; Keeling 1993).

[The data show an increase in the number of HIV and AIDS cases among Latinas in the United States. A comparison by gender and ethnicity is found in Table 22. In fact, intravenous drug use and sexual contact with men seem to be the primary transmission modes for Latino women (Blasini-Caceres & Cook 1997). Weeks and colleagues (1995) concluded that, although the number of heterosexual cases is increasing among Latinas, the number of AIDS-prevention programs geared towards them continues to be inadequate.

[Among Latinos, Puerto Ricans have the highest incidence of HIV infection. Puerto Ricans also have the fourth-highest rate in the nation (NCLR 1992). According to the Centers for Disease Control and Prevention (1993), up to 70% of AIDS cases are related to intravenous drug use in Puerto Rico.

[Studies among Latinos have yielded different results in regard to awareness about HIV/AIDS. Dawson (1990) reported that 41% of Latinos said they had some knowledge about AIDS, compared to 39% for African-Americans and 48% for European-Americans. However, less than half (48%) of Latinos understood the connection between HIV and AIDS, compared to 69% among European-Americans. These figures did not vary greatly two years later, when Schoenborn, Marsh, and Hardy (1994) reported that 40% of Latinos, 47% of European-Americans, and 39% of African-Americans had “some” knowledge about AIDS. In a study of Latinos, Miller, Guarnaccia, and Fasina (2002) found lower knowledge levels about AIDS among individuals with lower acculturation levels and whose primary language was Spanish. The same study found that Latinos were knowledgeable about general facts and about transmission modes.

[Latinos are less likely than other ethnic groups to accurately identify HIV-transmission modes. Alcalay, Sniderman, Mitchell, and Griffin (1990) found that Latinos were more likely (36%) than European-Americans (15%) to believe they could get AIDS from blood donations. The same study found that Latinos were more likely than non-Latinos to believe that HIV transmission could occur through casual contact (e.g., hugging or from water fountains). Dawson (1990) found that 7% of Latinos believed it was “very likely” they could become infected with HIV by eating at a restaurant where the cook had AIDS, compared to 5% of European-American respondents. The researchers also found that 19% of Latinos believed they could catch AIDS from an unclean public toilet, whereas only 8% of the European-American respondents and 10% of African-Americans believed this to be an exposure category. In 2002, Miller, Guarnaccia, and Fasina found that Latinos could correctly identify transmission modes regardless of acculturation level.

[Knowledge about AIDS seems to be related to language preference among some Latinos. Research indicates that Spanish-speaking Latinos are more likely than bilingual Latinos to believe AIDS is spread through casual contact (Hu

Table 20

2000 AIDS Cases in the U.S. by Population Group

	Percentage of AIDS Cases	Percentage of Estimated Population
Whites	32%	71%
African-Americans	47	12
Hispanics/Latinos	19	13
Asian-Americans	1	4
Native Americans	< 1	1

Source: CDC 2002

Table 21

Adult Male AIDS Cases by Exposure Category

	White Non- Hispanic	Black Non- Hispanic	Hispanic
Men who have sex with men (MSM)	68%	27%	35%
Injection drug use (IDU)	12	36	36
MSM and IDU	8	6	5
Heterosexual contact	5	16	13
Other/Not identified	7	16	11

Source: CDC 2002

Table 22

2000 AIDS Cases in the U.S. by Gender

	Female	Male
Whites	1,895	11,466
African-Americans	6,545	13,218
Hispanics/Latinos	1,855	6,285
Asian-Americans	77	300
Native Americans	68	135

Source: CDC 2002

& Keller 1989). Another survey found that 24.1% of Spanish-speaking Latinos answered positively to the question, "Do you believe that one can catch AIDS from shaking hands with someone who has AIDS?" in comparison to 1.7% of English-speaking Latinos (Alcalay, Sniderman, Mitchell, & Griffin 1990).

[Hu and Keller (1989) found that, despite their lesser knowledge about AIDS, Spanish-speaking Latinos reported a higher interest in learning about AIDS (88%) than English-speaking groups (83%). Pérez and Fennelly (1996) found that Latino farm workers are willing to learn about AIDS, even though their reluctance to discuss sex has not decreased. One might expect that lower levels of knowledge about HIV/AIDS among Latinos in the United States would lead to more discrimination towards persons with AIDS. Instead, Alcalay et al. (1990) found no differences between Latinos and non-Hispanics in their likelihood to support AIDS victims' rights. (*End of update by M. A. Pérez and H. L. Pinzón-Pérez*)]

C. HIV/AIDS: Five Specific Emerging Issues

LINDA L. HENDRIXSON

AIDS as a Family Dilemma

As the AIDS pandemic continues through its second decade in the United States, unforeseen issues have emerged as important considerations in attempts to meet the needs of people living with AIDS (PLWAs).

What began as a disease syndrome affecting individuals has become a problem which confronts whole families in America. Researchers, health providers, and policymakers have had to re-work their approaches to take into account the impact that AIDS has on family members, both immediate and extended. Our definition of "family" has undergone much change throughout this pandemic. As we consider the people who care for PLWAs, and those who care about them, family has come to be defined much more broadly than before. The family of origin has been replaced or extended to include non-blood-related friends, lovers, AIDS buddies, and others who provide emotional and instrumental support.

For many PLWAs, estrangement from birth families is a way-of-life. AIDS exacerbates those earlier problems. Others become estranged after their diagnosis is discovered. Families who have not disclosed the illness of their family member live with fear of ostracism and discrimination. If an AIDS diagnosis is kept secret within the family, social isolation becomes a continuing problem. Family pressures escalate if children are involved, especially if those children are infected. The financial strain of caring for adults and/or children with AIDS can be considerable. Finding competent doctors is an additional serious challenge throughout the country. Medical costs, health insurance, adequate health-care, and social support, caregiving, child custody, disclosure, stigma, discrimination, loss, and grieving are among the troubling issues facing families and others living with AIDS (Macklin 1989).

Emerging Populations and Changing Locales

AIDS is no longer found in what were originally perceived to be the only affected American AIDS populations—white, middle-class gay men and minority intravenous drug users in the inner cities (Voeller 1991; Wiener 1991). AIDS is now found in:

- people who live in rural locations;
- middle- and upper-class women, many of whom do not misuse drugs or alcohol;
- women who have only vaginal sex with men;
- women who have rectal sex with men, but do not report this behavior;

- women who have received contaminated donor semen;
- women who have had oral sex with other women;
- middle- and upper-class men;
- men who have only vaginal sex with women, and do not have sex with other men;
- black, Hispanic, and Asian gay and bisexual men;
- teenagers who have been sexually abused as children;
- people who use drugs, such as heroin, but do not use needles;
- athletes who use contaminated needles while injecting illegal steroids;
- women with blood-clotting disorders;
- people who have received contaminated organ transplants and other body tissues;
- senior citizens; and
- babies who nurse from infected mothers.

There is no longer a statistically precise AIDS profile or pattern. To a great extent, epidemiological categories have become meaningless.

The spread of AIDS to rural and small-town locations is worth noting. Most people still equate AIDS with major urban areas, and, true, the numbers of cases are highest there. However, the pandemic has diffused from urban epicenters, past suburbia, and into small, rural enclaves in the U.S. (Cleveland & Davenport 1989) The spread of AIDS in Africa along truck routes, as men seek sex away from home, is not unlike the spread of AIDS along major highways in the U.S., as people travel in and out of metropolitan AIDS epicenters. The government is paying little attention to rural AIDS in America; it is the least understood and least researched part of our national epidemic, with numbers of infected rising dramatically.

Limited research shows that some PLWAs who left their rural birthplaces for life in the city, are now returning to their rural families to be cared for. But many PLWAs who grew up in cities are leaving their urban birthplaces and moving to the country where they believe it is healthier for them, mentally and physically. This is especially true for recovering addicts whose city friends have died of AIDS, and who hope to escape a similar fate.

Besides the "in-migration" of people with AIDS to rural locations, there are many indigenous people in small towns who are infected as well. The numbers of cases of HIV/AIDS is increasing rapidly in rural America, where social services are inadequate, medical care is generally poor, and community denial is a reality. Federal and state monies continue to be channeled to inner-city agencies, leaving rural and small-town providers with scant resources to ease increasing caseloads (Hendrixson 1996).

Complexion of the Pandemic

The face of AIDS is changing in other ways, as well. There is now a considerable number of infected people who have outlived medical predictions about their morbidity and mortality. These are divided into two groups: asymptomatic non-progressors, and long-term survivors. Both groups test HIV-antibody-positive, indicating past infection with human immunodeficiency virus.

Despite being HIV-antibody-positive, the first group shows no other laboratory or clinical symptoms of HIV disease. The second group has experienced immune suppression and some opportunistic infections, and is diagnosed as having AIDS, but continues to live beyond its expected lifespan (Laurence 1994). In addition, there are others who are inexplicably uncharacteristic:

- people who have been diagnosed with AIDS, but who do not test HIV-antibody-positive, meaning that there is no

indication of previous exposure to the virus, despite their illnesses;

- people who have “retro-converted” from testing HIV-antibody-positive to now testing HIV-antibody-negative; and
- people who are repeatedly exposed to HIV through sex or contaminated blood and who do not become infected.

Scientists have no explanation for these anomalies. Little research has been done on people who do not fit the accustomed pattern physicians look for. Yet, the very fact that they challenge medical expectations is a clue that they hold answers that may help thousands of others in this country.

In many ways, some new drug treatments have helped infected people forestall serious illnesses, turning AIDS into more of a chronic than an acute-illness syndrome. Yet many PLWAs have renounced AZT and other toxic antiretroviral drugs, because of their serious side effects. Increasing numbers of patients are embracing alternative therapies—physical, mental, and spiritual—rather than taking potent AIDS drugs. Others are combining the best of conventional and unconventional medicine in their own self-styled treatment plans. The new protease inhibitors offer much promise, but it is too early to know what side effects they may produce. The bottom line is that AIDS no longer automatically equates with death (“The End of AIDS” 1996).

HIV-Positive Children Coming of Age

As life is extended, more and more children born with the virus are moving through late childhood and early adolescence in relatively good physical health. New challenges await them and their families. Some children may know they are infected with HIV; others may not. They continue to grow socially, with sexual feelings beginning to emerge. How do we help them fit in with their uninfected peers? How do we teach them about their sexuality? How do we prepare them for dating situations? What do we say when they speak of marriage hopes? How do we teach them about safer sex? What new approaches in HIV/AIDS education should health teachers consider as these children enter their classes? Parents, teachers, and youth leaders are wrestling with new questions that were unanticipated ten years ago when we believed that HIV-antibody-positive children would not live much beyond toddlerhood.

New Paradigms, New Theories

At least one revolutionary theory about AIDS is gaining prominence, as a cure for the syndrome continues to elude us. Dr. Peter Duesberg, a cancer geneticist, virologist, and molecular biologist at the University of California-Berkeley, and a member of the elite National Academy of Sciences, along with other well-established scientists, has challenged the standard medical and scientific HIV hypothesis. He maintains that AIDS researchers have never definitively proven that HIV alone causes AIDS. He theorizes that HIV cannot be the sole cause of such a complex cascade of physiological events as the complete suppression of the entire human immune system, eventually leading to fatal opportunistic infections and conditions such as cancer and dementia.

Duesberg, one of the first scientists to discover retroviruses, the family of viruses to which HIV belongs, contends that HIV is a benign “carrier” retrovirus which a healthy immune system inactivates as it would any intruder. HIV antibodies result from this normal defense response. Being HIV-antibody-positive only means that a person’s immune system is working properly. It does not mean that the person will develop AIDS.

Duesberg and others believe that the serious immune suppression which manifests as severely lowered T-cell counts and opportunistic infections that may become fatal,

can result from one or more of the following factors, all of which are immune-suppressive:

- continuous, long-term misuse of legal and illegal recreational drugs, including sexual aphrodisiacs such as nitrite inhalants, used by men to facilitate rectal sex with other men;
- over-use of prescription drugs, including antibiotics, antivirals, and anti-parasitics, often taken for repeated sexually transmitted infections;
- toxic effects of AZT and other antiretroviral drugs, which are intended to interfere with cell DNA replication (“DNA chain terminators”), and, therefore, kill *all* body cells without discrimination;
- malnutrition, which often accompanies long-term illicit drug and alcohol use; or
- untreated sexual diseases and other recurring illnesses, which also suppress immunity.

One or a combination of these factors eventually brings on the potentially fatal condition which the CDC arbitrarily calls “AIDS.”

Duesberg points to the number of people with AIDS who do not test HIV-antibody-positive, as well as those who are HIV-antibody-positive but are not symptomatic. He questions why scientists are not interested in studying these people who defy the accepted AIDS dogma. Duesberg’s efforts to have his research papers published by the mainstream American scientific press, to present his views at scientific AIDS conferences, and to be awarded funding to do additional AIDS research have met with virtual failure in this country.

Duesberg (1996) has been shut out by the powerful medical/scientific establishment which pretends to be open to new ideas and theories, but which, he maintains, is chained to the HIV-equals-AIDS hypothesis. He presented his challenge in a 1996 book titled *Inventing the AIDS Virus*.

Conclusion

In the 15th year of the AIDS pandemic, we have no cure and no vaccine for this disease. Thousands have died in our country, most of them young people. Thousands more have died in other countries. New advances in drug treatments and alternative/holistic modalities have helped some American PLWAs, but many families continue to silently mourn the death of their loved ones. The stigma of AIDS is ever-present; the fear continues. Yet, compassion and love have emerged, as well, as caring people reach out to help those who are suffering. AIDS appears to have “dug in” for the long term while science looks for answers. In the meanwhile, we need to ask two questions. First, as scientists search for the truth of AIDS, are they asking the right questions? Second, as the disease shifts from its former pattern of early, premature death to a more manageable long-term chronic illness, are we meeting the needs of all the people infected and affected by this disease—PLWAs, their families, and their loved ones?

D. The Impact of AIDS on Our Perception of Sexuality

RAYMOND J. NOONAN

Little has been written on the impact that AIDS has had and continues to have on our collective sensibilities about sexuality and our innate needs to express aspects of our sexual selves. Research has been sparse, if nonexistent, on the various meanings ascribed—both by professionals in the sexual sciences and members of the general public—to either sexuality itself or to the disease complex of AIDS.

Professionals in any field often serve to support and maintain the various cultural norms of any given society.

As such, with the exception of the safety-valve role of those who might be referred to as the “loyal opposition,” rarely are there expressions of sentiments or ideas that seriously challenge widely held beliefs and assumptions. Within the various disciplines encompassing the sexual sciences, the struggling theory, for example, that HIV may not be the direct cause of AIDS (see previous section), is one of the few examples of such reassessments. Among the popular press, nevertheless, various accounts have sporadically appeared with critical appraisals of either our general or specific approaches to current AIDS perspectives, including Farber (1993, 1993ab), Fumento (1990), Patton (1990), and others.

Current Trends

It cannot be denied that AIDS is a serious, debilitating, and potentially deadly disease. Yet, the American response to it has often been one in which the reality of the disease, as well as myths promoted as facts, have been appropriated to further some related or unrelated political aim. Metaphorical allusions are often used to discuss the issue, not to impart factual information about or to motivate persons to AIDS prevention, but to further a political agenda or even to attack some political group(s) perceived as adversaries. Such political goals and targets have included:

- claims that AIDS is God’s punishment for sexual impropriety made by some homophobic religious leaders and others;
- instituting and promoting sex education by supporters;
- the promotion of male contraceptive responsibility by some health and sexuality professionals;
- AIDS used as a scare tactic to discourage sexual activity, particularly among the young, by some parents and others;
- providing the “scientific” reason for postponing sexual activity, being more selective about who one’s sexual partners are, and reducing the number of sexual partners, by some educational, political, and health authorities;
- the promotion of monogamy and abstinence;
- the promotion of community and solidarity among compatriots, from gays to fundamentalist Christians, who perceive they are under attack;
- the use of AIDS to promote anti-male, anti-white, and/or anti-Western attitudes; and
- the advocacy of some noncoital sex practices to communicate covert negative (heterophobic) views of heterosexuality and penile-vaginal intercourse (see Noonan 1996, 182-185).

For most sexologists and sexuality educators, the co-opting of the issues of protection and responsibility, especially for young people, reflects the intrinsically good part of human nature that seeks to find the “silver lining” in the dark cloud of HIV/AIDS. Although these political goals and targets probably do not apply to all people who are concerned about HIV/AIDS, these philosophies have had a more profound effect on overall public and professional approaches to sexuality and related issues than the number of their supporters would suggest. Some examples follow.

Although it is well known that anal intercourse offers the most effective way for HIV to be transmitted sexually, and that vaginal-penile intercourse is far less risky, rarely have investigators asked those whose infections are suspected to have been heterosexually transmitted, particularly women, whether and how often they engaged in anal intercourse. Instead, heterosexually transmitted HIV infections are assumed to be vaginally transmitted, although this is generally unlikely on the individual scale, and not likely to result

in an HIV epidemic in the heterosexual population (Brody 1995; National Research Council 1993).

Concentrating only on the condom for both contraception and STD/AIDS prevention ignores the effectiveness of spermicidal agents with nonoxynol-9 in the prevention of pregnancy and infection as a reasonable alternative for couples who object to condom use (North 1990) (see Table 18 in Section 9A on contraception). It also ignores the negative impact condoms have on sexual intimacy for some couples (Juran 1995).

In addition, our terminology with respect to AIDS has had a profound impact on our perception of sexuality. For example, the well-known slogan, “When you sleep with someone, you are having sex with everyone she or he has slept with for the last x-number of years,” is believed to be literally true by many people. The effectiveness of this slogan is seriously undermined when questions are raised about the kind of statistical and/or epidemiological evidence available to support this statement. To many, such slogans imply a view of sexuality that denigrates *all* sexual experiences, no matter how valid or valuable they are or have been. The “epidemic” of AIDS is another phrase that many, if not most, people believe to be literally true. They fail to realize that the word is being used in its metaphorical sense, with its emotional connotations being more important than its literal truth. The same can be said for the statement, “Everyone is equally at risk for AIDS.” Granted this statement is true, but only in the trivial sense that we are all, as mortal human beings, prone to sickness and death. The fact that ethnic and racial minorities in the U.S. are disproportionately represented in the AIDS and HIV-positive statistics (CDC 1996) should dispel that myth completely. Brandt (1988) has insightfully analyzed the notion of AIDS-as-metaphor:

At a moment when the dangers of promiscuous sex are being emphasized, it suggests that every *single* sexual encounter is a promiscuous encounter. . . . As anonymous sex is being questioned, this metaphor suggests that no matter how well known a partner may be, the relationship is *anonymous*. Finally, the metaphor implies to heterosexuals that if they are having sex with their partner’s (heterosexual) partners, they are in fact engaging in homosexual acts. In this view, every sexual act becomes a homosexual encounter. (p. 77, emphasis in original)

In fact, our very use of the terms “safe” or “safer sex” implies that all sex is dangerous, when in fact it usually is not (Noonan 1996a).

It is typical within American culture to ignore the chronic problems that result from the general American unavailability with sexuality and sexual pleasure. In terms of responding to the health issues surrounding AIDS, Americans have two choices:

1. We can continue to respond as we have to other sexual issues, by spotlighting them and ignoring the broader issues of sane healthy sexuality, which includes the celebration of sexual intimacy and pleasure. This narrow panic response is typical of American culture and its dealing with such issues as teenage pregnancy, child sexual abuse, satanic ritual practices, sexual “promiscuity,” the “threats” to heterosexual marriage and the family posed by recognition of same-sex marriages, and the “epidemics” of herpes and heterosexual AIDS; or
2. We can respond to the AIDS crisis within the context of positive broad-based accommodation to radical changes in American sexual behavior and relation-

ships. This broad-based, sex-positive approach could well include: the availability of comprehensive, more affordable, and more reliable sexual-health and STD evaluations for men, comparable to the regularly scheduled gynecological exams generally encouraged for women; the development of effective alternatives to the condom, including the availability of effective male contraceptives that are separated from the sexual act of intercourse, easy to use, and reliable; making birth control as automatic for men as the pill has been for women (ideally, they would also work to prevent STDs); the expansion of research to make all contraceptives safe for both women and men; the elimination of fear as a method to induce the suppression of sexual behavior; and sex-positive encouragement for making affirmative intentional decisions to have sex, in addition to the “traditional” support for deciding not to do so (Noonan 1996a).

At this time, it remains unclear whether the American response to AIDS will follow its customary pattern of initial panic in the mass media, followed by a benign neglect and silence prompted by our traditional discomfort with sex-positive values, or whether this country will, at long last, confront the issue of AIDS, and deal with it in the broader context of a safe, sane, and healthy celebration of sexuality.

11. Sexual Dysfunctions, Counseling, and Therapies

A. Brief History of American Sexual Therapy

WILLIAM HARTMAN and MARILYN FITHIAN

The scientific study of sexual dysfunctions and the development of therapeutic modalities in the United States started with Robert Latou Dickinson (1861-1950). Born and educated in Germany and Switzerland, he earned his medical degree in New York and began collecting sex histories from his patients in 1890. In the course of his practice, he gathered 5,200 case histories of female patients—married and single, lesbian and heterosexual—and published extensively on sexual problems of women (Brecher 1979; Dickinson & Beam 1931, 1934; Dickinson & Person 1925).

The turn-of-the-century popularity of Sigmund Freud's psychoanalysis strongly influenced early American sexual therapy. Although its popularity has faded significantly, the psychoanalytic model is still practiced or integrated with other modalities by some therapists working with sexual problems. The 1948 and 1953 Alfred Kinsey studies brought an increased awareness of human sexuality as a subject of scientific investigation that could include the treatment of sexual disorders as part of psychiatry and medicine. The pioneering work of Joseph Wolpe and Arnold Lazarus (1966) in adapting behavioral therapy, shifted sexual therapy away from the analytical and medical model, as therapists began to view dysfunctional sexual behavior as the result of learned responses that can be modified.

William Masters and Virginia Johnson began their epoch-making study of the anatomy and physiology of human sexual response in 1964. Their initial research with 312 males and 382 females, published as *Human Sexual Response* (1966), remains the keystone of modern sex therapy, not just in the United States, but anywhere sex therapy is studied or practiced. *Human Sexual Inadequacy* followed in 1970. Masters and Johnson used a male-female dual-therapy team, and a brief, intensive, reeducation process that involved behavior-oriented exercises like sensate focus. It appeared to be highly successful because they worked with a select population of healthy people in basically solid relationships. After their success with relatively simple cases,

they and other therapists began to encounter more difficult cases, which could not be solved with the original behavioral approach.

In the early 1970s, Joseph LoPiccolo advocated the use of additional approaches designed to reduce anxiety within the behavioral therapy model suggested by Masters and Johnson (LoPiccolo & LoPiccolo 1978; LoPiccolo & Lobitz 1973; Lobitz & LoPiccolo 1972). LoPiccolo's (1978) analysis of the theoretical basis for sexual therapy identified seven major underlying elements in every sex therapy model: 1. mutual responsibility, 2. information, education, and permission giving, 3. attitude change, 4. anxiety reduction, 5. communication and feedback, 6. intervention in destructive sex roles, lifestyles, and family interaction, and 7. prescribing changes in sex therapy.

John Gagnon and William Simon (1973) stressed the importance of addressing social scripting in sex therapy. Harold Lief, a physician and family therapist, pointed out the importance of nonsexual interpersonal issues and communications problems as factors in sexual difficulties. Lief (1963, 1965) also advocated incorporating the principles of marital therapy into sex therapy. As therapists began to integrate other modes of psychotherapy, such as cognitive, gestalt, and imagery therapies, it soon became apparent that there was no single “official” form of sex therapy. In addition, some sex therapists became sensitive to the impact and influence of ethnic values on some sexual problems (McGoldrick et al. 1982).

Helen Singer Kaplan, a psychiatrist at Cornell University College of Medicine, made an important and profound contribution to sex therapy when she blended traditional concepts from psychotherapy and psychoanalysis with cognitive psychology and behavioral therapy. Kaplan's *New Sex Therapy* (1974) explored the role of such important therapeutic issues as resistance, repression, and unconscious motivations in sex therapy. This new approach focused not only on altering behavior with techniques like the sensate-focus exercises, but also with exploring and modifying covert or unconscious thought patterns and motivations that may underlie a sexual difficulty (Kaplan 1974, 1979, 1983).

Specific areas of sexual therapy have been developed, including Lonnie Barbach's (1980) and Betty Dodson's (1987) independent work with nonorgasmic women, Bernard Apfelbaum and Dean Dauw's use of surrogates in their work with single persons, William Hartman and Marilyn Fithian's (1972) integration of films, body imagery, and body work with dysfunctional couples, and Bernie Zilbergeld's (1978, 1992) focus on male sexual health and problems.

There have been no major innovative treatments developed in sex therapy programs in recent years, although new refinements continue to occur. Some would comment that one does not have to reinvent the wheel when the results are good, but the early success rates have declined as the presenting problems have become more complicated and difficult to treat. Nevertheless, self-reported success rates from reputable sex therapy clinics run between 80% and 92%. However, critical reviews of sex therapy treatment models emphasize the paucity of scientific data in determining the effectiveness of such programs.

Today, few professionals who counsel clients with sexual difficulties see themselves as pure sex therapists. More and more, the term “sex therapy” refers to a focus of intervention, rather than to a distinctive and exclusive technique. Individual psychologists, psychotherapists, marriage counselors, and family therapists may be more or less skilled in providing counseling and applying therapeutic modalities appropriate to specific sexual problems, but each tends to

apply those interventions and techniques with which they are more comfortable. The American Association of Sex Educators, Counselors, and Therapists and the American Board of Sexology each examine and certify treatment professionals' knowledge of human sexual functioning as well as their skills in treating sexual dysfunctions. Board-certified therapists, counselors, and physicians are likely to be a more reliable treatment resource.

Informal support groups also provide opportunities for dealing with sexual problems and difficulties. Many hospitals and service organizations provide workshops and support groups for patients recovering from heart attacks, and persons with diabetes, emphysema, multiple sclerosis, cystic fibrosis, arthritis, and other chronic diseases. These support groups usually include both patients and their partners.

B. Current Status 2003

JULIAN SLOWINSKI, WILLIAM R. STAYTON,
and ROBERT W. HATFIELD [Updated
August 2003 by R. W. Hatfield]

Recently, American sex therapy has incorporated important advances in medicine and pharmacology. More-precise knowledge and techniques now allow a therapist to develop a hormone profile for a patient, monitor nocturnal penile tumescence, and check penile and vaginal blood flow. With patients now more likely to report negative side effects of medications on their sexual responses, physicians have developed strategies for altering the course of medication. New surgical methods improve penile blood supply. Moreover, prosthetics, vacuum devices, oral medications, and other aids, like injections, urethral suppositories, and electrical devices to stimulate erection, have been developed.

Breakthroughs are also occurring in female sex research with direct implications for sex therapy. Examples include the efforts of sex-affirming women to redefine sexual satisfaction in women's terms and to expand our appreciation of the spectrum of erotic/sexual responses beyond the phallic/coital (Ogden 1995), Joanne Loulan's (1984) exploration of lesbian sexual archetypes, sexual responses of women with a spinal cord injury, the effects on women's libido of homeopathics to increase the bioavailability of testosterone, and work combining testosterone with estrogen replacement to increase both sexual desire and pleasure in perimenopausal women. One sidelight in this exciting female sex research is that the old methods of sensate focus and pleasuring exercises are still working successfully. For example, the self-help materials are still very useful in working with preorgasmic women. The traditional sensate-focus exercises are still effective in working with desire and orgasm issues, painful intercourse, and vaginal spasms.

More good news are the trends in treating male sexual dysfunction today. For the motivated and cooperative male, there is treatment for virtually every dysfunction. In addition to the ever-helpful sensate-focus exercises, we have medications for increasing desire and arousal, such as yohimbe, a bark extract of the African tree yohimbe, and a combination of green oat and palmetto-grass extract. These are available through a physician's prescription, at health food stores, or through mail-order catalogs. As of mid-1995, there is enthusiastic anecdotal feedback from individual therapists who are using yohimbe and oat extract with their clients; but what is anxiously awaited—and needed—in this area are the results of controlled clinical studies to document the actual therapeutic effects, if any.

The vacuum pump for erections has been much improved with automatic monitoring of blood flow. With some clients, penile injections produce remarkable results. Monoxdydyl and nitroglycerin are being used as topical

preparations, as are prostaglandin E1 suppositories inserted into the urethral meatus. Taken alone, these medications are seldom effective in the long term. Without therapy, the person will often misuse or stop using the medication or method. However, when sex therapy is added, the success rate increases dramatically, because both the relationship and the dysfunction are being treated.

[Update 2003: Unquestionably, the 1998 introduction of Viagra (sildenafil citrate) oral pharmacological treatment for erectile dysfunction by the Pfizer Corporation heralded the greatest public focus on sexual dysfunctions since the 1965 Masters and Johnson publication of *Human Sexual Response*. Public awareness of this new drug came so suddenly that just one year after its introduction, the Viagra name was added to the *Oxford English Dictionary*. By 2002, over 20 million men (and a few women) had been prescribed more than one billion tablets retailing for \$6.00 or more per tablet. Pfizer reported 2002 sales of Viagra at \$1.7 billion. Just a few years earlier, Pfizer had projected that sales would be \$4.5 billion (Simons 2003). Although the medication is reported to be effective for as high as 70% of the men who try it, it appears that the human intricacies of sexual response and sexual relationships were not accounted for by the drug companies. Many men experiencing problems with erection did not suddenly become expert lovers or experience increased pleasure in their relationships with Viagra alone. In 2003, three additional drug company giants entered the market to compete with Pfizer. Bayer and GlaxoSmithKline are co-marketing Levitra (vardenafil HCL), with the Eli Lilly company due to introduce their entry (in late 2003 or early 2004) into the erectile-dysfunction-medication market with a drug called Cialis (tadalafil). TAP Pharmaceuticals will be introducing Uprima (apomorphine), also in 2003 or 2004. Five years of Viagra marketing (over \$100 million per year), and the anticipated expenditure of many hundreds of millions of additional dollars by Pfizer's new competition, will certainly bring with it added sex information and misinformation, symptom relief and frustration, and other ambivalent reactions to drug effects and side-effects.

[When an effective treatment for a male sexual dysfunction is discovered, it is invariably applied to women. The success of the vacuum device on erectile dysfunction has led to a female clitoral suction device called the Eros Clitoral Pump. Adequate research to determine the true effectiveness of this device has yet to be published. Human studies of attempts to treat female sexual dysfunctions with Viagra have not been encouraging, but given the relative financial success of Viagra, some drug companies are hoping for another breakthrough medication, this time for female sexual problems. (End of update by R. W. Hatfield)]

Problems

Several problems currently impede the delivery of sex therapy to clients. Primary among these is the state of flux in the insurance industry (third-party payers) with the shift toward managed care, health maintenance organizations, and provider networks. The availability of third-party payment makes it much more feasible for patients to avail themselves of sex therapy. The insurance industry has changed the entire healthcare-provider field by creating the impression that therapists, like others in the medical field, are not to be trusted to know how long therapy should last, or what methods should be used to treat psychodynamic problems. This has created the image that all psychological problems can be treated by brief therapy within a predetermined number of sessions or merely with medications. The insurance industry has also made confidentiality problematic, because clients must sign away some rights to confidentiality

in order to receive mental-health coverage, although the 2003 federal HIPAA regulations regarding patient records improved this situation somewhat. Increasingly, insurance plans refuse to pay for sex therapy. This has prompted many therapists to give a diagnosis that is acceptable to the plan, but not necessarily the most accurate diagnosis.

Secondly, the rise of the religious right appears to have had a negative impact on sex therapy in America. Although there has been no general decline in premarital sex in America, the "abstinence-only until marriage" ethic can be a considerable barrier to normal adolescent sexual rehearsal explorations for some people, and may well result in an increased likelihood of dysfunction when newlywed couples confront their sexuality and sexual functioning on the wedding night. Masters and Johnson, as well as several other researchers, have discovered that a high level of religious orthodoxy is significantly related to greater incidence of sexual dysfunction. Two responses are likely: The individuals and/or couple may become so stressed that it is difficult for them to function naturally within the permitted circumstances, or they may rebel even before marriage and get involved in promiscuous and/or risky practices.

A third concern is a growing challenge as to whether sex therapy is even a separate discipline. There are those who believe that sex therapy needs to be subsumed under psychology, marriage and family therapy, social work, or psychiatry. The fact is that few of these disciplines have educational or training programs that teach about the healthy aspects of sex and sexuality or the creative treatment of sexual problems.

Finally, the amount of money and effort given to research on female sexuality significantly lags behind research on male sexuality (di Mauro 1995).

Because humans are born sexual but not lovers, sex therapy is increasingly seen as including good sex education, good medicine, and good psychotherapy/counseling. In the last ten years, sex therapy has added important concerns related to gender-identity dysphoria, sexual (gender) orientations, and lifestyle issues.

[The Field of Sex Therapy] ROBERT W. HATFIELD

[Update 2003: One might expect that the decades following the 1970 birth of sex therapy as a profession would be characterized by ever-improving research into treatment methods, expansion of graduate programs designed to train sex therapists, and an increasing number of highly trained sex therapists available to those individuals and couples suffering from sexual problems and dysfunctions. The reality in the new millennium is much the opposite. There are only half as many board-certified sex therapists in 2003 than there were in the mid-1980s, and while recent surveys indicate that the actual prevalence of sexual disorders in the U.S. is probably higher than we ever previously believed, the number of medical schools and helping-professions graduate schools that provide basic sexuality education and training in the treatment of sexual dysfunctions is significantly fewer than in the 1980s.

[Today, those professionals available to the person or couple who seeks help come from a fragmented collection of specialties that rarely communicate with each other. That's not the way it began.

[A few noble professional organizations in the field of sexology were created over the past 45 years to be multidisciplinary groups of highly trained physicians, psychotherapists, social scientists, biologists, and many others who began to share their unique perspectives and knowledge to further the growth of the field. However, in 2003, while there are a larger number of sexology professional

groups than ever before, most are increasingly specialized, and almost all report fewer members each year.

[It seems counterintuitive that sex therapy as a field of study and as a profession is today in such disarray. There is no single explanation for the current situation. Knowledgeable scientists and clinicians have observed that useful theory regarding normal sexual functioning never coalesced; that early treatment methods avoided the complexity of the human sexual experience and focused almost exclusively on symptom elimination; that shifting corporate structures and vacillating national economies that could not or would not deal effectively with healthcare led to a rigid managed-care system that quickly limited or eliminated services such as counseling or therapy directed at intimate relationship issues; and, most recently, the rapid medicalization of the field of treating sexual problems by prescribing simple pharmacological or biomechanical interventions that appear to be much more economical.

[It is expected that the trends away from health-insurance support of sex therapy and the growth of the number of new sex drugs and devices will continue. The only signs that sex therapy may get a second wind of fresh research and new treatment methods while addressing its theory deficiencies is a very recent trend where several of the professional organizations are beginning to communicate and even collaborate with each other. The number of researchers, academicians, and clinicians who have true expertise in some area(s) of sexology is very small. It is fairly obvious to most expert observers that the field is much too small to survive the layers of fragmentation that have occurred over the past few decades. (End of update by R. W. Hatfield)]

Psychotropic Drugs

JULIAN SLOWINSKI, WILLIAM R. STAYTON,
and ROBERT W. HATFIELD

[Update 2003: Antidepressants, antianxiety, and anti-panic medications are being used in conjunction with psychotherapy in treating desire-, excitement-, and orgasm-phase problems, as well as paraphilic obsessive-compulsive behaviors (Coleman 2002). Studies are demonstrating that the most commonly prescribed category of antidepressant medications, SSRIs, can be useful in treating specific sexual disorders. A side effect of SSRIs, such as Zoloft, Paxil, and Prozac, is a predictable increase in the latency time for ejaculation by 3 to 5 minutes. While this can be an unwanted and frustrating side effect for some men, it has been beneficial for others who present with problems of ejaculatory control (early ejaculation). For women, SSRIs may have the similar unwanted side effect of increasing the latency to orgasm. Both genders who experience this medication side effect as unwanted can become frustrated in their sexual interactions, with frustration and distraction causing a loss of arousal or desire leading to the possibility of an iatrogenic sexual dysfunction. Behavioral sex therapy techniques to treat premature ejaculation are generally highly successful, but studies have shown that for those men who do not respond to these interventions, a relatively low dose of an SSRI medication is usually therapeutic. Interestingly, a majority of these medicated men maintained good ejaculatory control following a brief (2- to 3-month) use of the SSRI. For the others, discontinuation of the medication resulted in a return of the premature-ejaculation symptoms. This finding suggests the possible presence in some men of high levels of performance anxiety, relationship problems, or a constitutional tendency towards difficulty with ejaculation control.

[There have been encouraging findings (Coleman 2002) with the use of a variety of psychoactive medications in the

treatment of certain types of compulsive sexual behaviors (CSB). A significant number of CSB patients have realized near or complete relief from sexual obsessions and compulsions when taking certain medications. The most frequently prescribed and studied of these are the SSRI medications. Since these same medications have been found to often be effective for other types of obsessive-compulsive disorders, it is hypothesized that the neurotransmitter serotonin is associated with the symptoms.

[An unfortunate side effect of SSRIs is the frequent complaint by patients of some loss of sexual desire. Certain formulations of the SSRI medications have been found to be more likely to cause unwanted sexual side effects than others. It seems that whenever a new SSRI has been approved for sale by the FDA, the drug company makes strong claims that their antidepressant causes fewer sexual side effects than the competition. Actual clinical experience with the new medication often does not support the corporate claims. Sometimes, changing from one SSRI formulation to another may result in a reduction or relief from a side effect, but in other cases, careful clinical experimentation with dosage, time of day medication is taken, or other medication-management efforts can have a beneficial effect. As previously stated, if the medication has the effect of merely slowing down typical sexual responsiveness, the patient may become overly frustrated and begin to avoid interactions. Also, because the possibility of sexual side effects with these types of medications are commonly known among the general public, there is a significant likelihood of an expectancy effect, where any perceived change in responsiveness is exaggerated by worry or anxiety that the medication is causing problems. This is unfortunate, since it is known that effective treatment of depression, anxiety, and obsessive-compulsive symptoms can result in a return to normal or near-normal libido. A great deal more high-quality research is needed to help us understand the complex interactions of medications and the biopsychosocial aspects of human sexual functioning. On the pharmacopoeia's horizon is the possibility of clinically useful true aphrodisiac drugs. Although such a class of medication would almost certainly be misused and abused, it could also offer relief to many who suffer from desire or arousal dysfunctions. (*End of update by R. W. Hatfield*)]

Vulvodynia, a Newly Identified Syndrome

JULIAN SLOWINSKI

One of the new challenges facing American sex therapists and gynecologists today is the occurrence in many women of a painful burning sensation in the vulvar and vaginal area. This condition, recently named vulvodynia, or burning vulva syndrome, is a form of vestibulitis that can have a number of causes, from microorganisms that cause dermatitis to inflammation of the vestibular glands. The presenting complaint of these women is burning and painful intercourse. Some women develop secondary vaginismus. Discomfort varies from constant pain to localized spots highly sensitive to touch. In many cases, the psychological and relationship consequences are grave. Many women become depressed as a result and frustrated by attempts at treatment.

Current treatment includes topical preparations, laser surgery to ablate affected areas, dietary restrictions, and referral to a physical therapist to realign pelvic structure and reduce pressure on the spinal nerves serving the genital area. Some affected women have sought relief with acupuncture. Therapy may be enhanced by focusing on the effects of the condition on the sexual functioning of the patient, her relationship with her partner, and her self-image. Pain-reduction techniques, including self-hypnosis, have

proven valuable in some cases. Low doses of an antidepressant, including some SSRIs, may reduce the pain.

There is much work to be done in the treatment of vulvodynia, including making the public aware of this condition and educating physicians in the role that sex therapists can play in supporting these women and their partners.

The Medicalization of Sex Therapy

JULIAN SLOWINSKI, WILLIAM R. STAYTON,
and ROBERT W. HATFIELD [*Updated*
August 2003 by R. W. Hatfield]

There is an increasing medicalization in sex therapy today. Although this may at first seem to benefit many patients—and it does—there is a concern among sex therapists that many conditions will be summarily treated through medications by primary physicians, with a corresponding failure to address the dynamic and interpersonal aspects of the patient. In short, there is a danger of incomplete evaluation of the patient's status if only the medical aspects are considered and the therapist is left out of the process. In the ideal situation, the sex therapist and physician would collaborate on the treatment plan, using medication as indicated.

[*Update 2003*: Even though Viagra sales have been substantial, they are less than half of the expected sales. It is apparent that Pfizer and their newly arriving corporate competitors from Bayer/GSK, TAP Pharmaceutical Products, and Eli Lilly see this failure by Pfizer to meet market expectations primarily as a mere marketing problem to be solved (Simons 2003).

[Cursory diagnosis and the simple prescription of sexual-response-enhancing drugs such as Viagra may be adequate for some individuals who are experiencing only or primarily an acute medical problem. Five years of clinical experience with Viagra is revealing that this approach is likely to be inadequate or even destructive when sexual dysfunction is associated with more-complex human factors, such as guilt, shame, fear, trauma, and significant relationship dysfunction. On a personal level, large numbers of couples and individuals are discovering the simple truth that healthy and pleasurable relationships are more complicated than erections and lubrication. Sadly, many who gain or regain physiological erectile functioning discover that emotional and relationship problems remain, and they end up feeling more hopeless about themselves or their relationship than they did before taking the medication. It is obvious that many of these people eventually give up, unaware that their problems and solutions to the problems could not be found at any pharmacy.

[Current trends are not encouraging. There has been little useful information making its way to the general public regarding truths about the utility of medications for sexual functioning. There is every indication that corporate interests among drug companies will increase the flood of advertising that simplistically asserts that their product will solve the problem. Hundreds of millions of dollars a year are and will be spent to convince physicians and the general public of this. The public does not want to hear that humans are complicated, and science has always been woefully inadequate in publicizing their complex findings in a useful manner. What some call corporate greed appears to cause some large drug companies nowadays to grossly distort or exaggerate the benefits and lack of harm of their prescription medications until the FDA eventually steps in. Lately, it has been observed that corporations that produce prescription and nonprescription sex pills have begun to invent fictitious diagnostic categories, such as "Female Sexual Dysfunction," and then claim that their product effectively treats, or even cures the problem.

[Additionally, there is an exploding trend, with the apparent discovery by a large number of smaller companies, that the FDA takes little or no notice if the product is not a prescription drug and is marketed in small print as a food product. Anyone who reads their email knows that there seems to be an endless number of companies that tout that their vitamin-herbal-mineral product will enlarge your breasts, penis, or scrotum, or greatly enhance your erections, lubrication, desire, staying power, and overall sexual performance and enjoyment. Billions of dollars are being made by mainstream and back-alley businesses on the sexual unhappiness, misunderstanding, ignorance, and suffering of a significant proportion of our population. We are in an unfortunate moment in history in which diagnosis and treatment decisions are removed from the expertise of science and medicine, and replaced by the corporate decisions of healthcare insurance providers and drug companies. There is no encouraging indication of hope on the horizon that any person, institution, professional organization, business, or government agency can or will step forward to protect and educate us. Fortunately, this is not true in all world cultures, but in most essential ways, the United States remains with two feet firmly mired in the dark ages on issues of human sexuality and sexual health. And unfortunately, unique aspects of our culture make solutions to these problems much more complex than the problems themselves. Known and needed changes in the areas of religiosity, education, business, childrearing, and government are likely to occur at a painfully slow pace. (*End of update by R. W. Hatfield*)]

[Incidence Rates PATRICIA BARTHALOW KOCH

[*Update 1998:* Although it is extremely difficult to ascertain accurately the occurrence of the various sexual disorders and dysfunctions in the United States, research on various clinical and community samples has provided a glimpse as to their prevalence (Spector & Carey 1990). Sexual desire problems are the most common complaint seen in sex therapy in the United States, with affected men outnumbering women. It is also the most common sexual complaint of lesbian couples (Nichols 1989). Community studies indicate that 16% to 34% of the population experiences inhibited sexual desire. Between 11% and 48% of the female population may experience arousal-phase disorder, whereas 4% to 9% of males report this disorder. Erectile disorder is the most common complaint of men, and inhibited orgasm is the most common complaint of women seeking sex therapy in the United States. It is estimated that 5% to 10% of women in the general population experiences persistent or recurrent inhibited orgasm. On the other hand, inhibited orgasm is one of the least common dysfunctions among American males (1% to 10%). It seems to be a more common difficulty among gay men than among heterosexual men, however. The most common dysfunction of heterosexual men is rapid ejaculation, with 36% to 38% reporting persistent or recurrent rapid ejaculation. Dyspareunia is much more common in women than men, with 8% to 23% of women experiencing genital pain. Yet, few lesbian women report this difficulty. Over 100 diseases and disorders of the urogenital system have been linked with painful intercourse. (*End of update by P. B. Koch*)]

[Culturally Appropriate Counseling and Therapy

PATRICIA BARTHALOW KOCH
[*Update 1998:* Minority women and men in the United States experience the entire range of sexual problems and dysfunctions as those experienced by Anglo-Americans (Wyatt et al. 1978). However, most of the research has been conducted with samples of white, middle-class clients. This

has left a critical need for research regarding the effectiveness of various sex counseling and therapy techniques among males and females from various racial/ethnic groups (Christensen 1988).

[A primary issue is that most minority clients do not have the confidence in or financial resources for professional help and are most likely to turn to extended family or close friends—if anyone—with a sexual concern. Discussion of most sexual matters may be considered too intimate or shameful to discuss with anyone but a long-trusted confidante. People from minority groups may also have experienced prejudicial treatment from professionals in the dominant group that has led them to have mistrust, hostility, or expectations that their problem will not be understood. Thus, they usually come into contact with professionals only in a crisis when seeking help for legal, financial, reproductive, gynecological, or other medical problems, rather than for relationship or mental health issues.

[Professional helpers are overwhelmingly drawn from the white middle class and generally are middle-aged, and well educated (Atkinson et al. 1983). Their personal attitudes, values, and behaviors usually represent those of the dominant, more privileged culture. Unfortunately, the training of most sex counselors and therapists has not provided opportunities to become aware of and informed about the effects of gender, race/ethnicity, and class on their treatment of minority clients. Language barriers can be seriously problematic. Even when English is the primary language of therapist and client, an Anglo-American ethnocentrism may result in: misunderstanding, misdiagnosing, and/or mistreating a minority client's problem; trying to control aspects of the client's sexuality or fertility rather than helping him or her to make personally satisfying and culturally sensitive choices; or ignoring sources of help and support from within the client's culture (Christensen 1988; McGoldrick, Pearce, & Giordano 1982). The therapist may need to focus, not just on the individual, but also on the institutions and sexist/racist policies that may be affecting the client adversely (systemically induced dysfunction). (*End of update by P. B. Koch*)]

[Sexuality of Menopausal Women

PATRICIA BARTHALOW KOCH

[*Update 1998:* As America's baby boomers experience mid-life and older age, the sexual concerns of peri- and postmenopausal women have gained greater attention. Older women have been increasingly discussing sexual issues, along with their other health concerns (such as hot flashes, osteoporosis, and heart disease), with their physicians, and are turning to sex counselors and therapists for help. Some of the chief complaints experienced by mid-life heterosexual women are decreased sexual desire, decreased frequency and intensity of orgasm, and decreased frequency of sexual behaviors with a partner, although some women experience heightened sexual response and satisfaction during this time (Mansfield, Voda, & Koch 1995). Interestingly, mid-life lesbian women report less decline in sexual functioning and satisfaction than do their heterosexual peers (Cole 1988).

[Hormone replacement therapy (HRT) has been widely touted as a "miracle" drug to help women fight the "estrogen deficiency disease" of menopause and maintain their youth (e.g., smoother skin and elimination of hot flashes) and health (e.g., decreased risk of heart disease, osteoporosis, and perhaps Alzheimer's disease). However, others have addressed the naturalness of menopause and raised questions as to the actual and relative health risks involved with the use of HRT (such as increased breast cancer) (Love 1997). Regarding sexual functioning, estrogen seems to be important in maintaining vaginal lubrication and perhaps

vaginal vasocongestion, whereas testosterone seems to be important for the pleasurable sensations associated with sexual arousal (Anderson 1991). There are also natural ways to replace estrogen, such as a diet high in soy-based foods, and vaginal dryness may be reduced with a vaginal lubricant, such as K-Y jelly.

[It should not be assumed that sexual concerns of mid-life women are always related to hormonal menopausal changes, since various research studies have found no connection, or only a weak link, between sexual functioning and menopausal status (Mansfield, Voda, & Koch 1995). Growing older in our culture also creates difficulties for women, such as perceived loss of attractiveness and value, that can affect self-esteem and sexuality. Continued or new difficulties in an ongoing sexual relationship can precipitate sexual concerns. As women reach mid-life, they may become more assertive about having their needs met, rather than fulfilling the more traditional gender roles and male phallogocentric definitions of sexual satisfaction (Ehrenreich, Hass, & Jacobs 1987, 153; Ogden 1995). Indeed, a partner's ill health or declining sexual responsiveness may also affect the couple's sexual relationship. Thus, in diagnosing and treating a mid-life woman's sexual concerns, physiological, psychological, relational, and sociocultural factors should all be considered (Mansfield & Koch 1997). (*End of update by P. B. Koch*)]

[*Male Erectile Problems* ROBERT T. FRANCOEUR

[*Update 1998*: Throughout recorded history, impotence or erectile dysfunction (ED) has been a major concern of men, and the curing of this sexual dysfunction one of medicine's shadiest niches, populated by hundreds of bizarre remedies ranging from ground rhinoceros horns, boar gall, and tiger-penis soup to mail-ordered electrified jockstraps and a never-ending offer of magical pills containing no more than common vitamins and herbs.

[In 1966, inflatable and flexible penile implants were introduced, followed by surgery to boost penile arterial flow in 1973. In 1982, the Food and Drug Administration approved a vacuum pump that pulls blood into the penis by creating a vacuum around a sheathed penis. In the same year, a milestone demonstration by Giles Brindley, a British physician, opened a new door to a major medical breakthrough in the treatment of erectile dysfunction. On-stage at a medical conference in Las Vegas, Brindley demonstrated the result of injecting the penis with papaverine, a drug that lowers blood pressure. Several penile injection therapies were soon being tested and welcomed by patients, including: alprostadil; "cocktails" of papaverine, phentolamine, and prostaglandin E1; and phentolamine combined with the protein VIP. Urethral suppositories containing alprostadil were approved by the FDA in 1997. In 1998, pills containing sildenafil, apomorphine, and phentolamine were in various stages of testing and FDA approval (Stipp & Whitaker 1998).

[In December 1992, the National Institutes of Health convened a Consensus Development Conference to address the issue of male erectile dysfunction (National Institutes of Health 1992). Specific issues investigated included:

1. The prevalence and clinical, psychological, and social impact of erectile dysfunction;
2. The risk factors for erectile dysfunction and how they might be used in preventing its development;
3. The need for and appropriate diagnostic assessment and evaluation of patients with erectile dysfunction;
4. The efficacies and risks of behavioral, pharmacological, surgical, and other treatments for erectile dysfunction;

5. Strategies for improving public and professional awareness and knowledge of erectile dysfunction; and
6. Future directions for research in prevention, diagnosis, and management of erectile dysfunction.

Among their findings, the panel concluded that:

1. The term "erectile dysfunction" should replace the term "impotence";
2. The likelihood of erectile dysfunction increases with age, but is not an inevitable consequence of aging;
3. Embarrassment of patients and reluctance of both patients and healthcare providers to discuss sexual matters candidly contribute to underdiagnosis of erectile dysfunction;
4. Many cases of erectile dysfunction can be successfully managed with appropriately selected therapy;
5. The diagnosis and treatment of erectile dysfunction must be specific and responsive to the individual patient's needs, and compliance as well as the desires and expectations of both the patient and partner are important considerations in selecting appropriate therapy;
6. Education of healthcare providers and the public on aspects of human sexuality, sexual dysfunction, and the availability of successful treatments is essential; and
7. Erectile dysfunction is an important public health problem, deserving increased support for basic science investigation and applied research.

[In the early 1980s, an estimated 10 million Americans suffered from erectile dysfunction. In 1987, a federally funded survey, the Massachusetts Male Aging Study led by Boston University urologist Irwin Goldstein, provided evidence for NIH to triple the early estimate of erectile dysfunction to 30 million Americans.

[*Update 2003*: Pharmaceutical companies concerned about their public images and the stockholders' focus on the bottom line resulted in caution about entering this area, despite the enormous profit potential. That reticence quickly ended in April 1998 with the successful introduction of Viagra by the Pfizer Corporation. Today, several other major pharmaceutical companies are rushing to find and market "sex cures." While citizens can be hopeful that the drug companies will be more ethical than the shaman and snake-oil salesmen of the past and present, the state of corporate ethics as we move into the new millennium does not promote optimism.

[When Pfizer Pharmaceutical released the first erection pill in 1998, the initial demand by men—and women—for this prescription medication far exceeded the expected market. For many weeks after Viagra's release, television programs, newspapers, and magazines were filled with discussions of the erection pill, of other possible modes of delivery including a transdermal gel, and the use of this medication by both men and women. While early reports and discussions focused on the "miracle of better loving through chemistry," it quickly shifted to broader psychological and relationship repercussions, both beneficial and harmful, for both men and women who have lived with impotence for some time. Health insurance companies quickly moved to limit their coverage of the medication, leaving potential users wondering about the cost of \$6 to \$10 per pill and their ability to pay. At the same time, questions are being asked how the insurance companies can justify paying for the erection pill while they refuse to pay for the cost of the birth control pill and mammograms. Sex therapists, like Leonore Tiefer, have warned that the erection pill is yet another example of the tendency of Americans to medicalize sex and seek "magic bullet" therapy:

The primary disadvantage of medicalization is that it denies, obscures, and ignores the social causes. . . . [T]he spotlight directed on "the erection" within current medical practice isolates and diminishes the man even as it offers succor for his insecurity and loss of self-esteem. Erections are presented as understandable and manipulable in and of themselves, unhooked from person, script, or relationship (Tiefer 1995, 155, 167).

[Perhaps the early cautions and criticisms have been at least partially supported. By 2003, Viagra sales have been disappointing, with Pfizer realizing less than half the sales that they expected (Simons 2003).

[One beneficial effect of Viagra has been that discussion of men's problems with erections entered the public domain, where men can more openly admit their dysfunction and a desire to try the new medication. Similarly, their partners now feel freer to talk about the topic. This public discussion of erectile problems, like the open discussion of oral sex that followed allegations of sexual impropriety against President Clinton, may have a salubrious effect on American sexual life (Kaschak & Tiefer, 2001; Kleinplatz, 2001). (*End of update by R. T. Francoeur, with R. W. Hatfield*)]

[C. Holistic and Touch Therapies

ERICA GOODSTONE

[*Update 2003:* In contrast to the increased medicalization of sex therapy in contemporary practice is the expanding use of various touch therapies and other holistic therapeutic modalities. These therapies typically seek to integrate the mind and the body and to focus on the person as a whole, with benefits that can extend to the relationship and other aspects of life.

[Touch has always been an integral part of sex therapy as originally created by Masters and Johnson (1970), i.e., touch between the two sexual partners as homework assignments, not usually in the office and not between the sex therapist and client. Typically, homework assignments involve only a few types of touch: sensate focus, touching and stroking erogenous body parts (including penis, vagina, and breast stimulation) as part of foreplay, and oral-genital stimulation, as well as specific techniques for specific dysfunctions, such as the stop/start and squeeze techniques for premature ejaculation, and vaginal stimulation or insertion of dilators to alleviate dyspareunia and vaginismus.

[Touch affects more than just sexual performance. Gentle and nurturing touch can resurrect desire and eliminate sexual dysfunctions by alleviating physical aches and pains, relaxing the body so that blood flow can increase, and calming the spectator mind. Touch therapy that does not involve sensual or sexual stimulation can actually open the door to sensual awareness, emotional expression, positive thinking, and, ultimately, more pleasurable and satisfying intimate love relationships.

[Studies of touch-therapy methods (massage therapy, acupuncture, acupressure, craniosacral therapy, reflexology, Therapeutic Touch, etc.) and body-psychotherapy modalities (bioenergetic analysis, Rubenfeld synergy, hakomi, etc.) have shown promising and impressive improvements in the functioning of clients suffering from physical and emotional illnesses, post-traumatic stress disorder, sexual abuse issues, and even sexual dysfunctions (see, e.g., <http://www.umi.com/hp/Products/Dissertations.html>; <http://www.amtamassage.org/publications/enhancing-health.htm#8>; <http://www.acupuncture.com>; <http://www.eabp.org>; <http://www.usabp.org>).

[Dr. Tiffany Field's Touch Research Institute at Jackson Memorial Hospital in Miami, Florida, and Dr. John

Upledger's Healthplex Center in Palm Beach Gardens, Florida, have amassed an impressive amount of data in studies of the benefits of their particular modalities, massage therapy and craniosacral therapy, respectively (<http://www.miami.edu/touch-research/>; <http://www.upledger.com/therapies/cst.htm>). Numerous studies, some conducted by the National Center for Complementary and Alternative Medicine of the National Institutes of Health (<http://www.nlm.nih.gov/nccam/camonpubmed.html>), have shown the healing benefits of massage, acupuncture, and acupressure. Many doctoral dissertations and other studies have focused on the benefits of Therapeutic Touch, a method developed by Dr. Delores Krieger, a nurse educator at New York University in New York City (<http://www.therapeutic-touch.org>; <http://www.phact.org/e/tt/>). Further research is needed to determine the effectiveness and benefits of the various modalities with respect to sexuality and sexual dysfunctions.

[The following simplified categorization of touch and holistic therapies indicates the enormous, largely untapped resources available to therapists and clients in the field of sex therapy.

[*Traditional Massage, Swedish Massage, and Massage Therapy*

[Massage is probably the best known, most thoroughly researched, and one of the few licensed methods of touch therapy in this country. Carefully draping the client's body with a sheet and towels, the therapist typically utilizes oils and creams, as well as herbal and aromatic essences, music, soft lighting, and basic massage strokes directly on the client's skin. The goal is usually to alleviate muscular tension, improve circulation, eliminate painful nerve constrictions, treat acute and chronic soft-tissue injuries and problems, and relieve stress by relaxing the mind and body.

[*Contemporary Western Massage and Bodywork*

[Expanding upon the practice of traditional massage therapy, these methods may include the use of water, ice, heat, chair massage, onsite massage, medical massage, sports massage, pregnancy massage, infant massage, and more recently, animal massage.

[*Structural, Functional, Movement, and Alignment Therapies*

[These methods of touch therapy (e.g., Alexander Technique, Feldenkrais, and Myofascial Release) utilize techniques to improve body alignment, organ functioning, flexibility of movement, hormonal balance, and integration of the body as a holographic system. These methods may involve actual re-sculpting of the connective tissue, improved flow of cerebral spinal fluid, lymph drainage, realignment of subluxated vertebrae, trigger-point release, or simply guiding the body to move in an easier, more fluid, and graceful manner.

[*Asian Bodywork*

[These methods of touch therapy (e.g., Acupuncture, Acupressure, Chi Gong, and Thai Massage) originated in different parts of Asia and are mostly derived from Traditional Chinese Medicine Theory. This ancient theory describes the health of the body in terms of the five basic elements (fire, water, earth, metal, and wood) and the functioning of the 12 pairs of primary meridians and the eight extraordinary meridians, lines of energy flowing in specific patterns throughout the body. Stimulating points along the meridians using finger, hand, foot, knee, or elbow pressure, and in some cases, fine needles, the goal is to release restrictions in the flow of energy (or *chi*) throughout the body.

[Energetic Bodywork]

[These methods of touch therapy (e.g., Polarity Therapy, Reiki, and Chakra Healing) focus on the energetic fields within and surrounding the body. These methods range from direct contact on the skin, to indirect contact an inch to a foot or more above the body, to distant indirect contact from another room, another city, or anywhere on the planet. Training may be simple to complex, requiring anywhere from one weekend of basic training, to several years of ongoing instruction, to a secretive initiation process open to only a select number of students.]

[Somatic and Expressive Arts Therapies]

[These methods include body-centered therapies that may or may not involve actual touch. Through movement, dance, sports, yoga postures, martial arts, dramatic performances, artistic expression, and visualization, as well as through hands-on touch, the body may allow us to express emotions and feel sensations that have previously been unavailable to our conscious minds. Some practitioners are trained artists, some have received training in one or more body-therapy methods, while others are graduates of accredited academic programs.]

[Body Psychotherapy]

[The common element of all body-psychotherapy methods (e.g., Rubenfeld Synergy, Bioenergetic Analysis, Core Energetics, and Reichian Therapy) is the focus on body awareness and the judicious use of touch during the psychotherapeutic session. The touch may vary from very gentle and respectful of the client's needs to more-forceful touch focused on breaking through defenses and body armoring. A body-psychotherapy session may include guided imagery, focused breathing, role playing, movement, expressive arts, as well as emotional release work. Body psychotherapists are trained and certified in both psychotherapy and body-therapy methods or in specific body-psychotherapy modalities.]

[Current sex therapists may choose to study a particular body-therapy modality and enroll in a training program to learn how to use touch therapy in combination with their counseling and therapy techniques—and then apply this knowledge and understanding to the practice of sex therapy. Without any additional training, however, sex therapists can employ the services of qualified, certified, and/or licensed body-therapy practitioners as an adjunctive and associative practice with some of their clients.]

[Further information can be obtained at the Center for Loving Touch website, <http://www.sexualreawakening.com>. Here you will find links to many of the major body-therapy and body-psychotherapy organizations, including the U.S. Association for Body Psychotherapy. (*End of update by E. Goodstone*)]

D. Education and Certification of Sex Therapists

JULIAN SLOWINSKI and WILLIAM R. STAYTON

Since American sex educators, counselors, and therapists are not licensed by any government agency, reputable professionals in the field operate under one of several traditional professional licenses as part of their practice as a physician, psychologist, psychoanalyst, social worker, marriage and family counselor, or pastoral counselor.

The American Association of Sex Educators, Counselors, and Therapists (AASECT) does offer its own certification for sex educators, counselors, and therapists following successful completion of specified training programs that include supervised practice. Continuing education credits are required for renewal of this certification.

E. Sex Surrogates: The Continuing Controversy

RAYMOND J. NOONAN [*Updated by R. J. Noonan*]

Three decades after Masters and Johnson pioneered modern sex therapy, the use of sexual partner surrogates, despite a long history of controversy, continues, largely because it has been found by some professionals to be an effective therapeutic modality in certain circumstances for persons without partners and for specially challenged persons with physical limitations. Still, as Dauw (1988) has noted, little in-depth research has been conducted about surrogates, their effectiveness, or their appropriateness in working with specific sexual dysfunctions. Misconceptions about surrogates are widespread (Apfelbaum 1984), in part, because of a common confusion between the roles of sex surrogates and prostitutes, based on the potential for intimate sexual interaction and the surrogate being paid for her or his work. Roberts (1981) has suggested that "the most common misconception" is of the surrogate as "an elitist type of prostitute." In addition, some authors have commented on the effects of media accounts of sex surrogates, which have tended to focus on the bizarre, the sensational, and even the untrue (Braun 1975; Lily 1977).

The distinction commonly noted between surrogates and prostitutes usually relies on the intent of the sexual interaction: the prostitute's intent being immediate gratification localized on genital pleasure, whereas the surrogate's intent is long-term therapeutic reeducation and reorientation of inadequate capabilities of functioning or relating sexually (Brown 1981; Jacobs et al. 1975; Roberts 1981). In 1970, Masters and Johnson noted that "... so much more is needed and demanded from a substitute partner than effectiveness of purely physical sexual performance that to use prostitutes would have been at best clinically unsuccessful and at worst psychologically disastrous."

[*Update 2003: IPSA, the International Professional Surrogates Association (<http://members.aol.com/Ipsa1/home.html>), remains the organization most involved with surrogate partner therapy, primarily training new surrogates and educating the public and professionals about its potential benefits (Vaughan 2004). (*End of update by R. J. Noonan*)]*

In describing the therapeutic process, IPSA (n.d.) wrote,

A surrogate partner is a member of a three-way therapeutic team consisting of therapist, client and surrogate partner. The surrogate participates, as a partner to the client, in experiential exercises designed to build the client's skills in the areas of physical and emotional intimacy. This partner work includes exercises in communication, relaxation, sensual and sexual touching and social skills training.

Others, including Allen (1978), Apfelbaum (1977, 1984), Brown (1981), Dauw (1988), Masters and Johnson (1970), Roberts (1981), Symonds (1973), Williams (1978), and Wolfe (1978) have described, either briefly or in part, typical surrogate sessions or alternative models. According to Jacobs, et al. (1975): "The usual therapeutic approach is slow and thorough. Exercises are graduated and concentrate on body awareness, relaxation and sensual/sexual experiences that are primarily non-genital." Where appropriate, the surrogate also teaches "vital social skills and traditional courtship patterns which finally include sexual interaction." However, none of these writers gave a perspective of the relative amount of time or importance that each aspect of the surrogate therapy session or program places on the entire process. Such a perspective would give a clearer understanding of the true functions of a sex surrogate that would allow the integration of the use of surrogate therapy into a

useful theoretical perspective relative to clinical sexology, as well as to normative sexual functioning.

The use of sex surrogates was introduced by Masters and Johnson (1970) as a way to treat single men who did not have partners available to participate in their couple-oriented sex-therapy program. As the practice evolved, surrogates sometimes specialized in working with specific populations, such as single heterosexual or homosexual men, with couples as a coach, or with people with physical disabilities.

Today, the use of surrogates remains controversial with complex legal, moral, ethical, professional, and clinical implications. [Update 2003: As of mid-2003, surrogate partner therapy, when performed under the supervision of a licensed therapist, is completely legal throughout the U.S. (Vaughan 2004). (End of update by R. J. Noonan)] Although Masters and Johnson eventually abandoned the practice (Redlich 1977), the use of professional sex surrogates has been ethically permissible as part of the sex therapist's armamentarium, according to the American Association of Sex Educators, Counselors, and Therapists (AASECT 1978, 1987). Still, a recent version of AASECT's (1993) *Code of Ethics* ceased to mention the use of surrogates explicitly. Instead, the 1993 code merely stated that a member of AASECT should not make a "referral to an unqualified or incompetent person" (p. 14), which would presumably refer to surrogates, among others.

In their 1987 *Code of Ethics*, however, and in at least one earlier version, AASECT addressed the issue of surrogates directly, and promulgated the parameters for their ethical use, including the understanding that the surrogate is not a sex therapist or psychotherapist, and that the therapist must protect the dignity and welfare of both the client and the surrogate. In addition, it outlined how issues of confidentiality and consent should be addressed. In many ways, this document is similar in putting the client's welfare first to the *Code of Ethics* espoused by the International Professional Surrogates Association (IPSA 1989). Among IPSA's strict requirements for members are the necessity that surrogates practice only within the context of the therapeutic triangle consisting of the client, surrogate, and supervising therapist, that the relationship with the client always be within the context of the therapy, that the surrogate recognize and act in accordance with the boundaries and limitations of her competence, and that the surrogate be responsible for all precautions against pregnancy and disease. Confidentiality and continuing-education requirements are also among the 17 items listed in the code, although the surrogate's primary role as a cotherapist or substitute partner in any given therapeutic situation is left open to agreement between the therapist and surrogate.

In 1997, there were estimated to be fewer than 200 surrogates worldwide, according to Vena Blanchard, president of IPSA (personal communication, March 15, 1997), with maybe 100 practicing in the U.S.A. [Update 2003: As of mid-2003, Blanchard estimated that there were fewer than 100 practicing surrogates in the country (Vaughan 2004). (End of update by R. J. Noonan)] These numbers are down by about two thirds from the 300 estimated to be practicing in the U.S. in 1983-1984 (Noonan 1995/1984), a time when the number of surrogates peaked. However, the downward trend of the subsequent decade, caused primarily by fears surrounding AIDS, has been showing signs of reversing since the mid-1990s, according to Blanchard, who pointed to the number of new surrogates being trained and requesting training by IPSA. Still, according to Blanchard, only a few urban areas, primarily on the two coasts (mostly in California), have surrogates working, with most of the country not being served.

Noonan (1995/1984) surveyed 54 sex surrogates who were part of a surrogates' networking mailing list representing about 65 to 70% of all known legitimate trained surrogates in 1983-1984. The 54 surrogate respondents represented about 36% of the 150 estimated known surrogates, who were estimated to be approximately one half of all surrogates practicing in the U.S. at the time. In addition to demographic data, the instrument asked respondents to estimate the percentage of time they spent in each of seven activities with clients. The data gathered seemed to support strongly the hypothesis that sex surrogates provide more than sexual service for their clients, spending about 87% of their professional time doing nonsexual activities. In addition to functioning as a sexual intimate, Noonan found that the surrogate functions as educator, counselor, and cotherapist, providing sex education, sex counseling, social-skills education, coping-skills counseling, emotional support, sensuality and relaxation education and coaching, and self-awareness education. The results indicated that a majority of time is spent outside of the sexual realm, suggesting further that surrogate therapy employs a more holistic methodological approach than previous writings, both professional and lay, would seem to indicate. Clearly, the sex surrogate functions far beyond the realm of the prostitute.

Specifically, Noonan's (1995/1984) results showed that the surrogate spends much of her or his time talking with the client, with approximately 34% of the time spent giving sexual information, as well as reassurance and support. Almost one half of the surrogate's time (48.5%) is spent in experiential exercises involving the body nonsexually, with the majority of that time devoted to teaching the client basically how to feel—how to be aware of what is coming in through the senses. Combining the two averages, we find that the surrogate typically spends 82.5% of the therapeutic time enhancing the cognitive, emotional, and sensual worlds of the client. Only after this foundation is developed does the surrogate spend almost 13% of the time focusing on erotic activities, including sexual intercourse, cunnilingus, and fellatio, and teaching sexual techniques. The remaining 4.5% focuses on social skills in public settings, clearly the least important aspect of what the surrogate deals with.

Finally, a profile emerged of the "average" sex surrogate in 1983-1984: she is a white female, in her late 30s/early 40s, and not very religious. She is one way or another single with 1.4 children, college-educated, lives in California, has been practicing as a surrogate for four years three months, and sees 27 clients per year. Finally, she is a heterosexual who does not need to concern herself or her partner with chemical or mechanical methods of contraception, because she has been sterilized (Noonan 1995/1984). It is interesting to note that among the 54 respondents, six of the surrogates had earned doctorates, with the average being a bachelor's degree plus some advanced study, indicating the atypically high level of educational achievement in this group.

Present and Future Issues

Surrogate therapy has no doubt changed somewhat over the past two decades for various reasons. These changes need to be elucidated, documented, and incorporated into our collective knowledge about normative sexuality and how to address the various problems we have created or maintained around its expression.

Since 1983, the impact of AIDS has become a deep concern of both surrogates and therapists. Exactly how it has affected the work of surrogates remains to be studied. Certainly in the years immediately following Noonan's (1995/1984) study of the functions of sex surrogates, many surrogates, who in retrospect were not particularly at risk for HIV

infection, stopped practicing or modified their practice as surrogates out of fear. Many therapists also stopped referring clients to surrogates out of fear of legal liability. As the reality of HIV infection has become better known, surrogates, who are mostly female working with heterosexual males, are continuing to help clients function better sexually while promoting responsible sexual behavior at all levels. [Update 2003: A recent report indicated that some surrogates began to focus on integrating safer sex and condom use into the therapy to help clients more effectively deal with the new reality, which continues today (Vaughan 2004). In addition, given the current emphasis on pharmacological treatment of some sexual dysfunctions, it remains to be seen what kind of impact this will have on surrogate therapy, especially in light of the fact that such dysfunctions are likely to increase with the greying of America. (End of update by R. J. Noonan)] Little or no research exists that has investigated how gay male surrogates, who worked mostly with gay male clients in the 1980s, have changed their practice.

Since the 1980s, women have become more aware of how surrogates might help them effectively deal with various sexual dysfunctions. Some female clients will ask their therapists, or seek out therapists who are open to the possibility, to find a male surrogate with whom they might work. Largely because of the sexual double standard that continues to operate in many, if not most, therapists, however, most clients of surrogates continue to be male. The degree to which women have begun to work with surrogates to solve their sexual problems, or who consider it a viable option, are questions that require additional research. In addition, the differences that may exist in the design of the therapy program itself and how a female client might work with a surrogate, as compared to how males work with surrogates, is also a topic open to research. It appears that heterosexual male surrogates remain today the rarest of sex surrogates, as in the early 1980s.

Despite these research needs, the population of surrogates is likely to remain resistant to study, both because of the legal ambiguities often involved with their practice and the fact that the use of surrogates retains a relatively high visibility in public consciousness, although surrogates themselves are usually quite invisible. Because they are a small group, they will be difficult to study with any reasonable assurances of confidentiality.

The most troubling aspect of research on sex surrogates may be the indication, yet to be verified by any research, that there are probably many more surrogates working with clients and therapists in the United States, who are independently trained by varying standards by the therapists with whom they may be working, and who are both isolated from other surrogates and from researchers. This leaves them unaware of the most recent knowledge and advances in the field, because rarely are therapists trained in working with surrogates. It also deprives us of the knowledge gained from experience that these "hidden" surrogates may have learned.

12. Sex Research and Advanced Professional Education

A. A Research Assessment ROBERT T. FRANCOEUR

The United States has a long tradition and unequalled wealth of sexological research. The survey work of Alfred Kinsey and his colleagues in the 1940s and 1950s and the clinical/therapeutic research of William Masters and Virginia Johnson are but tips of the iceberg, referred to and cited in almost any discussion of sexological research anywhere in the world (Brecher 1979; Bullough 1994; Pomeroy 1972).

Sexological research in the United States today is vital to the management of many social and public health problems. Each year, one million teenage girls become pregnant, a per-thousand-rate twice that of Canada, England, and Sweden, and ten times that of the Netherlands; the disproportion is similar for teenage abortions (Jones et al. 1986). The nation spends \$25 billion on families begun by teenagers for social, health, and welfare services. One million Americans are HIV-positive and almost one quarter of a million have died of AIDS. Yet only one in ten American children receives sexual-education that includes information about HIV/AIDS transmission and prevention. One in five adolescent girls in grades 8 through 11 is subject to sexual harassment, while three quarters of girls under age 14 who have had sexual relations have been raped. These and other public health problems are well documented and increasingly understood in the context of poverty, family trauma, ethnic discrimination, lack of educational opportunities, and inadequate health services. However, there is little recognition of the need for sexological research to deal effectively with these problems. Congress has several times refused or withdrawn funding for well-designed and important surveys because of pressure from conservative minorities (di Mauro 1995).

In 1995, the Sexuality Research Assessment Project of the Social Science Research Council (605 Third Avenue, 17th Floor, New York, New York 10158) published a comprehensive review of *Sexuality Research in the United States: An Assessment of the Social and Behavioral Sciences* (di Mauro 1995). This report identified and described major gaps and needs in American sexological research. There is a serious lack of a framework for the analysis of sexual behaviors in the context of society and culture. This framework is needed to examine how sexual socialization occurs in families, schools, the media, and peer groups, and to address the complex perspectives of different situations, populations, and cultural communities. Areas of need identified by the project include: gender, HIV/AIDS, adolescent sexuality, sexual orientation, sexual coercion, and research methodology. Three major barriers hindering sexuality research are 1. the lack of comprehensive research training in sexuality, 2. inadequate mechanisms and efforts to disseminate research findings to policymakers, advocates, practitioners, and program representatives in diverse communities who need this information, and 3. the lack of federal, private-sector, and academic funding for research.

[Gender Differences in Sex Research]

RAYMOND J. NOONAN

[Update 2003: A perplexing problem that has repeatedly emerged in sex surveys of men and women regarding their sexual attitudes and behavior is the differing levels of sexual activities that each sex tends to report. Males tend to report higher levels of various sexual activities with greater sexual permissiveness than do females, which tends to reflect cultural gender-role expectations. This has led to such anomalies as heterosexual men reporting more sexual partners than heterosexual women do, which one would expect to be statistically equivalent. Thus, the limitations of self-reports become a salient question affecting the validity of any results, as well as public policy based on them. One possible explanation suggested that men overreported their sexual partners, activities, and so on, and women underreported them to accommodate society's double standard.

Alexander and Fisher (2003) sought to shed some light on this question through the imaginative use of a research technique called the "bogus pipeline," in which they asked men and women questions in written surveys about their sexual attitudes and behaviors under the false belief that

their truthfulness could be detected (in this case, by being attached to a polygraph that was actually non-functioning). Results were compared with those of two groups, one in which the testing was anonymous (but without the belief that truthfulness was detectable), and one in which there was the possibility that someone might see the answers (the "exposure threat").

Although the results were not as clear as expected, they indicated that under the exposure-threat conditions, answers reflecting traditional sex differences with respect to sexual behaviors were more likely, whereas when they thought their truthfulness could be detected, the women's and men's responses were more similar. In fact, the responses of the women were generally more exaggerated than the men's, meaning their sexual activity was greater than normally found in surveys, which was attributed to the fact that women have greater expectations to respond and be perceived in socially appropriate ways (Alexander & Fisher 2003). Thus, women and men may be more similar than different, and further research needs to clarify these findings, as well as have them applied to future research on sexual behaviors. (*End of update by R. J. Noonan*)

B. Advanced Sexological Institutes, Organizations, and Publications

MARTHA CORNOG and ROBERT T. FRANCOEUR

[*Rewritten and updated in August 2003 by
M. Cornog and R. T. Francoeur*]

Advanced Sexuality Education and Institutes

The longest-established American sexological research institution is the Kinsey Institute for Research in Sex, Gender, and Reproduction, based at the University of Indiana, Bloomington, Indiana (<http://www.kinseyinstitute.org>). Another major, younger institution is the Institute for the Advanced Study of Human Sexuality (IASHS; address: 1525 Franklin Street, San Francisco, CA 94109, <http://www.iashs.edu>), which has its own degree program—see below. Two additional key organizations focus strongly on sexual research and public policy: the Sexuality Information and Education Council of the U.S. (SIECUS; address: 130 West 42nd Street, Suite 350, New York, NY 10036, <http://www.siecus.org>), and the Planned Parenthood Federation of America (PPFA; address of headquarters: 434 West 33rd Street, New York, NY 10001, <http://www.ppfa.org>).

The libraries of the Kinsey Institute and the IASHS both have extensive collections on sexuality, including research, policy, and erotica. The SIECUS and PPFA libraries also have significant holdings, as does California State University at Northridge (CSUN) with its Vern and Bonnie Bullough Collection on Human Sexuality. A more complete selection of libraries specializing in sexuality topics, including homosexuality, may be found via the index to the *Directory of Special Libraries and Information Centers* (Gale Research).

A number of U.S. universities grant degrees with majors or concentrations in sexology and/or sex education, counseling, and therapy. Extensive listings of all types of educational programs of all types is available from the Society for the Scientific Study of Sexuality (<http://www.sexscience.org>; click on "Resources" and then on "Educational Opportunities"), and at the Kinsey Institute website (<http://www.kinseyinstitute.org>).

- *The Alfred Kinsey Institute for Research in Sex, Gender, and Reproduction* and the University of Indiana in Bloomington offer an undergraduate individualized major in human sexuality, a doctoral minor in human sexuality through the Kinsey Institute, and a doctoral minor and undergraduate interdisciplinary major in Gender Studies.

- *The Institute for the Advanced Study of Human Sexuality*, now in its 27th year, offers five graduate degree programs and five certificate programs for those wishing academic and professional training in human sexuality, specifically for persons who intend to make the field of human sexuality a major focus in their professional careers. On-site and distance learning courses are scheduled so as to accommodate the busy professional. The Institute is home of the most comprehensive sexological library in the world, the result of more than 27 years of archival research and efforts to obtain the rights for the reproduction of film and other materials for student use. The library system contains more than 75,000 books, 150,000 magazines, journals, and pamphlets, 50,000 videotapes, 200,000 films, and more than 900,000 photographs and slides. The Institute's degree programs and certificate programs have been approved and registered by the California Bureau for Private Postsecondary and Vocational Education (BPPVE). For further information, contact: <http://www.iashs.edu> or 415-928-1133.
- *California State University in Northridge* offers an interdisciplinary minor in Human Sexuality through the College of Social and Behavioral Sciences. CSUN is also the base for the College of Social and Behavioral Sciences' Center for Sex Research (<http://www.csun.edu/~sr2022/>) and the extensive Vern and Bonnie Bullough Library Collection on Human Sexuality. Contact: Coordinator, Dept. of Family Environmental Sciences, 18111 Nordhoff St., Northridge, CA 91330.
- *University of Minnesota Program in Human Sexuality*, the only American graduate program with an endowed chair in Human Sexuality, and the Department of Family Practice and Community Health offer educational opportunities in medical school education, academic courses, continuing education, Sexual Attitude Reassessment (SAR), and a post-doctoral clinical/research fellowship. Contact: <http://www.med.umn.edu/fp/phs/phsposd.htm>.
- *Columbia University School of Public Health*, New York, NY, offers a Sexuality and Health track, an inter-departmental program, jointly created and delivered by the Departments of Population and Family Health and of Sociomedical Sciences, leading to a master in public health (M.P.H.) degree.
- *San Francisco State University* (San Francisco, CA), offers an undergraduate minor and a master of arts degree in Human Sexuality Studies in the Human Sexuality Studies Program, to provide students with knowledge about processes and variations in sexual cultures, sexual identity and gender-role formation, and the social, cultural, historical, and ethical foundations of sexuality, intimate relationships, and sexual health. Contact: SFSU, Human Sexuality Studies Program, 1600 Holloway Avenue, San Francisco, CA 94132; tel.: 415-405-3570; <http://www.sfsu.edu/~bulletin/current/programs/humsexst.htm>.
- *Widener University's Center for Education, School of Human Service Professions*, in Chester, PA, offers master's and doctoral programs in Human Sexuality Education. The program continues the tradition of the graduate program at the University of Pennsylvania (where it operated the past 20 years). Clergy, educators, counselors, and others who wish to become certified sex educators, to do counseling or therapy, to get advanced training, or to engage in sex research may apply. Contact: Program Coordinator, Human Sexuality Education, 987 Old Eagle School Road, Ste. 719, Wayne, PA 19087; tel.: 610-971-0700; William.R.Stayton@widener.edu.
- *The American Academy of Clinical Sexologists* (AACS), headed by Dr. William Granzig at Maimonides Univer-

sity in North Miami Beach, Florida, offers mental health counselors, clinical social workers, marriage and family counselors, and psychologists a two-semester program leading to certification in sex therapy, and a doctoral degree program in clinical sexology. For those who wish to practice sex therapy, a program of continuing education in certain sexological subjects, which, when certain other requirements are met, qualify a graduate student for state certification as a sex therapist. Students may also qualify for a doctor of philosophy degree in Clinical Sexology by combining the two semesters of certification study with an additional four semesters of study and completion of a doctoral dissertation. Contact: <http://www.esextherapy.com>; tel.: 407-645-1641. For the program on Long Island, NY, contact: womentc@aol.com.

- *Université du Québec au Montréal (UQAM)*, in Montréal, Québec, Canada, offers North America's undergraduate and master's-level degrees in *Sexologie*. The program has over 25 full-time faculty in a wide range of disciplines. All instruction is in French.
- *University of Guelph* (Guelph, Ontario, Canada) offers graduate programs, summer course workshops, and an annual institute through the Department of Family Relations and Applied Nutrition.

In the late 1960s, several American medical schools introduced programs in human sexuality into their curricula for training physicians. These programs reached their zenith in the early 1980s. By the late 1980s, many of them were under fire from newly appointed conservative administrators and threatened with cutbacks and elimination. Indications suggest a significant decline in sexuality training for physicians and other healthcare professionals, but the picture is not clear, because no one has studied the situation nationwide. (See Richard Cross' comments in Section C below.)

Two East Coast institutes are focused on the interconnection of sexuality and religion:

- Religious Institute on Sexual Morality, Justice, and Healing, 304 Main Avenue, #335, Norwalk, CT 06851; tel.: 203-840-1148; <http://www.religiousinstitute.org>.
- Center for Sexuality and Religion, 987 Old Eagle School Road, Suite 719, Wayne, PA 19087; tel.: 610-995-0341; <http://www.ctrsr.org>.

Sexological Organizations

There are three major American sexological membership organizations:

- The American Association of Sex Educators, Counselors, and Therapists (AASECT). Founded in 1967; currently around 1,500 members. Address: P.O. Box 5488, Richmond, VA 23220; <http://www.aasect.org>.
- The Society for the Scientific Study of Sexuality (SSSS). Founded in 1957; currently around 1,000 members. Address: P.O. Box 416, Allentown, PA 18105; <http://www.sexscience.org>.
- The Society for Sex Therapy and Research (SSTAR). Founded in 1974; currently about 200 members. Address: 409 12th Street NW, P.O. Box 96920, Washington, DC 20090; <http://www.sstarnet.org>.

Several dozen other groups exist for various types of professionals concerned with sex-related issues. Typical among these are: the Association for the Behavioral Treatment of Sexual Abusers, the Association of Nurses in AIDS Care, the National Council on Family Relations, the Society for the Philosophy of Sex and Love, and the Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues.

At least 100 U.S. advocacy and common-interest organizations deal in one way or another with advocacy for gay and lesbian viewpoints or provide a vehicle for the gay and lesbian practitioners of a profession or hobby to socialize or work together. Among the largest and most comprehensive are the Lambda Legal Defense and Education Fund, the National Gay and Lesbian Task Force, and Parents, Families, and Friends of Lesbians and Gays, each with 15,000 or more member/contributors and budgets in the millions of dollars. Typical of smaller special-interest groups are: Federal Lesbians and Gays (federal government workers), Gay and Lesbian Medical Association, Good Gay Poets, International Association of Gay and Lesbian Martial Artists, International Gay and Lesbian Travel Association, and Lesbian and Gay Bands of America.

Similar organizations exist in America for many sexual viewpoints and behaviors other than homosexuality—and for sexual matters perceived as problems. An all-too-brief sampling from the 40th edition of the *Encyclopedia of Associations* (the *EoA*, from Gale Research Publications) includes: Adult Video Association (pro-pornography/erotica), Americans for Decency, American Sunbathing Association (nudism), DC Feminists Against Pornography, Eagle Forum, Focus on the Family, Impotents Anonymous, National Association of People with AIDS, North American Swing Club Association and the Lifestyles Organization (both recreational nonmonogamy), Renaissance Transgender Association, Sex Worker Foundation for Art, Culture, and Education, Sexaholics Anonymous, Society for the Second Self (Tri-Ess, for transvestites), and Women Exploited by Abortion. Browse the *EoA* index under subjects like “sex,” “AIDS,” and so on, for more organizations.

Other, often-small special-interest groups may not be listed in the *EoA* but can be located by scanning sex-related websites and publications like *The Black Book*, edited by Bill Brent and Lori Selke (Black Books, <http://www.blackbooks.com>). Such groups include DPF (Diaper Pail Friends: infantilism and nepiophilia, <http://www.dpf.com>), the National Association of Rubberists (rubber or latex fetish, <http://www.rubberist.net>), and the Society of Janus (sodomasochism, <http://www.soj.com>).

Sexological Journals and Publications

U.S.-published professional journals that focus on sexuality-related research and commentary include: *Archives of Sexual Behavior*, *Annual Review of Sex Research*, *Electronic Journal of Human Sexuality*, *Journal of Bisexuality*, *Journal of Child Sexual Abuse*, *Journal of Gay and Lesbian Psychotherapy*, *Journal of the Gay and Lesbian Medical Association*, *Journal of Gender Studies*, *Journal of the History of Sexuality*, *Journal of Homosexuality*, *Journal of Lesbian Studies*, *Journal of Marriage and Family*, *Journal of Psychology and Human Sexuality*, *Journal of Sex and Marital Therapy*, *Journal of Sex Research*, *Journal of Sex and Aggression*, *Marriage and Family Review*, *Journal of the History of Sexuality*, *Maledicta* (language), *Sexuality and Culture*, *Sexuality and Disability*, and *SIECUS Report*. This is not an exhaustive list; consult periodical directories at a public or university library for other titles.

For identifying U.S. national and local gay and lesbian newspapers and magazines, consult the most recent annual edition of *Gayyellow Pages* (Renaissance House). A less comprehensive and less frequent, but quite useful sister guide to small sex-topic periodicals, as well as organizations and vendors, is *The Black Book*, noted above. Large periodical directories may also list some of these publications. (End of update by M. Cornog and R. T. Francoeur)]

[C. International Sexuality Description Project

ROBERT T. FRANCOEUR

[Update 2003: The editors of the four-volume *International Encyclopedia of Sexuality* (1997, 2000) and this 2003 in-depth report on 62 countries, the *Continuum Complete International Encyclopedia of Sexuality*, welcome the appearance of an important complementary project, the International Sexuality Description Project. The following summary is based on information supplied by David P. Schmitt.

[ISDP is an anonymous survey study designed to assess sexual attitudes and behaviors across a large number of cultures (Schmitt et al. 2003). Founded by David P. Schmitt of Bradley University in 2000, the ISDP includes a network of psychologists, biologists, sociologists, and other social scientists from 56 nations. In total, more than 100 research scholars took part in the ISDP and administered an anonymous sex survey to 100 men and 100 women, typically college students in their country. The ISDP survey was translated from English into 30 languages using a translation/back-translation procedure and was eventually administered to a total sample of over 17,000 people. The ISDP survey included measures of romantic attachment styles, global self-esteem, the "Big Five" personality traits, short-term mating desires, human mate-poaching behaviors, sociosexuality, and the "Sexy Seven" measure of human sexuality (Schmitt & Buss 2000).

[In its first report (Schmitt et al. 2003), ISDP addressed the hypothesis of evolutionary psychologists that men and women possess both long-term and short-term mating strategies, with men's short-term strategies differentially rooted in the desire for sexual variety. The ISDP survey results supported the existence of culturally universal sex differences in the desire for sexual variety.

[A second report focused "on adult romantic attachment, specifically gender differences in the 'dismissing' form of adult romantic attachment. Dismissing romantic attachment orientations are indicated by an avoidance of close personal relationship and the tendency to prevent romantic disappointment by maintaining a sense of relational independence and emotional distance." This article critically evaluates whether men are universally more dismissing than women (Schmitt & Buss 2003).

[A follow-up study, the ISDP-2, is currently underway and will include samples from more than 60 cultures. In this new study, they have included measures of impression management, sex-role ideology, sexual aggression, domestic violence, HIV/AIDS knowledge, and HIV/AIDS risk behavior. The founding director of the ISDP, David P. Schmitt, may be contacted at dps@bradley.edu. (End of update by R. T. Francoeur)]

D. Sexuality Education of Physicians and Clergy

Medical School Sexuality Education

RICHARD J. CROSS

Medical schools have always taught certain aspects of sexuality, e.g., the anatomy of the male and female sex organs, the menstrual cycle, basic obstetrics, and some psychology and psychiatry. That picture began to change about 30 years ago when Harold I. Lief (1963, 1965), a psychiatrist at Tulane University Medical School in Louisiana, wrote articles pointing out that most Americans regarded physicians as authorities on human sexuality, that the field of sexology was changing fast, and that only three medical schools in the country were even trying to teach modern sexology. The situation gradually improved, and when Harold Lief and Richard J. Cross, a physician who had introduced sexology education at the Robert Wood Johnson

Medical School at Rutgers University in New Jersey, sent a questionnaire to all medical schools in the U.S. and Canada in 1980, they found only three schools that said they did not teach sexuality. However, they did not publish their results because of the poor response rate and apparent unreliability of self-serving responses from medical school administrators. It was clear, however, that the improvement was limited; part of the change reported was because of different interpretations of the questionnaire and differing definitions of "sexuality." No one knows just what is being taught in the different medical schools today.

Part of the problem is that medical schools have traditionally defined education as the acquisition of factual information and certain skills by students. In the field of sexuality education, affective learning is also important. The greatest shortcoming of most practicing physicians is their discomfort. Since early childhood, they have been taught that sex is a private subject and that it is impolite and/or improper to talk about it. Physicians, who have not learned to confront and overcome their discomfort in talking about sex, transmit to their patients nonverbal, and sometimes verbal, messages that they do not want to hear about sexual problems. Their patients, who are often equally uncomfortable, cooperate by not raising any sexual issues. The result, too often, is "a conspiracy of silence," in which sexual issues that sometimes have a great impact on health never get discussed.

A number of medical schools have instituted courses or short programs in sexuality that emphasize attitudes, values, and feelings, rather than the memorization of factual information. These courses make extensive use of sexually explicit, educational films and videos and panels of people who are willing and able to talk about their personal sexual experiences. Following each large-group session, the students break into smaller groups who meet with facilitators to process what they have heard and seen with an emphasis on their personal feelings and reactions. Such programs seem to give medical students a better understanding of their own sexuality, a greater tolerance for unusual sexual attitudes they may encounter in their patients, and greater comfort in dealing with and discussing sexual issues.

Unfortunately, these programs rarely elicit enthusiastic support from the medical school faculties, who, after all, have been selected for their expertise in analyzing scientific data. Time is jealously guarded in the medical school curriculum. Money has always been a concern in higher education, but money gets tighter year-by-year, and small groups are expensive to organize and run. Many sexuality programs in medical schools are elective, which is sad, because the students who need these courses most are often the least likely to register for them.

Despite 30 years of improved sexuality education, most American doctors still do an inadequate job of helping patients with sexual problems. Comprehensive courses seem to help, but in the current conservative political and economic climate, it seems unlikely that they will be greatly expanded in the near future. In fact, there are indications that some programs are in danger of being cut back. There is, on the other hand, a small but growing move in the Association of American Medical Colleges to go beyond stuffing facts into students by dealing with attitudes and feelings in the medical school curricula. If this takes hold, sexuality courses may lead the way. Time alone will tell.

Sexuality Education for Clergy in Theological Schools and Seminaries

PATRICIA GOODSON and SARAH C. CONKLIN
History. Protestantism has historically enjoyed the status of dominant religion in this country, but democracy, with its

emphasis on religious freedom and pluralism, has nourished the establishment of countless religious groups. Because these groups are numerous, and the education of their leadership varies considerably, a discussion of clergy training in sexuality requires qualification.

The main focus here will be on the seminaries and students included in the studies conducted by Conklin (1995) and Goodson (1996). Denominationally, the emphasis in these studies was mainly on Protestant and Roman Catholic clergy, although Jewish seminary faculty members were interviewed for the study by Conklin. By including both conservative and liberal schools and denominations, the largest religious groups are represented, but the samples are neither random nor the results generalizable.

Seminaries and theological schools are defined here as institutions of higher education accredited by the Association of Theological Schools (ATS). They offer post-baccalaureate degrees leading to ordination and licensure of pastors, priests, ministers, rabbis, chaplains, and pastoral counselors (categories broadly referred to as clergy).

Traditionally, clergy students have been characterized as young, white, and male, but this profile is slowly changing. First, it is becoming an older population composed of more part-time and second-career students. Second, diversity in both ethnicity and gender is increasing. In a comparison of motivations, women were more inclined to report entering seminary to discover "ways to best serve Christ in the church and the world" or "personal spiritual growth and faith development" rather than "preparing to be a parish minister," which was the overwhelmingly reported motivation for men entering seminary (Aleshire in Hunter 1990, 1265). In terms of sexuality education, seminary students are now perceived as being "more diverse in attitudes, more willing to share personal experiences, and more open about sexual orientation" than in previous generations (Conklin 1995, 231).

Conflict over whether seminary education accents professional training or personal formation may be a factor accounting for the apparent lack of emphasis on sexuality content (Kelsey 1993). As the percentage of female students has increased, greater awareness and sensitivity about the negative sexual experiences of women has been accompanied by curricular changes. As clinical settings for counseling practice have been included in most seminary curricula, less emphasis has been placed on foundational education (languages, such as Latin, Greek, and Hebrew, are less often required), but issues of training remain problematic, especially concerning sexuality education.

The scientific literature contains abundant evidence of the positive role that clergy may have in health promotion generally and in sexual health promotion, specifically. One study affirmed, for instance, that nearly half of all referrals made by clergy to mental-health professionals "involved marriage and family problems" (Weaver 1995, 133).

Recently, however, this supportive role has come into question as trust in clergy generally has been undermined by the misconduct of a few. Fortune (1991) contends that omission of sexuality components in professional training misses an intervention opportunity for clergy students to explore ethical boundary issues concerning what appropriate sexual conduct consists of prior to entering the profession. Such evidence clearly points to the appropriateness of marriage, family, and sexuality content in clergy training, but such content seems lacking or is limited by various internal and external restrictions.

Prevalence. When seminary course offerings were surveyed in the early 1980s, only a small number of courses included the term *sex* or *sexuality* in their title or description

(McCann-Winter 1983). It might be assumed that sexual content is included in courses not so named, but this low prevalence still indicates that sexuality content is not prevalent in most clergy training programs.

A review of literature on training in pastoral counseling cites one study in which 50 to 80% of the sampled clergy thought their training in pastoral counseling was inadequate and did not equip them to deal with marital counseling issues (Weaver 1995). A study by Allen and Cole (1975) comparing samples of Protestant seminary students in 1962 and 1971 found that the students in the more recent sample did not perceive themselves as better trained in family-planning issues than those students in 1962. A recent study by Goodson (1996) documented that 82% of the Protestant seminary students surveyed declared having had zero hours of training in family planning in their seminaries, and 66% expressed desire for more training on this topic.

When seminary faculty members who include some aspect of sexuality in their courses were interviewed (Conklin 1995), they indicated that they did not identify themselves as sexuality educators, and they expressed anxiety about how their teaching of sexuality content would be viewed by others. Yet, they expressed optimism and hope, because sexuality content and courses are sought and positively evaluated by students, even though not required. There is eagerness and enthusiasm by students, congregants, and clergy to have sexuality issues addressed openly and to move in the direction of health, justice, and wholeness.

Content. Profound changes have occurred in the past four decades regarding sexuality education in seminaries. Resources which were once viewed as advantageous are now seen as outdated. More use is being made of commercial films, literature, and case studies. Printed materials with sexuality content have vastly increased in both quantity and quality. The Sexual Attitude Reassessment (SAR) model, providing intense and condensed exposure to a range of explicit materials, panels, and speakers interspersed with small-group processing, is still viewed with both affirmation as effective and with suspicion as risky (Rosser et al. 1995).

Increased awareness of the pervasiveness of negative outcomes related to sexuality has provided the impetus for continuing-education requirements, mandatory screening of various sorts, development of training programs, trainers, centers, and professional counselors, therapists, and consultants focusing on prevention of various kinds of violations. An understanding of sexuality based upon the content of sexual relationships, rather than the form of sexual acts, is described as a paradigmatic change now underway.

In the Conklin study (1995), sexual orientation and related terms were included, either as central concerns or peripherally, in all but one of the 39 interviews with seminary faculty. Prevention of harm seemed a more common goal than promotion of sexual health, and resources, language, and experiences for classroom use which focus on positive aspects of sexuality seem to be lacking. Examples of content frequently mentioned in the interviews included sexual violence, such as rape, abuse, and incest, sexual harassment and misconduct, sexually transmitted diseases, and sexual compulsivity. Content having religious connections included ordination, celibacy, incarnation, sexual theology, and sacrament.

Support and Resistance. While the need for professional sexuality education within seminaries has been documented in a few studies, and Conklin's qualitative assessment has indicated strong faculty support for teaching sexuality content, some resistance is still expected. Limitations may arise from diverse sources, such as denominational executives

and curriculum committees, seminary reward and assignment systems for faculty, financial restrictions, and students' reluctance to deal with sexual issues or be in value conflict with their institution or instructor's teaching.

Goodson's survey (1996) of the attitudes of Protestant seminary students toward family planning identified 4.5% of conservative students, as compared to 0.9% of non-conservative students ($p < .05$), espousing unfavorable views of family planning, and potentially opposing its teaching in seminary. With this same sample, when analyzing a statistical model to predict intention to promote family planning in their future careers, the variable "attitudes toward sexuality" emerged as a strong mediator of the relationship between the variables "religious beliefs" and "attitudes toward family planning." While "religious beliefs" exhibited a correlation of 0.81 with the "attitudes toward sexuality" variable, conservative students had, on average, more-negative views of sexuality when compared to their non-conservative counterparts. The difference was statistically large: 1.04 standard deviation units, and significant at the 0.001 level of probability.

Resources and Intervention Needs. Given these findings, it is clear that religious beliefs need to be considered when selecting resources and planning interventions. At present, it seems broad-based support for sexuality education comes from insurers encouraging risk-reduction measures to prevent actionable behaviors which could lead to claims or litigation. Some administrative encouragement of faculty efforts has been reported, especially in response to student pressure or suggestions from peers or superiors. However, this support seems to be far outweighed by administrative indifference or caution, although perceived hostility has decreased.

A high standard has been set by faculty members who have taught and written about sexuality. Impetus to do more, not less, seems dominant, especially among faculty. However, no one has clearly articulated as a unified plan of action what there should be more of in this area. There is, however, some openness toward planning and development rather than a rigid adherence to an already conceived plan or model. A current resource encouraging the development of plans or models is the Center for Sexuality and Religion in Wayne, Pennsylvania.

As we see it, a two-pronged approach to sexuality education is needed, in which promotion of assets and prevention of deficits are both necessary (Conklin 1995). Clearly, the main assets of Protestant and Catholic churches include their nurturing, caring, and supportive environments, as well as maintenance of centers for dissemination of knowledge and training of their leaders. Nevertheless, such training has been characterized as deficient, and the need to plan, implement, and evaluate appropriate sexuality programs is notorious. The outcomes of a successful two-pronged intervention, which balances emphasis on both sexual health and sexual harm, may be worth pursuing, if we consider the important role clergy and churches have had, and may continue to have, in promoting the health and well-being of people in this country.

[Update 2003: Reports of clergy sexual misconduct in the media have reinforced the belief that theological education must actively seek to professionally train male and female clergy and ministers to competently and responsibly care for and minister to the well-being of individuals (including their sexual health). In order to provide this preparation, theological schools may need to revise and implement curricula to address sexuality-training needs. The authors developed and administered an assessment of sexuality education currently offered in American seminaries and theological schools. The instrument included a measure of institutional

readiness to begin or share sexuality-related experiences (Conklin 2001). Surveys went to all 183 institutions in the U.S. accredited at the time by the Association of Theological Schools (ATS). Thirty-seven percent ($N = 69$ schools) responded. Questions addressed both developmental and educational experiences contributing to formation (personal development) as well as professional academic preparation for leadership roles in ministry.

[Results varied from 85% reporting current curricular efforts in which the sexuality content is embedded, to 47% saying they offered courses in which the sexuality content "stands alone," to 12% citing previous noncurricular events (workshops, convocations, or spiritual direction) in which the sexuality content was embedded. When *all* questions were counted, those concerning noncurricular efforts and previously offered courses, as well as current curricular efforts, the frequency of responses was equally split between those who did offer sexuality-related courses, content, or experiences and those who did not. An implication to be drawn from this finding is that about the same number of schools report doing nothing regarding teaching of sexuality as report doing something. But one needs to remember that two thirds of the 183 seminaries did not respond. The content and duration of *what* the theological schools *are* doing still needs to be investigated. Also, the attitudes of clergy toward pastoral counseling, and their training regarding sexuality issues, are questions needing further research (Goodson 2002). Although many schools express willingness to implement and share sexuality-education efforts and some clergy report feeling competent to counsel regarding sexuality issues, much more needs to be done. (End of update by S. C. Conklin & P. Goodson)]

[Sexuality and American Popular Culture

RAYMOND J. NOONAN

[Update 2003: Popular culture encompasses the cultural artifacts and practices of the masses. And it is through American popular culture that we have exported our sexual ideology to the world, which may, in part, have provided the fuel that energizes religious fundamentalist fanatics to commit terrorist acts (see discussion on Sexuality and Terrorism in the United States in Section 1, Basic Sexological Premises). Indeed, it is usually these images from American popular culture that most ordinary people think of when they think of Americans and who we are. It is typically young and brash, and it lives in the present with only fleeting recognition of the past or the future. It encompasses literature and the visual arts, theater and the cinema, and music. It also embraces fashion and the media. In the last 30 years, it has begun to have a history, which is continually being written, and, indeed, a philosophy.

[In that respect, it is much like the history of previous decades, in which Hollywood movies exported American culture to Europe and the rest of the world, similar to, although more efficiently than the rest of the world exported their cultural artifacts to the United States. Marshall McLuhan (1964) might have explained it as a natural extension of the impact of the new medium—motion pictures—that involved the viewer through the two most-immediate senses, sight and sound, more deeply than the written word. Of course, it occurred even much earlier, more slowly again and sporadic, this time over centuries or so, when the East and West met in the days when the great sailing ships opened new horizons. The influence on sexual practices in Japan, for example, can be seen in their erotic art of the 1800s, as these cultures began to show the influence of con-

tact with Western cultures, for better or worse (Kronhausen & Kronhausen 1970ab).

[Thus, much of popular culture is enabled by technology. It has been noted that almost every technological innovation is soon used for sexual expression (Noonan 1998c). It was true of Gutenberg's printing press in the 1400s and the camera in the 1800s. It was true more recently of the videocassette recorder (VCR) and video camera, and later, cable television; and it is true today of the DVD and the Internet and World Wide Web. All facilitated the sharing of sexual ideologies and experiences.

[As a result, we had a rich erotic literature develop that was rather cheaply and easily disseminated, both into and out of the country, extending the erotic "writing of harlots" that has evolved little through the ages. After all, there are only a finite (though extensive) number of ways our anatomy can fit together that is satisfying for most people. The banned writings of D. H. Lawrence, Henry Miller, and many others are just part of a long tradition that has largely become assimilated into everyday literature, film, and television. Advertising especially capitalizes on the erotic impulse to sell practically anything. Thus, the groundbreaking work of Lawrence and others of the genre have entered a baroque period, where the art is refined, but not much of it is cutting-edge or often even exemplary. Much of it is stylized and predictable, and, when it is good, it touches a chord in many readers or viewers as "real." That is often the demarcation between gratuitous sex in the media and pornography, on the one hand, and sex that could be a part of one's ordinary life—that is part of one's own storyline, good or bad, on the other.

[Thus, the following sections highlight several contemporary topics that are continuing to have a profound impact on American sexual culture in our everyday lives. The first is the ubiquitous Internet, originated by the U.S. Defense Advanced Research Projects Agency (DARPA) and driven by Cold-War fears of nuclear war that eventually became a means of communication for scientists. It was finally released for commercial use in the mid-1990s, at which time development advanced rapidly, often driven by sex-related entrepreneurs, especially those seeking the best and most-profitable ways of delivering explicit sexual images to a vast, worldwide market (see Noonan 1998c). The first article appeared in volume 3 of the first edition of the *International Encyclopedia of Sexuality*, when the Internet boom was still new. The second article updates that one, and focuses on contemporary online sexual activities and the diverse uses that sexologists and the general public have made of the medium as its sophistication and use have spread in the intervening years. In addition, it looks at some of the problems, such as compulsive Internet sexual behaviors, and their implications for sex-related therapies.

[The third article looks at the cutting-edge on the literary front: gay and lesbian literature. It might be said that this genre is at the stage that sexually oriented literature depicting the diverse lifestyles of heterosexuals was decades ago, when society broke the bonds of postal regulations and other laws prohibiting the sale and distribution of authors who have since become classics in erotica, if not American and English literature. As noted above, such depictions have become commonplace in literature, film, and television, with little extraordinarily novel. Gay and lesbian literature, on the other hand, being relatively recently released from similar, if not somewhat greater prohibitions, is poised to break new ground and to produce future classics. Indeed, new courses in gay and lesbian literature are being written and offered more frequently in colleges across the nation.

[The fourth article delves into sexually explicit lyrics in popular music, offering a look at the historical antecedents,

often hidden, that have been a part of the folk and even classical tradition for at least two centuries. Thus, critics, whose contemporary uproar in the United States over sexually explicit words and concepts in rap and hip-hop and other popular genres continues to make headlines, need look back no further than Cole Porter and the psychedelic music of the 1960s for sexual content in the musical lyrics of our nearest previous generations.

[The final article takes a sociological look at fashion in America and the reciprocal influence that it has on a generation's sexuality and how their sexuality, in turn, along with current events, influences the fashions of the day. It, too, looks at the historical antecedents of how contemporary fashion, widely recognized by sexologists as accentuating the secondary sex characteristics of both males and females to make them more attractive to potential friends, lovers, or spouses, has changed through the ages. Thus, fashion reflects the images of attractiveness that define each generation and its social context within then-current definitions of gender and the place of each in the social hierarchy and the cultural sphere. (*End of update by R. J. Noonan*)]

A Door to the Future: Sexuality on the Information Superhighway

Sexuality and the Internet SANDRA BARGAINNIER

People interested in sexual topics have always been quick to explore a new mode of communication—from graffiti on a prehistoric cave wall, movable type, photography, and radio, to video cameras, VCRs, and videocassette rentals and sales—as a way around the censorship society uses to regulate and limit the dissemination of sexual information. The most recent new mode of communication, the computer-based "information superhighway," the Internet or simply "the Net," is no exception. From its birth, the Net has raised images of erotica, pornography, and cybersex available in the privacy of one's home. The Net does provide sexuality information for the general "online" public, but it can also provide a wealth of reliable information for sex researchers, sex educators, and sex therapists. However, the use of the Net to access sexuality information has also brought the inevitable sequel of society's effort to regulate this new avenue of sex information.

The Internet is not a physical or tangible entity, but rather a giant network which interconnects innumerable smaller groups of linked computer networks. In early 1995, the global network of the Internet had 2 million Internet hosts; in late 1995-1996, 5 million hosts; and in early 1996, 9.5 million hosts. This is expected to double to 20 million hosts sometime in 1997. However, the number of Internet hosts is misleading, because many hosts limit access of their users with firewalls and other electronic barriers.

Gateways to a variety of electronic messaging services allow Internet users to communicate with over 15 million educational, commercial, government, military, and other types of users throughout the worldwide matrix of computer networks that exchange mail or news. These rapidly developing, and constantly changing, network information and retrieval tools are transforming the way people learn, interact, and relate. These networks provide users with easy access to documents, sounds, images, and other file-system data; library catalog and user-directory data; weather, geography, and physical-science data; and other types of information (Schwartz & Quartermann 1993). Professional journals, papers, conferences, courses, and dialogues are increasingly delivered electronically.

Although the federal government initiated the Internet during the "Cold War" as a way to send top-secret information quickly and securely, no government or group controls

or is in charge of the Internet today. The Internet depends on the continuing cooperation of all the interconnected networks (Butler 1994). Because there is no proprietary control, anyone can send email (electronic mail), start a newsgroup, develop a listserv, download files, and/or have their own World Wide Web (WWW) home page or Web site. This freedom has opened the cyberspace doors to the sexuality arena.

For sexuality professionals, the opportunities in cyberspace are limitless. Email is just one of many functions. This one-on-one mode of electronic communication allows colleagues to communicate and collaborate in their research worldwide, pursue new leads quickly, test new ideas and hypotheses immediately, and build networks of like-minded colleagues. Whole documents can be attached to email, sent electronically around the globe, and downloaded by the recipients almost instantly. Both time and money can be saved by editing online and bypassing postal delays and costs.

Many American university professors communicate with their students by email. Lessons, syllabi, and homework are passed back and forth with email. Email can also provide the shy or quiet students in a class another venue for participation.

Listserv mailing lists are similar to email, but instead of communicating with only one other person, communication takes place among many. Many Americans of all ages subscribe to a mailing list and use it as a good place to debate issues, share professional ideas, and try out new concepts with others. Subscribers automatically receive correspondence from others who belong to the list. It is like reading everyone's email about a particular topic. Hundreds of listservs exist, including those that address rape, gay and bisexual issues, feminist theory, women's health, AIDS, addictions, survivors of incest, and advocacy, to name a few.

In addition to sending email to individuals or to a mailing list, Americans are increasingly meeting people and sharing interests through newsgroups. Like listservs, newsgroups are open discussions and exchanges on particular topics. Users, however, need not subscribe to the discussion mailing list in advance, but can instead access the database at any time (Butler 1994). One must access a special program called a newsreader to retrieve messages/discussions from a newsgroup. A local site may have many newsgroups or a few.

Newsgroups are as diverse as the individuals posting on them. Usenet newsgroups are arranged in a hierarchical order, with their names describing their area of interest. The major hierarchies are talk, alt, biz, soc, news, rec, sci, comp, and misc. Some examples of newsgroups in the field of sexuality are: sci.med.aids, talk.abortion, soc.women, soc.men, soc.bi, alt.sex, alt.transgendered, alt.sexual.abuse.recovery, and alt.politics.homosexuality. This hierarchy and system of naming help the user decide which groups may be of interest.

Many groups provide informative discussions and support. Other groups are often magnets for "flamers" (those who insult) or people posing as someone else (i.e., a young adult male posing online as a lesbian). One benefit of the newsgroup is that anyone can read the articles/discussions but not participate. These voyeurs are called "lurkers." This may be a safe starting point for a few months until one has an understanding of the group, their history, and past discussions. "Newbies" (newcomers to groups) are often flamed if they ask neophyte questions in some newsgroups. Reading a newsgroup's "FAQ" (frequently asked questions) page prior to inquiring online is one way newbies can avoid being flamed for naive or inappropriate inquiries.

In addition to transmitting messages that can be read or accessed later, Internet users can also engage in an immediate dialogue (called "chat") in "real time" with other users. Real-time communication allows one-to-one communica-

tion, and "Internet Relay Chat" (IRC) allows two or more people to type messages to each other that almost immediately appear on the other's computer screen. IRC is analogous to a telephone party line. In addition, most commercial online services have their own chat systems allowing members to converse. An example of a chat system is the Human Sexuality Forum on CompuServe, a proprietary online network that also offers members access to the Internet.

In addition to email, newsgroups, listservs, and chats, one can access information by transferring files from one computer to another with FTP (file transfer protocol). One important aspect of FTP is that it allows files to be transferred between computers of completely dissimilar types. It also provides public file sharing (*The Internet Unleashed*, 1994). These files may contain text, pictures, sound, or computer programs.

Another method of connecting with remote locations is through Telnet. Telnet allows the user to "log in" on a remote machine in real time. For example, a student can use Telnet to connect to a remote library to access the library's online card catalog.

American sexuality professionals now communicate, collaborate, and discuss issues with colleagues around the globe. They can also access information from around the world. Two of the more common methods for accessing information are Gopher and the World Wide Web (WWW). A user can collect data, read conference proceedings, tap into libraries, and even search for jobs online.

Gopher guides an individual's search through the resources available on a remote computer. It is menu driven and easy to use. Most American colleges and universities have a local Gopher menu. Gopher can also be accessed through most commercial online services. Gopher allows users to access information from various locations. The National Institute for Health, the Centers for Disease Control and Prevention, and the National Library of Medicine are just a few examples of sites that are accessible via Gopher.

Most information sites that can be reached through Gopher can also be accessed via the World Wide Web. The "Web" uses a "hypertext" formatting language called hypertext markup language (HTML). Programs called Web browsers that "browse" the Web can display HTML documents containing text, images, sound, animation, and moving video. Any HTML document can include links to other types of information or resources. These hypertext links allow information to be accessed and organized in very flexible ways, and allow people to locate and efficiently view related information, even if the information is stored on numerous computers all around the world.

Many organizations now have "home pages" on the Web. The homepage typically serves as a table of contents for the site, and provides links to other similar sites. Some websites that may be of interest to the sexuality professional are: the Society for the Scientific Study of Sexuality (SSSS) [<http://www.sexscience.org>]; the Kinsey Institute [<http://www.kinseyinstitute.org>]; the Sexuality Information and Education Council of the United States (SIECUS) [<http://www.siecus.org/>]; the Queer Resources Directory [<http://www.qrd.org/qrd/>]; and Tstar [<http://travesti.geophys.mcgill.ca/~tstar/>]. TStar provides resources and information for the transgendered community. The TStar home page is also a gateway to other resources on the Web, such as the Lesbian, Gay, Transgendered Alliance, and the Gay, Bi-Sexual, Lesbian, and Transgender Information from the United Kingdom. [Editors' Note: *The SexQuest Web Index for Sexual Health* provides links to many of the best sexuality research, education, and therapy sites on the Web: <http://www.SexQuest.com/SexQuest.html>.]

Sex researchers, educators, and therapists can use email, listservs, newsgroups, and the World Wide Web for updated information and resources. Sexuality professionals can also use the Internet as a new frontier for sex research. Approximately 200 active Usenet newsgroups deal with sex and variations of some sexual theme (Tamosaitis 1995). Very few have researched who these newsgroup users are, what sexuality knowledge they possess, what sexual attitudes they hold, or in which types of behavior they engage.

In the fall of 1994, a modified version of the Kinsey Institute Sex Knowledge Test was distributed to 4,000 users online (Tamosaitis 1995). The results showed that over 83% were male, white, highly educated, single, middle- to upper-class, and not afraid of technology. The majority were in their 20s and 30s and predominantly bicoastal, with 63% living either on the West or East coasts. The survey demonstrated that both the sexually oriented and general online user group respondents are more knowledgeable about women's sexuality issues than they are about comparable men's issues when compared to the general offline population polled (Tamosaitis 1995). This study, the first of its kind, could provide the impetus for further online research. Of the 20 most popular Usenet newsgroup forums, half are on sex-related topics (Lewis 1995).

Several universities are also concerned about sexually explicit material and are limiting or prohibiting access to certain newsgroups. In November 1994, Carnegie Mellon University moved to eliminate all sexually oriented Usenet newsgroups from its computers. Stanford, Penn State, Iowa State and other universities have also attempted to limit access (Tamosaitis 1995).

Legal Challenges to Free Speech on the Internet

BARBARA GARRIS

Politically, any mention of sexuality in international cyberspace, from the most benign to the most perverse, is currently under scrutiny in the Supreme Court. In June 1995, Senator James Exon offered the Communications Decency Act of 1995 as an amendment to the Telecommunications Act of 1996, which was then included in the Telecom Act as Title 5, Section 507. The Communications Decency Act (CDA) expands regulations on obscene and indecent material to minors which would be transmitted to them through the telephone lines by way of the worldwide Internet, or any other online service (Italiano 1996; Lewis 1995; Lohn 1996).

The bill included, in a very subtle unthreatening way, elements of the old Comstock Act of 1873, which, in the past, made it a crime to send material on birth control and abortion through the postal service (Schwartz 1996a). This archaic act, inserted by Representative Henry J. Hyde, a longtime abortion foe, remains on the legislative books today as 18 U.S.C. Sec. 1462. Elements of the Comstock Act prohibiting dissemination of contraceptive information and the sale of contraceptives to married and single women had been declared unconstitutional in various decisions, the last two in 1966 and 1972. However, the prohibition against providing information about abortion remains on the books to the present. In the new Communications Decency Act, the maximum fine for providing information about abortion has been raised from \$5,000 to \$250,000 for anyone convicted of knowingly transmitting any "obscene, lewd, lascivious, filthy, or indecent" communications on the nation's telecommunications networks including the Internet. Meanwhile, other legislators sponsored legislation, the Comstock Clean-up Act of 1996, to repeal completely the remnants of the Comstock Act.

The Telecommunications Act of 1996 was signed by President Clinton on February 8, 1996. Although the Presi-

dent signed the bill into law, he immediately issued a disclaimer, saying that

I do object to the provision in the Act concerning the transmission of abortion related speech and information. . . . The Department of Justice has advised me of its longstanding policy that this and related abortion provisions in current law are unconstitutional and will not be enforced because they violate the First Amendment [protecting freedom of speech].

The CDA was included in the Telecommunications Act supposedly to squelch online pornography and make the World Wide Web and the Internet, as well as other online services, "safe" for children. But the wording crafted by Internet-illiterate congressmen was so vague and overly broad that even the most innocent use of health-related information could result in a \$250,000 fine and two years in prison. Free-speech activists, spearheaded by the American Civil Liberties Union, Electronic Freedom Foundation, American Library Association, and many others, were appalled and filed suit to keep at bay any prosecution and punishment for this alleged online crime until the case can be heard by the United States Supreme Court.

Suit was immediately filed by the American Library Association and the Citizen's Internet Empowerment Coalition in the United States District Court for the Eastern District of Pennsylvania seeking a preliminary injunction against the CDA on the constitutional grounds of the right to free speech. "Plaintiffs include various organizations and individuals who, inter alia, are associated with the computer and/or communications industries, or who publish or post materials on the Internet, or belong to various citizen groups." The case was heard before Judge Sloviter, Chief Judge, United States Court of Appeals for the Third Circuit, and Judges Buckwalter and Dalzell, Judges for the Eastern District of Pennsylvania.

An injunction was granted on June 11, 1996, after all three judges had schooled themselves with hands-on experience with the Internet. The basis for the injunction was threefold:

1. That whatever previous decisions had been handed down limiting indecent expression on other media (such as cable television and radio) could not be applied to cyberspace,
2. Control over pornography aimed at children rested with the parents and schools, not with the government nor with online services transmitting the offensive material, and
3. There was no technological way available to the Internet of checking the age of Internet users, except the use of credit card numbers, to access hardcore pornography.

All three judges saw the CDA as patently unconstitutional and asked the Supreme Court for a final ruling (EPIC 1996; McCullough 1996; *The New York Times* 1996; Quinttner 1996; Schwartz 1996b).

On July 1, 1996, the U.S. Department of Justice officially filed an appeal. In its September 30, 1996, edition, *HotWired* magazine reported that the U.S. Department of Justice was stalling for time, and the U.S. Supreme Court granted them an extra month to submit filings. The case was supposed to have been heard in the Supreme Court in October 1996, but no new hearing date had been published as of November 1996. As of March 1997, the CDA was going to the Supreme Court, with a decision expected in June.

Judge Dalzell's opinion sums up the ongoing debate over sex on the Internet:

True it is that many find some of the speech on the Internet to be offensive, and amid the din of cyberspace many hear discordant voices that they regard as indecent. The absence of governmental regulation of Internet content has unquestionably produced a kind of chaos, but as one of plaintiffs' experts put it with such resonance at the hearing: "What achieved success was the very chaos that the Internet is. The strength of the Internet is that chaos."

Just as the strength of the Internet is chaos, so the strength of our liberty depends upon the chaos and cacophony of the unfettered speech the First Amendment protects.

For these reasons, I without hesitation hold that the CDA is unconstitutional on its face.

Since the filing of this case, three other state cases have been brought to court. A New York City case, filed April 30, 1996, by Joe Shea, a reporter for the *American Reporter*, sought to overturn the CDA, claiming that the law limits freedom of speech for the press. On July 29, 1996, the court ruled in favor of Shea. This case is expected to be folded into the primary case brought to the Supreme Court by the American Civil Liberties Union (ACLU) et al. suit mentioned above. At the same time, journalism professor Bill Loving of the University of Oklahoma filed suit against the university charging that it blocked access on April 1, 1996, to a newsgroup, "alt.sex," after the university received complaints from a fundamentalist religious organization. Loving claimed that restricting students' access to the Internet is a violation of their First Amendment rights. (As of late 1996, he was awaiting the University's response.) Finally, effective July 1, 1996, the Georgia State General Assembly passed a law providing criminal sanctions against anyone falsely identifying themselves on the Internet. A suit (*ACLU of Georgia et al. vs. Miller et al.*), seeking a preliminary injunction against the Georgia statute, was filed September 24, 1996, by the ACLU, Electronic Frontiers Georgia, Georgia State Representative Mitchell Kaye, and others. As of late 1996, the hearing had not been held.

Summing Up

SANDRA BARGAINNIER

What is considered sexually explicit? Are safe-sex guidelines considered sexually explicit? Obviously, this type of law could disband the educational and informative sex-related Internet resources and the sex-related newsgroups.

Another concern associated with the Internet is the loss of community in the real world and the formation of online communities. Opponents believe that people are not honest about who they are in cyberspace, which is a fantasy land. Proponents say that virtual communities provide a place for support, information, and understanding. Many feel that gender, race, age, orientation, and physical appearance are not apparent in cyberspace unless a person wants to make such characteristics public. People with physical disabilities or less-than-glamorous appearances find that virtual communities treat them as they always wanted to be treated—as thinkers and transmitters of ideas and feelings, not just an able body or a face (Rheingold 1995). Many young people can be part of a community for the first time in their life by interacting with an online community. An online community might, for example, provide a teenage lesbian who feels alienated at school and home with a sense of self-worth and understanding.

Not since the invention of television has a technology changed how a nation and a world spend their time, gather information, and communicate, as has the Internet. Sexuality professionals and the public have the capacity to access tremendous amounts of sexual information, some of it valid and educational, some of it entertaining, and some that oth-

ers might label "obscene." But who is to judge? Sexuality professionals need to get involved before others judge what is deemed acceptable sexuality information. The Internet will also serve as a new frontier for sex research, sex education, sex information, collaboration, and communication (Tamosaitis 1995).

[Online Sexual Activity

AL COOPER and ERIC GRIFFIN-SHELLEY

[Update 2003: The Internet is a key element in the Information Age in the United States, as well as worldwide, in which "rapid and far reaching technological advances are revolutionizing the ways in which people relate, communicate, and live their daily lives" (Jerome, DeLeone, Folen, Earles, & Gedney 2000). Sexuality is an integral part of these phenomena such that Online Sexual Activity (OSA) has been dubbed the "next sexual revolution" (Cooper & Griffin-Shelley 2002).

[The search engine *Google* now examines over three billion Web pages (Google 2003), up from one billion less than three years ago (Inktomi 2000). Sex is the most searched-for topic on the Net (CIOL 2001). The 172 million Americans online represent over half of the U.S. population (Nielsen NetRatings 2003), and worldwide there are 605 million Net users (Nua 2003). Twenty to 33% of people use the Net for online sexual activity (Cooper, Delmonico, & Burg 2000; Egan 2000).

[As with any human activity, Internet use has advantages, e.g., opening a previously inaccessible market, and disadvantages, e.g., identity theft. It stands to reason, then, that the same is true for Internet activities involving sexuality (Cooper, Scherer, Boies & Gordon 1999; Barak & King 2000). This chapter will provide a brief overview of these important and evolving issues. The speed of this revolution, and the intensity of its impact, are because of the "Triple A Engine" of accessibility (anytime, anywhere), affordability (a quick and easy local phone call), and anonymity (the perception that your identity is hidden) (Cooper, Scherer, Boies, & Gordon 1999). In addition, Internet activity can have a "disinhibiting" effect (Suler 2001), i.e., allowing people to engage in sexual activities that they might not otherwise have done. A geometrically expanding literature (Griffin-Shelley 2003) and research base (Noonan 2001) substantiate the power of this revolution.

[Definitions

[For research and clinical work to proceed with a scientific foundation, one of the first steps is the development of a common agreed-upon nosology. Cooper and Griffin-Shelley (2002) have proposed this set of definitions:

[*Online Sexual Activity* (OSA) is defined as use of the Internet for any activity (including text, audio, and graphic files) that involves sexuality, whether for purposes of recreation, entertainment, exploration, support, education, commerce, efforts to attain and secure sexual or romantic partners, and so on.

[*Cybersex* is a subcategory of OSA, and can be defined as using the medium of the Internet to engage in sexually gratifying activities, such as, looking at pictures, engaging in sexual chat, exchanging explicit sexual images or emails, "cybering" (i.e., sharing fantasies over the Internet which involve being sexual together while one or both people masturbate), and so on.

[*Online Sexual Problems* (OSP) includes the full range of difficulties that people can have because of engaging in OSA. Such difficulties include negative financial, legal, occupational, relational, and/or personal repercussions from OSA. The "problem" may range from a single incident to a

pattern of excessive involvement. The consequences may involve feelings of guilt, loss of a job/relationship, STDs, and so on.

[Finally, *Online Sexual Compulsivity* (OSC) is a subtype of OSP and refers to excessive OSA behaviors that interfere with the work, social, and/or recreational dimensions of the person's life. In addition, there are indications of a "loss of control" of the ability to regulate the activity and/or to minimize adverse consequences (Cooper 1998; Cooper 2000; Griffiths 2001; Delmonico, Griffin, & Carnes 2002).

[Sexual Education and Information]

[Clearly, anonymously accessible and affordable information on human sexuality available worldwide at any time is a sex educator's dream. These dreams are becoming reality through the efforts of professional organizations such as the American Association of Sex Educators, Counselors, and Therapists (www.aasect.org) and businesses such as www.bettersex.com or www.sex-centre.com (Bay-Cheng 2001). As with any health topic, the quality of information varies widely from the most empirically based and up-to-date to the most biased and misinformed, so consumers need to proceed with caution having a "buyer beware" attitude (Barak & Fisher 2001).

[People appear more comfortable obtaining information on sexuality via the Internet because of the "Triple A" and the accompanying capacity to reduce shame and inhibition (Millner & Kiser 2002). Online "sexperts" offer news, answers to frequently asked questions (FAQs) (Ochs & Binik 2000), education, e.g., the "Sexploration" columns of www.MSNBC.com, and individual consultation. Sexual education efforts are international in scope, e.g., Lunin, Karizanskaya, Melikhova, Light, & Brandt-Sorheim (1997) report on efforts in Russia. Although beyond the scope of this article, online therapy for relationships and sexual issues is expanding, although many legal, ethical, and professional concerns remain to be resolved.

[Research on the reasons people engage in online sexual activity is in the early stages (Cooper, Scherer, Boies, & Gordon 1999; Cooper, Griffin-Shelley, Delmonico, & Mathy 2001). Cooper, Scherer, Boies, and Gordon (1999) found that for the 9,265 respondents in their study, most used adult websites, sex chat, and other sexual activities as "casual recreation"; 91.7 % spent less than 11 hours per week on online sexual activity and 46.6% spent less than 1 hour per week. Eighty-four percent of men and 80% of women were satisfied with their online sexual activity, and 87% reported never feeling guilt or ashamed. Most people (81.6%) of the second large scale study ($n = 7,037$) indicated that their online sexual activity served as a "distraction." Just under a third used online sexual activity for education (31.7%) and to cope with stress (29.9%) (Cooper, Griffin-Shelley, Delmonico, & Mathy 2001). Other reasons for online sexual activity included meeting people online for face-to-face (f2f) dating, socializing, engaging in sexual activities that the person would not do in real time, getting support for sexual concerns, and purchasing sexual materials.

[Gender has appeared to be an important variable in the early research in terms of Internet sexuality (Cooper, Scherer, Bois, & Gordon 1999; Cooper, Delmonico, & Burg 2000; Goodson, McCormick, & Evans 2001; Leiblum & Doring 2002). Women tend to be less involved in online sexual activity and prefer interactive media, i.e., chat rooms to more-voyeuristic activities like viewing pictures. Of note, recent research in Sweden (Cooper, Månsson, Daneback, Tikkanen, & Ross 2003) indicated that more-sophisticated research designs might significantly increase the percentage of women who participate in this type of research. Leiblum

and Doring (2002) and Podlas (2000) suggest cyberspace may be the leading edge of a continuing frontier for women's sexual liberation.

[Sexually Disenfranchised and Alternative Communities]

[Lesbian, gay, bisexual, and transgendered youth have appeared to suffer delayed development because of the intense hatred, discrimination, shame, and humiliation that the dominant culture expresses towards them. For example, most put off "coming out," and even their own understanding and acceptance, until they leave home for college or the city where there is more freedom, acceptance, and respect for their orientation. The Internet is changing that by giving sexually disenfranchised adolescents information, role models, peers, and opportunities for interaction unheard of even at the end of the 20th century (Burke 2000; Ross & Kauth 2002). These teens and other sexual minorities no longer have to live in shame, fear, and isolation (McKenna 2001). They can learn the "how tos" of sex through informative websites, pictures, and videos. They can connect with other people like themselves in online discussion groups, email lists, chat rooms, and instant messaging (Plymire & Forman 2000; Ross & Kauth 2002). They can find people and places to "hook up" to explore their sexual preference without having to go to bars, bathhouses, or bathrooms, or other clandestine rendezvous spots.

[Men who have sex with men are finding new vistas on the Net, but not without risks such as transmission of STDs (Bull, McFarlane, & Reitmeijer, 2001; Benotsch, Kalichman, & Cage, 2001; Elford, Bolding, & Sherr, 2001; Ross, & Kauth, 2002). At the same time, the Internet may offer new ways to prevent problems related to sexual activity (Bull & McFarlane, 2000; Bull, McFarlane, & King, 2001; Hospers, Harternick, Van Den Hoek, & Veenstra, 2002). The Net can also be a vehicle for support and health information for those already suffering from STDs and HIV/AIDS (Reeves, 2001; Kalichman, Benotsch, Weinhardt, Austin, & Luke, 2002; Kalichman, Weinhardt, Benotsch, DiFonzo, Luke & Austin, 2002).

[Of course, the broadening of opportunities and freedom are not limited to sexual minorities. Any person or group may find love and sexual expression via the Net. Those who feel they are unattractive can establish relationships based more on their communication skills than their physical appearance. Support and connections have created the possibility of alternative cyber communities for sexual minorities and those with disabilities (Pendergass, Nosek, & Holcomb 2001; Tepper & Owens 2002). Elderly people who want to continue to be emotionally and sexually active are making connections and finding new vistas open to them from all over the world.

[People with atypical sexual interests and illegal preoccupations can find new arenas via the Net (Galbreath, Berlin, & Sawyer 2002; Kim & Bailey 1997). People, particularly men, are experimenting with a seemingly endless series of sexual variations, from voyeuristic interests (including pictures and video files from "spy cams") to exhibitionistic sites where those with their own "webcams" offer free or paid glimpses into their lives (Waskul 2002). The dominant/submissive lifestyle and sadomasochism are well represented and often link online and face-to-face ("f2f") experiences for those seeking them (Palandri & Green 2000). People with fetishes, from bestiality to trampling and even pedophilia (Durkin & Bryant 1999), are there for those looking for community (Galbreath, Berlin, & Sawyer 2002). Despite preliminary research indicating that much of this activity is beneficial, or at least benign, there is enough

that is not (Cooper, Galbreath, Becker, & Griffin-Shelley 2003) that policymakers and legislators, as well as the general public, have expressed concern and inquired about how to control and regulate this global phenomena.

[Online Relationships]

[The impact of the Net on courtship and sexual relationships is only beginning to be the subject of empirical studies despite the increasing numbers of people who are using it for these purposes (Cooper, Scherer, & Marcus 2002). Success stories and disasters are regularly heard on the news, in consultation rooms, and, of course, across the Internet. Clearly, opportunities for meeting romantic and sexual partners have increased because of the Net, and online dating services, such as match.com and eharmony, are experiencing rapid growth and increased acceptance (Levine 2000). Proximity, physical appearance, and similarity do not play the role they do in face-to-face encounters (Cooper & Sportolari 1997), and the disinhibiting effect of Internet communication (Suler 2001) may lead to quicker and deeper connections between people.

[One of the early problems reported by clinicians was "Internet infidelity" (Shaw 1997; Young, Griffin-Shelley, Cooper, O'Mara, & Buchanan 2000). Some assert that the lack of actual contact negated the reality of the "affair," while others point out that partners reported that the feelings of violation and betrayal were similar to what they experienced when the infidelity involved face-to-face sexual contact (Schneider 2002).

[It may be possible to deceive and defraud people more easily in cyberspace than in real time. Stories abound of people who have found their "true love" online (Seiden 2001), as well as accounts of people discovering that the person they were connecting to lied about their gender, age, appearance, or life circumstances (Cornwell & Lundgren 2001). As the research about what makes for a good long-term relationship (Gottman 1994) becomes clearer and the instruments to measure those traits become more robust, this powerful medium may ultimately be proven to be better at helping a person to choose a life-mate than doing it "the old fashioned way," i.e., without the benefit of computer-assisted technology. At the same time, because of the increased likelihood of fantasy and projection being a larger part of online relationships, users will need to be cautious and aware that there may be a greater chance of reenacting traumatic and unsuccessful relationships in this venue (Schwartz & Southern 2000). Younger people who have "grown up with the Net" will find it an increasingly integral part of their romantic and sexual lives (Cooper, Månsson, Daneback, Tikkanen, & Ross 2003). Finally, as people become more sophisticated about life in cyberspace and online relationships, and more of the "facts" are known and disseminated, the chances will increase that more good and less harm will be the result.

[Online Sexual Problems/Online Sexual Compulsivity]

[While the majority of online sexual activity has not led to problems, it does for some (Griffiths 2000; Putnam 2000; Stein, Black, Shapira, & Spitzer 2001). Research suggests that as many as a quarter of male Internet users indicate some level of difficulty associated with online sexual activity. Cooper, Scherer, Bois, and Gordon (1999) and Cooper, Griffin-Shelley, Delmonico, & Mathy (2001) indicated that 8% of users report Online Sexual Problems (OSP). Cooper, Delmonico, and Burg (2000) identified 1% of their sample as having Online Sexual Compulsivity (OSC). In addition, this research supports what clinical practice reports, i.e., that some people (perhaps 15%) are "at risk" for online

sexual problems, even when they do not have a prior history of acting out sexually (Cooper, Delmonico, & Burg 2000).

[Young people are not the only populations that can blossom or suffer as a result of their online romantic and sexual activity. Shy, lonely, and vulnerable adults (separated, divorced, or isolated), as well as those in a host of other "minority" categories (including the disabled or mentally ill) can find both happiness and harm via the Internet. Most adults are naïve about, or unaware of, the specific vulnerabilities of this medium, and are susceptible to victimization online via deception, romantic role-play, fraud, and exploitation.

[There are also secondary victims of people who have online sexual problems, i.e., people who suffer consequences because of the OSP person's Internet activities (Schneider 2000; Schneider 2002). For example, a wife and her children were left to survive on their own when their husband/father was caught in a police sting of people exchanging child pornography. Likewise, the congregation in a local synagogue was abandoned when their rabbi was abruptly fired after repeated incidents with online sexual activity.

[The implications for clinical practice include requiring expanded knowledge of behavioral problems that are new (e.g., cyber-affairs), expansions of existing disorders (e.g., cyber exhibitionism), and additional unhealthy opportunities for those with longstanding problems (e.g., pedophilia online) (Cooper & McLoughlin 2001). Some clinicians see the need for providing online education and/or counseling around sexual issues (Newman 1997; Graugaard & Winter 1998), as well as simply encouraging clients to use the Net as a resource and support network (Putnam 2000; Kalichman, Benotsch, Weinhardt, Austin, & Luke 2002). Noonan (1998c) has suggested terminology, *self-defined lovemap-inappropriate sexual arousal* (SDLISA), to describe the kinds of unexpected responses that some individuals may have from viewing gay or pedophilic (or other paraphilic) images that are not congruent with their identified lovemap. Such responses might be more significant today because of the ease with which such images might be encountered on the Internet, either by accident or curiosity or otherwise, and should be investigated.

[Treatment for online sexual problems and online sexual compulsivity is usually multi-modal, including individual, group, and couples therapies, as well as encouragement to obtain a medication evaluation when appropriate (Cooper & Marcus 2003; Orzack & Ross 2000; Putnam & Maheu 2000; Schneider and Weiss 2001; Delmonico, Griffin, & Carnes 2002; Griffin, Moriarty, & Delmonico 2001).

[Children, Adolescents, College Students, and Young Adults]

[Children and adolescents are growing up with the Internet as part of their lives (Longo, Brown, & Orcutt 2002). From school research projects to chatting with friends, young people in America are increasingly familiar with the Internet's power for self-help and self-harm. As with other groups, the Net opens up unheard-of opportunities, e.g., friends around the world, and terrifying dangers, i.e., pedophiles posing as peers. Parents, teachers, legislators, and police are struggling to keep up and encourage healthy online activity while protecting this obviously vulnerable population (Finkelhor, Mitchell, & Wolak 2000). Nevertheless, Noonan (1998c) has noted how the notion of sexual predators online has been greatly exaggerated, particularly in comparison to the much greater risk of harm documented in many offline contexts, e.g., risk of intra-family sexual abuse.

[Children, obviously, need more help and supervision than teenagers. Resources are emerging (Flowers-Coulson, Kushner, & Bankowski 2000; Hagley, Pearson, Carne 2002; Longo et. al. 2002) to assist caregivers around Internet use. The first suggestion, as always, is to talk to children and teens. We know that most parents have difficulty talking to children and adolescents about sexuality. The Internet offers opportunities for sex education unparalleled a few years ago (e.g., www.siecus.org; www.plannedparenthood.org), including those for sexual minorities (e.g., www.youthresource.org for gay, lesbian, bisexual, and transgendered youth). In addition, there are safe places to ask questions from premier health professionals filling in the gaps where parents and sex educators leave off (Mayo Clinic 2000). Adolescence is a time of identity development, experimentation, and education (Goodson, McCormick, & Evans 2000a; Goodson, McCormick, & Evans 2000b; Roffman, Shannon, & Dwyer 1997; Shpritz 1997; Zillman 2000). The online environment offers teens a new and broader stage to "try on" differing personas, ages, and even sexual orientations (Longo, Brown, & Orcutt 2002).

[Unwanted exposure to sexual material or activity can be troubling and may even be traumatic, especially for children and youth who are not developmentally ready to handle more-adult sexual activity. Accidental encounters can happen through misspelling a URL, using a search engine without blocking software, or intrusive and sexually suggestive emails ("spam"). Purveyors of sexual materials and pedophiles may also be much more aggressive in the fairly anonymous world of cyberspace (Mitchell, Finkelhor, & Wolak 2001).

[Children and adolescents are also "at risk" for online sexual problems, online sexual compulsivity, and Internet addiction (Young 1998). Few empirical data currently exist about this area, but we know from offline life that children and teens can be sexual victimizers as well as victims. As children get older, they, obviously, are more capable of engaging in paraphilic behaviors, as well as sexually stalking, harassing, and assaulting others on- and offline. If children or teenagers meet online contacts in real time, they may also be at higher risk for transmission of STDs and HIV/AIDS (Cooper, Scherer, Bois, & Gordon 1999; McFarlane, Bull, & Rietmeijer 2002), although paradoxically, the Internet may also have unrivaled potential to help with STD prevention and safer sex efforts (Keller, Labelle, Karimi, & Gupta 2002).

[Ethics and Regulation: Work Environments, Legal Considerations]

[The newness of the Internet makes ethical guidelines for behavior and regulation an evolving landscape (Plant & Donahey 2002). As individuals and groups encounter difficulties, guidelines and policies are being developed. This is happening in businesses, online service provider organizations, schools and universities, and private and governmental agencies. These responses include identifying problematic material and behaviors, as well as defining appropriate responses and restrictions (Cooper, Golden, & Kent-Ferraro 2002). The rapidly increasing usage of the Internet from the workplace has provided a brand new avenue for the availability, spread, and distribution of sexually related material and its consumption by employees with jobs that require them to go online everyday (Cooper, McLoughlin, Reich, & Kent-Ferraro 2002). In fact, approximately 50% of all Internet users use accounts that are financed by their employers, and in one study, almost 20% of the 40,000 surveyed adults reported engaging in online sexual activity while at work (Cooper, Scherer, and Mathy 2001). This corroborates data from other sources, which report that adult-

content sites are the fourth most visited category while at work (Goldberg 1998), and that 70% of all adult-content traffic occurs during the 9-to-5 workday (Carnes 2001). The implications of this phenomenon are potentially huge and of growing concern to clinical and organizational psychologists, as well as employers (Cooper, Safir, Rosenmann, Scherr, & McLoughlin, in press).

[Law enforcement at all levels, as well as policymakers and legislators are struggling to respond to new forms of sexual violence via the Net. These challenging scenarios include online harassment (Biber, Doverspike, Baznik, Cober, & Ritter 2002; McGarth & Casey 2002), cyber stalking (Deirmenjian 1999), cyper "peeping" or voyeurism/exhibitionism (Waskul 2002), rape websites (Gossett & Byne 2002), child seduction (Quayle & Taylor 2001), cybersex with minors (Jaffee & Sharma 2001), adult sex shops and pornography (Fisher & Barak 2000), child pornography (McCabe 2000; Burke, Sowerbutts, Blundell, & Sherry 2002), male violence (Cunneen & Stubbs 2000), and online pedophilia (Durkin 1997; Durkin & Bryant 1999). At the same time, other groups are concerned that control of the Internet is going too far, and thus, they are organizing to advocate for freedom and liberty in cyberspace, e.g., www.peacefire.org, which promotes computer programs capable of circumventing blocking software.

[The Future of Internet Sexuality]

[The future involves harnessing the power of the Internet to improve sexual relationships (Cooper, Scherer, & Marcus 2002). In part, this means refining the research methodology (Binik 2001; Cooper, Scherer, & Mathy 2001; Ochs, Mah, & Binik 2002) and gaining access to more data in order to better understand this geometrically expanding phenomena (Cooper, Månsson, Daneback, Tikkanen, & Ross 2003; Mustanski 2001; Noonan 1998c, 2001). It is also true that the "Triple A" provides an opportunity for better, more honest, and more accurate information on all aspects of sexuality, including: sexual preference (Renaud, Rouleau, Granger, Barasetti, & Bouchard 2002), orientation (Sell 1997), sexual disenfranchised populations (Appleby 2001; Quartaro & Spier 2002; Ross & Kauth 2002; Rhodes DiClemente, Cecil, Hergenrather, & Yee 2002), the function and impact of explicit sexual stimuli (McCabe 2000; Mehta 2001; Fisher & Barak 2001), and various other atypical sexual practices and behaviors (Ochs, Mah, & Binik 2002). Also, as the Internet facilitates and makes research on sexuality easier, more will become known about the lesser-known sexual practices in various countries and communities around the globe. Already, Internet-based studies are emerging from Israel (Barak & Safir 1997), Sweden (Cooper, Månsson, Daneback, Tikkanen, & Ross 2003; Tikkanen & Ross 2000), and China (Wang & Ross 2002). If the science of sexuality is to become an increasingly recognized and respected field, then the more empirical data that can be gathered on every facet of it, the better.

[In addition to having a future, Net sexuality has existed long enough to have a past (Noonan 1998c; Stern 2001; Stern & Handel 2001). It is increasingly clear that the Internet has much to offer, both in terms of benefits, as well as some highly problematic areas, in relation to human sexuality. With more research to guide and expand the empirical knowledge base, increased attention to resources and training for clinicians and sex educators around these issues, and a more mature and sophisticated understanding of the online world, the impact of the Internet could help the world to move towards the more empowered and enhanced relationship with sexuality that most of us seek. (*End of update by A. Cooper and E. Griffin-Shelley*)]

[Gay and Lesbian Literature in the United States: The Politics of Inclusion/Exclusion]

MICHAEL HYDE

[Update 2003: The difficulty in dealing with the notion of gay and lesbian literature in the United States is having to identify what is meant by "gay and lesbian literature," whether it be the literature produced by gays and lesbians, a literature that describes gay or lesbian experience or showcases gay and lesbian characters, or, more appropriately, some nonspecific amalgam of both. A great deal of what might actually be described as "gay or lesbian literature" has been written by authors who are neither lesbian nor gay, and just as equally, what might be—but never is—labeled as "heterosexual literature" finds its origins in lesbian and gay writers.

[This idea of a particularly gay and lesbian literature, as distinct from some other literature, is a uniquely American one as well as an increasingly dated one. The cordoning off of gay and lesbian literature from a mainstream literature arose for two reasons: from homophobia, on the one hand, and on the other, from the push of a minority culture to know and define itself. Prior to the Stonewall Uprising in 1969, literature explicitly centering on the experiences of gays and lesbians was largely an underground literature, considered subversive and part of a counterculture, produced and sold almost exclusively by lesbian and gay publishers and booksellers. Some crossover into mainstream American literature did exist, however—James Baldwin's *Giovanni's Room*, Gore Vidal's *The City and the Pillars*, or Ann Bannon's *Odd Girl Out* or *Women in the Shadows*—prior to the 1970s, but such crossovers were much more the exceptions than the rule. Other writers dealt with the pressure to conform to a mainstream literature through the use of literary masks or personae that transformed stories of same-sex desire into more widely acceptable works of heterosexual desire. In Willa Cather's 1918 novel, *My Antonia*, for example, her first-person narrator identifies himself clearly as male, but as Cather's novel evolves, the narrator fails in so many traditionally masculine roles that he becomes more of a mouthpiece for Cather's own feelings of same-sex longing and affection than a fully evolved heterosexual male character (Faderman 1995).

[The Stonewall Uprising in 1969 marks what is considered by many to be the beginning of the gay civil rights movement, and subsequently, publishing witnessed a surge of gay and lesbian writing, primarily because of the heightened visibility of the gay and lesbian community. Not surprisingly, then, gay and lesbian literature post-Stonewall acquired a profound and important connection to a political movement. Lesbian and gay writers became more and more aware of the potential within themselves—whether desired or not—to become voices for and, to some degree, responsible to, a larger community.

[During the 1970s, some of the most influential literary works were notable for their frankness in rendering the experience of gays and lesbians, particularly the sexual experience of gays and lesbians. Perhaps two of the most resonant and enduring fictions were Andrew Holleran's *Dancer from the Dance* and Larry Kramer's *Faggots*, clear descendents of John Rechy's *City of Night* from 1963, a fictional investigation of gay male prostitution. Both *Faggots* and *Dancer from the Dance*, published in 1978, highlighted fast-paced geographies of Manhattan nightclubs and Fire Island affluence, engaging issues of alcoholism, drug abuse, and promiscuity as reflective of a particularly gay lifestyle. Kramer's *Faggots* had been intended as a satire of the life the novel described, but many readers engaged the work, not as social critique,

but as purely descriptive of gay life. Although both of these works sold well, to both gay and straight audiences, the works were also harshly criticized (both within and outside the gay community), as the novels seemed not only to glorify unlawful behavior and promiscuity, but also suggested a gay identity that was linked primarily to such behavior.

[Rita Mae Brown's *Rubyfruit Jungle* in 1973 proved to be an equally groundbreaking and unapologetic celebration of lesbian sex and sexuality. Very little writing throughout the 1970s actually examined themes of growing up lesbian or gay. *Rubyfruit Jungle* offered a previously underrepresented look at a girl's coming of age—emotionally, physically, intellectually, and sexually—as she moves from her Southern roots, in love with the head cheerleader, to a series of comedic sexual adventures. Prior to the 1970s, lesbian characters in more-mainstream fiction were relegated to two types—largely the *femme fatale* or the medical oddity (Faderman 1995); Brown's central character signaled a sharp change in the types of roles lesbians might occupy in fiction.

[While the gay and lesbian community drew strength from this shared sense of "difference," minority politics also creates a tension in its assertion of "sameness" to the majority—in this case, heterosexual—culture. The stories of Armistead Maupin, first appearing in the *San Francisco Chronicle* in 1976 and later collected in *Tales of the City*, evolved a world in which gay and straight characters coexisted with equal weight, the stories shifting tonally from the comic to the touching, and to a degree, shrugging off expectations of how minority characters should behave in fiction. Often, characters representative of any minority group (sexual, racial, or ethnic) have been expected to behave as positive role models for their community, but the genius of Maupin's *Tales of the City* lay in his willingness to let his characters behave with all the positive and negative traits of their everyday human counterparts. As gay and lesbian literature started to reflect more and more the verisimilitude of lived life, gay and lesbian characters, less and less, would need to exhibit saintly behavior to be allowed a place in fiction.

[Gay and lesbian poetry during the 1970s concerned itself largely with identity politics, although themes of sexual endeavors and homosexual affections were likewise characteristic. Allen Ginsberg, made famous by his poetic treatise *Howl* (1955), continued his use of the literary medium as a forum for public shock and protest, writing about sexual desire in ways both celebratory and shocking, in *Mind Breaths* (1978). Richard Howard's *Two Part Inventions* (1974) imagined poetic dialogues between historical and literary personae, in one exemplary case divining a conversation between gay literary giants, Walt Whitman and Oscar Wilde, placing homosexuality within a larger literary-historical context.

[Throughout the 1970s, the lesbian rights movement aligned forcibly with the feminist movement, producing some of the most powerful poetry in American literature. So much of lesbian feminist poetry during the 1970s and into the 1980s worked to articulate the desires and concerns—as well the epistemological stance—of the lesbian and feminist movements, building on groundbreaking ideas from such radical idealists as Andrea Dworkin, whose *Woman Hating: A Radical Look at Sexuality* (1974) revolutionized thinking about the roles of gender and sexuality in America. Lesbian feminist poets like Adrienne Rich (*Diving into the Wreck*, 1973; *Twenty-One Love Poems*, 1977) and Marge Piercy (*The High Cost of Living*, 1978) pushed for a redefined sense of womanhood that was all inclusive and empowering, and the poetic voice became one of protest and deep sensitivity where goals of feminists and lesbians could unite in the push for change (Bennett 1995). Adrienne Rich's notion of a "lesbian continuum"—along which all women could situate

themselves in terms of their affection for fellow women—greatly influenced the work of lesbian feminists, theorists, and writers throughout much of the following decade.

[In the 1980s, lesbian writing continued mainly to be a vehicle for voicing social concerns and identity politics. Audre Lorde, a black lesbian feminist, emerged as a powerful voice with *Zami: A New Spelling of My Name* in 1982 and, in 1984, with *Sister Outsider*, a collection of influential essays concerning race, gender, sexuality, and identity in America. Lorde's writing, although forceful and unapologetic, exhibited a profound grace and sensitivity to peoples of all racial, gender, and sexuality orientations, and her firm belief in the connection of her own lesbian sexuality and black heritage as one linked identity, assisted in unifying efforts for change within both minority communities. Chicana writers, Gloria Anzaldúa and Cherrie Moraga, dissatisfied with what they viewed as the backseat role of non-whites in the feminist movement, compiled *This Bridge Called My Back: Writings by Radical Women of Color* (1981), which articulated the challenges of simultaneously occupying two minority positions (racial and sexual) in America. Writer and cultural theorist, Sarah Schulman, notable for her risky and experimental styles, examined the relationship between aesthetics, politics, and identity. In *The Sophie Horowitz Story* (1984), for example, a lesbian reporter trails feminist bank robbers, and Schulman's novel jabs at the essentially misogynist tendencies in the detective-novel genre. In her challenging of traditional narrative forms, Schulman examines the role of art in shaping politics and social change, encouraging her readers to question *meaning* and how meaning is derived. During the latter half of the 1980s, the detective genre became a popular medium for lesbian writers in general, evidenced by Katherine Forrest's *Murder at the Nightwood Bar* in 1987 or Mary Wings' *She Came Too Late* in 1987 and *She Came in a Flash* in 1988 (Summers 1995).

[Much of gay fiction during the early 1980s followed in a new form of *bildungsroman*: the "coming out" story. As gay and lesbian communities moved toward a renewed sense of solidarity, "coming out" stories allowed their own writers the possibility of self-expression and self-healing and afforded their gay and lesbian readers the knowledge that they were not alone in feeling the stresses of a minority culture. Edmund White's *A Boy's Own Story* in 1982, a semi-autobiographical fiction, epitomized the subgenre, following an adolescent's coming of age and of sexual identity in the American Midwest. Remarkable for its emotional openness and frank description of sexual encounters, *A Boy's Own Story* reached both gay and straight readers. Randal Kenan's *A Visitation of Spirits* (1989), set in the American South, followed in a similar vein, treating themes of race and homophobia, as a family comes to terms with a son's sexual identity. In the way that White's Midwestern landscape shows the power of geography on identity, Kenan's *A Visitation of Spirits* takes a virtually unprecedented look at the intersection of race and homosexuality within a particularly volatile Southern landscape, with consequences remarkably divergent from the geographies of suburban and urban luxury and escapist indulgence characteristic in the fiction a decade before.

[Historically, gay and lesbian communities have been joined under the same aegis of homosexuality, often without taking into account the effect of gender on this singular label of homosexuality and how distinctly lesbian and gay communities do emerge, one from the other. In the latter half of the 1980s, as lesbian writing focused on gender politics and gay justice, gay male writing centered more and more on the sudden AIDS crisis that seemed so endemic to the culture of gay men living at that time. Paul Monette's *Borrowed Time: An AIDS Memoir* (1988) was written after the death of his

lover to AIDS and proved to be one of the most powerful books ever written concerning the experience of AIDS and its aftermath of personal loss. Andrew Holleran's *Ground Zero* (1988), David Feinberg's *Eighty-Sixed* (1989), and James Purdy's *Garments the Living Wear* (1989) all touched on the epidemic that so affected and began to describe gay communities throughout the late 1980s. Journalist Randy Shilts' book, *And the Band Played On: Politics, People and the AIDS Epidemic* (1987), detailed the effects—both small and large, personal and bureaucratic—leading to the spread of AIDS throughout the United States and the devastation, in the wake of the religious-conservative backlash, felt supremely within the gay community.

[The subject of AIDS continued to be a topic of gay writing throughout the 1990s. Playwright Tony Kushner's work brought the crisis to both heterosexual and homosexual theater audiences. Kushner's *Angels in America: A Gay Fantasia on National Themes* existed in two sections, *Part I: Millennium Approaches* (1992) and *Part II: Perestroika* (1993), and showcased main characters infected with AIDS. The play worked to characterize the state of America not only in terms of sexual identity, but racial and ethnic as well. *Part I: Millennium Approaches* appeared on Broadway in 1993 and won the Pulitzer Prize for drama that year. In some sense, the medium of theater first showed the signs of gay-subject or gay-themed work reaching a large audience in a formidable way. Jonathan Larson's widely popular and critically successful musical, *Rent*, which appeared on Broadway in 1996, likewise featured gay personages, one of whom dies of AIDS. Larson, himself, was not gay, but his work underscored a heterosexual concern for the AIDS epidemic that had been so widely regarded as a gay disease, and also announced an emergence of a "gay literature" into a more mainstream venue.

[Until the beginning of the 1990s, lesbian literature had functioned primarily as a polemical literature, advancing a politics and an agenda as opposed to attempting appeal to a wider, non-lesbian readership (Faderman 1995). Throughout the 1990s, however, literary works appeared that posited a lesbian identity as only one facet of an individual's identity, in a way making the lesbian agenda appear gentler and closer to mainstream. Jenifer Levin's *The Sea of Light* (1993), Paula Martinac's *Home Movies* (1993), Carol Anshaw's *Aquamarine* (1992) and *Seven Moves* (1996), and Blanche McCrary Boyd's *The Revolution of Little Girls* (1992) offered glimpses of lesbian characters not bound fully by lesbian communities, but integral to and incorporated into a more everyday America. Dorothy Allison's *Bastard Out of Carolina* (1992), a finalist for the National Book Award, fictionalized the author's own harsh experience growing up lesbian in the South, and garnered both critical and popular success.

[One work of gay literature to have had perhaps the biggest reach throughout mainstream America was Michael Cunningham's *The Hours* (1998), a novel inspired by Virginia Woolf's *Mrs. Dalloway*. *The Hours* imagines the lives of three separate women—Virginia Woolf being one of these—interweaving the three stories into a singular narrative movement. *The Hours* spent weeks on *The New York Times* Bestsellers List, was awarded both the 1999 Pulitzer Prize and PEN/Faulkner Award, and was adapted into a recent film of the same name, starring Nicole Kidman, Meryl Streep, and Julianne Moore.

[The popularity and success of *The Hours*, perhaps, signals the disappearance of a gay and lesbian literature as separate from some otherwise "mainstream" literature, and hints at a future of assimilation, in which "homosexuality" will not be placed in opposition to a "normalcy." To a certain degree, media and advertising have allowed a greater visibility

and viability of the gay and lesbian communities that help to afford their literature a place with booksellers (Shulman 1998; Arnold 2003). However, a clear distinction seems to exist between a literature that shows gay and lesbians as affectionate, which is permissible, while a literature showing gays and lesbians as sexual or desirous, is not. In 1997, for example, David Leavitt's novella, *The Term Paper Artist*, was pulled from publication in *Esquire*, after chiefs at the magazine feared advertisers would be offended by Leavitt's descriptions of man-to-man oral sex; the censorship of Leavitt's piece caused long-time *Esquire* literary editor, Will Blythe, to resign in protest of the magazine's decision.

[As gay and lesbian literature moves to become more mainstreamed, opinions differ on whether this will be a good or bad thing. Those reluctant to the mainstreaming of a gay and lesbian literature—and of gay and lesbian culture in general—fear that certain stories and certain voices might falter to homogenization. Publishing trends, however, reveal that new commercial markets have been opening up for gay and lesbian writers, not just in terms of literary fiction and poetry, but also in terms of the genre fictions (e.g., detective, romance, and horror) geared toward gay readers (Arnold 2001). Such growth and evolution seems promising, not only for gay writers and readers, but also for the roles they might play and occupy within the larger culture of the United States. (*End of update by M. Hyde*)]

[Varied Sentiments: The Expression of Sexuality in Music

RAYMOND J. NOONAN

[*Update 2003*: It has been said that each generation thinks it invented sex, that it was the first to discover one of life's most magnificent treasures. Perhaps nowhere is this more evident than in the musical record of each generation's contribution to the lyrics of its age. What is important to a generation—and to a society—can be found embedded in the lyrics of its popular songs. One way to evaluate the validity of sentiments expressed in the music is to observe how often people choose to listen to it in their free time—and like sex, enjoying music is a most popular pastime. And by far, one of the most prevalent themes found throughout this repertory, past and present, is that of romantic love—and, if one looks deeper, the celebration (as well as sometimes the denigration) of sexuality—in all its permutations. For most people, their relationships are what provide meaning to life. Music, the mirror of life, reflects the best and worst of life back to us, from anger and sexism to the profoundest love and eroticism.

[Studies of the arts with predominantly sexual themes—sometimes called the “erotic arts”—has a long, if sometimes not wholly respected, history, with treatises on sex in literature, the performing arts (e.g., film, video, theater, and performance), and the visual arts (e.g., painting, drawing, photography, and sculpture) being the best represented in both the academic and popular literature. All of these lend themselves to the printed page by affording the author and reader the benefit of photographs and film stills as illustrations of the text. Music, however, has not lent itself as effectively to books and journals, or any of the traditional print media. In printed form, music notation requires some skill to interpret and some musical talent and training to even approach an understanding of how the piece is supposed to sound, or sometimes even to discern what verse follows another. Furthermore, the printed notation of most modern (popular) music only provides a bare-bones outline of the words, melody, rhythm, and accompaniment of any particular song. The “arrangement” chosen by the artists, as well as the individuals' or groups' own innate voices and styles, then create the distinctions that separate one version of the

song from another. Just as the printing press revolutionized the collection and dissemination of knowledge, and engravings and photographs made it possible to illustrate a text with a picture worth a thousand words, so, too, are advances in multimedia computer technology revolutionizing the future of all literature by allowing us to create texts that can be viewed on electronic screens accompanied by both high quality images and sound. Thus, we are beginning to see hypertext “books” on compact disk (CD), digital versatile disk (DVD), and on the Internet illustrated with examples derived from moving video pictures as well as “snapshots” of digitally recorded or “sampled” sounds taken from diverse sources. Histories of music are coming alive.

[What follows is a review of various musical genres and the way principally American songwriters have addressed or portrayed sexuality in their lyrics. It will proceed largely from where other writers have left off. Of necessity, the review cannot be comprehensive because our musical heritage—even what currently exists in recordings—is so extensive. We will, however, review the highlights of what Cray (1969) called the “Erotic Muse,” the myriad ways in which sexuality has appeared in our musical literature, with an emphasis on the music of the United States and the English-speaking Western world during the last 200 years. We will elucidate the sentiments expressed and, to some extent, their meanings within their time and culture. We will not delve deeply, since this has been done elsewhere as noted below, into the sexual aspects of music purely as sound and rhythm, or as a motivator, subtext, or accompaniment to movement or dance or lovemaking.

[Historical Antecedents

[As a subject for serious writing, either academic or journalistic, the profoundly important and eternal interrelationship of sexuality and music has had relatively little written about it in the past few decades. The sole exceptions have surrounded publicity about attempts by small but vocal self-styled censors within government and a few private parents' groups to promulgate “studies” which “prove” the harm to children, women, and others that sexually explicit lyrics in popular music—dubbed “porn rock” by critics—has caused. This reflects, in general, both a deep ignorance of the long connection of sexuality and music and an almost universally inadequate comprehensive sexuality education program or critical-thinking component of most education. It is exacerbated by an official predisposition to conceptualize sexuality primarily in terms of its sometimes problematic aspects accompanied by largely hypocritical moral pretexts, and to focus on useless, superficial, or oppressive “solutions.”

[By the early 1960s, few scholars with training in the sexual sciences had explored the topic of sex and music. Of those outside of sexology who did, the most important studies were by musicologists interested in tracing the lineage of popular folk songs from the traditional music that had been passed from generation to generation of the common people through oral transmission. While a large part of this oral tradition in English probably has been lost, much of it was collected by folklorists in England and America during the folklore revival of the 1800s (and during the two centuries previous in England and other countries) and stored hidden in various libraries across the world. What music scholars discovered was that many of the original songs from which the folk songs were derived embodied sexual situations described with explicit imagery. These songs, when finally written down, were then passed on to posterity only after they had been revised or obliterated to conform to the “moral” expectations of the educational, religious, and

political leaders of each era. The importance of these discoveries will be discussed shortly. The reader is referred to Cray (1969) and Reeves (1965) for a more complete history of the process that occurred and the mechanisms that probably took place. Oscar Brand (1962), himself a scholar and folksinger, writing on the modern American folk song revival in the 1960s, discussed a similar process, though with some differences, that occurred during the ascendancy of folk music at that time, and its impact on today's music.

[Bridging this interest in folklore with sexology is *The Horn Book* by Gershon Legman (1964), by far the most important study of eroticism in folklore and folk song that has ever appeared in the English language. A former bibliographer for Alfred Kinsey, Legman, an erudite scholar with a breadth and depth of knowledge of erotic folklore equalled by none, looked at and evaluated the written record of erotic literature and music that had been amassed by collectors of erotica during the past 500 years, the sum of which appears to have been largely unknown by other scholars. His work clearly elucidates the role that sexuality has played in the history of music in all cultures in all times and should provide scholars with a foundation upon which any research or discussion of sexuality and music henceforth will be based.]

[The earliest consideration of the topic in the sexological literature was written before 1910 by Havelock Ellis (1936b) in his opus, *Studies in the Psychology of Sex*, in which he discussed the influence and effects of music on animals and man and the roles he believed it played in arousing sexual attraction within the framework of Darwin's model of natural selection. Among general surveys of sexual science that have appeared more recently, the most extensive review of sexuality in the music of the Western world was an article by MacDougald (1973) in *The Encyclopedia of Sexual Behavior*, edited by Albert Ellis and Albert Abarbanel (1973). Laemmel (1976) also briefly covered the topic in his overview of sexuality in the arts in the mostly psychiatrically oriented volume edited by Sadock, Kaplan, and Freedman (1976). Webb (1975) provides the most comprehensive perspectives on all the erotic arts, including insightful sections devoted to popular music and musical theatre, in which he highlighted some of the developments in musical eroticism that had also occurred through the 1960s. MacDougald (1973) noted that, by the time he wrote his article in 1961, only eight scientific studies, none of them definitive, existed about the interrelationship of music, "the most expressive and least tangible of the arts," and sex. In his survey, he discussed the transition from religious to secular music and the rise of the classical tradition in which woman would become a vital part of a previously all-male world. He also considered some of the popular forms of music up to the 1950s, including Latin American, modern, and jazz dancing, and some of the popular singers of the 1940s and early 1950s.]

[Rock 'n' roll, which originally appealed primarily to the young—and which became so problematic for so many adults since its inception because of its inherent sexual overtones—was in its infancy, and so was not treated at all by MacDougald (1973). So, too, were two of the antecedents of rock music—folk music and the blues—not covered, because so many of these songs, as noted above, were suppressed and hidden from view. Then, too, traditional demarcations of culture into "high" and "low," as well as generational biases, may have played a part, in which certain forms of culture were not deemed worthy of scholarly consideration. Webb's (1975) observations on rock 'n' roll and the blues, as well as the musical theater using a rock format, were more salient, because he wrote his analysis from a perspective that benefitted from its occurring during a phase of the latest sexual revolution that overlapped almost two

thirds of the two decades of rock history at the time he wrote it. Laemmel (1976), on the other hand, devoted only several superficial paragraphs to the subject. Nashville-style and other country music had not yet fully developed or matured into the form we know it today, and so was not considered by any of these writers. The profound revelations in folk music noted above also seems to have been unknown to them.]

[The Ellis and Abarbanel (1973) volume, however, did include an article on sexual dynamics in dance in which Nikolais (1973) traced the role of sexuality in and on modern dance from Isadora Duncan onward, including psychological interpretations of art by Freud and Jung and their application to dance; another article by Goodman (1973) discussed social dancing, where the dance was shown to symbolize the erotic interactions of men and women in a mutually enlightening, socially acceptable way that allowed them to move together or withdraw gracefully as they so chose. (This is reminiscent of D. H. Lawrence's (1936/1953) reference to Romeo's statement, "To me, dancing is just making love to music," to which Lawrence responded, "To the music one should dance, and dancing, dance.")]

[MacDougald (1973) traced the historical connection of sexuality and music by noting that many musical instruments originated as representations of the genitalia whose primary use was to celebrate the functions of sex and/or fertility by early peoples. For example, in the Pacific islands, Africa, and Asia, some early drums were shaped as, and represented, the vulva and were played with a drumstick representing a phallus. The flute also has been historically identified as a symbolic penis. MacDougald (1973) wrote,

Although this symbolic identification might seem naive to us, it has had great significance in many sexual manifestations—circumcision, menstruation, ceremonies, dances, rituals, etc.—around the world. In a number of European languages the word "flute" has definite sexual connotations, cf. the English expressions "the living flute," "the silent flute," "the one-eyed flute," etc. as in "The Cupid" (1736) Farmer:

The flute is good that's made of wood
And is, I own, the neatest;
Yet none the less I must confess
The *silent flute's* the sweetest. (p. 747)

[A similar symbolism continued into the 17th-century classical baroque period in Europe, during which a number of "love instruments" that symbolically connected Eros and music came into wide use, including the *viola d'amore*, the *oboe d'amore*, and the *clarinette d'amour*. Even in the 20th century and since, the manner in which some rock and blues musicians play their instruments suggests a strong connection to their erotic origins.]

[While the intent of much of the music prior to the Middle Ages was purposely sexual, medieval music took on a specifically nonworldly religious tone under the Roman Catholic Church. After the Dark Ages, however, secular interests began to signal the emergence of the Renaissance that would begin in a few centuries. Sexual love would prove to be a strong impetus toward that artistic and intellectual revival and began to make its appearance in music, as well as the other arts.]

[Ballads and lyrical songs about love apparently were the first nonreligious songs written, appearing in Europe during the 12th and 13th centuries in Provence in the south of France. The poet-musicians who wrote them were called *troubadours* and were usually members of the nobility, often knights, and sometimes commoners. Their music and

poetry, which were devoted to chivalrous love, later spread to the north of France where *trouvères* imitated the new movement. From Provence, also, the love poetry and music of the *troubadours* spread to Italy and, more importantly, to Germany, where the *minnesingers* developed their own narrative style, being less formal and less distant than their French counterparts (Apel 1969).

[Out of the writings of the *troubadours* and *minnesingers* of this era came a bold new concept that would give people a glimpse of some future era: a view of woman as active and passive, in MacDougald's (1973) words, "a feminine creature to be loved and to love." This is perhaps the most important development in the secular musical celebration of the vernacular of Europe, and it stood in stark contrast to the Catholic religious music that had dominated the continent for a millennium. This movement eventually evolved into the 16th-century classical tradition of the Renaissance, during which madrigals were composed in which woman and love were mere abstractions. MacDougald (1973) wrote,

[... D]uring the Dark Ages Christianity effectively stifled the composition of secular "emotional" music, resulting in a thousand long years in which virtually no love songs, certainly one of the fundamental urges of the human heart, were composed! Although the musical dictatorship of the Church was ironclad for centuries, it could not restrain the natural inherent desire of man to sing of nonchurchly things. (p. 748)

[Thus, secularity began to merge with sacred music, paralleling, but lagging centuries behind, the gains realized during the emergence of the *troubadours* and those who followed their spirit. It is interesting to note that, in the classical tradition, there is a distinction between the art song (created with serious artistic intent by accomplished musicians) and the folk song (arising in the vernacular of the common people by untrained musicians). It could be said that the folk (i.e., popular) songs of the day that arose from the people were analogous to the vulgate of the Catholic Church, that is, both were in general circulation and both were for the masses (cf. *vulgar*, of the common people). In that sense, it can be seen how all nonclassical music might be considered vulgar (or, by extension, obscene, following the modern corruption of the word). Thus, we see a similar pattern during the 16th through the 20th centuries, particularly with regard to the folk and blues songs that arose from ordinary people in their day-to-day lives, that contrasted with unofficially or officially sanctioned popular music that avoided, but did not always completely destroy, the emotionality derived from sexual eroticism. The second millennium would finally end with a rich literature of songs specifically confronting and affirming our sexual heritage on a variety of levels. The reason for the love song's primacy in this new secular order are seen quite clearly by Legman (1964):

Erotic poetry, especially in the form of song, is extremely ancient. It was considered by the Greeks to be a special form of the poetic art, with its own muse, Erato—she with the lyre—indicating the intimate relation to music. This relation is always sensed, as to erotic poetry in particular, and is clearly admitted by the repressive religious objection to all music other than that used in worship, and even there with the prohibition of certain too 'sensual' instruments and 'lascivious' modes. . . . The only other forms of poetry thought worthy of muses by the Greeks were lyric and heroic poetry (that is to say, songs and ballads, but on themes other than erotic), and these were understood to be derivative. They could hardly have preceded love poetry, or rather love song, which is, after all, not unique to the

human species or even to the mammalian order. The love-calls and sexual displays of any number of male animals and birds, even insects . . . imply a long pre-history of erotic song and erotic dance, as integral parts of the sexual approach of living creatures, long preceding the appearance of human life on earth. (p. 408)

[By the turn of the 17th century, a new form of musical expression was being developed in Italy in the classical tradition (but with additional roots in the folk tradition, as Legman (1964) notes)—the opera—that was to continue the trend of introducing woman, not as a symbol, but as a human being with a host of human characteristics, good and bad, into European music. The reader is referred to MacDougald (1973) who has summarized these developments in detail with numerous examples from the operatic repertoire. I will note simply that he attributes chiefly to Mozart the transition of woman from being nonexistent as an active, motivating force at the end of 16th century to being an integral and vital part of the classical operatic tradition by the end of the 18th century. Laemmel (1976) states further that the overture to Mozart's *Don Giovanni*, which immortalized the Don Juan theme, "initiated the romantic movement in music by dramatizing the eternal battle between the sexes." Sexuality, love, and sensuality would reach a pinnacle in classical music in the 19th and early 20th centuries with operatic and symphonic works, some performed with the eroticism underscored in ballet, by Wagner (*Tristan and Isolde*, 1865), Bizet (*Carmen*, 1875), Rimsky-Korsakov (*Scheherazade*, 1888), Debussy (*Prélude à l'Après-midi d'un Faun*, 1892-1894), Stravinsky (*Le Sacre du Printemps*, 1913), Ravel (*Bolero*, 1928), Shostakovich (*Lady Macbeth of Mtsensk*, 1934), and others.

[An illustration of the response of the media provides some insight into the impact that one of these operas had when it was performed. "Shostakovich is without a doubt the foremost composer of pornographic music in the field of art," said one critic in 1955 (MacDougald 1973) in reference to the sexual imagery of *Lady Macbeth of Mtsensk*, while the Soviet *Pravda* criticized how, in it, "'Love' is smeared all over the opera in the most vulgar manner" (Gillespie 1968). Legman (1964) notes further how popular dances, such as the "Bunny Hug," the "Turkey Trot," the "Tango," the "Shimmy," the "Twist," and others since the 16th century, all evoked religious and moral opposition when they first appeared. People today are seldom aware of how ubiquitous self-styled 'defenders of the public morality' have been, and that virtually every new form of music and dance was criticized on those grounds throughout history with varying degrees of success in their suppression.

[In the first decade of the 20th century, an important form of vocal and instrumental music indigenous to America was introduced by Jelly Roll Morton called "the blues." Soon afterward, "jazz" appeared as the background music in the brothels of New Orleans, co-evolving with the blues from ragtime, minstrel-show music, and early brass and string bands (Abel 1969; Webb 1975). Laemmel (1976) notes the erotic roots of jazz, the first major artform to be born in America, and suggests the name's derivation from *jass*, a sexual term in a Creole dialect for the Congo dances. By the middle of the 20th century, this new type of music, more overtly sensual, was having a significant impact on musical expression. The rhythm of swing by such artists as Louis Armstrong, Benny Goodman, Duke Ellington, Gene Krupa, and Lionel Hampton had solidified "the beat" as a necessary component of popular music and jazz. Because rhythm is an inherent component of sexual activity, rhythm in music is considered an aspect that cannot be divorced

from its sensual and sexual overtones and their relationship to dance. This period was also the time when the voices of popular stars like Peggy Lee, Sarah Vaughan, and Lena Horne evoked sexual feelings in their audiences, as did the voice of one of the first teen idols, Frank Sinatra. MacDougal (1973), presumably reflecting his own generation's attitudes toward the music of his youth, describes one of the most important composers of that period, whose lyrics boldly and uniquely expressed specifically sexual themes:

When the subject of sex and popular music arises, one automatically thinks of that genius, Cole Porter, whose *oeuvre* is a kind of musical erotikon, to use an apt word. The lyrics that Porter writes are admittedly the "sexiest" of any writer and it is contended that he likewise composes "sexy music." It is undeniable that his songs . . . do possess a haunting appeal that induces an erotic mood.

[Porter's songs, indeed, have a universal appeal—perhaps because of their eroticism and positive affirmation of the power of love—that has helped his music survive into the rock era. His songs continue to be recorded by contemporary artists of all musical persuasions, the 1990 collection of Porter songs, *Red, Hot & Blue*—recorded by various artists both as a tribute to Porter, who had to hide his homosexuality to practice professionally, and as a means of benefiting AIDS research and relief—being a noteworthy example. As such, one could call Porter the first modern songwriter in the contemporary popular song idiom. He was the muse whose musical influence most directly presaged the range of sexual ideas expressed in the lyrics of music popular in the closing decades of the 20th century to the present.

[Describing Porter's lyrics as "sexy" also introduces three of the predominant underlying questions usually asked about sexuality in musical lyrics, one's answers to each betraying a different philosophical stance in the continuing debate on the topic: How does the vocabulary a songwriter uses influence the response to the music—both by the intended audience and by would-be censors? What is the purpose of sexuality in music today and is it necessary for song lyrics to depict only "acceptable" behavior and feelings? and Is it a legitimate function of songs to excite or seduce, i.e., to "turn on" the listener by creating an erotic mood?

[At the same time that Porter's songs would enjoy wide popularity, "race music" would, by the 1950s, be limited to black venues and audiences. This genre would often be more sensual and sexually direct than their white counterparts. Nevertheless, these songs would soon be introduced to white audiences, as various singers in the 1950s, especially Elvis Presley, began adapting ("covering") what became known as rhythm and blues, which is sometimes still used synonymously for much of this early black-inspired rock 'n' roll. Still, these covers were typically more suggestive than direct.

[Simultaneous important developments would emerge in the 1960s, a renaissance decade in American popular music. At the dawn of the decade, black performers with artistic roots in rhythm and blues would lay the groundwork for what would later be known as soul music. Groups such as the Supremes, the Temptations, and others exemplified the so-called "Motown sound," while the Ronettes, the Exciters, and others pioneered the innovative recording techniques of Phil Spector's "wall of sound." The dominant sentiment expressed in much of this music was that of teenage love with only the mildest hint of sexuality, *per se*. In the meantime, the Beatles ushered in a new era in popular music, a revolution which quickly influenced and reflected the growing "youth culture," which, with the new sexual revolution, the civil-rights movement, worldwide student pro-

tests, and the new psychedelic-drug era, spawned a host of American and British rock groups. They, too, were influenced by rhythm and blues. Finally, by the end of the decade, the folk revival began, which was more heavily influenced by the social movements mentioned above, with Bob Dylan, Joan Baez, and others, especially Dylan, paving new paths, which would later merge with rock as folk-rock, probably the first of rock music's eclectic penchant for fusing with other musical styles. In 1969, Dylan experimented further with country music in *Nashville Skyline*, which contained the well-known specifically sexual song, *Lay Lady Lay*. Country songs by both male and female artists would, in the 1970s and beyond, also focus on sexual themes, including premarital sex, adultery, divorce, and other topics, such as Loretta Lynn's celebratory song, *The Pill*.

[Popular songs with sexually explicit lyrics would remain mostly invisible until rap music became widely popular in the 1990s. Similar developments occurred among largely white audiences with heavy metal and other minor genres of rock music. Rap music is rightly considered the most significant American musical innovation since jazz. Arising from the urban-ghetto experience of young blacks, rap has antecedents in both African-American rhythm and blues (R&B, the immediate predecessor if not the actual beginning of rock 'n' roll) and the "talking blues" of early American folk music, both of which became more widely popularized in the 1960s as noted above. Additional roots derive from the Caribbean as well as the Negro spirituals of the black slave experience. Rap is itself not a single genre, but has been broken into various "topical" areas, such as hip hop, as well as along geographical lines, i.e., New York City versus Los Angeles. Widely popularized across both black and white audiences in the United States, as well as other races and internationally, during the 1980s, rap, since the 1990s, is heard on radio and television and in the movies. As one might expect, based on our previous discussion of sexual expression in song lyrics, sexuality has come to play an integral part of rap lyrics.

[The most controversial form of rap, not surprisingly, therefore, are those songs which express sexual ideas—or more precisely, those that use unconventional "street" language to express these ideas—in their lyrics. The group which, in its early years, most typified this genre, variously known as "explicit" or "dirty" rap, was 2 Live Crew, a rap group based in Miami, Florida, in the 1980s. In fact, 2 Live Crew would go on to relive, in a sense, the path followed by Lenny Bruce through arrests and the courts in his groundbreaking comedy bits, which similarly used street language and sex, as well as satirical jabs at religion and politics, in the 1950s and 1960s, paving the way for today's standup comedians. Of particular significance is a word that they used and other performers continue to use today, the expletive *fuck* and its various derivatives, which, although it has its obvious sexual meaning, is more often used to signify camaraderie and shared generational experiences—an important aspect of the music of youth—as well as a host of other nonsexual meanings. Still, sex is where these words derive their power. Numerous other black artists would further develop the rap idiom with explicitly sexual themes or language, along with a few white artists, most notably, Eminem.

[*Sexual Themes in Popular Song Lyrics*

[Musical lyrics could be a goldmine to sexologists, as well as to any student of human nature who takes the time to listen to their content and context. While many say that the beat, with its "primitive" cadence suggesting sexual rhythms, is the prime motivation behind many forms of today's popular music, the lyrics—perhaps more so than the instrumental parts of the songs—embody the wide range of

expression we conceptualize as sexual. In contemporary Western culture, the music and the beat provide the background for our sexual, social, and private lives—even our work lives—especially for the young, but also increasingly for the rest of us. Indeed, it has been so for people of all ages in all cultures in many parts of their lives throughout the centuries. Yet, it is the lyrics on which many adults focus today—particularly those intended for young audiences—because of their often sexual content. MacDougald (1973) has noted that one of the problems in examining the relationship of sex to music is the confounding nature of “association,” that which imparts meaning to a song without its necessarily being explicitly sexual. Thus, a title suggesting romanticism, or even the situation in which a song is experienced, will color one’s perception of the erotic attributes of a song or its effects on any particular listener. Noonan (1998b) has also noted how one’s own personal successes and failures in intimate relationships can have a similar impact on one’s perception of sexuality in other sociopolitical contexts.

[While the underlying eroticism of early rock ‘n’ roll was subject to criticism since its beginnings in the 1950s, (it is well known by now that the very term *rock ‘n’ roll* is a euphemism for sexual intercourse), the lyrics tended more to suggest sexual situations than to describe or depict them directly. As rock has matured, this has become less so. As the “baby boomers” got older, their music began to reflect more of the issues they considered important—and sexuality at the beginning of the current sexual revolution which began in the 1960s and continues to evolve—was a most important part of life. Not that suggestion has been any less represented on the contemporary music scene, but our perception of it has changed. What appears to offend many people today, at least ostensibly, is the explicit slang that has become apparently more prevalent than in the past. Part of this perception has arisen from the fact that, while the use of this language has probably not increased in daily life during the rock era, the airing of the language via the public airwaves, both on radio and television, has increased as restrictions by government agencies like the U.S. Federal Communications Commission (FCC) have gradually eased. This has been attributed, at least in part, to the rise of cable television networks (as well as video rental stores) which allow viewers a greater choice of viewing options—and viewers have tended to choose the more “adult” options, i.e., those that reflect the language and situations that make up their world or their dreams. Indeed, given the choice of an “edited-for-television” film and its uncut version, most will choose the original—and broadcast stations make a point of noting with much fanfare when a particular film is being shown for the first time “in its entirety” within its broadcast area. Others have noted how versions of popular theatrical films are sometimes released in two versions: an R-rated (restricted) American version and a complete version (with more sex) for Europe, South America, and other areas in the world.]

[Simultaneously, both broadcast and cable television networks, most notably Music Television (MTV), began exploiting a new artform, the music video—a powerful marketing tool for selling recordings that was discovered in the early 1980s—which became increasingly popular. While their kinetic energy was ideally suited to the young and to the medium, music videos have greatly influenced many other forms of commercial fare, especially television advertising, as well as live theater and film, with music videos even aimed at adult audiences appearing in large numbers with its own music network, VH1, as well as networks aimed at various ethnic audiences (e.g., Black Entertainment Television, BET, and the various flavors of MTV). A discussion of the sexual content of the visual part of music

videos is beyond the scope of this article, but suffice it to say that music videos have generated at least as much concern for the shallow and stereotypical ways in which they depict sexuality and the sex roles of men and women as for the presumed sexual messages they promote. Some have even argued that music videos and the recordings they represent are promoting sexual activity among those who would not otherwise tend to be sexual. While few professionals seem to have refuted the illogical argument that sex needs to be promoted, that argument has been used with great emotional force in the suppression of both sexually explicit—and sexually implicit (“suggestive”)—lyrics over the last two centuries. (*End of update by R. J. Noonan*)

[Seduction of Fashion: A Sociological Perspective

RUTH P. RUBINSTEIN

[*Update 2003:* The seven deadly sins were guidelines for behavior instituted by Judeo-Christian authorities as central to an orderly social life (Lyman 1978). The importance of each of these cultural constructs depended upon the political context of a particular period. Throughout the history of Western society, however, expectations and behavior were gender specific, where men were expected to work and women were expected to follow. Moving up the social-class structure and employment outside the home as avenues of getting away from family authority were usually closed to women. They depended upon the men in their family. To attract a man, a woman had to stand out. Fashionable attire evolved around arousing male/female interest and entailed the violation of two of the seven deadly sins—the sin of lust and the sin of pride.

[The Sin of Lust

[Women’s fashions sought to arouse male interest in two distinct ways: It demonstrated her family’s wealth and encouraged male lust. Clothes that hug the body, expose the body, and use a variety of color and ornament, Church fathers decreed, distracts male attention from spirituality. Hence, women should refrain and focus on modest attire. In the Church’s first 500 years, women were exhorted to renounce male dress and to cover their heads as a sign of subservience to men (I Cor. 11:4-10; I Cor. 14:34-35; I Tim. 2:11-15; Reuther 1974).

[Lust was the longest recognized, best known, and always a part of the seven deadly sins, observed sociologist Sanford Lyman (1978). He notes that marriage is a link, not only to the wedded couple, but also to families, lineages, and status groups. For this reason, sexual expression is an objective of societal control mechanisms (Lyman 1978, 92).

[St. Augustine had observed that the male organ activates itself independent of desire. It is independent of a male’s will, responsibility, and control. It was only after Adam and Eve sinned did they recognize that they were naked—that they were stripped “from the grace that prevented the bodily nakedness from causing them embarrassment.” Thereafter, all mankind was afflicted with what Augustine referred to as “the insubordination of the flesh.” This insubordination resulted in a sense of shame (Lyman 1978, 55).

[Augustine’s lust-shame theory accounted for the near-universal covering of male genitalia. The liberation of lust from human will accounted for the origins of the injunction for female modesty, the requirement for privacy during sexual intercourse, and the grudging necessity for marriage (Lyman 1978, 56-58).

[The Sin of Pride

[Theologians and social commentators locate the sin of pride in men and argue that men adorning themselves indi-

cates pride. According to Allanus de Insulis, the evil in the sin of pride is that the prideful man is removed from sacred and communal constraints. He divorces himself from its kind, disregards his associates, separating himself from those who can restrain him. It is a person with a haughty ego. The human frame itself is pressed into service in behalf of arrogance (Lyman 1978, 141).

[Gregory the Great argued that pride entails arrogance that emanates from within the person, where the male favors himself in his thought. He silently utters his own praises and uses attire to glorify himself (Lyman 1978, 136). Georg Simmel relates male pride to the wearing of adornment. He suggests that adornment "intensifies and enlarges the impression of the personality by operating as a sort of radiation emanating from it" (Lyman 1978, 142). "The personality is more when it radiates" (Lyman 1978, 143).

[The phenomenon of fashion began as an expression of male pride. It emerged in the court of the Duke of Burgundy, Philip the Bold, in the late 14th century. For a great feast at Amiens he appeared in a voluminous black-velvet overcoat with long wide sleeves (*houppelande*), the left sleeve of which was decorated with roses worked in gold, sapphires, rubies, and pearls (Kemper 1977, 77). Philip's successors—John the Fearless, Philip the Good, and Charles the Bold—continued to emphasize clothes that reshape the body and emphasize sartorial splendor (Kemper 1977, 77).

[In the collection of her Majesty, the Queen of England, there is a painting called "The Field of the Cloth of Gold" (ca. 1520, anonymous). It portrays Henry VIII and his entourage of 5,000 winding their way to the Castle of Guiness where the French King Francis I had his headquarters. Henry VIII is portrayed in the outfit depicted in the painting made famous by Holbein the Younger. The king's distinctive style consists of broad shoulders, barrel-chest, and a prominent codpiece wearing the Renaissance style of slashing. The style entails the simultaneous display of several layers and colors of fabric, giving the impression that the outfit is bejeweled.

[The meeting between Henry VIII of England and Francis I of France was an extravagant event that relied on dress and courtly procession to persuade the courts and noble guests of the power of each of the rulers. Called "The Field of the Cloth of Gold," the meeting lasted 20 days, during which the kings visited, dined, jousted, and "excelled in the theatrical acts of courtesy and friendship," observed Phyllis Mack (1987, 59). As in other such occasions, this one, too, had spectators, some of which were prostitutes who traditionally followed the troops.

[Although ceremonial robes alter very slowly and are less likely to be affected by fashion changes, they are nevertheless an important source of male pride. In the French court, they made their last impressive appearance at the assembly of all estates called by Louis XVI on May 5, 1789. Men of the nobility wore "magnificent gold—embroidered court dress and hats with flowing plumes" (Batterberry & Batterberry 1977, 192). Until the French Revolution, much of male attire was designed to reflect a man's access to wealth, prestige, and power.

[American social critic, economist Thorstein Veblen, identified the motivation underlying the pursuit of fanciful attire by men. In *The Theory of the Leisure Class* (1899), he argued that that it was not sufficient to have possession of power and wealth; such ownership must be put on evidence—hence, fashionable attire. Fashionable attire consisted of three essential elements: sumptuous fabrics indicating wealth, garments designed in the latest style, i.e., indicating being in the know; and in a style that informs that so attired, the individual could not possibly engage in physical labor (Veblen 1899, 33-80).

Male members of the aristocracy were also portrayed with armor, swords, gold chains, and jewels.

[Initially, only the husbands' appearance mattered. But with the increase in wealth, the manner in which wives and children were attired began to matter. To support his claim, a man's dependents had to dress according to his rank. Veblen (1899, 120-121) characterized the clothing of wives and children as vicarious consumption.

[Male attire was seductive in the sense that it suggested that a man who is well dressed or fashionably attired had access to resources that women need. He could secure appropriate clothes, a roof over their heads, and obtain food for her and their potential children.

[Lust and Pride

[Renaissance dress and Cavalier styles are two fashions where male attire committed both sins, the sin of lust and the sin of pride. Prior to the Renaissance, for over a thousand years, male attire in Europe consisted of a robe (tunic) long or short and a loose-fitting belt. The body and its contours were concealed. In the second half of the 14th century in Italy, older men continued to wear the long robe, but young well-to-do men adopted a style that violated the norm of modesty by adopting sexy and prideful appearance. Male dress hugged the body, exposed the body, and used a variety of color and ornament—the Church's definition of seductiveness.

[*Renaissance Dress.* Renaissance male dress consisted of a short jacket cut tightly to the body reaching the upper thigh. The sleeves were close fitting and buttoned from the elbow to the wrist. The upper part of the sleeve was tailored in such a way that made it possible to move the arm freely. The short outfit exposed the legs, which were covered in skin-tight hose. Each leg was cut separately and fastened to the inside of the jacket with corded laces somewhat like shoestrings. Calling further attention to the body was the use of two contrasting colors, where the color used on the left leg and left arm matched the right side of the jacket. The right leg and arm matched the left side.

[The hose, which were two separate articles, were supposed to overlap at the top, but often did not. Bending down often meant exposing the buttocks and "what is inside." This led to much criticism. Around 1370, the two pieces together were sewn in the rear, leaving an opening in the front, which was then covered by a separate triangle of cloth. This addition was transformed into a codpiece—an article of dress celebrating male virility. Renaissance style of dress was modified and worn throughout the Western world.

[The inspiration for the new style was the Greco-Roman tradition that celebrated the virtue of the naked body (Hollander 1978, 83-85). An early version of the décolleté can be found in the Snake Goddess of Crete; clinging or transparent draped garments that covered, yet showed off the body, making the female body even more alluring, can be found in the sculptures of the Parthenon.

[*Cavalier Fashion.* Associated with the Dutch, the Cavalier fashion was international in scope. It was worn by King Henry IV of France and King Charles I of England. It was a playful fashion (Batterberry & Batterberry 1977, 132, 138-139). The wire and padding that gave male dress its structure and stiffness were eliminated. The ruff had become smaller and then softer. The dress consisted of a doublet (jacket) where some of its buttons were left unbuttoned. The breeches were left drooping, and the hose allowed to fall untidily around the shoe tops. There was also a big moustache, playful ribbons, sashes, bows, and a flamboyant felt hat sitting precariously on the wearer's head. The image conveyed the mes-

sage that there were few barriers to male-female interaction (Kybalova, Herbenova, & Lamarova 1968, 177, 180, 183).

[Design Approaches to Fashion]

[In his book, *The Psychology of Clothes*, psychologist J. C. Flugel (1966) observed that there are three different orientations to the development of a style. One is where the body itself is of little interest. A profusion of garments are hung on the body. Maximum gorgeousness is achieved by piling one luxurious garment over another in a way that leads to interesting variations in line, and a profusion of glorious colors. Royal robes are an example of this style (Flugel 1966, 156). Layering of fabric was used in the 17th-century portraiture of the nobility by Velasquez, Rubens, and Van Dyck to achieve a sense of sumptuous "nonchalance" appropriate to noble sitters, as Hollander (1978) observes.

[A second orientation is the desire to show the attractive features of the body better. Clothes are used to frame the body. The third orientation involves rendering the body more alluring by using "transparencies and half-concealments" (Flugel 1966, 157). These are garments that reveal the form of the body and give it an additional grace. Flugel (1966, 160) explained that a new female fashion, a period's desired appearance, can also evolve by emphasizing a new part of the body, or a feature, by treating it as reflecting the spirit of the period. The body part or feature displayed is rendered as "seductively alluring" as a special center of "erotic charm." In the Middle Ages, for example, the corset was used "to make the breasts inconspicuous." As the ascetic trend of the Middle Ages diminished, the breasts were brought out of hiding and female fashion focused on the abdomen. Women were portrayed as if pregnant. They also adopted the gait and carriage distinctive of pregnancy. Flugel called this theory "the shifting erogenous zones theory of fashion." With each new fashion, there is a change in emphasis. The focus is transferred from one part of the body to another. Unfamiliar, the image generates interest. A new erogenous zone had been thus created.

[Another source of fashion was the style of dress adopted by a king's mistress—a woman who had successfully attracted and kept a king's attention. Her style became a source of fashion. Madame de Pompadour, the mistress of King Louis XV of France perfected and popularized the robe à la Française to such an extent that it "practically became the French national costume" (Batterberry & Batterberry 1977, 161-165; Kemper 1977, 105-106).

[With little chance for respectable employment, women had to depend on the men in the families for survival. Women until the 1980s had little opportunity to acquire wealth, prestige, and power. Over the centuries, Western European women developed styles of appearance that enabled them to capture male attention. They enhanced their physical appeal, yet remained within the bounds of modesty. Where these images were successful and enabled the woman to attract the attention of the man she wanted, her style was adopted by other women; it became the fashion, and the image became integrated into the vocabulary of images existing in Western culture. Three such images have been identified: adopting elements of male dress, creating an image of harmony, and the glamorous look. These styles are integrated into the vocabulary of images generally available in Western society. In the United States, they were popularized by actresses and fashion designers who searched for a costume to convey the image of a character on the stage, in movies, and in personal appearances.

[A new seductive image was offered by the art and literature of the 1950s. Ballet had acquired new importance after World War II, and designer Clair McCardle offered the bal-

lerina look for everyday attire. The style emphasized long limbs, flat-chestedness, ballet slippers, and hair swept back to reveal a long delicate neck. Embodying these qualities was actress Audrey Hepburn, a former ballet student. She was chosen to play the role of an inexperienced teenager falling in love with a sophisticated older male. She appeared in about 12 movies of the same theme, and in each she conveyed the essence and vulnerability of a new bloom (Rubinstein 2001, 139-150).

[Cultural fascination with adolescent sexuality was reflected in the success of *Lolita*, the novel by Vladimir Nabokov (1954), which was initially banned. Also conveying vulnerability was the partiality of teen and young adult women for their older brother's or father's shirt, jacket, or coat. Overwhelming in size, these garments made the young women look smaller and in need of adult care. The vulnerable teenager was decreed seductive in the December 1968 issue of *GQ* magazine. A panel of 30 men psychologists, sociologists, and members of the editorial staff believed it to be one of the basic images American men would enjoy (*GQ* 1968). This cultural atmosphere helped to legitimize a liaison between an older mature male and a romantic teenager. Each of the seductive images emerges in a specific socioemotional context, each with its own impact on the interaction.

[Male Attire: Rationality and Self-Restraint]

[With the spread of the puritanical ethos in England in the 19th century, male fashion in England ceased. Calvinism's strong aversion to the ostentation and etiquette of the courts, as well as to all the luxury and extravagance, were replaced by a demand for thrift (Harvey 1995). A new fashion of sobriety and modesty for both men and women appeared. Male attire became form-following rather than form-fitting, and in "funereal" somber black. It reflected the puritanical ethos for thrift. According to the German sociologist Rene Konig, a man's suit today is "fundamentally a direct descendant of the puritan dress, a political demonstration against the ostentation of the court" (Konig 1973, 117). Lively colors, the scintillating velvet, and silk fabrics that characterized the clothing of the nobility today can be found in Roman Catholic countries.

[It is a common phenomenon that men in uniforms look seductive. The sizing standards developed during the Civil War made it possible for ready-to-wear military uniforms to reflect rationality and self-restraint. The uniform conveyed to women that, in addition to physical prowess, the soldier was upright and dependable.

[The male suit has continued to offer middle-class women a sense of security. To convey prowess, hip-hop male outfits often include massive gold jewelry around the neck. The fingers are ornamented with heavy rings or with tatoos on each of the fingers.

[Despite positive reviews by the industry, the enterprise of American menswear designer John Bartlett failed, when his artistically designed collection used a variety of colors and was body-hugging, i.e., seductive in the Church's definition. The male puritanical ethos allows veering only in the direction of affirming social identities.

[Spirit of the Period]

[A specific sociocultural context and the attire of celebrities were also a source of seductive images. The aesthetic that characterized the flapper was that of youthfulness (Flugel 1966, 161-162). Visually, the flapper of the 1920s conveyed intensity, energy, and volatility (Sage 1926, 216). Social critics described its impact as leading to a revolution of "morals and manners." The flapper bobbed her hair, and her dresses were tight, straight, and short, with a low waist

usually placed about the hips. Her chest was flattened, her waist was hidden, and her legs were kept in plain view. Moreover, women frequented the saloons and drank with men, swearing and smoking. They also used contraceptives (Yellis 1969, 46-47).

[The birthrate declined during the Depression of the 1930s, when the fashionable style came from Paris. It was long, lean, and plunging in the back. After World War II, it became patriotic to have children, and Dior's 1947 "New Look" was transformed into the "pregnant look" and "the sack" look. These styles concealed the pregnancy. The art of dress gave in to the miniskirt in the 1960s. The miniskirt is youthful in feeling and allowed freedom of movement.

[The 1980s—the era characterized by the pursuit of wealth and conspicuous consumption—was an era of too many stretch limousines, too many yachts off Newport Beach, and too many fur coats in Aspen (Phillips 1990). To better convey the image of success, American businessmen flew to England to buy 'bespoke' suits—a dark suit made to order by English tailors. The realm of black had continued to spread. Moreover, the tailoring industry in England shifted emphasis from the ostentatious, body-hugging attire the dandies wore, to a form-following suit in dark funereal color announcing self-restraint. President Reagan, on the other hand, also had a custom-made suit, but he had his made in Los Angeles, the movie capital. It was made from specially woven yarn in earth-tone colors. Being an actor, he was aware that a color of cloth that complements one's skin tone enhances appearance and encourages affective response.

[Production of women's fashions in France emanated from the need to provide skilled women with work. The revolutions of the 19th century had disrupted the economy and left many women unemployed and their children hungry. According to Charles Frederick Worth, Empress Eugénie couturier, the king had asked him to create a new fashion with each new season. Everything his wife wore was immediately copied, first by the upper class and then it filtered to the lower classes. To make sure that members of the upper class did spend their money on new clothes, he instituted the practice that those wishing to appear before him must be dressed in the latest fashion. France became the center of fashion.

[In the United States of the 1960s and 1970s, informality and youthfulness characterized female fashion. Fashion in the Reagan White House (in the 1980s) had become increasingly form-fitting, slinky, and slithering, accentuating female curves, and expensive. It was based on what Flugel described as "the interplay of concealment and half transparencies." Exposed backs, low necklines, side and front slits, and the pouf were expected to create sexual allure (Rubinstein 2001, 299). Nancy Reagan's delight in clothes, balanced for color and ornament, extravagant and luxurious, was consistently reported in the news. The fashion reflected the spirit of the 1980s—glorification of capitalism, free markets, and finance (Cannon 1990). In 1985, looking rich was very important. Television programs focused on the real and imagined lives of wealthy people, such as *Lifestyles of the Rich and Famous*, *Dallas*, and *Dynasty*, which were enormously popular with the American public.

[The fashion during the Clinton presidency was for the young. There were skirts that looked like flimsy silk half-slips, shoes styled like bedroom slippers, body-hugging pants made of snakeskins and with wild-animal prints. Harking back to the Garden of Eden and the jungle, this fashion suggested sexual temptation and danger.

[Soon after George W. Bush assumed the presidency, snakeskin pants, bags, and jackets disappeared. The young continue to wear their low-riding pants (where the naval is

exposed). Also exposed are the feet. Flip-flops, footwear traditionally worn around the swimming pool to prevent slipping or on the beach as protection from the hot sand, had become fashionable and were called "toe cleavage" by Guy Trebay of *The New York Times* (June 17, 2003). Flip-flops are the simplest of all footwear—two scraps of leather or cloth. With little structure, they are the cheapest to produce and most affordable, but offer the foot little support. Clothes, too, offered little support. Schoolgirls' jumpers, miniskirts, and tops were offered in bold color combinations, or a prairie skirt with a nipped Victorian jacket, tattered jeans with rosebud-striped silk jacket, and a denim dress dripping with cowry or puka shells worn for good luck by indigenous groups. Spring/Summer 2003 outfits could be asymmetrically hemmed, spliced, or bisected, *The New York Times* accurately predicted (September 22, 2002). The jewelry in fashion consisted of two styles, one with earrings worn close to the ear, the other dangling downward, as if the wearer hoped to reach the forces underlying the universe for nurturing, support, and protection.

[*American Popular Culture*. Hip-hop attire increases the size of the individual and says, "I am here, you can't ignore me." The trendy jeans have strategically placed faux-faded stripes that direct the observer's gaze towards the genitals. The young know the look they want and they search for it. Finding the right style was about "being yourself."

[The essence of pride and lust are also conjured in fantasy images. These images reflect what societal gatekeepers think women want from men and what they think men want from women.

[*What Women Want from Men*. In the figure of Superman, the bespectacled mild-mannered newspaper reporter, Clark Kent, was invulnerable to the forces of evil once he changed into a Superman costume. He saved women and destroyed criminals. He, however, was unable to connect to his beloved Lois Lane (Kimmel 1996, 211-212). Another fantasy hero was the cynical, dangerous, hard-boiled detective—a central character in film noir. He was depicted as a man who made the world safe for women and children. He was sexually alluring, but unavailable for marriage (Savage 1998). Perhaps the most famous reflection on what men want from women was a statement made by the actor Humphrey Bogart in June 1945, "I'm tough and intend to stay that way."

[*What Men Want from Women*. The "bombshell" and the "pinup" were two distinct images that men had created. The term *bombshell* first emerged in the 1930s during the Depression. The name referred to big-bosomed women who worked outside the home and were economically and socially emancipated (E. T. May 1988). Images of pinup girls accompanied men through the depth of the Depression, the battlefields of World War II, and the war in Korea. *Esquire Magazine* viewed female sexuality as an inspiration to American fighting men. Artist Alberto Vargas and George Petty were commissioned to depict images of ideal females that came to be known as "pinup girls." The images consisted of curvaceous young women in skintight short shorts. Among those posing were famous actresses: Marilyn Monroe, Betty Grable, and Rita Hayworth. Military men used pinups to adorn their vehicles, noses of bombers, and anything else they could (Christian 1998).

[In conclusion, the dichotomies of Male/Female and Lust/Pride established by Christianity were intellectual constructs that became 'a taken for granted' social reality. They underlie the organization of society, patterns of interaction and social life congruent with these social constructs. For some, these social distinctions may have been

false, resulting in the closing of the possibility of patterns of interaction and expressions of emotion that enhanced societal development and personal growth. The direction that American fashion takes as we enter the new world concerned with international strife and war is likely to reflect these new realities in much the same way. (*End of update by R. P. Rubinstein, in memory of Paul Shapiro, Ph.D.*)

[Concluding Remarks

[Change, Diversity, and Conflict: Points and Counterpoints

DAVID L. WEIS

[*Update 1998*: In the beginning of this chapter, we identified the assessment of how change occurs in a context of conflict between diverse social groups as a major theme in our analysis of sexual behaviors and values in the United States. Subsequent pages are rich in details relating to this theme. The reader is encouraged to savor the entire chapter and digest all of these details. However, we would like to conclude by recapitulating and integrating some of the major points related to this theme.

[Change

[Over a quarter of a billion Americans, representing a wide variety of ethnic, racial, and religious traditions, continue to struggle with the interface of science, technology, and society in all domains of life, nowhere less or more intimately than in our sexual behaviors and values. Recent computerized technology has enabled us to produce, access, and consume more information than has ever been possible in the history of the world. As we noted elsewhere, professionals and the public can now turn to the Internet, rather than to more traditional sources, to obtain sexual information, receive counseling, and even interact sexually. This provides many redundant opportunities. For example, persons who have felt alienated and isolated from the sexual “mainstream,” such as the physically disabled and transgendered, have found information, support, and a new medium for self-expression on the Net. Yet, the use of this technology is not without conflict. The war over censorship versus freedom of speech and self-expression, waged with other print and broadcast media, is continuing with renewed fervor as state-of-the-art technology tests the limits of access to sexual information and sexually explicit dialogues and materials.

[As we have seen in every aspect of our sexuality examined in these pages, numerous changes are taking place in Americans’ collective and individual sexual lives. As Weis described in “Demographic Challenges” at the beginning of the chapter, various factors are having an impact on the experience of sexuality: the changing racial/ethnic fabric; the “graying” of America; and more-varied lifestyle patterns (e.g., increases in wives/mothers working outside of the home and in the number of cohabiting couples, and a growing disconnection between childrearing and married life).

[Yet, the public representation and institutionalized values of American sexuality are often not keeping pace with the realities of people’s private lives. For example, it is well documented that television, considered the most influential medium in American life, continues to present stereotypical views of gender roles, which do not reflect the realities of people’s personal, family, sexual, and work lives. As Weis noted in Section 8 on unconventional sexual behaviors, while heterosexual marriage is the modal pattern for sexual relations in the United States, sizable percentages of Americans depart from this assumed norm to engage in nonmarital sexual expressions, including premarital, extramarital, same-gender, and unconventional sexual behaviors and relationships. Contrary to the goals of most public policies and programs dealing with adolescent sexuality, the

facts demonstrate that “premarital virginity” has largely disappeared in the United States.

[Because change is actually a constant within people’s sexual lives on both the individual and societal levels, research must focus more on the process and dynamics of sexuality rather than simply recording “social bookkeeping.” More-varied and complex qualitative and quantitative research methodologies and analyses must be applied to the study of human sexuality.

[Diversity

[The theme of diversity is woven throughout every thread of sexual life within the United States. Our country is known for being a “salad bowl” of diversity with a continuous struggle to achieve its promise of human rights—no matter one’s gender, racial/ethnic background, socioeconomic status, religious persuasion, or physical characteristics.

[Much of our public and scholarly discourse about sexuality still relies heavily on simplistic, often dichotomous, categorizations for complex phenomena, such as gender, race, ethnicity, and sexual orientation. However, the sexologists who contributed to this book have tried to expose perspectives and research supporting the complexity of personal characteristics as they interface with sexual expression. Although this was not always possible, since scholarly research and information about diversity and sexuality tend to be limited, it is important to note the many aspects of diversity that are treated in some detail. The complexity of gender (Section 7) is evident in the paradigms of the “gender rainbow” (Leah Schaefer and Constance Wheeler), “gender flavors” (June Reinisch), “gender landscapes” (James Weinrich), and the identification of five sexes (Anne Fausto-Sterling). Samuels, and Pérez and Pinzón-Pérez (Section 2B) emphasize the varied characteristics and cultures of those labeled “African-Americans” or “Latinos,” and the effects of these upon individuals’ sexuality. Koch (Section 2B) dispels the myth of “the feminist” representing a monolithic ideology. Francoeur and Perper (Section 2A) explore the varieties and complexities of fixed and processual religious groups, a diversity highlighted by Forrest’s (Section 2A) discussion of the sexual values found among members of the Church of Jesus Christ of Latter-Day Saints, or Mormons. The work of Kinsey, Klein, Weinberg, Williams, Pryor, and Moses and Hawkins, among many others, illuminates the diversity among homosexually and bisexually oriented people (Section 6). In discussing adult heterosexualities, Weis (Section 5) describes the varieties of sexual expression and relationships among married and nonmarried individuals. Francoeur and Koch (Section 8B) describe the diversity among sex workers, while Love (Section 8D) points out that the United States has more fetish clubs than any other country in the world, and discusses some common and unique fetishes. These are but a few examples of how every aspect of sexuality is reflective of and affected by diversity. It is obvious that a major challenge to American thinking about sexuality requires that we stop viewing sexuality in simplistic terms of male or female, black or white, gay or straight, marital or nonmarital, or normal or abnormal.

[We still have great strides to make in closing the gaps in our knowledge and understanding of how sexuality is affected by and reflective of diversity. The majority of past and current research does not conceptualize or operationalize many personal and social variables as multidimensional (e.g., gender, race, and sexual orientation)—when they are addressed at all. Koch’s 1997 study of the 12 quantitative research articles published in *The Journal of Sex Research* in 1996 reveals, for example, that the race/ethnicity of the

subjects is not reported in two thirds of the studies. For the other third of the studies, no statistical analyses are presented to examine similarities or differences, based on race/ethnicity, in the sexual topics being examined. Similarly, in half of the 12 quantitative studies, the sexual orientation of the subjects was not reported. In the one study that identified the subjects' sexual orientation, no analyses of similarities or differences, based on sexual orientation, was conducted on the independent variables under study. None of the research examined the interaction among variables such as gender, race/ethnicity, and sexual orientation. As we have repeatedly seen throughout this book, these interactions are paramount for an accurate and realistic understanding of human sexuality. The sexual experiences of Anglo-American heterosexual men often differ from those of Anglo-American heterosexual women, which also differ from those of Anglo-American gay men, which also differ from those of African-American gay men, which also differ from those of African-American lesbians, which also differ from those of Latina lesbians, and so on. Our research sensibilities and methodologies must become more sensitive and sophisticated if we are to truly advance sexual science, education, therapy, and policy.

[Without adequate research, and sometimes even with it, people rely on stereotypes to form personal opinions and public policy. Too often these stereotypes lead to adverse judgments or prejudices. These prejudices then influence individual and collective actions, resulting in discrimination against underrepresented groups. This text was filled with examples of discrimination affecting people's sexual relationships, sexual health, and sexual rights. For example, women of lower socioeconomic status in the U.S.A. have much more restricted access to legalized abortion services than do women of higher economic status. Individuals from marginalized groups are disproportionately affected by sexually transmissible diseases, including HIV disease, because of poverty and poorer education and healthcare. Gay men and lesbian women are the last large minority group in the U.S.A. that generally has no legal protections against discrimination. They are subjected to discrimination in all areas of their lives: housing, employment, healthcare, relationship and family formation, and military service, as well as being targets of gay bashing and other hate crimes. Sexual scientists, researchers, educators, and other professionals, as well as citizens at large, must take action to stop ignorance and prejudicial attitudes from continuing to shape public policy, resulting in harm to people's health and well-being.

[Conflict

[With the advancements in science and technology, the diverse groups in our society have not been able to keep abreast by implementing concomitant social progress. It seems that the more things change, the more they stay the same. As described in the section on "Contraception, Abortion, and Population Planning," abortion, especially until "quickening," was widely practiced throughout the history of the United States until the second half of the 19th century. At that time, various factions of "social purity" groups banded together with branches of government to restrict sexual freedoms and control reproduction. Laws, including the "Comstock Law," began to alter 200 years of American custom and public policy towards contraception and abortion. The anticontraceptive provisions of the Comstock Law were enforced until 1936, when finally a federal appeals court overturned them based on the medical authorities who supported the safety and reliability of contraception.

[Following are examples that illustrate the "point" and "counterpoint" of sexual conflicts in the United States.

[Points

- Today, we are experiencing a well-organized and often successful resurgence of the social purity movement, which is restricting sexuality education, sexual health, sexual research, and many sexual freedoms. For example, there are currently more barriers to U.S. women's access to abortion than since the Supreme Court's 1973 *Roe v. Wade* decision. The moral issues of groups of religious and political conservatives are more influential in determining legislated public policy than the well-researched and documented public health concerns surrounding non-access to legalized abortion. New "Comstock laws" are being enacted that once again restrict access to birth control information and services, even though the weight of the authority of the medical world supports their safety, reliability, and necessity.
- Federal funding of abstinence-only education is another example of policy and practice being driven by special interest groups' concern with moral issues rather than by knowledge gained through experience and research. Abstinence-only education has been shown, both nationally and worldwide, to be less effective in preventing unintended pregnancy and sexually transmissible disease risk than more-comprehensive forms of sexuality education. Yet, some effective sexuality education programs are being replaced throughout the country with the less-than-effective abstinence-only ones. At the same time that a nationwide study of puberty documents that half of America's black girls and one in five white girls has begun puberty by age 8 (the 3rd grade), school boards, administrators, and parents are abandoning sexuality education or postponing it until junior or senior high school, even in states with sex education mandates.
- In addition, our knowledge of normative sexual development throughout the lifespan, particularly in childhood and adolescence, is severely hampered by lack of funding and other barriers established by conservative "social purity" groups that wield power through federal, state, and local governments. Funding for sexuality research by well-respected scientists, like Udry and Laumann, has been blocked, despite the fact that such research is critical to expanding our basic knowledge of sexual development, practices, and relationships, as well as reducing sexual health risks, including HIV disease.

[Counterpoints

- Despite long-term opposition of some groups to contraception and abortion—the Comstock Laws, arrests of Margaret Sanger for distributing birth control, opposition of the Popes to "artificial" birth control, and the recent successes of the "pro-life" movement to restrict access to abortion—the general trend over the course of the 20th century has been a greater ability of women and couples to control their fertility and greater use of a variety of family planning practices.
- Despite a century of efforts by various adult groups to limit adolescent premarital sexual behavior, the clear trend of the 20th century has been increasing percentages of adolescents engaging in premarital sexual practices at progressively earlier ages. By the 1990s, fewer than 10% of American youth are virgins on their wedding day. Attitudes have also become progressively more permissive.
- Despite the efforts of some groups to restrict the availability of sexual information and to block sex education

in the schools (again, a century-long effort), the general trend has been toward more sex education in the schools and greater availability of information through a number of sources, particularly various media. Nevertheless, conservative members of the Senate and House of Representatives did pass a bill limiting sexual information on the Internet; however, the Supreme Court ruled the law unconstitutional.

- Although many sexual issues remain controversial, discourse about sex has become freer and more open. More people talk about sex in public settings and discuss a wider variety of sexual practices than in the past. For example, public discussions of homosexuality are much more common now; and everyone seems to be talking about oral sex in the wake of the sexual allegations against former President Clinton. There is also more sexual content on American television, both on the networks and cable; in movies, including in the theaters and on videocassettes; in all forms of printed material, such as general-circulation and sexually explicit magazines; and in all forms of popular music, from heavy metal and rap to country music.
- Homosexuality has become increasingly visible. The “coming out” of Ellen in a television sitcom series of that name is one example of this greater visibility. In addition to Ellen, there are more gay characters being portrayed on American television and in movies than ever before. There is also a growing availability of gay-related fiction. Disney and other corporations have begun to extend job benefits to gay couples, although conservative groups threatened to boycott Disney because of this. Hawaii is considering some kind of legal recognition of homosexual unions or marriage, although other states have stated that they will refuse to legally recognize such unions. Even the U.S. Supreme Court has ruled that same-gender sexual harassment does exist. However, gays still have not been granted full equality in the U.S. and face continuing challenges to their civil rights.
- Finally, the rising age at marriage and the growing divorce rate throughout the 20th century have increased the relative percentage of unmarried adults, at any one time, who are pursuing various nonmarital lifestyles and relationships. There seems to be greater awareness of this trend and acceptance of this trend in adult sexual expression.

[Some of the obstacles we face in better understanding American sexual values and behavior originate and work within the scientific community itself. Scientists from various disciplines must learn to work together in a more collaborative fashion to examine the various contributing factors and outcomes of specific sexual development, health, and educational issues. Competition between biological, psychological, and sociocultural research perspectives and practices needs to be minimized and a more holistic biopsychosocial perspective adopted.

[As we begin the 21st century, the historical theme of sexuality being embedded in change, occurring within a context of conflict among diverse social groups in the United States, will certainly continue. The spheres of influence of various social groups will ebb and flow with changing demographics and social consciousness. The dimensions of change will be directly affected by the speed and direction of technological development. As in the past, persons with fixed-world ideological views will continue to try to impede social progress in adapting to change and diversity. Yet, on balance, the trend throughout American history has been towards liberalization in sexual attitudes and behaviors. It is

our belief that education, research, and human rights will continue to be critically needed guideposts in the determination of sexual values, practices, policies, and programs in the United States in the future. (*End of update by D. L. Weis*)]

[An American “Call to Action” to Promote Sexual Health and Responsible Sexual Behavior

ROBERT T. FRANCOEUR and RAYMOND J. NOONAN,
with CHRISTIAN J. THRASHER.

[*Update 2003:* About 60 experts in various facets of sexuality in America worked with us and with David L. Weis and Patricia Barthelow Koch, our knowledgeable coeditors on this chapter, to develop this extensive examination of sexuality in the United States. We cannot speak for our contributors. We also decided not to speak for ourselves as editors. But we want to have a brief statement and summary to bring the many pieces of this American mosaic together.

[We could find no better working statement to express the underlying message of this survey of American sexual attitudes and behaviors than the “Call to Action” issued in 2001 by David Satcher, M.D., Ph.D., the 16th Surgeon General of the United States. In the last year of his appointment by President Bill Clinton as Surgeon General, Dr. Satcher committed himself and the U.S. Department of Health and Human Services to community-based research studies that linked together the sexual health of Americans with responsible sexual behavior. In 2001, as he left office and President George W. Bush entered the White House, Dr. Satcher’s *Surgeon General’s Call to Action to Promote Sexual Health and Responsible Sexual Behavior* was released. The *Call to Action* was developed through a collaborative process. Its content was based on the strongest science ascertained with broad input from a diverse spectrum of health professionals, academics, policymakers, parents, teachers, clergy, social service workers, and social movement representatives. The *Call to Action* utilized public and private platforms to raise awareness about health problems related to human sexuality and their effects on all Americans, especially the economically disadvantaged, racial and ethnic minorities, persons with different sexual identities and orientations, disabled persons, and adolescents, as well as persons of all ages and backgrounds.

[The overall goal of the *Call to Action* was, and is, to open up and facilitate a mature, respectful, honest, and thoughtful discussion about sexuality. As a country, Americans must understand that sexuality encompasses more than sexual behavior, sometimes referred to as the “-uality” of sexuality. Sexuality has many aspects beyond the physical ones that we are saturated with everyday in this country. Sexuality is a fundamental part of human life.

[With Ford Foundation support, Dr. Satcher and the National Center for Primary Care at Morehouse School of Medicine in Atlanta, Georgia, are working to develop a strategy for improving sexual health, as well as increasing public discourse about human sexuality in the United States using The *Call to Action* as a framework. A National Advisory Committee has been formed with leaders from many different disciplines within the field of sexuality to guide these domestic efforts in furthering the *Call to Action*.

[Sexuality is an integral part of human life. It carries the awesome potential to create new life. It can foster intimacy and bonding as well as shared pleasure in relationships. Yet, it can have negative aspects, including sexually transmitted infections, HIV/AIDS, unintended pregnancy, and coercive or violent behavior. These result from America’s inability to deal appropriately with human sexuality, an inability we share with many other nations of the world. All individuals

and communities share important responsibilities for sexual health. These include assurance of access to culturally and developmentally appropriate comprehensive sexuality education and sexual and reproductive healthcare and counseling; the need to make informed sexual and reproductive choices; the need for respect for diversity; and freedom from stigmatization and violence on the basis of gender, race, ethnicity, religion, or sexual orientation.

[In the words of Dr. David Satcher,

Finding common ground might not be easy, but it is possible. The process leading to this *Call to Action* has already shown that persons with very different views can come together and discuss difficult issues and find broad areas of agreement. Approaches and solutions might be complex, but we do have evidence of success. We need to appreciate the diversity of our culture, engage in mature, thoughtful and respectful discussion, be informed by the science that is available to us, and invest in continued research. This is a call to action. Americans cannot remain complacent. Doing nothing is unacceptable. Our efforts will not only have an impact on the current health status of our citizens; they will lay a foundation for a healthier society in the future. (End of update by R. T. Francoeur and R. J. Noonan)]

[Epilogue: A Transcultural Inventory of Courtship and Mating

JOHN MONEY*

[Editors' Note: John Money, Ph.D., is considered by many sexologists as the most important theoretical sexologist of the 20th century, offering many insights and connections across the many disciplines that make up sexology and sexosophy, the philosophical underpinnings of sexual beliefs and practices. While reading his contribution, consider how the many aspects of sexuality covered in this chapter might fit together as a unified whole within the rubric of Money's characterizations. Given that the United States is a multicultural nation derived from many other nations, these concepts can help to explain the origins of the various attitudes, beliefs, and behaviors described in this chapter, which did not develop overnight. It will be more difficult, however, to resolve some of the conflicts that might have been predicted by his synthesis, yet it might ultimately help to resolve some of the conflicts by providing better understanding of the commonalities that exist among all Americans, as well as among all human beings; thus, they can be applied to all of the countries in this *Encyclopedia*. Of primary importance, perhaps, is that Money's synthesis includes the importance of both the mind and the body together, hence his well-known criticism of the false dichotomy of pure essentialist and social-constructionist adherents. Although some of his theses remain controversial, perhaps his synthesis, together with our "Call to Action" in the previous section, might help us to sort out those attributes that are culturally dysfunctional in the modern world, eventually leading to a sane sexual society that benefits everyone.

[Evolutionary Derobotization

[Update 2003: Around the world, people who share a common heritage include in that heritage explanations and legends, among others, of creation, life in the hereafter, and procreation. The action patterns of courtship and mating exist synchronously as maps in the brain and its nervous system and in the mind. They are robotic in apes and in monkeys and

even more so in four-legged mammals than they are in our own human species. Robotism of an action pattern of courtship and mating means that it is highly replicative or stereotyped from one occasion to the next and from one partner to another. By contrast, a nonrobotic action pattern of courtship and mating is developmentally more subject to individual idiosyncrasy and to community doctrine. The term, *lovemap* (Money 1986, 1999), is the overall term that I coined for the concept of the action pattern of courtship and mating, the wide diversity and underlying universals of which can be found in the pages of this chapter and throughout the *Encyclopedia*. The lovemap includes ideation, imagery, and practices, i.e., the way we form our ideas and imagery relating to sex and the way we develop our behavioral practices.

[In the absence of replicable experimental evolutionary data, one must be satisfied with conjecture. It is my conjecture that derobotization of the prototypic human lovemap was part of a more widespread derobotization of action patterns once phylogenically mapped in the human brain; and that derobotization was the price to pay, so to speak, for the evolutionary emancipation of the human language map (speechmap) from a robotic system of hoots and howls into a system of syntactical reasoning, symbolic logic, and mathematical calculation.

[Ten Constants of Sexual Doctrines

[Doctrines of courtship and mating differ from one community to another, to a greater or lesser degree, on the basis of ten constants: progeny, age, morphology, gender, pedigree, caste or class, number, duration, privacy, and accessories. The annotations that follows apply predominantly, though not exclusively, to the doctrine of sexuality in Christendom.

[1. *Progeny*: Singly or severally, the action patterns of human courtship and mating are both recreational and procreational. As a species, we have, however, been bio-engineered to procreate dieciously, that is by the union of male and female, and not parthenogenically. Diecious procreation is the pivotal constant around which devolve the other constants of our courtship and mating doctrine. Until very recent times, failure to procreate was considered grounds for annulment of a marriage and was attributed to barrenness of the female, not to sterility or impotence of the male partner. Arguments about contraception is a recent phenomenon. For most of human history, predictably effective contraception did not exist. Having progeny implies also the provision of family and community care of the offspring.

[2. *Age*: Procreatively, it makes sense that age matching should prevail over age mismatching in social doctrines of courtship and mating. In the system of arranged marriages, however, an infant or child may be betrothed to an adult partner, but without copulation until the age of maturity. The age of the end of childhood may be arbitrarily legislated to extend from the onset to the end of adolescence. Thus, a young adult man or woman who has sex with, say, a 17-year-old may be charged in one culture with sexual child abuse. At the older extreme of the age scale, in another culture, an adult of 60 who has sex with a 25-year-old may be envied or ridiculed, but not accused of sexual abuse. In the juvenile years, age-matched sexual rehearsal play that is positively endorsed in the ideology of one society is prohibited and abusively penalized in another.

[3. *Morphology*: Chronological age and morphological age are not necessarily in perfect agreement. When they disagree, morphological age is given precedence. Take the example of a pubertally precocious boy who, by age 6 has the mature morphological development, although short in

*Supported by the National Institute of Child Health and Human Development, Department of Health and Human Services, Grant #R25-HD00325-46.

stature, of advanced teenage. He is misconstrued by strangers as a socially retarded teenager, not a socially advanced juvenile. Conversely, a morphologically retarded hypopituitary-dwarfed girl aged 19 is misconstrued as a prepubertal child presenting herself as a young adult woman. In uncounted ways, our morphology is also our destiny.

[4. *Gender*: As members of a diecious species, we come to expect of our fellow human beings that their morphology and appearance will be concordant with the action patterns of their courtship and mating. Historically and transculturally, however, there are examples of communities that have not only tolerated, but idealized male/female bipotentiality—the other sex for procreation and the same sex for playfulness. Homosexuality and heterosexuality in ideation, imagery, and practice, may be concurrent, or they may occur sequentially. Each may be fixated and may exclude the other, but exclusive homosexuality has not occurred with a sufficiently high incidence to slow the population explosion of the human species. Contemporary technology that permits ascertainment of the sex of a fetus and its abortion only if it is female has already changed the sex ratio at birth in some parts of the world in favor of an excess of boys. For them, subsequently, there are too few age-matched females for traditional family formation. People with a fixation on sex reassignment nowadays call themselves transgendered (not transvestite or transsexual as formerly). Diagnostically, they are classified as having a gender-identity disorder whereas, more accurately, they have primarily a body-image disorder.

[5. *Pedigree*: Human beings are designed phylogenically to live in troops and to be troop bonded. To the extent that they are members of the same family of birth, they share genes in common. Alternatively, they may be totemic kin by assignment. Either way, if a couple has the correct totemic pedigree relationship, they may be obliged to procreate and, if not, forbidden to do so. Thus, whereas first-cousin marriages may be the ideal in one culture, they may be prohibited as incest in another. Keeping track of the totemic pedigree of an entire community may have constituted a major deployment of the human intellect in ancient times, as it continues to do among Aboriginal elders of Australia's Arnhem Land today (Money et al. 1970).

[6. *Caste and class*: Our primate heritage dictates not only that we are a troop-bonding species, but also a species that recognizes a hierarchy of authority and leadership within the troop. Thus, a community's code of courtship and mating specifies matching of procreating couples on the criteria of caste, class, title, race, religion, language, wealth, or some other special criterion. A partnership that is legally miscegenation and an abomination in one community may be idealized or romanticized as a source of power and privilege in another.

[7. *Number*: As well as being troopbonders, human beings are pairbonders. The action pattern of neonatal nutritional bonding are, in part, prototypes of those that will later come into play as action patterns of procreative pair bonding. At its most intense, this kind of bonding is known as limerence or as being lovesmitten or lovestruck. Limerence is typically for one partner at a time, but there may be more than one partner, if not concurrently then sequentially; and partners may be either matched or mismatched on the criterion of social class, caste, age, or fidelity.

[8. *Duration*: Single or multiple partnerships each may be either transient or long-lasting. As is the case in some bird species, monogamous fidelity that appears to be lifelong, may actually apply to lifelong pairing for parenthood (nest building, incubation, and feeding of the young, season after season), and not with respect to copulation. The proof

lies in DNA testing of each generation. A doctrine that specifies monogamy as the ideal may persecute nonconformists, or it may tolerate separation and divorce, or turn a blind eye to an affair—a system within a system. Duration covers any length of time, from a hurried lunchtime assignation to the anonymity of a one-night stand, to a “seven-year-itch” marriage, or to a love affair in limerent perpetuity. The youngest age for the onset of a long-lasting love affair (Money 1997, 122) is as early as age 8, if not earlier. Worldwide, juvenile sexual rehearsal play is condemned more often than it is condoned or imbedded in social doctrines of sexuality. Illegitimate grandparenthood is an economic issue as well as an issue of morality.

[9. *Privacy*: One arrives naked on this planet, and it takes not weeks or months, but years of exposure to the sexual taboo to develop a full sense of shame or guilt about exposing the naked sex organs and their action patterns. A taboo imposes a negative sanction on an action pattern normally manifested in the course of human development, for example, the taboo on eating certain foods, on talking to members of certain kinship groups, or offending ancestral spirits. The taboo on sex is particularly effective, as it is nonlethal, but is subject to some degree of on/off regulation. Its function in society, when instilled at a very young age, is that thenceforth, the very threat of its sanctions calls forth obedience. Thus a taboo is a political weapon. Its presence is a temptation to some to rebel against it, which is precisely what happened in the 1960s and 1970s, the era of the sexual revolution in Western civilization. We still live in the era of the counterrevolution. The privacy rule is total when it applies to any public manifestation of courtship and mating, including kissing. Not only genital eroticism, but also genital exposure for a gynecological examination may be subject to taboo. In the electronic or print media, depiction of the genitalia and their action patterns may be prosecuted as obscene and pornographic. Indeed, pornography may be defined as that which is explicitly seen or heard in public when a doctrine's privacy rule regarding sexual pairing is disregarded. By the same token, multipartnered sex, as in group-sex parties, is outlawed, except for the infrequent celebration of ceremonial carnivals or bacchanals. Under conditions of severely crowded family living, the scarcity of auditory and visual privacy interferes with intimacy in courtship and mating. Likewise, the scarcity of privacy interferes with diagnostic and prognostic observation and recording of data at first hand in couples with a complaint of sexual malfunction. The privacy rule skews data on the prevalence of genital adornment by piercing, tattoo, or scarification—and likewise data on genital mutilation as a sequel to clitoral or penile circumcision.

[10. *Accessories*: Copulatory toys include vibrators, dildos, butt plugs, cock rings or straps, and various paraphernalia specific to selective paraphilic lovemaps, notably those in the category of sadomasochism or of bondage and discipline. The copulatory accessory that is by no means a toy, however, but a pregnancy planner or preventer, is the contraceptive device or substance. Contraceptives range from the condom and the intrauterine device (IUD), to the hormonal Pill or patch. In the public forum, contraception arouses the same strong passions as do abortion and sterilization as methods of replacing procreational sex with recreational sex. There is no accessory, either medicinal or mechanical, that offers complete prophylaxis against the lethal human immunodeficiency virus (HIV), which is the agent of acquired immune deficiency syndrome (AIDS). As of the year 2003, HIV faced a challenge for lethality, namely the corona virus that is the agent of severe acute respiratory syndrome (SARS). SARS may be spread by, *inter alia*, sexual contact, whereas

HIV is spread predominantly by that route. Other sexually transmitted diseases (STD), though of great individual and public health concern, are not inexorably deadly.

[Phylism Theory]

[There are no passes or failures generated by the ten constants of a doctrine of courtship and mating, for they do not constitute a test but rather an agenda. They are applicable to the systematic gathering and inventorying of data pertaining to the sexual ideation, imagery, and practice of a single individual or of an entire community. A doctrine's propositions may be highly consistent with one another or chaotically inconsistent and contradictory. A doctrine, no matter how self-contradictory, must first be recorded nonjudgmentally before judgment can be passed.

[The ten constants have their origin in logical analysis of such philosophical antitheses as are represented in teleological versus mechanistic, hereditary versus acquired, organic versus intrapsychic, or nature versus nurture. My own position on all of these antitheses is that each of the pair needs the other, without which there is a void. The contribution of each needs to be established, not by proclamation, but empirically, step by laborious step. The bits and pieces of the building blocks of the ten constants of ideation, imagery, and practices of human sexuality I like to call *phylisms*. That means they belong to all of us collectively and phylogenically as members of our species—for example, the transcendental experience of orgasmic climax. The metaphorical buildings made from phylismic building blocks are ontogenic. They embody individual history, which may or may not be shared by other people.

[Phylism theory is an outgrowth of imprinting theory: At a critical or sensitive stage of development, there is a threefold confluence of an innate recognition mechanism, an innate releasing mechanism, and an innate response mechanism. The classic example is that of a newly hatched duckling that recognizes a moving squat-shaped thing (usually, of course, the mother duck), which in turn triggers an innate releasing mechanism, which in turn releases the actual response of following the squat-shaped moving thing. The long-term outcome is that following the moving thing, even if it is a waddling human being, becomes fixated (think native language) for a prolonged period of time (see below under *paraphilias*).

[Phylisms of Courtship]

[Remnants of our robotic past can be observed when two people are mutually attracted and make a move on each other. Whether in an urban club or park, or in a tribal rainforest, the action patterns are similar regardless of individual, ontogenic embellishments. Much abbreviated, they are as follows (based on Givens 1983; Perper 1985; Eibl-Eibesfeldt 1985; Money 1998, Ch. 1): eye contact, stare, blush, gaze averted, eyelids droop, gaze again, squint, smile, vocal animation, breathiness, louder voice, silly laughter, mutual rotation, move closer, wet lips, adjust clothing to uncover skin, inadvertent touch, mirror gestures, synchronize movements, hold hands, pat, embrace, kiss and fondle with accelerated heart rate and breathing, sweating, genital secretions, dry mouth, and butterflies in the stomach. Although not inevitable, copulation ensues.

[The courtship responses of men and women are not identical but complementary to one another, as they are in the act of procreative copulation. Women on the whole are more dependent on contractive (touch) than on visual stimuli for the arousal and maintenance of erotic responsiveness. Contractation applies to tactile or dactylic (fingering and fondling) senses. Women are not erotically unrespon-

sive to the visual image of sexuality nor are men unresponsive to contractive stimuli. The difference between men and women is not absolute, but a matter of proportion. Men are aroused at a distance not by smell, as is typical in other mammalian species, but by what the eyes see. From an evolutionary perspective, it may well be that human male eroticism is a spinoff from bipedal locomotion. Derobotized, we meet one another eye to eye, vertically, in a sexual encounter, whereas four-legged mammals meet one another horizontally, rump end to snout end, in a robotized sexual encounter. Thus, bipedal locomotion may have been an evolutionary forerunner of derobotization of both the lovemap and the speechmap (see above) in us human beings.

[The male-female difference in the ratio of visual to contractive sexuality is entrenched in the doctrine of sexual orthodoxy in Christendom. Since we live in the era of the globalization of goods and services, our sexual doctrine becomes globalized also. Thus, the sexuality of tribal peoples in remote places becomes observed and recorded by people whose own doctrines are Westernized and judgmental. Observers condemn and neglect that which they study while they are studying it. Until the very recent past, for example, official ethnology did not accept the idea that falling in love was scientifically suitable for study in tribal peoples.

[It is commonly avowed that contractive sexuality is superior to concupiscent sexuality. The former, it is claimed, is more romantic and spiritual, and ostensibly less carnal and animalistic than concupiscent sexuality (Money 2003). It is love, not lust. Too much or too little of either type, however, can give cause for clinical concern. It can give cause also for political concern by reason of linking politically correct sexuality to romantic sex and to women only. Politically incorrect sexuality is linked to carnal sex and to men only.

[Sambian Orthodoxy]

[A prime example of a doctrine of sexuality before exposure to the doctrine of Christendom is that of the Sambia people of Papua New Guinea studied by Gilbert Herdt (1981, 1987; see summary in Section 13 of the chapter on Papua New Guinea in this volume). This was not a sex-negative doctrine, but it was linked to abusive indoctrination in boyhood in preparation for intertribal killing to qualify for manhood. In a Sambia farming hamlet, when a cohort of prepubertal boys in the mid-juvenile age group were separated from the perceived dangers of the influence of females, they lived, ate, and slept together in the long house, a kind of male dormitory. They were ready for the first stage of their initiation into manhood. Its ceremonial beginning lasted several days and nights and can be summed up as brutal ceremonial hazing and brainwashing, including food, water, and sleep deprivation, nose piercing, and being hauled naked across the shoulders of a male sponsor along an avenue of older males armed with whips for lashing them. The mystery of the secret ceremony of sucking the flute consisted of enforced sucking of the penis of an older, unmarried youth in the men's house. It was the duty of the older boy (or boys) to supply the younger ones with enough "men's milk" to ensure that they would be able to develop pubertally. When the younger boys became old enough to make men's milk themselves, then it was their duty to have it sucked out by still younger ones.

[The mystery of what happened in the men's house must be kept secret from all females and uninitiated males. Looking at or talking to females, even one's mother, was strictly forbidden. At around age 20, the tribal age of marriage, the tribal elders found a suitable bride in a neighboring hamlet. The candidate for marriage had to prove his worthiness by

participating in an intertribal war party, and returning home with the body of a slain enemy. Initiation was final and complete when the first child was born.

[Some men raised up in this system fell in love with their wives, though some did not. A few had evaded the men's milk ritual as often as possible, but none had become exclusively gay in the Western sense.

[Women talked only to women about their sexuality, so that, in the absence of a woman ethnologist, data are lacking. After World War II, Australian governmental patrols suppressed the indigenous sexual orthodoxy in favor of the orthodoxy of Christendom.

[Malleability: The Paraphilias

[During its critical formative stage as a personalized lovmep in the individual, or as a shared doctrine in the community, human sexuality is self-evidently malleable to some degree. That does not by any means signify that sexuality is infinitely malleable regardless of chronology. Nonetheless, it is an all-but-universal axiom in Western culture that sexuality is forever malleable and subject to voluntary control. Sexuality that proves to be unmalleable is at risk of being classified as lawbreaking and maybe a crime. It is subject to chastisement, punishment, deprivation, torture, and in some instances, the death penalty.

[Only a small cadre of biomedical scientists engage in a truly scientific search for causal explanations of human sexuality and its aberrations, which is nowhere more clear than in the case of the paraphilias, legally known as the perversions. Paraphilias often give the impression of being as idiosyncratic and contrived as the plot of a novel or screenplay and, therefore, easily altered. That puts the cart before the horse insofar as an author may well have drawn on his or her own uniquely paraphilic disposition for the theme of his or her art. Thus, the novels of the Marquis de Sade gave his name to sadism, the paraphilia, and those of Leopold von Sacher-Masoch gave his name to masochism.

[It is a remarkable feature of the paraphilias that no two people have a paraphilia which is an exact replica, the one of the other. It is the theme that they share, not the precise details. It is also remarkable that, despite idiosyncratic variations, the paraphilias can be cataloged as exemplifying seven major themes or stratagems. These stratagems are trickeries whereby neither love nor lust is forfeited, but both are saved by being separated or dissociated, often with one partner for love and another for lust.

[The origin of the paraphilic stratagems is probably before recorded history, and they probably embody extremely ancient paradigms of wisdom (so ancient that they are called paleodigms; Money 1989). They now survive in the legends and myths of folk wisdom—for example, the folk wisdom that sacrifice leads to expiation of guilt. Listed by name only, the seven grand stratagems of the paraphilias are as follows: sacrifice and expiation; marauding and predation; mercantilism and venality; fetishism and talismanism; stigmatism and eligibility; protectorship and rescue; and solicitation and allure (see Money 1997, 252; 1999, 125).

[At one extreme, paraphilias may be rated as inordinately fixated and life threatening. At the other extreme, by contrast, they are ludic (playful) and erotically enhancing.

[The transcultural record is incomplete as is also the historical record, so that the comparative occurrence and prevalence of the paraphilias in time and place is not known. One likely possibility is that the paraphilias are specifically an offshoot of Christendom's dark side. They represent a slowly progressive evolutionary accommodation to the austerity of Christendom's doctrine of sexuality for procreation only. In other words, the social evolution of

paraphilic sexuality is taking place under our very noses and we are not perceiving what is happening.

[The majority of the paraphilias are not named in *DSM-IV-TR* (APA 2000) except as "Not Otherwise Specified." For many of these, there was no scientific name until the book *Lovemaps* was published (Money 1986). Earlier, they had been named, if at all, only in street slang, or in the criminal justice vocabulary of lawbreaking, or in the ecclesiastical vocabulary of heresy. Their recognition as sexological syndromes began in tabloids and pictorials where individuals could search for and maybe correspond with others similar to themselves. Then, at the end of the 20th century, came the great invention of the Internet on which people with the same paraphilia could find and communicate with one another. On the Internet, unknown paraphilias became known and compared, and little-known paraphilias became more prevalent than had previously been suspected, women's paraphilias included. It remains to be seen whether or not the Internet confirms that women's paraphilias are more contractative than men's, and men's more visual than contractative.

[It would be scientifically foolish to expect the human genome to be phylogenetically coded for a fetish for nylon pantyhose, since nylon is a 20th-century invention. However, it would not be foolish to propose that the erotic feel of human skin might be transposed on an ontogenetic basis to nylon, and that the erotic feel of nylon could thenceforth become fixated, if not indefinitely, then for an extended period of time (think native language again). The paraphilias are, indeed, strongly resistant to change. However, over the years of a lifetime, a paraphilia may spontaneously metamorphose or undergo remission (Lehne & Money 2000, 2003).

[Doctrinal and Sexual Orthodoxy

[In human sexuality, doctrinal orthodoxy is under the control of those who have the power to enforce it by way of laws, taboos, prohibitions, and punishments. The information provided, in the United States and country-by-country, in this *International Encyclopedia* allows a scholar to trace the global range and dispersal of Christendom's doctrine of sexual orthodoxy. In other cultures in the United States, as well as in other countries, information about the history and current status of Muslim, Confucian, Buddhist, Hindu, animist, and Shinto religious influences provides similar insights into doctrinal orthodoxy in non-Christian cultures. Given the rapid pace of globalization and cultural interactions, neither doctrinal nor sexual orthodoxy are static doctrines. Both are actively in the process of evolving. (*End of update by J. Money*)]

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