THE ESSENTIAL HANDBOOK OF WOMEN'S *Sexuality*

Donna Castañeda, Editor

VOLUME ONE

Meanings, Development, and Worldwide Views

The Essential Handbook of Women's Sexuality

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The Essential Handbook of Women's Sexuality

Donna Castañeda, Editor
Foreword by Florence L. Denmark, PhD

Volume 1

Meanings, Development, and Worldwide Views

Women's Psychology
Michele A. Paludi, Series Editor

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Series Foreword

> Because women's work is never done and is underpaid or unpaid or boring or repetitious and we're the first to get fired and what we look like is more important than what we do and if we get raped it's our fault and if we get beaten we must have provoked it and if we raise our voices we're nagging bitches and if we enjoy sex we're nymphos and if we don't we're frigid and if we love women it's because we can't get a "real" man and if we ask our doctor too many questions we're neurotic and/or pushy and if we expect childcare we're selfish and if we stand up for our rights we're aggressive and "unfeminine" and if we don't we're typical weak females and if we want to get married we're out to trap a man and if we don't we're unnatural and because we still can't get an adequate safe contraceptive but men can walk on the moon and if we can't cope or don't want a pregnancy we're made to feel guilty about abortion and . . . for lots of other reasons we are part of the women's liberation movement.
>
> Author unknown, quoted in *The Torch,* September 14, 1987

This sentiment underlies the major goals of Praeger's book series, Women's Psychology:

1. Valuing women. The books in this series value women by valuing children and working for affordable child care; valuing women by respecting all physiques, not just placing value on slender women; valuing women by acknowledging older women's wisdom, beauty,

aging; valuing women who have been sexually victimized and viewing them as survivors; valuing women who work inside and outside of the home; and valuing women by respecting their choices of careers, of whom they mentor, of their reproductive rights, their spirituality, and their sexuality.

2. Treating women as the norm. Thus the books in this series make up for women's issues typically being omitted, trivialized, or dismissed from other books on psychology.
3. Taking a non-Eurocentric view of women's experiences. The books in this series integrate the scholarship on race and ethnicity into women's psychology, thus providing a psychology of *all* women. Women typically have been described collectively; but we are diverse.
4. Facilitating connections between readers' experiences and psychological theories and empirical research. The books in this series offer readers opportunities to challenge their views about women, feminism, sexual victimization, gender role socialization, education, and equal rights. These texts thus encourage women readers to value themselves and others. The accounts of women's experiences as reflected through research and personal stories in the texts in this series have been included for readers to derive strength from the efforts of others who have worked for social change on the interpersonal, organizational, and societal levels.

A student in one of my courses on the psychology of women once stated:

> I learned so much about women. Women face many issues: discrimination, sexism, prejudices . . . by society. Women need to work together to change how society views us. I learned so much and talked about much of the issues brought up in class to my friends and family. My attitudes have changed toward a lot of things. I got to look at myself, my life, and what I see for the future. (Paludi, 2002)

It is my hope that readers of the books in this series also reflect on the topics and look at themselves, their own lives, and what they see for the future.

I am proud to have Dr. Donna Castañeda's book set in the Women's Psychology series at Praeger. Dr. Castañeda has brought together an impressive group of scholars and advocates who have provided us with up-to-date research on topics such as women's sexuality in middle and later years; female initiation rituals; the intersectionality among sexuality, work, and parenting; sexual rights; lesbian sexuality; bisexual women; and women with disabilities. Her attention to cultural issues in women's sexuality is most welcome and needed in the field. Dr. Castañeda has raised the bar for texts on women's sexualities. This is the essential reading in the

field. This book set may be used in undergraduate and graduate courses as well a reference for researchers on women's sexuality.

This set provides readers with the opportunity to accomplish the goals of this series and offers suggestions for all of us who want to know more about women's sexualities. I congratulate Dr. Castañeda and her contributors on offering us this impressive book set. They have dispelled myths and replaced them with facts about women's sexualities. Their greatest accomplishment is bringing this material to a general audience. I thank them for honoring me by publishing their work in this series.

Michele A. Paludi

REFERENCE

Paludi, M. (2002). *The psychology of women* (2nd ed.). Upper Saddle River, NJ: Prentice Hall.

Foreword

In reading the chapters in this book set, I am reminded of how far women's sexuality has come over the last two centuries. In the 19th century, sexuality was viewed as something that should be repressed and not talked about in the public sphere, especially for women. Women who discussed issues such as sexual pleasure and desire were viewed quite negatively. However, over the years, and through the 20th century, women's sexuality became a highly discussed topic, and as women were provided with more legal rights, so too did they use this freedom to express themselves in ways they had not previously. It is with great excitement that women can now talk about sexuality openly as our male counterparts have done for so long. Having this two-volume set focused wholly on women's sexuality is evidence of how far we have come on this issue.

This set is a remarkable collection of writings on women's sexuality from authors who are respected leaders in their fields. Volume 1 of this set is titled "Meanings, Development, and Worldwide Views." This volume provides chapters on sexual pleasure, desire and satisfaction in women, sexuality across various developmental stages in women's lives, international perspectives, and human and sexual rights for women. Despite the modern tendency toward women's rights and sexual freedom, even today there are vast differences in beliefs and practices across the world. This section provides insight into how women's sexuality is viewed in different countries worldwide.

Volume 2 is titled "Diversity, Health, and Violence." This volume focuses on various issues, including diversity, health, mental health, and violence, and their relationship to women's sexuality. It covers everything from sexuality as related to pregnancy and HIV to pornography, sex

trafficking, and sexual trauma. In addition, there is a section that focuses on how sexuality is viewed amongst various cultural and racial groups as well as in the LGBT community.

The editor of this two-volume set has gathered the most current research regarding women and sexuality and brought it into the fore. It contains an expansive collection of topics and is, without a doubt, a one-of-a-kind, relevant, and significant resource. I would encourage any psychologist to add this text to their libraries, particularly those involved with or interested in international, social, psychological, gender studies, and multicultural and cross cultural issues.

Florence L. Denmark, PhD

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Special thanks to Michele A. Paludi for her invaluable support, advice, and encouragement at every stage in the development of this book set. She has been a wonderful mentor to me in this project. I also thank Debbie Carvalko at Praeger for all her helpful editing advice and good ideas along the way. I am tremendously grateful to the contributors to this book set for their incredible chapters and I appreciate their patience and dedication to this project. Finally, to Tom and Keon Barkhurst, special thanks for your support, cheerful good humor, and caring. They keep me going.

Introduction

Carol S. Vance wrote in her groundbreaking publication on women's sexuality *Pleasure and Danger: Exploring Women's Sexuality* that the "hallmark of sexuality is its complexity: its multiple meanings, sensations, and connections" (1985, p. 5). This quote illustrates the approach and purpose of this two-volume book set on women's sexuality. Women's sexuality is complex and multifaceted and has expanded, as a field of inquiry, to encompass a range of perspectives, theories, topics, and findings. While no one publication could encompass all that is pertinent to women's sexuality, the two volumes in this book set provide a comprehensive picture of some of the most important issues in the field of women's sexuality. It brings to bear the latest thinking and research on women's sexuality across a diversity of topics by a group of accomplished scholars.

An overarching theme that is present across the various chapters included in the two volumes is the clearly contextual nature of women's sexuality and that it cannot be understood by examining sexuality at one level of organization alone. Women's sexuality is not only an individual and personal experience embedded in the physical and material realities of bodies and biology, personal sexual identities, and individual development over time, but is also influenced by the interpersonal context, life experience, cultural meanings, gendered dynamics of power and oppression, and layers of silence in the family and in society surrounding sexuality, as well as various larger forces, such as global migrations, politics, and economics. All of these elements interact in complicated ways to influence women's sexuality and they are all reflected throughout the chapters in this book. Likewise, while most chapter authors are from the field of psychology, a number of them are from outside the discipline of psychology,

including philosophy, communications, nursing, anthropology, and political science; even those within psychology are heterogeneous, with authors from the fields of clinical, social, and developmental psychology included.

Each volume is divided into several content areas. The theme for volume 1 is "Meanings, Development, and Worldwide Views" and it begins with chapters on sexual desire (chapter 1), sexual satisfaction among heterosexual women (chapter 2), and women's sexuality in close relationships (chapter 3). These chapters set the stage for understanding fundamental issues related to women's sexuality. They are followed by chapters that look at women's sexuality across important developmental periods and events, such as adolescence (chapter 4); motherhood, work, and sexuality (chapter 5); menopause (chapter 6); and women's sexuality from the middle to late adulthood (chapter 7). They demonstrate that to understand women's sexuality, one must consider the role of individual development and stages of family life. An international perspective is taken in the next section to examine sexuality issues in a set of diverse countries and cultures, as well as the preeminent issue of sexual rights as human rights that is a major focus of sexuality activism around the world. These include investigation of female initiation rituals and sexuality socialization in northern Mozambique (chapter 8); sexuality issues among Vietnamese women (chapter 9); an examination of the context of women's sexualities, sexual rights, and violence in Mexico (chapter 10); and a feminist account of the struggle for sexual rights in Muslim societies (chapter 11). These chapters not only demonstrate the commonalities across cultures and societies in the sexuality issues women confront, but they also provide clear evidence that what sexuality issues may be most salient in a particular society and the resources and options available for women to confront these issues can be quite different.

The last section in this volume focuses on women's bodies, the media, and sexuality. These chapters describe and explore how cultural ideals and expectations, as transmitted through the media, influence not only how women experience their sexuality, but how their sexual relationships may be affected as well. Beginning this section is a chapter that examines how binge eating disorder may affect women's sexuality (chapter 12). This is followed by an investigation of media influences across the 20th century and up to the present on women's decision to remain voluntarily childless and the implications of this for constructing women's sexuality (chapter 13). The last chapter in this section describes the difference between erotica and pornography and how they may affect women's sexuality (chapter 14).

The theme for volume 2 is "Diversity, Health, and Violence" and how these may be implicated in women's sexual lives. First, lesbian love, sex, and relationships are examined and this chapter includes an incisive account, among other topics, of how few accurate depictions of lesbian sexuality and close relationships can be found in the media (chapter 1).

This is followed by a chapter on women's sexuality and bisexuality, where the complexities of bi identity, sexuality, love, and relationships are discussed (chapter 2). Finally, a chapter discusses the concept of interpretive intimacy in the lives of trans women, including an examination of the factors that may constrain as well as facilitate this complex process (chapter 3). This section is followed by one where the notion of diversity is approached. While diversity in women's lives can be defined in many ways, in this section it refers to ethnic/racial/cultural and ability/disability diversity. These chapters include ones that discuss sexuality and sexual health issues for women with physical disabilities (chapter 4); First Nation women (chapter 5); Latinas (chapter 6); Asian and Asian American women (chapter 7) and African American women (chapter 8). The next two sections focus on important health and mental health-related topics and their relationship to women's sexual lives. First, the chapter on the experience and construction of changes to women's sexuality after breast cancer describes and discusses how women with breast cancer may experience a range of serious emotional changes due to the removal or change in a breast and the side effects of cancer treatment (chapter 9). Next, the chapter on HIV/AIDS and women's sexuality discusses, among other issues, how promoting a positive sexuality for women is central to HIV prevention among them (chapter 10); finally, the chapter on childbearing examines how women's sexual activities may vary across pregnancy and the postpartum period and the physical, psychological, and social factors that influence these (chapter 11).

The section on sexuality, mental health, and therapy includes chapters that discuss the ongoing controversy over defining and diagnosing women's sexuality (chapter 12); reconceptualizes the role of power in sexual interactions that include BDSM (an acronym that refers to a wide range of consensual sexual activities loosely grouped into the categories bondage and discipline, dominance and submission, sadism and masochism [or sadomasochism], leather, fetish, and kink) (chapter 13); healing and restoring women's sexuality after the experience of trauma (chapter 14); the right to intimate citizenship in the sexual lives of women with enduring mental illness (chapter 15); and, finally, a chapter that provides a critique of approaches to women's sexual problems and provides a set of recommendations that may lead to alternative, women-centered and women-positive therapeutic approaches to help women with such problems (chapter 16).

The last section in volume 2 takes on the issue of violence and women's sexuality. It begins with a review of the research on the causes and consequences of abusive relationships, including how they may affect women's sexuality (chapter 17). The second chapter in this section analyzes how the sexualization of women and girls influences and promotes sexual violence against them (chapter 18). The final chapter in this section describes in detail the scope and parameters of sex trafficking and sexual

exploitation of women across the globe and how it may affect women's sexuality (chapter 19).

As editor, I am likely biased, but to read the chapters in these two volumes, to experience the intellectual scope and depth of each of the fascinating topics they deal with is breathtaking. They each offer thought-provoking insights and intriguing ideas, and although the chapters cover seemingly disparate fields, my hope is that this book stimulates dialogues across these fields along with new and continued study and research on women's sexuality.

Donna Castañeda

REFERENCE

Vance, C. S. (1985). *Pleasure and danger: Exploring female sexuality.* Boston: Routledge & Kegan Paul.

Part I

Sexual Meanings

Chapter 1

Sexual Desire in Women

Pamela C. Regan

> "What Makes a Woman Bedable?" (*Cosmopolitan*)
> "How to Spark His Desire (Again & Again & Again)" (*Redbook*)
> "60 Wild, Erotic Ways to Excite Your Lover" *(Woman's Own)*
> "What's Sexy Now! 85 Secret Tricks" (*InStyle*)
> "The Body Language of Lust" (*Cosmopolitan*)

These quotations, taken from the headlines of several contemporary women's magazines, underscore the almost obsessive fascination with which the media and reading public approach the topic of sexual desire. With each new issue, these and countless other articles conspire to teach women that sexual desire is important—that sexual passion is a vital ingredient in "healthy" romantic relationships, that sexual desirability is an essential attribute to possess (and seek in a potential mate), and that if their own or their partners' sexual interest wanes they should take immediate steps to rekindle the spark. To some extent, these suppositions are correct. Although women (and men) can feel and express a variety of sexual responses within their relationships, a growing body of scientific research

reveals that sexual desire plays an especially pivotal role in the attraction process (particularly as people fall in love) and has important implications for the dynamics and emotional tenor of ongoing marital and other romantic relationships.

This chapter explores sexual desire in women. First, sexual desire is differentiated from other, related sexual responses, such as sexual arousal and sexual activity. Next, the question of how much sexual desire women typically experience is examined. Then, several of the major determinants or correlates of female desire are reviewed, including individual-level factors (with an emphasis on hormones and hormonally mediated female life events) as well as partner characteristics (such as physical attractiveness) that excite women's sexual passion. Finally, the role of sexual desire in women's ongoing romantic relationships is explored.

CONCEPTUALIZATION AND MEASUREMENT: WHAT IS SEXUAL DESIRE AND HOW IS IT ASSESSED?

Sexual desire (also called *sexual interest, sexual attraction, passion,* or *lust*) is the motivational component of human sexuality, and it is most typically experienced by women (and men) as an interest in sexual activities, a drive to seek out sexual objects or to engage in sexual acts, or a wish, need, or craving for sexual contact (Bancroft, 1988; Kaplan, 1979; Levine, 1984, 2003; Regan & Berscheid, 1999). The experience of sexual desire is presumed to be distinct from other sexual responses, including *sexual arousal* (which involves physiological arousal, genital excitement, and the subjective awareness of physiological/genital arousal; Green & Mosher, 1985; Masters, Johnson, & Kolodny, 1982, 1994), *sexual activity* (which consists of overt sexual behaviors, such as masturbation, kissing, or intercourse), and *sexual feelings* that are associated with these responses (such as satisfaction, fulfillment, and pleasure).

Desire, arousal, and activity frequently co-occur, and thus often are experienced relatively simultaneously (see DeLamater, 1991; Kaplan, 1979). For example, the sight of an attractive person may cause a woman to feel an urge to engage in sexual activities with that other and to fantasize about what sex with him or her might be like. These lustful feelings may subsequently produce physiological arousal (e.g., increased voluntary muscle tension, increased heart rate, elevated blood pressure) and genital excitement (e.g., vaginal lubrication). The subjective awareness of this physiological and genital arousal may, in turn, increase the desire for sexual contact and may result in actual sexual behavior. After orgasm or sexual satiation, the woman's body will return to its pre-aroused state and her degree of sexual desire also may decrease. Thus, the interrelationship among desire, arousal, and activity is complex; each response can influence the others and they may co-occur. Researchers, nonetheless,

consider each experience to be a separate component of the human sexual response cycle.

Sexual desire varies along at least two dimensions. The first dimension is quantitative and concerns the magnitude of the desire that is experienced. Both the intensity and the frequency with which desire is experienced can vary within one individual over time. For example, a woman may experience sexual desire on numerous occasions one week, only to feel no desire at all the following week; similarly, she may possess a powerful sexual urge at one point in time and then a much less intense sexual need at another. In addition, women (and men) differ in the chronic amount of desire that they experience; some generally have a very low level of sexual appetite, whereas others habitually experience high levels of desire.

The second dimension along which sexual desire varies is qualitative and concerns the specificity of the desired sexual goal and sexual object. A woman in the throes of desire may wish to engage in a very specific sexual activity (e.g., intercourse) with a very specific other individual (e.g., the partner). Alternately, she may simply have an urge to engage in some form of sexual activity with an unspecified partner; in this situation, both the sexual goal and the sexual object are diffuse rather than specific.

Because desire is a subjective internal experience rather than an overt physical or behavioral event, scientists generally measure it with self-report methods (see Regan & Berscheid, 1999). Women might be asked to respond to questions about their feelings in general or for a specific other person (e.g., a dating partner or spouse) and they might be asked to rate their overall level or amount of desire ("How much sexual desire do you experience?"), the frequency of their sexual urges ("How often do you experience sexual desire?"), or the intensity or degree of their sexual attraction to their current partner ("How intensely do you desire _____ sexually?," "How sexually attracted are you to _____?").

HOW MUCH SEXUAL DESIRE DO WOMEN TYPICALLY EXPERIENCE?

The question of whether men or women are the more "lustful" sex—and, relatedly, how much sexual desire is "normal" for each sex—has long been of interest to scholars. Many early theorists and clinicians concluded that women possess lower levels of sexual passion or drive than do men. For example, when considering the sexual life of men and women, the German physician and scholar Richard von Krafft-Ebing (1886/1945) pronounced, "Man has beyond doubt the stronger sexual appetite of the two" (p. 14). Although the view of male and female sexuality espoused by Krafft-Ebing and his 19th-century contemporaries (e.g., Jefferis & Nichols, 1896) is outdated, certainly there are pronounced differences between women and men in many aspects of sexuality, including frequency of

certain types of sexual activity (e.g., masturbation), affective responses to intercourse, and general sexual attitudes. For example, existing literature reviews indicate that women tend to hold more negative attitudes than do men toward casual (uncommitted) sexual activity as well as toward extramarital sex, report engaging in various forms of sexual activity, such as masturbation, to a lesser extent than men, and have a less positive emotional reaction than men to intercourse experiences (Oliver & Hyde, 1993; Regan, 2008; Sprecher & McKinney, 1993).

In addition, although relatively few researchers have specifically investigated sex differences in desire, the available studies suggest that women do, in fact, experience feelings of sexual desire or interest less frequently than men. For example, in one early investigation, Useche, Villegas, and Alzate (1990) surveyed a sample of Colombian high school students and found that fewer young women (49%) than young men (80%) reported experiencing sexual desire at least once a week. A survey of college students conducted around the same time yielded similar results (Beck, Bozman, & Qualtrough, 1991). More recently, Regan and Atkins (2006) examined both the self-reported frequency and the intensity or level of sexual desire among a community sample of 676 men and women. In this study, participants first received a definition of sexual desire and indicated whether or not they had ever experienced it; next, they rated their overall level of sexual desire on a nine-point scale (with 1 = *very little* and 9 = *a great deal*); finally, they rated how often they experienced sexual desire in general (again on a nine-point scale, this time anchored by 1 = *never* and 9 = *extremely often*) and estimated how often they actually experienced sexual desire on a daily, weekly, monthly, or yearly basis (responses to this item were coded so as to reflect weekly frequency rates). There were a number of findings, illustrated in Table 1.1. First, although the majority of participants (more than 97%) reported having experienced sexual desire, significantly fewer women (96%) than men (99%) indicated having experienced this particular sexual feeling. Second, women reported having a lower overall level of sexual desire than did men. Sex differences also were found with respect to frequency of sexual desire. Specifically, women reported having experienced sexual desire less often than did men and, when asked to estimate the actual frequency with which they experienced desire, women's estimated frequency (roughly 9 times per week) was significantly lower than men's estimated frequency (about 37 times per week).

Considered together, the results of existing research thus suggest the following conclusions. First, both sexes, particularly in adolescence and young adulthood, feel sexual desire fairly frequently (in fact, sexual desire may be the single most common sexual experience among teenagers and adults). Second, women typically report experiencing sexual desire less often than do men. Third, when asked to rate their level or amount (as opposed to frequency) of desire, women tend to report a lower amount

Table 1.1 Sex differences in frequency and intensity of sexual desire

Measure	Men	Women
Percentage having experienced sexual desire	98.8*	95.9*
Self-rated level (intensity) of sexual desire	6.9*	5.6*
Self-rated frequency of sexual desire	6.8*	5.3*
Estimated frequency of sexual desire (number of episodes per week)	37.0*	8.7*

Note: Starred means within each row are significantly different.

than do men. Thus, although desire is a common experience for both men and women, women do appear to be less "lustful" than men. However, as discussed in the following section of this chapter, women are also subject to greater variation in hormone levels than men, and as a result are particularly prone to fluctuations in desire. Consequently, in any given span of time, there will be occasions when a woman's intensity or frequency of desire exceeds that of her male counterpart. There will also be times when his desire exceeds hers and times when the two experience roughly equal frequencies or levels. Thus, the question of how much desire is "typical" (and, relatedly, whether sex differences in desire exist) is a difficult one that can only be answered by future research that examines the pattern of women's (and men's) levels of desire over time.

HORMONES AND HORMONALLY MEDIATED LIFE EVENTS: THE BIOLOGICAL BASIS OF FEMALE SEXUAL DESIRE

In their quest to understand the dynamics of sexual desire, most researchers have focused on variables associated with the individual, such as personality traits or dispositional tendencies, demographic characteristics, chronic mood states, physical and mental health variables, hormonal or biological processes, and any other relatively enduring features or attributes that a person may possess. A number of individual-level factors have been implicated in the ability to experience sexual desire. For example, women (and men) with serious physical illnesses, including cancer, diabetes, and Parkinson's disease, typically report decreases in their overall level of sexual interest following the onset of their illness, and their desire levels are usually lower than those reported by healthy adults (Koller et al., 1990; Schover, Evans, & von Eschenbach, 1987; Schreiner-Engel, Schiavi, Vietorisz, Eichel, & Smith, 1985). Depression and other forms of major mental illness are also associated with decreased desire, as is excessive and chronic use of alcohol and other recreational drugs (see Regan & Berscheid, 1999). Chronological age, too, is negatively correlated with sexual desire; cross-sectional studies consistently find a decline in sexual interest with

advancing age among women and men (Purifoy, Grodsky, & Giambra, 1992; Schiavi, Schreiner-Engel, Mandeli, Schanzer, & Cohen, 1990).

Hormones and hormonally mediated life events constitute a particularly potent individual-level factor. Research indicates that both endogenous (internally generated) and exogenous (externally administered) sex hormones contribute to the timing and magnitude of sexual desire. There are four sex hormones (androgens, estrogens, progesterone, and prolactin). In women, these hormones are produced by several of the glands within the endocrine system, including the adrenal glands, the pituitary gland, and the ovaries. Of the various sex hormones, the androgens (masculinizing hormones) are the most strongly implicated in the experience of female sexual desire (see Regan, 1999).

Testosterone

In women, the androgen *testosterone* is synthesized primarily in the adrenal cortex and, to a lesser extent, in the ovaries. A growing body of research reveals that the ability to experience sexual desire is associated with the action of this particular hormone. A literature review conducted by Regan and Berscheid (1999) revealed the following conclusions:

- Levels of testosterone are positively correlated with self-reported levels of sexual desire and frequency of sexual thoughts in healthy women. That is, the higher the level of available (free or active) testosterone in a woman's bloodstream, the more sexual desire she reports experiencing and the more often she indicates having sexual thoughts.
- Women who have undergone surgical procedures, such as adrenalectomy (removal of the adrenal glands), resulting in a sudden decrease in their levels of testosterone report decreased feelings of sexual desire.
- Treatment with synthetic steroids that suppress the synthesis of testosterone produces diminished sexual desire. This result has been observed in women who are given androgen antagonists to treat various androgen-dependent hair and skin problems (e.g., acne, alopecia, hirsutism, seborrhea); such treatment often is associated with a reduction in self-reported sexual desire, fantasies, and urges.
- The administration of testosterone (and other androgens) has been noted to result in an increase in the strength and frequency of sexual desire among women complaining of diminished sexual interest and women with androgen deficiency syndrome (an androgen deficiency caused by chemotherapy, hysterectomy [removal of the uterus], or oophorectomy [removal of the ovaries]).

These findings suggest that some minimum level of testosterone is necessary for the experience of sexual desire.

In addition to exploring the action of individual sex hormones on desire, researchers also have investigated the association between desire and female life events and changes that are hormonally mediated, such as the menstrual cycle, pregnancy, and menopause.

The Menstrual Cycle

Most women menstruate, and therefore experience rhythmic fluctuations in the primary sex hormones. One complete menstrual cycle generally ranges from 21 to 35 days in length, although the majority of women menstruate at approximately 28-day intervals (for a review of measurement techniques and phases of the menstrual cycle, see Regan, 1996). Some researchers have noted an association in women between the ovulatory portion of the menstrual cycle and increased sexual desire. The ovulatory phase generally occurs 14 days after the onset of the menses and is characterized by declining estrogen levels, rising progesterone levels, and relatively high amounts of the androgenic hormones. Specifically, a number of women have prospectively and retrospectively reported a significant increase or peak in sexual desire, feelings, fantasies, and dreams during this phase of the cycle (e.g., Adams, Gold, & Burt, 1978; Benedek & Rubenstein, 1939a, 1939b; Cavanagh, 1969; Harvey, 1987; Stanislaw & Rice, 1988).

This pattern is not universal, however. For example, several prospective studies have revealed an association between the mid-follicular phase or first postmenstrual week (characterized by low androgen and progesterone levels and rapidly rising estrogen levels) and peaks in sexual interest and desire (Laessle, Tuschl, Schweiger, & Pirke, 1990; McCullough, 1974; Udry & Morris, 1977; Walker & Bancroft, 1990). Peaks in sexual desire also have been observed to occur during the late luteal period, commonly referred to as the premenstrual period (Chaturvedi & Chandra, 1990; Davis, 1926; Stewart, 1989). This phase of the menstrual cycle is associated with low androgen levels and rapidly falling progesterone and estrogen levels. At least for some women, then, sexual desire is more likely to peak during nonovulatory phases of the menstrual cycle.

The studies cited above all found a single peak in desire, reported by women who experienced only one noticeable heightening or intensification of sexual feelings during the course of each menstrual cycle. Some women, however, experience more than one peak in sexual interest. Interestingly, the majority of those who report two reliable peaks in sexual desire each month also tend to do so during the ovulatory, mid-follicular (first postmenstrual week), or late luteal (premenstrual) phases, providing additional support for the hypothesis that all three of these phases are

likely to be associated with heightened desire and interest (e.g., Alexander, Sherwin, Bancroft, & Davidson, 1990; Davis, 1926; Hart, 1960; Silber, 1994).

Thus, it seems that sexual desire, in general, appears to reach its peak intensity or greatest frequency during certain menstrual cycle phases for some women. The subset of women who experience one single peak in desire tend to do so at ovulation or during the weeks immediately prior to or subsequent to menstruation. Those women who experience more than one peak in desire also tend to do so during those three phases. Other women, however, do not report reliable peaks or fluctuations in their feelings of sexual interest and desire (e.g., Davis, 1926; Hart, 1960). For these women, desire may be high, low, or moderate; whatever the case, this aspect of sexual response appears to progress along on a relatively even keel, untouched by soaring highs or precipitous lows. Consequently, no single rhythmic pattern emerges that can be said to definitively characterize women's sexual experience.

Pregnancy

Pregnancy is a time of sudden and dramatic shift in levels of circulating hormones, particularly progesterone and the estrogens. A number of retrospective, cross-sectional, and prospective investigations indicate that this female life event, with its progressive increase in progesterone, estradiol, and estriol levels, is reliably associated with changes in sexual desire in most women. Reviews of the literature (e.g., Regan & Berscheid, 1999; Regan, Lyle, Otto, & Joshi, 2003) reveal that women in the first trimester of pregnancy, whose relatively stable levels of estrogenic hormones and progesterone undergo a sharp increase toward the end of the trimester, generally report or recall a decline from their prepregnancy levels of sexual desire. This trend continues during the second trimester, a time of enormous elevation in progesterone and estradiol, with most women reporting or recalling less sexual interest than during the first trimester. However, for a small proportion of women, the second trimester is marked by no additional reduction in desire (i.e., sexual interest remains at the lowered first trimester level) or by a return of desire to prepregnancy levels. Retrospectively and prospectively, women experience the greatest decline in sexual interest during the last few months of pregnancy, particularly as delivery draws increasingly near. Hormonally, this trimester is characterized by rising estradiol levels, smaller increases or sometimes decreases in progesterone, and large increases in estriol production.

The general pattern of decreased sexual desire that characterizes pregnancy is at least partially the result of changes in a woman's normal hormonal milieu. However, nonhormonal factors also may play a role. A normal full-term pregnancy is marked not only by increases in progesterone and estrogen, but also by a variety of somatic and psychological

changes that may in themselves significantly alter sexual desire. For example, many women experience nausea, bloating, fatigue, lower backache, breast tenderness, and other physical conditions that can render sexual activities uncomfortable and reduce the desire for sexual contact (e.g., Oga et al., 1995; Zib, Lim, & Walters, 1999). Similarly, mood fluctuations are relatively common throughout pregnancy (Steiner, 1998), and depression, irritability, and other mood disturbances are linked to reduced sexual desire (see Regan & Berscheid, 1999). In addition, although sexual activity during a normal pregnancy generally will not harm the mother or developing child (von Sydow, 1999), some women may hold negative beliefs concerning such activity while pregnant. Indeed, more than half of the women who participated in one early investigation (Falicov, 1973) specifically reported that fear of harming the fetus contributed to their decreased interest in sex throughout the first trimester (also see Bogren, 1991; Lumley, 1978).

Menopause

The term *perimenopause* or *climacteric* refers to a transitional period of declining female reproductive capacity and ovarian function that encompasses the menopause, or final menstrual flow. *Postmenopause* refers to the entire period of life following the final menstrual flow (e.g., Gosden, 1985). The primary hormonal changes associated with perimenopause are decreased total ovarian production of estrogens and the eventual cessation of cyclic estradiol secretion, as well as decreased concentrations of androgens, progesterone, and prolactin (e.g., Benjamin & Seltzer, 1987).

Some research supports an association between menopause and a decline in sexual desire or interest. Women monitored throughout perimenopause, for example, report experiencing significantly fewer sexual thoughts and fantasies than prior to the last menstrual period (e.g., McCoy & Davidson, 1985), and also retrospectively report less desire for intercourse since the menopause (e.g., Channon & Ballinger, 1986). However, the reduction in desire reported by some of these women may be due, at least partially, to the various vaginal changes and symptoms associated with decreased estrogen levels. For example, McCoy and Davidson (1985) found that postmenopausal women who indicated experiencing fewer sexual thoughts or fantasies than they had prior to menopause also suffered more from lack of vaginal lubrication during intercourse. Similarly, women who retrospectively reported a decrease in sexual desire since entering perimenopause (Channon & Ballinger, 1986) also were significantly more likely to suffer from vaginal dryness and experience pain during intercourse. In view of these findings, it is likely that what some peri- and postmenopausal women experience is not a lack of desire for sexual activity per se, but rather a lack of interest

in uncomfortable sexual activity. In addition, other researchers have not found evidence for reduced desire among postmenopausal women (e.g., Cutler, Garcia, & McCoy, 1987; Persky et al., 1982). A prospective, 11-year longitudinal study conducted by Koster and Garde (1993) found no relationship between self-reported sexual desire and menopausal status in a large group of 51-year-old women, suggesting that the capacity for and experience of sexual desire may not be dramatically altered by the onset of ovarian decline.

In sum, it is difficult to know what effect the decrease in estrogens and other sex hormones associated with menopause has on sexual desire; however, most studies seem to suggest that this hormonally mediated life event does not necessarily result in decreased sexual desire.

SEX APPEAL: WHAT PARTNER CHARACTERISTICS DO WOMEN FIND SEXUALLY DESIRABLE?

Although a woman's subjective experience of sexual desire clearly is related, at least in part, to the levels of circulating hormones in her body, hormones alone do not determine whether she will or will not feel sexual interest. A host of other factors also come into play, some of which involve the partner or desired object.

Certain partner attributes appear to incite sexual passion more than others. In particular, research suggests that physical appearance is the attribute most likely to capture a woman's sexual interest (for reviews, see Regan, 2004; Sprecher & Regan, 2000). For example, in one early investigation of sexual desirability or sex appeal, Regan and Berscheid (1995) asked a group of heterosexual female college students to list all the characteristics a man could possess that would cause him to be sexually desirable to women. The single most important desire-causing characteristic, mentioned by 79 percent of women, concerned a physically attractive appearance or various aspects of an attractive physical appearance (e.g., facial appearance, height, muscular build, broad shoulders). Women also specified attributes related to sensitivity (e.g., compassion, gentleness, kindness, caring, and ability to share and discuss feelings; 40%) and a good overall personality (21%). Typical responses included the following:

- We are attracted to a well-built, strong man who is clean and well-groomed—this causes desire as opposed to a man who is super skinny or obese. We want someone who is honest and interested in pleasing us. We desire a man who appreciates us and isn't afraid of our sexual appetites or preferences.
- A great fit body and nice clothes. This doesn't mean that's all I'm looking for, but to be sexually attracted—yes.

- Based on physical characteristics, I would say the way a person looks, such as his face, eyes, lips, and a well-toned body. A man must be caring, kind, and gentle. He must be able to show his feelings and let you know he cares about you. Those qualities are sexually desirable.
- The most important characteristic that would make me sexually interested in someone is the way he looks. It's what I would notice first. I would feel desire for someone who is handsome and also masculine in the way he looks and the way he acts. But not aggressive masculine—gentlemanly masculine, if that makes sense. A guy who is comfortable with himself and who is comfortable with women, who gives off a sense of being honest and able to express his feelings openly.

It is apparent from these responses that although women believed that a number of attributes determine sex appeal, physical attractiveness was considered the most important.

The results of mate preference studies, in which participants rank order or rate a variety of characteristics in terms of importance or desirability in a potential partner, corroborate these findings. For example, when considering their ideal partner, female high school students in Regan and Joshi's (2003) study rated attributes related to physical appearance (e.g., physical attractiveness, sexy appearance) as most sexually desirable, followed by attributes related to sexual drive (e.g., sexually passionate, sexually responsive, high sex drive) and interpersonal skill and responsiveness (e.g., relaxed in social settings, friendly, easygoing, attentive to others' needs). Research conducted with adult heterosexual women (e.g., Regan, 1998a, 1998d; Regan & Berscheid, 1997; Sprecher & Regan, 2002) and adult homosexual women (e.g., Regan, Medina, & Joshi, 2001) reveals a similar preference pattern. In one such investigation (Regan, Levin, Sprecher, Christopher, & Cate, 2000), more than 300 female university students indicated their preferences for a large variety of characteristics. Interpersonal attributes, including expressiveness and openness, a good sense of humor, and friendliness and sociability, were rated as most sexually appealing. Almost equally important were characteristics related to physical appearance—women also desired a partner who possessed high levels of physical attractiveness, athleticism, physical health, and sexy looks. Third in importance were attributes related to intellect and mental drive, such as intelligence, ambition, and education. The least sexually appealing characteristics concerned similarity (on demographic characteristics, attitudes, interests, and hobbies) and social status (e.g., earning potential, material resources).

Although researchers have devoted little attention to the concept of sexual *un*desirability, data collected by Regan and her colleagues (e.g., Alusha & Regan, 2008; Regan & Chapman, 2001) as part of an ongoing

exploration of sexual desire substantiates the association between physical attractiveness and sex appeal. These researchers asked 450 heterosexual women to list or describe in a free-response format all the characteristics that would render a man sexually undesirable or repellant. Although women considered a variety of characteristics to be sexually unappealing (including poor hygiene and undesirable personality traits), the most commonly cited attribute category concerned physical appearance (79% mentioned appearance variables, ranging from general overall unattractiveness to specific facial or morphological features). Examples of participants' responses include:

- I would be turned off by someone who has no sense of humor, who is unathletic and fat, who isn't spontaneous about the sex, who doesn't take care of himself (no shower, bad breath, etc.), who is stuck on himself. I don't want an uptight, conservative, old, smelly, short man with no aspirations or dreams.
- I don't want my sexual partner to be unattractive, to be fat, to have bad hygiene habits, and to be shorter than myself.... He can't be an idiot.... No man with a boring personality. If he's inexperienced with sex, no. Also, no mood swings or severe emotional disturbance.
- Physically, size is incredibly important. First off, he can't be shorter than I am. Anyone who's straight shaped or pear shaped won't get my attention. I like a nice triangular upper body, well-muscled but lean (not overly developed like those body builders).... If he is inarticulate to the point where he can't hold a conversation with me, there is no way I'll take him to bed. If he can't kiss, it's over. If he's married or committed to somebody, it doesn't start. Pimples or acne scars aren't very appealing. If he doesn't shower on a regular basis, I don't want to get close enough to smell him. Bad teeth are a definite strike, as are unproportionately large noses.

In sum, most women—whether younger or older, heterosexual or homosexual—consider an attractive physical appearance, a sexually passionate nature, a kind disposition and good overall personality, and a relaxed and responsive interpersonal style to be particularly sexually appealing.

WHAT ROLE DOES SEXUAL DESIRE PLAY IN ROMANTIC RELATIONSHIPS?

Sexual desire plays a key role in the process of romantic attraction and relationship development (Regan, 2004). For example, a woman who finds herself sexually attracted to another person may be more likely to initiate interpersonal contact with that other (or respond positively to his or her

overtures), thus leading to the beginning of a romantic relationship. She may even be more likely to fall in love with that person.

Relationship scholars have long argued that intense sexual desire is associated with, and can produce or heighten, feelings of passionate love (see Berscheid, 1988; Ellis, 1954; Lewis, 1960/1988; Regan, 1998c; Tennov, 1979), and a growing body of empirical research substantiates this theoretical supposition. When Ridge and Berscheid (1989) asked a sample of undergraduates whether they thought that there was a difference between the experience of being in love with and that of loving another person, almost all (87%) of their participants, both female and male, emphatically claimed that there indeed was a difference between the two experiences. When asked to specify the nature of that difference, sexual desire was listed as a key distinguishing feature (i.e., participants were much more likely to cite sexual desire as descriptive of the in love than of the loving experience).

Similar results were reported by Regan, Kocan, and Whitlock (1998). These researchers asked a sample of men and women to list in a free-response format all the features that they considered to be characteristic or prototypical of the state of being in love. Out of the 119 spontaneously generated features, *sexual desire* received the second highest frequency rating, cited by 66% (*trust* was the most frequently cited feature, mentioned by 80% of respondents). In other words, when thinking of passionate love, most women (and men) automatically thought of sexual desire. In addition, this feature was viewed as more important to the passionate love concept than behavioral sexual events, including *caresses* (cited by only 1.7% of participants), *kissing* (cited by 10%), and *sexual activity* (cited by 25%).

Two person perception experiments provide support for these prototype study results. [Person perception experiments are commonly used in social psychological research and essentially involve manipulating people's perceptions of a relationship and then measuring the impact of that manipulation on their subsequent evaluations and beliefs.] In the first experiment, Regan (1998b) provided a sample of undergraduates with two self-report questionnaires ostensibly completed by Rob and Nancy, a student couple enrolled at the same university. This couple reported that they experienced either no sexual desire for each other or a high amount of sexual desire for each other, and that they either were currently engaging in sexual intercourse with each other or were not sexually active. Participants then estimated the likelihood that the partners experienced passionate love as well as a variety of other relationship phenomena. The results revealed that women and men believed that dating partners who desire each other sexually are more likely to be in love with one another (as well as more likely to experience a variety of other positive relationship events, such as happiness, satisfaction, trust, and commitment) than dating partners who do not desire each other sexually, regardless of their current level of sexual activity.

The second experiment, a conceptual replication of the first, confirmed these results. Here, participants received information about a heterosexual dating student couple who ostensibly reported that they were currently passionately in love with each other, or that they loved each other, or that they liked each other. Participants then estimated the likelihood that the members of the couple experience sexual desire for each other and the amount of desire they feel for each other. Analyses revealed that women and men perceived partners who were characterized as being passionately in love as more *likely* to experience sexual desire than partners who loved each other or who liked each other. Similarly, partners who were passionately in love were believed to experience a greater *amount* of sexual desire for each other than partners who loved each other or who liked each other. Interestingly, sexual desire was believed to be no more likely in a loving relationship than in a liking relationship, and greater amounts of sexual desire were not believed to occur in loving relationships than liking relationships. Again, it seems that women (and men) view sexual desire as an important feature of passionate love relationships and not of relationships characterized by feelings of love and/or liking.

Although few researchers have directly examined the association between sexual desire and passionate love in ongoing romantic relationships, some evidence suggests that the two experiences co-occur and, in fact, are strongly connected. For example, during the process of scale validation, Hatfield and Sprecher (1986) administered their Passionate Love Scale (PLS) and a battery of other measures to students involved in romantic (e.g., dating, cohabiting) relationships. These researchers found that PLS scores for both men and women were significantly positively correlated with several measures of current desire for sexual and/or physical interaction with the partner (including self-reported desire to be held by the partner, to kiss the partner, and to engage in sex with the partner). In other words, women (and men) who are very passionately in love also tend to experience higher levels of sexual desire for their partners than do women (and men) who are less passionately in love.

Research conducted by Berscheid and Meyers (1996) also provides evidence for the association between desire and passionate love. Using what they termed a "social categorical method," these researchers asked a large sample of undergraduate women and men to list the initials of all the people they currently loved, the initials of all those with whom they were currently in love, and the initials of all those toward whom they currently felt sexual attraction or desire. For each respondent, the researchers calculated the probability that persons named in the sexually desire category also were named in the in love and love categories. These sets of probabilities then were averaged across respondents, and the results indicated that 85 percent of the persons listed in the in love category also were listed in the sexually desire category, whereas only 2 percent of those listed in the

love category (and not cross-listed in the in love category) were listed in the sexually desire category. Thus, the objects of participants' feelings of passionate love (but not their feelings of love) also tended to be the objects of their lust.

More recently, Regan (2000) asked a sample of men and women currently involved in dating relationships to indicate the amount of sexual desire, passionate love (further defined as the state of being in love with the partner), liking, love, and a host of other experiences they currently experienced in their relationships. Not surprisingly, the results revealed that sexual desire and passionate love were positively correlated (i.e., the more participants desired their dating partners sexually, the more they reported being in love with those partners). Similar associations were not found between sexual desire and liking, or between sexual desire and loving. Thus, in accord with earlier research, feelings of sexual desire appear intimately linked with the experience of passionate love. Moreover, in addition to experiencing significantly greater amounts of passionate love, participants who reported higher amounts of sexual desire for their partners were more satisfied with the relationship, were less likely to think about ending the relationship, and were less likely to consider beginning a relationship with a new partner than participants who felt lower amounts of desire. For women, feelings of desire were also negatively correlated with sexual attraction to other individuals (i.e., the more a woman desired her partner, the less likely she was to report being sexually attracted to other men).

This set of empirical findings suggests that sexual desire has implications for the emotional tenor and the interpersonal dynamics of romantic relationships. Women believe that sexual desire is part and parcel of the being in love experience and that relationships with high levels of sexual attraction between the partners are healthier (i.e., contain higher levels of interpersonal trust, satisfaction, happiness, and commitment) than less desire-filled relationships. And women who are sexually attracted to their current partners are, in fact, more likely to report feelings of passionate love for those partners as well as a host of other positive relationship outcomes (such as satisfaction) and less likely to report potentially destructive experiences (such as thoughts of relationship termination and feelings of sexual attraction toward other individuals).

Of course, it is important to recognize that sexual desire, though generally present in high levels initially in many romantic relationships and certainly indicative of feelings of passionate love, satisfaction, and so forth, may not remain at those same high levels throughout a couple's entire relationship. Over time, partners commonly experience decreased sexual desire for each other. Because the ability to experience sexually passionate feelings is associated with the partners' health, age, hormonal variations, and other factors (including the loss of novelty that occurs as partners

become habituated to each other), a reduction in their sexual desire is to some extent inevitable (see Regan & Berscheid, 1999). This is particularly the case for women, who—as we have discussed—experience dramatic hormonal fluctuations across the menstrual cycle and in association with other life events (such as pregnancy and menopause), and who consequently are particularly prone to alterations in their frequency and intensity of desire. Changes or reductions in desire, thus, do not necessarily imply that a relationship is dysfunctional or that a woman is dissatisfied and has fallen out of love with her partner.

Sometimes, however, a reduction in sexual interest (particularly if it occurs suddenly and/or is sustained for a long period of time) may signal a relationship problem. Many clinicians and health professionals believe that sexual desire is strongly influenced by the emotions experienced within a relationship and/or directed toward a partner (e.g., Maurice, 2007; McCarthy, Ginsberg, & Fucito, 2006; Pietropinto, 1986). Indeed, a growing number of clinical case studies illustrate the corrosive impact of anger, hostility, anxiety, stress, and other emotions on sexual desire. For example, based on her pioneering case studies of men and women with sexual desire disorders, Kaplan (e.g., 1979, 1996) concluded that fears of rejection by the partner, poor communication, and power conflicts frequently produce anxiety and anger, which appear to rapidly and automatically activate an emotional turn off mechanism that suppresses sexual desire. Similarly, other scholars (e.g., Arnett, Prosen, & Toews, 1986; Trudel, 1991) have observed that negative affect stemming from interpersonal conflict may elicit a stress response that causes diminished sexual desire.

Empirical research with clinical samples supports the prediction that diminished sexual desire may signal the existence of difficulties in a couple's relationship (e.g., Dennerstein, Koochaki, Barton, & Graziottin, 2006). In one early investigation, Stuart, Hammond, and Pett (1987) administered a marital adjustment scale to a sample of married women who were diagnosed with inhibited sexual desire (ISD), married women who reported normal sexual desire, and the spouses of women in both groups. The women in the ISD group had significantly lower marital adjustment scores than did women in the non-ISD group. Moreover, the spouses of women in the ISD group also reported significantly lower overall adjustment in their marriages than did the spouses of women in the non-ISD group.

Studies conducted with nonclinical samples confirm that relationship quality is associated with sexual interest in the partner. For example, Hällström and Samuelsson (1990) conducted a longitudinal study in which they asked a large sample of married or cohabiting women to indicate (on two occasions, six years apart) their present degree of sexual desire (i.e., whether they perceived it as strong, moderate, weak, or absent) and to report whether they received sufficient emotional support from their partner (yes/no) and had a confiding relationship with him (yes/no). The

researchers found that a perceived lack of a confiding relationship with, and insufficient support from, the partner at the first assessment predicted a decrease in self-reported sexual desire over time. Similar results were reported more recently by Brezsnyak and Whisman (2004), who surveyed a sample of married couples and found that the amount of sexual desire that wives (and husbands) experienced for each other was strongly positively correlated with their level of relationship satisfaction (also see Davies, Katz, & Jackson, 1999).

In sum, clinical case studies and empirical research suggest that sexual desire may function as a thermometer to relationship quality. When sexual interest is present at a high and/or steady level, women (and their partners) are likely to experience love, satisfaction, and other positive outcomes; when interest drops suddenly or precipitously, there may be an underlying interpersonal reason. Unfortunately, there is no easy cure for diminished sexual desire. However, recent clinical outcome studies suggest that the most effective therapeutic treatments are those that conceptualize sexual disinterest as a couple issue rather than as a female or (male) problem, and that consequently incorporate techniques that involve both partners (such as communication skills training and sexual intimacy exercises; for a review, see Ullery, Millner, & Willingham, 2002). Although sexual disinterest is not necessarily a sign that a romantic relationship is in trouble, the interpersonal context clearly plays an important role in creating and sustaining sexual attraction between partners.

SUMMARY

Sexual desire is one of the most pervasive sexual responses that women experience during adolescence and throughout adulthood. Almost all women report having felt desire by the time they reach their college years, and most experience it with some regularity (ranging from one to eight times a week, on average, according to the available studies). Many factors are associated with female sexual desire, including demographic attributes (e.g., chronological age), mental and physical health variables (e.g., chronic illness, mood disorders), and hormonal processes and hormonally mediated life events (e.g., menstrual cycle, pregnancy). In addition, researchers have identified a number of specific partner characteristics that are likely to incite (e.g., physical attractiveness, interpersonal skill, and responsiveness) or dampen (e.g., physical unattractiveness, poor hygiene) a woman's sexual interest. Sexual desire, more than any other sexual response, is associated with the experience of passionate love and may promote the early stages of romantic attraction and relationship development. Women believe that sexual attraction is an important component of passionate love, and the level of sexual desire that women feel for their romantic partners not only predicts their degree of passionate love, but also their satisfaction

with the partner and their desire to maintain the relationship. Although reductions in sexual passion are not uncommon in most romantic relationships, sudden or sharp decreases may signal the development of an underlying interpersonal problem or issue; to some extent, then, sexual desire functions as a thermometer to overall relationship function. In sum, sexual desire has profound implications for the quality of a woman's life.

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Chapter 2

Sexual Satisfaction in Heterosexual Women

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Sexual satisfaction refers to an individual's subjective evaluation of their sexuality. Not only is sexual satisfaction a key aspect of sexual well-being and sexual health (Laumann et al., 2006; World Health Organization [WHO], 2006), there is robust, converging evidence that supports the relevance and importance of sexual satisfaction to overall well-being (e.g., Laumann et al., 2006). In addition, both cross-sectional and longitudinal data suggest that the quality of a couple's sexual relationship is important for their concurrent and future levels of relationship satisfaction, as well as for their relationship stability (Christopher & Sprecher, 2000; Karney & Bradbury, 1995).

In almost all cultures, men's sexual satisfaction is valued. The same has not been true for women's sexual satisfaction, historically. In many cultures, there continue to be strong taboos surrounding female sexuality, and in such cultural contexts, sexual satisfaction is viewed exclusively as a male prerogative. In contrast, the current mainstream sociosexual landscape of the Western world sanctions and legitimizes the pursuit of sexual satisfaction for both men and women; that is, social norms explicitly and

implicitly acknowledge that it is important that both men and women are satisfied with their sexual lives (see review by Schwartz & Young, 2009). In fact, mainstream social norms have shifted so much that sexuality is linked with the competent enactment of both masculine and feminine roles (Tiefer, 2001).

Studies with nonclinical samples of individuals in dating and long-term relationships demonstrate that most women in North America report high satisfaction with their sexual relationship (Byers, Demmons, & Lawrance, 1998; Lawrance & Byers, 1995; MacNeil & Byers, 2005, 2009). Nonetheless, there is variability in women's (and men's) levels of sexual satisfaction, such that some women do not experience their sexual relationship as satisfying. Therefore, the goal of this chapter is to examine individual and interpersonal factors that contribute to women's sexual satisfaction. A comprehensive understanding of these factors is valuable at many levels. It can inform us of risk factors for experiencing lower levels of sexual satisfaction. It also can help us delineate the mechanisms by which these risk factors translate into lower sexual satisfaction. Ultimately, this knowledge can help us develop education, prevention, and intervention programs aimed at enhancing women's sexual satisfaction. Because there has been very limited research investigating predictors of sexual satisfaction in sexual minority women, we limit our review to factors that predict sexual satisfaction in heterosexual women. It is unclear whether these findings also apply to women in same-sex relationships and, as we note in the final section of this chapter, this gap in the literature needs to be bridged in future studies.

Life events and biological factors, such as hormones, pregnancy, childbirth, and lactation, influence women's sexual satisfaction. Similarly, social and cultural factors that define cultural and subcultural norms regarding interpersonal violence and women's roles affect women's experiences of their sexuality (Kaschak & Tiefer, 2001). However, a discussion of biological and sociological factors is beyond the scope of this chapter and we have focused on psychological variables.

DEFINING SEXUAL SATISFACTION

Too often, research on sexual satisfaction has been devoid of a conceptual definition. In this chapter, we distinguish sexual (dis)satisfaction from sexual problems or difficulties. Individuals who report low sexual satisfaction are more likely to report problems related to their sexual response (Dunn, Croft, & Hackett, 2000; MacNeil & Byers, 1997). However, some women report low sexual satisfaction even though they do not have problems related to sexual desire, arousal, or orgasm. Conversely, some women experience a sexual problem or dysfunction, but still report high sexual satisfaction. Thus, health and wellness in general, and sexual well-

being and satisfaction in particular, are not simply the absence of disease, symptoms, or dysfunction, just as happiness is not the lack of depression (WHO, 2006).

Our conceptualization of sexual satisfaction is informed by the work of Lawrance and Byers (1995), who define sexual satisfaction as "an affective response arising from one's subjective evaluation of the positive and negative dimensions associated with one's sexual relationship" (p. 514). There are a number of advantages to this definition. First, it includes both positive and negative dimensions of sexual functioning. Second, it is based on a subjective, rather than objective, evaluation of one's sexual relationship. Third, this definition conceptualizes sexual satisfaction as a global sentiment, rather than as an evaluation of a specific aspect of one's sexual relationship, such as satisfaction with the frequency of sexual activity or satisfaction with consistency of orgasm. A woman's satisfaction with these specific aspects of sexual activity may affect her overall sexual satisfaction; but, as we will see, there are a number of other individual, dyadic, and cultural factors that may also affect her sexual satisfaction.

Lawrance and Byers' (1995) definition of sexual satisfaction also highlights the interpersonal or relational context in which sexual activity occurs (i.e., satisfaction with the sexual relationship). Thus, in this chapter, we distinguish the construct of sexual satisfaction from an individual's evaluation of sexual activity that does not involve another person, such as masturbation. An important implication of defining sexual satisfaction as an individual experience that occurs in a dyadic context is that this recognizes that an individual's sexual satisfaction is influenced by his or her partner's levels of satisfaction as well as by other partner and relationship characteristics.

THE INTERPERSONAL EXCHANGE MODEL OF SEXUAL SATISFACTION

Most research on sexual satisfaction has proceeded atheoretically, making it difficult to arrive at a comprehensive understanding of factors that affect sexual satisfaction. However, more recently, Lawrance and Byers (1992, 1995) developed the Interpersonal Exchange Model of Sexual Satisfaction (IEMSS), a social exchange model, as a framework for understanding sexual satisfaction within relationships (Byers & Wang, 2004; Lawrance & Byers, 1995; Sprecher, 1998). The IEMSS proposes that individuals are more sexually satisfied if: (a) they experience a more favorable balance of sexual rewards and costs in their relationship (i.e., if they experienced high sexual rewards and low sexual costs); (b) this balance compares favorably to their expectations; (c) they perceive that their own and their partner's levels of sexual rewards and costs are approximately equal; and (d) they are more satisfied with the nonsexual aspects of the

relationship. According to Thibaut and Kelley (1959), sexual rewards are exchanges between partners that are gratifying and pleasing to the individual, and sexual costs are exchanges between partners that demand physical or mental effort or cause pain, embarrassment, anxiety, or other negative affect. Thus, individuals differ in the extent to which they find particular sexual exchanges (e.g., oral sex, amount of affection expressed during sex, how easily they or their partner reach orgasm) rewarding or costly. Thus, the IEMSS incorporates both individual- and dyadic-level factors. In a series of studies, Byers and colleagues have demonstrated the validity of the IEMSS (i.e., support for these predictions) for individuals in both dating and long-term relationships in Canada and China (Byers et al., 1998; Byers & MacNeil, 2006; Lawrance & Byers, 1995; Renaud, Byers, & Pan, 1997). Furthermore, in these studies, the model accounted for a large percentage of the variance in sexual satisfaction (between 58% and 79%).

The IEMSS explicitly takes into account the interpersonal context of sexuality and emphasizes the role of both nonsexual aspects of the relationship and sexual exchanges in determining sexual satisfaction. Indeed, Byers (1999, 2011) noted that data demonstrating the relevance and unique contribution of nonsexual relationship factors, such as relationship satisfaction, to sexual satisfaction led her and Lawrance to include nonsexual aspects of the relationship as one of the key determinants of sexual satisfaction.

We begin our discussion of factors leading to sexual satisfaction by examining demographic and individual factors, followed by a discussion of nonsexual and sexual dyadic factors. A better understanding of which demographic and individual factors are associated with lower levels of sexual satisfaction can help us identify high-risk groups or characteristics that might place an individual at risk for experiencing low sexual satisfaction.

DEMOGRAPHIC FACTORS

In general, most demographic variables have not been shown to be associated with sexual satisfaction. This includes race (Henderson-King & Veroff, 1994; Tomic et al., 2006), education (Tomic et al., 2006; Træen, 2010), income level, and employment status (Tomic et al., 2006). However, there is evidence that women's sexual satisfaction decreases with age (Call, Sprecher, & Schwartz, 1995; Laumann et al., 2006; MacNeil & Byers, 1997) and that married women report higher levels of emotional sexual satisfaction than women who are single or cohabiting (Laumann et al., 1994).

Researchers have proposed and, in some cases, tested possible mechanisms to explain the associations between age and relationship status and women's sexual satisfaction. With regard to age, two mutually nonexclusive mechanisms have been examined. It is possible that increased health

problems that occur with advancing age explain declines in women's sexual satisfaction (Laumann et al., 2006). It is also possible that habituation with one's partner (i.e., getting used to and, consequently, becoming less interested in sex with one's partner through repeated experience) contributes to a decline in sexual satisfaction over time (Klusmann, 2002). However, more research is needed before we can draw definitive conclusion about mechanisms to explain the age-related changes in sexual satisfaction.

With regard to relationship status, married women's higher levels of sexual satisfaction than women in other relationship types may be explained by the higher levels of commitment implied by a marital relationship (Waite & Joyner, 2001); that is, the factors that underlie the link between relationship type and women's sexual satisfaction are likely to be relational. These are reviewed in a later section.

INDIVIDUAL FACTORS

Personality Characteristics and Affective Tendencies

Researchers have examined whether certain personality characteristics and affective tendencies predict women's sexual satisfaction. One of the most studied personality variables is the tendency to experience negative emotions, often termed neuroticism (Costa & McCrae, 1992). Research suggests that women higher in neuroticism are less sexually satisfied, although the strength of this association tends to be small (Donnellan, Conger, & Bryant, 2004; Fisher & McNulty, 2008). In addition, there is a small negative association between women's sexual satisfaction and their husband's level of neuroticism (Donnellan et al., 2004). Affective tendencies that are theoretically and empirically related to neuroticism also tend to have small to moderate negative associations with women's sexual satisfaction. These include trait and state anger (Bélanger, Laughrea, & Lafontaine, 2001), anxiety symptoms (van Minnen & Kampman, 2000), and depressive symptoms (van Minnen & Kampman, 2000). Given the considerable construct overlap between the variables discussed in this section, research is needed that considers these factors together. This will clarify whether there is a common factor or set of factors that emerge from these variables as well as the unique contributions of each variable.

Attachment style is another characteristic that has been found to be associated with women's sexual satisfaction. Attachment styles develop in infancy but carry over into adult relationships, particularly romantic relationships (Shaver & Mikulincer, 2006). There are two broad categories of attachment styles: secure and insecure. Individuals with a secure attachment style tend to trust and rely on their partners for support, and individuals with an insecure attachment style tend to experience anxiety

and/or avoid intimacy in their relationships. More specifically, insecure individuals high in attachment anxiety tend to worry that their romantic partners will not be sufficiently available to them and fear being rejected. Insecure individuals high in attachment avoidance tend to distrust their partners and try to maintain independence from them. Generally, women with insecure attachment styles report lower sexual satisfaction (e.g., Davis et al., 2006). For example, Davis and colleagues (2006) found that both anxious and avoidant insecure attachment tendencies were associated with lower emotional and physical sexual satisfaction and satisfaction with control over sexual aspects of the relationship.

Erotophilia/erotophobia is the tendency to respond to sexual stimuli with either positive or negative affect (Fisher, Byrne, White, & Kelley, 1988). Not surprisingly, women who are more erotophilic (i.e., who tend to respond more positively to sexual stimuli) report higher levels of sexual satisfaction, and the relationship between these variables was strong (Hurlbert, Apt, & Rabehl, 1993).

Cognitions

Researchers have investigated the link between a number of cognitions and sexual satisfaction. Several studies have found that young women's perceptions about their bodies (i.e., body image) are moderately related to their sexual satisfaction. Specifically, young women with more positive attitudes and feelings about their bodies (i.e., more positive body image) report greater sexual satisfaction (Pujols et al., 2010). This is not due to actual differences in body size, because body image has been shown to be related to sexual well-being even after controlling for body size (Pujols et al., 2010; Weaver & Byers, 2006). However, other studies, including two studies using samples of older women (aged 38–58 and 40–70), have not found such an association, suggesting that body image may be more relevant to younger women's sexual satisfaction (Dundon & Rellini, 2010; Weaver & Byers, 2006).

Possible Mechanisms

Researchers have speculated on possible mechanisms that might explain the link between neuroticism, insecure attachment, affective tendencies, and lower sexual satisfaction. First, an individual's cognitions may explain some of the associations between personality variables and sexual satisfaction. Fisher and McNulty (2008) speculated that people higher in neuroticism tend to have more negative cognitions, and that these cognitions may, in turn, color their perceptions of their sexual experiences. Similarly, it is likely that individuals who are less securely attached would experience more negative thoughts about their relationship and

that individuals who have poorer body image would experience negative thoughts about sexual activity. Indeed, Pujols and colleagues (2010) have shown that women who experience more frequent distracting and nonerotic thoughts related to body image during sex report lower sexual satisfaction. This suggests that negative affect results in cognitions that distract women from focusing on the sexual activity and sexual pleasure, lowering sexual satisfaction.

Another proposed mechanism to account for these relationships is couple communication. For example, Fisher and McNulty (2008) speculated that neuroticism may affect sexual satisfaction by influencing the nature of couples' discussions. In support of this view, they found that the negativity of couples' discussions partially accounted for the association between wives' neuroticism and the couples' sexual satisfaction. Along the same lines, Davis and colleagues (2006) found that individuals who were more insecurely attached were more inhibited in communicating their sexual needs to their partners, which in turn was associated with lower physical satisfaction and lower satisfaction with control over sexual aspects of the relationship (although not with emotional satisfaction). It is likely that erotophobic individuals also would have more difficulty communicating their sexual likes and dislikes than do individuals who respond more positively to sexual cues.

Overall, these results suggest that one way in which individual difference variables affect sexual satisfaction is by influencing communication in general and sexual self-disclosure in particular. Accordingly, the remainder of this chapter focuses on an interpersonal model of sexual satisfaction, reviewing the role of dyadic factors in sexual satisfaction, and outlining directions for future work that emphasize the central importance of interpersonal factors to women's sexual satisfaction.

DYADIC FACTORS

Nonsexual Dyadic Factors Affecting Sexual Satisfaction

Two nonsexual dyadic factors have been identified as important to sexual satisfaction: relationship satisfaction and nonsexual communication.

Relationship Satisfaction

There is converging evidence from different populations and research groups demonstrating that there is a strong association between sexual satisfaction and relationship satisfaction (e.g., Byers, 2001; Byers & Demmons, 1999; Cupach & Comstock, 1990; Kisler & Christopher, 2008; Lawrance & Byers, 1995); that is, individuals who are more satisfied with the nonsexual aspects of their relationship are also more satisfied with the

sexual aspects and vice versa. Because these findings are based on correlational results, they do not indicate the direction of the relationship. The IEMSS proposes that high relationship satisfaction results in high sexual satisfaction. However, other researchers have proposed the converse (i.e., high sexual satisfaction results in high relationship satisfaction; Kisler & Christopher, 2008). A third possibility is that the relationship is bidirectional.

Henderson-King and Veroff (1994) conducted a two-year longitudinal study with newly married couples and found support for the bidirectional hypothesis. However, the data analytic strategy used in this study did not control for the association between sexual and relationship satisfaction at Time 1, calling into question the validity of their findings (Byers, 2005). Using a sample of dating couples, Sprecher (2002) found evidence that earlier relationship satisfaction results in later sexual satisfaction but not vice versa. In contrast, Yeh and colleagues (2006) found that higher levels of sexual satisfaction predicted increased levels of relationship satisfaction for both married men and women over five time periods, suggesting a causal relationship from initial sexual satisfaction to subsequent relationship satisfaction. In contrast, earlier relationship satisfaction did not predict later sexual satisfaction. Finally, using a sample of community participants in long-term relationships, Byers (2005) found that although changes in relationship and sexual satisfaction occurred concurrently, there was limited evidence that higher relationship satisfaction leads to high sexual satisfaction or vice versa. However, she did find some preliminary evidence that the two variables are causally linked for specific groups of participants (i.e., participants whose relationship satisfaction is decreasing and those whose sexual satisfaction is increasing). These results, and the inconsistencies in the findings in various studies, suggest that the association between relationship and sexual satisfaction is complex, perhaps varying for individuals in different situations. Nonetheless, there is little doubt that, for at least some individuals, low and/or decreasing relationship satisfaction results in low sexual satisfaction. Because these studies all used community or university samples, most participants were likely relationally and sexually satisfied. Future research is needed that includes individuals who are dissatisfied with the sexual or nonsexual aspects of their relationship to fully explore the causal relationship between sexual and nonsexual satisfaction.

General Relationship Communication

The quality of communication between romantic partners is a central focus of many influential models of relationship functioning. For example, behavioral models posit couples' communication as a key mechanism leading to relationship satisfaction and stability (Karney & Bradbury,

1995). In addition, couples themselves cite communication difficulties as one of the primary reasons for seeking therapy for relationship problems (Doss, Simpson, & Christensen, 2004). Indeed, Chesney, Blakeney, Cole, and Chan (1981) found that couples seeking therapy endorsed poorer nonsexual relationship communication than did couples not seeking therapy, in addition to poorer sexual communication. Several researchers have found that more positive verbal communication is associated with greater sexual satisfaction in both dating and long-term relationships (Byers & Demmons, 1999; MacNeil & Byers, 2005, 2009).

Communication can vary in the extent to which it conveys positive and negative feelings, contains positive or negative messages, is unassertive, assertive or aggressive, and self-discloses personal information. There is little research on the extent to which each of these aspects of communication is associated with sexual satisfaction. However, Byers and her colleagues (Byers & Demmons, 1999; MacNeil & Byers, 2005, 2009) have demonstrated that individuals who self-disclose more personal nonsexual information (e.g., values, political views) to their partner report higher sexual satisfaction. Furthermore, they found that nonsexual self-disclosure contributed to sexual satisfaction over and above the contribution of sexual self-disclosure. Research is needed on the extent to which other types of communication are associated with sexual satisfaction.

Sexual Dyadic Factors Affecting Sexual Satisfaction

According to the IEMSS, the balance of sexual rewards to sexual costs affects sexual satisfaction, such that individuals with higher sexual rewards and low sexual costs are more sexually satisfied. Sexual communication is an important mechanism by which couples negotiate a mutually pleasurable sexual script; that is, a sexual script that results in high sexual rewards and low sexual costs for both partners. Below, we consider the roles of sexual exchanges and sexual communication in affecting sexual satisfaction.

Sexual Exchanges

In a series of studies, Byers and her colleagues demonstrated support for the proposition that a more favorable balance of sexual rewards to sexual costs is associated with higher sexual satisfaction for men and women in both dating and long-term relationships (Byers et al., 1998; Byers & MacNeil, 2006; Lawrance & Byers, 1995; Renaud et al., 1997). They also demonstrated that there is a wide range of sexual exchanges that people find rewarding and/or costly. For example, in their study of long-term couples they found that, on average, the men endorsed 28 sexual rewards and 11 sexual costs and the women reported 27 rewards and 11 costs (Lawrance

& Byers, 1995); that is, both the men and women found their sexual relationship to be more rewarding than costly. For the most part, there was no significant difference in the percentage of men and women who indicated that each sexual exchange was a reward and/or a cost. However, women were more likely than men to report rewards reflecting emotional relational qualities of the sexual relationship. They were also more likely to report costs reflecting physical and behavioral aspects of sexual interactions. These researchers also have shown that women's expectations about how rewarding and costly their sexual relationship should be affects their sexual satisfaction over and above the actual sexual rewards and costs they experience.

An individual's own experience during sexual activity affects their sexual satisfaction (Lawrance & Byers, 1995). However, research on the IEMSS has demonstrated that the partner's experience during sexual activity also affects the individual's sexual satisfaction. For example, Byers and MacNeil (2006) found that, for both men and women, the partner's evaluation of his or her own sexual experience affected the individual's sexual satisfaction, even after accounting for the individual's own sexual experience. In addition, in several studies, Byers and her colleagues have shown that the more individuals perceive that their own and their partner's rewards and costs are equal, the more sexually satisfied they are (Byers et al., 1998; Byers & MacNeil, 2006; Lawrance & Byers, 1995; Renaud et al., 1997). This, again, underscores the importance of dyadic factors to sexual satisfaction.

Within the IEMSS framework, both sexual communication and sexual frequency are conceptualized as specific sexual exchanges. Because there has been considerable research on these two exchanges, we turn to these next.

Frequency of Sexual Activity

Many studies have demonstrated that women (in both heterosexual and same-sex relationships) who engage in sexual activity more frequently report greater sexual satisfaction (e.g., Christopher & Sprecher, 2000; Farr, Forssell, & Patterson, 2010; Henderson, Lehavot, & Simoni, 2009; Yucel & Gassanov, 2010). Yucel and Gassanov (2010) speculated that there is a bidirectional relationship between sexual frequency and satisfaction. Specifically, they argued that couples who are not satisfied with their sexual relationship may consequently have sex less often; conversely, couples who have sex infrequently may feel less sexually satisfied as a result. However, Fahs and Swank (2011) found that most women in their study experienced a mismatch between their sexual satisfaction and sexual frequency (i.e., report high frequency and low satisfaction or, more commonly, low frequency and high satisfaction).

It is particularly interesting to consider sexual frequency when examining models of sexual satisfaction, because couples' frequency of sexual activity has been shown to decrease over time, without corresponding changes in sexual satisfaction (see review by Christopher & Sprecher, 2000). One possible explanation for this finding is that couples expect the frequency of sexual activity in their relationships to decrease over time, and thus are not disappointed or dissatisfied when such changes occur as long as other aspects of the relationship remain positive. Another possibility is that sexual quality has a larger impact on sexual satisfaction in long-term relationships than sexual frequency, and sexual quality remains high for most couples (Lawrance & Byers, 1995; MacNeil & Byers, 2009).

Sexual Communication

In general, researchers have documented that better sexual communication is associated with higher sexual satisfaction (e.g., Byers & Demmons, 1999; MacNeil & Byers, 1997, 2005, 2009; Purnine & Carey, 1997). According to Metts and Cupach (1990), there are two pathways by which good sexual communication results in higher sexual satisfaction. On the one hand, as a sexual exchange, sexual self-disclosure can enhance positive affect in the relationship, such as feelings of relationship closeness and intimacy, thereby resulting in higher sexual satisfaction. On the other hand, sexual self-disclosure allows partners to negotiate a mutually pleasurable sexual script; that is, by discussing and negotiating sexual preferences and desires, couples can enhance sexual rewards and minimize sexual costs which, in turn, increase sexual satisfaction. This instrumental role of sexual self-disclosure and sexual communication is important because it is inevitable that a couple will face goal incompatibilities in their sexual relationship. Even for couples who match on their levels of sexual desire, it is likely that there will be differences between partners with respect to other aspects of their sex life, such as preferred timing and length of sex and sexual activities. A series of studies conducted by Byers and colleagues have found support for these two pathways in which sexual communication enhances sexual satisfaction (Byers & Demmons, 1999; MacNeil & Byers, 1997, 2005). However, it is important to note that the opposite causal pathway is also very plausible, although this has not been investigated empirically. A positive and satisfying sexual relationship may create an interpersonal context that allows a woman to feel that she can be sexually assertive, self-disclose, be open to her partner's view of sexual problems, and so forth. It is also possible that the mechanisms by which sexual communication leads to sexual satisfaction change over time. For example, it may be that in the early stages of the relationship, sexual self-disclosure plays a significant role in facilitating the development of a sexual script that is satisfying and enjoyable to both partners. At later

stages of a relationship, the quality of sexual communication may exert its influence on sexual satisfaction by enhancing intimacy and closeness.

Despite the importance of sexual communication to sexual satisfaction, it is difficult for many couples to discuss their sexual relationship (Sanford, 2003). Based on their clinical experience, Metts and Cupach (1990) identified a number of barriers to sexual communication, including: (a) concerns that these discussions might identify discrepant sexual desires or preferences between partners which, in turn, could threaten the relationship; (b) beliefs that talking about sex is immoral; (c) feelings of embarrassment, shame, or guilt; (d) worries about partner response (e.g., "Will my partner be angry or upset if I bring up a sexual issue?"); (e) assumptions that it should not be necessary to discuss sex within the context of an intimate relationship; (f) beliefs that emotional intimacy, not sexual intimacy, leads to closeness with one's partner; and, (g) feelings of inadequacy due to lack of experience or perceived skill discussing sexual issues.

As with nonsexual communication, researchers have not clearly delineated the types of verbal and nonverbal sexual communication that have the greatest impact on sexual satisfaction. Indeed, the only aspect of sexual communication that has been examined in relation to sexual satisfaction is sexual self-disclosure. Byers and her colleagues have demonstrated that greater sexual self-disclosure is associated with higher sexual satisfaction (Byers & Demmons, 1999; MacNeil & Byers, 1997, 2005, 2009). To assess sexual self-disclosure, they asked respondents to rate the extent to which they share their sexual likes and dislikes in a number of areas with their partners. Furthermore, in one study, MacNeil and Byers (1997) found that greater disclosure of one's sexual preferences to one's partner was associated with higher levels of sexual satisfaction, even after controlling for levels of nonsexual disclosure. This suggests that sexual self-disclosure plays a unique role in sexual satisfaction over and above being in a generally disclosing relationship. However, in these studies, sexual self-disclosure and sexual satisfaction shared only between 4 percent and 24 percent of their variance. Thus, it is likely that other aspects of sexual communication also contribute to sexual satisfaction, such as assertiveness, style of resolving sexual conflicts, and ability to listen and validate the partner's perspective. MacNeil and Byers (2005, 2009) provide indirect evidence that ability to listen to the partner's perspective is important to sexual satisfaction. They found that individuals were more sexually satisfied if their partner had a greater understanding of their sexual likes, but not their sexual dislikes.

Sexual assertiveness is defined as the ability to initiate wanted sexual activities, refuse unwanted sexual advances, inquire about a partner's sexual health status, and insist on safe sex practices (Morokoff et al., 1997). We could find no studies that have examined the association between sexual assertiveness and sexual satisfaction. However, individuals who

are more assertive in their sexual communication report more positive sexuality-related outcomes in other areas, such as safer sex practices and transmission of sexually transmitted infections, as well as higher sexual self-efficacy (Quina, Harlow, Morokoff, & Burkholder, 2000). Furthermore, it is difficult to imagine having a satisfying sexual relationship if one does not feel control over one's sexuality and freedom to express one's sexual needs. Thus, sexual assertiveness may be a prerequisite for sexual self-disclosure which has been shown to be associated with sexual satisfaction. Assertiveness in communicating intimate needs is not strongly associated with general assertiveness (Morokoff et al., 1997). This suggests that it is important to investigate the relationship between sexual assertiveness and sexual satisfaction specifically.

We also could find no studies that have examined the link between discussion of sexual problems and sexual satisfaction. Yet, sexual discussions are rated as more difficult than discussion of other issues (Sanford, 2003), suggesting that a couple's style of discussing sexual differences may impact their sexual satisfaction. In keeping with this view, Rehman and colleagues (2011) found that the quality of couples' interaction when solving a sexual conflict was more closely tied to relationship satisfaction than was their interaction when discussing nonsexual conflict. This suggests that sexual conflict discussions become high-stakes conversations. When such high-stakes conversation does not go well, the impact on relationship and sexual satisfaction may be greater than for a conflict discussion that is deemed to be more commonplace.

LIMITATION AND FUTURE DIRECTIONS

Research on sexual satisfaction is in its infancy stage (McClelland, 2010). Nonetheless, researchers have identified a number of variables that are associated with women's sexual satisfaction. In terms of individual factors, women tend to be more sexually satisfied if they are older, in a stable long-term relationship, experience fewer distracting and nonerotic cognitions, and are more erotophilic. On a dyadic level, women tend to be more sexually satisfied if they have higher overall relationship satisfaction, have better sexual and nonsexual communication with their partner, engage in sexual activity more frequently, and engage in a mutually pleasurable sexual script. Thus, any model of sexual satisfaction that does not account for the relational context of sexual experiences is missing a key, likely the most important, piece of the puzzle. It is encouraging that research on sexual satisfaction is increasingly moving toward focusing on interpersonal factors in sexual satisfaction. Throughout this chapter, we have noted limitations of studies we have reviewed. Below, we discuss some additional broad theoretical and methodological issues, accompanied by recommendations for future research.

Theoretical Issues

Much of the research on sexual satisfaction has proceeded atheoretically, making the mechanisms behind these relationships unclear. In contrast, the Interpersonal Model of Sexual Satisfaction (Lawrance & Byers, 1992, 1995) provides a conceptual framework to enhance our understanding of factors affecting sexual satisfaction. In general, research has supported the propositions of this theory; that is, women's sexual satisfaction in a dyadic context is affected by the quality of the nonsexual aspects of the relationship, their experience of the sexual exchanges within the relationship, their beliefs about how sex should be, and their partner's experience of the sexual relationship. Nonetheless, more work is needed on a conceptual level to fully understand factors that contribute to women's sexual satisfaction; that is, there are multiple causal pathways at different levels of analysis that likely play a role in women's sexual satisfaction. An important benefit of integrative models is that they represent a shift from a piecemeal approach to the study of sexual satisfaction. Below, we discuss some broad issues that need to be incorporated into these models and tested empirically.

It is important to investigate the interplay between individual and dyadic factors in influencing sexual satisfaction. It is possible that certain dyadic strengths, such as good sexual communication in a relationship, can compensate for individual risk factors, such as negative cognitions that interfere with an individual's ability to focus on the pleasurable aspects of sex. It is also possible that other dyadic factors (e.g., poor communication) may exacerbate individual risk factors (e.g., a tendency to experience negative emotions), leading to declines in sexual satisfaction.

There are few meditational models that test mechanisms behind the associations between specific variables and sexual satisfaction, particularly when testing dyadic variables (see MacNeil and Byers' [2005, 2009] work on the mechanisms behind the association between communication and sexual satisfaction as an exception). It is important that researchers propose and test additional mechanisms. Furthermore, to fully understand the differential importance of various mechanisms, they need to be tested simultaneously in a combined model. Here, we provide the example of two mechanisms that we believe to be relevant to the study of sexual satisfaction—the power dynamics that exist in a couple and cognitions about the relationship.

Interpersonal power plays an integral role in determining whether a woman feels that she has the legitimacy to voice her preferences, to negotiate sexual exchanges, and to ask her partner about his sexual history.[1] Bandura (1990) noted that even if an individual is aware of how to protect against sexually transmitted diseases, her or his likelihood of translating that knowledge into safer sex practices depends, at least in part, on the

individual's sense of personal power over the sexual interaction. Indirect support for the potential role of power outcomes in sexual satisfaction emerges from a study conducted by Brezsnyak and Whisman (2004), in which they found that egalitarian decision-making patterns were associated with higher levels of female (and male) sexual desire.

Women's individual-level cognitions, including the extent to which they experience distracting and non-erotic thoughts, influence their sexual satisfaction (Purdon & Holdaway, 2006). It is likely that dyadic-level cognitions also influence women's sexual satisfaction. The importance of cognitive appraisals is also highlighted in the IEMSS. In keeping with predictions based on the IEMSS, Byers and her colleagues (Byers et al., 1998; Byers & MacNeil, 2006; Lawrance & Byers, 1995; Renaud et al., 1997) have shown that a sexual script that compares favorably to an individual's expectations (i.e., the balance of rewards and costs they actually experience is equal to or higher than their expectations about how rewarding and costly their sexual relationship should be) results in higher sexual satisfaction than if the same script does not compare favorably to their expectations. However, these researchers have not identified the pathways between expectations, sexual exchanges, relationship quality, and sexual satisfaction.

There are likely other important dyadic-level cognitive variables that have not been studied empirically and affect women's sexual satisfaction. These include women's expectations of how a particular sexual interaction will unfold, how her sexual partner would respond to requests for change in their sexual repertoire, and her attributions for her partner's behavior pertaining to sex (e.g., "He is always going to put more sexual demands on me than I am capable of fulfilling because his appetite is insatiable"). For example, data from research on couple (nonsexual) conflict shows that beliefs about what is going to happen when a couple encounters conflict directly influenced the types of communication strategies that the couple used during a conflict discussion (Epstein & Baucom, 2002). Furthermore, these expectations contributed to evaluations of the problem-solving discussion afterward, above and beyond the actual communication exchange that occurred during the interaction. One possible mechanism for this finding is that overall relationship quality affects dyadic sexual cognitions which, in turn, affect sexual communication and sexual exchanges and sexual satisfaction. Another possibility is that dyadic sexual cognitions affect sexual satisfaction directly. In addition, there are a number of questions pertaining to dyadic level sexual cognitions that need to be explored in future work. For example, it would be informative to examine whether there are systematic differences in couples' expectations for solving sexual versus nonsexual conflicts in their relationship and, if so, whether this affects their success at resolving sexual problems compared to other types of problems and, in turn, their sexual satisfaction.

One of the major challenges in developing and testing models of sexual satisfaction has to do with establishing the causal relationship between variables. This problem pertains to both individual and dyadic factors. Sexual satisfaction is a dynamic phenomenon, and thus issues of causality can be particularly thorny and difficult to disentangle. Questions of causal connections between, for example, relationship satisfaction and sexual satisfaction and between sexual communication and sexual satisfaction arise at the conceptual level. Furthermore, our current methods, largely cross-sectional designs, limit our ability to draw any causal connections.

Finally, it is possible that the direction of the relationships between variables as well as the impact of life events (e.g., work stress, family relationships) is differentially relevant at various stages of the relationship; that is, the factors that contribute to or detract from sexual satisfaction early in a relationship are likely different from factors that contribute to sexual satisfaction later on. However, we know little about the differential importance of different variables at different stages of a relationship. Longitudinal research is needed to establish the direction of these relationships as well as whether the mechanisms that underlie them change over time.

Methodological Issues

There are a number of methodological issues that have characterized the research on sexual satisfaction. One of these is content overlap between predictor and outcome variables. For example, measures of relationship satisfaction often include items related to sexual satisfaction and communication. Thus, to assess the connections between these aspects of relationships, it is important to use measures that assess global sentiments toward the relationship that do not confound relationship processes (e.g., communication, sexual frequency) and subjective evaluations of the relationship (Fincham & Bradbury, 1987; Lawrance & Byers, 1995).

Even when researchers have attempted to focus on how aspects of the relationship affect and are affected by sexuality, they have largely failed to measure relational and sexual processes from a dyadic perspective (Orbuch & Harvey, 1991). A true interactional perspective can only be tested when data are gathered from both partners, so that researchers can examine the influence of characteristics of the individual and of their partner on sexual satisfaction. Unfortunately, only a handful of studies have included data from both partners (e.g., Purnine & Carey, 1997; MacNeil & Byers, 2005, 2009).

There has been little longitudinal research on sexual satisfaction, even though this type of research is essential for establishing the causal direction of relationships and the mechanisms that underlie them. The few longitudinal studies that have been conducted to examine the association between relationship and sexual satisfaction have used a two-wave

design. A single assessment of a predictor variable may underestimate the real association between two variables because it is unlikely to represent the value of the variable at other times. Because estimates of longitudinal relationships based on such data are likely to be unreliable (Karney, 2001), future longitudinal research on sexual satisfaction will be important to have more than two waves of data collection. In addition, analytically, these investigations have relied on between-subject techniques to examine longitudinal effects. This type of analytic approach favors prediction over description; it informs us that values of variable 1 significantly predict values of variable 2 at a later time, but gives us no information on how the two variables change, their rate of change, or whether there are individual differences in change (Davila, Karney, Hall, & Bradbury, 2003). One reason that such multiwave designs may not have been widely used in the past is that the statistical challenges associated with analyzing such data were daunting. With the advent of growth curve analyses, this type of analysis is now possible.

A final limitation is that researchers have tended to use samples that are high in sexual satisfaction and predominantly white and well-educated. Furthermore, there has been little research on factors affecting the sexual satisfaction of sexual minority women. The extent to which findings can be generalized to more diverse samples is not known.

CONCLUSION

Sexual satisfaction is the feeling that arises from considering all the positive and negative aspects of one's sexual relationship (Lawrance & Byers, 1995). It is important to women personally as well as to their relationship satisfaction, relationship well-being, and overall well-being. Thus, it is important to fully understand factors that influence women's sexual satisfaction. In this chapter, we reviewed demographic, individual, and dyadic factors that have been shown to be associated with women's sexual satisfaction. Although the IEMSS provides a framework understanding factors affecting women's sexual satisfaction, more work is needed to fully delineate the mechanisms by which these variables result in higher sexual satisfaction.

NOTE

1. We recognize that power is a notoriously difficult construct to operationalize, and researchers have distinguished between power bases (e.g., education, income), power processes (e.g., negotiation), and power outcomes (e.g., decision about which sexual behaviors to engage in or to avoid) (Cromwell & Olson, 1975). Each of these dimensions may be relevant to understanding women's sexual satisfaction.

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Chapter 3

Women's Sexuality in Close Relationships

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> Women need a reason to have sex. Men just need a place.
> —Billy Crystal

Desire, passion, love, sex, power, infidelity, and jealousy. These words capture some of the dynamics of sexual relationships that women and men experience throughout their lives. Whether sexuality occurs inside or outside a close relationship, it is inherently an interdependent process. Just as it takes two to tango, it takes (at least) two people to form a close, sexual relationship. This book focuses on women's sexuality, and there is good reason for such a focus: people have long been fascinated with sexuality, especially women's sexuality. Historically, sex has been lauded in works of art, poetry, and theatre, and sex has been feared and decried by religious leaders, many of whom advocated sex only within marriage for reproductive purposes (Hatfield, Luckhurst, & Rapson, 2010). Our collective fascination with women's sexuality is evidenced in a number of ways. For example, the Greeks and other ancient civilizations had goddesses devoted to fertility. Many of Shakespeare's plays were written about men's

attempts to win the hearts of the maidens whom they loved. More recently, entire social movements were founded on liberating women's sexuality.

Just as poets lauded women's sexuality, scientists have also tacitly implied that women's sexuality manifests more dynamic trajectories over their lifetime than does sexuality over the lifetime of men. In the scientific literature, numerous terms have been used to describe women's sexuality. Women have been described as sexual gatekeepers (Peplau, Rubin, & Hill, 1977), have been attributed with high erotic plasticity (Baumeister, 2000), and have been posited to have sexual fluidity (Diamond, 2008). Collectively, these terms imply that there is something distinct to the sexuality of women as compared to the sexuality of men. The primary focus of this chapter is sexuality within the romantic pair-bonds women form throughout their lives. We also discuss other important phenomena that may be generally situated outside of close relationships, but still have significant influence on close relationships once they are formed (e.g., sexual attitudes). Although the term sexuality may often refer to sexual behaviors, particularly vaginal along with oral and anal sex (e.g., Herbenick et al., 2010), we adopt a broader definition and view sexuality as embodying multiple dimensions of both attitudes and behaviors (DeLamater & Hyde, 2004). Thus, we view sexuality as including (but not limited to) intimacy, communication, sexual desires, and sexual behaviors (e.g., kissing, intercourse).

Our chapter is divided into two sections. First, we discuss the trends in women's sexual attitudes and behaviors, including changes over the last several decades and the link between women's sexual attitudes and behaviors. Second, we turn our attention to the sexuality-related processes within women's close relationships; these processes include sexual attraction and partner choice, relationship initiation behavior, love and intimacy, exchange in sexual relationships, same-sex sexuality, and the dark side of close relationships.

THE LANDSCAPE OF WOMEN'S SEXUALITY: ATTITUDES AND BEHAVIORS

Women enter close relationships with a variety of wants, needs, desires, and beliefs—their sexual attitudes. Women's sexual attitudes may differ from those of men, although to a varying degree. Thus, researchers have amassed a large body of literature on gender differences in sexual attitudes and behaviors. These differences pertain to multiple dimensions of attitudes and behaviors located both outside and inside close relationships (e.g., Petersen & Hyde, 2010; Schmitt, 2005). Below, we highlight the uniqueness of women's sexuality by comparing their sexual attitudes and behaviors to those of men. Then, we summarize theoretical perspectives that explain these gender differences. We end this section by discussing the attitude-behavior link in women's sexuality.

Gender Differences in Sexual Behaviors

Differences in men's and women's sexual behaviors begin as early as their first sexual intercourse experience. On average, women tend to have their first sexual intercourse at a slightly older age than men (Laumann, Gagnon, Michael, & Michaels, 1994; Petersen & Hyde, 2011). In a large nationally representative study, it was found that among people born between 1953 and 1972, 37 percent of women had sex before the age of 16 compared to 48 percent of men; the modal age of first intercourse for women was 17 compared to 16 for men (Laumann et al., 1994). During adulthood, however, the percentage of women who reported having had sex during their lifetime is fairly similar to the percentage of men. In a more recent nationally representative study, about 90.7 percent of women between the ages of 25 and 29 reported having had sex in their lifetime compared to about 89.3 percent of men in this age range (Herbenick et al., 2010). Likewise, a review of meta-analytic and national data set studies concluded that the sex difference in the prevalence of heterosexual intercourse is small (with women reporting somewhat less frequent intercourse than men; Petersen & Hyde, 2011). Specifically, it appears that although sex is less prevalent in adolescent women (compared to adolescent men), "the prevalence of heterosexual intercourse among adults is comparable for men and women" (Petersen & Hyde, 2011, p. 153).

Although adult women are just as likely as adult men to be sexually active, some evidence indicates that women may have fewer sexual partners over their lifetime compared to men. For example, two studies that used a representative sample found that women reported having fewer sexual partners on average in their lifetime than men (Laumann et al., 1994; Smith, 1998). Petersen and Hyde (2011), in their meta-analysis, also found that women reported fewer sex partners than men, although this difference was small across the studies that they reviewed. Several explanations have been proposed to explain these gender differences, including gender differences in the definition of sex and biased self-reports (see Willetts, Sprecher, & Beck, 2004, for a review of explanations for the sex differences in reported sexual partners).

Most sexual behaviors require a partner. There is, however, a sexual behavior that can be performed alone and outside of close relationships: masturbation. Meta-analytic studies have found that the frequency of masturbation was one of the largest differences between women's and men's sexual behaviors. Women masturbate much less often than do men, though the magnitude of this sex difference has decreased over the last two decades (Oliver & Hyde, 1993; Petersen & Hyde, 2010, 2011). Research using an American probability sample, for example, found that about 84.6 percent of women between the ages of 25 and 29 have masturbated in their lifetime compared to 94.3 percent of men in that age range. This gender difference

was larger in older adults: 58.3 percent of women over 70 reported to have masturbated in their lifetime compared to 80.4 percent of men (Herbenick et al., 2010). Likewise, women are much less likely to use pornographic materials than men, which is also one of the most robust differences between women's and men's sexual behaviors (Petersen & Hyde, 2010, 2011).

Gender Differences in Sexual Attitudes

Women and men differ in some of their attitudes toward sex in relationships. These differences begin with attitudes toward virginity and continue toward sexual standards and general sexual permissiveness. College women report less distress about and more positive reasons to staying a virgin than do college men (Sprecher & Regan, 1996). Similarly, women's premarital sexual standards are on average less permissive than the sexual standards of men, especially for early stages of relationships (e.g., for a first date or in a casually dating relationship).

Sexual standards capture the degree to which people believe sex is appropriate before marriage. Some measures of sexual standards assess the degree to which people believe it is appropriate to have sex in a premarital relationship of varying emotional involvement, from first date to engagement (e.g., Sprecher, McKinney, Walsh, & Anderson, 1988). Researchers who first investigated college students' premarital sexual standards in the 1950s and 1960s found that most women (and even men) endorsed an abstinence standard: sex was considered permissible only within marriage (Reiss, 1964). This sexual norm has shifted toward more permissiveness over time, as college students typically endorsed the permissiveness with affection standard (sex is permissible in committed relationships) in the 1980s (Sprecher et al., 1988), 1990s (Sprecher & Hatfield, 1996), and more recently, the 2010s (Sprecher, Treger, & Sakaluk, 2011). Women, however, are more likely than men to believe that commitment is a necessary precursor for sex (e.g., Schmitt, 2005). Thus, women generally do not approve of sex in less intimate stages of relationships (e.g., first date), but do approve of sex in more committed stages of relationships (e.g., seriously dating). Men, on the other hand, generally approve of sex in casual stages of relationships to a greater degree than do women (or disapprove of sex less in casual relationships stages). Like women, men also generally approve of sex more in committed stages of relationships than in casual stages (e.g., Sprecher & Hatfield, 1996).

Research based on other measures of sexual permissiveness yields similar conclusions of less sexual permissiveness in women than men. For example, Hendrick and Hendrick's (1987) Sexual Attitudes Scale assesses sexual attitudes as consisting of four components: permissiveness, sexual practices, communion, and instrumentality. Research with this scale typically yields gender differences in two components. Women tend to be less permissive than men, disagreeing more with items such as "Casual sex is

acceptable," and less instrumental than men, disagreeing more with items such as "Sex is mostly a game between males and females." Women (and men), however, agree most with the communion component of the Sexual Attitudes Scale and fairly strongly believe that "sex is the closest form of communication between two people" (e.g., Gall, Mullet, & Shafighi, 2002; Hendrick & Hendrick, 1987).

Using a single score that captures people's sexual attitudes and behaviors, Simpson and Gangestad's (1991) Sociosexual Orientation Inventory assesses the degree to which a person requires commitment in a relationship before having sex. Those who require commitment before sex are considered restricted and those who do not require commitment before sex are considered unrestricted. Women are, on average, more restricted in their sociosexual orientation than men (who are more unrestricted). Research using college and cross-cultural samples has found that women, compared to men, tend to disagree with certain statements, such as "Sex without love is OK," and desire fewer sexual partners over their lifetime (Schmitt, 2005; Simpson & Gangestad, 1991; Sprecher et al., 2011).

Theoretical Perspectives on Gender Differences in Sexual Attitudes and Behaviors

Why do women and men differ in their sexual attitudes and behaviors? Researchers have typically employed two theories to explain gender differences in various dimensions of sexuality. The theoretical framework known as *socialization,* or *social learning* theory, suggests that gender differences in sexuality emerge from learned gender roles that are socialized during development (e.g., Petersen & Hyde, 2010). Other related theories, such as script theory, further assume that men and women follow different scripts in their sexual behaviors which are reinforced by various social aspects (e.g., media; DeLamater & Hyde, 2004). For example, the socialization framework would argue that women take a less active role in relationship initiation (e.g., being asked on a date by men) or possess less permissive sexual attitudes, because society or culture encourages and reinforces such attitudes and behaviors. These behaviors are further embedded within various scripts women and men use to act in socially appropriate ways (e.g., men paying for dates).

The *evolutionary* view of human sexual behavior (e.g., Buss, 1995), on the other hand, argues that human behaviors are based on underlying cognitive mechanisms which are present in modern humans, because they contributed to their ancestors' reproductive fitness (i.e., ability to survive to reproductive age and successfully reproduce). These cognitive foundations (and their subsequent behaviors) evolved over time via natural selection (adaptation to general environmental constraints) and sexual selection (adaptations to constraints in finding a mate). Evolutionary theorists

attribute gender differences in sexuality to differences in the focus of women's and men's investments in relationships and reproduction (i.e., parental investment; Buss & Schmitt, 1993; Gangestad & Simpson, 2000). Because women's investments in reproduction entail greater risks, including a nine-month long internal incubation period, birthing, and breastfeeding, they are hypothesized to be more selective of their mates, and thus have generally more restricted sexual attitudes. Men, on the other hand, have generally less risk in reproduction (some risks include uncertainty about an offspring's genetic relatedness, i.e., paternal uncertainty), as they only contribute sperm in mating, and thus may actually benefit from more permissive mating strategies that may maximize the likelihood of reproduction (i.e., being more permissive of short-term, sexual relationships; Buss & Schmitt, 1993). Socialization and evolutionary theories often yield similar or identical hypotheses. Some argue that this may be because evolved human idiosyncrasies and cultural norms reinforce one another reciprocally (e.g., Kenrick, Li, & Butner, 2003). In other words, social norms emerge over time from evolved idiosyncrasies and continuously reinforce human behavior.

Putting Attitudes and Behaviors Back Together: The Attitude-Behavior Link in Women's Sexuality

Although attitudes and behaviors are generally linked, the strength of the attitude-behavior relationship appears to be different for women and men. According to Erotic Plasticity Theory (Baumeister, 2000), women exhibit a lower attitude-behavior consistency than men: women's sexual attitudes do not predict their sexual behaviors as well as men's sexual attitudes predict men's sexual behaviors. In other words, women's sexual attitudes and behaviors are more influenced by social factors than those of men. Baumeister found support for his hypothesis in a large-scale analysis of the sexuality literature. For example, Baumeister referred to a study by Wilson (1975) that found that women with more education (a social influence) tend to be more permissive in their sexual attitudes than women with less education; education, however, had no influence on men's sexual permissiveness. In addition, Baumeister discussed work that has found inconsistencies between women's (but not men's) attitudes and behaviors. As one example, Baumeister cited a study by Herold and Mewhinney (1993) which showed that although only a minority of women anticipated having casual sex with someone, a majority of them reported having had casual sex with someone.

Another large-scale analysis of the link between sexual attitudes and behaviors was done by Wells and Twenge (2005), who explored the attitude-behavior consistency in women and men using a cross-temporal meta-analysis (i.e., an investigation of trends in sexual attitudes and behaviors

across numerous studies, over time). Specifically, they analyzed 530 studies that were published between the 1940s and 1990s and found that, over time, women became more approving of premarital sex, experienced less sexual guilt, became more sexually active, began engaging in oral sex more often, and began having sex at an earlier age. Not surprisingly, given their more liberal attitudes about sex, men exhibited much less change in their sexual attitudes and behaviors over time. Similarly, a meta-analysis conducted by Petersen and Hyde (2010) found that the difference between women's and men's sexual behaviors (e.g., age of first intercourse) decreased over time, such that women's sexual attitudes and behaviors became more permissive, whereas men's sexual attitudes and behaviors remained fairly stable.

Unlike Baumeister (2000), who concluded that women's attitude-behavior link is weaker than men's attitude-behavior link, Wells and Twenge (2005) argued that the attitude-behavior link is actually stronger in women than in men. Specifically, they found that women's attitudes at decade n – 1 predicted women's behaviors at decade n, which then predicted behaviors at decade n + 1 (note of course that these are not the same women in each decade). For example, women's attitudes in the 1960s predicted corresponding changes in behaviors in the 1970s, which then predicted the corresponding attitudes in the 1980s. For men, the associations between attitudes and behaviors were weaker. Attitudes at decade n–1 predicted behaviors at decade n, with no other temporal relationships being statistically significant. To reconcile their findings with those of Baumeister (2000), Wells and Twenge suggested that the differences may well stem from a different level of focus. Whereas Baumeister examined specific studies that focused on individuals in particular situations, Wells and Twenge focused on global or overall patterns over time with different women in each decade. Thus, Wells and Twenge noted that "inconsistencies of women's attitudes and behaviors in individual situations would not be observed in our data" (p. 259).

In summary, women are on average less permissive in their sexual attitudes and behaviors compared to men, although their attitudes and behaviors have become more permissive over time. Furthermore, it appears that women experience more variability in their sexual attitudes and behaviors (i.e., change in sexual preference) compared to men. In the next section, we shift our focus away from global sexuality processes to a discussion of women's sexuality in the domain of close relationships.

THE FOREFRONT OF WOMEN'S SEXUALITY: CLOSE RELATIONSHIPS

For women, sex generally occurs within a close, committed relationship, not withstanding notable exceptions (e.g., "friends with benefits relationships"; Paul, McManus, & Hayes, 2000). Thus, the domain of close

relationships is at the forefront of women's sexuality, especially in light of the critical importance of closeness and intimacy that close relationships provide. In this section, we discuss women's sexuality specifically within close relationships, focusing on issues of attraction, relationship initiation, the transition to, and the exchange of sex. We will also discuss the dark side of sexuality in close relationships, including extradyadic involvement and sexual transgression.

Sexual Attraction and Attractiveness

Attraction is typically characterized as a positive evaluation of and a strong desire to be around another person (Graziano & Bruce, 2008). In the context of close relationships, attraction often entails sexual desire. Researchers have used numerous empirical methods to assess the traits that people find attractive in a potential partner. Two of the most popular methods are the *mate selection* paradigm and the *bogus stranger* paradigm. In the mate selection paradigm (e.g., Lippa, 2007), participants are presented with a list of traits (e.g., warmth, good looks) and asked how much they desire each trait in a partner for a specific type of relationship (e.g., short-term relationship, marriage). In the bogus stranger paradigm (e.g., Byrne, 1971), participants respond to a hypothetical person (e.g., with ratings of attraction). Participants are frequently led to believe that the person they are rating is an actual other. In bogus stranger studies, at least one characteristic of the hypothetical other is manipulated (e.g., attitude similarity). Other paradigms that are used to research attraction include analyses of real or hypothetical personal ads people place in public forums (e.g., Pawlowski & Koziel, 2002), social interaction studies in which two actual participants are paired for an interaction (e.g., Sprecher & Duck, 1994), and more recently, speed-dating studies where multiple participants go on a series of mini dates with other daters and provide ratings of each other after the dates (e.g., Finkel & Eastwick, 2008).

What do women find desirable in a sexual partner? It appears that the highest rated qualities that women seek in a mate, especially a long-term partner, are *intrinsic* traits, such as warmth, kindness, and intelligence (Buss, 1989; Lippa, 2007). Men also desire these intrinsic traits in women, although several differences between women's and men's trait preferences are apparent. Specifically, women tend to rate a potential partner's social status (e.g., high salary) as more important and physical attractiveness as less important than do men (e.g., Buss, 1989). Both women and men, however, rate social status and physical attractiveness lower in desirability compared to the intrinsic traits described above.

Women's mate preferences may also vary according to biological (or hormonal) signals; particularly, signals from the ovulatory or menstrual cycle. Women's ovulatory cycles influence fluctuations predominantly in their ro-

mantic partner preferences for short-term (i.e., uncommitted) rather than long-term relationship preferences (e.g., Gangestad, Simpson, Cousins, Garver-Apgar, & Christensen, 2004). Compared to women who are non-fertile (i.e., in the luteal phase of the ovulatory cycle), fertile women (i.e., in the follicular phase of the ovulatory cycle) desire men with more masculine faces (i.e., male composite faces with exaggerated differences from female composite faces; Penton-Voak & Perrett, 2000) and more masculine voices (i.e., lower frequency; Puts, 2005). Fertile women also exhibit an increased preference for dominant men (Havlicek, Roberts, & Flegr, 2005) and attend longer to consumer items denoting (particularly men's) status (e.g., expensive cars; Lens, Driesmans, Pandelaere, & Janssens, 2012). Although women tend to prefer physically symmetrical men at all times, this preference is especially strong when they are fertile (Gangestad & Thornhill, 1998).

Relationship Initiation

Women and men can initiate relationships in a variety of ways and settings via direct and indirect strategies (see Cunningham & Barbee, 2006). A direct initiation strategy involves one person approaching another for the explicit purpose of initiating a relationship (e.g., asking someone out on a date). Indirect strategies are more covert and may involve nonverbal communication that signals romantic or sexual interest, such as flirting (e.g., Moore, 1985).

Generally, women tend to use indirect strategies more than men and direct strategies less than men (Clark, Shaver, & Abrahams, 1999; Moore, 1985). In her observational study of women's flirting behaviors in natural settings, Moore (1985) estimated that about 20 percent of direct relationship initiation attempts were made by women (the remaining 80% were made by men). The indirect strategies that women use to solicit initiating behaviors include nonverbal behaviors, such as smiling, eye contact, eyebrow flashing, glancing around the room, laughing, and hair flipping (Eibl-Eibesfeldt, 1989; Moore, 1985; Walsh & Hewitt, 1985). Moore (1985) also calculated the frequency with which women displayed flirting behaviors in several settings. Moore found that in a singles bar women displayed about 70.6 flirting behaviors per hour, whereas they displayed about 18.6 flirting behaviors per hour in a snack bar and 7.5 flirting behaviors per hour in a library. In some instances, women may display nonverbal behaviors that could be classified as flirting (e.g., smiling) without the intention to lure a mate. Men, however, often misperceive such platonic (i.e., non-sexual or friendly) flirt-like gestures as signs of women's sexual interest (Haselton & Buss, 2000).

Other ways in which women may elicit initiating behaviors in men may be through their clothing (Cunningham & Barbee, 2006). For example, in one field study conducted in an Austrian discotheque, researchers assessed

women's self-reported motivation to obtain a sexual partner and their salivary levels of testosterone and estradiol, which facilitate sexual desire (Grammer, Renninger, & Fischer, 2004). Women who were more motivated to obtain a sexual partner (as indicated by hormone and self-reported levels) were found to wear more revealing clothing than women who were less motivated to obtain a sexual partner. Interestingly, women were particularly likely to do this at a time during their ovulatory cycle when they were most fertile. Fertile women have also been found to groom and ornament themselves more (Haselton, Mortezaie, Pillsworth, Bleske-Rechek, & Frederick, 2007) and wear more revealing clothing (Durante, Li, & Haselton, 2008) than women at other stages of their ovulatory cycle.

Transitioning into Sex

Sex in most types of close relationships rarely occurs immediately after a woman has met her partner or experienced attraction. Excluding some types of short-term sexual relationships (e.g., hook-ups), women typically transition to sex within a close pair-bond. Within this bond, women have a variety of motives for having (as well as not having) sex, and these motives may be nested within broader reasons, such as love, intimacy, and physical pleasure.

Transitioning into sex for women may be influenced by a variety of motives. In an investigation of the reasons why couples had their first intercourse, Christopher and Cate (1984) found that couples' reasons could be classified into four broad categories: positive affection (e.g., love), physical arousal prior to intercourse, obligation to or pressure from partner, or circumstantial factors (e.g., alcohol use). Christopher and Cate found two gender differences in terms of what couples believed was important in facilitating their first intercourse. Specifically, women rated positive affection to be more important and obligation to be less important than did men. Yet, women and men agreed that positive affection was the most important reason to have first intercourse in a relationship (Christopher & Cate, 1984, 1985).

More recently, Meston and Buss (2007) asked undergraduates, graduate students, and members of the community to list the general reasons they have had sex in the past. They then presented the resulting list of 237 unique reasons to a different sample of undergraduate students and asked them to rate how often each reason influenced them to have sex. Meston and Buss's unique reasons yielded four global components: physical reasons (e.g., stress reduction), goal attainment reasons (e.g., revenge), emotional reasons (e.g., love and compassion), and insecurity reasons (e.g., self-esteem boost). Interestingly, women endorsed all the components less than men except emotional reasons, for which no gender difference was found. This finding is consistent with other research on the motivation to

have sex, which found that men tend to be more motivated to have sex (i.e., desire sex more) compared to women (e.g., Peplau et al., 1977). The studies that have investigated women's and men's motivation to have sex, regardless of whether it is their 1st or 100th time, show that women (and men) believe that love—or a similar intimate or interpersonal reason—is the most significant motivator for having sex (Christopher & Cate, 1984, 1985; Meston & Buss, 2007).

Sexual Gatekeepers

If men desire sex more than women, then are men more likely to initiate sex while women are more likely to limit it? This pattern of gender differences in initiation and rejection of intercourse, referred to as sexual gatekeeping, was first demonstrated by Peplau and colleagues (1977) in a longitudinal study of undergraduate heterosexual dating couples. Peplau and colleagues found that women's sexual attitudes were better predictors of whether the couple had sex and when the couple had sex (i.e., earlier or later in the relationship). Also, 64 percent of the men indicated that their partners' desire to abstain from sex was a significant reason why the couple did not have sex (compared to 11% of the women). Thus, Peplau and colleagues concluded that "characteristics of the woman were better predictors of whether a couple had coitus than characteristics of the man" (Peplau et al., 1977, p. 93). Similarly, Sprecher and Regan's (1996) examination of reasons why heterosexual college students abstained from sex found that men were more likely than women to endorse the reason: "My current (or last) partner is (was) not willing."

Scholars have proposed several theories to explain why women would act as gatekeepers. Evolutionary theorists, for example, argue that women are more selective with their mates, and thus with whom they would have sex because of their unique risks in having sex (e.g., Gangestad & Simpson, 2000). Social learning and socialization theorists argue that gatekeeping emerged from learned gender roles, in which men are given more social power to initiate sex and women are socialized to limit sex (Peplau et al., 1977).

Sex, Love, and Intimacy

Close relationships researchers have studied the phenomena related to the quality and the outcomes of a relationship, such as whether a relationship will be maintained or terminated. Part of this research also examined the role of sexuality in these relationship phenomena (e.g., love, intimacy, satisfaction). We discuss the associations between sexuality and these relationship phenomena and how these associations may differ for men and women, next.

In the scientific literature, love has been defined in numerous ways, including as an emotion or as a physiological state (Aron, Fisher, & Strong, 2006; Hatfield & Sprecher, 1986). It has also been conceptualized in various ways, including as a combination of varying levels of intimacy, commitment, and passion (the triangular theory of love; Sternberg, 1986), or as manifesting in one or more of six different styles (e.g., Eros being passionate, or sexual love; Hendrick & Hendrick, 1986). The link between sex and love (especially passionate love; Hatfield & Sprecher, 1986) is well-established. For example, physiological research has found that activity in brain areas associated with love and sexual arousal overlaps, although to a small degree (Aron et al., 2006). People also believe that those in love have sex and those who have sex are in love (Regan, 1998).

As discussed earlier, research on college students' premarital sexual standards found that many college students believe that sex is permissible in a relationship that entails strong affection or love between romantic partners, with marriage (which in itself may entail multiple kinds of love) being the pinnacle of such long-term relationships (Sprecher et al., 1988). Thus, both women and men believe that love is an important prerequisite for marriage (Simpson, Campbell, & Berscheid, 1986). Other research has found that for both women and men, love is associated with sexual intimacy (Christopher & Cate, 1988), sexual attraction (Meyers & Berscheid, 1997), and sexual desire for a romantic partner (Regan, 2000).

As many scholars agree, intimacy is an important component of love, and is thus also related to sexuality. As described earlier, Sternberg's (1986) triangular theory of love considers intimacy as one of its three components. Intimacy is often viewed as the feeling of closeness to and the sharing of emotions and experiences with another person (Schaefer & Olson, 1981). Some scales that measure intimacy in relationships also measure sexuality. For example, Schaefer and Olson (1981) measured intimacy as consisting of five components, and sexuality was one of those components (an example item is "I am satisfied with our sex life"). Women typically have and provide more intimacy in their close relationships than do men (e.g., Cordova, Gee, & Warren, 2005). Likewise, as discussed earlier, women are more likely to endorse intimate reasons for why they have sex compared to men (Hatfield et al., 2010; Meston & Buss, 2007).

The Interpersonal Exchange of Sex

Some scholars have viewed relationships as analogous to economic marketplaces where the exchange of various goods occurs throughout interactions (e.g., Sprecher, 1998). As in economic markets, people are motivated to maximize the rewards and avoid or minimize the costs associated with their social interactions. This economic-based social exchange theory

has been used to predict various relationship phenomena, such as relationship satisfaction and commitment.

The goods that people, including dating couples, mutually exchange may come in many forms, including love, status, services, information, goods, money, and sex (e.g., Cate, Lloyd, Henton, & Larson, 1982). In relationships, partners often exchange across diverse resources, which include sex (Foa & Foa, 1974). For example, one partner can give her or his partner a gift and receive sex in exchange for that gift. Women tend to value expressive contributions toward their relationships (e.g., sexual fidelity, loving the partner) more than men (Regan & Sprecher, 1995).

As an exchanged resource, sex can entail rewards as well as costs. One study (Lawrance & Byers, 1995) that examined perceived rewards and costs of sexual activity in college students found that some of the most frequently endorsed rewards (from a checklist of 46 items) associated with sex were comfort with the partner and the fun associated with sex. Another reward, especially for women, was having sex with the same partner. The costs, on the other hand, especially for women, included having sex when they were not in the mood.

Receiving too many rewards or too many costs, relative to one's partner, can lead to inequitable relationships, which may lead to relationship dissatisfaction and negative affective reactions, such as anger when underbenefitted or guilt when overbenefitted, especially for women (Sprecher, 1998). For example, the perception of being underbenefitted in relationships, especially for women, may be related to having extradyadic sex (Prins, Buunk, & Van Yperen, 1993).

Sexual economics theory (Baumeister & Vohs, 2004) argues that sex is a resource that women possess and men desire. Thus, men may attempt to exchange other resources to acquire sex from women. Women may be more reluctant to have sex compared to men (e.g., Peplau et al., 1977) because women possess a valued resource that men attempt to acquire by exchanging various gifts (Sprecher, 1998). The value of resources (e.g., gifts) that are exchanged for sex may be influenced by various factors (Baumeister & Vohs, 2004). For example, if there are many men and few women (a high sex ratio), then the demand is high and the supply is low; thus, the value of the goods that are exchanged for sex can increase.

Female–Female Sexuality

An examination of women's same-sex sexuality may help elucidate various insights that may otherwise be covert in heterosexual relationships. The relationship between partnered women may be influenced by various factors to a different degree than people involved in other types of sexual relationships, including heterosexual women or gay men (e.g., Peplau, Padesky, & Hamilton, 1983). For example, if women contribute more

intimacy to their close relationships than do men (e.g., Duffy & Rusbult, 1986), then are lesbian relationships more intimate than gay or heterosexual relationships (e.g., Kurdek, 1998)?

Sexual orientation or the preference for a sexual partner of a specific sex (either opposite-sex, same-sex, or a preference for both) is composed of multiple attitudes (e.g., sexual partner preferences) and behaviors (e.g., practicing specific sexual positions). Thus, sexual orientation has been found to exhibit more variability over time in women than in men. Specifically, fluctuations in women's sexual orientation over their lifetime have been called sexual fluidity (e.g., Diamond, 2008). Changes in women's sexual orientation may appear fairly sporadic. For example, in one wave of her longitudinal research, Diamond (2008) found that some women who began the study as lesbians redefined themselves as heterosexual, bisexual, or unlabeled, at least once over the 10-year span of the research.

Lesbian relationships typically entail a high degree of closeness, relationship satisfaction, and equality (Kurdek, 2003; Peplau et al., 1983; Peplau, Cochran, Rook, & Padesky, 1978). Compared to (particularly adolescent) heterosexual couples, lesbians define sex as less centered around achieving orgasm and tend to view behaviors, such as kissing and hugging, as sexual activity (Frye, 1990). Although lesbians may have sex less frequently than heterosexual and gay relationships (Blumstein & Schwartz, 1983), they report having high rates of orgasms (Peplau et al., 1978) and the same degree of sexual satisfaction (Blumstein & Schwartz, 1983) as heterosexual women. Similarly, longitudinal research has found that overall, lesbian couples perceived their relationships to be of higher quality compared to gay and heterosexual couples (Kurdek, 2008).

The Darker Side of Relationships: Jealousy, Infidelity, and Sexual Abuse

Although sexual relationships can produce many positive outcomes for people's lives, they may entail some negative outcomes as well. We conclude our discussion of women's sexuality in close relationships by examining aspects of the dark side of relationships: jealousy, infidelity, and sexual abuse.

The valence of some frequently mentioned words people use to describe relationships are positive, such as love and commitment (Fehr & Russell, 1991). Jealousy, however, is also highly associated with close relationships (Fitness & Fletcher, 1993). Jealousy is a negative affective reaction experienced when a person perceives that a real or imagined rival will jeopardize her or his relationship (Buss, Larsen, Westen, & Semmelroth, 1992). For women and men alike, experiencing jealousy may trigger other negative emotions, such as anxiety, fear, depression, and helplessness

(Pines & Friedman, 1998). Experiences of jealousy, however, may be a normal part of experiencing passionate love (Hatfield & Sprecher, 1986).

Theorists have identified two main types of infidelity that may trigger jealous reactions (Buss et al., 1992). *Emotional* infidelity entails a person developing a strong affection or emotional bond for someone other than her or his primary relationship partner, but without having sex with that other person. *Sexual* infidelity entails a person having sex with someone other than the primary partner without any emotional attachments to the person. Although women find both cues of infidelity distressing, they tend to report being distressed more by emotional than by sexual infidelity (e.g., Treger & Sprecher, 2011). Women's distress at emotional infidelity is often explained by evolutionary theory, as emotional cues from a mate signal commitment and resources that are used to care for offspring (Buss et al., 1992). Social learning theorists, however, argue that women are more distressed by emotional infidelity not because of parental investment, but because they believe a man who falls in love with another woman would also have sex with her (Harris, 2003).

Though the experience of a partner's infidelity is highly distressing for women, some research suggests that women may have more reasons (i.e., predictors) for committing infidelity than do men. Research that used representative samples has estimated that about 11–15 percent of women have cheated on their spouse (Laumann et al., 1994; Wiederman, 1997), and the incidence of infidelity is higher among younger (vs. older) women and men (Wiederman, 1997). Buss and Shackelford (1997) analyzed various correlates of committing extradyadic sex in newlywed couples, and found that personality variables predicted the likelihood of committing infidelity better for women than for men. Women high in neuroticism (i.e., emotional instability) or narcissism (i.e., excessive self-love) and low in conscientiousness were found to be more likely to commit infidelity than women on the opposite poles of these personality dimensions. Furthermore, women who were unhappy with their marriage were found to be more likely to commit infidelity than men who were unhappy with their marriage. Women (but not men) have also been found to be more likely to commit infidelity if they are between the ages of 30 and 50 (compared to women under 30 and over 50; Wiederman, 1997), are not religious (Forste & Tanfer, 1996), or have more education than their partner (Forste & Tanfer, 1996).

Sexual abuse is another dark side of close relationships. Women are more often the victim of abuse in relationships than are men (see Spitzberg, 2010). One study that used a large sample of college students found that about 53.7 percent of the women had reported experiencing some sort of sexual abuse, including rape (15.4%) and attempted rape (12.1%; Koss, Gidycz, & Wisniewski, 1987). Another study estimated that about 50 percent of the reported cases of rape occur within dating relationships

(Koss, Dinero, Seibel, & Cox, 1988). Sexual coercion can also occur in marriages. Over the last three decades, scholars have estimated that between 10 and 26 percent of women had sex with their husbands due to their husbands' physical or verbal abuse (Finkelhor & Yllö, 1985; Painter & Farrington, 1999; Russell, 1982). Similarly, women who have an abusive husband tend to have more sex than women who have a nonabusive husband, possibly because wives with abusive husbands have sex out of fear of retaliation (DeMaris & Swinford, 1996).

In sum, the close relationship is the primary context in which women's sexuality unfolds. Women's sexual desires, needs, and behaviors significantly influence every stage of the relationship, regardless of whether that influence is direct or indirect. An examination of female–female sexuality can lead to many unique insights about women's sexuality that may otherwise not be salient in heterosexual relationships, such as women's sexual fluidity, more general definitions of sex, and more intimacy and closeness in lesbian relationships. Although people's close sexual relationships lead to many positive outcomes in people's lives, they may also have a darker side: women tend to be sexually abused in relationships more than men and tend to have more reasons to commit infidelity than do men.

CONCLUSION

Sexuality, and especially the sexuality of women, has long fascinated people, and social scientists have been exploring this human fascination for more than five decades. In this chapter, we have discussed what we believe to be some of the most important dimensions of women's sexuality in close relationships. Our discussion spanned issues, such as women's sexual attitudes and behaviors, sexual attraction, relationship initiation, motivation to have sex, same-sex sexuality, and the dark side of sexual relationships. Although a focus on women's sexuality can yield many important insights, sexuality is inherently an interpersonal process. Thus, researchers who use a more holistic, interdependent approach to studying sexuality may get closer to solving the mystery of human sexuality that has fascinated us for so long.

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Part II

Developmental Aspects of Women's Sexuality

Chapter 4

Latina Adolescent Sexual Desire

Bianca L. Guzmán and Claudia Kouyoumdjian

> Be afraid of *La cosa* between your legs to run from it like the plague not to look in that direction because that meant I wanted it . . .
>
> Ruth Behar (2001, p. 307)

In the United States, a country that is governed by white supremacist and patriarchal values, women's sexual desire is often fetishized as hot, exotic, and sexy (Ramirez Berg, 2002). In general, adolescent female sexual desire is conceptualized through a hegemonic lens in which males define and sell female sexual desire. There are now many popular forums that on the surface appear to allow for the articulation of young female sexual desire in images, speech, and personal style. Overwhelmingly, however, young women's apparently new-found sexual autonomy is spoken only through fashion, television shows, music, magazines, and books (Harris, 2005). Today's teen world is one of bra tops and hot pants and clothes that encourage the proud display of curvaceous bodies. There has also been an increase in commercial books for and about young women's sexuality

with titles like *Promiscuities, The Ethical Slut, Fast Girls, Cunt, Clit Notes,* and *Going All the Way.* Moreover, there is a multitude of young pop stars of all ethnic backgrounds, such as Shakira, Lady Gaga, Katy Perry, and Nicki Minaj, who seemingly exude sexual confidence. It appears that the feminist message that women are sexual subjects and have sexual subjectivity has become confused with a neoliberal message of what female sexual desire is through consumerism, which is produced primarily by men for women (Harris, 2005). This message of celebration of female empowerment and desire continues to have a hegemonic script of beauty and objectifies women, particularly women of color (Sandoval, 2003). One has to begin to wonder: where is the voice of women and girls in this discourse? What are adolescent girls articulating about their own sexual desire? What do we really know about the development of sexual desire in young women?

At the moment, it appears that asserting sexual desire for many young women of today is linked with the display of a consumer lifestyle that requires girls from a very early age to present themselves as both a desiring subject and desirable product. Images and discourses of young women's sexual desire are commoditized and sold back to them through fashion, beauty and lifestyle products, music, and accessories. In this way, the articulation of the missing discourse of desire has enabled the constitution of young girls as consumer citizens, and at the same time it produces them as new kinds of desiring subjects of, and desirable objects for, heterosexual consumption. Indeed, these new discourses of desire reproduce many elements of hegemonic heterosexual relations that do not consider the emerging sexual desire of young women.

In turning our attention to ethnic girls, and specifically Latina girls, it appears as though they too have bought into the idea that female desire is what can be bought and sold. In this sense, they are no different than girls of other cultures, in that they believe they have obtained some sexual freedom because they are able to wear midriff shirts and sassy make up. In the case of Latina girls, they also have ethnic magazines that appear to offer sexual liberation for young women, yet continue to perpetuate the idea that desire is meant for the male gaze. For example, the common images seen in magazines, such as *Latina* and *Teen Vogue en Español,* are of a very young woman with low cut cleavage, short tight skirts, full red lips, long dark hair, high-heeled shoes, light brown skin, and a mixture of innocence and wildness in her gaze (Darder & Torres, 1998). Given that many adolescent girls participate in this industry-driven picture of female desire, what room is left for how other factors, such as family, culture, friends, and personal agency, have on the sexual desire of girls?

If we are unwilling to accept that all female sexual desire is what is sold to us, then what is a more appropriate understanding of adolescent female desire? According to Lamb (2010), the word desire is used to describe the

sexually embodied feelings that girls possess and that girls are similar to boys in wanting sex. Subjectivity contrasts with objectification and is used to describe girls' ownership of their desire. And pleasure is often used synonymously with desire, but generally indicates that girls, like boys, can feel and want pleasure in sex. Advocating sexuality based on desire, subjectivity, and pleasure appears to be a response to three historically problematic areas for women and girls: objectification, abuse, and victimization (Fine, 1988, 2005). Defining girls' sexual desire by primarily using a male standard negates the ability of girls to begin to define what desire is for them. Therefore, in this study, we examine how Latina early adolescent girls conceptualize desire from their point of view. In general, there has been a dearth of information about what constitutes sexual desire from a girl perspective, so our research will fill a need for research on how sexual agency, sexual drive, and sexual behaviors impact the sexual desires of Latina early adolescent girls who have primarily not engaged in vaginal sex. In the next section, we review the ways in which Latino culture conceptualizes female sexuality in general and Latina girls' sexuality in particular. This discussion provides the cultural context of sex for Latina early adolescent girls to set the stage for understanding sexual agency, sexual drive, and sexual behaviors.

LATINO CULTURE AND GIRL SEXUAL DESIRE

In traditional Latino homes and communities, the topic of sexuality is often avoided altogether or discussed indirectly. Latinas have to negotiate their desires between the binary constructs of the *Virgen* and the *puta* (Hurtado, 2003). These ideas stem from traditional Latino culture that involves *marianismo* and *machismo.* There is little space between this binary for the cultivation of a healthy sense of sexual agency that accounts for desire, or what Fine (2005) refers to as "thick desire." Within this binary, the sexual desires of Latina girls must be repressed and silenced in accordance with the socially acceptable yet hegemonic *Virgen* archetype or stigmatized as grotesque with the label of *puta* should their desires leak from their disciplined bodies. Within these paradigms, there is little room for being anything other than these two extremes. If Latina girls buy into this binary, it may serve as a strategy of containment for Latina adolescent sexuality, thus limiting what they can envision as possibilities for their own sexual desires, agency, and health. These are reinforced by messages to girls and women to "fear la cosa between your legs," as the quote by Ruth Behar suggests at the beginning of this chapter.

MATERNAL COMMUNICATION

The women in the lives of these girls often pass down the ways that girls should behave sexually. These women are often their mothers and

extended family members, such as grandmothers, sisters, aunts, and cousins. The conversations about sexuality usually occur during a *consejo, platica,* or *cuento* (Villenas, 2006; Villenas & Moreno, 2001). *Consejos* are usually a unidirectional form of nurturing advice and moral lessons designed to influence behaviors, *cuentos* are stories that are usually told to teach a moral lesson, and *platicas* are bidirectional conversations that involve the sharing of personal thoughts and experiences. In terms of sexuality, the binary of being a good girl or a bad girl is usually reinforced during these conversations. There is always a *cuento* available about a girl who has shamed the family with a teenage pregnancy or run away with a boyfriend before marriage. Ultimately, the lesson to be learned by these conversations is that sex should only occur within a heterosexual relationship that involves marriage. These messages are more often found among families that endorse traditional cultural values. We predict that young girls who experience more *consejos, platicas,* or *cuentos* about sex from their mothers will report less desire.

Research suggests that the more acculturated an adolescent female is the more likely she is to engage in early sexual behaviors (Edwards, Fehring, Jarrett, & Haglund, 2008; Marín & Gamba, 2003; Schuster, 2003). Acculturation has been defined as the process by which one is influenced by the host culture, in this case U.S. culture, and one's own culture of membership (Berry, 2003). Common indicators of acculturation include parental birthplace, language, traditions and customs, and social affiliations (Zane & Mak, 2003). Hall (1997) has also indicated that culture is primarily shared through language and suggests that language operates as a signifying process in which people construct meaning. It has been suggested that, as Latinas become more acculturated, they are more likely to ascribe to more U.S. egalitarian gender roles (Marín & Gamba, 2003) that may include a greater acceptance of sexual expression for females.

Multiple studies have indicated that less acculturated Latina adolescents are significantly less likely to have had sex than their more assimilated peers (Afable-Munsuz & Brindis, 2006; Jimenez, Potts, & Jimenez, 2002; Upchurch, Aneshensel, Mudgal, & McNeely, 2001). When asked about their reasons for abstaining, less acculturated Latinas more frequently reported waiting until marriage than highly acculturated Latinas (Jimenez et al., 2002). Given the importance of the potential impact of culture on the emerging sexual identity and desire of Latina girls, it appears necessary to examine how culture impacts these young women. For our study, we examine how parental birthplace of both mother and father might influence the ways in which Latina early adolescent girls express their sexual desire. We hypothesize that girls who have a mother and a father who are born in a Latin American country hold more traditional Latino sexual values than parents born in the United States and therefore

will express less sexual desire. In addition to parental birthplace, we also examine how language spoken at home by parents and number of individuals living in the home impact the degree of sexual desire expressed by Latina girls. We predict that, in the families in which Spanish is spoken more frequently, the Latina girls will express less sexual desire. Finally, we predict that the more family members that live in the home that could provide *consejos*, *platicas*, and *cuentos* about sexual behaviors the less sexual desire Latina girls will report. In the following section, we review the role of peers in sexual desire.

PEER PRESSURE

Much of the research on peer pressure is related to the sexual decision making of adolescent girls (Teitelman, Bohinski, & Boente, 2009). In general, this research suggests that peers have a broad range of impact, from very little to a significant impact, on the sexual behavior of adolescent girls (Maxwell, 2002). Some research suggests that it is the actual peer sexual behavior that influences these young girls' decision to engage in sexual acts (Hampton, McWatters, Jeffery, & Smith, 2005). Specifically, adolescent girls are influenced by what types of sexual behaviors their friends are engaging in, and they are more likely to engage in these behaviors in order to feel like they fit in (Maxwell, 2002). Other research suggests that adolescent girls engage less frequently in sexual behaviors if they are more conservative in their sexual attitudes, and if they perceive their peers to be engaging in risky sexual behaviors (DeGaston, Weed, & Jensen, 1996; Driscoll, Biggs, Brindis, & Yankah, 2001). Yet, other research suggests that it is not their friends/peers *actual* behavior that influences these young women, but it is what these young women *think* their friends/peers are doing that influences their decisions (Halpern-Felsher, Kropp, Boyer, Tschann, & Ellen, 2004).

One of the main differences noted in the literature about Latina girls is that many Latina girls are driven by cultural norms, which tend to be more conservative regarding sexuality. Therefore, it can be posited that Latina early adolescents are likely to be more conservative and place greater weight on familial ties over friendship (Denner & Coyle, 2007). This might suggest that for these girls peer behavior may not be as influential in their decisions to engage in sexual activities (Denner & Coyle, 2007), and in turn may not have a large impact in their perceptions of sexual desire. Although this information is important for understanding the sexual behavior of Latina girls, there is little research examining how peer pressure influences sexual desire. Therefore, it is important to examine further if Latina early adolescent girls' perceptions of what they *think* their peers are doing are important to the ways in which they conceptualize their own desire.

SEXUAL AGENCY

Many feminist theorists have linked desire with sexual subjectivity, pleasure, and agency (Fine, 1988, 2003; Lamb, 2010; Thompson, 1995; Tolman, 1999, 2001, 2002). In terms of a definition, sexual subjectivity is the contrast of female objectification and it is used to describe a girl's ownership of her desire. As mentioned previously, the concept of pleasure has been used to signify that girls can and do feel and want pleasure in sex. Bay-Cheng (2003) connects sexual desire with sexual agency, which she operationalizes as "the ability to advocate for one's interests in the sexual arena." Therefore, it appears that a girl's sexual desire is complex and involves at least subjectivity, pleasure, and agency. In this research, we define sexual agency as the articulation of sexual subjectivity, which Tolman (2001, 2002) suggests is a girl's experiencing herself as a sexual being, one who feels entitled to sexual pleasure and sexual safety, who makes active sexual choices, and who has an identity as a sexual being.

Research has begun to examine how Latina girls socially construct their gendered sexuality (Asencio, 2002; Denner & Dunbar, 2004; Denner & Guzmán, 2006; García, 2006). Recently, there has been some research on how sexual agency impacts first sexual experiences (García, 2009). This research provides some insight into how Latina youth approach their sexual agency. The main findings of García's research was that girls identified two types of relationships as appropriate for virginity loss in which they could assert their sexual agency—those defined by love and those characterized by a mutual sentiment of caring. In her key study of the sexual, romantic, and reproductive lives of more than 400 teenage girls, Thompson (1990) found that young women who positively described their first intercourse experience were often informed about certain matters, such as their bodies, pleasure, and safer sex, whereas those who were not as informed communicated that they thought they had no sexual choice with regard to their first intercourse experience. Despite the important knowledge that has been garnered about first sexual experiences and sexual agency, there is a need for research on how a girl's sexual agency about her sexual wants and thoughts impacts her concepts of sexual curiosity and pleasure. Therefore, in our research, we examine how sexual agency impacts a Latina girl's feelings of sexual curiosity and pleasure, which we are conceptualizing as important components of sexual desire that have not often been critically examined in empirical research.

SEXUAL DRIVE

Adolescence is a long and complex developmental period, lasting from about ages 10 to 18. Expectations about what is appropriate or healthy for developing sexuality may differ in important ways, depending on

where an adolescent is in the process. For some girls, sexual experiences can be physically and emotionally satisfying throughout adolescence (Thompson, 1990; Tolman, 2001, 2002). For some girls, and under some circumstances, however, sexual experiences can be anything but satisfying. Sexual interactions can rouse negative emotions, such as guilt, shame, anger, regret, and disappointment (e.g., Moore & Davidson, 1997; Sawyer & Smith, 1996; Tsui & Nicoladis, 2004), particularly if they occur in the context of coercion and abuse (Impett & Tolman, 2006; Jordan, Price, Telljohann, & Chesney, 1998). Sexual development is normative in adolescence, including the maturation of sexual organs and hormonal changes. However, the general U.S. adult population lacks acceptance that adolescents experience sexual desire, especially young girls. This may lead girls to feel confused and to have negative emotions when they do experience desire.

Furthermore, if we continue to examine sexuality within a developmental perspective, then developing a healthy sexual drive is one of the tasks of adolescence (Christopher, 2001; Gagnon & Simon, 1973; Tolman, 2002). However, as mentioned previously, because much of the research on adolescent female sexuality is organized around diminishing risks and negative outcomes (Ehrhardt, 1996), we know very little about the positive dimensions of girls' sexual experiences and drive. Although there is a substantial amount of literature tracking girls' sexual behavior and use of protection, particularly for girls of color, little is known about adolescent girls' experiences of healthy sexuality. If we use a developmental lens, we can posit that healthy sexual behavior occurs in a progression of behaviors. It also seems plausible that for some girls early adolescence is the time when sexual behaviors begin to occur with partners. Some research has suggested that the early sexual behaviors of Latina girls include an array of behaviors, some of which are kissing and intimate touching (Guzmán & Dello Stritto, 2011).

Research also suggests that there are gateway sexual behaviors that eventually lead girls to vaginal sex (Rosenthal & Smith, 1997; Thornton, 1990). These behaviors include mutual masturbation, digital stimulation, and oral sex (Lindberg, Jones, & Santelli, 2008; Smith & Udry, 1985). It is less clear how these sets of behaviors progress for Latina girls, since much of the research suggests that Latina girls will engage in vaginal sex but not necessarily in oral or anal sex. Moreover, some research suggests that younger girls will engage in riskier sexual practices, such as oral and anal sex, when they are dating boyfriends who are three or more years older (Gowen, Feldman, Diaz, & Yisrael, 2004). This research also suggests that girls of color and particularly Latina girls are less likely to use contraceptives consistently. Finally, this research also suggests that three out of five Latina girls who engage in inconsistent or unprotected sexual intercourse get pregnant within their first year of sexual initiation. Indeed, because adolescent girls' sexuality is largely ignored until it results in adverse consequences, such as

pregnancy or sexually transmitted infections (STIs), researchers have developed a narrow perspective and body of knowledge on the developmental progression of sexuality and desire in relation to girls.

For Latina early adolescents, it appears important to understand what experiences lead them to want to engage in sexual behavior and how these behaviors become part of their sexual development. In a study of college women, almost two-thirds (61%) of the sample rated their first sexual experience as either perfect, very good, or good (Darling, Davidson, & Passarello, 1992). However, in this same study, less than one-third (28%) of women perceived their first sexual experience to be physically satisfying and less than one-third (28%) perceived their first sexual experience to be psychologically satisfying. This is indeed important information about how older adolescent girls experience first sex. What is missing from this research is how instances of sexual behavior in early adolescence, including kissing and intimate touching, impact both the positive and negative feelings of sexual behaviors and desire in later adolescence. Furthermore, we know little about what contributes to sexual satisfaction for early Latina adolescent girls. Although numerous studies have investigated correlates of sexual satisfaction in adult women (see review by Sprecher & Cate, 2004), no research to date has explicitly examined the factors that enable adolescent girls and young women to have positive, satisfying sexual experiences. In this study, we investigate how sexual agency and sexual drive impact early Latina adolescents' thoughts about pleasure and desire, a dimension of healthy adolescent sexual development that has not been previously examined.

SEXUAL BEHAVIORS

Much of the research about sexual behaviors and adolescent girls focuses on when they initiate sexual activity and less on what that sexual activity means for them, beyond negative outcomes. For example, we know very clearly that, among Latina youth, the number of 15- to 17-year-olds who report ever having had sex fell drastically from 49 percent in 1995 to just under 25 percent in 2002 (U.S. Census, 2007). We also know that Latina adolescents have sexual activity rates lower than those of female African American adolescents and comparable to those of white female adolescents, (Abma, Martinez, Mosher, & Dawson, 2004). However, they seem to fare less well in terms of unintended pregnancies, teenage birth rates, and risk for STIs, including HIV and AIDS (O'Donnell, O'Donnell, & Stueve, 2001; Von Ranson, Rosenthal, Biro, Lewis, & Succop, 2000). Moreover, it appears that much of the research is highly concentrated on the negative outcomes that sexual activity may create (Denner & Guzmán, 2006; Lescano, Brown, Raffaelli, & Lima, 2009; Teitelman et al., 2009; Trejos-Castillo & Vazsonyi, 2009).

There is also very little information about what types of sexual behaviors Latina girls engage in beyond vaginal sex and how those behaviors

are related to sexual desire. It is also important to understand how these young women conceptualize desire and how that desire may lead to further sexual activity. There is one recent study that has examined what types of sexual behaviors Latina girls are engaging in and how those behaviors are impacted by self-efficacy and drug use (Guzmán & Dello Stritto, 2011). In this study, most of the sample had not engaged in vaginal sex; however, the authors found that some girls were engaging in a variety of sexual acts that ranged from kissing to anal sex. It appears that there is a discourse missing that discusses how pleasure and sexual desire impact what sexual behaviors Latina girls are engaging in and how this information may lead to a more comprehensive understanding of Latina sexual health. For the purposes of our study, we examine how a number of sexual behaviors impact the sexual desire of Latina girls.

Given the limited research in understanding Latina girls' sexual desire, our goal was to examine factors that influenced their reports of sexual curiosity and pleasure that we conceptualize as desire. First, we predicted that demographic characteristics (i.e., parental country of origin, language, household size), would impact sexual desire via acculturation (i.e., adolescents with foreign-born parents who spoke more Spanish at home would report lower levels of desire). Moreover, if these girls have more opportunities to discuss sexual norms (i.e., household size), we predicted that they will also express lower levels of desire. Our second goal was to examine the role of parents and peers, with parental communication about sex being linked to lower levels of sexual desire and peer pressure for sex being linked to higher levels of sexual desire. Our third goal was to examine individual level variables, such as sexual agency, sexual drive, and sexual behaviors on adolescents' beliefs of curiosity and pleasure (desire), with higher levels of agency, drive, and behaviors being linked to higher levels of sexual desire.

METHOD

Sample and Procedure

The data used for this study are derived from a large-scale intervention study called the Community Awareness and Motivation Partnership (CAMP), which is a theater-based project aimed at decreasing teenage pregnancy rates and increasing the safer sex behavior of adolescent males and females through schools for a safer sex comprehensive education. The CAMP intervention consists of an assembly style theater production and a series of workshops conducted in each individual classroom during academic school time that address the issues portrayed in the plays (for an additional discussion of the CAMP project see Guzmán, Casad, Schlehofer-Sutton, Villanueva, & Feria, 2003; Guzmán et al., 2003). The

intervention was implemented in one public high school on the South East side of Los Angeles in Southern California.

This school was selected to participate because the school administrators agreed to the project programming. The students that were enrolled in the ninth grade were invited to take part in the study. They were given an assent form and the parents were given a consent form that indicated that they would be participating in a project that would discuss issues related to teenage sexuality, including sexual acts, pregnancy, partner violence, STIs, and sexual desire. The consent form also specified that the data collected would remain confidential and anonymous. A total of 340 adolescents who returned signed consent and assent forms participated in the intervention. The data reported on for this study is from a subsample of 165 Latina females who completed the pre-questionnaire prior to the intervention.

The research evaluation component of the project consisted of collecting data one day prior to the intervention and three days after the conclusion of the intervention. The questionnaire used for the data collection was developed by the research team based on scale items developed by the Office of Family Planning (California Department of Public Health, Office of Family Planning, 2010). Participating teens completed questionnaires in a group setting during school hours in their health education classes. Each questionnaire took approximately 40 minutes to complete, and teens did not receive compensation for their participation in the project.

The sample for this study consisted of 165 females, who self-identified as being Latina with a mean age of 14.3 years. In terms of their sexual orientation, 82 percent reported being heterosexual, 1 percent bisexual, and 14 percent gay/lesbian. In terms of demographic characteristics, 49 percent of the girls lived in homes in which Spanish was spoken the majority of the time by the adults in the household, 16 percent spoke primarily English, and 35 percent spoke both English and Spanish. When asked if they currently had a boyfriend, 55 (33.3%) girls said yes, 108 (65.5%) said no, and 2 (1.2%) did not respond to this question.

Measures

In order to test our predictions, we used the sections of the pretest questionnaire that asked about sexual desire, maternal communication, peer pressure, sexual agency, sexual drive, sexual behaviors, and demographic characteristics (i.e., language spoken at home, parental country of origin, number of individuals in the household).

Sexual Desire

A six-item subscale was created that measured participants perceptions of why they thought other teens engaged in vaginal, oral, and anal

intercourse. This scale is used as a proxy for what adolescents believe for themselves. The stem of the question read: "Which of the following do you think are reasons that teens engage in vaginal sex?" The same stem was used for the oral and anal sex questions. The question items were the following: (a) because it feels good and (b) because they are curious. A five-point Likert scale (from 1 = not at all true to 5 = very true) was utilized for the response set. The items were scaled and the reliability of the scale was $\alpha = .89$. The six scores were averaged and these mean scores were used in all subsequent data analysis. Thus, higher scores on this scale indicated greater sexual desire.

Maternal Communication

A five-item subscale was used that measured how frequently in the last six months girls engaged in the following conversations with their mothers: (1) your questions about sex, (2) ways to prevent a pregnancy, (3) ways to protect yourself from sexually transmitted infections/diseases (STIs/STDs), (4) reasons to wait to have sex, and (5) how to handle sexual pressure by our friends or potential partner. The response choices ranged from 5 = five or more times to 1 = never. The reliability for this scale was $\alpha = .89$. The five scores were averaged and higher scores on this scale indicated more mother–girl communication.

Peer Pressure

A six-item subscale was created that measured participants perceptions of why they thought other teens engaged in the three sexual activities (i.e., vaginal, oral, and anal sex). The stem of the question read: (1) "Which of the following do you think are reasons that teens engage in vaginal sex?" The same stem was used for the oral and anal sex questions. The response options for each question were the following: (a) because everyone else is doing it and (b) because there is pressure to do it. Participants responded on a five-point Likert scale (from 1 = not at all true to, 5 = very true). The items were scaled and the reliability of the scale was $\alpha = .91$. The six scores were averaged and these mean scores were used in all subsequent data analysis. Thus, higher scores on this scale indicated greater peer pressure.

Sexual Agency

An eight-item scale was created that measured participants' reasons for waiting to engage in sex. The stem of the question read: "Which of the following reasons for waiting to have sex are true for YOU?" The response options for the question were the following: (a) It's against my religious values, (b) My parents would be upset, (c) I don't want to get a sexually transmitted

infection/disease, (d) I don't want to get pregnant, (e) I'm waiting until I get married, (f) I am not old enough yet, (g) I have not met the right person, and (h) I'm just not ready to have sex. A five-point Likert scale (from 1 = not at all true to 5 = very true) was utilized for the response set. The eight items were scaled and reliability for the scale was $\alpha = .84$. A mean score was used for analyses. Higher scores on this scale meant that girls were making active sexual decisions and had a positive sexual identity toward sexual behavior.

Sexual Drive

Sexual drive was derived using three questions about the girl's intentions for vaginal, oral, and anal intercourse. Adolescents responded to the following item: "Will you have sexual intercourse (penis in vagina) in the next year?" The same stem was used for oral (mouth on penis or mouth on vagina) and anal (penis in butt) sex. Response options included: (a) I'm sure I won't, (b) There's about a 50/50 chance, and (c) I'm sure I will. The three items were scaled and reliability obtained was $\alpha = .76$. A mean score was used for analyses and higher scores on this scale meant greater intentions to have sex in the next year.

Sexual Behavior

Sexual behavior was derived by summing nine possible sexual behaviors. These behaviors were kissing, masturbation, making out with clothes on, making out with clothes off, finger banging, hand job, oral sex, vaginal sex, and anal sex. Scores ranged from 0 = never engaged in any sexual behavior to 9 = engaged in all sexual behaviors listed. Higher scores indicated girls were engaging in greater numbers of sexual behaviors.

Demographics

Participants were asked what language the adults in their home spoke most of the time, and were provided three response choices: 1 = English, 2 = Spanish, and 3 = Both English and Spanish. Moreover, participants reported the country of origin of their mothers and fathers (i.e., 1 = U.S.-born, 2 = Foreign-born) and the total number of people living in their household, including themselves.

A correlational analysis was conducted between the control variables (i.e., language, parental country of origin, household size), independent variables (i.e., maternal communication, peer pressure, sexual agency, drive, and behaviors), and the dependent variable (sexual desire), in order to examine the strength of the relationships among variables. Finally, a multiple regression analysis was used to test the predictive value of the multiple sexual constructs in desire.

RESULTS

Descriptive Statistics

As seen in Table 4.1, on average girls felt *not sure* or that it was *somewhat true* that having desire as expressed by sexual curiosity and pleasure was something adolescents can have (M = 3.60,.94). In terms of peer pressure, girls report that they think that it is *true* that adolescent's feel pressure to have oral, anal, and vaginal sex (M = 3.37, SD = 1.13). Participating girls also reported on average to have communicated at least once with their mothers about sexual issues, pregnancy, reasons to wait to have sex, sexual peer pressure, and STIs (M = 2.01, SD = .91). In terms of sexual agency, on average girls reported that they thought that it was *somewhat true* that adolescents should wait to engage in sex (M = 2.51, SD = .46). Finally, in terms of sexual drive, on average the participants reported that they were *sure* they would not engage in sexual activity in the next six months (M = 1.21, SD = .38). Adolescent girls engaged in a range of sexual behaviors, ranging from kissing to intercourse. The frequency of these behaviors is listed in Table 4.2, scores ranged from zero behaviors to nine, with a mean of 2.28 behaviors (SD = 1.77).

A correlational analysis was conducted to examine the strength of the relationship between sexual desire, maternal communication, peer pressure, sexual agency, sexual drive, sexual behaviors, and the demographic characteristics (i.e., language use, maternal and paternal country of origin, and number of family members in the household). As shown in Table 4.3, the results indicate that there was a significant positive correlation between peer pressure and desire. Sexual behavior and sexual drive were also positively correlated with sexual desire. Contrary to our prediction, parental country of origin and home language use were not associated with girls' desires. Maternal communication was not significantly associated with any of the variables of interest, and so it was removed

Table 4.1 Descriptive statistics for sexual desire and the predictor variables

Variable	Mean (SD) (N = 165)
Sexual Desire	3.60 (.94)
Household Size	5.56 (1.97)
Maternal Communication	2.01 (.91)
Peer Pressure	3.37 (1.13)
Sexual Agency	2.51 (.46)
Sexual Drive	1.21 (.38)
Sexual Behaviors	2.28 (1.77)

Table 4.2 Sexual behaviors

Characteristics	Frequency	Percentage (%)
Have you ever engaged in any of the following activities?		
Kissing	140	85
Masturbation	28	17
Making out with clothes off	23	12
Anal sex	7	4
Making out with clothes on	105	65
Oral sex	20	12
Hand job	26	16
Digital stimulation	25	15
Vaginal sex	20	12

*These data does not account for individuals who may have participated in more than one sexual behavior, and therefore percentages will not add to 100 percent

Table 4.3 Zero-order correlations between sexual desire and predictor variables

	1	2	3	4	5	6	7	8	9
Sexual desire	–								
Language	–.02	–							
Maternal origin	.07	.23**	–						
Paternal origin	.08	.04	.39**	–					
Household size	.15*	.05	.01	–.03	–				
Maternal communication	–.01	.08	.08	–.04	.02	–			
Peer pressure	.76**	.01	.03	.06	.05	.10	–		
Sexual agency	.14	–.03	.02	–.01	.04	.07	.31**	–	
Sexual drive	.15*	.04	–.01	.11	.08	.08	–.11	–.49**	–
Sexual behaviors	.23**	–.01	–.11	.06	–.05	–.01	–.03	–.30**	.60**

*$p < .05$, **$p < .01$

from any subsequent analysis. Also, there was a significant negative correlation between sexual agency and sexual drive and behaviors. Furthermore, there was a positive correlation between sexual agency and peer pressure. In order to further test our predictions and explore whether peer pressure, sexual agency, sexual drive, and sexual behaviors had a significant impact on girls' sexual desire, a multiple regression analysis was conducted.

Regression Results

In step 1, the control variable language was entered first into the equation, followed by maternal and paternal country of origin, and household

Table 4.4 Regression results of the predictors of Latina early adolescents' sexual desire

Model	Variables	F (df)	R^2	ΔR^2	B
Step 1	Language	1.59 (4,125)	.02	–	−.01
	Maternal country of origin				.11
	Paternal country of origin				.08
	Household size				.16
Step 2	Language	156.49 (1,124)	.56	.53	−.01
	Maternal country of origin				.07
	Paternal country of origin				.03
	Household size				.12*
	Peer Pressure				.73**
Step 3	Language	9.54 (3,121)	.64	.08	−.01
	Maternal country of origin				.11
	Paternal country of origin				−.01
	Household size				.11*
	Peer pressure				.74**
	Sexual agency				.05
	Sexual drive				.14
	Sexual behaviors				.20**

*$p < .05$, **$p < .01$

size. In step 2, peer pressure was entered into the model, and in step 3, sexual agency, sexual drive, and sexual behaviors were entered. The results are shown in Table 4.4. In step 1, the control variables accounted for 2 percent of the variance but were not significant predictors of sexual desire, except for household size. In step 2, we entered peer pressure into the model, which explained 56 percent of the variance. In step 2, household size and peer pressure were both significant predictors of sexual desire, whereas other demographic characteristics were not significant predictors. In step 3, we entered sexual agency, sexual drive, and sexual behaviors, which explained 64 percent of the variance in the model. In step 3, household size and peer pressure remained significant predictors of sexual desire; in addition, sexual behaviors significantly predicted desire. The results of the combined model show that household size, peer pressure, and girls' sexual behavior significantly predict sexual desire.

DISCUSSION

As mentioned earlier, much of Latino culture creates a dichotomy of sexuality for Latina girls and women. This dichotomy involves labeling girls as either virgins or whores, based on their behavior. This idea about sexuality is primarily ingrained in Latina girls by the female members of their households through *consejos, platicas,* and *cuentos.* Therefore, we

predicted that Latina girls who came from traditional family homes and had more conversations about sexual issues with their mothers would report experiencing less desire, since Latino sexual morals do not allow for the idea that women should experience desire, especially outside of marriage. Based on our correlational analysis, we found that having conversations with mothers about sexual issues (*consejos, platicas,* and *cuentos*) did not have a significant relationship to sexual desire. This is a somewhat surprising finding, given that much of the literature on parent communication would suggest that parents have some influence in the adolescent's construction of their beliefs, with adolescents from immigrant parents having more conservative values. Additionally, we did find that household size positively impacted sexual desire—the more individuals in the household, the more desire expressed by these young girls. Based on this finding, it appears that although Latina girls may not be talking to their mothers about desire, they may be talking about desire to other family members living in their household. These individuals may be sisters, cousins, and aunts who may be more acculturated into the U.S. mainstream culture, and therefore hold more positive beliefs about female sexuality, including the idea that women can and should have desire. This conclusion is merely speculation, and future research should examine more closely the role that other family members have on the sexual desire of early Latina adolescents.

With regards to our prediction that the more peer pressure Latina girls perceive the more likely they are to experience desire was supported by our data. This information is in line with much research that suggests that peers have a significant impact in the initiation of sexual activity of girls (DeGaston et al., 1996; Denner & Coyle, 2007; Driscoll et al., 2001; Halpern-Felsher et al., 2004; Hampton et al., 2005; Maxwell, 2002; Teitelman et al., 2009). This is not a surprising finding, given that girls may be spending large amounts of time with friends, and therefore have ample opportunity to discuss sex, sexuality, and desire. Future research on this topic must delve further into how desire and sexual behavior is impacted by peer pressure. An examination of these connections will contribute to a fuller picture of the sexual development of Latina girls.

We also predicted that Latina girls who reported having greater agency about their convictions about engaging in sexual activity would experience more sexual desire. Our prediction was not supported by our data. The limited amount of research on sexual agency and girls suggests that when girls have stronger sexual agency the more pleasurable their first sexual experiences will be (Thompson, 1990). Research specifically on Latina girls suggests that these girls experience greater agency in initiating sexual behaviors if they can define the relationship as one in which there is love or a mutual sentiment of caring (García, 2009). Although this research provides some information about agency and sexual behavior, it

does not examine desire and sexual behavior. This study seems to be one of the first that examines agency in relation to desire and sexual behaviors. Clearly, our findings suggest the need for further research. Perhaps, we did not find a significant relationship among sexual agency and desire because of the items we used. In our scale, we asked girls to report what was important to them in waiting to have sex. Future research should examine what types of thoughts, such as good feelings about sexual encounters or feelings of love for your sexual partner, impact the sexual desire of Latina early adolescents.

We also predicted that Latina girls who had more sexual drive to engage in sexual activity would experience more sexual desire. It is surprising that our analysis did not support this prediction. Research does suggest that the more an adolescent is willing to engage in sex the more likely they are to engage in it in the future (Buhi & Goodson, 2007); however, desire has not been explicitly examined. It is plausible that the articulation of when you will engage in sex is unrelated to how these girls feel about their sexual desire. It might also be plausible that, as mentioned previously, young girls might be disassociated from their own feelings of desire because they are only aware of desire as it is sold to them. They may not associate their feelings of desire with sexual behavior, because the media and our society has instilled the idea that desire is meant to only serve an outward appearance of who you are as a girl/woman. Therefore, future research should examine more closely how sexual drive, sexual activity, and sexual desire may impact a young girl's sexual identity. This information can potentially create a more comprehensive understanding about how early adolescent Latina girls experience themselves as sexual beings.

Finally, we predicted that the more sexual behaviors Latina early adolescents were engaging in the more sexual desire they would experience. It is not surprising that our data supports this prediction. As mentioned earlier, if we examine sexual behavior from a developmental progressive stage, then our findings fit the idea that the more sexual behaviors these girls are engaging in the more desire they are likely to develop. This also might suggest that with more sexual activity comes a greater understanding of one′s own sexual behavior and desire. What would be important to tease apart is whether there are certain sexual behaviors that lead to more desire and sexual activity or whether the progression of sexual behaviors leads to more desire and sexual activity. As mentioned earlier, research suggests that Latina girls will engage in vaginal sex and bypass a progressive stage of sex that first involves intimate touching, oral sex, and then move on to vaginal sex. It would be important to examine whether it is certain sexual behaviors and their frequency that build desire or if it is the progression of behaviors that builds desire or some combination of these behaviors.

In conclusion, our research contributes to the idea that early adolescent girls do experience desire, and that understanding their desire from a positive developmental perspective gives us a broader picture of what role desire has in the lifespan of women, and in particular Latina early adolescents. Our findings also suggest that the topic of desire and women should not be primarily broached as a physical health issue, such as a hormonal imbalance (Lobo, Rosen, Yang, Block, & Van Der Hoop, 2003) or part of a medical condition, such as polycystic syndrome (Elsenbruch et al., 2003). Moreover, female desire should not only be discussed in terms of sexual dysfunction or for women who have chronic and terminal illnesses, such as cancer and HIV (Basson, 2006; Bova & Durante, 2003; Rothblum, 2000). Desire needs to be front and center in the discussion of women's sexual health throughout the lifespan. As Fine (2003) has suggested, it is time for us to acknowledge that women of all ages experience desire and that we should examine how desire creates a complete picture of women's sexuality. Until we can conceptualize a more accurate picture of female desire throughout the lifespan, our public discourse about female sexuality will be driven by pathology, which includes abuse, rape, incest, disease, and dysfunction.

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Chapter 5

Tensions and Intersections: Motherhood, Work, and Sexuality in U.S. and India Contexts

Alyson L. Burns-Glover and Bharati S. Kasibhatla

Women's lives exist within the intersections of their social roles, identities, and daily activities (Cole, 2009; Taylor, 2009; Weber, 1998). These intersections are affected by geographic (Townsend, 1991; Singh, 2010), national (Craig & Mullan, 2010), and cultural (Hofstede, 2001; Williams & Best, 1990) contexts. In this chapter, we address how women's lives are enacted in two multicultural democracies that have experienced significant changes in work and family roles for women in the past two decades: the Republic of India and the United States of America. Within these countries, questions of work, gender, and sexual well-being must be confronted with concomitant attention to other identities (race, class, ethnic, sexual) to fully appreciate women's lived experience.

In the United States, researchers have recognized that economic conditions have changed rapidly, the majority of women will work outside the

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home (Spain & Bianchi, 1996), and that this social change will affect women's sexual lives (Hyde, DeLamater, & Durik, 2001). Likewise, the Indian Council of Social Science Research has responded with a three-volume review of current research, new insights, and understandings about rapid change, cultural values, and daily social practices that influence behaviors in India (Pandey, 2001). Included in this review is a focus on feminist challenges to sex role socialization theories which failed to "encompass the multiplexity of the lives of men and women and underplays the dimension of power and *change induced conflict and tension*" (Bharat, 2001, p. 340; emphasis added). Indeed, the emergence of a uniquely *Indian* psychology has included more attention to situation-dependent preferences for social behaviors. This psychological focus on sociohistorical conditions, rapid social change, and multilevel (culture, gender, race, class, ethnicity) analyses of human behaviors has emerged contemporaneously with the U.S. scholarship noted above. Rapid social change in both nations invites comparisons of their lived experiences and how these influence their adaptations to these change-induced tensions. This chapter will review the interwoven concepts of work, sexuality, and motherhood in the lives of U.S. and Indian women.

WOMEN, WORK, AND WOMEN'S WORK

Internationally, the historical trend has been for more women across more social classes to enter the paid workforce. Within these two heavily populated, multicultural, democratic countries such change is being enacted within diverse class, cultural, political, and historical conceptions of gender, work, and sexual relations with the attendant complexities in processes and outcomes (Seymour, 2001; Stebbins, 2001; Vepa, 2009).

In India, this trend has been felt most acutely with the advent of globalization and the restructuring of work (Ganguly-Scrase, 2003; Kim-Puri, 2005); rise in two-career families within the middle classes (Bhatnagar & Rajadhyaksha, 2001); and expansion of home-based or nonunionized low wage work in the working classes (Ghosh, 2002; Pillai & Shanta, 2011). These exist along with a dual message of gender role liberalization for women, but with normative expectations for the primacy of family relationships (Das, 2011; Roland, 1988; Sinha, Sinha, Verma, & Sinha, 2001) and expressive traits for *both* genders (Sethi & Allen, 1984).

In their review of four epochs (postindependence to mid-2000) of work and family research in India, Rajadhyaksha and Smita (2004) point out that while feminist and social policy researchers focused their attention from the 1970s to the 1990s on political analyses of structural oppression of impoverished women, psychological research at that time attended to family relations, gender roles, and working women within urban, more affluent, populations. For example, Shukla and Kapoor (1990) studied sex

role identity, decision making, and marital satisfaction in middle-class Indian couples. Women's employment was considered as part of a valued resource theory of marital power (anything a partner brings to the marriage that helps the other person satisfy needs/goals). The findings indicated that both women's employment (economic) and androgynous traits (competence, assertiveness, interpersonal effectiveness) were important resources within the marriage. Employed, androgynous *middle-class* Indian wives had more decision-making authority. When decision making was shared, there was also higher reported marital satisfaction.

With the advent of liberalized Indian economic policies in the early 1990s, the effects of globalization on work and family life for women *across* classes became of interest. This line of inquiry found little improvement in the lives of women: the majority of the findings showed that women experienced tensions between their home and work roles while men experienced tension between work and spousal obligations. However, researchers concluded that these family friendly measures "offered more as an imitation of western organisational practices rather than from a genuine concern to enable (women) workers to handle work and family responsibilities" (Rajadhyaksha & Smita, 2004, p. 1678).

In the West, beliefs about gendered roles and how they affect family-work intersections also point to the importance of class analyses. Men's relative share of household labor is consistently predicted by his employment hours and his own gender ideology. However, men's own unemployment did not always translate into increases in his participation in household work; the findings are decidedly mixed and inconsistent. A key predictor of his level of housework is the man's acceptance of the wife as a *co-provider* (Coltrane, 2000). Researchers also note that husbands and wives diverge in their perceptions of how many cleaning responsibilities men actually take on in the home. The majority of qualitative and quantitative studies conclude that working mothers and fathers appear to have vastly different experiences of the multiple role demands—parent, partner, worker, and so on. For mothers alone, role strain was located not just in the balancing of the time and task demands of home and work, but also low family cohesion—lack of commitment, help, and support from other family members (Lee, Vernon-Fegans, Vazquez, & Kolak, 2003). Narrative data indicate that "institutional, interactional, and cultural factors reinforce one another to maintain or create gender differences throughout early parenthood" (Singley & Hynes, 2005, p. 392).

In her work on egalitarian families in the United States, Deutsch, Kokot, and Binder (2008) have consistently documented the effects of ideologies of empowerment and superwoman efforts for career-mother balance. In a recent study of heterosexual college women's expectations for such relationships, Deutsch and her colleagues examined these expectations in association with the women's own gender ideologies, beliefs about mothering,

work demands, and family dynamics. Three paths toward equality in marriage emerged: both scale back, both rearrange work schedules, and outsourcing. The majority of these respondents did believe that they would have some kind of an egalitarian marriage. How this was to be enacted was reliably correlated with their beliefs about children's needs—the primacy of the mother role (e.g., "There are many things only a mother can provide") and the belief that their work would be equally valued. In this study, the outsourcing was only conceptualized as hiring others to do the work; no mention was made of extended family cooperation or assistance. Within the United States, a formula for women's work-home balance has emerged as a social narrative of fulfillment within one's career paired with a dominant discourse about intensive mothering, monitoring, and being available to one's children (Guendouzi, 2006).

This class-based and gendered vision of work-family intersections in the West is less occluded when lesbian couples' experiences are addressed. In Mezey's (2008) study of lesbians' choices about motherhood, she noted that the organizing factor in their decision was actually class status. Lesbians anticipating motherhood reported that work roles and demands actually discouraged them from becoming a parent. Mezey identified two factors: work provided economic stability or mobility and the absence of health insurance or domestic partner benefits to support parenting. These material realities remind us that social conditions interact with gender constructions in a myriad of ways seen and unseen.

TIME AND TENSIONS

Everingham (2002) notes that much of the discourse about working mothers' struggle for work-family balance is located in a postindustrialist conception of time being *clock* time. Modern conceptions of time attempt to compartmentalize them into clock, social, and natural domains. For women, these divisions are illusory. The nature of domestic life, "chores punctuated by the length of task rather than the clock" (Everingham, 2002, p. 338), the biological needs of nursing infants, and the schedules of other family members, all contribute to how women experience time. Time must be *made* to engage in any activity and it falls to women to produce it.

Contrary to Western conceptions of lifecycle changes in women's investments in their mothering versus worker roles, researchers found that parental role commitment in the case of India *increased* with age and marital role commitment decreased. For middle-class women, family roles are considered "central to their very being" and take precedence over demands from occupational roles and intimate relationships (Bhatnagar & Rajadhyaksha, 2001). In a study of effects of wives' employment on Indian couples' role perceptions and performance (Ramu, 1987), researchers found that couples agreed on ideal roles for the husband, irrespective of

the woman's employment status (in fact, women in dual-earner couples had the *most* conservative attitudes). A husband's nonparticipation in domestic duties was mitigated by the deployment of other family members or hiring domestic servants. Time is also contingent on women's class background. Cleaning is relegated to women of the working classes, giving middle and upper-class women the time to take care of their maternal duties and careers and creating different timelines for women of both classes. Men, on the other hand, are not required to devote time to domestic duties.

When decision making in Indian families was analyzed, similar patterns were found (Shukla, 1987). Such arrangements reflect both (a) the informal power of women in Indian family systems (they hire, direct, and have authority over others) and (b) the maintenance of Indian socioreligious norms of male status and the primacy of women's natural roles as wife and mother. Recent research also differentiates between the typical nuclear family level of analysis prevalent in Western research and the realities for Indian women with duties to extended family members both inside and outside their own homes (Rout, Lewis, & Kagan, 1999).

This has also been the case the United States. "In reality, poor women have always worked, rich women have always had childcare, and many women from all socioeconomic levels, with and without children, have worked out informal arrangements that have not been captured by official tallies" (Halpern, 2005, p. 398).

MODERNIZATION AND TRANSFORMATIONS OF INTIMATE RELATIONSHIPS

Increasing exposure among the Indian middle class to Western conceptions of consumerism and class mobility has created attendant tensions between modernity and traditionalism (Fernandes, 2000). However, the majority of research has documented the differences between these two multicultural countries in self-concept (Dhawan, Roseman, Naidu, & Rettek, 1995; Schmitt, Allik, McCrae, & Benet-Martinez, 2007), approaches to feminism (Purkayastha, Subramaniam, Desai, & Bose, 2003), and gender ideologies (Gibbons, Hambey, & Dennis, 1997; Hofstede, 2001; Mahalingham, 2003; Sethi & Allen, 1984; Williams & Best, 1990). These two also differ in their concepts of romantic love and marriage (Hofstede, 2001; Levine, Sato, Hashimoto, & Verma, 1995), as well as duties and roles within heterosexual marriages (Deutsch et al., 2008; Ramu, 1987).

India and the United States have developed different sociocultural expectations for couples' relationships. A critical difference is in the resilience of the tradition of arranged marriages in India. Within middle and upper classes/castes, this practice has not only reflected both traditional religious beliefs regarding female sexuality and family honor, but also

has served to maintain stratified social arrangements in the face of rapid changes in technology, economics, and daily habits that threaten cultural identities (Netting, 2010). Even with the advent of globalization and liberalization of some sexual attitudes in Indian society, sexual conservatism and gender double standards are still the norm amongst college youth (Ghule, Balaiah, & Joshi, 2007).

In traditional societies, such as India, the relationship is constructed by different expectations about choice (arranged marriage), locality (living near or with paternal or maternal family), endogamy (within caste/class), and beliefs about intensity of childcare and mother-child bond (Craig & Mullan, 2010; Roland, 1988).

When characteristics of marriage satisfaction (e.g., love, loyalty, and shared values) and dimensions of personal wellness (e.g., love, spirituality, friendship) were rated by Indian couples in arranged marriages and compared to U.S. participants' scores, researchers found no significant difference in overall marriage satisfaction or the love subscale of personal wellness between these two cultures and marriage types. However, differences with small-to-medium effect sizes were found in ratings of the importance of love and loyalty, with U.S. respondents rating these as more important than Indian respondents did. In the U.S. culture, where choice of mate is the norm, respondents place a high value on love as the prerequisite to a successful marriage. Loyalty, therefore, is an expression of one's commitment to the choice made. In the Indian case of arranged marriage, romantic love was not the necessary precondition to the marriage. Indian conceptualizations of loyalty are located in their expectations that marriage will involve adjustment to the partner after marriage and desire to fulfill the wishes of their natal families (Myers, Madathil, & Tingle, 2005).

Members of the middle classes of India practice a form of arranged, endogamous companionate marriage, in which both individual needs for love and personal fulfillment coexist with practices that replicate and maintain caste/class distinctions. Although modern marriages may reflect some concern with personal choice and emotional attraction to one's partner, "endogamy is still normal, and caste is rarely ignored" in such attraction (Fuller & Narasimhan, 2008, p. 750). At the same time, an emerging body of qualitative, feminist analysis also asserts that postcolonial Indian women of the middle and upper classes are engaged in a whole-scale struggle to renegotiate gender identity, sexuality, and autonomy over their bodies. The modern Indian woman is also struggling to establish her sexual autonomy within her family, her marriage, and within cultural norms for the primacy of motherhood in Indian feminine identity (Orchard, 2007). In her review of the meaning of the bra to Indian women, Sukumar (2007) asserts that the bra a woman chooses to wear (type, color, fabric) "is a tool to conform to society, a tool to express her sexuality, a tool to secure her place in society and a dictionary of her character" (Orchard, 2007, p. 267).

MOTHERING IN THE MATRIX: U.S. AND INDIAN CONSTRUCTIONS

Feminist psychology has succeeded in challenging essentialist canards about mothering and the role of women as caregivers. Oberman and Josselson (1996) reconceptualize mothering as a *matrix of tensions* experienced by all mothers, where conceptions of self, sexuality, isolation, and maternal control exist in the intersection between social myth and the daily tests of other roles women must enact. In interviews with heterosexual couples, mothering was revealed to be part of a larger gender legacy that conceives of it as a gendered talent, in which women were natural experts, fathers were observers, and mothers were responsible for the children across all domains and time frames (Cowdery & Knudson-Martin, 2005).

Norms of child rearing and mothering differ considerably between the Indian and the dominant cultural context of the United States. As Roland (1988) noted, the Indian model of mothering would be considered aberrant in the U.S. context. While the U.S. mother is expected to prepare a child for autonomy and independence, the "normal Indian woman, on the other hand prepares her child for intense familial interdependencies through her symbiotic mothering" (Roland, 1988, p. 239).

HOLDING SEX CONSTANT: GENDER AND LESBIAN MOTHERS

When heterosexual mothers' experiences are compared with lesbian mothers, the matrix they both inhabit is infused with gendered expectations and heteronormative dynamics. Results of the *USA National Lesbian Family Study* indicated that lesbian couples report high levels of shared responsibilities in child rearing, paid labor, and household chores (Gartrell, Rodas, Deck, Peyser, & Banks, 2006) and more efficacy in actually enacting such equality (Downing & Goldberg, 2011). However, even lesbians' egalitarian impulses confront the quotidian realities of parenting; while lesbian couples are more likely to espouse an egalitarian norm for the relationship, the biological mother of their young children will "often perform more childcare and non-biological mothers often work longer hours in paid labor, at least when the children are young" (Downing & Goldberg, 2011, p. 102). The nonbiological mothers were more likely to perceive that the division of labor was equal than the biological mothers, and they were also more likely to report more tension in their attempts to balance work and family. At the same time, respondents also emphasized that they were avoiding sex-stereotyped divisions of labor.

In the Indian context, researchers have focused primarily on how mothers living in poverty across ecocultural settings (e.g., agricultural vs. urban) balanced their childcare and work demands (Kaur, Menon, & Konantambigi,

2001). These mothers' balancing efforts are located in a complex web of relationships among "the subsistence activities of a group, the nature of support available, and the role of other family members in providing childcare" (Kaur et al., 2001, p. 195).

Including culture, ethnicity, class, and sexual identity in our analyses underscores the complexities of women's lived experiences of the socially constructed identity of *mother.* The same attention must be applied to a discussion of mothers' sexual relationships and daily obligations.

MOTHERHOOD, SEX, AND SEXUALITY AT THE INTERSECTIONS

"Maternal sexuality is a topic that makes virtually everyone anxious" (Weisskopf, 1980, p. 767). While this author was addressing the intrapsychic and societal discomforts that arise from dichotomized concepts of the nurturer versus sexualized woman, here we address the quotidian realities of how mothers are afforded the time, space, and right to assert themselves as sexual beings.

Female sexuality in toto is freighted with political and historical implications (Correa & Parker, 2004). Female sexual subjectivity has only recently been operationalized in Western psychological research (Horne & Zimmer-Gembeck, 2006), and this subjectivity is both a focus of inquiry in studies of well-being and a cause for concern amongst feminists, the overarching theme being a concern about a larger cultural shift toward hypersexualized teens and the implications of women becoming sexual *subjects* rather than objects (Wouters, 2010). Even the most contentious discussions about erotic plasticity and evolutionary adaptive differences in sexual drives acknowledge that the *expression of* female desire is bounded by prevailing social attitudes, women's lesser status, power, and sexual double standards (Ghule et al., 2007; Hyde & Durick, 2000).

When sexual desire is contextualized within women's roles as mothers, the picture becomes even more complex. In a study of perceptions of sexuality and motherhood, researchers reported that Israeli Jewish respondents' ratings of target women revealed orthogonal schema: the more a woman was seen as sexual, the lower she was rated on mothering (Friedman, Weinberg, & Pines, 1998). Despite these known intrapsychic and social conflicts, there is still a paucity of generalizable research on how mothering, work (gendered expectations and daily activities), and sexuality coexist for women (Koert & Daniluk, 2010).

Instead, female sexuality is persistently problematized and women are consistently tasked with solving the problem of their desire (or lack thereof), particularly within the context of mothering and the maintenance of heterosexual relationships. As Leiblum noted in her review of gender differences in sexual desire, "female desire is stifled by a host of

social factors that impede and discourage free sexual expression" (2002, p. 66).

Personal distress can arise from the sociocultural pressures on young mothers in the United States to demonstrate a "seamless transition to having it all together—perfect bodies, great sex with spouses, loving and cheerful relationships with children, active social lives and professional success" (Trice-Black & Foster, 2011, p. 96). These pressures are located within a larger narrative in which sexuality from adolescence to middle age is constructed by media and the society to which it markets its reality. "In magazines directed to both groups, sex is described as the work and worry of women. In both cases, women are deployed as the managers of sexual expression in the interest of the continuation of heterosexual marriage" (Clarke, 2009, p. 425).

In her discussion of sexuality within lesbian families, Gabb (2001) interrogates these management strategies by offering the lesbian family as a contrapuntal voice to gendered assumptions about female sexuality. Presumed biological inevitabilities regarding postnatal decreased sex drive should be located within social conditions of families, not the hormonal status of mothers. The intersection of the mother social role and lesbian sexual identity challenges the heteronormative story: a "good mother" is sexless, selfless, and therefore *not a man.* Gabb offers a construct of family sexuality. In these families, sexual education and conversation is located within the reality that parental sexuality is unrelated to procreation and procreation does not arise from their sexual behaviors.

BABY NEEDS AND MOTHER LOVE: SEXUALITY, BREASTFEEDING, AND CO-SLEEPING

The nexus of sexuality and mothering is most obvious in how women negotiate and enact social norms and traditions related to infant care: namely, where the baby sleeps and what the baby eats. Both are influenced by the mother's other roles (worker, parent, caregiver) as well as social constructions of good mother and good sexual partner.

In the case of lactation, much research has attended to the factors that facilitate or inhibit rates of breastfeeding (Centers for Disease Control, 2010) across ethnic, racial, and socioeconomic strata, but little has interrogated either the inherent sexuality of the act or the pressures put on mothers to produce milk. This is also rooted in the ambivalent sexism underlying attitudes held by both genders toward the practice of breastfeeding in public settings. In her study of both genders' responses to photos of women breastfeeding in public or private, Acker (2009) found that public breastfeeding in the U.S. context elicits powerful tensions between the sexualized breast and the ideology that selfless mothers breastfeed, but do so in private and with a modesty befitting their sexless status. These

breastfeeding attitudes are influenced by U.S. women's sense of body consciousness and sexualization of the breast (Rodriguez-Garcia & Frazier, 1995). In a study of young, educated college women, the majority of the respondents did intend to breastfeed for a few months, but they also had negative attitudes toward breastfeeding in public (Johnston-Robledo, Wares, Fricker, & Pasek, 2007).

Although women report generally positive attitudes toward breast changes associated with pregnancy and breastfeeding, "the experiences of sexual arousal during nursing can cause conflicts and discomfort" and "it is not uncommon for women to feel that 'sharing their breasts' with their male partners is not quite right so they avoid sexual exchange" (Leiblum, 2002, p. 63).

Avishai (2007) locates breastfeeding in the discourse of a body project for class- and race-privileged women. Breastfeeding becomes another project for these women to manage, measure, and maintain. She concludes that American women are "relearning an embodied, reproductive, and mothering practice within a specific cultural context, one that is heavily stratified, highly consumerist, and deeply invested in bodily discipline" (Avishai, 2007, p. 149). The lactating mother's project is then to control her own needs, purchase the needed supplies, and establish the clock-based routines of when and where she is "allowed" to nurse her infant.

Even within lesbian couples, breastfeeding presented different meanings for the biological and nonbiological mother. Some nursing mothers shared the heteronormative belief about a special connection to the nursed infant and some focused on the level of commitment it entailed. Others, however, focused only on the practicality of feeding. Among the nonbiological mothers, some reported feeling "relegated to the role of secondary mother" (Goldberg & Perry-Jenkins, 2007, p. 314). In this study, the sexual issues surrounding the access to and pleasures of the breast for the nonnursing partner were not addressed nor reported.

Just as beliefs about breasts express core ideas about sexuality and mothering, where the baby sleeps is an indicator of any given culture's beliefs about mothering, sexuality, and socialization into the norms of the culture. Modern Western, industrialized societies have developed a perplexing antipathy toward co-sleeping. The American Academy of Pediatrics went so far as to advise against the practice, leading to a reduction in reports of bed sharing, at least among middle-class participants, presumably because of concerns about safety for their infants (Norton & Grellner, 2011). However, parents often receive contradictory advice from these experts; some touting the benefits, others expressing dire warnings (Germo, Chang, Keller, & Goldberg, 2007).

In his review of clinical opinion and empirical research, Okami (1995) documented the rise of clinicians' concerns about exposure to parental sexuality (i.e., primal scene) or nudity despite the paucity of any evidence

to support the concern. Empirical studies of exposure to parental sexuality points out its relation to social class (middle class less likely than working class) and the absence of any "negative consequences for adult functioning" (Okami, 1995, p. 58).

In one of the few studies that addressed effects on marital intimacy, Germo and colleagues (2007) asked both fathers and mothers in heterosexual relationships to describe sleeping arrangements and rate various aspects of family life and the marital relationship. Despite convergence in endorsement of bed sharing in general, gender differences were apparent. Mothers across all sleep groups (solitary, planned co-sleeping, or reactive co-sleeping) did not differ in their ratings of marital intimacy, but the fathers of children with sleep problems (reactive co-sleeping) had the lowest marital quality ratings.

The research has as its explicit concern the supposed effects of co-sleeping on the disruption of both the parents' and the children's sleep patterns (with the assumption that sleeping apart and through the night is normative). In contrast, the practice of co-sleeping in India is often extended beyond infancy. Bhavneet, Malhi, and Kashyap (2006) reported that 93 percent of children in their study shared beds with parents, despite the availability, in many cases, of a separate room.

According to Hoffman (2007), parents are confronted with often conflicting sources of "expert" opinion, but "much of the advice they get is driven by personal philosophy, public policy, and economics, having nothing to do with the well-being of babies and their families" (p. 355). Consequently, where and when a woman sleeps becomes another contested terrain of women's sexual and mothering identities.

TENSIONS AND SEXUAL WELL-BEING

Considerable debate arises in any discussion regarding the problem of female sexual desire. While modern concerns in India have focused on concerns about the unleashing of desire among middle- and upper-class women (Puri, 1999), in the United States, there has been a feminist backlash against "disease mongering" approaches to supposedly hormonally mediated low levels of female (hetero)sexual desire (Tiefer, 2006) and assumptions that women's work outside the home has a negative effect on their sexual functioning (Hyde et al., 2001).

Hyde and her colleagues (2001) studied 570 pregnant women and 550 husbands and partners of those women. They did not find the uniform decreases in sexual satisfaction to be related to a woman's work status (full, part time, homemaker), rather, they found that the saliency of worker or spouse identities predicted frequency of intercourse, sexual satisfaction, and attraction to one's spouse. They concluded: "To the extent that individuals hold 'husband' or a 'wife' to be a salient identity, the

relationship—specifically, the sexual aspects of the relationship—appears to benefit" (Hyde et al., 2001, p. 22). Hyde and her colleagues explicitly question the attribution of reduced sexual drive to fatigue or overwork. They believe changes in sexual behavior within couples must be understood as a part of a larger discussion of commitment, gender roles, and beliefs about sexuality itself, not the stressors of the work week alone.

In a large-scale U.S. study of females between the ages of 18 and 102, researchers reported that the most common sexual problem was low desire (Shifren, Monz, Russo, Segreti, & Johannes, 2008). Their findings indicated that unlike men, who have increased sexual dysfunction as they age, the pattern of distressing sexual problems (lack of desire combined with distress; lack of arousal or orgasm) is inconsistent in research with women. They found that the rates of sexual problems related to low desire peaked in middle age (45–64), and were associated with depression, anxiety, thyroid problems, and urinary incontinence. Both psychosocial and biological problems contributed to changes in women's sexual desire.

In an online survey of predominantly white, college-educated respondents (Ellison, 2002) women's reports of sexual problems fell into two categories: "lack of interest, fatigue, or lack of time due to family and work obligations" and "discrepancies in desire for sexual activity or preferences for various sexual activities" (p. 150). Fatigue, being too busy, and lower levels of sexual desire were the three most commonly reported problems. Ellison considers these to be embedded in "socio-cultural, political, or economic factors" as well as "sexual problems related to partner and relationship" (p. 150). Her findings inform her reconceptualization of female sexual desire that rejects a medical view of sexuality that erases the relational context of sexuality.

According to the Waite and Joyner (2001) analysis of the 1992 National Health and Social Life Survey, "Physical satisfaction with sex is higher for men and women who have sex more often and when the female partner always or usually has an orgasm" (p. 258). That frequency is often contingent on the factors elucidated in Ellison's study (2002): time, fatigue, and quality of the relationship. So, as Hyde and colleagues may have found that saliency of roles (work vs. spousal) was predictive, they also acknowledged that any explanation of the links between work schedules and sexual desire would require "a multiple-theory, multiple-process approach" (p. 22).

Similarly, Indian women's sexuality is explicitly tied to larger concerns with nationality, autonomy, and political conditions that affect their ability to protect their sexual and physical health. Jejeebhoy (1997) calls on Indian population-control programs to take women's holistic reproductive health into account. The availability of resources for women is crucial to their ability to make choices that promote sexual and reproductive health, whereas the absence of these resources leads to poor health outcomes.

The Indo-U.S. collaboration, Research & Intervention in Sexual Health: Theory to Action (RISHTA; also means relationship in Hindi and Urdu) to promote sexual health focused on urban poor communities in Mumbai, where patriarchal culture and men's extramarital sexual behaviors put women at significant health risk (Bojko et al., 2010). The defining feature of the RISHTA project is the provision of psychoeducational resources. Specific attention was paid to gender roles and responsibilities, relationship tensions, and sexuality, including the reduction of sexual violence. The results of the study indicated that the wives who reported greater sexual satisfaction had husbands at lower risk for extramarital sexual activities.

Rocca, Rathod, Falle, Pande, and Krishnan (2009) assert that educational, economic, and empowerment programs that fail to acknowledge the complex social norms and local practices can, in fact, increase Indian women's vulnerability to intimate partner violence. In fact, their study indicated that love marriages might result in an increased risk of domestic violence as opposed to arranged marriages, because a love marriage might imply the loss of traditional social support. The study shows the importance of intersections among different factors, such as sexuality, class, gender, and domestic violence, in specific contexts. It is only by taking the cultural interplay of different factors into account that one can formulate effective intervention strategies.

In considering the United States, Collins (2008) reminds us that a focus on intersections enables analyses that connect domestic violence, structured as only a gender-related issue in the popular imagination, to the problem of social and national development. Intersectional analysis, as it is applicable to domestic violence, has far-reaching implications for the integration of gender and sexuality studies into sociopolitical analysis. Panda and Agarwal (2005) provide a trenchant critique of models of empowerment promulgated by government agencies whose measures fail to address the role of abuse of women and girls (sexual, physical, and mental) in a country's economic development.

Go and colleagues (2003) studied the effects of gender, class, and sexuality in their analysis of the politics of HIV prevention in Chennai slums. In the context of a working-class and poor city neighborhood, the gender norms are quite rigid; an ideal woman is supposed to be submissive and obedient, whereas an ideal man must be the provider and maintains the family's reputation in the community. This description of the ideal gender roles encompasses gender, sexual, and class norms, so that while male promiscuity is acceptable, if the woman is perceived as being promiscuous, her husband stands the risk of being considered a pimp who benefits economically from her promiscuity. These authors point out that, in this context, intervention strategies, such as the use of condoms, can backfire as "a woman's initiation of condom use is seen as a sign of insubordination, or more commonly, as a sign of her infidelity; both are common triggers to

violence" (Go et al., 2003, p. 268). Avoiding violence is a regular struggle for many women and obedience and silence are common coping mechanisms, as is acquiescence to sex in order to avoid violence.

For working-class women in the United States, Higgins and Browne (2008) found similar challenges to their sexual health and autonomy. Their study, which compared reactions to the question of sexual refusal among middle- and working-class American men and women, included working-class women's reports that forgoing their right to sexual refusal was a coping strategy against domestic violence. These working-class respondents also expressed a belief in a biological basis for sexuality and that men needed sexual release or they might resort to violence. The authors concluded that while poor and working-class women acknowledged a woman's right to sexual refusal, however, "exercising this right can come with costs, including infidelity, conflict, or even violence" (Higgins & Browne, 2008, p. 220).

While there have been significant gains in women's status for upper- and middle-class Indian women, class structures constrict these gains for poor women. Chastity and patriarchy are reinforced through the institution of dowry, which is illegal in India, but is still practiced widely. Dowry is a practice in which the bride's family transfers wealth and consumer goods to the groom and his family. Bloch and Rao (2002) argue that the violence associated with dowry is a tool to continue extracting payments and the transfer of wealth to the groom's family for years into the marriage. While most studies find that higher class status serves as a protection against domestic violence, Bloch and Rao note that a woman from a wealthy family is likely to face more violence in a bid to extract more money from her parents. This transfer of wealth is enabled by the fact that violence is interpreted as a sign of the husband's dissatisfaction with the marriage; in this instance, class, sexuality, and gender share a symbiotic relationship. The effect of violence in marriage is to place sexuality within its purview, making sexuality an extension of the unequal relationship.

Women's access to economic resources in *her own right* may reduce her risk for such violence. Panda and Agarwal (2005) point out that female ownership of property is a factor that not only serves as a deterrent against domestic violence, but also enables the woman to escape domestic violence. In their study of domestic violence in Kerala, the authors found that the ownership of property is far more important in preventing domestic violence than employment or other factors.

While the institution of dowry is part of the Indian context, in the United States, economic conditions surrounding choices to stay or leave violent relationships must also be considered. Pollack, an economist, calls attention to the surrounding "marriage market" conditions and to the impact of liberalization of divorce laws in certain states and subsequent reduced rates of domestic violence, female suicides, and uxoricide (Pollack, 2004).

Work, motherhood, and sexuality all respond to rapidly changing conditions in the larger society and nation-states. As India and the United States react to the continued changes in women's roles, labor market conditions, and women's expectations for sexual autonomy, we must continue to address these external forces.

INTERCULTURAL AND INTERSECTIONAL CONCLUSIONS

In this chapter, we have reviewed U.S. and Indian women's lives at the intersections of work, motherhood, and sexuality. While each of these areas has its own dedicated corpus of theory and data, an intersectional and transnational analysis provides important opportunities to reflect on the effects of the myriad of *change-induced tensions* women have experienced in the past three decades. These points of similarity between the U.S. and Indian contexts are particularly significant when considered along the intersections of class, gender, and sexuality.

Women and women's work in both cultures is defined and constrained by gendered experiences of time. In the West, the rigid bifurcation of work and home time creates different exigencies for U.S. women than it does for men. In our consideration of women's mothering and work, we found that both U.S. and Indian women face challenges to balance multiple roles. In the Indian case, the separation of the domestic and the work sphere are dependent on class. In the United States, class, race, and sexuality all influence conceptions of motherhood and working mothers.

In the case of sexuality, complex, internalized, and socially enforced expectations all contribute to a woman's *need to make time* to be a sexual being. A woman's social, political, and economic power each influence her rights to be an autonomous sexual being. Changes in time and over time have both had powerful effects on modern Indian and U.S. women's lives as mothers, workers, and intimate partners. We invite a continued intersectional and transnational analyses to chart these tensions and their future resolutions.

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Chapter 6

Menopause and Women's Sexuality

Barbara A. Sommer

WHO IS THE MENOPAUSAL WOMAN?

She is a woman who has gone for a year without a menstrual period, and the absence of the period is not due to pregnancy, lactation (nursing), or illness. In the United States, she is between the ages of 48 and 52, at least when starting out the transition (though it can begin earlier). She may be younger and surgically menopausal (i.e., menopause resulted from the removal of her ovaries, an operation that might have accompanied a hysterectomy [removal of the uterus/womb]).

The odds that she is married are about 50/50. She may or may not have a sexual partner. It is very likely that she has children who may be grown, but may not be independent. They may be a source of support or a source of some grief, depending on their own life trajectories.

Her socioeconomic status may range from very elite to extremely deprived. Social distinctions have little effect on the decline of the ovaries, which leads to the hormonal changes associated with menopause. Women with more resources may have better means of coping with its effects (e.g., being in better health or having to deal with fewer of life's stressors).

In this chapter, we address the changes of menopause and their implications for a woman's sexuality. We also address what does not change and what may or may not change. The picture is complicated because we are describing individuals who have survived five decades of life with its accompanying frustrations, pleasures, opportunities, and experience. Menopause brings hormonal changes to midlife. A woman's sexual history, turn-ons, inhibitions, preferences, and personality dysfunction are not likely to change. However, her self-perception and expectations may alter as a consequence of menopause and aging. Other midlife changes may take place at the same time as menopause—events related to health, employment, income, family responsibilities, living arrangements, and stressful life events.

THE CHANGE

The physiological changes of menopause take place over a number of years. A female's full complement of potential eggs is present before birth, and by the time of birth about half of them have already been lost. Then the rate of loss slows dramatically. After puberty, the eggs (ova) ripen and produce the hormones that underlie the rhythmic fluctuation of the menstrual cycle. Around age 40, the rate of loss picks up again, and by about 50.4 years, there are no ova remaining. The result is a sharp decline in the ovarian hormones, estrogen, and progesterone, and the end of menstruation. Hence the term "menopause"—*meno* is Greek for menses (menstruation) and *pause* means to stop. The normal range of age at last menstrual period is from 48 to 52 years, but it can occur anywhere between 35 and 58 years of age. Menopause is a time of transition, of changing hormonal levels, and of changes in the body organs that have receptors for these hormones. Over time, the hormonal levels stabilize and one's physiology reaches a new equilibrium. Menopause is more a matter of stages than a single event.

STAGES OF MENOPAUSE

Menopause is not a single event, but rather defines a process that takes place over a five-year period or longer. Its timing varies among individuals and is affected by health and lifestyle (e.g., smoking). Most women go through the stages shown in Table 6.1, although some may seesaw back and forth or even skip a stage. Table 6.1 uses menstrual bleeding criteria to define the stages of menopause. Hormonal levels may also be used, but are not as easily applied. Age range and duration vary. It is not possible to apply specific ages, although we can approximate them. The peak reproductive years are between 25 and 30. Ovarian hormone output gradually declines through the 30s and 40s. Follicular Stimulating Hormone (FSH) gradually increases throughout the menopausal transition. During

Table 6.1. Stages of menopause

Stage	Reproductive	Menopausal transition		Postmenopause		
	Late	Early	Late[1]	Early[1]		Late
	Perimenopause[2]					
Duration of stage	Variable	Variable		1 year	4 years	Until death
Menstrual cycles	Regular	Variable cycle length (cycles varying by 7 or more days)	60 or more days without menstruating	1 year without a period	None	
Endocrine	Increased FSH	Increased FSH	Increased FSH			

Source: Adapted from Harlow et al., 2007.
[1] Stages most likely to be characterized by vasomotor symptoms.
[2] Literal meaning is "about or around the menopause." Sometimes the term "climacteric" is used.

a normal menstrual cycle, FSH is suppressed by estrogen. When estrogen declines, FSH increases. About 30 percent of women between the ages of 40 and 45, who are cycling regularly, will show an occasional increase in their FSH level (Soules et al., 2001).

During the Late Reproductive stage, some women begin to experience symptoms. The symptoms may occur in different combinations and with differing levels of severity. Other women have no symptoms. Vasomotor symptoms (hot flushes, night sweats) are most likely to occur around the time of a woman's last menstrual period.

These stage criteria do not apply to women using hormonal therapy. They are menopausal, insofar as their ovarian output is declining, but it is more difficult to discern because of the effect of replacement hormones on bleeding pattern and symptoms.

FINDINGS FROM LARGE-SCALE POPULATION STUDIES

There are limitations in generalizing from women who report problems to clinics or physicians. They may not represent the population of women as a whole. Although older women can be surveyed about their menopausal experience, recollection is subject to forgetting and distortion over time. Real-time (prospective) accounts are more reliable than after-the-fact (retrospective) recall. There have been three large population-based studies designed to address these issues by following women as they go

through the menopausal transition: the Study of Women's Health Across the Nation (SWAN) (Avis et al., 2009); the Seattle Midlife Women's Health Study (Woods, Mitchell, & Julio, 2010); and the Melbourne Women's Midlife Health Project (Dennerstein, Randolph, Taffe, Dudley, & Burger, 2002). The results of these studies differ in some respects because different questions were asked. In this section, we review the findings of each of these major studies, and then see what generalizations emerge.

Study of Women's Health across the Nation (SWAN)

SWAN is a prospective longitudinal study of more than 3,000 U.S. women, who entered the study at ages 42–52 years. The sample was drawn from seven locations across the United States, each with a sample half white and the other half from one of the following ethnic groups: African American, Japanese, Chinese, or Hispanic.

At the beginning of SWAN in 1996–1997, 79 percent of the study group reported that they had engaged in sex with a partner within the last six months. With regard to the importance of sex, nearly one/third found it very important, while nearly a quarter said it was not important. Compared to the white women, African American women rated sex as more important and Chinese and Japanese rated it less so.

Asked why they did not engage in sexual activity, two-thirds said it was because they lacked a partner. Among those with partners who chose not to engage in sex, one-third said it was due to lack of interest. The next percentage was 16 percent whose partner was too tired or busy. The following reasons were given for why they engaged in sexual activity: to express love (90%), for pleasure and enjoyment (90%), because their partner wanted to (75%), or to relieve tension (75%) (Cain et al., 2003).

Participants were interviewed annually about their previous year's experience. In the subsequent five years, although about the same percentages were engaging in sexual activity, there was an increase in the number of women reporting vaginal or pelvic pain during sexual intercourse—26 percent of the perimenopausal women compared with 17 percent of those not yet in transition. More frequent sexual activity was related to happiness with the relationship and starting a new relationship. Less frequent sexual activity was related to negative attitudes toward aging, perceived stress, and depression. There were ethnic differences, in that the African American and Hispanic women reported more and the Chinese and Japanese women less frequent sexual activity (Avis et al., 2005).

As the women reached the late transition stage, they reported increased pain with sexual intercourse and reduced sexual desire. These reports were unrelated to other sexual variables, such as importance of sex, sexual arousal, frequency, pleasure, or emotional satisfaction with partner. The strongest factor predicting positive sexual function was the perceived

importance of sex for the individual. Other positive factors were psychological functioning and a change in relationship. Factors having a negative effect on sexual function were age, being married, and vaginal dryness. The earlier reported ethnic differences remained (Avis et al., 2009).

Seattle Midlife Women's Health Study

The Seattle study began in the early 1990s. A subset of 286 women kept health diaries into menopause in which they rated how much they felt sexual desire in the preceding 24 hours on a five-point scale from not at all to very much. The ratings were made 8–12 times a year on a predetermined schedule that was linked to their menstrual cycle and urine specimen collection.

Sexual desire gradually decreased from the late reproductive phase to early postmenopause, with the steepest drop occurring from the late transition to early postmenopause (three years before the final menstrual period to two years after).

Factors that were positively associated with desire were the use of hormone therapy and an increase in estrogen level, exercise, and alcohol intake. Smoking was negatively related to desire, along with higher levels of perceived stress, symptom severity, older age, depressed mood, and increasing length of time with partner (Woods et al., 2010).

Melbourne Women's Midlife Health Project (MWMHP)

The Melbourne project began in 1991 and followed about 2,000 Australian-born women for eight years through the menopausal transition. The number of women reporting sexual problems went from 42 percent from the early transition stage to 88 percent in the late transition stage. Their mood reports did not differ over time.

Age was associated with reduced interest in sex, but menopausal status was important (i.e., remained when age was held constant). A decline in sexual interest was associated with declining estrogen levels. There was no direct relationship between hormone levels and mood. Women who had undergone surgical menopause were at a high risk for low sexual desire.

The decline in sexual interest was also associated with decreased well-being, decreasing employment, and symptoms, such as flushes, heart palpitations, and joint and muscle pain. In an 11-year follow-up, women still using hormone therapy reported greater sexual responsiveness and higher frequency of sexual activities than nonusers.

In summarizing their findings, the researchers concluded that estrogen plays an important role in sexual response at menopause. Estrogen levels correlated positively with sexual response (defined as sexual interest, arousal, enjoyment, orgasm), but they added that psychosocial factors

may have a greater effect (i.e., life experiences, feelings for partner, and mood; Dennerstein, 2010).

In summary, many women, but not all, report reduced sexual desire and sexual arousal around the time of menopause. The changes of menopause occur over an extended period of time. The pace and intensity of change may vary from one woman to another. For some women, the change is dramatic, for others, hardly notable. With regard to sexual interest and response, the physical changes of menopause matter. But so do a lot of other things—in particular, relationship variables (quality, newness), physical health (fitness, lifestyle), and psychosocial factors (mental health, stress, culture, past experience). We take a closer look at the specific factors influencing sexuality during a woman's middle-age years found in these and other studies.

HORMONAL FACTORS

The menopausal transition takes approximately four or five years. There is a decline in fertility beginning around age 35, but little change in menstruation patterns. In the late transition phase, estrogen and progesterone decrease rapidly. Although there is some estrogen produced in the skin and fat tissue, most of it comes from the ovaries, which are the sole source of progesterone.

Testosterone, another important hormone, is produced in the ovaries and adrenal gland. Both women and men produce testosterone, the latter about seven times as much as the former in the early adult years (Palacios, Tobar, & Menendez, 2002). Current opinion is that neither progesterone nor estrogen has a direct role in sexual desire and motivation in women of any age. Testosterone seems more important in that regard. There is considerable debate about the degree of testosterone decline during menopause and the effect it may or may not have on sexual function, and a role for estrogen in sexual response cannot be ruled out (Dennerstein, 2010). Sex hormones are very similar in their structure, and testosterone is a precursor of estrogen. The role of one or the other may depend on what sequence in the hormone synthesis in the body is considered.

Another problem that applies to all the reproductive hormones is that it is difficult to ascertain from circulating blood levels just how much of the hormone is actually affecting the receptors in the various parts of the body. Not all circulating hormone is available to the receptors. The difficulty is particularly marked in judging hormonal effects on the brain, as only a limited amount of active hormone crosses the brain–blood barrier, and the brain itself may synthesize some hormones (Palacios et al., 2002).

Estrogen has an important role in maintaining the vagina, urinary system, breasts, along with affecting the cardiovascular system and the brain. One of the earliest and most common menopausal symptoms is decreased lubrication and increased vaginal dryness, due to reduced estrogen levels.

Tissue in the urogenital areas (vulva, uterus, bladder, urethra) becomes weakened and dry, susceptible to infection and inflammation. The vagina shortens and loses elasticity. Change in the vagina's acid-alkaline balance can cause itching, discharge, and irritation. The changes can be quite rapid—a matter of six to eight weeks (Bachmann & Leiblum, 2004). One result is that sexual intercourse may become painful.

In the pelvic area, muscle ligaments relax. Problems around the bladder and rectum resulting from childbearing may become more noticeable as vaginal tissue thins. Some incontinence may result. There is a reduction in pubic hair and pubic fat. The fat content of the breasts is reduced and their arousal-based swelling and nipple erection declines. The skin is less sensitive to touch.

Sexual arousal is likely to take longer. The problem of vaginal dryness can be dealt with though the use of commercially available over-the-counter lubricants. For some women, hormonal replacement therapy is effective. Bladder training and Kegel exercise (tightening and releasing the muscles at the outlet of the pelvis) can reduce incontinence, and there are medical and surgical options. Sexual activity with or without a partner (i.e., masturbation) helps to maintain vaginal tissue by improving blood circulation.

The decline in estrogen produces hot flushes (the most frequently reported change), perspiration, night sweats, sleep disturbance (difficulty falling asleep and/or staying asleep), and mood swings—characteristics that might not be conducive to ideal sexual activity.

HORMONAL TREATMENT

Taking exogenous (externally produced) hormones reduces hot flushes and night sweats and improves the physiological state of the vagina, but many women still complain of vaginal symptoms Timing may be important with regard to the state of estrogen receptors in the body. Replacement early in the transition is more effective (Huang, 2007). On the negative side, estrogen increases the risks of blood clots and may encourage growth of breast cancer cells. Current clinical practice is to use hormonal treatment as a short-term therapy (Petersen, 2007).

NONHORMONAL FACTORS AFFECTING SEXUALITY AT MENOPAUSE

Menopause is associated with aging, and thus can exert a psychological effect as well as a physical one—as a symbol of the decline in youth and a reminder of mortality. Psychological and cultural factors come into play as a woman transitions from her reproductive years to her aging years. The journey can be difficult in a culture such as ours that puts a very high value on female youth, physical attractiveness, vivacity, and good nature.

From journalist and author, Gail Sheehy:

> I was 48 and recently remarried, quietly reading on a snowy Sunday night and playing footsie with my new husband, when a little explosion went off in my brain. It felt like a power surge. I looked down at the pages I had just finished reading and my mind was blank. I felt hot, then clammy and cold. I lay down, but my heart began racing. For the first time since my earliest period, I felt profoundly ill-at-ease within my body.
>
> As more mysterious changes followed over the next few months—sudden energy crashes, bouts of the blues, bloating, headaches, heart palpitations, mind fogs and, of course, hot flushes—I began to wonder if I was losing it. Not only losing my mind, but losing my usual sexual élan. I felt about as desirous and desirable as day-old bread that's been reheated in the microwave.
>
> The worst part was the fear that this metamorphosis was going to change me into an old woman overnight, and I would never be the same me again. (Sheehy, 2009)

Sheehy wasn't the same, but came through feeling more strong, sure, and sexy—less inhibited. In her words "older is bolder." This positive outcome may not occur for all women. Some are choosing genital surgery, and this industry is capitalizing on concerns about aging and loss of sexual attractiveness. There are procedures to tighten the vagina so as to enhance the sexual experience for both partners. Terms used are vaginal rejuvenation, designer vaginoplasty, revirgination, and G-spot amplification. Other procedures claim to improve the appearance of the labia. In 2007, the American College of Obstetricians and Gynecologists (ACOG) advised against these procedures, citing the lack of data supporting their effectiveness and potential complications, such as infection, altered sensation, adhesions, scarring, and pain with intercourse. ACOG also pointed out that the appearance of external genitals varies widely among individuals and that women may not be aware of that fact (ACOG, 2007).

Without minimizing the contribution of the hormonal changes of menopause, the results from the large-scale studies suggest that general and mental health status is more important than menopausal factors with regard to sexual satisfaction. Menopause and health play an important role in sexual satisfaction, but so do the psychosocial factors of relationship, sexual history, personality, culture, and life situation.

Relationship/Partner

Whether or not one has a partner, and the quality of that relationship (e.g., having an interested and active partner) will play a critical role with

regard to sexual satisfaction. Passion and intense romantic love diminish over time. Women in new relationships tend to report higher levels of sexual satisfaction than those in long-term relationships. A new relationship can rekindle sexual desire.

Sexual History, Personality, and Attitudes

Having been sexually active and satisfied earlier in life is associated with later satisfaction. As noted, arousal takes longer. There may be an interaction between sexual responsiveness and personality factors. There is some indication that sexual satisfaction is positively related to extraversion and negatively related to neuroticism. SWAN data indicate that importance of sex to the individual is a major contributor to sexual desire and response.

Culture

Cultural factors are likely to have an impact on sexual behavior and satisfaction at menopause. Cultures vary considerably with regard to their perceptions of and attitudes toward menopausal women. They also vary widely with regard to views of women's sexuality and as to what constitutes appropriate and inappropriate sexual behavior. The scope of this chapter is limited to viewing sexuality and menopause within the predominant North American culture. Even within that narrow context, some differences have been noted. For example, in the SWAN study, Chinese American and Japanese American women reported less importance and more pain associated with sexual activity during menopause. Compared with white women, the African American women reported greater importance, frequency, and pain, but less arousal, emotional satisfaction, and physical pleasure.

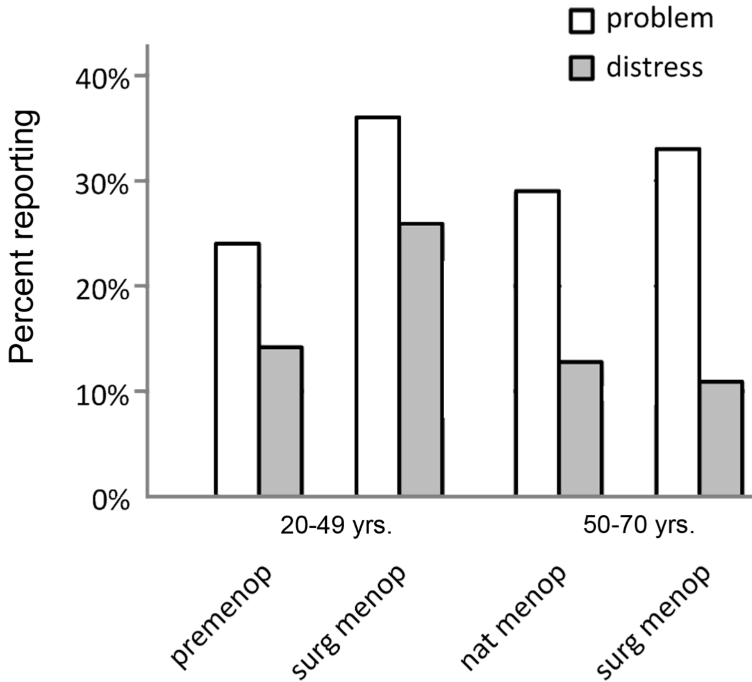
Life Situation

Moderate-to-high level of social support is associated with sexual satisfaction. Stress, low social support, and marital disharmony are associated with reduced sexual satisfaction. Women in better mental and physical health report higher levels of satisfaction. Menopause does not recognize socioeconomic differences, but women in better socioeconomic circumstances are in a better position to cope with the changes of menopause.

SEXUAL PROBLEMS VERSUS DISTRESSING SEXUAL PROBLEMS

In order to judge the impact of menopause on sexual function, it helps to have some idea of how prevalent sexual problems are in the female

Figure 6.1 Percent of Women Reporting low Sexual Function and Distress about It, by Age Group and Menopausal Status.



Source: Adapted from Leiblum et al., 2006.

population. A U.S. survey of more than 30,000 women in 2005 found that 44 percent of the women reported at least one sexual problem (low desire, low arousal, or orgasm difficulties). However, only 23 percent described these (or it) as personally distressing. Low desire was the most common problem.

The findings were examined for three age groups: 18–44 (reproductive age), 45–64 (mid-age), and 65 or older (elderly). The percentage of women reporting a problem of desire, arousal, or orgasm increased dramatically with age (27%, 45%, and 80%, respectively). For all three age groups, the number reporting the problem(s) as distressing was smaller. The largest percentage reporting distress was in the mid-aged group, which would include women going through menopause (45–64 years)—15 percent versus 9 percent among the 65 year or older and 11 percent for the younger women. Distressing problems of desire, arousal, and orgasm were less likely in older women in better health and having more education. The key term here is "distressing"—the problems increase with age, but the distress associated with those problems declines (Shifren, Monz, Russo, Segreti, & Johannes, 2008).

Another study on problems and distress reports findings from a mail survey of 952 U.S. women in 2000. Using ovarian status and age as criteria, the researchers described four subsets: (1) premenopausal, (ages 20–49), (2) surgically menopausal (ages 29–49), (3) naturally postmenopausal (ages 50–70), and (4) surgically postmenopausal (ages 50–70). Among the younger group, a surgically postmenopausal woman was three times as likely to report distress. In the older age group, there was no significant difference between the surgically menopausal and the naturally menopausal with regard to the number reporting distress. Figure 6.1 shows the results. Although there are differences among the groups, it is of note that the overall incidence of problems is less than 50 percent (Leiblum, Koochaki, Rodenberg, Barton, & Rosen, 2006).

The difference in problem incidence between the two studies may reflect their differing research designs. The data in the first study reflect the number of women reporting one or more sexual problems. Those in the second one are based on a composite score (sexual desire, arousal, orgasm, pleasure) with a cutoff to define low sexual function. What is consistent across both studies is the distinction between sexual problems and distressing sexual problems. Sexual problems are more distressing for younger women, and an early surgical menopause is particularly problematic with regard to sexual distress.

CONCLUSION

Taking an overall perspective on the menopausal transition, we can review what changes, what does not change, and what may change. The major changes are hormonal with their accompanying effect on the body, and perhaps on sexual desire and arousal. What do not change are the individual's prior sexual patterns, established preferences, inhibitions, and dysfunctions. The symptoms of menopause may make a women feel peculiar or different at times, but her underlying personality does not change. What may change around the time of menopause are health, life circumstances, such as employment, income, family, partner relationship, and self-perceptions associated with the meaning of age. Any or all of these may impact a woman's outlook and feelings with regard to sex.

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Chapter 7

Women and Sexuality in the Middle and Later Years

Claire Etaugh

> We didn't have the choice of time when the kids were young. Now we have time during the day. We seldom make love at nighttime. Now we can choose. It might be 10 A.M. or 2 P.M.—whenever we're feeling turned on.
>
> —65-year-old woman; in Doress-Worters & Siegal, 1994, p. 85

Did this opening vignette surprise you? It runs counter to the popular stereotype of the sexually disinterested older woman, one of a number of societal myths about the supposed asexuality of adults (especially women) in their later years. Despite such stereotypes, research shows that sex, sexual behavior, intimacy, and human relationships are fundamental human needs throughout the lifespan (Johnson, 2007; Sharpe, 2006). This chapter explores the fascinating diversity of women's sexuality during their middle and later years. We see that sexual activity and satisfaction vary among midlife and older women, just as they do among young women. Women who in their earlier years found sexual expression to be fulfilling typically continue to enjoy sex in their middle years and beyond. Other women, whose sexual desires were not strong earlier, may find that their

interest diminishes further during middle age. We start this chapter by examining prevailing views of the sexuality of women in midlife.

THE BIOMEDICAL PERSPECTIVE

The notion that women's sexuality declines in middle age because of the physical changes brought about by menopause is a popular belief among both the lay public and many professionals (McHugh, 2007). Menopause, the cessation of the menstrual cycle which typically occurs in the late 40s and early 50s, brings about a number of physical changes which may affect sexual activity (Wroolie & Holcomb, 2010). Decline in the production of estrogen is responsible for many of these changes. The vaginal walls become less elastic, thinner, dryer, and more easily irritated, which may cause pain and bleeding during intercourse. Decreases in vaginal lubrication can also lead to painful intercourse (Herbenick et al., 2010a). However, not all postmenopausal women experience these symptoms, but some premenopausal women do (Gannon, 1999).

The prevailing biomedical perspective emphasizes the relationship between declining hormone levels and declines in women's sexual desire and activity. Popular images and stereotypes of menopausal women are overwhelmingly negative in North America. Menopause continues to be described in the medical literature by a long list of negative symptoms and terms, such as estrogen deprivation and ovarian failure (Wingert & Kantrowitz, 2009). This perspective has led to the framing of menopause as a medical condition and to the search for treatments, such as female Viagra to treat women's alleged sexual dysfunctions and disorders (IsHak, Bokarius, Jeffrey, Davis, & Bakhta, 2010; Moynihan & Mintzes, 2010; Singer, 2010).

THE NEW VIEW PERSPECTIVE

An increasing number of critics of the biomedical approach note that, during the middle years, a number of life events and role changes occur that also can have an impact on women's sexual activity, desire, and intimate relationships. For one thing, women are confronting their own aging during this time and many are self-conscious about their aging bodies (Henig, 2004). During midlife, women also may be coping with a variety of psychosocial and interpersonal stressors, such as the illness or death of a spouse; divorce, separation, or other marital problems; difficult teenagers; children who are preparing to leave home; aging parents who require care; and/or work–family balancing issues (Dare, 2010; Nosek et al., 2010; Wroolie & Holcomb, 2010). A growing body of research supports the view that psychosocial and interpersonal factors such as these, and not biological changes, are the main causes of reduced sexual activity, desire, and

intimate relationships throughout women's lives (Brotto, 2010; New View Campaign, 2010).

There is widespread variability in how women socially construct and respond to their sexuality in middle age. We turn now to an exploration of patterns of sexuality during these years.

PATTERNS OF SEXUAL ACTIVITY

While some midlife women report a decline in sexual desire and the capacity for orgasm during these years, others report the opposite pattern (Birnbaum, Cohen, & Wertheimer, 2007; Brody, 2009; Tracy & Junginger, 2007). In one recent study of young and middle-aged heterosexual couples (Smith et al., 2011), nearly half of the women were unhappy about the frequency of sex in their relationship, with two-thirds of them wanting more. Some midlife women report an increased desire for nongenital sexual expression, such as cuddling, hugging, and kissing (Block, 2008; Groh & Serowky, 2009).

The extent of sexual activity in middle-aged women is strongly influenced by past sexual enjoyment and experience. Years of sexual experience can more than make up for any decrease in physical responsiveness (Rathus, Nevid, & Fichner-Rathus, 2010). Women who have been sexually responsive during young adulthood are most likely to be sexually active as they get older (Etaugh, 2008). In addition, both heterosexual and lesbian women who communicate openly with their partners and make changes in their sexual activities to adapt to menopausal changes are more likely than other women to report active and satisfying sex lives (Winterich, 2003).

Many postmenopausal women find that their sexual interest and pleasure are heightened. Books, such as *Sex and the seasoned woman* (Sheehy, 2006) and *Prime* (Schwartz, 2007), sing the praises of the sexual passions of midlife women. What are some possible reasons for this renewed sexual interest? One is the increase in marital satisfaction which often develops during the empty nest years (Etaugh, 2008). A second reason is freedom from worries about pregnancy (Torpy, 2007). This factor may be especially relevant for older cohorts of women for whom highly effective birth control methods were unavailable during their childbearing years. As one woman put it, "It's wonderfully freeing. I always hated the mess and the interruption of birth control. I was always anxious about getting pregnant and that put a damper on sex" (Doress-Worters & Siegal, 1994, p. 88).

Sexual activity typically decreases only slightly and gradually for women in their 40s and 50s. Greater declines in activity and in sexual satisfaction may result from physical or psychological changes, however (Fisher, 2010; Lindau & Gavrilova, 2010). The vaginal dryness that often results from declining estrogen levels can be easily remedied by use of

lubricants and moisturizers. Paradoxically, one of the best solutions is to have more sex! Sexual activity increases blood flow to the vagina, which makes the tissues fuller and also triggers lubrication (Brody, 2009; Gannon, 1999).

Signs of sexual arousal—clitoral, labial, breast engorgement, and nipple erection—become less intense in midlife, and sexual arousal is slower (Bjorklund, 2011). As one 51-year-old woman put it: "You know you are middle-aged when a 'quickie' takes forty-five minutes" (Doress-Worters & Siegal, 1994, p. 89).

Most menopausal women, however, experience little or no change in *subjective* arousal. Although the number and intensity of orgasmic contractions are reduced, few women either notice or complain about these changes. Furthermore, slower arousal time for both women and men may lengthen the time of pleasurable sexual activity (Etaugh, 2008).

Other physical causes affecting sexual activity include various medical conditions, certain medications, and heavy drinking (Brody, 2007). Medical procedures, such as mastectomy and hysterectomy, do not impair sexual functioning. In fact, many women experience improved sexual function, including greater sexual desire, an increase in orgasms, and a drop in painful intercourse following a hysterectomy (Hartmann et al., 2004; Wroolie & Holcomb, 2010). For those women who feel that their ability to enjoy sex after a hysterectomy is diminished, counseling can be helpful (Block, 2008). Similarly, mastectomy does not interfere with sexual responsiveness, but a woman may lose her sexual desire or her sense of being desired. Talking with other women who have had a mastectomy often helps. One resource is the American Cancer Society's Reach to Recovery program (Addis et al., 2006; American Cancer Society, 2008; Fisher, 2010; National Institute on Aging, 2009).

Sexual activity and contentment during middle age are more likely to diminish for individuals who do not have a partner (Huang et al., 2009; Lindau & Gavrilova, 2010). For example, in a recent nationally representative study of sexuality in Americans age 45 and over, only 1 in 10 who had no partner, but 6 in 10 of those with sexual partners, were satisfied with their sex lives (Fisher, 2010). While about three-fourths of men of all ages have a sexual partner, only two-thirds of young and middle-aged women do so. Among women aged 75 and over, only 4 in 10 have a partner (Lindau & Gavrilova, 2010).

SEXUALITY IN AGING LESBIAN AND BISEXUAL WOMEN

Currently, our knowledge about sexuality in aging lesbians and bisexual women is very limited, and what we do know is largely based on samples of middle-class, well-educated, white urban women. The

information available points out both the similarities and differences in the sexual lives and experiences of older heterosexual and sexual minority women (Garnets & Peplau, 2006). With respect to similarities, the sexuality of women—whether lesbian, bisexual, or heterosexual—tends to focus more on love and intimacy than does the sexuality of men. In addition, for both lesbians and heterosexual women, the frequency of sexual activity diminishes with increasing age. At the same time, many women in both groups remain sexually interested and active. A major difference between lesbians and heterosexual women is that penile penetration is the socially constructed norm for heterosexual intimacy, whereas lesbians put much greater emphasis on other forms of both genital and nongenital sexual activity (Garnets & Peplau, 2006). Moreover, compared with heterosexuals, lesbian partners share more equally in the initiation of sex (Lever, 1995). Interestingly, almost half of the older lesbians who have been studied have been married sometime during their lives (Beeler, Rawls, Herdt, & Cohler, 1999; Garnets & Peplau, 2006). Most of these older lesbians reached adulthood before the gay rights movement, at a time when "coming out" often resulted in severe negative consequences. Many married because that was the socially acceptable path to follow. Some of these women finally identified themselves as lesbians during middle age (Herdt, Beeler, & Rawls, 1997). As one woman in her 60s put it, "I spent years trying to make it in the heterosexual world because my sexual identity was wrong. When I finally allowed myself to love another women fully, it was like coming home—home at last" (Doress-Worters & Siegal, 1994, p. 87).

If little is known about sexuality in aging lesbians, even less information is available about the sexuality of older bisexual women. One longitudinal study (Weinberg, Williams, & Pryor, 2001) provides much of what we do know. Self-identified bisexual women were interviewed in 1983, 1988, and finally in 1996, when they ranged from 35 to 67 years of age. Four-fifths of the women self-defined as bisexual throughout the study, even though by 1996 one-third were having sex exclusively with men and one-fifth were having sex only with women. Reasons for the apparent discrepancy between sexual identity and choice of partners included a desire for monogamy and pressure to fit into either the heterosexual or lesbian culture.

SEXUALLY TRANSMITTED INFECTIONS IN MIDDLE AGED AND OLDER WOMEN

Whatever a woman's age, if she is sexually active, she is at risk for contracting sexually transmitted infections (STIs), including HIV. STIs have a disproportionate impact on women. They are transmitted more easily to women than to men and are more difficult to diagnose in women (Crepaz et al., 2009; Upadhyay & Murthy, 2010). In addition, women may be at high risk of STIs because of social and cultural norms that dictate that women

do not decline sexual intercourse with their partners or insist on the use of condoms (Crepaz et al., 2009; Teitelman, Seloilwe, & Campbell, 2009).

One factor behind the rapid increase in STIs is that the majority of women have relatively little knowledge of STIs and even less concern about contracting one (Friedman & Bloodgood, 2010). This is especially true for older women, who may view themselves as at low risk for STIs. Yet, today, about 1,300 new cases of HIV/AIDS, the most devastating of all the STIs, are diagnosed annually among women age 55 and over, and this number is growing (Prejean, Satcher, Durant, Hu, & Lee, 2006). In the mid-1980s, most AIDS cases among women in that age group were caused by blood transfusions. Now, heterosexual contact is the leading cause, as it is for women of all ages (The Body, 2008). One factor increasing older women's risk during heterosexual contact is the thinning of the vaginal tissues and the decrease in lubrication after menopause, which can lead to small skin tears or abrasions during intercourse, thus increasing the chance of HIV entering the bloodstream (Levine, 2009; National Institute on Aging, 2009).

Another factor in the rise of HIV in the elderly is the increase in sexual activity fueled by Viagra, but without a corresponding increase in condom use (Schick et al., 2010; Smith & Christakis, 2009). Many of today's aging baby boomers grew up before the HIV epidemic and didn't learn how to negotiate condom use with their partners. Furthermore, middle-aged women are less likely than younger women to ask about their partner's sexual or drug use history (Levine, 2009). The result is that most sexually active older singles report having unprotected sex (Rabin, 2010; Smith & Christakis, 2009).

Older women who have HIV infection may have a harder time than infected younger women in obtaining a correct diagnosis and treatment. Since older women are generally viewed as sexually disinterested and inactive, they are less likely to be asked by their physicians about their sexual activity or to be given information about safer sex practices (Jacobs & Thomlison, 2009). Few educational and prevention programs target this age group (Jacobs & Kane, 2009; The Body, 2008). Moreover, physicians do not expect to see AIDS in older women, and therefore they are more likely to make a late diagnosis or a misdiagnosis (Levine, 2009; The Body, 2008). Also, women of this age group are less likely to think of themselves as being at risk for AIDS, and so they may not think to ask for an HIV test (Jacobs & Thomlison, 2009; National Institute on Aging, 2009). Failure to diagnose HIV early can have serious consequences at any age, since it is harder to arrest the disease when it becomes more advanced. But older adults with HIV are even more likely to deteriorate rapidly because of their already weakened immune system (Aging and HIV, 2010).

HIV infection takes an enormous emotional toll on older women, many of whom live alone and are already trying to cope with physical,

economic, and personal losses. While today's younger women are used to talking more freely about sexual problems, this is difficult for many older women. They feel ashamed and may suffer alone, avoiding telling friends and family (Jacobs & Kane, 2009; The Body, 2008). Some avoid intimate contact with grandchildren, such as kissing on the lips, for fear of endangering the youngsters. Therapy groups are an important source of emotional support for these women (Ciambrone, 2003).

SEXUAL ACTIVITY IN LATER LIFE

The average woman in the United States and many other developed countries now lives to be more than 80 years old, and thus can be expected to live one-third of her life beyond menopause. Given this fact, it is remarkable that there has been so little research on sexual activity in older women (Sharpe, 2006). There is significantly less research on sex and sexual relationships among elderly adults than among any other age group (Lemme, 2006), and this is especially true for older women. As one example, in a special issue of the Journal of Social Issues, devoted entirely to sexuality a few years ago, there was not a single word about the sexuality of older women (Goodchilds, 2000). In those articles and textbooks that do discuss sexuality in the elderly, the emphasis is on dysfunction or disease rather than on healthy sexual development (Sharpe, 2006).

The question of when it is appropriate to call a pattern of sexual behavior a problem or a dysfunction has been raised by several scholars in recent years (Bancroft, Loftus, & Long, 2003; McHugh, 2007; Tiefer, 2001; Wood, Mansfield, & Koek, 2007). For example, should older women who have less sexual desire than when they were younger be labeled dysfunctional? Bancroft and colleagues (2003) found in a review of research that only one-third to one-half of women who were defined as having a "problem" using the research criteria considered themselves to have a problem. These researchers concluded that women's own construction of their sexuality, and not researchers' standardized criteria, ought to form the basis for designating a behavior pattern as functional or dysfunctional.

Most of today's older Americans grew up at a time when attitudes toward sexuality were more restrictive than they are today, particularly for women (Kontula & Haavio-Mannila, 2009; Mares & Fitzpatrick, 2004). Unlike men, many women were taught that they should not enjoy sex and should not initiate it. This double standard of sexuality for women and men exists for adults of all ages. But, older women also are subjected to the double standard of aging. That is, while men often are viewed as becoming more sexually attractive with age, the reverse is true for women, who, in their later years, are perceived as sexually inactive and sexually unattractive (Antonucci, Fiori, Birditt, & Jackey, 2010; Lai & Hynie, 2011). Men tend to choose younger women or women who look young as their sexual

partners and mates (Daniluk, 1998; Rathus et al., 2010), further limiting the availability of partners for older women.

Let us examine women's sexuality in later life—the benefits of sexual activity for elderly individuals, sexual behaviors and the factors affecting them, and enhancement of sexual experience in the later years.

BENEFITS OF SEXUAL ACTIVITY IN LATER LIFE

Sexual activity can have numerous physical, psychological, and emotional benefits for the elderly (Kontula & Haavio-Mannila, 2009; Lindau & Gavrilova, 2010). The physical benefits include improving circulation, maintaining a greater range and motion of joints and limbs in arthritic persons, helping one sleep, and controlling weight gain (Butler & Lewis, 2002; Doress-Worters & Siegal, 1994; Leitner & Leitner, 2004). Sexual activity among the elderly has psychological and emotional benefits as well. It can improve one's sense of well-being, increase life satisfaction, enhance a woman's feeling of femininity and desirability, offer an outlet for emotions, and provide a shared pleasurable experience (Leitner & Leitner, 2004). In the later years, sexual activities other than intercourse—oral sex, manual stimulation, caressing—bring pleasure with or without orgasm (Burgess, 2004; Rathus et al., 2010).

SEXUAL BEHAVIOR OF THE ELDERLY

Interest in sexual activity remains fairly high throughout adult life, especially for men, declining only gradually in the later years (Fisher, 2010; Herbenick et al., 2010b; Lindau & Gavrilova, 2010). In a recent national survey, 40 percent of men, but only 11 percent of women aged 75–85 reported still having sexual desires (Lindau & Gavrilova, 2010).

Still, some women find sex more satisfying and their attitudes toward sex more positive and open in later life. In one nationwide survey of Americans aged more than 60, 70 percent of sexually active women said they were as satisfied, or even more satisfied, with their sex lives than they were in their 40s (Leary, 1998). Once grown children have left the nest, couples may experience a "second honeymoon" as marital satisfaction increases (Aubin & Heiman, 2004; Connidis, 2010). (See the vignette at the beginning of the chapter.)

In the survey by Lindau and Gavrilova (2010), middle-aged and elderly men were more sexually active than women. More than 80 percent of men aged 57–64, two-thirds of those aged 64–75, and 40 percent between 75 and 85 had engaged in sexual behavior within the past year. Many of them had done so on a weekly basis. The corresponding figures for women, on the other hand, were 60 percent, 40 percent, and 17 percent, respectively. A major reason for the lower levels of sexual activity in women was lack of

a partner. In addition, good health is related to sexual interest and activity, and older women are less likely than men to report being in good or excellent health (Lindau & Gavrilova, 2010; Schick et al., 2010). Decreased sexual desire of one's partner is another reason for a decline in sexual activity among the elderly (Huang et al., 2009; McHugh, 2007).

FACTORS AFFECTING SEXUAL BEHAVIOR

A number of both physical and psychological factors influence sexual behavior in older women.

Physical Factors

The physical changes in the reproductive system that begin in midlife become more pronounced in the later years, as estrogen levels continue to decline gradually. Physical changes, illness, chronic disabilities, and medication can affect sexuality in later life (Lindau & Gavrilova, 2010; National Institute on Aging, 2009). However, even the most serious medical conditions need not stop women and men from engaging in satisfying sexual activity (Butler & Lewis, 2002). Heart disease, especially if one has had a heart attack, leads many older adults to give up sex, fearing it will cause another attack. But the risk of this attack is low. Most people can resume sexual activity within a period of several weeks. Stroke rarely damages sexual function and it is unlikely that sexual exertion will cause another stroke. Even if paralysis has occurred, appropriate sexual positions often can be found to compensate for it (Butler & Lewis, 2002). Arthritis, the most common chronic disability, causes joint pain that can limit sexual activity (National Institute on Aging, 2009; Read, 2004). Surgery and drugs can relieve the pain, but in some cases the medications decrease sexual desire. Exercise, rest, warm baths, and changing the positions or timing of sexual activity can be helpful. Medications, such as certain antidepressants and tranquilizers, also can reduce a woman's sexual desire. However, a physician can often prescribe a different medication without this side effect (Etaugh & Bridges, 2010).

Psychosocial Factors

A person's attitude toward sex-related physical changes can interfere with sexual activity more than the actual changes themselves. A major psychosocial constraint is the societal view that sexual desire in the elderly, especially elderly women, is abnormal (Block, 2008). As a result, older women who want to fulfill their sexual desires may feel apprehensive and guilty. In addition, many older women feel unattractive and self-conscious about their aging bodies (Henig, 2004). As a result, they may avoid sexual

activity with a partner or decide not to seek a new partner if they become widowed or divorced (Burgess, 2004).

Moreover, some older women have internalized a cultural ideology that places their partners' needs above their own (McHugh, 2007). In a study by Wood and colleagues (2007), some older women reported that their partners' sexual techniques left them unsatisfied, yet they felt uncomfortable expressing their own needs and desires. Other women, however, have learned to put their own needs on an equal footing with that of their partners. In the words of one woman, "Now I can just enjoy it. I don't have to be such a good citizen. When I was younger, I worried so much for my partner that I never got much real pleasure for myself" (Doress-Worters & Siegal, 1994, p. 83).

An additional constraint for residents of nursing homes is that the attitudes of nursing home staff are often not supportive of sexual behavior (Alexander, LaRose, Bader, Garfield, & Alexander, 2010). Although more nursing home personnel are respecting the wishes of their clients for sexual freedom and privacy (Johnson & Scelfo, 2003), many nursing home administrators feel that sexual activity on the part of residents causes problems, even if the individuals are married. Even masturbation may be strongly discouraged (Beers & Jones, 2004; Butler & Lewis, 2002; Villarosa, 2002).

ENHANCING SEXUALITY IN LATER LIFE

Sexual activity can be more rewarding for older adults, if individuals come to realize that sexual expression is a normal part of life regardless of age. Sex counseling can provide pharmacological, psychological, and practical assistance to help older individuals and couples overcome obstacles that restrict their sexual behavior (Leiblum & Segraves, 2000; Moll, 2002). Emphasizing the quality of the sexual relationship rather than performance can make sexual experiences more enjoyable for the elderly (Hillman & Stricker, 1994; Leitner & Leitner, 2004). Older individuals who are in supervised living arrangements need to be given opportunities to have private time together for intimate contact (Butler & Lewis, 2002; Doress-Worters & Siegal, 1994). In addition, healthcare professionals should provide information and counseling to the elderly regarding the impact of both normal physical changes and medical conditions on sexual functioning (Richardson & Lazur, 1995).

The many older women who are not in an ongoing physical relationship need to feel it is permissible to express their sexuality in whatever way is comfortable for them, whether it be enjoying their fantasies, engaging in masturbation, using a vibrator, or accepting an asexual lifestyle (Butler & Lewis, 2002; Read, 2004). While some older women are celibate because they lack the opportunity to meet partners, others choose to be celibate

but still enjoy sensuous experiences: " In Colette's novel, Break of Day, I discovered celibacy as a strategy for older women who too often see themselves as stripped of identity without a partner. Colette sees age fifty-five as the end of having lovers, but the beginning of an aloneness that is joyous and drenched in sensuality—particularly for the artist in all of us. It is a great gift to be one's self at last" (Marilyn Zuckerman, a poet in her 60s; in Doress-Worters & Siegal, 1994, p. 88).

CONCLUSION

In the middle and later years, some women report a decrease in sexual interest and activity, others an increase, and many report no change. The changes in roles, relationships, family involvement, employment, physical health, and other facets of life that characterize the natural progression through adulthood can and do affect sexuality (Gannon, 1999). The notion that sex is good and healthy for women and men at any age can be liberating. By the same token, however, we must be careful not to stigmatize those who prefer not to be sexually active or those who choose to be sexually active in ways that do not conform to widely held social norms.

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Part III

International Perspectives on Women's Sexuality

Chapter 8

Female Initiation Rituals and Sexualities in Northern Mozambique

Brigitte Bagnol

Initiation rites have been described as representing the step to adulthood and the ultimate loss of a child's innocence. They are seen as an important moment in the socialization process of individuals and the acquisition of gender, sexual, and linguistic/ethnic identities. During the rites, the young people are viewed as in a transition phase characterized by abnormality, noncooperation, and inversion of behavior (Moore, Sanders, & Kaare, 1999) that expresses the anti-structural state displayed by participants and is part of the "savoir faire" of ritual (Turner, 1969). The children are described as undergoing a transformation that affects their personalities. The separation of their social life and the cutting of old ties give rise to a rebirth often associated with the assignment of a new name (Martinez, 1989; Richards, 1956). This passage often involves body modification, such as in the case of circumcision, or physical punishment, accompanied by pain and fear. The body processes are done in concordance with cosmology and social rules (Bourdieu, 1999; Devisch, 1993; Jacobson-Widding, 1991; Snyder, 1999). Children receive information about etiquette, comportment, sexuality, death and burial, and sometimes about history (Beidelman, 1993;

Hamdani, 2001; Spring, 1976; White, 1953). This knowledge is often not unknown by the young people, but it is revealed during this segregation period in a different form, which is protected most of the time by secrecy.

Earlier conceptions, inspired by ethnographic work, looked at rites as stereotyped acts emanating from an unchanging and rigid tradition imposed on individuals (Spiegel & McAllister, 1991). Current anthropologic thought, informed by feminism and postmodernism, stresses the polysemic characteristic of the notion of rite, not exclusively as acts that regulate the conduct of individuals but as resources, directories of gestures, messages, and songs that people can use to make sense of certain phenomena or express their resistance. In this sense, the rites are not limited to the reproduction of existing cultural figures. They are contested, appropriated, and reinvented by individuals and groups (Goffman, 1967; Mottin-Sylla & Palmieri, 2011). They are enacted to give sense to people's experiences and existence, to establish roles and status, and as a manifestation of a belonging. They express a symbolic order (Bourdieu, 1989, 1991, 1999) and the highly complex and multifaceted cultural constructions of gender categorizations and ideologies (Meigs, 1990). Women are agents of the transformation, defining the forms they relate to each other and with their bodies, depending on the historical and cultural contexts (Bordo, 1993). There is thus a dynamic interrelation between the initiation rites and the various spheres—social, economic, religious, legal, political, and cultural—the rituals being an expression of these interactions, contradictions, and negotiations.

In Mozambique, as is the case in other countries, with slavery and the colonial and Christian penetration and independence, many economic, social, and religious aspects have changed, thus transforming the gender subjectivities and the rituals (El Saadawi, 2005; Fernandez, 2011; Green, 1999; Nnaemeka, 2005). Initiation rites, in particular, and aspects related to sexualities were the targets of a violent repression. A similar condemnation took place after independence, when the Frente de Liberação de Moçambique[1] (FRELIMO) government sought to abolish the traditional structures and practices, including initiation rites and circumcision, considering them obscurantist. These were identified as being an instrument of oppression and an obstacle to the construction of a "new" man and woman and an egalitarian society. In the early 1990s, several pressures, such as the war with the Resistência Nacional de Moçambique[2] and peasant insistence on maintaining certain practices, caused the FRELIMO government to become more tolerant of traditional culture and to assume that its political agenda should be harmonized with local beliefs. After the peace agreement in 1993, infrastructures were rehabilitated and economic life resumed, opening the country for new forms of development and interaction in a globalized world. It is in this context of continuous tension and negotiations that the rites are analyzed.

This study aims to identify how the requirements embedded in the structure of the rituals that relate to gender relations and sexual behavior—in conjunction with other social markers—are reflected, rejected, manipulated, and/or appropriated by women. Aware of the risk of generalization and of describing undifferentiated African cultures (Salo, 2010), I seek to trace the morphology of the teachings of initiation rituals highlighting how women reject, keep, and incorporate the social norms. This paper focuses on the rituals as a symbolic rebirth into womanhood, and a preparation for sexual life and reproduction as practiced in two provinces of northern Mozambique (Cabo Delgado and Niassa). It analyzes how rituals express patterns of intimacy, sexual involvement, notions of risks, and reproductive goals. It shows how, from an emic perspective, girls are empowered by the secret knowledge they acquire during the rituals, thus contributing to their maintenance.

While some authors emphasized the complicity of women in their oppression by their acceptance and reproduction of gender ideology, by following authors such as Ortner & Whitehead (1981), I try to identify the multiplicity of gender discourses and the ongoing construction of multiple, and sometimes contradictory, gender identities within the same culture and the same ceremony (Amadiume, 1987; Boris, 2007; Miescher, Manuh, & Cole, 2007; Mohanty, 1997). I also take into account the different, and sometimes conflicting, interests among women (Collier, 1988; Lamphere, 1974; Wolf, 1974). In addition to looking at women's potential transgressions, I identify forms of resistance as well as complicity. I recognize how women express their agency in the context of initiation practices. I argue that women create situations in which they can maneuver to maximize gains (Baal, 1975; Collier, 1988).

NORTHERN MOZAMBIQUE

Mozambique is a poor country, with 74.7 percent of the people living on less than one U.S. dollar per day (African Development Bank, 2010). It is estimated that 27 percent of the population walk more than one hour (Instituto Nacional de Estatística, 2010) to reach an often inadequately equipped health unit with poorly qualified staff. With 2.4 medical doctors per 100,000 people, only half of the population has access to services offered by the national health system (African Development Bank, 2010). The total fertility rate in the country is 5.5 children per woman—with 6.1 children in rural and 4.4 children in urban areas. The infant mortality rate is 93 for every 1,000 children younger than one-year-old (Instituto Nacional de Estatística, 2009).

With half the population under the age of 15, the two provinces of northern Mozambique where the study took place are mainly rural, with its inhabitants surviving through subsistence agriculture. All linguistic

groups are polygynous and trace descent through the female line (matrilinear). While the Kimwani linguistic group on the Indian Ocean coast and the Yao (also called Ajaua) in the Niassa province are predominantly Islamic, the Emakhuwa and the Shimakonde populations are influenced by the Catholic and various evangelical churches. However, many forms of beliefs and practices exist which combine these values with African religion. Beliefs in their ancestors thrive and orient attitudes and actions, despite colonial conquests, missionary Christianity, and globalization. Since the beginning of last century, authors working in the southern African region have shown the importance of reciprocity and exchange and the role of gifts to control rain, to ensure human and soil fertility, as well as to appease ancestors and promote their benevolence toward humans (see Berglund, 1976; Blokland, 2000; Feliciano, 1998; Janzen, 1992; Ngubane, 1977).

The Demographic Health Survey from 2003 indicates an infant mortality rate of 140 in Niassa and 177 in Cabo Delgado, which is superior to the national rate—indicating poor nutritional and health status in this region (Instituto Nacional de Estatística and Ministério da Saúde, 2003). The same study points to poor access to primary education and illiteracy affecting mainly women and girls (83.4% and 84.5% women do not read and write in any idiom, respectively, in Niassa and Cabo Delgado, compared to 44.6% and 46.7% for men).

The median age at first sexual relation is 15.9 years in Niassa and 15.1 in Cabo Delgado. Most of the men are circumcised (88% in Niassa and 93.3% in Cabo Delgado). Among the youth between 15 and 24 years of age who have already had sexual relations, the percentage of those who used a condom during their first intercourse is 3.2 percent and 3.6 percent among females and 7.1 percent and 1.8 percent among males in Niassa and Cabo Delgado, respectively (Instituto Nacional de Estatística and Ministério da Saúde, 2005).

In Niassa, 43.5 percent of women consider that a husband has the right to assault his wife physically if she refuses to have sexual relations with him; only 27 percent have the same opinion in Cabo Delgado (Instituto Nacional de Estatística and Ministério da Saúde, 2005). These data inform about the relation of power between men and women, women's ability to negotiate their sexuality, and highlight the context of inequality in which the initiation rituals takes place.

METHODOLOGY

In order to study the initiation rites of the four main language groups (Kimwani, Shimakonde, Emakhuwa, and Yao) of the two provinces, three villages in the Cabo Delgado province were visited (see Table 8.1) in December 2010. Another two villages in the Niassa province were visited in December 2011. This offered the opportunity to do participant observation

Table 8.1 Summary of main characteristics of girls' initiations

Province	District	Village	Linguistic groups	Age	Duration	Participation
Individual or 2/3 girls	Macomia	Pangane	Kimwani	First menstruation	2 days	
	Nangade	Ntamba	Shimakonde	6–9 cannot be initiated after giving birth	2 months	Individual with collective phases
	Montepuez	Nairoto	Emakhuwa	5–12	2 months	Ibidem
Niassa	Majune	Malanga and Macanga Um	Emakhuwa/ Yao	8–15	18 days	Collective
	Sanga	Malulo	Yao	8–11	4 weeks	Collective

in many of the different phases of the rituals. With November and December being the months of the longest school holidays, a significant proportion of initiation rituals are carried out at this time, following the recommendation of the Ministry of Education.

Involvement with men and women in their social environment and in the rituals was combined with formal and informal interviews. I interacted in Portuguese. In each village, a female colleague and a male colleague, who had been initiated following the practices of the area or in a way that was closely related to it, facilitated the contacts, gave their interpretations of events, and provided translation in the local Bantu language. Informed consents were obtained and confidentiality ensured. A total of 19 traditional leaders, health and education staff, and masters of initiation took part in individual interviews. Focus groups, totaling 27, were attended by 3–40 people, generally of the same sex. Male and female masters of initiation rites, godfathers, godmothers, boys and girls initiated or being initiated were involved, adding up to a total of 121 men and 142 women.

A DYNAMIC INSTITUTION

While in some regions of southern Africa initiation rituals have declined or even disappeared, in other regions they have endured (Rasing, 2001) undergoing transformations (Tamale, 2006). In Northern Mozambique, there is a great diversity of practices between linguistic groups, within the same linguistic group, between villages, or depending on the master of the initiation. There are also areas of merging and adaptation of

certain aspects of the rituals to allow more interactions and intermarriage between groups. Female initiation rites might be performed at adolescence or earlier (see Table 8.1). When girls are initiated at their first menstruation, the rituals usually involve a single child or very few and can be carried out during different periods of the year (Pangane village). Rituals may concentrate on large groups of youth of a similar age group (in all other villages visited), depending on the size of the village and distance or arrangements between villages. However, even when large groups of girls are undergoing their initiation in the same period, they might be segregated for long periods on their own (Ntamba village).

In the last few decades, in the north of both Cabo Delgado and Niassa provinces, the rituals went through significant changes. In the beginning of the 1980s, when I arrived in Mozambique, despite FRELIMO interdictions, these rituals were often carried out in secret, in the dry season, after the harvest, when people had food and money to afford the expenses and to allow for major festivities (Martinez, 1989; Organisação da Mulher Moçambicana, 1982–1983). Following government recommendation to ensure that children attend school, in most of the capitals of the districts visited, since the mid-1990s, the rites are held in December and January, during the hot and rainy season and school vacation. Concomitantly, in Ntambo and Nairoto, the male period of reclusion reduced from up to six months to two months to coincide with these holidays.

Another significant transformation of the ritual is that the age of initiation has been reduced from 12–14 to 6–8 years of age both for boys and girls, in the last two decades. For boys, this was mainly justified by the Muslim influence from Tanzania and Malawi, as in Islam the total removal of the prepuce—in contrast with the partial removal undergone previously—should be carried out at a young age.

On their side, women strive to keep their good reputation, with one of their younger female relatives initiating them before their sexual debut. Access to television and video in the main villages is seen as the main cause of their early sexual involvement. For the Shimakonde speakers, pregnant girls or girls with children cannot be initiated at all, and thus would keep the status of child, a *vanamako*, a person without value all their life. In such a context, women, in an effort to avoid this situation, initiate girls at a younger age. Although girls in these two villages can be initiated even if pregnant, Malanga and Nairoto register a similar trend with the rituals, which were previously performed after menstruation shifting to before menstruation. Accordingly, in both villages, the girls' rituals that were carried out in small groups during the whole year matching the outset of the first menstruation evolved to bigger concentrations occurring in the same period as boys' initiations. Nowadays, girls and boys come out of the ritual on the same day in the main annual village feast. The duration of the rituals increased in some cases (Emakhuwa in Macanga Um) and reduced in others (Makonde in Ntanda).

Due to the reduction of the age of initiation, most informants feel that girls are not able fully to assimilate the teaching from the initiation and that there is a disconnection between the content of the teaching and the age of the girls. The ritual is not anymore the ultimate step to adulthood. While in the past girls would often get married soon after initiation, these days some girls stay single for a while. Interestingly, showing a new approach both from the education system and from local communities, who previously forbade pregnant girls to attend school, in all the villages—and particularly in Pangane on the Indian Ocean coast—a few initiated youth were still studying. Even a few pregnant girls and girls with children were able to pursue their education after a ministerial decree was passed in 2003 encouraging them to do so and banning schools from expelling them, as happened in the past in a practice overtly discriminating against women and violating their right to study. While the education system pointed toward initiation rituals as the reason for girls to drop out of school, by expelling pregnant girls from education, it was establishing inequality between boys and girls. The motive for such discrimination was pregnancy, thus enshrining inequality due to the consequences of a sexual act and stating that a mother should not be allowed to study. Such regulation turns sexuality into a space through which state control can be deployed. Notions related to childhood/adulthood and connection between sexuality and appropriateness to study are being transformed locally and nationally. As a matter of fact, most of the young novices stated that they wished to proceed with their studies after their initiation. Similarly, most women desired to see their daughters continue to attend school. They justified their position by explaining that now even the education ministry was letting pregnant girls go to school. Being an adult and/or being a mother is/are not anymore an obstacle to girls' education. In a certain way, sexuality is starting to be accepted in the formal education system. While in the past primary and secondary school were seen as a space exclusively for children (the term being understood in opposition to initiated, to being sexually active, or being a mother), currently, female students can be young initiated, sexually active, and mothers.

While the notion of childhood and the implication of sexuality have been transformed in the last decades, similarly the conception of what it means to be a woman was deeply amended in Ntamba, because the young Shimakonde girls no longer observe the practice of stretching the labia minora, which represented an important aspect of their femininity (Bagnol & Mariano, 2008, 2011). This alteration was recent, as women aged 60 or 70 had elongated labia. Emakhuwa-speaking women still consider this practice a must and an important element of sexual foreplay. Another vaginal practice that disappeared three or four generations ago, among the Yao-speaking people of Malanga and Malulo, is the cutting of the clitoris. The reasons for the discontinuation indicate that girls were dying as a result of the intervention. It was impossible to confirm if the above-mentioned

practice included the removal of the clitoris (clitoridectomy) or only some cutting and pricking of the clitoris.

The changes in the ages of the initiated, in the duration of the ritual, in the period of the event, in the practices associated with femininity, and in the teachings registered in the last few decades illustrate the dynamism of the rituals and the continuous influence of political, social, economic, and religious factors. The possibility for young initiated mothers to continue to study and the introduction of sexual education in school also are recent transformations. Many fundamental elements of the rituals have been adapted to the changing socioeconomic situation of the region and vice versa.

THE SECRET

Initiation rituals are surrounded by an aura of secrecy and, as Beidelman (1993) noted, for a secret to have a social existence while the core of the secret might be kept hidden, its concealment needs to be well known. Men cannot come close to the house of the female initiation ritual, cannot see the girls who cover their faces when going out, although in some cases they can hear the songs which are rich in sexual metaphors. Aspects related to pain, corporal punishment, psychological distress (humiliation, isolation, separation from family and friends, and restriction of movements and behaviors) are hardly verbalized and described. The rule is not to reveal to people of the opposite sex, to persons not initiated in that specific tradition or not initiated at all, what happened during the ceremonies and how youth experienced it. Infraction of that rule is said to imply disease and death in the family of the person who breached it. While most adult people are aware that it is a way to protect the secret, the reason for the secret itself is not clearly explained. Ambiguities and ambivalences prevail. As a matter of fact, in all linguistic groups in the villages visited, girls and women of foreign groups could be initiated in exchange for payment to the master of initiation of an amount often superior to the amount requested for girls from the same linguistic group as the master. The foreigners are seen to be "learning the secret" and likely to reveal it.

The most difficult aspects to get information about, or to participate in, are the teachings and practices related to sexuality. For example, it was not possible to see the clay penis of the Makonde master in Ntamba as she argued that she had broken it and had not yet replaced it. In Nairoto village, the master claimed that she had forgotten to perform the part of the ritual concerning sexuality. This was in order to explain why it was not part of the final ceremony I attended. Distortion, concealment, lies, and misinformation were the communication and methodological fieldwork dilemmas. Fear and uncertainty dominated the research: fear of missing the core of the secret and uncertainty about how to navigate within

and at the margin of the secret. I acknowledge that knowing what not to know is a powerful form of social knowledge (Taussig, 1999) and an ethnographer's puzzle. How to reveal what cannot be said? I also have been perplexed in trying to grasp if this concealment was the result of the past negative experiences with Catholicism, colonialism, and FRELIMO's postindependence policies or only an expression of a deeper aspect of the rituals. Why were death, sexuality, procreation, and gender relations at the heart of the secret?

Although I am a white woman, by taking part in 2006 in the Lomwe[3] female initiation in Ecole village in the district of Alto Molocué in the province of Zambezia, I have acquired knowledge that allows me to demonstrate that I have been initiated. Fieldwork in 2005 in the Tete province on vaginal practices also familiarized me with teachings related to sexuality (Bagnol & Mariano, 2008). As a matter of fact, the opportunity given to me, to a female colleague of a neighboring linguistic group, and to a male coresearcher to be part of some of the female ceremonies on distinct occasions demonstrate some flexibility and willingness to open the doors. Similarly, I was allowed with my female colleague to see the secret mapiko masks owned by Makonde women in Ntamba. However, as Beidelman (1993) also mentioned, the secrets were never revealed casually and without payment or gifts.

But, intriguingly, while there is much talk about secrecy, most men and women of a specific linguistic group and geographic area who went through the rites know in general what happens in the initiation of the opposite sex. What is revealed is not completely new. People know the grammar of their culture (Beidelman, 1993), where and how certain knowledge is acquired, but are not allowed to express it publicly. This has implications when it comes to discussing gender relations or sexuality around various issues, such as girls' school attendance, commercial and intergenerational sex, or domestic violence. The rituals are pointed out to be the cornerstone for any interpretation and understanding of gender relations.

A SECRET: GENDER COMPETITION

The initiation ceremonies are the subject of much dispute, suspicion, and tension. The men say that women are holding many secrets and are dangerous. I heard many men and women saying: "We do not know what they are told during the initiation or what they do there" to elude responsibility for the teaching and behavior of young people of the opposite sex. It implicitly suggests that it is exactly in the ritual that young people receive the teaching. This situation of apparent competition—as opposed to collaboration—between genders and with other linguistic groups is the secret domain, a zone of nondialogue. The secret thus marks an area of tension between genders and a form of gender confrontation

and nonsharing between women of different linguistic groups, between men and women, and ultimately between the ones who know and the ones who do not. However, as I mentioned earlier most men know what women do in the initiation rituals in their region and women from other region can be introduced, like myself, into the secrets with gift exchange.

During the rituals, I observed in many instances that there are role plays of the other sex with cross-dressing. In Malanga (Majune), older women play male roles when they mimic intercourse between themselves or with the novices. In the process, roles and gender identities are transformed by individuals who adopt, resist, adapt, challenge, and create new roles and identities.

Among the Shimakonde linguistic group in the district of Nangade, cross-dressing dancers perform female sexual roles. Joking confrontation between men and women can be seen in the references to sex in public events, which are part of the rituals. In songs that precede the entry of boys in the initiation house, men mock women for "being nothing" and "having nothing." The songs establish power relationships between engendered people. Through songs, we are told that men have something that women do not have: the penis. These songs provide information about relations between men and women that influence everyday behaviors, including sexuality. Through circumcision, boys' masculinity is enhanced and adulthood achieved. Similarly, female initiation allows a step toward adulthood. But, contrary to the boys, the girls have other steps to reach. It is only when women give birth that they attain the highest female status. They become "mother of." This difference between boys and girls stresses the role of maternity. Having children is seen as a central part of women's lives and often the only route to full adult status. Gender and personhood are experienced as a process of transformation through rituals and life events. The girl child becomes a novice, an initiated (*mwali*), a mother, an infertile woman, and a spirit.

Similar to what happens in the male rituals, in their ritual women also confront or mock masculinity. It seems that Makonde women are the ones who challenge men the most. They did so by acquiring the mapiko mask, which is worn over the top of the head. It is the most valuable of all the masculine symbols because it expresses the connection with the esoteric, gender relations, male initiation ritual, male power, and the history of the country and the region. The masks are usually carved in secret and used in dances by the members of male secret groups. The dancers represent mysterious and terrifying spirits. Only initiated men should know that it is a human being. This secret was the main secret of the male initiation ritual. Boys, in a form of ordeal, have to come close to the mask and uncover it, finding out that it is a male dancer. Dias and Dias, a pair of ethnographers who studied the Makonde in the mid-20th century, wrote:

> . . . we are brought to affirm that mapiko has been the most powerful weapon that men used in this struggle against the women's prestige

> and supremacy; and that they transmitted it, from generation to generation, through puberty schools. (Dias & Dias, 1970, Vol. III, p. 393)

Women unveiled the secret of the mapiko dance on discovering that it was a male masked dancer and not a spirit. Women, in addition to discovering the men's secret, took ownership of the mapiko masks in the late colonial period (P. Israel, personal communication, May 2011) and abandoned their clay mask to perform the mapiko dance in the female initiation rituals in a clear defiance of men. This situation is kept in total secrecy, a feat which women feel extremely proud of. They get their masks produced in secret by male sculptors. They need to get a written authorization from the village administrative authority to carry mapiko masks from place to place and avoid being beaten or even killed if they are caught with them by men. By appropriating in secret the most significant male symbols, the women demonstrate the desire that they nurture to undermine masculinity and male status.

In dance, mime, and drama that are part of the rites, men and women play the roles of both sexes, demonstrating gender performativity and that gender identities are not fixed and homogeneous (Amadiume, 1987; Mohanty, 1997). The female mapiko dancer has a special position and respect in the female initiation group. She is the one who plays the male role and personifies the mockery. In the initiation ritual, women display different gender identities and power. They mimic the power relation between gendered individuals, the sexual relation, and by doing so they mock the reality, they empower girls to control their body and their sexuality and play with men. They are both accomplice and reproducing gender ideology, but at the same time they perform a contradictory point of view and different gender identities and gender roles. While symbolic violence and women's complicity in their oppression seems to limit their agency as Bourdieu (1999) emphasizes, Foucault (1988) points out the possibility for individual agency as the result of power and as an historical product. By stealing the male secret, Makonde women are transgressing the gender norms. They show their power and educate girls to express their freedom. There cannot be relations of power unless subjects have some degree of freedom, as Foucault (1988) argues. He also stresses that, for the individual, freedom consists of exploring the limits of subjectivity through transgression: refusing to be what you are. In the initiation rituals, Makonde women teach girls to subvert gender roles and power relations.

A SECRET: GENDER COMPLEMENTARITY

In addition to tensions, envy and provocation between genders, and, to add another layer of complexity, the initiation rituals are aimed at stressing complementarity between men and women. An example of this can be found in Niassa province, in Macanga Um village, in Majune district.

In the initiation, boys are taught that they "are coming from the vagina and they are going back in the vagina" in sexual encounters. This image conveys not only the reproductive role of the sexual act, but also the central place that the vagina and the women have in this process. Everything starts with the vagina and continuity is given by it. Because the parents will be remembered as ancestors by the children and grandchildren in the family rituals, children are the continuation of life after death. People will have their names assigned to the individuals of the new generations, within a process of reincarnation. From birth to the passage to spirit form, a complete cycle occurs. This holistic concept of sexuality in which death and reproduction are fundamental elements strongly links to Bataille's (1957) reflection on eroticism. Sexual complementarity in reproduction and eroticism are key elements of initiation.

Medeiros (2007), in his book about the initiation rites of the Makhuwa Lomwe, establishes the relationship between menstruation and circumcision, comparing the blood shed during circumcision with menstruation. He also states that, while women are considered naturally fertile, the boys need circumcision and drugs provided during the ritual to enhance their virility and fertility. As Moore phrases it, rituals can be seen "as moments or events where images and narratives about the nature of gendered identities, the relation between women and men and the powerful nature of sexuality are being reiterated and repeated" (Moore et al., 1999, p. 28). Through the performance of the rituals, individuals and groups find a space where their agency can be exercised and where their experience and interpretation of the body and the world is enacted. Through rituals, a symbolic order is displayed that establishes a connection between knowledge, social practice, and the cultural symbols within which individuals and groups have been socialized. The performance of initiation rituals is an expression of a biological and social world, in which groups celebrate and propitiate reproductive capacity (Rasing, 2001).

The transformation and the new relationships developed between individuals depend on the capacity to go through this rite of passage. The complementarity of gender (masculine and feminine) and the reversal of gender roles (women assuming masculine roles and vice versa) are constitutive elements of this ritual (Gennep, 1960; Moore et al., 1999; Turner, 1969).

A SECRET: EVERYBODY HAS SEX

The sexual act is both complementarity and secret. The banality of sexuality and its common widespread practice is one of the main revelations of at least some of the initiation rituals I was allowed to witness. In Niassa province, specifically in Majune, the capital of the homonym district, the

Master of Initiation Speaking about Sexuality. © Brigitte Bagnol. Used by permission.

Yao female master in initiation had a session during which she showed the wood penis to the young girls (see image above) and she explained:

> Long ago, when there was an initiation ritual, they used to say that you had to look for men; but now, you cannot do this because you will catch HIV/AIDS. If you look too much for sex you will catch the disease, AIDS. You cannot advertise, talk to dad or talk to mom about this. This has to stay with you. You cannot go out and say I was in the initiation (*unyango*) and they told me to have sex. You cannot say anything. Your mother, your sister, your aunts, your grandmothers have sex, but nobody says they do. But they do! Do not tell anyone! Because if you do, your parents would die, your mother, all your brothers would die if you reveal these things out there. Did you understand? Have you understood well?

From the female master's talk, it seems clear that the secret revolves around sexuality. It is forbidden to speak about sexuality with anyone, even if sexual relations are commonly practiced by the young girls' relatives. The youth learn from the master that, although sexual intercourse is a general practice, it is a secret. It is the secret of the initiation. Breaching the secret has a very dire consequence as it involves the death of relatives.

Public reference to sexuality undermines the authority of the individuals within the group. Reference to sex or a body part is an insult. To speak about the unspoken is to proclaim that people are no more related. The masters of initiation are usually women who have reached menopause, and thus are associated with less sexual heat and reproductive power. They are seen as cold. Speaking about the unspoken stresses their ritual potency that allows them to deal with the secret. The secret is thus embedded in the familiar life and daily experience, but it is revealed in a specific way in the context of the ritual—in exchange for payment and gifts, and never casually. The master of initiation has a different status from any other women, both during the initiation and in general. As with the traditional leader who, in some of the villages, evocates his ancestors to propitiate the good process of the ceremony, the female master also is responsible for connecting with her ancestors to ensure success in the ritual. Many gender roles are not related to the sex of the individual or his/her physique, but are influenced by other markers of identity, such as, in this case, age and the knowledge the master acquired from her own mother and then passing the knowledge on to her daughter. Therefore, relations of power are not fixed and based solely on perceived differences and culturally constructed between sexes, but rather processes that occur throughout life (Mohanty, 1997). Gender relations are situational because they vary, depending on specific contexts.

An aspect, also worthwhile noticing, is that in her speech the master stresses that while in the past young girls were encouraged to look for sex, these days they have to be aware of HIV/AIDS. In this sense, she contextualizes the messages transmitted during initiation and adapts them to the current reality. Showing her agency by introducing the issue of sexually transmitted disease, the master transforms the teaching and the messages given in initiation rituals in the past—forging a new notion of sexual involvement and risk.

A SECRET: SEX IS GOOD

In a certain way, contrasting with the warning of the master advising the novices that they should not look too much for sex, an important secret of boys and girls initiation is that sex is good. As stressed by the men in Ntamba (Mueda Plateau, Cabo Delgado): "The rite is to instill in girls the idea that sex is good." One of the dances taught during the female rituals in Niassa is called the sieve or sieving. This alludes to the circular movement that women should perform during sexual intercourse to ensure pleasure and maintain the man's erection. Similarly, in Nairoto, in Cabo Delgado, a song says: "If you're in bed you should do so [in reference to the movements]. If the man sees that you are not doing it he'll think you're cold." As happens with most of the secrets revealed during the rituals,

while the girls know the dance, its meaning is only disclosed during the rituals. Sexual knowledge, such as penetration, positions, movements, cleaning of the penis and the vagina after sexual intercourse, massaging of their partner, avoiding sexual contact during menstruation, and caring of menstrual fluids, are topics that are learned by girls.

While in Nairoto and Pangana education regarding menstruation and the importance of avoiding sexual contact in this period is given only to girls who already menstruate, in Malanga, this information was part of the initiation of all girls, even before menstruating. Black-white-red triads of primary colors are recognized as basic symbols which underline a model of thought (Jacobson-Widding, 1979). The importance of controlling the color of the vaginal fluids is taught to girls with the use of threads of beads of the three colors (Malanga). In the color system, white is associated with coolness (ancestors, rain, sperm, milk, semen, snake) and femininity. Red is associated with danger and infertility (witches, blood, miscarriage, fire, lightning) and is related to heat. A menstruating woman cannot cultivate the fields as she would compromise the harvest. The blood of a dead person on the soil can dry the land and provoke drought. Women and female sexuality are considered hot and dangerous, and able to compromise agricultural production and threaten death to cattle and men. Black is the color of the night, dry blood, and night witches (Feliciano, 1998; Kuper, 1982). Only when vaginal fluids are white are women allowed to have sexual intercourse. Failure to comply with these rules can have health consequences for the couple.

In Macanga Um, elderly men explained that during initiation boys are also taught that "they have to have sex." This is one of the main pieces of advice. After going out, they can wait for a while, but as soon as they have an erection they should have intercourse with a person of their age but outside the family to heal completely, "to shake the ashes." "They are cleaning to get the new fire." Like girls, boys are usually taught that they should have sex. In this case, intercourse is even seen as a definite way of healing from circumcision. The metaphor of the fire is usually associated with sexuality and heat. This heat is not only a physical heat, but is also a state of power in which the woman finds herself at a given time in her life. This power may be connected to the possibility of reproduction, to birth, and also to death.

A SECRET: WOMEN ARE POWERFUL

An important aspect of the teaching given during initiation ritual relates to the gender and sexual empowerment that are claimed to be provided to the girls (Kakonge & Erny, 1976; Rasing, 2001). As boys are taught not to be afraid of girls, girls are also encouraged not to be afraid of them.

During the rite in Nairoto, the novices dance and sing the song of the butterfly. With joined feet, they hold their *capulana*,[4] open it, and separate the knees, then close the feet and the cloth in rhythmic movements. They sing: "What is here? It is a butterfly! What is here? It is a butterfly!" The butterfly is the metaphor of a vagina with elongated labia. Like a butterfly that opens and closes its wings, the elongated labia needs to be open (to allow penetration) and closed (for women to feel complete and in good health; Bagnol & Mariano, 2008). Other songs educate girls not to fear big men: "Just grab the man's penis and introduce. It does not matter if it's big or small. Just introduce, introduce in the vagina." This song aims at advising the young girls that there are penises of different sizes, but they should not be afraid of any. Another song explains: "Here [in the vagina] there is all. There is corn. Now if you distribute [sex] for free, this is with you. If you do not wash it, it is with you." In these lyrics, the girls are advised that they should be provided with food and shelter from the person they get involved with sexually. But, if they have no return from their sexuality or if they do not have hygienic practices, it is their problem. In another song that relates to the previous perspective of an elderly woman is given: "My vagina is old, I cannot get anything. I cannot get corn, beans. Your vagina is beautiful, you will get corn, beans." The message is that sexuality is something precious that needs to be handled with care and cannot be spoiled as it ends. Old women do not manage to get food and shelter thanks to their vaginas, while young girls can. Girls are advised to find a partner who will care for them and to stick to him. Young girls are educated to expect economic support in exchange for their sexuality. Girl's agency is stressed. In the initiation ritual, young girls learn how important sexuality is and how to take control over their body so that it contributes to their livelihood.

Sexuality, in this context, is thus seen as empowering. Girls are pictured as being able to get what they want and men not being able to resist. The female child is liable, by virtue of her conduct, to provoke sexually the male adult. In Malanga, the night of the entry of the girls in the ritual, one song explained that when the girl sits with her mother she closes her legs. But, when she sits with her father, she normally sits with the legs open, revealing her panties. The song goes on to tell that usually the father does not resist and invites the child: "Let's have sex in the house" (Malanga). This teaching conveys information about the relationship between an adult male and female child. The adult cannot resist because he "cannot control himself." The rules of social behavior and gender relations are established based on the notion that a female child is responsible for her sexual involvement with an adult. She is dangerous even to her father because she is powerful and can provoke him sexually. The fact that a girl child is seen as provoking sexually an adult shows how a human rights perspective with definitions of childhood, age of consent, and sexual

abuse enshrined in national and international legislations might conflict with local perceptions.

Although the initiations rituals are carried out in a context of gender inequalities, with women often lacking access to land, education, political power, and so on, the rituals highlight their symbolic power. As referred to by Casimiro and Andrade (2011), there is an oversimplification around the term power, and its symbolic dimension is often ignored or under-valued. Notions of power, therefore, particularly those presented by Foucault (1994), constitute a reference point. Power can be looked upon as a network in which individual and social identities are made. Power is a form of *subjectivation*. Foucault argues that the social system makes differences between sexes seem natural, which hides oppressive social systems (Foucault, 1994). Along this line, perceived differences between men and women are taken as a basis to establish power relations in the context of the initiation processes. Women are powerful symbols because they are the only ones who can give birth. Controlling this capacity with both the complicity and resistance of women is what initiation ritual is about, as sexual reproduction is central to social reproduction. Women, as Baal (1975) and Collier (1988) have argued, create situations in which they can maneuver and fight to maximize gains. In this case, women use their sexuality to secure their livelihood and educate the youth to do so as well. This, as I have noted earlier, does not mean that it is in opposition to other strategies, such as getting educated and being employed—very remote possibilities in rural areas. However, in places where access to information, education, social, and economic options are limited, very often the only alternative for girls is to get married and to have children. Women are often educated in a way in which the aim of their life is limited to procreation over valorizing their sexuality. Their education and professional careers are often seen more from an economic perspective than as a personal achievements.

MULTIPLICITY OF GENDER

In order to maintain themselves, societies seek to convey to future generations their organizational and survival aspects, including scientific, political, philosophical, metaphysical, and aesthetic. In their daily practices, and in order to carry out and reproduce everyday actions (habits), people incorporate the dominant discourses, even when they oppress them, and begin to reproduce them without realizing the mechanisms that sustain the oppression. Attending the rites, children and adults express their agency and their adherence to a certain social organization and sharing of certain fundamental values for life in society. Most parents and children want the performance of the initiation rites. Parents want to feel the satisfaction of having sons and daughters growing older and getting

properly educated. The children of both sexes want to move as quickly as possible to be treated as responsible people worthy of respect and able to live with the adults. But men and women confront and resist the dominant discourses and, as seen earlier, for religious, political, ethical reasons, strive to modify and adapt them to their views. Girls, also, although going through the initiation ritual, might oppose some of the teachings.

During the rites, women do not all occupy the same positions and do not have the same powers. The age, the status they hold in society, and the passage through certain rites throughout life define the power relations between women. In this case, gender relations are not the most important markers. Age and passage through rites take precedence over gender (Miescher et al., 2007). Many feminists and academics stressed that to characterize women as a homogeneous category of disempowered people is a simplistic reduction (Mohanty, 1997). There is no homogeneous category of "woman" or "man" with a fixed identity. There are men and women who assume different positions and different ways of exercising power. These depend on different moments of existence and the functioning of several factors, including social class, race, ethnicity, education, religion, residence, age (not being initiated, having children, menopause, etc.), lineage (belonging to the royal line, etc.), the order in the offspring (first or last child, etc.), and the order in marriage (first or second wife, etc.) in cases of polygynous marriages, and so on.

During the initiation ritual, I witnessed in Nairoto a group of four girls who had been through their initiation in the previous year, and as they had reached menarche, went back in December 2009 to learn how to care for themselves during menstruation. As part of the education process, two of them were beaten by the older women. One was beaten because she was married and wanted to part from her husband and the other because she did not want to get married. Despite the education they receive and the social pressure, the youth are able to stress their own views and contend their relative opting to rule their own lives. This particular aspect shows the power relations between women of different generations. Older women often try to impose their ideas on the younger ones. The different, and sometimes conflicting, points of view among women (Collier, 1988; Lamphere, 1974; Wolf, 1974) are expressed in these episodes. The sexual and reproductive options available to an individual depend on the context, and usually decisions are made under a lot of pressure from relatives and peers. Thus, choices are never completely free or individual (Osório, 2004).

In *Age, Race, Class and Sex: Women Redefining Difference,* Audre Lorde (1984, p. 123) stresses that "the true focus of revolutionary change is never merely the oppressive situations we seek to escape, but the piece of the oppressor which is planted deep within us."

The incorporation of the dominant discourses and their reproduction are issues that the initiation ritual raises. But, in fact, initiation rituals also

give women of different ages and status an opportunity to ponder, reflect, transform, and reproduce forms of respect and obedience, as well as contestations.

CONCLUSION

Individuals are not born men and women, but are transformed by society into men and women. For example, many Makhuwa and Kimwani girls should lengthen their labia minora to become women and the Makonde must go through initiation rites, marry, and procreate. Only after procreation are they awarded the highest status by becoming the "mother of." The boy should be circumcised, thereby demonstrating through a physical change the modification that occurred in his personality and social status (Martinez, 1989). Gender identity is built on relationships that each one establishes with the family and society. To this is added the insight that is gained about their own bodies. The new relationships developed between individuals after the ritual depend on their capacity to go through this rite of passage (Gennep, 1960). The confrontation and complementarity of gender (masculine and feminine) and the reversal of gender roles (women assuming masculine roles and vice versa) are constitutive elements of this transformative ritual (Moore et al., 1999; Turner, 1969). The content of the secret and the transmission of the secret evolve and express the tensions around the most adequate ways to educate children in current society.

The existence of initiation rituals is not the result of an immutable tradition transmitted from generation to generation without an individual and collective reflection by participating adults and children. The rites are an expression of resistance by individuals and groups to the various forms of subjugations. In this learning how to belong to one of the two sexes, both, or neither, individuals embody the different gender subjectivities accepted as a norm or resist and create others. The same applies to sexual identity and linguistic identity/ethnicity. So, there are a variety of subjectivities between men and women, between women, and between men expressed in the initiation rituals.

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NOTES

1. The Mozambican Liberation Front that, after fighting an armed struggle against colonial rule, proclaimed Mozambique's independence in June 1975. FRELIMO took a Socialist and Marxist approach, which rejected some values of the so-called traditional society, and the initiation ritual was one of these. This agenda was, in many ways, similar to that of the missionaries of the pre-independence era.
2. RENAMO, the Mozambican National Resistance, was created by the Rhodesian Central Intelligence Organisation in 1977 and taken over in 1980 by the South African Security Forces.
3. The Lomué or Lomwe are part of the Makhuwa-Lomwe Group.
4. A piece of fabric used to wrap around the waist.

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Chapter 9

Sexuality Issues among Vietnamese Women

Khanh Van T. Bui

Vietnam has an underdeveloped program on sex research (Pastoetter, 2001). Perhaps the influence of the more ascetic aspects of Confucianism and Buddhism has made human sexuality unworthy of study in social science research (Khuat, 1998).[1] Whatever the reasons, there remains a lack of in-depth information on attitudes and practices regarding sex and sexuality of Vietnamese women (Vu, 2008). The little empirical research that does exist has to be interpreted with several caveats in mind.

First, much of the research on sexuality in Vietnam employs qualitative rather than quantitative methods. Researchers (e.g., Rydstrøm, 2006; Santillán, Schuler, Hoang, Tran, & Bui, 2002; Vu, 2008) typically conduct fieldwork that involves focus groups, individual interviews, and/or participant observation. Data from these research methods provide rich details about small samples of women, but the data may not be representative of the population from which they come.

Second, researchers tend to have convenience samples, recruiting participants from friends or referrals from friends (e.g., Bui, H. T., 2010), local public health officials (e.g., Go et al., 2002), or other snowballing techniques

(e.g., Phinney, 2008). These methods tend to select participants who are familiar with the research process and/or the value of research. These participants would understand that written informed consent forms (as used by Bui, K. C., Nguyen, Rasch, & Gammeltoft, 2010; Go et al., 2002; Khuat, 1998; Oosterhoff et al., 2008; Phinney, 2008) are a required part of research with humans, but these consent forms would seem strange and might even raise suspicion among Vietnamese women who rely mainly on verbal agreements.

Third, many Vietnamese tend to avoid open discussion about sex (Knodel, Vu, Vu, & Ghuman, 2007) because the topic is considered "sensitive" (Vu, 2008, p. S164), "delicate" (Zhang & Locke, 2002, p. 451), "impolite" (Blanc, 2004, p. 248), and "taboo" (Kelly, 2004, p. 111). Those who voluntarily talk about sex to researchers have overcome these inhibitions. Volunteers tend to be college educated (Khuat, 1998), urban (Bui, H. T., 2010; Knodel et al., 2007), and working for the government or a university (Bélanger & Khuat, 1998; Bui, H. T., 2010). These characteristics are not representative of the broader majority of Vietnamese women who work on farms.

Fourth, in contrast to women who voluntarily participate, some women may not have a choice. In large survey studies sponsored or approved by the government, respondents may not have the right of refusal (Goodkind, 1995b). In addition, sometimes the participants are asked by their supervisor or selected by commune or union leaders to participate in interviews or focus groups (e.g., Vu, 2008). Furthermore, sometimes village officials accompany the researcher during interviews (e.g., Goodkind, 1995b). When women do not freely volunteer to participate, this limitation raises the question of the extent to which these women are providing answers that are consistent with official policies on family planning. Such "courtesy biases" (Goodkind, 1995b, p. 99) could systematically reduce the accuracy of the data. Pastoetter (2001) argues that a neutral and unprejudiced understanding of Vietnamese sexual habits is hardly possible.

Finally, among Vietnam's population of 86 million (Teerawichitchainan & Amin, 2010), almost three-fourths still live in rural areas (Knodel et al., 2007); but most studies on sexuality have been conducted in urban areas, especially Hanoi, Ho Chi Minh City (formerly known as Saigon), and their surrounding vicinities. Rural life, however, differs vastly from urban life. Norms, especially sexual norms, are more strictly applied in rural areas than in urban areas (Go et al., 2002). In contrast, urban areas are more influenced by available Western media and less rigid about sexual norms and behaviors. Thus, some research findings on Vietnamese women's sexuality may differ by area of residence.

Having listed the above caveats, I now provide an overview of research on sexuality issues among Vietnamese women, first within marriage and then outside of marriage. I make this distinction, because in Vietnam "female sexuality not within the bonds of marriage is considered as

nonexistent" (Bélanger, 2004, p. 99) and marriage is "practically universal" (Vu, 2008, p. S167). For sexuality issues within marriage, I will discuss the lack of sex education prior to marriage, sex for procreation, preference for sons, frequency of sex, abortions, and sexually transmitted diseases (STDs). For sexuality issues outside marriage, I will discuss prostitution, premarital sex, abortions and STDs among single women, extramarital sex, and lesbianism.

SEXUALITY ISSUES WITHIN MARRIAGE

Lack of Sex Education prior to Marriage

Before marriage, parents tend not to speak to either male or female children about sexuality. The reasons seem cultural. From more than 1000 years of Chinese domination of Vietnam (110 BC–AD902, 1407–1427, and 1788–1789; Kelly, 2004), a lasting influence includes the adoption of Confucianism, which emphasizes a hierarchy of age that prevents easy communication between the old and the young (Blanc, 2004), especially about an impolite topic.

Outside the family, there is a lack of institutional sex education (Zhang & Locke, 2002), because of Vietnam's traditional bias against the public mention of anything sexual (Pastoetter, 2001). In a fieldwork study of a northern rural commune, Rydstrøm (2006) found that young Vietnamese women tend to have only limited knowledge about sexuality, fertility, and contraception. Although adolescents are taught about sexuality in school, the teaching is not very enlightening. As one teenage female informant explains, "Teachers don't talk about sex; they talk about plants and animals" (Rydstrøm, 2006, p. 292). Zhang and Locke (2002) suggest that teachers find sex difficult to explain or are poorly informed themselves. Blanc (2004) suggests that sex education raises awkwardness between teacher and students and a coeducational classroom presents a difficult situation for a teacher to speak about sex or genitals and still save face.

With no institutional sex education, adolescents resort to other sources for their information on sex. Rural adolescents get (mis)information about sex from friends. But even this method has its problems for girls. Consistent with the belief that talking about sex is "immoral" (Vu, 2008, p. S164), Rydstrøm (2006) found that some rural female adolescents claim that talking about sexuality may label them as having bad morality, which they strive to avoid. As for urban young people, a survey study about sexuality and AIDS found that, among 407 young men and women from Ho Chi Minh City between the ages of 15 and 29, books and newspapers are the most consulted sources, followed by television (see Blanc, 2004).

But sex should not be on the mind of a young unmarried woman. Instead, she is expected to cultivate *tu duc* (four feminine virtues, as specified

by Confucianism; Ngo, 2004): *cong* (industriousness in managing domestic activities and agricultural work), *dung* (appealing appearance), *ngon* (polite speech), and *hanh* (exemplary conduct). The *tu duc* ideals denounce free interactions between the two sexes and emphasize female domesticity. Furthermore, Vietnamese women are trained to obey three men: the father when unmarried and still living at home, the husband when married, and finally the eldest son when widowed (Rydstrøm & Drummond, 2004). Conformity to these expectations is believed to bring harmony to relationships, families, and society.

Sex for Procreation

Confucianism dictates that a woman shows good morality by remaining a virgin until marriage (Rydstrøm, 2006). Men concur. In a survey of 493 Hanoi men aged 18–55, 74.4 percent of the participants said that virginity in women is important (see Blanc, 2004).

Unmarried women live with their parents until they get married, at which point they go to live in the husband's home and serve as a maid to his family (Vu, 2008). Even if a married woman has a paid job, she still performs the housework for her husband's family (Rydstrøm & Drummond, 2004).

More importantly, a married woman is expected to bear children. In a snowball sample of 20 urban, middle class, and college-educated married individuals (50% women), H. T. Bui (2010) found that almost all her participants emphasized having children during the early years of marriage. Vietnamese women gain social recognition when they become mothers (Bélanger, 2004). Vietnam considers the family to be the core of society and sees human reproduction as a significant function and a responsibility of women (Rydstrøm & Drummond, 2004). But reproduction is not simply a married couple's decision. From interviews with 66 married women, 16 men, 20 health workers, and 20 community leaders from four rural communes in northern Vietnam, Santillán and colleagues (2002) found that reproductive decisions involve not only the couple, but also the extended family, community leaders, and even the state (Oosterhoff et al., 2008; Zhang & Locke, 2002).

In an analysis of 328 marriages from 1948 to 1989, Goodkind (1995a) found that couples who had chosen their mates were almost three times more likely to have had a first birth within 8–12 months of marriage compared to couples whose marriage was arranged, which was common prior to the 1960s. More broadly, nonarranged marriages were associated with a faster transition to parenthood throughout the first four years of marriage.

Regardless of whether the marriage is arranged or not, the bond between spouses is more of prescribed duty than affection. Sexual fulfillment for its own right, as opposed to procreation, has been largely absent

from the public discourse (Santillán et al., 2002). In a sample of 25 rural married women selected by local leaders of the Women's Union in a commune in northern Vietnam, Vu (2008) found that women believe sex for procreation purposes and for maintaining relationships is more understandable and reasonable than it is for satisfying women's desire and pleasure. Not surprisingly, in Santillán and colleagues' (2002) interviews and focus groups with 66 married rural women, they found that most women do not discuss sexual desire with their husbands and they rarely reveal their thoughts and feelings to their husbands during sex. One informant explains:, "The family will be happier if the wife treats sexual intercourse as a duty" (Santillán et al., 2002, p. 264).

Among educated urbanites, however, there is talk of sex for pleasure. From H. T. Bui's (2010) interviews with 20 college-educated, married individuals (50% women) in Hanoi, she concludes that there is a movement to endorse sexual satisfaction for its own end, and this movement is highly influenced by ideas from the West. But even among this college-educated sample, H. T. Bui finds that, after having children, married women may feel the need to deny their own sexual desire because they would be the ones who would "pa[y] for all the costs and risks" (Bui, H. T., 2010, p. S25) associated with failure of contraception.

Preference for Sons

Married women experience strong pressure to bear sons because Vietnamese culture practices patrilinearity. The continuity of the family line passes through the eldest son, who assumes primary responsibility for ancestor worship involving the veneration of the spirits of the deceased by their living relatives. Confucianism states that the souls of the ancestors reside with and control the fortune of the family. The eldest son in the family conducts the relevant ceremonies on the death anniversaries of the ancestors to ensure favorable fortune for the family (Vu, 2008). Consequently, patrilineal ancestor worship celebrates male progeny and defines boys and men as "inside lineage," but renders girls and women as "outside lineage" (Rydstrøm, 2006, p. 284).

Besides ensuring patrilinearity for the husband, sons bring benefits to the wife. With the birth of a son, the wife's status in the family increases. If her husband is the eldest son, then she can exercise great power in fending off the aggressions of his female relatives (O'Harrow, 1995), who have previously treated her solely as a maid. Furthermore, sons eventually become men who bring into the family home daughters-in-law who provide extra pairs of workhands for the family.

Failure to bear a son would result in constant anxiety for wives, because this failure would render them even lower status in the family and community (Zhang & Locke, 2002). Pastoetter (2001, p. 686) claims that giving

birth only to daughters is still regarded as the "only noteworthy female 'sexual dysfunction.'"

The desire for boys is so strong that a husband can take a second wife if the first wife cannot produce a son. In a village study conducted from 2000 to 2002, Bélanger (2004) documented several cases of men who had taken a second wife as a strategy to bear a son. If the second wife succeeded in giving birth to a son, the son was often raised by the first wife, if she was not already divorced by the husband (Oosterhoff et al., 2008).

Not only do husbands want sons, but mothers-in-law want grandsons. From interviews with 56 HIV positive women, Oosterhoff and colleagues (2008) found that the pressure to continue the family line is so strong that some prospective mothers-in-law hide their son's HIV positive status in seeking a wife for their son. Once found, the wife is expected to produce a male heir as soon as possible, while she and her husband are still alive, especially if the husband is the eldest or only son and despite the HIV health risks to the wife and the unborn child.

Frequency of Sex

In a survey study of 800 married respondents (50% women) from two urban and two rural communes in northern Vietnam, Ghuman (2005) found similar incidence of sexual activity in urban compared with rural areas. The percentage of married couples who report having sex with their spouse in the prior month declines with age from about 90 percent for couples in their 20s to about 50 percent for couples aged 55 and above. For all age groups, married women report lower levels of sexual activity than do married men. Ghuman believes this difference can be partially explained by the fact that, on average, women have slightly older spouses than do men and men's sexual activity declines with age. Finally, Ghuman also found only a small minority of the married women (from 5.3% to 11.5%, depending on residential history) report initiating sex solely or equally with their spouse.

Whereas Ghuman (2005) examined marital sexual activity in the prior *month,* Knodel and colleagues (2007) examined this activity in the prior *year.* Knodel and colleagues found that, in the first population-based quantitative study on how marital sexual activity changes with age in a sample of 2,592 respondents in 12 different age cohort-gender-residence (rural/urban) combinations of equal size, the percentage of married persons under 50 who report no intercourse during the prior year is very low (ranging from 1% to 3%, depending on age group) and similar to their American counterparts. For age groups over 50, however, the level of sexual inactivity among married Vietnamese is substantially higher than that for married Americans. For example, for the age group 60–69, 42 percent of the married Vietnamese were sexually inactive in the prior year compared to 13 percent of the married Americans.

Knodel and colleagues list several explanations for the difference. First, social disapproval of couples sleeping together once they reach middle age is longstanding and common in northern Vietnam (see also Khuat, 1998). Second, social disapproval of sex at older ages for women is inconsistent with maintaining sexual activity. In a qualitative study that employed a diary method to collect data from a sample of 27 participants (14 menopausal women and 13 husbands) from Hanoi, T.H.T. Nguyen (2007) found that both men and women view older women as asexual and women who have sex after menopause fear being labeled as a "lustful goat" (p. 162). Third, living with adult children, which is a common practice among older Vietnamese, may diminish the privacy needed for intercourse.

Knodel and colleagues also found that marital sexual activity generally shows no relationship with marital satisfaction and harmony. These researchers explain that marriage in Vietnam is traditionally more a concern of the families and lineages involved than a personal matter between husband and wife.

Abortions in Marriage

Abortion has been legal in Vietnam since 1954 (Bélanger & Khuat, 1999). Induced abortion is performed until 22 weeks of gestation (Bui, K. C., et al., 2010).

In an analysis of data from 27,097 currently married women aged 15–49 from the 2001 Vietnam National Health Survey, a population-based nationally representative survey, Teerawichitchainan and Amin (2010) found that, on average, a married woman in Vietnam has .67 abortions during her reproductive years, given current age-specific abortion rates. As noted by other researchers (e.g., Bélanger & Khuat, 1998; Nguyen, Martin, Nguyen, & Duong, 2010; Sedgh, Henshaw, Singh, Bankole, & Drescher, 2007), Vietnam's abortion rate is high in comparison to abortion rates in other East Asian countries.

Vietnam's abortion rate is high for several reasons. First, since 1988, the government has implemented a policy of one or two children with a minimum of 3–5 years between first and second births. The desire to avoid fines (one to three months' earnings, according to Goodkind, 1995b) for exceeding the two-child limit or violating the birth spacing rule motivates some couples to choose abortion (Zhang & Locke, 2002), especially given that the government provides abortion services free of charge or for a nominal fee (Teerawichitchainan & Amin, 2010).

Second, given the limit of two children and the preference for sons, some women choose to abort female fetuses or are pressured to do so. Guilmoto, Hoang, and Ngo (2009) report that Vietnam's sex ratio at birth (male births per female births) is increasing; in 2006 it reached 112, which is statistically above the biological standard of 105.

Third, women use abortion when available methods of contraception failed or were unacceptable. Some Vietnamese women cannot tolerate intrauterine devices (IUD), because they cause prolonged menstrual bleeding leading to loss of a lot of blood (Gammeltoft, 1999). Other women have unpleasant side effects with oral contraceptives (Santillán et al., 2002). As for condoms, married couples tend not to use them, because (a) men believe condoms reduce sensation, (b) men do not want to arouse suspicion in the wives that they have visited sex workers, (c) condoms cost money, and (d) women feel embarrassed about buying them because purchasing condoms advertises that the buyer is having sex (Kelly, 2004; Santillán et al., 2002). Male sterilization is not an option as contraception because both men and women believe that male sterilization makes men weak, dull, stupid, less clever, and more forgetful (Santillán et al., 2002). Finally, although men prefer withdrawal as a method of contraception (Bui, H. T., 2010), Teerawichitchainan and Amin (2010) found that the abortion rate is higher among women who use a traditional method (withdrawal or periodic abstinence) than among those who use a modern method (e.g., IUD, pill, or condom).

Fourth, some abortions are unnecessary. Abortions usually take the form of menstrual regulation, a procedure that induces menstruation within six weeks of the last period. The rate of unnecessary menstrual regulation has been found to be between 17 percent and 25 percent in a northern Vietnam province (see Zhang & Locke, 2002). The main reason for the unnecessary abortion is the unavailability or omission of a pregnancy test (Bélanger & Khuat, 1998). Some women choose menstrual regulation as a precautionary measure even when they are uncertain whether they are pregnant (see Teerawichitchainan & Amin, 2010).

Fifth, Vietnam's new population policy since 2001 emphasizes population quality, which discourages mothers from bringing sick or disabled children into the world. Among HIV positive pregnant women, the fear that the child would also be HIV positive and suffer lifelong discrimination or that they could not provide for the child lead them to choose abortion. In K. C. Bui and colleagues' (2010) qualitative study of 20 HIV positive pregnant women from two cities in northern Vietnam, the majority of the women (13) chose abortion.

STDs in Marriage

The first person in Vietnam to test positive for HIV was in 1990 (Ta, 2010). Since then, HIV prevalence has spread to all 64 provinces and cities in Vietnam. By March 2008, women accounted for 17 percent of people living with HIV/AIDS in Vietnam (Bui, K. C., et al., 2010). Many of them have been infected by husbands (or regular partners) who inject drugs.

One reason for the spread of HIV/AIDS is that men and women do not communicate adequately with each other regarding personal issues,

including safer sex practices (Kelly, 2004). H. T. Bui (2010) lists several plausible reasons for this inadequate communication: (a) women fear being perceived as promiscuous if they raise the topic of sex with their husband, (b) men and women lack the language to describe their sexual desires and fears because the culture does not provide or promote such language, and (c) men fear revealing their ignorance of sexual matters by discussing them. Whatever the reasons, the lack of communication about safer sex practices creates an "ideal breeding ground" (Pastoetter, 2001, p. 688) for AIDS and other STDs.

The spread of STDs among married women is also facilitated by a Vietnamese cultural belief that it is women's fate to suffer (Go et al., 2002), including risking infections from their husbands. From her interviews and focus groups with 25 rural women from a commune in northern Vietnam, Vu (2008) found a participant who compromised her desire to be free from disease by submitting to her husband's sexual demands. A theme among Vu's informants is that they have to "endure" and "please" (Vu, 2008, p. S172) their husbands to avoid violence from them. Vu also found that condoms are not widely used, even though her informants agree that many men get involved in casual sex when they work far away from home, as is the case of men who migrate to urban areas in search of employment.

In a sample of 36 rural and urban northern Vietnamese (50% women) who were recruited by referral from local public health professionals and through snowballing, Go and colleagues (2002) found through focus groups and in-depth interviews that participants endorse a double standard for STDs. Men with STDs are deemed "curious" because men are supposedly naturally tempted by commercial sex, whereas women with STDs are deemed "prostitutes" (Go et al., 2002, p. 476). Go and colleagues' informants claim that wives would remain loyal to a husband with STD, but husbands can beat and/or divorce a wife with STD.

Both shame associated with STDs and fear of being ostracized discourage women from seeking treatment. Also, women tend to put their responsibilities in maintaining the home and farm above their own needs and fail to seek timely care for health problems (Santillán et al., 2002). When they do seek health care, they encounter providers who may misdiagnose their STD or blame them for it (Go et al., 2002).

SEXUALITY ISSUES OUTSIDE OF MARRIAGE

Prostitution

Although the Vietnamese government categorizes prostitution, premarital sex, extramarital sex, and homosexuality as forms of social evils (Rydstrøm, 2006), only prostitution is illegal. Despite the legal ban, prostitution is widespread (Rushing, Watts, & Rushing, 2005) and easily accessible

(Phinney, 2008). The magnitude of sex work in Vietnam, however, is difficult to determine because more than 70 percent of all sex work is masked as entertainment industries (Rushing et al., 2005).

Prostitution thrives and grows in Vietnam (Walters, 2004) for various reasons. First, sex workers provide the outlet for men's homosociality. Urban men socialize in groups at brothels where they engage in sexual acts with female sex workers to demonstrate their masculinity and to experiment with sexual practices that they cannot perform with their girlfriends (Martin, 2010) or wives (Phinney, 2008). Regardless of their own personal attitude toward homosociality, men experience strong male peer pressure to participate in it to avoid social rejection (Martin, 2010; Phinney, 2008; Ta, 2010).

Second, use of sex workers' services has become a status symbol. Global market economy, after *doi moi* (renovation) policies were implemented in 1986, has led to the commercialization and sexualization of men's leisure activities. Urban men now have disposable incomes and they choose to spend it on commercial sex as a form of leisure (Phinney, 2008).

Third, men treat various recipients to commercial sex to achieve work-related benefits (Phinney, 2008; Ta, 2010). They treat (a) male colleagues to establish work friendships, (b) managers to gain promotion or other forms of advancement, and (c) clients to win business deals. These practices have become obligatory in many industries (Phinney, 2008).

Fourth, sex workers serve as friends and confidantes to some men. For example, men in dangerous jobs, such as coal mining, use commercial sex as a form of coping with depression, isolation, and fear of dying from work accidents (Ta, 2010).

Fifth, sex workers provide services to married men when their wives are unavailable for sex. A wife is unavailable for sex when she is nagging (Kelly, 2004), menstruating or pregnant (Phinney, 2008), or tired from a double agricultural and domestic work load (Go et al., 2002). She is also unavailable when there is a lack of privacy at home. For example, there is no separate bedroom for the couple, or they have to wait for the children to go to sleep before they can initiate sex, or the children are older now and stay up later than do the parents (Khuat, 1998).

But who are these sex workers satisfying the high demand for commercial sex? They tend to be poor women from rural areas. Poor women often flee their home villages to roam cities for work. When work is hard to come by, many of these women are lured into sex work (Khuat, 1998; Rushing et al., 2005) to support themselves and their families. Although these women break one norm (chastity) they uphold another norm (filial piety) by contributing to their families' material life circumstances. Vijeyarasa (2010) argues that it is a perversion of filial piety by which these women are manipulated, by a sense of duty, care, and gratitude, into prostitution. Walters (2004) believes that, without an effective state-sponsored welfare

system, women may become economically dependent on prostitution to support themselves and their families. Other reasons for falling into sex work (see Khuat, 1998) include troubled family relations, living beyond one's means, satisfying one's sex drive, or being trafficked into sex work. An estimated 20 percent of Vietnam's commercial sex workers are held in brothels against their will (Pastoetter, 2001).

From interviews with 20 migrant sex workers between the ages of 16 and 27 in northern Vietnam, Rushing and colleagues (2005) report that most of these women were raped and/or not allowed to use a condom for their first sexual experience, because they had been bought for their virginity to reduce the client's risk of infection. More generally, condom use largely depends on the customers' attitude (Khuat, 1998). A sex worker earns approximately US$1 per act, while the madam/procurer receives US$8 per act (Rushing et al., 2005). A prostitute can earn as much as US$180 per month, whereas the average government civil servant earns roughly US$30 per month (Pastoetter, 2001). Places where prostitutes offer services include hotels, inns, karaoke clubs, dance halls, beer houses, cafes, bars, massage parlors, restaurants, fishing huts, beaches, public parks, dyke embankments, barbershops, bus stations, and railway stations (Phinney, 2008; Walters, 2004).

Sex workers have access to health care, but the stigma attached to sex work deters them from seeking it. They prefer health education and care from their peers (Rushing et al., 2005). Although it is much easier for women to contract HIV from men than for men to contract it from women, female sex workers are blamed for the spread of HIV while male clients face no official or social responsibility for it (Kelly, 2004).

Premarital Sex

Blanc (2004) claims that Vietnamese people are willing to acquiesce to premarital sex if the two partners have a strong bond of love and if they plan to get married. However, Ghuman's (2005) survey study of 800 married respondents (50% women) from two urban and two rural communes in northern Vietnam reports high disapproval of premarital sex. Furthermore, only 12.3 percent of the men and 2 percent of the women in her sample report having had premarital sex. Among those who had premarital sex, 62.5 percent of the women in comparison to only 16.3 percent of the men eventually married the person with whom they had first sexual intercourse. Apparently, premarital sex is a precursor to marriage, much more so for women than for men.

In another study with 2,592 married respondents (50% women) from both northern and southern provinces, Ghuman, Vu, Vu, and Knodel (2005) find that the rates of premarital sex have been increasing for both men and women across three marriage cohorts: from 1963 to 1971, from 1997 to 1985,

and from 1992 to 2000. More specifically, the rates in the northern provinces for the three marriage cohorts are .5 percent, 4 percent, and 12 percent, respectively, for women and 7 percent, 13 percent, and 31 percent, respectively, for men. For the southern provinces, the rates are 3 percent, 5 percent, and 8 percent, respectively, for women; and 24 percent, 28 percent, and 31 percent, respectively, for men. These figures indicate that premarital sex is becoming more common, but it is still not widespread.

Bélanger and Khuat (1998) believe that premarital sex is a quiet revolution in Vietnam. From interviews with 20 single women who had abortions in Hanoi, Bélanger and Khuat found that a desire to express personal feelings of love and commitment motivated first sexual intercourse for these women. Most of them had sex with their boyfriends in hotel rooms that they took for a few hours while a few women relied on dark corners in public parks. All the women wanted to keep their sexual life hidden from families and even friends. They felt their reputation, status, and future would be seriously compromised if anyone knew of their premarital sex.

From interviews with more than 100 young adults (roughly 50% women) in Hanoi, P. A. Nguyen (2007) found that not only is premarital sex an emerging youth trend, but so is having multiple sexual partners simultaneously. Drummond (2006) argues that young Vietnamese women with disposable income have access to locations (e.g., cafés, discos, and hotels) wherein they can express their sexuality.

Abortions and STDs among Unmarried Women

When premarital sex results in a pregnancy, women usually choose abortion. One study estimates that single women have comprised of 20–30 percent of the total number of women seeking abortions in major Vietnamese cities (see Zhang & Locke, 2002). These single pregnant women choose abortion because (a) they are not ready to get married or they want to wait until they find a more suitable man to marry, (b) they wish to complete their education and work for a few years before marriage, and/or (c) they want to avoid bringing dishonor to themselves and their families (Bélanger & Khuat, 1999).

In a quantitative survey of 259 single women who had abortions in Hanoi, Bélanger and Khuat (1998) found that it took an average of six months for the women to have an abortion after their first sexual experience. Nearly half of these women have never discussed sexuality and reproduction with anyone and most of them have little knowledge about such topics.

H.K.H. Nguyen and colleagues (2010) argue that single women refrain from learning about reproductive health matters, including using contraceptives, because premarital sex is socially unacceptable. Bélanger and Khuat (1998) found that, from their interviews with 20 single women who had abortions in Hanoi, lack of contraception use is associated with

misconceptions. Some women believe that contraceptive methods are only for married women to adhere to the two-child limit, some associate the condom with only the prevention of HIV/AIDS, and some believe that using the pill could lead to infertility.

From the same interviews with the 20 single women who had abortions in Hanoi, Bélanger and Khuat (1999) report that some of these women avoid asking about risks and prevention of pregnancy and STDs because it may be a sign of knowing too much, which would threaten their image as being sexually inexperienced. In other words, their desire to pretend to be a virgin is stronger than their desire to become informed and to communicate with their sexual partners. H.K.H. Nguyen and colleagues (2010, p. S56) note that many single women continue to experience pressure to "present themselves as 'pristine'—devoid of sexual knowledge, experience and interest—both to the community and to their partners." This pressure may be felt more by young women who endorse traditional gender roles. In a quantitative study with a sample of 257 first- and second-year female students from universities in northern Vietnam, T. C. Bui and colleagues (2010) found that endorsement of traditional gender roles and norms is significantly associated with reduced self-efficacy to communicate with one's partner about safer sex matters, including condom use.

In contrast to the motivation to appear sexually inexperienced, some single women do not use contraception because they believe it signals unfaithfulness and lack of confidence in their partner (Bélanger & Khuat, 1998). Abortion, however, does not have this negativity attached to it. It can simply be seen as a practical postponement of marriage or it can be kept secret from one's partner.

Bélanger and Khuat (1999) suggest that the one reason abortion rate is high in Vietnam is that providing abortion services to unmarried women increases providers' income, but offering systematic counseling and encouraging the use of contraceptive methods does not. From interviews with 14 service providers of abortion in Ho Chi Minh City, H.K.H. Nguyen and colleagues (2010) found that a comprehensive and consistent approach to preabortion counseling is missing to prevent repeat abortions.

Given that premarital sex is becoming more common in Vietnam (Ghuman et al., 2005) and that 70 percent of the Vietnamese population is under 30 years of age (Nguyen, P. A., 2007), the lack of consistent use of contraception, particularly the condom, has negative public health consequences. For example, young adults aged from 20 to 29 account for 50.5 percent of HIV infections in Vietnam (Oosterhoff et al., 2008).

Extramarital Sex

Women's extramarital sex is not normative in Vietnam (Bélanger & Khuat, 1999). Nonetheless, O'Harrow (1995) argues that, in societies where

shame and the notion of virgin marriage operate, extramarital affairs outnumber premarital ones and a Vietnamese woman can cheat on her husband without regret as long as it is not known. If discovered, she would suffer public scorn and the loss of friends and sometimes families (Khuat, 1998). Santillán and colleagues (2002) found from their sample of 66 rural married women from northern Vietnam that a wife's infidelity is rarely forgiven because it supposedly destroys the happiness of her family.

Doi moi policies have unintentionally facilitated men's extramarital sex and have contributed to marital HIV risk for women (Phinney, 2008). Since the start of *doi moi* policies, men increasingly have moved into nonagricultural work (Go et al., 2002), which means working away from home, and thus having more opportunities for extramarital sex. Phinney (2008) suggests that women acquiesce to their husband's extramarital sex to maintain economic and social status because married women are dependent on the marital unit for survival.

Other Issues

Lesbianism

A "profound heteronormativity" (Rydstrøm, 2006, p. 291) pervades Vietnamese society. For example, none of the adolescents with whom Rydstrøm spoke in her fieldwork in a northern rural commune suggested that sexuality could be a relation between two women (or two men). Homosexuality is not outlawed in Vietnam but it is mocked (Kelly, 2004). Khuat (1998) claims that the people in Vietnam are less tolerant of homosexuality in women than in men. She points out that the attitude of people toward women who assume a male role in a lesbian relationship is much more negative than the attitude toward homosexual men assuming female roles. According to traditional expectations, women should be gentle, sweet, compliant, and knowledgeable about childbirth. Women who take on a masculine role challenge these expectations and are not welcome in Vietnamese society.

Unmarried Women Having Sexual Relations with Married Men

Some single and childless women decline marriage and choose, instead, to have sexual relations with married men. From interviews with 15 single women in Hanoi and two nearby villages, Bélanger (2004) found that these women see singlehood as a result of successfully avoiding undesirable unions. For example, some women from rural areas fear not being treated well by their future husband and his family and prefer to renounce marriage and stay with their parents.

Most women from Hanoi in Bélanger's (2004) sample have open, intimate, heterosexual relationships with married men. By doing so, they

make marriage with another man impossible because they have supposedly tarnished their morality and reputation. At the same time, their sexual liaison with married men quells rumors that they are lesbians. In other words, some of these women knowingly tarnish their reputation to repel the stigmatizing label of lesbian to themselves and to avoid social rejection of and by their family. As Bélanger points out, these women clearly contest the ideal of virginity and the dictate to confine sexuality to marriage.

Unmarried Women Asking for a Child from Married Men

Because of massive male casualty during the Vietnam War between the 1960s and the 1970s, increased emigration and migration of young men, and low life expectancy of men relative to women (Zhang & Locke (2002), some women remain single into their 40s. Many of these women sacrificed their youth to the Vietnam War (called the American War by the Vietnamese). After the war, these women found themselves to be unmarriageable. They also felt that their life was incomplete without a child and they feared facing old age alone, with no one to take care of them (Phinney, 2005). Because the 1968 Law on Marriage and the Family defines women's identity as first and foremost being a mother, these women interpreted this law as granting them the right to have a child out of wedlock (Phinney, 2005). Consequently, some of these women asked married men for a child (i.e., they entered a sexual relationship with a married man solely for the purpose of bearing a child).

Although the 1987 Law on Marriage and the Family recognizes that the children of these women are entitled to the same rights and obligations as those for children born in wedlock, the practice of asking for a child is not widely accepted, and these women and their children face discrimination (Khuat, 1998). Social exclusion has caused sexual and reproductive ill-being for these women. For example, 52 percent of single mothers suffer from reproductive tract infections or sexually transmitted infections (Zhang & Locke, 2002).

CONCLUSION

In this chapter, I have provided an overview of research on sexuality issues among Vietnamese women, first in marriage and then outside marriage. Cultural practices and global market economy have left married women with little say in their sexuality. They are expected to have been virgins until marriage, bear at least one son, accept their husband's extramarital sex, and suffer humiliation and judgment if they contract STDs. Unmarried women also have little say in their sexuality. For sex workers, condom use depends mostly on the customers' attitude. Single women engaging in premarital sex typically do not talk with their partners about

ways to prevent pregnancy or STDs out of fear of appearing sexually experienced. Finally, lesbians, single women who have sexual relations with married men to avoid rumors of being lesbians, and older unmarried women who ask for a child from married men are all stigmatized. Regardless of their marital status, one underlying theme in Vietnamese women's sexuality is the lack of communication with sexual partners about condoms and STDs and the lack of precautions against unwanted pregnancy and STDs. This predicament portends serious sexual health issues for Vietnamese women, given that premarital sex is becoming more common and men are using their disposable income on commercial sex.

NOTE

1. Vietnamese names appear in the order of family name, middle name, and finally first name. When Vietnamese authors list their names in this order in the byline, electronic databases tend to enter their first names as last names. Because I list Vietnamese authors' last names as last names, I advise readers who want to locate any cited research by Vietnamese authors to conduct searches by both the author's name and the title of the document. I provide both in the reference section.

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Chapter 10

Women's Sexualities, Sexual Rights, and Violence in Mexico

Adriana Ortiz-Ortega

Representations of Mexico worldwide oscillate between portraying a country dominated by *machismo* and subordinated women or as a magical land filled with color and where artists, such as Frida Kahlo and Diego Rivera, lived an intense amorous life while creating an impressive body of artistic work. A more realistic interpretation of Mexico is necessary to better situate women's sexual rights and exercise of their diverse sexualities in Mexico. During the last 40 years, Mexico has simultaneously experienced a transition to democracy as well as a recent intensification of violence and decreasing economic standards. In this context, it is feasible to state that women's sexualities are woven into a mosaic of contradictions, possibilities, and growing self-awareness.

Portions of this chapter are based on: Rosales-Mendoza, A. L., Flores-Soriano, A., Villaseñor-Farías, M., Pascacio-Giullén, B., & Allen-Leigh, B. (2009). Teaching sexualities and gender in Mexican universities. *International Journal of Sexual Health, 21*(4), 296–311.

SOME HISTORY

According to the Reform of Article 4th of the Mexican Constitution, men and women are equal in front of the law. This law permitted women to access contraception at a time in which population control was considered a priority. Since 1975, feminists actively agitated in favor of the inclusion of abortion among women's options, the elimination of violence against women, as well as the recognition of lesbian sexuality. Although more than 30 years had to elapse before these feminists' demands were legally recognized, during the 1970s, the Mexican government maintained a strong commitment to international relations and in 1975 acted as host for the First International Conference for Women organized by the United Nations; similarly, in 1979, the Mexican state participated in the United Nations International Assembly and signed the Convention for the Elimination of All Forms of Discrimination Against Women. In the decades that followed, the Mexican government participated in several international conferences on human rights, population, and development, as well as the Beijing conference and signed the Pan-American Convention to Prevent, Sanction and Eradicate Violence against Women (Inter-American Convention of Human Rights, 1994). Mexico only drafted a reform to its 1st constitutional article in March 2011, which banned discrimination due to sexual preference, and the Penal Code of the Federal District, the capital of Mexico, which penalizes hate crimes due to sexual orientation or gender identity. Also, in 2010, May 17 has been established as the Day to Celebrate Respect for Sexual Preferences and Tolerance. Regarding violence against women, in 2007, a Federal Law to Eradicate Violence Against Women was introduced. Regarding birth control, in the last five years abortion, as per women's request—up to 12 weeks of pregnancy—is legal in the Federal District, the capital of Mexico (Gómez González, 2011; Luxardo, Colombo, & Iglesias, 2011); similarly, in Mexico City, same-sex marriage and adoption is permitted. Nonetheless, legal transformation remains the outstanding terrain where political battles take place; 18 out of 31 states have defended the rights of the fetus and have made it constitutionally impossible for women to access abortion under any circumstance. For example, in Guanajuato, more than a dozen women—some of whom had spontaneous abortions (miscarriages)—are under trial and if they are sentenced, they would be spending up to 30 years in prison (García, 2010). Other legal reforms that favor women's social standing include the recognition of sexual preference in the First Constitutional Article (2010); the approval of a Federal Law to Fight All Forms of Discrimination (approved in 2003); and the General Law to Promote Equality Among Men and Women (approved in 2008; Díaz Perez, 2009).

The legal transformations listed above provoke the following reflections: first, legal change has been the key form of social transformation

endorsed by activists, and it is interesting to see that, although under strain, several positive changes have occurred. Second, to understand the possibilities and limitations of legal change in Mexico, it is necessary to state that legal debate is shaped to a large extent by conservative and liberal forces. These forces struggle in economic, social, and cultural terms to define the terms of public debate, images, and resources surrounding sexual rights in the country. Third and most important for the purpose of this article, as conservative and liberal forces struggle to define debates, a time lag exists between legal transformations and changes in psychosocial attitudes. In this context, discrimination and violence against girls, women in general, or lesbians, transsexuals or transgendered women remain, although this discrimination is being questioned and banned by new legal dispositions.

In effect, the full respect and exercise for sexual rights represents the extent to which Mexico upholds democratic values, as well as the extent to which the respect for the law prevails in this country. As proponents of reproductive justice state, women's reproductive health is connected to and affected by conditions in their lives that are shaped by their socioeconomic status, human rights violations, race, sexuality, and nationality. Therefore, defenders of sexual and reproductive health and rights argue that women cannot have full control over their sexual and reproductive lives unless various issues, such as socioeconomic disadvantage, racial discrimination, inequalities in wealth and power, and differential access to resources and services are addressed.

Multiple links between sexual rights and the respect for human rights show that in Mexico an incomplete respect for sexual rights exists. This means that although significant legal progress has taken place, a full recognition and exercise of such rights is not present. To better situate this comment, we should remember that sexual rights are at the intersection of various factors, such as race, skin color, sex, language, religion, nationality, social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, and civil, political, social, or other status.

SECULAR STATE AND SEXUAL RIGHTS IN MEXICO

The secular tradition that the Mexican state has upheld since independence from Spain in 1871 has faced several challenges from conservative movements, which throughout history have sought to regain the ruling of Catholic values and the leading role of the Catholic Church in public life. As the sexual diversity or sexual liberation movements gain salience, these movements also agitate. In this context, a growing control of media debates and a constant questioning of Mexican state faculties to make legal changes are underway; and members of conservative Catholic organizations, such

as Opus Dei, Caballeros de Colón (Gentlemen of Colon), have strong influence in public office and electoral matters.

In this context, fear of unemployment, physical violence, and lack of civil rights is on the rise. Paradoxically, this occurs at a time in which citizens organize and rally even more in favor of rights. Thus, regional variations are significant, as well as diversity in views due to education, urban–rural place of location, and religious (or lack of) beliefs. In Mexico, we quote a university professor whose views reflect ongoing contradictions. Specifically, when asked where do you see teaching and research on gender and sexualities studies going at the undergraduate and graduate level, the answer was:

> If you had asked me that same question a couple of months ago, it might have been a very optimistic answer; today it's not so much. I am truly worried; the national political climate and the U.S. political climate (that has such a great influence on Latin American countries) have been very negative in terms of the work associated with these subject matters in recent years. In Mexico, this will become more pronounced, these topics will be increasingly stigmatized in academia and therefore cause far more discomfort among academic authorities. We will be causing trouble for the institution by working on these subjects, so I think it will be complicated, I do think it will be complicated. (Anonymous professor) (Rosales, Flores-Soriano, Villaseñor, Pascacio-Guillen, & Allen-Leigh, 2009)

In short, in Mexico, we find a very complex psychosocial scenario: on the one hand, thanks to political activism undertaken by feminists and gay, lesbian, bisexual, transgendered, transsexual, and intersexual groups during the last 40 years, a growing recognition of sexual diversity exists in major urban centers. Similarly, a growing awareness of sexual violence has resulted in government programs to address domestic violence and sexual assault. What I wish to emphasize is that legal transformation, as incomplete as it might be for the full attainment and exercise of sexual rights, represents significant gains. It is interesting to notice how women organizing in favor of legal transformation regarding violence against girls, women, homoparental rights, or same-sex marriages has been effective in producing a public debate. Second, these laws significantly contribute to engendering democracy as women become social actors whose voices are heard. Nonetheless, it is necessary to state that a constant movement for psychosocial transformation is necessary. In Mexico, the limited impact of the law is the result of the combined effect of (1) the absence of a full respect for the law; (2) an absence of a culture of denouncing and follow-up of demands prevails; and (3) public servants, lawyers, and prosecutors, numerous times, share biased views that impede them from

applying the laws to protect women. In this context, it is not surprising that sanctions are not yet in place to curtail offenses carried out by perpetrators of violence against women or that less than two percent of crimes in general are solved in Mexico. The paradigmatic case of lack of justice for women and girls can be exemplified in the unresolved feminicides of women and girls, particularly in the state of Chihuahua and in the city of Juaréz in that state.

VIOLENCE AGAINST WOMEN AND GIRLS IN MEXICO

Official statistics regarding violence against women carried out in the 32 states of the Mexican Union show that 43.2 percent of women who are 15 years or older have suffered some form of violence coming from the hand of their partners. Specifically:

- 37.5 percent experienced emotional violence
- 23.4 percent underwent economic violence
- 19.2 percent encountered physical violence

In the context of widespread violence, it is easy to infer that sexual violence remains low (9%), possibly because women do not find the conditions to speak out on behalf of the abuse they experience. Outside of partner relations, 67 percent of women 15 years of age or older retold their experience with other forms of violence:

- 39.7 percent experienced violence in their communities where they lived
- 15.9 percent family violence
- 5.8 percent violation of their property rights
- 15.6 percent violence in schools
- 29.9 percent violence at work (ENDIREH, 2006)

Other forms of violence for women who hold sexuality outside of heterosexual norms is harder to measure as it does not figure yet in official statistics. Indirect measures can be found in the National Survey on Discrimination, according to its 2010 version:

- Four out of 10 people consider that the existence of sexual preferences in Mexican society provoke divisions among people in society.
- Mexico is experiencing a generational divide regarding sexual preferences, as 8 out of 10 people who are 50 years of age or older strongly

disagree or disagree with the idea that homosexuals should be given the right to adopt children.

- Seven out of 10 people who are between the ages of 30 and 49 hold that same idea and 6 out of 10 people between the ages of 12 and 29 also share that belief (ENADIS 2010).

Yet, Mexican people were more open to the idea of lesbians adopting children than they were to the idea of male couples doing the same. Although people strongly resist the idea of homoparenting, there is less resistance to interacting with homosexuals—3 out of 10 people between the ages of 25 and 34 would not be willing to live with them and 4 out of 10 people between the ages of 40 and 44 shared this view. Worse, in the 2001 Survey on Citizenship Practices, carried out by the Minister of the Interior, 66 percent of people interviewed stated that they agreed if the government wished to apply an HIV/AIDS test to all homosexuals (Secretaría de Gobernación and Instituto Federal Electoral, 2001).

Other official studies prove that at least one-third of lesbians or homosexuals interviewed have suffered insults and were the object of humiliation and sarcasm during their childhood and adolescence. It is interesting to note that homophobia is not solely directed against homosexuals but to the population in general, as insults are commonly used by adolescents: 1 out of 10 adolescents has experienced them. According to the already quoted 2010 National Survey on Discrimination, lesbians most commonly considered the main problem they faced was lack of acceptance and homosexual men said it was discrimination.

Studies carried out between 1995 and 2008 on hate crimes committed against people who have a sexual preference, such as homosexual, transsexual, or transgender, prove that 628 crimes for homophobia were committed, although most of these crimes were against male homosexuals (Brito & Bastida, 2009). It is indeed true that such level of violence limits women's willingness either to experience other forms of sexuality or to engage publicly in the defense of their rights. Not surprisingly, women experience greater forms of violence precisely at the time when they are gaining greater rights due to legal change. Worse, in the context of extensive drug dealing, traditional gender relations prevail and the costs of crimes fall primarily on the shoulders of women as they are the mothers, daughters, and sisters of murdered or missing men and women. In many cities, it is these women who have to undertake the impossible task of finding the missing and addressing the justice system outpaced by violence and overrun by corruption.

In Mexico, six prominent women human rights defenders have been murdered in the past two years. To give an idea of the difficulties women face, we find that the UN Special Rapporteur on the situation of human rights defenders recognized that threats, and especially explicit

death threats, against women human rights defenders are one of the main forms of violence in the region, with more than half coming from Latin America, most of those (27) from Mexico (Carlsen, 2011). If we seek to directly connect the issue of violence with women's sexualities, it is evident that the most extreme form of violence women experience is feminicide. Gender-based violence, including feminicide, has skyrocketed in the context of the overall violence. The number of feminicides in the state of Chihuahua since sending in the army has risen to 837, from 2008 to June 2011—nearly double the total feminicides from 1993 to 2007. When we take a step further exploring the connections between gender violence, violence in general, and sexual abuse in the lives of children, we find that laws to protect children from sexual abuse are weak. Mexico occupies the second place in the production of children's pornography and it is accompanied by different forms of child abuse. Although a system for recording practices or statistics of these matters are not fully documented, medical, social, and legal evidence records that children have been brought to testify about these abuses. This includes cases of children raped or abused by Catholic priests. In some states, such as Chiapas where women's legal suits against all types of violence exist and where women have presented testimonies of different forms of abuse, no official report on the subject exists. According to estimates, when one married woman is being abused, two children, on average, also are being abused.

The disturbing findings on child sexual abuse, violence against women, or discrimination in general continue to provoke important reactions geared toward producing legal changes at the federal or state level. Yet, the question remains as to how these can be accompanied by additional educational measures directed to reverse these trends.

EDUCATION AS MEANS TO PROMOTE RESPECT FOR WOMEN'S SEXUALITIES AND RIGHTS IN MEXICO

Studying women's sexualities in Mexico requires asking the questions: what are the possibilities or obstacles to positioning gender and sexualities as relevant fields of study within the academic production of universities, institutes, centers, and teaching and research programs in Mexico? Why does the study of such subjects still raise suspicions in academic spaces? It is necessary to highlight the importance of public universities in shaping the understanding of sexualities and gender to better understand what can be done to preserve these spaces. In Mexico, universities remain scarce sites where these issues can be articulated through profound reflection (Ortiz-Ortega & Pecheny, 2010).

During the last few decades of the 20th century, due to the growing independence of the academic sector from the political arena, Mexican

academic circles were able to make great strides in the rigorous study of social theories regarding gender relations and sexuality. Intellectual renovation in Mexican academic settings also became the space in which new generations of students could approach an otherwise intangible terrain.

Yet, it is important to ask ourselves questions about what is taught, how strong is the institutionalization of these programs, how widespread is the teaching? Since 1930, Mexico began to strengthen its public university system, but during the last 10 years, privatization as well as lack of public funding has limited the capacity of public universities. It is for these reasons that the institutionalization of sexualities as a field of study has mostly consisted of the well-intentioned actions of academic scholars strongly committed to such research and teaching. Therefore, institutionalization remains fragile.

Mexico is a pioneer in the Latin American region in terms of introducing the study of sexualities in the academic curricula which encompasses a broader notion of sexualities (Rosales et al., 2009). By sexualities studies, we refer to the exploration of the social, economic, cultural, and historical dimensions of the practices and discourses around sex. To be sure, sexualities studies have as a departure point the recognition that sexuality or sexualities are not only constructed through social relations, but are also in themselves an arena as well as a social relation shaping the rest of the social fabric. In terms of content, in Mexico, particularly in research, sexuality studies have privileged a pragmatic or applied approach that focuses mainly on the study of heterosexual sexuality, sexual violence, and high-risk practices within certain populations, with forays into the use of condoms, undesired pregnancies, and abortion. Meanwhile, more diverse ideas and practices, especially sexual pleasure, have remained relatively unexplored from an academic standpoint. Regarding teaching, topics relating to sexualities have had significantly less coverage, since only a few undergraduate and graduate programs at the national level include courses where sexuality is the main focus (such as the history of sexuality, sexual anthropology, gender and sexuality, body and sexuality, or sexual health). In addition, sexualities are approached in a rather limited way in one or two classes and some optional courses in over half of all 43 curricula researched by a nationwide study carried out in 2009 (Rosales, et al., 2009).

The incorporation of topics related to sexuality into a variety of majors and programs has seen little progress and faced many difficulties. New spaces are needed, especially given the emergence of conservative trends that fight for the defense of so-called family values, heavily linked to principles taken from certain religious tendencies that oppose the exercise of sexual and reproductive rights of women (especially abortion, but also contraception and others). Interestingly, gender studies have secured some spaces within Mexican academic circles and the institutional debate has assisted public policymaking. Currently, at least one university

in each state in Mexico offers courses and conducts research from a gender perspective or with gender as the main object of study. The same cannot be said regarding sexualities as a topic. Sexual and reproductive health areas have been developed, particularly after the Cairo (1994), Beijing (1995), and Beijing +5 and Beijing +10 Conferences (United Nations, 1994, 1995, 2000, 2005), achievements that have had consequences for public and private programs that meet the educational needs of various Mexican populations. Teaching related to sexualities carried out by civil society organizations in Mexico continues to focus on teen pregnancies, STDs, and HIV/AIDS, often from a risk management approach. More progress is still needed in order for the study of sexualities to find its place in the realm of human relations and contribute to make it possible for people to exercise their sexual citizenship in a way that generates pleasurable sexual experiences and personal well-being. Efforts to diversify the curricula to encompass an understanding of sexual values, practices, and discourses, as well as to create a postgraduate curriculum are underway at the Universidad Pedagógica Nacional (National Pedagogical University). This effort is important because this university serves teachers and professors who teach in elementary, high school, and university levels from all over the country. If approved, this program will expand nationwide, with particular emphasis in providing training to teachers located in the North, center, and South of the country.

CONCLUSIONS

We highlighted the advances as well as the perils surrounding sexuality faced by women in Mexico, paying particular attention to the progress in terms of legal change which facilitates women's access to sexual and reproductive rights. At present, it is necessary to frame women's sexuality by taking into account that many of Mexico's most significant human rights issues in 2010 stemmed from violent confrontations between state security forces and organized crime, as well as clashes among criminal groups. The Mexican military continues to commit serious abuses in public security operations, yet those responsible are virtually never held accountable. Journalists, human rights defenders, and migrants are increasingly the targets of attacks by criminal groups and members of security forces. Nonetheless, women's sexuality cannot be solely connected to violence, but to education, legal transformation, constant urbanization, and an ever expansion of women's consciousness that allows women to gain new entitlements in the sexual arena. In the last 20 years, Mexico has become a country where the Catholic Church no longer holds a monopoly on public and private morals. Therefore, the growth of religious diversity makes it possible for women to reinterpret their experience as new forms of sexual expression exist in the country (Gómez González, 2010).

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Chapter 11

Sexual Rights: A Feminist Account from Muslim Societies

Pinar Ilkkaracan

GLOBAL WARS ON SEXUALITY AND SEXUAL RIGHTS

At the Beijing +15 meeting of the United Nations (UN) held in March 2010 in New York, the most contested issues once again were sexual and reproductive health and rights, including abortion, sexual and reproductive health services, and sexuality education. A resolution put forward by the United States on "Eliminating Maternal Mortality and Morbidity through the Empowerment of Women" triggered the most controversial debate. Many governments, supported by the United States, opposed the inclusion of sexual and reproductive health services and rights; comprehensive sexuality education for adolescents—the group most vulnerable to maternal mortality; and the prevention of unsafe abortion as necessary measures to eliminate maternal mortality. The paradox of a resolution, aiming to eliminate maternal mortality and empower women that does not ensure sexual and reproductive health services and rights, provide comprehensive sexuality education or prevent unsafe abortion and the refusal of the demands of women's groups on all issues related to sexuality,

constitutes a recent and perplexing example of the debates on sexuality and sexual rights at the UN.

Indeed, how sexuality has become a contested political domain at the global level is perhaps most evident in the worldwide wars on sexuality witnessed at various UN conferences and meetings. Issues on sexual and reproductive health rights have been intensely disputed at the global scale since the 1994 UN International Conference on Population and Development (ICPD) held in Cairo (Friedman, 2003; Morgan, 1996). The notion of sexual rights, put forth by advocates from the international women's health movement during preparations for the 1994 UN ICPD meeting, was ultimately not incorporated into the final consensus document of the ICPD Program of Action, as reaching a consensus on the term "reproductive rights" proved challenging enough; however, the document did include several allusions to sexual rights (Klugman, 2000). A year later, "sexual rights" became a topic of major debate at the Fourth World Conference on Women held in Beijing in 1995, where an alliance of conservative Muslim and Catholic delegations strongly objected to its use. Issues of sexuality—especially sexual orientation, women's control of their bodies, and safe abortion—triggered the most controversial debates at the Beijing Conference, where a global alliance of women from all religious and cultural backgrounds, despite fierce opposition from conservative forces to the inclusion of "sexual rights," succeeded in incorporating paragraph 96 into the Beijing Platform for Action:

> The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences. (United Nations, 1996, A/CONF.177/20/Rev.1, Par. 96)

The Vatican and conservative Muslim and Catholic states, backed by some African and Latin American countries, have continued to oppose the inclusion of diverse sexual rights in UN documents since the Beijing Conference. Several subsequent UN events—the Beijing+5, Beijing+10, and Beijing+15 reviews held by the UN Commission on the Status of Women in 2000, 2005, and 2010, respectively; the UN General Assembly Special Sessions on HIV/AIDS in 2001 and 2006 and the 59th and 60th Sessions of the UN Human Rights Commission in 2003 and 2004—witnessed ferocious battles over issues related to sexuality and reproduction.

The most contentious issues and terms include language on sexuality, sexual rights, women's autonomy over their bodies and sexuality,

reproductive rights, comprehensive sexuality education/sex education, the right to safe abortion, youth sexuality, and sexual orientation or even girls' empowerment (as the term "girls' empowerment" could eventually include the right to sexuality education or free choice, as perceived by some conservative governments).

The Organization of the Islamic Conference (OIC) has emerged as a powerful alliance blocking progress on issues related to sexuality, particularly since 9/11, both at the UN Commission on Human Rights in Geneva and global UN conferences. In 2003 and 2004, Brazil introduced a resolution at the 59th and 60th Sessions of the UN Commission on Human Rights in Geneva that urged states to protect and promote the human rights of all persons regardless of sexual orientation. This was blocked by Pakistan, Saudi Arabia, Malaysia, Libya, Egypt, and Bahrain, with the support of various other countries under pressure from the Vatican.[1] Speaking on behalf of the OIC states, the Pakistani ambassador stated that adoption of this resolution would "cause serious offense to the religious values of 1.2 billion Muslims as well as to the followers of other religions and faiths around the world" (Girard, 2007, p. 346). A year later, in 2004, the resolution was postponed yet again, in the face of pressure from the OIC and the Vatican. Middle Eastern states, in particular, Iran, Egypt, Pakistan, Libya, Iraq, and Sudan, have taken the lead in opposing any rights related to sexual orientation (Ilkkaracan, 2008).

SEXUAL RIGHTS AS A SITE OF INTENSE POLITICAL STRUGGLES IN MUSLIM SOCIETIES

On International Women's Day in 2010, Turkey's State Minister for Women's Affairs, Selma Aliye Kavaf, in an interview she gave to the daily news *Hurriyet*, triggered ample public debate and garnered extensive criticism after declaring she believed homosexuality to be a biological disorder that requires treatment (Bildirici, 2010). Kavaf was protested against widely by the country's lesbian, gay, bisexual and transgender (LGBT) movement and women's groups, through press statements and demonstrations that demanded her resignation and trial for insult, and incitement to enmity and hate crimes against LGBT people (Jones, 2010). The LGBT association KAOS GL in Ankara filed a criminal complaint against the minister at the Office of the Ankara Public Prosecutor for inciting the public to hatred and hostility against homosexuals, according to articles no. 216 and 218 of the Turkish Criminal Code.

Turkey is certainly not the only Muslim country that has become a site of intense political struggle around sexual rights. In October 2008, the House of Representatives in Indonesia passed the widely contested antipornography bill, defying years of protest from women's groups, human rights activists, ethnic and minority groups, and LGBT groups, as well as

artists. The bill criminalizes all works and acts deemed obscene and capable of breaching public morality; opponents claim it was used as a political strategy to boost support among the predominantly Muslim voter base for the parties backing the bill. Chairwoman of the National Commission for Women's Protection, Kamala Chandrakirana, gave voice to the opposition, stating, "This [bill] only shows that the House and the government have politicized morality and religion and are just using them as a means of retaining power" (Khalik, 2008).

In October 2008, Malaysia became the site of political debates regarding a fatwa against "tomboys" that was issued by the National Fatwa Council, the main body of Islamic clerics in the country. The edict forbade girls to sport short hair or dress, or walk and act like boys. Over the last decade, the Malaysian government has allowed state religious authorities to engage in the moral policing of Muslim communities throughout the country (Liow & Asi, 2008). As a net effect of these trends, and the government's evident refusal to stem them, a creeping conservatism has settled into the Malaysian sociopolitical sphere, which became a matter of grave concern for both the women's movement and non-Muslims in Malaysia (Lee, 2008). In this context, the fatwa signified a continuation and extension of moral policing politics in Malaysia, despite promises by the Malaysian government to combat so-called moral policing after human rights, labor, and women's groups made several complaints about privacy violations in 2005 (Kent, 2005). As the edict made headlines around the world, it was also protested by many groups, including a leading Malaysian women's human rights organization, Sisters in Islam (SIS): "SIS believes it is not Islam's obsession to police people's morality, find people's faults or to spy on its followers. Islam is also totally against defaming one's character. In fact Islam regards privacy and preserving one's dignity as one of human's intrinsic basic right. Thus any man-made law cannot violate these basic rights enshrined in Islam."[2]

The events in Indonesia, Turkey, and Malaysia portrayed above, and the political and public debates they triggered, epitomize the intense political and social struggles on sexuality and gender in Muslim societies. However, political contestations of sexuality and gender are by no means unique to Muslim societies. Sexuality has become a fiercely debated issue in many countries in both the North and the South in the past two decades. In the 2000s, for instance, the Bush administration's policies on a variety of concerns—from HIV prevention and sexuality education to gay marriage and sex work—became hot political and electoral issues within the United States, and a focused campaign that influenced American policy on trade, foreign assistance, and international relations (Girard, 2004). The Bush administration instrumentalized U.S. bilateral aid policies as an effective tool to push and shape the terms of sexual politics for the world. By various means, including intimidation, censorship on research,

pressure on Christian organizations working overseas, and selective funding limited to research and NGOs which supported its ideology, the Bush government attempted to hinder condom use and pushed for so-called abstinence-only programs for HIV/AIDS prevention around the world, despite the many experts who unrelentingly criticized this approach as endangering the lives of millions of people across the world (CHANGE, 2004; Gill, 2004; Susman, 2004; Walgate, 2004). The so-called ABC approach to AIDS prevention, adopted by the Bush government under the influence of the Christian right, called for A—abstinence, B—being faithful, and C—condoms; but condoms were to be promoted only to high risk groups, such as sex workers and drug abusers, while sexual abstinence was to be the objective for all unmarried young people. In May 2005, Brazil turned down US$40 million in U.S. assistance on HIV/AIDS in defiance of American dictates on its HIV/AIDS policies. Brazil's national AIDS commissioner explained Brazil's position on the issue, saying, "For us it was an ethical issue. We have to reach every segment of society, with no discrimination. Besides, no country is supposed to decide what another country must do" (Kaplan, 2005).

THE FALSE DICHOTOMY OF AN "ISLAMIC" VERSUS A "CHRISTIAN"/"WESTERN" SEXUALITY

Control of women's sexuality, which remains patriarchy's most powerful tool in most societies, is achieved via intricate mechanisms of political, economic, social, and cultural manipulation, including coercion and violence. Within this context, religion—especially monotheistic religions of Islam, Christianity, or Judaism—are often misused as a powerful instrument of control with the goal of legitimizing violations of women's human rights. The mechanisms used to maintain this control vary according to location, time, class, and race, and depend on the economic and political realities of a particular community.

Like many other religions, Islam does not have a static or monolithic tradition. Islam has interacted with sociopolitical and economic conditions at particular times and in specific geographic locations to ensure its survival and power. As such, it has not only absorbed the practices and traditions of the two other monotheistic religions in the area it was born—Judaism and Christianity—but also the pre-Islamic practices and traditions of the geographic location in which it strove to survive and gain power as a cultural and political system. Thus, it is very difficult to define what is intrinsic to Islam in shaping sexual behavior. The issue becomes even more complicated when we attempt to explore the differences between various schools of Islamic thought, which can exist in parallel even within the same community. Various discourses on sexuality and Islam often fail to consider the differences in practice among Muslim communities. They

also tend to overlook the areas of negotiability created by social taboos and silences related to sexual behavior. Nonetheless, even discourses based on an analysis of the Koran, and the literature traditionally accepted to establish the normative practices of Islam, can lead to contradictory conclusions about the construction of women's sexuality. On the one hand, Islam recognizes that *both women and men* have sex drives and the right to sexual fulfillment. Eroticism is presented as both a taste of heaven and a divinely ordained necessity on earth for reproduction. Women, like men, are believed to experience orgasms. The Islamic view of the world removes any guilt from the sexes, but it does so in order to make them available to each other. Satisfaction and legitimate pleasure may take place only within the framework of Islamic marriage, *nikah.*

On the other hand, particularly in terms of sex drive, male and female are seen as opposites: men as rational and capable of self-control; women as emotional and lacking self-control. As in many other cultures, the social construction of gender differences in Islam derives from a hypothesis of women's and men's allegedly "fundamental" biological, psychological, and social-sexual differences. Thus, Muslim societies show a great degree of diversity in constructions of sexualities over time, geography, and cultures, even within a specific country or community (Ilkkaracan, 2000).

Diverse misogynist practices, existing in various Muslim societies, such as female genital mutilation (FGM), honor killings, or forced marriages, which have increasingly become topics of media and public attention in European countries, are incorrectly portrayed as Islamic practices in the Western media. In fact, each of these practices is prevalent in only some Muslim communities, and nonexistent—or even unheard of—in many others. Their origins mostly lie in the local, economic, cultural, and social conditions of a particular region or community that usually predate the arrival of Islam. FGM, for instance, has mistakenly been linked to Islam, although there is no Islamic citation that makes it a religious requirement (Toubia, 2000). FGM is prevalent in certain African countries, such as Burkina Faso, Central African Republic, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ivory Coast, Senegal, Sierra Leone, Sudan, Tanzania, Togo, and Uganda.

In many other Muslim countries, FGM is not only nonexistent, but also was unheard of until Egyptian feminist activists carried the issue onto the global agenda during the International UN ICPD held in Cairo in 1994. On the other hand, honor crimes, a practice prevalent in some Middle Eastern countries, including Turkey, Jordan, and Palestine, as well as Pakistan, is unheard of in Muslim communities or countries in sub-Saharan Africa or Southeast Asia.

Portraying such diverse local practices, such as FGM, honor killings, or forced marriages, as Islamic practices based on Islam as a religion, not only contributes to an erroneous perception of Islam and the rising Islamophobia

in Western countries since 9/11, but also to the power of the religious right movements in Muslim societies. These movements are engaged in a socio-political struggle to construct a Muslim versus Western culture to increase their political power and to gain supporters for their cause. In this struggle, they especially make use of issues related to sexuality; for instance, they depict homosexuality, sexual liberation, and women's sexual autonomy or the concept of sexual rights as human rights as Western concepts or elements of Western culture vis-à-vis an assumed/constructed Muslim culture, thereby claiming that these practices or concepts threaten the social and moral order of their construction of the so-called Islamic world.

THE WIDE DIVERSITY IN MUSLIM SOCIETIES

To speak of a unified Islamic world on any political or social matter—including issues related to sexuality or gender equality—is almost impossible. Muslim societies show a great degree of diversity in geography, culture, time, and local interpretations of Islam. The wide range of formulations of legal codes pertaining to gender and sexuality throughout the Muslim world is one of the best examples of this diversity. Legal reforms that have redefined gender relations over the past century vary greatly between countries. Several Muslim countries adapted secular legal systems; for instance, Turkey, which has a 99 percent Muslim population, adopted Western legal codes (the Swiss Civil Code and the Italian Penal Code) in 1926, aiming to achieve full secularization. Other Muslim countries that have a secular legal system include Indonesia, Azerbaijan, Kazakhstan, Kyrgyzstan, Bosnia, Albania, Senegal, Gambia, and Chad.

The majority of other Muslim countries have a combination of legal codes, having abandoned Islamic jurisprudence (*shariah*) in all areas, except for their own interpretation of Islamic jurisprudence for the personal status law. These include mainly the laws on family (i.e., the private sphere and the status of women), though with certain reforms. Countries that adhere to *shairah* laws in all areas (the Gulf countries and postrevolutionary Iran) constitute a minority in the Muslim world.

The issue of diversity becomes even more complex when one looks at wide differences in the interpretations and codifications of Islam among various schools of Islamic jurisprudence, *Sunni* or *Shi'a,* or even within these schools themselves. For instance, *Sunni* Islam is divided into four schools of law in jurisprudence, the *Hanafi, Maliki, Hanbali,* and *Sha'afi.* The wide range of Islamic interpretations on abortion exemplifies the diversity among various schools of law: While some schools give unconditional permission to terminate a pregnancy without justification before 120 days into the pregnancy (*Zaydi,* and some *Hanafi* and *Sha'afi* schools), the *Maliki* school argues for a categorical prohibition of abortion altogether (Shaikh, 2003).

THE NEGATIVE IMPACT OF COLONIZATION

In many Muslim countries where homosexuality is criminalized, the penal code is not based on Islamic law, but on colonial laws. The British Empire and France criminalized consensual homosexual conduct in many Muslim societies in the 18th and 19th centuries (e.g., in Bangladesh, Malaysia, Nigeria, Pakistan, Sudan, and Sierra Leone, among others). Even after France decriminalized homosexual acts in France in 1791, it continued to impose its criminalization of homosexuality in its colonies. This was due to the belief in the 19th century that, as depicted by many Western (colonial) writers, Muslim societies were decadent and backward, and homosexuality was permitted and widespread. They claimed that homosexuality was an Oriental or Muslim vice (Sanders, 2005). Interestingly, a century later, we observe the opposite: political leaders in certain Muslim countries, for instance Iran or Malaysia, depict homosexuality as an imported Western construct. Muslim countries are not alone in this recent and rising trend. Many African leaders have joined this chorus in recent years, although there is extensive evidence of sexual relations between people of the same sex and of transgender cultures throughout Africa, even if how these practices and cultures are labeled and understood varies from place to place and may differ from Western LGBT identities and cultures (Tamale, 2003).

Alternatively, anticolonialist movements, in their struggle against colonial domination, have also often led to further restriction of women's human rights and sexual autonomy in the name of creating a Muslim identity; thus, further limiting women's space and capacity to struggle for sexual autonomy. Nationalist movements and ideologies that accompanied the foundation of nation-states posed contradictory roles for women. As they disrupted traditional gender roles and relations, they allowed women—especially those from the middle and upper classes—to participate more fully in social and political life. Yet, they also redefined women's roles as mothers and bearers of the nation and its newly constructed legacy, leading to the emergence of new strategies to control women, and especially their sexuality, which was meant to serve the reproduction and maintenance of the newly constructed "national identity" and "uniqueness" of the community. A good example of this is the imposition of Islamic dress codes, for instance, headscarves (*hijab*) on women, even in countries where it has been untraditional for many centuries, such as Bangladesh or Pakistan.

THE CONTEMPORARY ESCALATION OF POLITICAL STRUGGLES ON SEXUAL RIGHTS IN MUSLIM SOCIETIES

In the past decades, issues related to sexuality and women's bodies have increasingly become sites of political contestation in Muslim societies due

to certain socioeconomic and political developments, and with contradictory impacts. The rise of the Islamic religious right and increasing public support for religious right ideologies—which recently gained new dimensions due to increased Islamophobia, militarization, and new wars in the region in the aftermath of 9/11, as well as the U.S. occupation of Iraq and the Israeli attack on Lebanon in 2006—has tightened the existing space for liberal reforms, including those concerning sexuality. Increased U.S. military presence in the Middle East has led to anti-American/anti-Western sentiments in all Middle Eastern countries, including Turkey, while also generating support for religious right movements.

The post-9/11 context has increased the dilemmas faced by activists in Muslim societies who advocate for sexual rights, such as the eradication of customary practices, women's autonomy over their sexuality and bodies, or recognition of different sexual identities. Although globalization has created an environment where international networking for sexual rights has gained importance, many activists feel that international engagement in the promotion of these rights ironically serves to exacerbate existing stereotypes, both about the women living in the region as suppressed, passive, or unable to defend their rights and about the Muslim world as a whole as backward, static, and culturally irreconcilable with Western values.

On the other hand, the increasing impact of feminist movements, the rising visibility of various social movements demanding democratization, and the technological revolution that has enabled the networking of LGBTQ communities, even in countries where homosexuality is criminalized, has led to various political demands for sexual autonomy and rights.

In Turkey, for instance, a three-year campaign led by women's and LGBT organizations, the "Campaign for the Reform of the Turkish Penal Code from a Gender Perspective" with its many demands for full sexual autonomy and rights, triggered numerous and widespread public debates, made frequent front-page headlines in the media, and occupied Turkey's public agenda for three years, breaking several taboos on issues related to sexuality in Turkey.

The campaign, initiated and coordinated by Women for Women's Human Rights (WWHR)-NEW WAYS, was successful in achieving more than 35 amendments in the penal code toward recognition of women's legal entitlement to sexual and bodily autonomy and rights, despite strong opposition from the right-wing, Islamist AKP (Justice and Development Party) government. The campaign aimed to transform (a) the underlying philosophy and principles of the old penal code that constructed women's bodies and sexuality as belonging to their families, fathers, husbands, and society; (b) eliminate all articles in the old penal code that constituted violations of women's human rights, particularly sexual and bodily rights; and (c) to ensure that progressive and current definitions of sexual crimes

were included in the law. Throughout the campaign, advocates emphasized the *holistic* nature of their demands, stating that their aim was not the revision of a number of articles, but rather a complete reform of the penal code, an overhauling of its patriarchal framework so as to legally recognize women's autonomy over their bodies and their sexuality within Turkish law.

The three-year campaign succeeded in securing not only a revolutionary change in the underlying philosophy of the Turkish Penal Code toward women's autonomy over their sexuality and bodies, but also changed about 40 amendments to the penal code. These changes, which were strongly opposed by the government at the beginning of the campaign, constituted a groundbreaking shift in the overall perspective of the Turkish state and the public toward women's legal entitlement to sexual and bodily autonomy and rights (Ilkkaracan, 2010).

A UNIQUE EXAMPLE OF INTERNATIONAL SOLIDARITY FOR SEXUAL RIGHTS IN MUSLIM SOCIETIES: THE COALITIONFOR SEXUAL AND BODILY RIGHTS IN MUSLIM SOCIETIES

The Coalition for Sexual and Bodily Rights in Muslim Societies (CSBR) is one of the transnational networks for the promotion of sexual, bodily, and reproductive rights at national and international levels. The coalition is unique not only because it is the only transnational advocacy network working on sexual and reproductive rights across Muslim societies, but also because it set an example by bringing together academic institutes and nongovernmental organizations working on diverse issues and with diverse populations that are affected by the violations of their sexual and reproductive rights, such as women's groups, human rights NGOs, LGBTQ groups, and HIV/AIDS organizations. The coalition has initiated a new, holistic, multidisciplinary and multimovement discourse on sexuality and sexual rights, including the right to sexual pleasure.

CSBR, as an international solidarity network of 40 NGOs and academic institutes advocating for sexual and reproductive rights at the national and international levels, works across 15 Muslim countries, including Turkey, Egypt, Lebanon, Palestine, Jordan, Sudan, Yemen, Algeria, Morocco, Tunisia, Pakistan, Bangladesh, Malaysia, Indonesia, and the Philippines. It was founded in 2001 by representatives of 11 leading feminist NGOs in the Middle East and North Africa, following the "Women, Sexuality and Social Change in the Middle East and Mediterranean" conference organized by WWHR-New Ways in Istanbul, Turkey. In this groundbreaking meeting, NGO representatives, activists and academics from the Middle East and North Africa came together for the first time to discuss sexuality in the region, and decided to establish a solidarity network for organizations

advocating for sexual, reproductive, and bodily rights as human rights in the region. The coalition expanded to South and Southeast Asia in 2004, as a result of demands from NGOs and activists from these regions.

The coalition is founded on the fundamental principle that all people, regardless of their gender, citizenship, class, age, religion, marital status, ethnic identity, sexual orientation, gender expression, and mental and physical ability, have the right to bodily and sexual integrity and autonomy, and the right to freely decide on all matters concerning their sexuality and reproduction.

At a CSBR meeting held in Beirut, Lebanon, in December 2005, titled "Inclusive Approaches to Sexuality," CSBR members decided that the aim of the coalition was to work for the rights of all nonconforming sexualities:

> In particular considering the national contexts in the Middle East and South/Southeast Asia, where sexuality per se and sexual rights are repeatedly being oppressed and manipulated with ever rising conservatism, nationalism and militarism, a single faceted or fragmented approach to sexual rights may be even detrimental to advocacy efforts around sexual rights and freedoms. Thus, adopting an *inclusive approach to sexualities* . . . forming fruitful alliances rather than reinforcing divisions are . . . more useful choices. The right to non-conforming sexualities should include all sexualities which fall outside the heteronormative, patriarchal social constructs of 'expected or accepted' sexual behaviour. In this respect, in addition to . . . LGBTQI, the term [non-conforming sexualities] also refers to women, and in some instances men, who choose to live outside the norms of a heteronormative patriarchal society, e.g. women who choose not to get married, women with multiple partners, women who express their sexual desires openly, young women who experience their sexuality different than what is already defined by their families and society. (Ercevik-Amado, 2006)

The multidisciplinary work of CSBR includes areas such as solidarity and exchange of information for advocacy at the national level; research that aims to deconstruct political, religious, moral, and cultural notions that lead to the violation of sexual and bodily rights in Muslim societies; annual Sexuality Training Institutes to encourage and strengthen advocacy and research on sexual and reproductive rights in Muslim societies; and advocacy for sexual and reproductive rights at the UN.

On November 9, 2009, CSBR organized the first international campaign on sexual and reproductive rights in Muslim societies under the slogan "One Day, One Struggle." More than 20 organizations volunteered as national focal points to organize the campaign in their countries, in Bangladesh, Cyprus, Egypt, Indonesia, Lebanon, Malaysia, Pakistan, Palestine,

Sudan, Tunisia, and Turkey. More than 200 organizations were involved in the campaign to advocate for sexual, bodily, and reproductive rights at the national level on various relevant and related issues, ranging from breaking taboos on sexual rights (Bangladesh) to the right to safe abortion (Egypt); from repealing laws that violate sexual and bodily autonomy (Malaysia) to decriminalizing homosexuality (Cyprus).

CONCLUSION

The above analysis demonstrates that sexuality has increasingly become a site of political contestation both at national and global levels and in new areas of political struggle. On the one hand, transnational right-wing alliances that include the religious right, nationalists, militarists, and conservatives construct new discourses on sexuality in efforts to increase their political power and influence. In Muslim societies, these forces recently gained new dimensions due to increased Islamophobia, militarization, and new wars in the region in the aftermath of 9/11, as well as the U.S. occupation of Iraq and the Israeli attack on Lebanon in 2006, which tightened the existing space for liberal reforms, including those concerning sexuality. The post-9/11 context has increased the dilemmas faced by activists in Muslim societies who advocate for sexual rights, such as the eradication of customary practices, women's autonomy over their sexuality and bodies, or recognition of different sexual identities. While globalization has created an environment where international networking for sexual rights has gained importance, many activists feel that international engagement in the promotion of these rights ironically serves to exacerbate existing stereotypes both about the women living in the region as suppressed, passive or unable to defend their rights, and about the Muslim world as a whole as backward, static, and culturally irreconcilable with Western values.

On the other hand, there are growing coalitions of women's and LGBTQI groups, sex workers, HIV/AIDS and health organizations, youth groups, and regional or international organizations and alliances working on issues related to sexuality or sexual and reproductive health and rights that demand a new, holistic, and rights-based understanding of these issues.

In this context, there is a need for these diverse groups to go beyond identity politics and forge alliances in order to challenge hierarchies, inequalities, and multiple discriminations based on sexuality, gender, class, race, caste, health, or other issues of inequality to develop new discourses based on a holistic approach to sexuality, integrating the intersecting inequalities around sexuality, as well as bridging the assumed North/South or West/East divides.

Given that discourses on sexuality have until recently been dominated by men, patriarchal and heteronormative states, religious institutions, and capitalist alliances based on entrenched inequalities of gender, class, race, ethnic divisions, sexuality, disability, or global hierarchies, and given that in the age of globalization sexuality has once more become a political tool for global inequalities, regionalisms, and global power struggles, we need to create our own discourses on sexuality to enhance our power.

Yet, creating our own discourses in Southern or regional alliances should not be understood as divisive, but as the opposite; as enriching and nurturing the struggle for sexual rights at the global level, including the UN, through breaking taboos on sexuality; showing links between sexuality and development; enhancing global knowledge on sexuality and people's sexual lives; demonstrating the significance of sexuality in social, economic, and political struggles; and pushing for global progress and equality for all.

NOTES

1. Mexico and Costa Rica, which initially stood in favor, eventually bowed to pressure from the Vatican to oppose the resolution.
2. "Sisters in Islam Hits Out at 'Tomboy' Fatwa," *Malaysian Insider,* November 21, 2008.

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Part IV

Women's Bodies, the Media, and Sexuality

Chapter 12

Her B.E.D. and Her Bed: What We Know and What We Might Guess about the Sexuality of Women with Binge Eating Disorder

Elizabeth Diane Cordero

To eat and to have sex are part of being human. Although an individual person can live without the latter, appetites for both activities are essential to the survival of humankind. Eating and sex are also sensual processes that allow for the experiencing of pleasure via the body; thus, to enjoy food or sex is to enjoy what one's body can do. However, human beings do have some control over their engagement in eating and sex, and societies and cultures throughout the world typically develop values surrounding restraint from and indulgence in eating and sex that often do not take into account the biology that underlies either one.

Perhaps because eating and having sex are both biological and sensual activities with sociocultural standards associated with them, a woman who has a harmful relationship with food might also have problems that impede her enjoyment of her sexuality. Binge Eating Disorder (B.E.D.) is one pattern of maladaptive eating that interferes with a woman's health—and possibly the quality of her sexual life—in unique ways. B.E.D. is a mental disorder that has been recognized only recently, and what is unknown about women with B.E.D. and their sexuality far outweighs what

is known. The purpose of this chapter is to describe what has been found and what might be inferred about women with B.E.D. and their sexuality. To do so, various topics, such as B.E.D. symptoms and development, weight, and body image, are examined to build an understanding about what sex and sexuality might be like for a woman with B.E.D. What we find is that B.E.D. is related to a woman's struggles to take pride in who she is and to take pleasure in what her body can feel.

HER B.E.D.

B.E.D. is introduced as its own clinical entity for the first time in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V; American Psychiatric Association, 2010), which is scheduled to be published in 2013. The act of binge eating, however, is a symptom that spans all eating disorders, including bulimia nervosa and anorexia nervosa (Haedt-Matt & Keel, 2011). Bulimia nervosa is characterized by a regular pattern of binge eating and compensation for the caloric intake; a person with bulimia places an unhealthy importance of body image on her self-esteem, and is diagnosed according to the nature of the compensatory activities in which she engages. Someone with the Purging subtype expels the calories by vomiting or with the use of laxatives or diuretics, whereas someone with the Nonpurging subtype over-exercises or fasts to make up for the food intake. To currently qualify for a diagnosis of bulimia, episodes of binge eating and subsequent compensation must occur at least twice weekly for three months. At present, symptoms of anorexia nervosa include extreme thinness, distorted perceptions about the body, excessive fear of being fat, and the loss of menstrual periods for at least three months (amenorrhea) in postmenarchal women. Although patients who exhibit the restricting subtype severely limit their food intake, some individuals with anorexia engage in cycles of binge eating and purging, and are categorized as Binge-Eating/Purging subtype. Other unhealthy relationships with food and body image that do not meet criteria for a diagnosis of anorexia or bulimia are categorized as Eating Disorder, Not Otherwise Specified, including patterns of binge eating without compensation for caloric intake. B.E.D. was included, however, as a diagnosis for further study in the DSM-IV (American Psychiatric Association, 1994) and its text revision (DSM-IV-TR; American Psychiatric Association, 2000) in order to promote research and discussion about whether or not B.E.D. should be its own disorder.

Someone with B.E.D. binge eats regularly. An eating binge is defined as the consumption of large quantities of food in a short amount of time, coupled with the feeling that one lacks control while doing so. These eating binges cannot be better classified as a symptom of another eating disorder (e.g., bulimia, anorexia binge-eating/purging subtype). To qualify

for a diagnosis of B.E.D., a person needs to feel very distressed about her binge eating and display at least three of five other features associated with her binges: She eats more quickly than normal, she eats past the point she is comfortably full, she eats a lot of food even though she is not actually hungry, she eats by herself because she is embarrassed by her eating and/or she experiences disgust, depression, or guilt after the eating binge (American Psychiatric Association, 1994, 2000, 2010). These attributes have been found to be a valid and important criteria for a diagnosis of B.E.D. (Grilo & White, 2011; White & Grilo, 2011), with post-binge disgust, depression, or guilt being the most common attribute among women (White & Grilo, 2011). In the DSM and DSM-IV-TR (American Psychiatric Association, 1994, 2000), eating binges needed to occur at least two days per week for six months. The frequency criterion proposed for the DSM-V has been decreased, so that a person who binge eats at least once per week for three months will be eligible for a diagnosis of B.E.D.

People from all walks of life struggle with B.E.D. Lifetime prevalence of B.E.D. across ethnic groups is from 2.31 percent to 9.4 percent for women and from 1.35 percent to 2.0 percent for men; for both genders, these rates are higher than those seen for anorexia and bulimia, although there is less of a gender discrepancy (Alegria et al., 2007; Hudson, Hiripi, Pope, & Kessler, 2007; Nicdao, Hong, & Takeuchi, 2007; Sherwood, Harnack, & Story, 2000; Striegel-Moore & Franko, 2008; Taylor, Caldwell, Baser, Faison, & Jackson, 2007). There is some evidence that eating binges are different for women than for men, too. Women are more likely to mention a loss of control during an eating binge, eat sweets during a binge, and binge eat in response to distressing emotions (Masheb & Grilo, 2006; Reslan & Saules, 2011; Striegel-Moore et al., 2009). Regarding sexual orientation, one study of adolescents and young adults indicates that binge eating is a problem seen more so in sexual minorities than heterosexuals (Bryn et al., 2009). Mean age of onset for B.E.D. in women is 23.1–25.4 years and the average lifetime duration for B.E.D. in general is 7.15–14.4 years (Hudson et al., 2007; Pope et al., 2006; Taylor et al., 2007). Thus, hundreds of thousands of people face B.E.D., which means that many, many women experience physical pain, revulsion, misery, and shame on a regular basis at some point in their lives, possibly for several years.

Multiple theories have been proposed to explain the development of binge eating and B.E.D. Research has found that both genetic and environmental factors play a role in the etiology of B.E.D. (e.g., Hudson et al., 2006; Mitchell et al., 2010). B.E.D. is linked with mood, anxiety, and personality disorders (Hilbert et al., 2011; Javaras et al., 2008; Wilfley, Friedman et al., 2000), and problems with affect regulation account for a significant amount of variance in binge eating (Whiteside et al., 2007). Some psychological theories conceptualize binge eating as a way to cope with distressing cognitions and feelings (Bekker & Spoor, 2008; Hawkins & Clement,

1984, as cited in Bekker & Spoor, 2008). One intriguing framework is escape theory (Heatherton & Baumeister, 1991). Escape theory suggests that binge eating helps a highly self-conscious person to switch her focus from any troubling thoughts she is thinking to physical sensations and the environment. The act of eating metaphorically pulls her out of her head and into her body; thus, she can flee from her usual self-aware state and its accompanying stress. Escape theory, and other theories that consider binge eating as a method of affect regulation, assumes that people experience increased negative affect before a binge and decreased negative affect during and/or after a binge. Haedt and Keel (2011) note that research supports the former notion, but findings are mixed with regard to the latter. In their meta-analysis of research that utilized ecological momentary assessment to investigate binge eating, Haedt-Matt and Keel found that participants with B.E.D. do not experience subsequent reductions in negative mood after an eating binge. In fact, participants with B.E.D. actually feel worse after their eating binges. When it comes to escape theory in particular, Haedt and Keel point out that research participants cannot get away from their awareness of themselves during an eating binge if they are asked to evaluate their emotions while they eat (i.e., the escape that binge eating is supposed to provide may be thwarted by research participation). Thus, more research is needed to examine the tenets of models of binge eating and B.E.D.—and of escape theory, in particular—to determine the advantages to binge eating, even if these advantages only take place during but not after the eating binge.

HER B.E.D. AND HER WEIGHT

Not all women with B.E.D. are obese, and not all obese women have B.E.D. Nonetheless, most research has found an association between B.E.D. and weight (e.g., Hudson et al., 2007; Nicdao et al., 2007; Wilfley, Schwartz, Spurrell, & Fairburn, 2000; Wilfley, Wilson, & Agras, 2003), which is not surprising given the pattern of increased caloric intake and lack of compensatory activities that characterize B.E.D. Approximately 64 percent of women in the United States are overweight or obese (Flegal, Carroll, Ogden, & Curtin, 2010), and the prevalence of B.E.D. among obese individuals is estimated to be almost double the rate in the general population (Smith, Marcus, Lewis, Fitzgibbon, & Schreiner, 1998; Striegel-Moore & Franko, 2008; Wilfley et al., 2003). The overlap in these statistics implies that research about the stigma and other variables associated with being overweight or obese applies to a significant portion of women with B.E.D.

Overweight and obese people with or without B.E.D. face various types of prejudice because of their size. In a review of research pertaining to obesity and stigma, Puhl and Heuer (2009) describe how obese people are discriminated against in several arenas, including occupational, educational,

and social settings. Puhl and Heuer also discuss several studies from different countries that have found negative attitudes toward obese people in health care settings, including opinions among medical doctors that obese people are lazy, ugly, and sexually unattractive. How can a woman with B.E.D. who is obese and having sexual difficulties talk comfortably to her physician about her problems if there is a good chance that her physician thinks so poorly of her?

Obese women face particularly strong stigma within the realm of relationships and sexuality. Obesity appears to be more acceptable for men than for women (Bess, 1997). Research conducted on undergraduate samples has demonstrated that men and women rate obese women as less likeable, less attractive, less erotic, and less desirable as a sexual partner than nonobese women, obese men, or people with physical disabilities (e.g., Chen & Brown, 2005; Harris, 1990; Latner, Stunkard, & Wilson, 2005; Regan, 1996). Heterosexual obese women are at a particular disadvantage in attempts to attract mates, as men are more derisive of obese partners than are women (Chen & Brown, 2005). The amount of prejudice obese women face appears to vary among ethnic groups, with European Americans expressing the highest amount of prejudice (Latner et al., 2005). Sadly, overweight and obese individuals express rates of prejudice against obese people that are similar to normal weight individuals (Latner et al., 2005), indicating internalization of sociocultural attitudes toward obesity that may carry over to their thoughts and feelings about themselves. If obese women, including those with B.E.D., are treated as undesirable and as less sexual beings as young adults, it is possible that they incorporate these ideas into their self-concepts and maintain them over the course of their lifetime (Regan, 1996).

HER B.E.D. AND HER BODY IMAGE

It is crucial to examine what women think and how they feel about their bodies, to understand what it is like for them to engage in an activity that is as particularly body involved as sex (Wiederman, 2000). Body image includes perceptions of one's appearance and the self-evaluation of those perceptions: a person compares herself to what she has learned is considered attractive, and may be distressed if she does not think she meets her (society's) standard of beauty. In the United States, thin is "in," and it is arguably the most important criterion of beauty in mainstream American society. Models are approximately 6 inches taller but weigh 23 percent less than the average American woman (Bennett, 2007), and magazines and infotainment television shows are packed with stories about diets and celebrity weight loss secrets. Thin is ideal in the United States, and with the definition of "thin" becoming more and more stringent, many women feel they do not measure up despite how much of their bodies they trim down.

The subjective, appraisal component of body image is a key process. Women who are objectively underweight and, therefore, close to meeting the sociocultural thin ideal, still often display as much dissatisfaction with their appearance as normal or overweight women (Hoyt & Kogan, 2001). In research samples from around the world, binge eating and B.E.D. have been associated with greater body dissatisfaction and shape concerns in normal weight, overweight, and obese women (e.g., Ivezaj et al., 2010; Legenbauer et al., 2011; Wilfley et al., 2003). Correspondingly, obese women with B.E.D. overestimate their size—a pattern seen in women with anorexia and bulimia, too (Legenbauer et al., 2011). Although disturbed body image is not an official symptom of B.E.D., negative body image is a typical phenomenon experienced by women with B.E.D.

Women are more likely than men to express that their body image affects their sexual relationships (Ambwani & Strauss, 2007). Researchers have investigated several aspects of women's body image (e.g., weight concern, perceptions of sexual attractiveness, appearance evaluation, body esteem), and many studies have uncovered significant relationships between body image variables and women's sexual functioning, such as sexual avoidance (La Rocque & Cioe, 2011); sexual problems, anxiety, and assertiveness (Weaver & Byers, 2006); sexual esteem (La Rocque & Cioe, 2011; Weaver & Byers, 2006); frequency of sexual encounters and orgasms (Ackard, Kearney-Cooke, & Peterson, 2000; Koch, Mansfield, Thurau, & Carey, 2005); initiation of sex (Ackard et al., 2000); sexual desire (Koch et al., 2005; La Rocque & Cioe, 2011; Seal, Bradford, & Meston, 2009); and sexual satisfaction (Koch et al., 2005; La Rocque & Cioe, 2011; Pujols, Meston, & Seal, 2010). Among women with sexual dysfunctions, body esteem was shown to be related to sexual arousal, lubrication, orgasms, and satisfaction (Seal & Meston, 2007). Findings are mixed, though, about the associations between body image and sexual variables in women. For example, Davison and McCabe (2005) did not find a direct relationship between women's body image and sexual satisfaction. Research about mediators of the relationships between body-related and sex-related variables further illustrates the complexity of the connections between and among these variables. Healthy body image, for instance, is negatively associated with sexual avoidance, but this relationship is mediated by sexual esteem, satisfaction, and desire (La Rocque & Cioe, 2011). Much of the research about women's body image and sexuality has been descriptive; thus, neither causality nor true mediation can be inferred. Because body image begins to develop in childhood and before the onset of sexual functioning, it is likely that body image shapes initial sexuality and that these two phenomena impact each other over the course of a woman's lifetime (Sanchez & Kiefer, 2007).

Body image that pertains specifically to the sexual context is especially noteworthy to consider in a discussion of women's sexuality. Although

correlated with overall body image (Ålgars et al., 2011), Yamamiya, Cash, and Thompson (2006) found that contextual body image during sex, such as awareness of appearance during sex, is a better predictor of a woman's sexual experience than is overall body image. Their results revealed that the more body dissatisfaction a woman experiences in the sexual context, the more likely it is that she has low sexual self-efficacy, assertiveness, and self-confidence to refuse sex, along with increased feelings of sexual ambivalence and emotional disengagement during sex. Regarding the genital area in particular, the most recent research suggests that dissatisfaction with the appearance of her genitals is associated with a woman's self-consciousness during sex; self-consciousness during sex is related to lower sexual esteem and satisfaction as well as reduced desire to avoid risky sexual behavior (Schick, Calabrese, Rima, & Zucker, 2010). A study conducted in Finland found that genital satisfaction was positively correlated with frequency of sex and sexual functioning, but only approximately half of the women studied were satisfied with their genitals' appearance (Ålgars et al., 2011). Dissatisfaction with her most intimate physical parts impedes a woman's ability to enjoy her intimate sexual experiences.

A particularly hurtful experience is when a woman's body dissatisfaction reaches the level of body shame. Body shame can arise when a woman believes herself to be worthless for having failed to achieve physical beauty (e.g., Sanchez & Kiefer, 2007). Whereas a woman with positive body image is more likely to feel at ease while taking her clothes off in front of her partner, having sex with the lights on, and trying new techniques (Ackard et al., 2000), a woman with body shame is self-conscious during sex, and subsequently struggles to feel arousal and pleasure (Sanchez & Kiefer, 2007; Steer & Tiggemann, 2008). Women's body shame is associated with decreased sexual functioning (Steer & Tiggemann, 2008) as well as inconsistent condom use despite higher numbers of recent sex partners (Littleton, Breitkopf, & Berenson, 2005). Women who are not only dissatisfied with, but also are actually ashamed of their bodies, encounter more problems enjoying their bodies and appear to not value their bodies or themselves enough to protect themselves.

HER B.E.D. AND HER SEXUALITY

Research devoted to B.E.D. and sexuality is sparse, hence knowledge about women with B.E.D. and their sexuality is rather limited. B.E.D. only began to be mentioned in the DSM in 1994 when the DSM-IV listed it as a diagnosis for further study (American Psychiatric Association, 1994). Thus, B.E.D. research is in its infancy as is the diagnosis itself, and much of the research about B.E.D. has been dedicated to uncovering the nature of B.E.D. and providing support for it as its own entity (e.g., Grilo & White, 2011; Hudson et al., 2006; Javaras et al., 2008; Striegel-Moore & Franko,

2008; White & Grilo, 2011; Wilfley et al., 2003; Wilfley, Friedman et al., 2000; Wilfley, Schwartz et al., 2000). However, inferences may be drawn from investigations of sexuality and obesity in general, including those few studies of sexuality, obesity, and B.E.D.

Given the overlap between B.E.D. and obesity, data from studies of obesity and sexuality are helpful to understand what sex and phenomena related to it might be like for many women with B.E.D. The sexual life of an obese woman and of a normal weight woman may share more similarities than differences, as some studies have found few significant relationships between weight and sex-related variables (Kaneshiro et al., 2008; Wee, Huang, Huskey, & McCarthy, 2008). Kaneshiro and colleagues (2008) found that women's body mass index (BMI) was not related to frequency of sexual encounters. Likewise, weight is not associated with presence of human papilloma virus or Herpes Simplex Virus type II antibodies (Nagelkerke, Bernsen, Sgaier, & Jha, 2006; Wee et al., 2008), but mildly obese women are least likely than women in other weight categories to report a history of sexually transmitted diseases (Wee et al., 2008). There is no association between BMI and lack of condom use among women with multiple partners (Wee et al., 2008), although a French study found that obese women under the age of 30 are more likely to have unintended pregnancies and less likely to use oral contraceptives or to seek services for contraception (Bajos, Wellings, Laborde, & Moreau, 2010). Results are mixed with regard to whether or not weight is associated with sexual abuse or sexual orientation (Adolfsson, Elofsson, Rössner, & Undén, 2004; Kaneshiro et al., 2008; Smith et al., 2010). Regarding the number of sexual partners, the tendency is for research to find that overweight and obese women have fewer casual or recent sex partners, but whether or not weight is linked to the number of lifetime partners is unclear (Kaneshiro et al., 2008; Nagelkerke et al., 2006; Wee et al., 2008). In general, studies, thus far, have found some but not many associations between obesity and different facets of sexuality.

Obesity appears to be associated with aspects of the actual sexual experience, too, although debate continues as to which ones. An Italian study determined that sexual arousal, lubrication, orgasms, and satisfaction correlated negatively with BMI, and that BMI was a better predictor of sexual functioning than was age (Esposito et al., 2007). However, neither sexual desire nor pain correlated with BMI. Research from Turkey, published later, found BMI to have similar inverse relationships with sexual satisfaction and orgasms in women, but no relationships between BMI and sexual arousal or lubrication (Yaylali, Tekekoglu, & Akin, 2010). Likewise, a Swedish study failed to find a pattern of sexual dissatisfaction among overweight and obese individuals (Adolfsson et al., 2004), and a French investigation found no differences among overweight, obese, and normal weight women for sexual desire, arousal, and pain (Bajos et al., 2010). This

same study, though, found that obese women devalued their sexuality as a part of their well-being more so than did normal weight women. In the United States, Kolotkin and colleagues (2006) compared patients in a residential weight loss program to patients evaluated for gastric bypass surgery and obese controls who were not participating in a weight loss program. Participants were asked about their enjoyment of sex, sexual desire, difficulties with sexual performance, and avoidance of sex because of their weight. Higher BMI was inversely associated with quality of sexual functioning, particularly for women. The gastric bypass candidates indicated more impairment to their sexual functioning than did the residential patients or controls, and the residential patients indicated more impairment than controls. Regarding BMI among female participants, gastric bypass candidates had higher BMI than did controls and controls had higher BMI than the residential patients. The obese population is heterogeneous (Bess, 1997), and it may be that obesity just impacts some aspects of sexuality (Yaylali et al., 2010), obesity is a significant factor only in women who have sexual difficulties (Esposito et al., 2007), or that studies that did not uncover significant relationships between obesity and sexual functioning did not measure all pertinent variables (e.g., intervention seeking), including presence or absence of B.E.D. (Castellini et al., 2010).

Only two studies have examined B.E.D. and sexuality. Both studies took place in Europe, and both looked at the relationship between B.E.D. and sexuality in obese women. Research conducted in Switzerland compared sexual functioning among obese women with B.E.D., obese women without an eating disorder, normal weight women with bulimia, and normal weight women without an eating disorder (Jagstaidt, Golay, & Pasini, 2001). Although obese women with B.E.D. reported less body dissatisfaction than did normal weight women with bulimia, they reported more body dissatisfaction than did obese women without B.E.D., despite no mean differences in weight between the two groups. A positive correlation was obtained between body dissatisfaction and sexual dissatisfaction among obese women with B.E.D., and both eating disorder groups reported more sexual problems and avoidance than the other two groups. Obese women with B.E.D. reported more sexual disturbance and less sexual satisfaction when compared to obese women without an eating disorder. Furthermore, obese women with B.E.D. reported engaging in less sex than all three other groups; there were no significant differences among the three other groups with respect to frequency of sexual encounters. The second study, performed in Italy, compared obese women with and without B.E.D. to normal weight women (Castellini et al., 2010). The two obese groups indicated engaging in less sexual activity and reported poorer sexual functioning than the normal weight group. Emotional eating was the strongest predictor of sexual functioning among both obese groups, but body image concerns and impulsivity were inverse predictors of sexual

functioning in the B.E.D. group only. When compared to obese women without B.E.D., obese women with B.E.D. reported less sexual desire, arousal, lubrication, orgasms, and satisfaction. Impulsivity and sexual satisfaction were negatively correlated among obese women with B.E.D. who had multiple sex partners, which might indicate that the impulsivity that underlies B.E.D. also underlies sexual functioning. The results of these two studies imply that a woman with B.E.D. experiences a pattern of sexual functioning that is vulnerable to problems above and beyond those related to any impairment associated with weight.

How might we make sense of what we have learned about women with B.E.D. and their sexuality? Again, obese women in general appear to have some sexual difficulties (e.g., Bajos et al., 2010; Esposito et al., 2007; Kolotkin et al., 2006). Obese women with B.E.D. report more sexual dysfunction than obese women without B.E.D., suggesting that there is something about B.E.D. that reduces women's ability to enjoy their sexuality. The lack of control over eating might lead women with B.E.D. to feel a sense of shame about themselves that affects their sexuality, or it might be that decreased interest in sex or reduced sexual quality of life lead to more food consumption (Castellini et al., 2010). It also might be that obese women with B.E.D. have internalized sociocultural prejudices about obese people more so than obese women without B.E.D., and that they see themselves less as sexual beings because they have learned that they are considered less sexual. Bess (1997) suggests that obese people have the same level of sexual desire as those who are not obese, but are either rejected or avoid sex to avoid rejection.

The association between B.E.D. and sexual impairment for women is heartbreaking, but curious in light of the escape theory of binge eating. Escape theory posits that binge eating is a form of affect regulation that allows for a highly self-aware person to retreat from her mind into her body, at least during the eating binge (Heatherton & Baumeister, 1991). If a woman turns to food to cope with anxiety-provoking thoughts, why would she not be as equally likely to turn to sex, another sensual process? One potential reason why sex might not be as effective at affect regulation as an eating binge for women with B.E.D. is because of associated body dissatisfaction. Sexual interactions, unless autoerotic, are partnered situations. A woman who wants to escape from distressing thoughts will not be able to (depending on her sexual partner's attentiveness and talents) if sex reminds her to worry about how she looks or what her partner thinks of her body. Concerns about what their partners think about their sexual performance are negatively associated with women's body esteem (Pujols et al., 2010). Masters and Johnson (1970) coined the term "spectatoring" to reflect how self-evaluative thoughts during sex interfere with the sexual experience. Such spectatoring might not happen while a woman is by herself. Seal and Meston (2007) experimentally manipulated body

awareness in a community sample of women with sexual dysfunctions. They found that the body awareness induced by sitting alone and nude in front of a mirror increased perceptions of mental and physical sexual arousal while listening to erotica, and they suggest that this pattern of results might have been obtained because the experimental manipulation was a nonpartnered situation. Sexual occurrences that are indeed sexual interactions with other people might be situations in which women with B.E.D. remember that they might be judged and that they are dissatisfied or even ashamed of their bodies. Food, however, does not ridicule and can be interacted with while clothed, which means that binge eating does not put a woman in circumstances in which she cannot escape her concerns.

Other components linked to B.E.D. may underlie the sexual impairment that women with B.E.D. face. Obese women with B.E.D. who have multiple sex partners indicate higher levels of impulsivity along with lower levels of sexual satisfaction, and it might be that the impulsivity related to B.E.D. underlies sexual dissatisfaction (Castellini et al., 2010). Additionally, affective nonreactivity and disconnection has been demonstrated to be uniquely and inversely predictive of sexual body esteem and tactile threshold or the amount of stimulation needed for a woman to feel a sensation (Brody, Houde, & Hess, 2010; Fink, Foran, Sweeney, & O'Hea, 2009). Women with B.E.D. who binge eat as an endeavor to regulate their emotions might find it difficult to feel positive about themselves sexually as well as to feel physical pleasure during sex. Perhaps acting to suppress affect, or acting on impulse, comes with a cost to quality of sexual life in women with B.E.D.

Self-objectification should be taken into consideration for its potential to underlie the sexuality of women with B.E.D. Objectification theory (Fredrickson & Roberts, 1997) proposes that women who live in societies that objectify the female body are vulnerable to the internalization of this process. Women who engage in self-objectification evaluate themselves in terms of how others might see and judge them, and whether or not they can bring others some sort of enjoyment. A woman high in self-objectification will not only find herself spectatoring during sex, and thus preoccupied with her appearance and performance, but will also direct her attentions and priorities toward her partner's pleasure rather than her own. Self-objectification inevitably leads to a focus on appearance as well as other avenues through which a woman might gratify others. Self-objectification has been linked to mental health problems, including disordered eating, sexual dysfunction, and body dissatisfaction and shame (see Tiggemann, 2011, for a review). Results from experimental manipulations of state self-objectification have demonstrated that self-objectification induces body shame (e.g., Calogero, 2004; Fredrickson, Roberts, Noll, Quinn, & Twenge, 1998; Hebl, King, & Lin, 2004), and one study found that increased self-objectification predicted restrained eating (Fredrickson

et al., 1998). No studies, as of yet, have examined self-objectification in the context of B.E.D. and sexuality. In light of evidence that self-objectification is related to eating, sexual functioning, and body image, it is likely that self-objectification plays a role in the sexual experience of women with B.E.D. If a woman with B.E.D. is dissatisfied with her body and prioritizes being pleasing to her sexual partner, she might think that she is not up to the task of satisfying her partner. She might then binge eat, in part, to cope with her consequent critical thoughts and feelings of failure.

LIMITATIONS TO WHAT WE KNOW ABOUT HER B.E.D. AND HER SEXUALITY

There are several limitations to the knowledge that has been generated about B.E.D., sexuality, and related topics. There are cultural variations to values and ideals about eating, sex, and women's bodies, which render it imperative that these phenomena be studied within cultural contexts. The two studies of women with B.E.D. and their sexuality were conducted in Europe, and it is unclear how much the results can be generalized to women with B.E.D. who live in the United States. Correspondingly, the vast majority of the studies about B.E.D., obesity, stigma, body image, and sexuality that were carried out in the United States relied on predominately heterosexual, European American samples that were most often recruited from college campuses. It is unknown as to how many of the relationships between the variables, described in this chapter, are present for women who identify with other ethnic groups, sexual orientations, age ranges, and educational backgrounds and socioeconomic statuses, or how physical (dis)ability or religion factor into the relationships among the variables. The few investigations of B.E.D. and sexuality did not include normal weight women with B.E.D. into their samples, making it difficult to know what sexuality for normal weight women with B.E.D. is like. Moreover, what can be extrapolated from the obesity literature to illustrate the sexual life of obese women with B.E.D. is uncertain, despite the overlap of obesity and B.E.D. Obese individuals with B.E.D. demonstrate more problems with mental and physical health than do obese individuals without B.E.D. (Wilfley et al., 2003). However, the majority of studies of obesity and sexuality neither assessed nor controlled for the presence of B.E.D., and it is likely that their samples had several participants with B.E.D. Researchers and practitioners are just beginning to understand women with B.E.D. and their sexuality, and questions remain as to how much of what has been learned is applicable to women with B.E.D. given their heterogeneity.

The research methods employed to study women with B.E.D. further limit what has been learned about their sexuality. Most studies have utilized correlational designs with self-report measures. To be fair, many of

the variables of interest to the discussion of women with B.E.D. and sexuality are subjective or internal phenomena, including body image and sexual satisfaction. Variables that are subjective or internal are tricky to assess without some kind of self-report, and any objective means of doing so might not be as meaningful to the phenomenological experiences of the individuals that researchers want to understand. Some variables, such as presence of B.E.D., would be unethical or take an extraordinary amount of cleverness to manipulate experimentally. The reliance on correlational designs, however, restricts the ability to establish causal pathways among the variables. The utilization of experimental, longitudinal, and qualitative methods would provide a fuller picture of women with B.E.D., as would diverse self-report methods, such as ecological momentary assessments that involve repeated ratings over time.

WHAT WE NEED TO FIND OUT ABOUT HER B.E.D. AND HER SEXUALITY

Given that research about B.E.D. and sexuality in women has just begun, there are a plethora of future directions for this area of inquiry. In addition to the aforementioned limitations of the extant literature, there are myriad subjects that are unaddressed about women with B.E.D. and their sexual lives. If B.E.D. is linked to problems with sexual desire, arousal, lubrication, orgasms, and satisfaction (Castellini et al., 2010), then why? Are the reasons behind these relationships psychological, biological, or a combination of both? Are these problems seen only in women with B.E.D. who are obese? How does B.E.D. affect partner availability and selection? Is the role that body image plays in sexuality similar between women with and without B.E.D.? Do religious prohibitions on sex influence women with B.E.D. differently than those without B.E.D.? What types of variables serve as protective factors against sexual dysfunction in women with B.E.D.? Are there aspects of sexual interactions that are more uncomfortable than other aspects? Do women with B.E.D. masturbate and do they orgasm when they do? Do they fantasize? What about? These are but a few of the questions that need to be answered to understand sexuality among women with B.E.D.

One noteworthy area that needs attention from researchers and practitioners is prevention and intervention. If sexual impairment is established as being linked or actually caused by B.E.D., it is critical that work be done to help improve quality of sexual life for women with B.E.D. Treatment for B.E.D. could involve a component about sex and goals can include healthy changes in the arenas of sexuality. Likewise, B.E.D. should be assessed and treated if present among women who struggle with sexual dysfunction. Such treatments should be based on means that have empirical support for their efficacy. It might be helpful to educate women with B.E.D. about

their genitalia as well as partnered positions and nonpartnered techniques that facilitate sexual satisfaction; it would be helpful to educate their partners about these topics, too. Thus, the development of appropriate educational materials for women with B.E.D. and their partners is needed, as is continued research about what positions and techniques these materials should describe. On a sociocultural level, advocacy to reduce stereotypes, stigma, and stringent ideals about beauty would effect positive change for women with B.E.D. Being overweight or obese is associated with health problems, but the shame that mainstream American society has attached to being overweight and obese is not inherent to these conditions. The severe thin ideal, the various manifestations of weight prejudice, the process of self-objectification, and the level of ridicule about size that has been deemed acceptable in the United States destroy many women's ability to enjoy who they are and what their bodies can feel. Women with B.E.D. might binge eat or not take pleasure in sex because of the distress over implicit and explicit messages that their worth depends on whether or not they meet others' standards. Researchers, health care professionals, and educators should work together to develop preventions and interventions that create lasting change for women with B.E.D., which will involve targeting sociocultural standards and ideals in general.

CONCLUSION

B.E.D. is a disorder characterized by regular episodes of eating binges with an accompanying loss of control. People from various types of demographic groups struggle with B.E.D., particularly women. There is much to be learned about the etiology of B.E.D., but it is probable that eating binges become a way to cope with troubling thoughts and emotions. B.E.D. is associated with weight gain and obesity; therefore, many women with B.E.D. face the stigma that society has created around being overweight. Women with B.E.D. are often dissatisfied with their bodies and body dissatisfaction has been linked to reduced quality of sexual life. Obesity has also been linked to sexual problems, and the few studies on obesity, sexuality, and B.E.D. point to B.E.D. being related to sexual problems beyond the contributions of weight. Extant knowledge about women with B.E.D. and their sexuality is limited, however, and there are numerous topics left for researchers and mental health professionals to examine.

To be clear, we do not know if B.E.D. causes sexual difficulties, if sexual difficulties cause B.E.D., or if other phenomena underlie both. It is likely that the pathways between B.E.D. and sexuality are complex given the biological, psychological, and sociocultural factors involved with or attributed to eating and sex. Therefore, prevention and intervention efforts should be as multifactorial as possible to bring about women's healthy enjoyment of food and sexuality.

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Chapter 13

Mediated Representations of Voluntary Childlessness, 1900–2012

Julia Moore and Patricia Geist-Martin

Pronatalism permeates cultures across the globe, perpetuating the belief that all people should procreate. Women are especially pressured to have children due to multiple sociocultural factors, including fear of the decline of the "white race," delaying marriage and childbearing, women entering the workforce, and women's traditional roles in the home. The perception that women's sexuality ultimately serves the purpose of procreation is the foundation of historical and contemporary pronatalist ideology, although its presence is much more subtle and complex today given the shift in sexual identity that occurs after childbearing (Koert & Daniluk, 2010; Trice-Black, 2010). Regardless, pronatalism lingers in cultural discourses that subtly suggest that certain types of women should have more or less children.

Only one scholarly source was identified that traces the history of childlessness in the United States. Elaine Tyler May (1995) outlined childlessness—mostly involuntary—through the 20th century, dedicating one chapter to the "childfree movement" from 1966 to 1995. However, voluntary childlessness is unique from involuntary childlessness and has a history that predates

second wave feminism. Voluntary childlessness, often synonymous with childfree and childless by choice, indicates a permanence of choice to refrain from childbearing and childrearing. The distinction between voluntary and involuntary childlessness is important because voluntarily childless women are stigmatized more than temporarily or involuntarily childless women (Koropeckyj-Cox, Romano, & Moras, 2007).

Two gaps in the literature exist that have led to the writing of this chapter. First, a comprehensive historical review of voluntary childlessness that spans the entire 20th century and into the 21st century has yet to be accomplished. Such an undertaking is enormous, because, comparatively speaking, women have very little history recorded in history books and before the advent of contraception they had less autonomy to decide to never have children. Second, research on voluntary childlessness has yet to fully consider mediated representations of women who have chosen to never have children. One reason for this is the lack of fictional voluntarily childless characters; those who can be identified in books, television, or film often end up having children or are never explicitly identified as permanently and voluntarily childless, leaving their childbearing status open to interpretation.

Considering these important gaps in the literature, this essay weaves together the scholarly conversation with mediated representations to illustrate the interplay between cultural discourses about women who choose childlessness and women's expected position as (eventual) mothers. Utilizing examples from scholarly journals, books, magazines, and Internet media, this chapter explores the progression of popular discourse about voluntarily childless women from 1900 through 2012, tracing how mediated representations have contributed to our cultural understanding of women's sexuality and what implications these discourses have for women's experiences in the present.

The following sections first describe the relationship between discourse and media, outlining the theoretical framework of media framing analysis that is used in this chapter. Second, the cultural representations of voluntary childlessness are categorized into four separate, yet interconnected discourses. Examples from scholarly and popular representations are woven together to describe the historical context of the discourse. Third, implications for women today are discussed, including the ways in which each discourse continues to manifest in contemporary media. Theoretical implication, practical implications, and directions for future research are suggested.

DISCOURSE AND MEDIA

The naturalization of women's sexuality has occurred through the interplay of ideology, cultural discourses, and mediated messages. This analysis

adopts Mann and Huffman's (2005) definition, where discourse is a "historically variable ways of specifying knowledge and truth that both constrain and enable writing, speaking and thinking" (p. 57). This chapter also embraces Baxter's (2003) idea of discourse where "there are always plural and competing discourses constituting power relations" (p. 8) within any given context. Therefore, discourse is a form of ideological practice that is constructed through individual and cultural language use. Discourse is reproduced through everyday communication and mediated messages, maintain pronatalist ideologies; pronatalist ideologies then become reproduced in cultural discourses. Considering the cultural discourses that have historically shaped our understanding of the relationship between women's sexuality and childbearing is critical to understanding how women today manage pronatalist pressure to achieve the unattainable status of "superwoman" (wife, mother, and worker; see Nicolson, 2002; O'Brien Hallstein, 2010). Understanding the history of public thought on voluntary childlessness is, therefore, an important scholarly endeavor.

Multiple studies on the discourses surrounding voluntary childlessness have been published. Discourses identified include derogation (or moral flaw), compensation (or activities used to make up for childlessness), and regret (the outcome of childlessness; Morell, 1994), as well as disbelief, disregard, and deviance (Gillespie, 2000). Each of these discourses negatively frames voluntarily childless women in terms of her individuality, considering the position of the individual within pronatalist cultural pressures to be a mother (Hird, 2003; Hird & Abshoff, 2000; Park, 2002). Rather than focusing on the discourses surrounding the voluntarily childless individual, this analysis expands on the previously identified discourses to consider the macrorepresentation of voluntary childlessness as an abstract social construct.

Scholarly literature is a mediated representation of truth, and is therefore useful to examine in conjunction with popular mediated representations of society. Mediated communication can be defined as is any type of message that is delivered through a form other than face-to-face verbal and nonverbal communication. Forms of media include print (books, newspapers, magazines), mass (radio, television, film), and new media (Internet and social media; McQuail, 2010). Mediated messages often reproduce cultural discourses and have the power to influence audiences. Multiple theories exist to explain the power that media, especially mass media, has over public thought. Agenda setting describes the process by which mass media shapes the issues that become most important to the public. Framing expands on agenda setting by describing *how* mass media frames issues in addition to *what* issues are presented. Frames define problems, diagnose causes, and make moral judgments (Entman, 1993). Framing is, therefore, an important tool for understanding the representation of discourse in mediated messages.

Both agenda setting and framing are relevant to this analysis, for both assume that mass media has an influence on public opinion. However, instead of identifying agendas or frames used in news media, this analysis adopts a critical approach to understanding larger cultural discourses that are reinscribed through academic and popular media. The reasons for this are two-fold: first, the array of media utilized in this analysis is great and spans over a century, making a traditional frame analysis improbable; second, discourses were ultimately chosen to imply a connection between mediated representation and the experiences of voluntarily childless women throughout the 20th century.

REPRESENTATIONS OF VOLUNTARY CHILDLESSNESS

Analyses of scholarly and cultural representations of women who choose childlessness reveal four categories of discourse that highlight the cultural meanings of voluntary childlessness from 1900 to 2012. Articles and books on the topic of voluntary childlessness were scoured to uncover how women without children have been represented in mediated communication. Qualitative coding was utilized to build the overarching categories that emerged as prominent discourses across time. The examples used to illustrate each discourse are by no means exhaustive, but are meant to serve as representative examples from each discourse. Furthermore, other competing discourses can be found by considering other facets of voluntary childlessness by narrowing the search to a specific institution, including medicine or religion. For the purpose of this chapter, the broadest set of mediated representations available was chosen to gain a big picture understanding of voluntary childlessness in the United States.

The first two discourses, *a social responsibility* and *an individual imperfection,* were prominent ways of understanding voluntary childlessness between 1900 and 1940. The third discourse, *a consequence of feminism,* spanned from 1900 through to the 1980s, peaking during the women's rights movements of the 1910s and 1970s. The fourth and final discourse, *fulfillment without children?* emerged in the early 1970s and is the most popular discourse today, slowly overshadowing the previous three discourses. The question mark at the end of *fulfillment without children?* represents the resistance that still exists to this discourse as well as the way the other three discourses continues to seep into contemporary public thought.

A Social Irresponsibility

Between 1900 and 1940, procreation was seen as an act of social responsibility that women bore to society. Women's sexuality was considered a tool of procreation, only to be utilized within marriage to fulfill her social duty (Wilcox, 1900). This discourse was at its height during the eugenics movement,

represented most often in scholarly writings by members of the eugenics community. "Race progression," the foundation of eugenics, required race improvement and self-perpetuation (Lichtenberger, 1909); in other words, procreation is a social responsibility by those deemed fit to improve society. Eugenics is founded on the principle of selective reproduction, and the scholarly literature at the time makes clear that the social burden women bear is different across classes. Women with more socially desirable traits were expected to have more children, while "feeble-minded" women and women with less desirable social and economic traits were urged to have fewer or no children (Robb, 1920; Snedden, 1929). Voluntary childlessness was, therefore, encouraged in certain women and admonished in others.

However, eugenics went beyond encouraging family size. Women were compulsory sterilized for "feeble-mindedness" in many states (Pernick, 1997), while many "fit" childless women were simultaneously barred from voluntary sterilization due to economic circumstances (Pilpel, 1975). The reasons for the legality of compulsory sterilization were threefold: (a) disease prevention, (b) societal well-being outweighed individual interests, and (c) persuasion was deemed inadequate (Pernick, 1997). The premise of eugenics rested on the belief that physical and mental traits were largely inherited and individuals should marry in such a way that would ensure better offspring. The foundation of eugenics, therefore, perpetuated the simultaneous discourses of voluntary childlessness as a social responsibility (for women with undesirable traits) and a social irresponsibility (for women with desirable traits).

Eugenicists adopted a three-phase approach to elevating eugenics to national importance. First, it had to be accepted in academe as fact; second, it had to be recognized as a serious social issue; and third, it had to be introduced to the nation (Galton, 1904). To introduce eugenics to the general population, eugenicists relied on positive representations of family and negative representations of disabled children in order to subconsciously persuade certain desirable women make the decision to have children (Ladd-Taylor, 2001). The First International Eugenics Congress was formed in 1912 "for the definite purpose of advancing the eugenics propaganda" (Pearl, 1912, p. 395). The attempt to introduce eugenics into popular public opinion worked; by 1947, 30 states had enacted sterilization laws and more than 43,791 individuals were sterilized (Birthright, Inc., 1947).

The discourse of social irresponsibility was perpetuated through two types of mediated messages: books for young women's consumption and through illustrations published in magazines and newspapers. In the introduction to *The Three Gifts of Life* (Smith, 1913), Thomas Denison Wood wrote:

> By far the most valuable part of the work of the home belongs to the girl, the woman, the mother . . . her health, her character, her

> personality, her womanliness; are all of vital importance not only to herself but to human society as a whole and to the human race indefinitely. (p. viii)

Smith goes on to describe the importance of race instinct. This instinct is framed as positive in two aspects. First, women who bear children are elevating the needs of their race over their individual needs. Second, women build their own character when they self-sacrifice for racial well-being. The social benefit of compulsory sterilization was also framed in terms of economics through cartoons printed alongside popular newspaper and magazine articles. Illustrations depicted the negative social consequences of feeble-minded women who had children, and the social consequences were often framed in terms of economic costs to society (Allen, 1997); for example, sterilization was much less expensive than paying for a criminal or person with disabilities.

During the eugenics movement, women were bombarded with mediated messages about their racial obligation to bear—or not bear—children. The success of the eugenics movement can be attributed to the combination of scholars perpetuating eugenics as truth at a time when relatively little was known about genetics and popular mediated messages citing the truth behind eugenics. It was not until World War II that eugenics fell out of favor in the United States due to the association the movement had with Nazi Germany (Allen, 1997) and the discourses surrounding voluntarily childless women began to shift. However, a social irresponsibility discourse did not exist alone during the first portion of the 20th century; a discourse that framed voluntary childlessness as an individual imperfection was also prominent. While the social responsibility discourse described the act of choosing childlessness, the individual imperfection discourse attempted to explain the reasons for the act.

An Individual Imperfection

The social irresponsibility discourse surrounding voluntarily childless women occurred simultaneously with the discourse of individual imperfection, popular between 1900 and 1940. The choice to remain childless was explained as a character flaw. Internal attributes of women were blamed for the increase in voluntary childlessness, rather than considering the complex external factors that often contributed to choosing childlessness, including economic and relational hardships.

This discourse of individual irresponsibility is apparent in the scholarly literature from 1900 through 1940. According to Popenoe (1936), "the great bulk of the voluntary childless marriages are motivated by individualism, competitive consumption economically, and an infantile, self-indulgent, frequently neurotic attitude toward life" (p. 472). In research studies on

voluntary childlessness, women without children were described as selfish, aimless (Stephens, 1910), immoral (Hoffman, 1909), and "deficient in human sensibilities" (Fite, 1916, p. 63). While attempting to pinpoint the root of declining birth rates on women's selfishness, one scholar openly waived the possibility of voluntary childlessness. Involuntary sterility—instead of contraceptive use—was seen as the most plausible explanation for the declining fertility rates in the United States (Kiser, 1939). Kiser quoted a survey participant in his conclusion to indicate the central premise of his research: "I firmly believe that most childless women are physically unable to have children . . . life without children is a very dreary dissatisfyed [*sic*] life, judging by myself and friends" (p. 68).

The discourse of individual imperfection was illustrated through the publication of multiple books addressing the dichotomy between working women and mothers. In *The Woman who Toils,* published serially in *Everybody's Magazine,* two privileged women, Bessie Van Vorst and Marie Van Vorst, assume lower class identities to work as factory girls. The discourse of individual imperfection is illustrated in a letter from President Theodore Roosevelt to Bessie Van Vorst, published as a forward in the 1905 printing of the *The Woman Who Toils:*

> If a man or woman, through no fault of his or hers, goes throughout life denied those highest of all joys which spring only from home life, from the having and bringing up of many healthy children, I feel for them deep and respectful sympathy. . . . But the man or woman who deliberately avoids marriage, and has a heart so cold as to know no passion and a brain so shallow and selfish as to dislike having children, is in effect a criminal against the race, and should be an object of contemptuous abhorrence by all healthy people. (Van Vorst & Van Vorst, 1905)

Roosevelt also used his political platform to endorse eugenics and perpetuated the individual imperfection discourse. He participated in the First International Eugenics Congress in London in 1912. He effectively set an agenda for the nation that framed women's patriotism as a function of their sexuality (Lovett, 2007). Roosevelt's anti–birth control and antifeminist speeches and letters were published in women's magazines, including the *Ladies Home Journal* and in *Butterwick Company2s* sewing magazine (Lovett, 2007). His harsh criticism for women who chose childlessness was adopted by many citizens at the time. His position effectively changed the way families were presented in print media, emphasizing large families and centralizing the children (Lovett, 2007).

The implications of the social irresponsibility discourse for women were great. At a time when women were entering the workforce in greater numbers, they began to take on more economic responsibility, making it

difficult for many women to manage work and home life. The decision to abstain from childbearing was often pragmatic for the women, but scorned by higher class women who did not need to work. Women who chose childlessness between 1900 and 1940 were bombarded with messages about their disservice to their race and their deficient moral character, for "morality appears to be exclusively a matter of social obligation" (Fite, 1916, p. 53). The discourses discussed, thus far, touch on a social expectation and an individual flaw; the following discourse considers an external, historical factor that was seen as a catalyst of the increase in voluntary childlessness. The discourse framing voluntary childlessness as a consequence of feminism is particularly interesting because the discourse shifted from a negative consequence to a positive consequence to not a consequence at all.

A Consequence of Feminism

Voluntary childlessness had been discussed as a consequence of feminism since the early 1900s, spiking first in the 1910s and then again in the 1970s. The scholarly conversation on voluntary childlessness quieted after World War II, with some articles tackling the increase in population (Woofter, 1949) and changing family forms (Hiltner, 1953). The topic reemerged in full force during the second wave feminist movement[1] of the late 1960s and 1970s, a movement that grew out of civil rights and demanded equality in the home and in the workforce. Although the two time periods attributed the declining birth rate to feminism, they are distinct in the message and the medium.

The rise in childlessness in the early 20th century was often discussed as a negative effect of feminism, where women were being "deprived of motherhood" (Commander, 1907, p. 273). Ethyl Colquhoun (1913), and anti-suffrage writer, considered feminism a threat to women's rights: "The true woman's movement must be one which . . . aims at strengthening woman in her normal sphere and developing her along lines suggested by her sex needs and characteristics" (p. 422). Proponents of women's movement that emphasized inherent sex differences over sex equality denounced voluntary childlessness as an unnatural choice that ultimately harmed women's rights in the domain of the home.

Those who viewed the decrease in childbearing as a negative consequence of feminism utilized media as a way to impel women to have children. Newspaper columns, "deploring the decay of the population," and magazine articles, "appealing to the patriotism of women," urged women to sacrifice their individualism for the selfless cause of nationalism (Hollingworth, 1916, p. 23). The medium of art has also been used to sustain the elevation of motherhood, including the representation of Madonna (Hollingworth, 1916). Favorable representations of motherhood created to

influence women's opinion became particularly important, for "childless marriages are more and more commonly idealized in works of fiction, in photodrama and other art products" (Snedden, 1929, p. 350). Although the dueling of representations of motherhood and non-motherhood initially served to perpetuate certain ideological agendas, the variety of representations likely opened up a space that normalized a multitude of possibilities for women whose sexuality was increasingly portrayed in a variety of mediated representations.

In the late 1960s and early 1970s, voluntary childlessness began to be talked about as a legitimate life choice in academic spheres, ultimately shifting away from the discourses of social responsibility and individual imperfection. In one of the first journal articles exploring voluntary childlessness from a positive perspective, Veevers (1974) suggested: "In terms of population policy, explicit attempts should be made to legitimize childlessness as a respectable alternative marriage form" (p. 405). The 1970s feminist movement facilitated a shift in thinking (Letherby, 2002) where not having children began to be considered as a socially responsible life plan because of growing population and environmental concerns (May, 1995).

A shift in language has also been attributed to feminism. In the 1970s, voluntarily childless individuals adopted the word "childfree" to denote themselves from "childless" individuals. The suffix *free* indicates agency and a freedom from a social obligation, where the suffix *less* indicates a lack. Interestingly, according to the Oxford English Dictionary, the first publication of the word "child-free" was in a 1913 issue of the *American Journal of Sociology.* In a section titled "Modern Feminism and Sex-Antagonism," Ethel Colquhoun, the anti-suffragist writer cited above, described how the current "admiration gained now by the child-free woman tends to demoralize women, otherwise contented with their normal functions" (Colquhoun, 1913, p. 422). The "normal functions," as outlined in Colquhoun's series of articles published in *Quarterly Review* and *Nineteenth Century,* urged women to "treasure [motherhood's] importance rather than succumbing to the selfish lures of university education and careerism" (Bush, 2007, p. 129). Regardless of its origins, the word childfree has come to represent a positive alternative to childless in the academic and popular vernacular of the 1970s (Veevers, 1980). More research into the word childfree is needed to understand its implications today, where not all voluntarily childless individuals consider themselves childfree (Moore, 2012).

Although feminism has opened up many possibilities for childbearing decisions within the scholarly community, popular media has been reluctant to attribute new reproductive freedom to feminism. In fact, many popular representations of women in the 1990s and 2000s can be considered postfeminist,[2] including *Sex and the City, Ally McBeal,* and *Bridget Jones'*

Diary, where feminism is seen as redundant (McRobbie, 2004). This shift from a negative consequence of feminism to a positive consequence of feminism to a postfeminist disregard for feminism has resulted in media representations that perpetuate the false notion that equal rights have been achieved and women can now have it all (Dow, 1996). The possibility for women to attain superwoman status has permeated public thought, subduing the cultural discourses of voluntary childlessness as a consequence of feminism. Very little mention of feminism's legacy can be seen in popular media today, though it is still acknowledged in scholarly writings on the topic. As postfeminist notions have overtaken popular media, a fourth and final discourse has begun to emerge. The discourse of *fulfillment without children?* permeates popular ideas of childlessness, revealing a more positive yet still contradictory understanding of voluntary childlessness.

Fulfillment without Children?

The discourse of a fulfilled life without children paralleled the discourse of a voluntary childlessness as a positive consequence of feminism in the 1970s. Scholars began to reconsider past notions of voluntarily childless women at the same time that social organizations for people without children began to emerge. One such organization was the National Organization for Non-Parents, founded in 1972, to provide a social outlet and socially responsible message about population control. NON was featured in four editions (three articles and one letter) of *Time* between 1972 and 1979 and gained considerable attention through a variety of media outlets (Behavior, 1972; Letters, 1972; Morrow, 1979; People, 1972).

A newspaper article by Yenckel (1979) in the *Washington Post,* titled "Private Lives: Childless by Choice," profiled multiple voluntarily childless individuals. The article described individuals' stories and included an interview with Houseknecht (1977, 1978, 1979), a sociologist who published many articles on the topic in the 1970s and 1980s. The article challenged popular myths of the time, including the perception that voluntary childlessness results in regret, dissatisfactory marriage, loneliness during the holidays, and an unfulfilled life. NONs purpose was not only to shift cultural perceptions about those who choose to never have children, but also to encourage all individuals to seriously consider the possibility of not having children. NON distributed a pamphlet entitled "Am I Parent Material?" that asked questions like "What do I want out of life and myself?" and "How would a child interfere with my growth and development?" (Yenckel, 1979). Although NON gained considerable media attention during the 1970s, the previous discourses surrounding voluntary childlessness continue to linger into the present in the form of increasingly subtle stigma.

Research in the last two decades has begun to illuminate a changing perception, especially among convenience college samples. Voluntarily childless women in romantic dyads were once rated as less caring and less driven than involuntarily childless women or mothers, and less emotionally healthy than mothers (Lampman & Dowling-Guyer, 1995), and perceived as less well-adjusted and liked less than involuntarily childless wives (Calhoun & Selby, 1980). These perceptions may be changing. Koropeckyj-Cox and colleagues (2007) conducted a vignette experiment on undergraduate students, revealing that childfree couples were rated highly on relational quality; however, childfree couples were also rated more negatively than involuntarily childless couples or parents, indicating the persistence of stigma.

Research on actual outcomes of choosing childlessness indicates that voluntarily childless individuals are not so different from parents. In elderly populations, childlessness is not associated with loneliness or depression, but gender and marital status is (Bures, Koropeckyj-Cox, & Loree, 2009; Zhang & Hayward, 2001). Older childless adults also benefit from significantly more income and wealth than their parental counterparts (Plotnick, 2009).

The publication of numerous articles, including many personal narratives, in popular magazines and newspapers illustrates the increasing acceptance of voluntary childlessness. Excerpts from Pamela Haag's book, *Marriage Confidential,* in *Time* (*Time* staff, 2011); blogs in the *New York Times* (Parker-Pope, 2011; Segboer, 2011); and first-person narratives of choosing childlessness and in *Salon* (Shoot, 2010; Tsigdinos, 2011) display this trend. Voluntary childlessness has likely become more legitimate because it has become associated with other growing movements, including environmentalism. A December 2011 article published in the *Huffington Post* details a married couple's reasons for remaining childless (Harte & Harte, 2011). The authors cite new research on how having one child increases each parent's lifetime carbon emission legacy by nearly six times (Murtaugh & Schlax, 2009). Framing their choice to never have children in terms of climate change legitimizes their decision by simultaneously refuting the discourse of social irresponsibility and individual imperfection for not having children for environmental reasons is both socially responsible and selfless.

Considering the interplay between each of the aforementioned discourses opens up new questions about women's sexual identities. Are certain groups of women expected to have children more than others? How is pronatalism manifested today? What are the identity implications for women who choose childlessness today? And how has the Internet changed the landscape of cultural discourse? These questions are considered in the next section, followed by a discussion of theoretical implications, practical implication, and directions for future research.

IMPLICATIONS FOR TODAY

Pronatalism has never been true to its etymology. Pronatalism has, and continues to be, a force that burdens certain women more than others. Societal expectations for who should and who should not procreate were clearly named by academic authorities and penetrated the public through various popular media representations. As some individuals began to challenge the prescribed role of motherhood through fiction and art (Snedden, 1929), women had a greater repertoire of representations to align with, ultimately leading to feminist scholars adopting voluntary childlessness as a legitimate life choice. Academic and popular discourses eventually began to shift toward considering the possibility of having a fulfilled life without children, regardless of social status.

However, the fulfilled life discourse, identified in this analysis, ends with a question mark to indicate the subtle differences that exist across perceptions of women without children. One of the greatest criticisms of feminism is the invisibility of women of color, lesbians, and women with disabilities (Thornham, 2006). Like most research on women, the topic of voluntary childlessness has focused primarily on white, straight, married women. Considering the few research studies on the perceptions of voluntarily childless women outside this demographic, the discourses of social irresponsibility and an individual imperfection still linger today.

Recent research exploring intersections of voluntarily childless identities indicate that heterosexual white women face the most pronatalist pressure to have children. In a study on Australian students' attitudes toward parenting decisions, heterosexual childfree women are seen as more happy, mature, and individualistic than mothers, while childfree lesbian women are seen as less happy, mature, and individualistic than lesbian mothers (Rowlands & Lee, 2006). Heterosexual African American women who choose childlessness also continue to be perceived more negatively than heterosexual white women (Vinson, Mollen, & Smith, 2010), demonstrating a subtle but persistent cultural belief that certain women should be having fewer children.

Concern over the dwindling "White America" has also been evoked in popular news media recently. In January 2012, Pat Buchanan, a conservative commentator and politician, was suspended indefinitely from his broadcasting job at MSNBC when he commented on his latest book, *Suicide of a Superpower* (Buchanan, 2011). Buchanan's comments would have been in line with scholarly and public thought during the first half of the 20th century; but in contemporary society, they were not tolerated by mainstream media. In *Suicide of a Superpower,* Buchanan (2011) writes that having fewer children "means a more rapid death and disappearance of Western man" (p. 189). He continues: "The child-centered society has been succeeded by the self-centered society" (p. 188), and the "rise of the

egalitarian society means the death of the free society" (p. 207), reiterating the previously popular discourses of individual irresponsibility and negative consequence of feminism. His remarks are eerily similar to those of eugenicists at the turn of the 20th century. Regardless of Buchanan's indefinite suspension from MSNBC, the book reached number four on the *New York Times* best sellers hardcover nonfiction list (Best sellers, 2011), indicating that some Americans are open to Buchanan's thoughts on the future of the United States.

The changing discourses surrounding voluntary childlessness shift and recycle over time, paralleling the sociopolitical climate of the West. Each discourse, identified in this review, remains in some capacity today. These discourses, perpetuated through media, have multiple identity implications for women. Economic pressure to attend college and enter the workforce paired with the trend of postponing (or forgoing) marriage has made it impossible for women to fulfill the superwoman ideal. Some women have managed this cultural pressure to do it all by rejecting motherhood altogether (Kelly, 2009). The rise of popular media depictions of voluntary childlessness as a legitimate life choice paved the way for a childless life. Although NON disbanded in 1982 after changing its name to the National Alliance for Optional Parenthood in 1978 ("National Alliance," n.d.), voluntarily childless women—and men—can now cultivate their identities through Internet support groups and online resources, closing the geographic gaps that have previously prevented local social organizations from flourishing.

Internet media has become central to the identity construction for many voluntarily childless individuals. The *Childfree* LiveJournal community boasts more than 7,000 members and the *Childfree Life* forum houses more than 2,000 members. Internet media, unlike mass media, allows people to connect with each other and cocreate childfree identities (Moore, 2012). Little research has been conducted on the online identity formation of voluntarily childless women. At least one study suggests that some childless women adopt an online identity that defines themselves in terms of children (specifically as "Savvy Aunties") to the detriment of their own adult relationships (Hayden, 2011). This occurs because the discursive space women reside in continues to conflate woman with mother (Hayden, 2011). More research is needed on childfree-specific online spaces to begin to understand the role Internet media plays in the identity construction of voluntarily childless women.

Theoretically, this research has multiple implications for understanding voluntary childlessness from a historical perspective. This analysis demonstrates that cultural discourses ebb and flow with sociocultural events (such as World War II, feminist movements, and the advent of the Internet), and can be understood through close examination of scholarly literature and popular mediated representations.

Practically, this analysis sheds light onto the historical uncertainty women have endured during public intrusion into their private, reproductive choices. Women continue to bear the burden of societal success, as evidenced through the resurgence of social irresponsibility discourses from conservative political figures. Furthermore, women do not simply endure pressure to have children; they face pressures to have a certain number of children, conceive them in a certain way, and raise them in a certain way. Many lessons can be learned about the cultural burden placed on women by reflexively considering how the past continues to influence today.

Future avenues of research include the exploration of the mediated representations of, media consumption by, and participation in Internet media by voluntarily childless women and men. A few studies have explored the representation of voluntary childlessness in nonfiction print media (Chancey & Dumais, 2009; Giles, Shaw, & Morgan, 2009), but one area that is severely lacking is analysis of the fictional representation of women who choose childlessness in books, television, and film. Such representations are limited but do exist, including satirical depictions in a 1996 episode of *Seinfeld* (Mehlman & Ackerman, 1996) and a 2004 episode of *The Simpsons* (Vitti & Anderson, 2004). Future research may consider detailed accounts of popular media by conducting close readings, rhetorical analyses, or content analyses to understand how voluntary childlessness is framed in popular, contemporary media.

In addition to considering single episodes, books, or films, our understanding of cultural discourses surrounding the experience of individuals who are voluntarily childless may be enhanced by a general overview of prime time television or major motion picture representations of voluntary childlessness through content analyses of multiple texts. Childless characters and mothers could be coded for actions and personality traits to compare the mediated representation to social perceptions and realities of childlessness. A study, such as this, would complement previous research on cultural discourses of motherhood, voluntary childlessness, and sexuality, affirming the link between discourse, public thought, and media.

Scholars may also wish to explore the implications voluntary childlessness in postfeminist culture. Of the discourses identified in this analysis, a condition of feminism seems to be absent from popular media today but still discussed in academe. Do younger voluntarily childless women associate their decision with feminism? Are current mediated representations in line with postfeminist thought? Qualitative or quantitative analyses may be conducted to consider how gender, sexuality, and parenthood are conceptualized by individuals. This would lend insight into the ways in which scholarly and popular notions of the history of voluntary childlessness differ.

In sum, the possibilities for understanding voluntary childlessness in today's culture are expansive and relevant. Current concerns about the economy and the environment open up new possibilities for reconstructing women's sexuality. The rising cost of raising children paired with declining natural resources may soon disconnect the interconnectedness of womanhood and motherhood, allowing women to make decisions about childbearing with less pronatalist pressure. Until women's sexual identity is untangled from motherhood and women of all races and abilities are considered fit to have children, women will continue to be subtly stigmatized for their reproductive choices and failure to achieve "superwoman" status.

NOTES

1. Second wave feminism: Second wave feminism spanned from the late 1960s until the early 1980s. It is characterized by multiple internal divisions; however, as a whole, second wave feminism was characterized by demand for equal pay, equal education, and access to contraception and abortion (Thornhan, 2006, p. 27).

2. Postfeminism: As defined by Rosenfelt and Stacey (1987), "postfeminism demarcates an emerging culture and ideology that simultaneously incorporates, revises, and depoliticizes many of the fundamental issues advanced by Second Wave feminism" (p. 341). The nature and scope of postfeminism continues to be debated (see Gamble, 1996).

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Chapter 14

Women, Erotica, and Pornography

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Women's thoughts and feelings about and sexual responses to erotica and pornography have been the subject of numerous investigations over the past five decades (e.g., Izard & Caplan, 1974; Rupp & Wallen, 2008). More recently, the impact of pornography on women's sexual relationships, beyond these internal individual reactions, has begun to be explored (e.g., Bridges, Bergner, & Hesson-McInnis, 2003; Russell, 1988; Senn, 1993b; Shaw, 1999; Shope, 2004). Theoretical contributions and empirical investigations across this period come together to demonstrate that while there are many similarities between women and men, women's consumption patterns, physical and psychological reactions, and sexual relationship experiences related to erotica and pornography are not directly parallel to men's.

Understanding women's thoughts about and emotional responses to sexually explicit materials is increasingly relevant. The adult sex industry has grown exponentially with technological advances, with annual sales of more than 12 billion dollars (AVN, 2006). The United States produced more than 13,000 adult videos in 2005, an increase of 60 percent over a 10-year

period. Major corporations now invest in or distribute adult materials (PBS, 2011). Entire movie studios have been created that specialize in adult entertainment. Moving from print to video to the Internet, materials have become increasingly diverse, much less expensive, and much easier to access (Barron & Kimmel, 2000; Cooper, 1998). In particular, the invention of home entertainment devices, such as VHS and DVD players, have led to increasing numbers of people exposing themselves and others to explicit material; the ability to do so in a private setting has reduced a significant access barrier and virtually eliminated concerns people may have had about being seen in a sex store. The internet has also blurred the boundaries between consumers and producers: now anyone with a digital camera can quickly create an explicit video or photograph and upload it to a private or commercial website. This boundary blurring also means that sexual materials created in one context (e.g., with a romantic partner as part of lovemaking) can now be distributed in ways that are more public, even without the actors' consent. (Recent media scandals involving sex tapes released by past partners, such as those of Paris Hilton, Pamela Anderson, and Kim Kardashian, illustrate this point well.)

In this chapter, we review literature related to women and sexually explicit materials. We begin by distinguishing between erotica and pornography, and describe women's thoughts and emotions associated with each. We turn next to the effects erotica and pornography have on women's sexual responses. We then describe patterns of women's experiences with sexually explicit material, focusing in large part on why women's usage rates are lower than those of men and how sexually explicit materials impact women's romantic relationships. We end with some concluding remarks summarizing the research on women, erotica, and pornography, and recommendations for future studies.

PORNOGRAPHY VERSUS EROTICA

Attempts have been made to categorize the universe of sexually explicit materials into subgroups. For instance, some researchers have been concerned with whether the materials show explicit sexual acts or penetration (hard core materials) versus nudity (soft core materials; Winick, 1985). Others have focused on the medium of the materials, such as whether participants consumed explicit novels, magazines, or videos (Lawrence & Herrold, 1988). However, it has not always been clear that these distinctions were relevant for women's experiences with these materials. One exception is the distinction between materials made by men for male consumption and those made by and for women (e.g., Laan, Everaerd, van Bellen, & Hanewald, 1994). Specifically, although both types may contain similar sexual activities, women-made erotica is said to differ from man-made materials by settings (e.g., an elevator vs. a brothel), camera angles

(e.g., long shots vs. close-ups of genitalia), and presence and length of foreplay.

Now, with a base of research to support the distinction, two general groups of sexually explicit materials are recognized. One, pornography is focused on the combination of sexual explicitness with violence and/or degradation. Russell (1993) defined "pornography as material that combines sex and/or the exposure of genitals with abuse or degradation in a manner that appears to endorse, condone, or encourage such behavior" (p. 2–3). In contrast, erotic materials contain no degradation, violence, or dehumanizing and sexist content. Instead, they focus on egalitarian depictions of sexual activity between consenting adults (Steinem, 1980).

Senn and Radtke (1990), building on Steinem's (1980) and Check's (1984; cited in Check & Malamuth, 1986) research with men, distinguish between three types of explicit materials: violent and sexist pornography, nonviolent but sexist and dehumanizing pornography, and nonviolent/nonsexist erotica. Importantly, the authors argue that it is not the nature of the *sexual* acts portrayed in adult materials that make them pornographic, violent, or degrading; rather, the presence of inequality, submission, and implied or actual violence matters. In their research, they found high agreement among female raters who were categorizing a series of magazine images according to these three definitions. They also found that both violent and nonviolent but sexist pornography resulted in increased negative mood in women after they viewed a series of such images. In contrast, erotic (nonsexist and nonviolent) images and scenes of nature did not negatively impact mood. Similar findings were obtained in a follow up study (Senn & Desmarais, 2004): women viewing pornography (both violent and nonviolent) reported a dislike of the images and experienced an increase in negative mood, while women viewing egalitarian erotica reported higher liking of the images and increased positive mood. Interestingly, the greatest variations between women in their responses occurred for the erotic images, likely because once reactions to the sexist or violent content is not present, differences in attitudes toward whether sexual imagery is acceptable or not could emerge. In fact, Senn's (1993b) later findings of a distinctly conservative perspective held by a subgroup of religious and nonreligious women (which we review in greater detail in a subsequent section) support the notion that reactions to erotica, more than pornography, are driven by beliefs and attitudes toward sex.

Studies of the effects of pornography highlight the importance of distinguishing between materials that are degrading and/or violent (hereafter referred to as *pornographic*) and materials that depict sexual exchanges between equals (hereafter referred to as *erotic*). Senn and Radtke's (1990) study supported the negative impact pornographic images had on women's mood, while erotic images improved mood. Others have found distinctions between the effects of erotic and pornographic materials, too. For instance,

Golde, Strassberg, Turner, and Lowe (2000) had men view one of four types of films: degrading and sexually explicit, nondegrading and sexually explicit, degrading but not sexually explicit, and nondegrading and nonexplicit. Following the film, participants completed questionnaires assessing attitudes toward rape. They found that participants in the two degrading film conditions reported significantly higher rape supportive attitudes than participants in the other two conditions. Their results suggest that the sexual explicitness of films is not what leads to negative effects; rather, the presence of inequality and degradation or sexism within videos is problematic.

Given the importance of degradation in explicit materials, Cowan and Dunn (1994) conducted a study to see which aspects of explicit materials in particular lead to perceptions of these materials as degrading. The researchers had both male and female participants view brief film clips from explicit videos and rate each on a number of adjectives, including how obscene, offensive, disgusting, dehumanizing, degrading to women, and aggressive the films were. These were combined into a single measure of degradation. They found that videos in which women were treated as objects rather than people, where one person is issuing commands or orders to another person, and where men ejaculate on women (particularly on their faces) were rated as most degrading by both men and women than videos with themes such as sex that is one-sided, where one person's pleasure is the focus while the other's is not, or films that showed unequal status among characters (such as a young woman and an older man). In short, active subordination and objectification were critical to perceptions of degradation in these explicit films.

Commonly available sexually explicit materials tend to be almost entirely those which are pornographic by these definitions (i.e., material that is degrading, sexist, or even violent). A recent content analysis of popular adult films found more than 60 percent of scenes coded had male characters ejaculate on women's faces, 49 percent had one character insult another (e.g., calling someone a bitch), and 41 percent included one character slapping another (Bridges, Wosnitzer, Scharrer, Sun, & Liberman, 2010). Importantly, nearly all aggressive acts (both verbal and physical) were perpetrated by men on women.

In review, while many attempts have been made to subcategorize sexually explicit materials, the critical distinction that arises in both theoretical discourse and experimental studies is whether the material contains themes of violence and/or degradation. As we briefly reviewed above and see in the following section, it is not the sexual acts themselves that appear critical to understanding women's thoughts, feelings, and sexual arousal to explicit materials; rather, it is the extent to which such materials show women as less than human, objects to be used, and as second-class citizens. To the extent that they are degrading and violent, women

(understandably) report greater dislike for and more negative emotions in response to pornography than to erotica. However, emotional responses to explicit materials are not synonymous with sexual responses. We, therefore, turn to women's sexual arousal in response to pornography and erotica.

WOMEN'S SEXUAL RESPONSES TO EXPLICIT MATERIALS

A number of researchers have investigated women's sexual responses to both pornographic and erotic stimuli (as defined above) in order to understand women's sexuality better. In fact, utilizing sexual media as research stimulus materials may be the most common method for gathering real-time data on women's sexual responding. These sorts of studies typically involve bringing women into the laboratory, showing them pictures or movies, or having them read written passages that are sexually explicit. In an effort to measure sexual responding to visual materials, these studies focus almost exclusively on various factors related to sexual arousal.

Understanding how women respond to different types of sexual media is complicated by the vast differences in types of sexual responding for women during arousal. Specifically, measuring and defining responses that would typically be associated with sexual arousal, an appetitive desire for or at least openness to sexual activity, have been the subject of debate within the field of sexology. Studies examining women's sexual arousal have relied on two very different forms of measurement: physiological measures (including galvanic skin response and heart rate, but more commonly vaginal blood volume or pressure pulse and labial temperature) and women's self-reported sexual arousal. Stated differently, studies of women's sexual responses to explicit materials have concerned themselves with body indicators of arousal (physical arousal) or women's perceptions of their arousal (psychological arousal). Despite a relatively recent recognition by many scholars as to the multifaceted and complex nature of sexual responding during arousal (e.g., Basson et al., 2003), these two forms have often been mischaracterized implicitly or explicitly as representing real and perceived sexual responding. The presumption, then, has been that the two should be synchronized, as they are more frequently in men.

In fact, it is most often the case that women's physical and psychological arousal are not in complete agreement, or concordant (e.g., Laan & Everaerd, 1995). This discordance, in turn, has been thought to represent some sort of dysfunction in the sexual response cycle. For example, researchers hypothesized that these discordant women were more likely to be unaware of their own bodies (e.g., Morokoff & Heiman, 1980), were anxious about sexual content and concerned about appearing interested

in sex (e.g., Palace & Gorzalka, 1990), or had better cardiovascular fitness (Brody, 2006), or had less sexual experience (Brody, 2007). While some of the reasons for differences between physical and psychological arousal may be due to sexual experiences or sexual functioning, many scholars argue and provide evidence that variability in women's sexual responses to explicit materials cannot be understood as wholly a product of sexual functioning (Basson et al., 2003; Byrne, Fisher, Lamberth, & Mitchell, 1974; Chivers & Bailey, 2005; Laan & Everaerd, 1995; Senn, 1993a). This may be especially true given that PDE inhibitors (the class of drugs that increase genital blood flow, like Viagra) have not been shown to be effective in women with arousal or desire dysfunctions (Mayer, Stief, Truss, & Uckert, 2005).

Perhaps, most problematic for using physiological measures to understand women's responses to different types of sexual media is that these physiological responses appear to be automatic or reflexive to a variety of nonspecific stimuli (Chivers & Bailey, 2005; Laan & Everaerd, 1995; Ponseti & Bosinski, 2010; Suschinsky, Lalumiere, & Chivers, 2009). For instance, vaginal blood flow increases when watching videos of nonhuman primates engaging in sexual acts (Chivers & Bailey, 2005), during subliminal priming of nude female images in a heterosexual sample (Ponseti & Bosinski, 2010), while viewing two women engaging in sexual acts in a heterosexual sample (Chivers & Bailey, 2005), while watching sexual media of physically forceful sexual encounters (e.g., Laan & Everaerd, 1995), and even when watching depictions of rape (Suschinsky et al., 2009). In each case, and quite unsurprisingly, women reported low subjective arousal to these visual materials. Nevertheless, measures of vaginal blood flow or vaginal pulse amplitude increased. In other words, in large samples of mostly sexually functional females, self-report and physiological arousal were discordant and subjective measures of arousal seemed to be better measures of the appetitive features in these visual stimuli than physiological measures. Furthermore, a tremendous amount of research exists regarding the confusing but somewhat frequent phenomenon of lubrication (lubrication is achieved through increased vaginal blood flow and volume) during rape (for a review, see Levin & van Berlo, 2004), and draw attention to the low reliability of physiological arousal as an indicator of subjective sexual arousal.

Exciting research using brain imaging technologies have also illuminated the differences in how men and women process sexual stimuli. For example, a study on brain activation during genital stimulation found women exhibit less activation in areas related to bodily awareness than do men, but evidence a greater amount of activation in areas related to complex problem solving and information integration (Georgiadis, Reinders, Paans, Renken, & Kortekaas, 2009). This occurred even in women who achieved orgasm. In other words, these data suggest that arousal, even in

completely sexually functional women, consists of much more than just bodily arousal. Data such as these suggest that, at minimum, subjective forms of sexual arousal must be measured in conjunction with physiological measures in order to understand the impact of sexual materials on women.

In short, one cannot infer the totality of sexual arousal from genital measurements in women. However, a concern researchers have had in utilizing women's self-report of their sexual arousal has been that self-report is subject to biases and misrepresentations. For many reasons, it is possible that women would not be forthright regarding their arousal to sexual media in scientific studies. The alternative, to rely on physiological measures of sexual arousal, is nevertheless more problematic. If researchers use physiological measures as the true or pure measure of sexual arousal in women, they are likely to conclude falsely the effects of sexually explicit materials or what sorts of sexual media women "really" like.

Without knowledge about the relatively independent mechanism of physiological arousal (and its relative lack of concordance with subjective sexual arousal), women who experience physiological arousal during situations where disgust, fear, or anger is their prominent emotional response may be particularly confused and distressed. This is certainly true in cases of rape. In response to the conflict between physiological arousal and negative emotions, women may convince themselves that they must have been aroused, truly, for why else would their body respond in this way? From a scientific perspective, a lack of appreciation for the discordance between subjective and physiological arousal in women could lead to false conclusions regarding the sorts of sexual stimuli that result in appetitive sexual responses.

As a whole, research finds significant differences between what stimuli men and women find sexually arousing. Early hypotheses regarding these differences proposed that women would be cued more by romantic (i.e., relational) than sexual (i.e., purely physical) elements of sexually explicit scenes (Fisher & Byrne, 1978; Schmidt, 1975). Data suggested that women's subjective sexual arousal is more highly determined by relationship context and other external environmental cues than men's arousal (Laan & Everaerd, 1995). For instance, many studies suggest that women's subjective arousal is better predicted by the relationship between the actors who are depicted (Chivers & Bailey, 2005; Kelley & Musialowski, 1986; Mosher & MacIan, 1994; Ponseti & Bosinski, 2010; Rupp & Wallen, 2007a, 2008, 2009; Suschinsky et al., 2009) rather than the sexual acts portrayed within the explicit material. Although not well-controlled for content, early studies suggested that women favored sexual media containing more relational components, where the actors appeared more caring toward each other, than sexual media that contained fewer relational components and less caring (e.g., Mosher & MacIan, 1994). Kelley and Musialowski (1986)

found that after repeated exposure to a sexually explicit film depicting a man and a woman engaging in sexual intercourse, heterosexual women responded with higher subjective sexual arousal to a second film that portrayed the same actors engaging in novel sexual behaviors with one another, while heterosexual men responded more to a novel film that portrayed new actors engaging in the same sexual behaviors. The authors suggest this is because women were more aroused by depictions that suggested a continued relationship between the actors.

When viewing sexually explicit materials, women tend to focus on different content than do men. Rupp and Wallen (2009) found that women reported greater arousal to sexual media in which genitals occupied less space, allowing for other factors, such as scene setting to be visible, than when close-ups of genitalia were present. They also reported greater arousal when the characters appeared to be in a relationship (for instance, when the woman's gaze was directed toward her partner) than when the female actress appeared to be focused on the viewer (i.e., when the female gaze was directed toward the camera and not the other actor).

In a different study, Rupp and Wallen (2007a) found women look more often at the background and peripheral parts of images (i.e., cues for the setting of the sexual act depicted) and clothing of actors than do men. In contrast, men spend most of their viewing time looking at exposed body parts, particularly genitalia. These gender differences in gaze were evident even though both men and women reported subjective sexual arousal to the images. In a similar study using eye-tracking technology, Lykins, Meana, and Strauss (2008) found these gender differences in gaze were evident even when both men and women reported similar subjective sexual arousal to the images.

Studies that examine women's arousal to pornography, rather than erotica, consistently find women report low or no subjective arousal to violent and degrading sexual imagery (Ponseti & Bosinski, 2010; Suschinsky et al., 2009), although physiological indicators may suggest otherwise. In many cases, women also report negative emotions, such as disgust, to pornography (Koukounas & McCabe, 1997; Senn & Radtke, 1990). Thus, when caring relationships between the characters portrayed in sexually explicit materials seem implausible (due to the violent nature of their sexual interactions), women report fewer arousal responses.

One question we might ask is whether women's responses to sexually explicit images, reviewed above, are specific to sexual imagery or whether they are similar to women's responses to sexual stimuli of all kinds (including a partner's touch or masturbation). Do women also attend to contextual cues more than bodily sensations in these other contexts? Investigations of brain activation during sexual stimulation provide insights into this question. In one study, researchers examined the neural responses of men and women during sexual stimulation (these authors did

not distinguish between the often used distinction of arousal and plateau phases of sexual arousal) and orgasm (Georgiadis et al., 2009). During the arousal phase (which would be most comparable to studies that explore women responding to sexually explicit imagery), women exhibited less neural activation in brain areas associated with awareness of bodily sensations (e.g., insular cortex) than did men. Instead, women tended to experience increases in brain areas associated with attention, concentration, and higher order problem solving (i.e., frontal gyrus). This suggests that women attend more to a variety of stimuli, rather than just genital sensations, than do men during any type of sexual stimulation and not just during viewing of erotica and pornography.

When taken as a whole, some conclusions can be drawn from research on sexual responses to explicit materials. Both heterosexual men and women show highest genital arousal to explicit images (e.g., close-up views of genitalia or explicit sexual intercourse), with less arousal responses found for auditory or imaginal exposure (Heiman, 1980; Laan & Everaerd, 1995; Stock & Greer, 1982). The evidence for how women respond to visual sexual stimuli may add to the explanation for lower usage rates, as most produced and marketed pornography tends to include depersonalized images that focus more heavily on genitals or degrading images of women (Bridges et al., 2010). When erotic materials include more relational components, women do tend to respond favorably. As Rupp and Wallen (2008) note in a recent review of this topic, the differences in arousal responses for men and women to sexual media may reflect a bias in the sexual materials that are produced. Women may become similarly aroused by visual materials as men when the sexual media include content that fits the criteria, described above, to increase female sexual arousal. That said, there may still be a difference between men and women in sexual material consumption and interest as these tend to increase with greater levels of testosterone (Rupp & Wallen, 2007b). Thus, while there may be some sex differences in responses to sexual media, negative responses to these media by women do not appear to be a product of the sexual content, but rather the demeaning and, at times, violent content of most sexual media.

WOMEN'S EXPERIENCES WITH SEXUALLY EXPLICIT MATERIALS

While recognizing the role of context in women's arousal, all of the research cited so far has been done in laboratory settings, for the most part ignoring the complicated ways in which sexually explicit materials are implicated in women's lives. Therefore, we turn now to exploring women's experiences with pornography and erotica: How are these materials present in their personal lives, particularly their intimate relationships?

Starting with Kinsey's seminal work (Kinsey, Pomeroy, Martin, & Gebhard, 1953), researchers have found consistently that women view sexually explicit materials less often than do men. Despite a sexual revolution, a civil rights movement, second and third wave feminism, and astounding technological advances, such as the invention of the personal computer, internet, and smart phones, and despite claims of the media and the pornography industry to the contrary (e.g., Blue, 2009; Carey, 2011), Kinsey's findings are as true today as they were six decades ago (Bridges & Morokoff, 2011; Carroll et al., 2008). Men remain the major consumers of all forms of sexually explicit materials, with one important exception: women consume romantic and erotic novels in far greater quantity than do men (Salmon, 2004).

A number of reasons for the gender difference in pornography consumption have been proposed. Some have argued that there are biological or evolutionary reasons. For example, Hamann, Herman, Nolan, and Wallen (2004) find evidence for gender differences in activation of certain brain regions in response to viewing explicit images. In general, men's brains respond with greater activity to pictorial depiction of sex than do women's. Malamuth (1996) suggested that the different mating pressures faced by men and women may account for differences in adult material consumption. Specifically, evolutionary explanations suggest that men had to be ready to respond quickly to visual cues from women that they were ready and willing to engage in intercourse. In contrast, women's fertility is more cyclical and, in general, women act as sexual gatekeepers: usually avoiding the risk of pregnancy except during their most fertile times, when they would be searching for a suitable mate who could provide both a healthy child and resources for the family. Although evolutionary explanations for sex differences in response to explicit material have proliferated in the past decade, scientific evidence supporting them remains sparse and the problematic heterosexist assumptions beneath them unchallenged.

A second explanation offered for the differences between men's and women's consumption of explicit materials is gender role socialization (Beggan & Allison, 2003). Theories about the repressive way women were socialized vis-à-vis their sexuality arose during the sexual revolution in the 1970s and were important in helping society understand the role of nurture in women's sexual functioning. These theories called attention to the ways in which little girls and women were rewarded or punished for certain behaviors. In particular, women who demonstrated a high interest in sex (whether it was frequency, variety, or fantasy) were often subtly or overtly put down, labeled negatively (such as being called a whore), or made to feel ashamed (e.g., Friday, 1973). Although increased attention to the role that socialization plays in women's sexual behavior has enhanced our understanding greatly, even when encouraged to abandon such stereotypes or when raising girls to be more expressive, there remain gender differences in explicit material consumption.

Yet another explanation comes from the field of communications, where researchers began to ask questions about what the content of explicit materials looked like and how that content, or the stories that were told in these materials, might relate to their appeal (or lack thereof). Out of a body of work examining media scripts, we learned that most pornography tells a story about sex that occurs outside the context of a committed relationship, among strangers, in a way that puts one group (men) in control of another group (women). Women are often portrayed as sexually insatiable, always eager for rough sex with many men, and as orgasmic responders to men's penises and, in particular, ejaculate (Brosius, Weaver, & Staab, 1993; Cowan, Lee, Levy, & Snyder, 1998). However, Senn and Radtke (1990) and Glascock (2005) demonstrate that many women respond negatively to such portrayals. For instance, Bergner and Bridges (2002) found many women involved with men, who are heavy pornography users, report in online forums that they experienced a sense of not measuring up to sexual and beauty ideals portrayed by women in pornography. Similarly, using focus group discussions, a sample of 30 young women reported concerns about being compared unfavorably to women in pornography by their male partners (Boynton, 1999). These recent qualitative studies with women support what Weaver, Masland, and Zillmann (1984) found in their experimental studies with men many years ago: pornography can interfere with men's judgments of their own sexual partners.

If sexual scripts in pornography help account for gender differences in explicit material consumption, then perhaps scripts that better fit women's ideals result in increased demand by women. Certainly, the adult industry has been working aggressively to increase its consumer base by developing and promoting materials toward women and couples. Beggan and Allison (2003) report on methods one female pornographer uses to increase the appeal of her films for women. The authors note that these films often include sex taking place within long-term romantic relationships, a greater focus on kissing and caressing than best-selling pornographic videos (e.g., Bridges et al., 2010), and avoidance of potentially degrading practices, such as anal sex or focusing on the male characters' ejaculation. While some laboratory studies do show women's subjective sexual arousal is greater for erotica than pornography (e.g., Laan et al., 1994), in general, attempts to create a market of explicit materials for women have been unsuccessful.

The fact that Vivid Entertainment Group, a company that produces sexually explicit films, has marketed many of their films to couples is interesting, and consistent with a new but growing body of research that documents contextual factors impacting women's use of adult materials. Specifically, studies are increasingly showing that when women choose to view explicit material, it most often occurs with a romantic partner (Bridges & Morokoff, 2011; Daneback, Træen, & Månsson, 2009). Recent surveys of college stu-

dents show that while 94.7 percent of men and 61.4 percent of women have viewed sexually explicit materials, only 9 percent of these male users do so with a romantic partner, while nearly one-fourth (22%) of female users regularly view with a romantic partner. Additionally, 31.4 percent of college women report that their partners have asked them to view an explicit film, although 7.5 percent refused such a request (Bridges, 2010).

It is important to separate women's purposeful consumption of explicit materials, which a minority of women engage in on a regular basis (Carroll et al., 2008), from having seen pornography, which most women have, both within the context of heterosexual relationships (consensual and nonconsensual) and in the regular activities of their daily lives (e.g., at parties, in the work place, pop-ups on computers, etc.) (e.g., Bridges, 2010; Senn, 1993a, 1993b; Shaw, 1999). A survey conducted by one of the authors finds that 90.4 percent of women have seen sexually explicit material, but that nearly two-thirds (61.7%) of these exposures were accidental or passive rather than having been actively sought (Bridges, 2010). Indeed, exposure to explicit images in the workplace is considered a form of sexual harassment and approximately half of employees in companies in the United States, Great Britain, and Australia report having experienced this (Sullivan, 2004).

Despite what the above review of physiological and subjective sexual arousal suggests, not all women respond in the same way to sexually explicit materials. In fact, there is considerable heterogeneity. While there are no single studies, yet, examining these various factors together, differences between women's responses to sexually explicit material may be due to early childhood sexual experiences (positive and negative), sexual socialization, sexual education, adolescent and adult sexual experiences (again, positive and negative), attitudes and beliefs, and the quality of the romantic relationship. Senn's (1993b) study of women's varied perspectives on pornography found many commonalities between women, but differences in their prior exposure to explicit materials, their willingness to be involved in partnerships where pornography was consumed, their beliefs about legal controls of explicit materials, and their beliefs about the relationship between the role of messages found in such media on their sexuality and relationships, among other factors. In her mixed method research, Senn found women could be clustered according to their views on pornography. For instance, one group of women held negative attitudes toward pornography, have had a lot of exposure to it in their lives, and have trouble avoiding it. These women find such images particularly disturbing because they degrade or depict violence against women while simultaneously creating unrealistic beauty standards against which women in real life cannot easily compete. Many of these women had been involved with a man who used pornography, an experience that was generally perceived negatively. A second group of women also held negative views of pornography, but primarily from a belief that sexually explicit materials of all

kind were immoral. These women avoided pornography (and had no difficulties doing so), saw themselves as different from female pornography actresses, and had relatively little experience with explicit media (either personal use or a partner's use). A third group of women also focused on the negative effects of pornography, but primarily concerned themselves with the need to protect children and young adults from highly sexualized imagery. These women had little personal experience with pornography, but may have been in relationships with men who did consume it. Importantly, and in contrast to the first group of women, their male partners were not using pornography to harm or intimidate their female partners. Finally, a fourth group of women expressed ambivalence or mildly positive views about pornography. In general, these women had not seen a lot of pornography themselves, although the experiences they had were generally positive and arousing. (Senn later hypothesized that these women may have been using erotica rather than violent or degrading pornography.) They experienced a conflict between thoughts on the one hand that this was normative and acceptable behavior, while on the other hand having mixed emotions about pornography (particularly a partner's use). Like this fourth group of women, Ciclitira (2004) interviewed 34 women in Great Britain regarding their experiences with and perceptions of pornography. In general, women reported holding conflicting views: on the one hand, most found it to be degrading or problematic, particularly regarding its messages about women. On the other hand, women sometimes reported being sexually aroused by these images.

One important reason why women may respond more negatively to pornography than do men (or why women's responses are so varied) is that for many women pornography has been used in conjunction with or as a form of violence against women. While feminists have long argued, and research is clear that simplistic causal relationships between pornography cannot be upheld (in contrast to the powerful earlier slogan by Robin Morgan: "Pornography is the theory, Rape is the practice"), there is evidence of relationships between men's pornography consumption and their attitudes, beliefs, and sexual behavior (see Malamuth, Addison, & Koss, 2000, for one such review; and Russell,1988, and Malamuth, 1998, for comprehensive theoretical models), which then have an impact on the sexual lives of women they are involved with. Qualitative research with women has provided evidence that pornography is directly implicated in harms some women experience in their sexual relationships with men (e.g., Bergen & Bogle, 2000; Russell, 1988; Schwartz & DeKeseredy, 1998; Shaw, 1999; Shope, 2004). Russell (1982) began this body of research by asking a large random sample of women in San Francisco whether they had "ever been upset by anyone trying to get you to do what they'd seen in pornographic pictures, movies, or books?" Studies in Canada and the United States since then have found that between 7 percent and 24 percent of women have been upset when pornogra-

phy was introduced into their sexual relationships in this way (reviewed in Schwartz & Dekeseredy, 1998). Silbert and Pines (1984) did not ask a specific question about pornography of the prostituted women they interviewed, and yet 25 percent of women who were raped mentioned that the rapist had used or mentioned pornography in the attack. Cramer and McFarlane (1994) and Shope (2004) found that the pornography consumption of male abusers was related to the presence of sexual violence experienced by women who were in relationships with them. Whether or not one believes that pornography consumption can in some circumstances be considered an addiction, women are also reporting reductions in their own quality of sexual relationships with long-term partners who consume large quantities of pornography. For instance, Bridges (2010) found significant correlations between men's use of sexually explicit materials and their lack of interest in sex ($r = .52$, $p = .016$) and sense that sex was not pleasurable ($r = .44$, $p = .044$). In contrast, there was no relation between women's use of explicit materials and their sexual functioning. Doidge (2007) provides neurobiological explanations for how repeated engagement with pornographic imagery creates increasing desire for consumption while simultaneously making sexual intimacy with a real life partner more dull, uninteresting, and difficult.

We, therefore, have clear indications that for some women pornography has direct negative influences on their sexual lives. Some women are actively intimidated, exploited, or harmed by pornography. It has been implicated in some sexual assault experiences. Other women are in relationships with men who are problematic or high users and find their sexual and relationship satisfaction declining. Many women respond negatively to the degradation and violence female actresses in pornography sustain. Many more are exposed to graphic images against their will, at work or in other accidental ways. These experiences would be expected to profoundly alter these women's responses to sexually explicit materials.

CONCLUSIONS

At this point, five conclusions are certain from the research. First, women's sexual preferences and responses are not parallel to men's and are more affected by contextual factors, cognitive appraisals, and emotions. Second, there is truly a meaningful distinction between erotica and violent or degrading pornography that appears to be due to violence and degradation of women, and not to sexual explicitness. On average, women do not like violent or degrading pornography and they experience negative emotional effects in response to viewing it. Third, not all women respond similarly to sexually explicit materials. One important distinction in personal responding is that many women implicate pornography use by a male as a weapon in or out of their relationships. Women vary the most in their reactions to erotica, primarily based on their judgments about the ac-

ceptability of sexual materials. Fourth, nearly all sex research with women has been conducted on heterosexual samples; relatively little is known about bisexual and lesbian women. There is some emerging evidence that sexual orientation is an important moderator of many of these relations (Chivers, Seto, & Blanchard, 2007). Future studies will need to explore in greater detail the diverse experiences and attitudes toward sexually explicit materials both erotic and pornographic that bisexual and lesbian women have. Fifth, what we know about the relationships between erotica and pornography and women's sexual response is strongly embedded in the methods we use to study it, and most studies of sexual response are completely without a realistic context. This seems to have less impact on studies of men's sexuality than it does on women's.

In addition to focusing on women of all sexual orientations, future studies will need to pay attention to how experiences and attitudes change with a culture that increasingly sexualizes and degrades women (American Psychological Association, Task Force on the Sexualization of Girls, 2010; Dines, 2010), even outside the context of pornography. Senn and Desmarais' (2004) study, using the same sexually explicit materials as in Senn and Radtke (1990), suggests that a reduction in negative evaluation (albeit still negative) is occurring across time for materials. Furthermore, sexualized portrayals of men and women and girls and boys are permeating society, including toys, clothing, television programs, and movies. Even people who choose not to consume pornography are influenced by its messages about gender, sexual behavior, and self-worth, a point well-captured in the book, *Pornified* (Paul, 2006).

Finally, we note that so many of these questions have viewed women from a deficit perspective—what is wrong with women that they do not respond to pornography in the same way as do men? What are women missing (such as being sexually liberated) that would make them otherwise enjoy this obviously good thing? Clearly, many women respond positively to sexual media when it portrays sex as a part of a relational whole rather than simply a depersonalized act. It is likely that many men and boys would also have more complex relationships with their own sexuality if the pornography industry did not control what is, and is not, desirable.

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Volume 2

Diversity, Health, and Violence

Women's Psychology

Michele A. Paludi, Series Editor

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Series Foreword

> Because women's work is never done and is underpaid or unpaid or boring or repetitious and we're the first to get fired and what we look like is more important than what we do and if we get raped it's our fault and if we get beaten we must have provoked it and if we raise our voices we're nagging bitches and if we enjoy sex we're nymphos and if we don't we're frigid and if we love women it's because we can't get a "real" man and if we ask our doctor too many questions we're neurotic and/or pushy and if we expect childcare we're selfish and if we stand up for our rights we're aggressive and "unfeminine" and if we don't we're typical weak females and if we want to get married we're out to trap a man and if we don't we're unnatural and because we still can't get an adequate safe contraceptive but men can walk on the moon and if we can't cope or don't want a pregnancy we're made to feel guilty about abortion and . . . for lots of other reasons we are part of the women's liberation movement.
>
> Author unknown, quoted in *The Torch,* September 14, 1987

This sentiment underlies the major goals of Praeger's book series, Women's Psychology:

1. Valuing women. The books in this series value women by valuing children and working for affordable child care; valuing women by respecting all physiques, not just placing value on slender women; valuing women by acknowledging older women's wisdom, beauty,

aging; valuing women who have been sexually victimized and viewing them as survivors; valuing women who work inside and outside of the home; and valuing women by respecting their choices of careers, of whom they mentor, of their reproductive rights, their spirituality, and their sexuality.
2. Treating women as the norm. Thus the books in this series make up for women's issues typically being omitted, trivialized, or dismissed from other books on psychology.
3. Taking a non-Eurocentric view of women's experiences. The books in this series integrate the scholarship on race and ethnicity into women's psychology, thus providing a psychology of *all* women. Women typically have been described collectively; but we are diverse.
4. Facilitating connections between readers' experiences and psychological theories and empirical research. The books in this series offer readers opportunities to challenge their views about women, feminism, sexual victimization, gender role socialization, education, and equal rights. These texts thus encourage women readers to value themselves and others. The accounts of women's experiences as reflected through research and personal stories in the texts in this series have been included for readers to derive strength from the efforts of others who have worked for social change on the interpersonal, organizational, and societal levels.

A student in one of my courses on the psychology of women once stated:

> I learned so much about women. Women face many issues: discrimination, sexism, prejudices . . . by society. Women need to work together to change how society views us. I learned so much and talked about much of the issues brought up in class to my friends and family. My attitudes have changed toward a lot of things. I got to look at myself, my life, and what I see for the future. (Paludi, 2002)

It is my hope that readers of the books in this series also reflect on the topics and look at themselves, their own lives, and what they see for the future.

I am proud to have Dr. Donna Castañeda's book set in the Women's Psychology series at Praeger. Dr. Castañeda has brought together an impressive group of scholars and advocates who have provided us with up-to-date research on topics such as women's sexuality in middle and later years; female initiation rituals; the intersectionality among sexuality, work, and parenting; sexual rights; lesbian sexuality; bisexual women; and women with disabilities. Her attention to cultural issues in women's sexuality is most welcome and needed in the field. Dr. Castañeda has raised the bar for texts on women's sexualities. This is the essential reading in the

field. This book set may be used in undergraduate and graduate courses as well a reference for researchers on women's sexuality.

This set provides readers with the opportunity to accomplish the goals of this series and offers suggestions for all of us who want to know more about women's sexualities. I congratulate Dr. Castañeda and her contributors on offering us this impressive book set. They have dispelled myths and replaced them with facts about women's sexualities. Their greatest accomplishment is bringing this material to a general audience. I thank them for honoring me by publishing their work in this series.

Michele A. Paludi

REFERENCE

Paludi, M. (2002). *The psychology of women* (2nd ed.). Upper Saddle River, NJ: Prentice Hall.

Foreword

In reading over the chapters in this book set, I am reminded of how far women's sexuality has come over the last two centuries. In the 19th century, sexuality was viewed as something that should be repressed and not talked about in the public sphere, especially for women. Women who discussed issues, such as sexual pleasure and desire, were viewed quite negatively. However, over the years and through the 20th century, women's sexuality became a highly discussed topic, and as women were provided with more legal rights, so too did they use this freedom to express themselves in ways they had not previously. It is with great excitement that women can now talk about sexuality openly as our male counterparts have done for so long. Having this two volume set focused wholly on women's sexuality is evidence of how far we have come on this issue.

This set is a remarkable collection of writings on women's sexuality from authors who are respected leaders in their fields. Volume 1 of this set is entitled "Meanings, Development, and Worldwide Views." This volume provides chapters on sexual pleasure, desire, and satisfaction in women, sexuality across various developmental stages in women's lives, and human and sexual rights for women. Additionally, this volume has a section on international perspectives. Despite the modern tendency toward women's rights and sexual freedom, even today there are vast differences in beliefs and practices across the world. This section provides insight into how women's sexuality is viewed in different countries worldwide.

Volume 2 is entitled "Diversity, Health, and Violence." This volume focuses on various issues, including diversity, health, mental health, and violence, and their relationship to women's sexuality. It covers everything from sexuality as related to pregnancy and HIV to pornography, sex trafficking,

and sexual trauma. In addition, there is a section that focuses on how sexuality is viewed amongst various cultural and racial groups as well as in the LGBT community.

The editor of this two-volume set has gathered the most current research regarding women and sexuality conducted and brought it into the fore. It contains an expansive collection of topics and is, without a doubt, a one-of-a-kind, relevant and significant resource. I would encourage any psychologist to add this text to their libraries, particularly those involved with or interested in international, social, psychological, gender studies and multicultural and cross cultural issues.

Florence L. Denmark, PhD

Acknowledgments

Special thanks to Michele A. Paludi for her invaluable support, advice, and encouragement at every stage in the development of this book set. She has been a wonderful mentor to me in this project. I also thank Debbie Carvalko at Praeger for all her helpful editing advice and good ideas along the way. I am tremendously grateful to the contributors to this book set for their incredible chapters and I appreciate their patience and dedication to this project. Finally, to Tom and Keon Barkhurst, special thanks for your support, cheerful good humor, and caring. They keep me going.

Introduction

Carol S. Vance wrote in her groundbreaking publication on women's sexuality *Pleasure and Danger: Exploring Women's Sexuality* that the "hallmark of sexuality is its complexity: its multiple meanings, sensations, and connections" (1985, p. 5). This quote illustrates the approach and purpose of this two-volume book set on women's sexuality. Women's sexuality is complex and multifaceted and has expanded, as a field of inquiry, to encompass a range of perspectives, theories, topics, and findings. While no one publication could encompass all that is pertinent to women's sexuality, the two volumes in this book set provide a comprehensive picture of some of the most important issues in the field of women's sexuality. It brings to bear the latest thinking and research on women's sexuality across a diversity of topics by a group of accomplished scholars.

An overarching theme that is present across the various chapters included in the two volumes is the clearly contextual nature of women's sexuality and that it cannot be understood by examining sexuality at one level of organization alone. Women's sexuality is not only an individual and personal experience embedded in the physical and material realities of bodies and biology, personal sexual identities, and individual development over time, but is also influenced by the interpersonal context, life experience, cultural meanings, gendered dynamics of power and oppression, and layers of silence in the family and in society surrounding sexuality, as well as various larger forces, such as global migrations, politics, and economics. All of these elements interact in complicated ways to influence women's sexuality and they are all reflected throughout the chapters in this book. Likewise, while most chapter authors are from the field of psychology, a number of them are from outside the discipline

of psychology, including philosophy, communications, nursing, anthropology, and political science; even those within psychology are heterogeneous, with authors from the fields of clinical, social, and developmental psychology included.

Each volume is divided into several content areas. The theme for volume 1 is "Meanings, Development, and Worldwide Views" and it begins with chapters on sexual desire (chapter 1), sexual satisfaction among heterosexual women (chapter 2), and women's sexuality in close relationships (chapter 3). These chapters set the stage for understanding fundamental issues related to women's sexuality. They are followed by chapters that look at women's sexuality across important developmental periods and events, such as adolescence (chapter 4); motherhood, work, and sexuality (chapter 5); menopause (chapter 6); and women's sexuality from the middle to late adulthood (chapter 7). They demonstrate that to understand women's sexuality, one must consider the role of individual development and stages of family life. An international perspective is taken in the next section to examine sexuality issues in a set of diverse countries and cultures, as well as the preeminent issue of sexual rights as human rights that is a major focus of sexuality activism around the world. These include investigation of female initiation rituals and sexuality socialization in northern Mozambique (chapter 8); sexuality issues among Vietnamese women (chapter 9); an examination of the context of women's sexualities, sexual rights, and violence in Mexico (chapter 10); and a feminist account of the struggle for sexual rights in Muslim societies (chapter 11). These chapters not only demonstrate the commonalities across cultures and societies in the sexuality issues women confront, but they also provide clear evidence that what sexuality issues may be most salient in a particular society and the resources and options available for women to confront these issues can be quite different.

The last section in this volume focuses on women's bodies, the media, and sexuality. These chapters describe and explore how cultural ideals and expectations, as transmitted through the media, influence not only how women experience their sexuality, but how their sexual relationships may be affected as well. Beginning this section is a chapter that examines how binge eating disorder may affect women's sexuality (chapter 12). This is followed by an investigation of media influences across the 20th century and up to the present on women's decision to remain voluntarily childless and the implications of this for constructing women's sexuality (chapter 13). The last chapter in this section describes the difference between erotica and pornography and how they may affect women's sexuality (chapter 14).

The theme for volume 2 is "Diversity, Health, and Violence" and how these may be implicated in women's sexual lives. First, lesbian love, sex, and relationships are examined and this chapter includes an incisive account, among other topics, of how few accurate depictions of lesbian

sexuality and close relationships can be found in the media (chapter 1). This is followed by a chapter on women's sexuality and bisexuality, where the complexities of bi identity, sexuality, love, and relationships are discussed (chapter 2). Finally, a chapter discusses the concept of interpretive intimacy in the lives of trans women, including an examination of the factors that may constrain as well as facilitate this complex process (chapter 3). This section is followed by one where the notion of diversity is approached. While diversity in women's lives can be defined in many ways, in this section it refers to ethnic/racial/cultural and ability/disability diversity. These chapters include ones that discuss sexuality and sexual health issues for women with physical disabilities (chapter 4); First Nation women (chapter 5); Latinas (chapter 6); Asian and Asian American women (chapter 7) and African American women (chapter 8). The next two sections focus on important health and mental health-related topics and their relationship to women's sexual lives. First, the chapter on the experience and construction of changes to women's sexuality after breast cancer describes and discusses how women with breast cancer may experience a range of serious emotional changes due to the removal or change in a breast and the side effects of cancer treatment (chapter 9). Next, the chapter on HIV/AIDS and women's sexuality discusses, among other issues, how promoting a positive sexuality for women is central to HIV prevention among them (chapter 10); finally, the chapter on childbearing examines how women's sexual activities may vary across pregnancy and the postpartum period and the physical, psychological, and social factors that influence these (chapter 11).

The section on sexuality, mental health, and therapy includes chapters that discuss the ongoing controversy over defining and diagnosing women's sexuality (chapter 12); reconceptualizes the role of power in sexual interactions that include BDSM (an acronym that refers to a wide range of consensual sexual activities loosely grouped into the categories bondage and discipline, dominance and submission, sadism and masochism [or sadomasochism], leather, fetish, and kink) (chapter 13); healing and restoring women's sexuality after the experience of trauma (chapter 14); the right to intimate citizenship in the sexual lives of women with enduring mental illness (chapter 15); and, finally, a chapter that provides a critique of approaches to women's sexual problems and provides a set of recommendations that may lead to alternative, women-centered and women-positive therapeutic approaches to help women with such problems (chapter 16).

The last section in volume 2 takes on the issue of violence and women's sexuality. It begins with a review of the research on the causes and consequences of abusive relationships, including how they may affect women's sexuality (chapter 17). The second chapter in this section analyzes how the sexualization of women and girls influences and promotes sexual violence against them (chapter 18). The final chapter in this section describes

in detail the scope and parameters of sex trafficking and sexual exploitation of women across the globe and how it may affect women's sexuality (chapter 19).

As editor, I am likely biased, but to read the chapters in these two volumes, to experience the intellectual scope and depth of each of the fascinating topics they deal with is breathtaking. They each offer thought-provoking insights and intriguing ideas, and although the chapters cover seemingly disparate fields, my hope is that this book stimulates dialogues across these fields along with new and continued study and research on women's sexuality.

Donna Castañeda

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Vance, C. S. (1985). *Pleasure and danger: Exploring female sexuality.* Boston: Routledge & Kegan Paul.

Part I

Sexual Orientations

Chapter 1

Lesbian Love, Sex, and Relationships

Suzanna M. Rose and Asia A. Eaton

Lesbian love in the 21st century has entered a new era in terms of how it is perceived and portrayed compared to earlier times. Images of lesbians before the second wave of feminism generally stereotyped women who loved women as sick, immoral, or perverted. These women were not only stigmatized for engaging in supposedly "unnatural" sexual practices, but also for their alleged shortcomings as women (Cameron & Kulick, 2003). Challenges to the model of lesbians as "deficient" women began to occur with the development of a modern lesbian community in the late 20th century, when lesbians began publicly to celebrate the sensuality, danger, intensity, and comfort of love between women. Lesbian scholars also corrected the historical record using evidence from love letters and poetry throughout the ages that showed the passion, warmth, and compassion of lesbian love (e.g., Faderman, 1991). Objective scientific research beginning in the 1970s further served to dispel beliefs that lesbian love was somehow lacking compared to heterosexual love. Summarizing this early research in 1982, Peplau and Amaro concluded that most lesbians tend to be in committed relationships, to value them greatly, to have high levels of

relationship and sexual satisfaction, and to be egalitarian in terms of roles and responsibilities.

A substantial body of research about lesbian love and relationships now exists that permits a more complex profile to be drawn. Much of the research has been limited to questions concerning how a stigmatized identity affects lesbians, such as the consequences of homophobic violence and minority stress or how lesbians compare with heterosexual norms for sexuality and relationships. However, these findings have generated interest concerning not only the nature of lesbian relationships, but also in how understanding lesbian relationships might contribute to insights about human relationships more generally (e.g., Markey & Markey, 2011; Rose, 2000).

In this chapter, we provide an overview of current research on lesbian love, sex, and relationships with an emphasis on five areas: (a) media images of lesbians, (b) gender roles, (c) sexuality, (d) relationships, and (e) Internet communities. We conclude by exploring how the legalization of same-sex marriage might affect lesbian relationships and identifying some interesting questions for future research.

MEDIA IMAGES OF LESBIANS

Portrayals of lesbians in the mainstream media are relatively new. Until the 1990s, lesbians had virtually no representation; their presence and viewpoints had been symbolically annihilated through their relative invisibility (Gerbner & Gross, 1976). On the rare occasion that lesbians appeared, they were likely to be psychopaths or suicidal (e.g., *Basic Instinct, The Children's Hour*) (Russo, 1987). In 1993, however, a number of popular news magazines, including *Newsweek, New York* magazine, and *Vanity Fair,* featured lesbians on their covers in quick succession. These positive portrayals kicked off a brief era during which it was chic to be lesbian (Ciasullo, 2001). Since then, lesbian characters in the media were more likely to be shown as more stereotypically feminine than as unattractive or mentally ill.

Lesbians in television and popular films now most commonly are portrayed as feminine in body type and dress (e.g., slim, feminine attire), interested in shopping, monogamous, and asexual or sexually passive. For instance, Ciasullo's (2001) analysis of the bodies and images of lesbians in popular television, film, and magazines in the 1990s indicated that lesbians were homogenized and heterosexualized through the exclusive use of femme body types and representations as white and upper middle class. Similarly, a 1995 *Friends* episode featured a lesbian wedding; each woman in the couple was slim, white, and feminine, and at the wedding ceremony each held bouquets and wore their hair in ringlets.

Lesbians as conspicuous consumers, deeply monogamous, and asexual were other images portrayed by the television shows *The L Word, Queer as Folk,* and *Ellen,* respectively. *The L Word* began running in 2004 and

followed the lives of a group of lesbians living in Los Angeles. The lesbian lifestyle in *The L Word* was portrayed as an elite, edgy, and worldly life among a group of mostly white women with ample money and time with which to explore and exercise avant-garde tastes (Burns & Davies, 2009). The only diversity displayed was in their appreciation for exotic clubs, art, and political positions. *Queer as Folk,* a U.S.-Canadian nighttime cable television drama that ran from 2000 to 2005 offered viewers an ensemble cast with seven white, middle-class gay and lesbian characters. The two lesbian characters were feminine in appearance and were aligned with monogamy, domestic relationships, and child rearing—all heteronormative practices (Peters, 2009). Unlike the gay male characters, the lesbian characters were rarely shown having sex and were portrayed as being generally uninterested in sex. Indeed, one gay male character, Brian, said that only "dickless fags" imitate lesbians through monogamy.

Finally, *Ellen,* the prime time television show that ran from 1994 to 1998, took a positive step toward dispelling stereotypes when the well-liked lead character, Ellen Morgan, came out as gay. However, Ellen's coming out was very asexual. Although Ellen had onscreen relationships with men before coming out, she did not have any romantic or sexual interactions with women when or after she came out. The Morgan coming out sequence led to the following joke: "Q: What do you call a lesbian that only sleeps with men? A: Ellen Morgan" (Yescavage & Alexander, 1999). The show *Ellen* has thus been characterized as highly consumable and inoffensive (e.g., Ciasullo, 2001), portraying a lesbian heroine who is all-American, clean-cut, and does not flaunt her sexuality or sexual relationships.

Images in Lesbian Media

Portrayals of lesbians in lesbian-targeted media tell a different story about appearance and desire compared to the sanitized version of mainstream media. For instance, Milillo (2008) examined 150 advertisements from lesbian magazines (*Curve, Girlfriends,* and *OUT*) and compared them with a random selection of 150 advertisements from heterosexual women's magazines (*Glamour, Elle,* and *Mademoiselle*). In general, the lesbian models were shown as agentic individuals, actively pursuing gratification and connectedness. In contrast, the thrust of models in the mainstream advertisements was on the agency and power of the product being sold. Also, models in popular lesbian magazines varied more in age and weight than mainstream models, were more androgynous in appearance, and were more likely to be shown in full clothing. They were more often shown looking directly at the camera, touching another person, or as active in outdoor and community settings.

Lesbian erotica examined by Morrish and Sauntson (2011) also revealed themes of individuality and agency. They used linguistic methods

to explore representations of lesbian desires and identities from two lesbian magazines published in the 1980s and 1990s: *On Our Backs* and *Bad Attitude.* Analyses of the frequencies of lexical items across these texts revealed that, in terms of sexual activity, there were a large number of verbs that showed attunement to the partner (e.g., *feel, know, say, touch*). In terms of references to the body, the importance of *hands* was primary and of genitals was secondary. A bondage and discipline focus also was found reflecting the interests of the specific audience for these magazines (e.g., *leather, harness, cuffs, spanking*); words related to power, dominance, and control also were common (e.g., *pain, power, control*). However, these actions were often qualified by adjectives, such as *gently* and *slowly,* implying that the partner's pleasure was a primary concern. Overall, lesbian sexuality was portrayed as simultaneously powerful and affectionate.

In sum, the mainstream media appears to have moved toward presenting lesbians as being narrowly portrayed, similar to heterosexual women in terms of appearance, interests, and sexuality. Lesbian media allowed more uniqueness of expression and agency that more fully characterized lesbians' individuality.

LESBIAN SEXUALITY

Although lesbians have gained some visibility in the media as just shown, their sexual identities, gender roles, and sexuality for the most part are unnamed. As a result, what is known about lesbian sexuality has been limited by the heteronormative nature of language that is used in research on sexual behavior. The term "have sex" is a case in point. Three steps are essential for heterosexual interactions to be considered "having sex": (a) preparation for intercourse (foreplay), (b) intercourse, and (c) male orgasm (Maines, 1999). It is likely that when heterosexuals are asked how often they "have sex," the answer reflects the number of male orgasms that occurred, not female orgasms or other types of sexual behavior. In fact, many heterosexuals do not consider oral sex, anal sex or mutual masturbation, or a variety of other forms of sexual contact as "having sex." For instance, Sanders and Reinisch (1999) reported that 19 percent of heterosexuals did not consider penile-anal intercourse to be "having sex" and 40 percent did not view oral-genital contact as "having sex."

Marilyn Frye (1990) eloquently addressed the inadequacy of heteronormative language to encompass lesbian sexuality:

> Lesbian sex, as I have known it, most of the time that I have known it, is utterly *in*articulate. Most of my lifetime, most of my experience in the realms commonly designated as "sexual" has been pre-linguistic, non-cognitive. I have in effect, no linguistic community, no language, and therefore, in one important sense, no knowledge. . . . Men's

meaning, and no women's meanings, are encoded in what is presumed to be the whole population's language. (p. 311)

Information about lesbian sexual behavior, then, obviously is constrained by what language is available to frame research questions. A number of studies have concluded that lesbians have sex less often than heterosexual or gay male couples (e.g., Blumstein & Schwartz, 1983; Jay & Young, 1979; Laumann, Gagnon, Michaels, & Michaels, 1994). For example, Blumstein & Schwartz (1983) found that among couples together two years or less, 83 percent of married heterosexual couples and 94 percent of gay male couples reported having sex at least once a week, compared to 76 percent of lesbian couples. However, these findings may be contested by the fact that many behaviors relevant to lesbian sex were not included, for example: number of orgasms during "having sex," average duration of "having sex," anal sex, manual vaginal stimulation, use of sex toys or vibrators, types of sexual positions, mutual masturbation, and tribadism (clitoral stimulation obtained by pressing against a partner's body, also referred to as grinding or scissoring). In addition, other studies found no difference in sexual frequency between heterosexual and lesbian women (e.g., Matthews, Tartaro, & Hughes, 2003).

Duration of having sex or sexual intercourse is a particularly relevant factor associated with women's sexual satisfaction. Masters and Johnson (1970) concluded that it takes, on average, about 20 minutes of sustained vaginal penetration for most heterosexual women to have an orgasm. Here, lesbians may have the advantage in terms of providing their partners with orgasm, including multiple orgasms. Frye (1990) explained that lesbians most likely take 30 minutes to an hour to "have sex," something that on average takes heterosexuals about 7 or 8 minutes as reported by Patrick and colleagues (2005). Rose, Cobb, and Pelli (1992) also reported that the consensus within two lesbian focus groups was that their use of the term "have sex" referred to a sexual interaction lasting from five minutes to four hours and involving multiple sexual behaviors and orgasms. Similarly, Nichols (2004) found that lesbians typically spent 30–60 minutes on a typical sexual encounter compared with 10–30 minutes for heterosexual women.

The "more frequent sex is better" represents a heteronormative standard of valuing quantity over quality. One might argue that if quantity is important to adequate sexual functioning, a less heteronormative measure would be prevalence of female orgasm. Using this standard, lesbians would be highly adequate. Lesbian couples have high frequency of orgasm, with from 83 percent to 94 percent reporting they are almost always orgasmic with a partner and 46 percent saying they were frequently or always multiorgasmic (e.g., Douglass & Douglass, 1997; Jay & Young, 1979; Loulan, 1984). In comparison, only 26–29 percent of heterosexual women

report experiencing regular orgasm during heterosexual intercourse (e.g., Hite, 1981; Laumann et al., 1994). Interestingly, many lesbians place less emphasis on orgasm in their relationships relative to other behaviors, such as hugging, cuddling, and fondling (Masters & Johnson, 1979).

Given that heterosexuality is a primary assumption in the construction of gender and sexual identity, how do lesbians enact sexuality and perform sexual and gender identity in their talk? Research by Bolsø (2001) with Norwegian lesbians provides an example of how lesbians reinterpret language to suit their own experience. The 17 self-identified lesbians that were interviewed spontaneously referred to "taking" another woman or being "taken" themselves in sexual acts and interchanges. This discourse was also found in lesbian erotic and romantic reading. Taking is typically associated with heterosexual activity in which the man is active and sexually satisfied, whereas the woman is subordinate and may or may not have an orgasm. However, lesbian participants equated taking with giving another women an orgasm. As one participant noted: "I have heard . . . that it is important to come simultaneously, but that is spoiling sex for me. I would then have to concentrate on taking the other person and at the same time that person is supposed to take me" (Bolsø, 2001, p. 462). Thus, these women had subverted a heterosexual term for intercourse by redefining it such that taking was the act of pleasuring one's partner.

Roth (2004) provided further examples of the pervasiveness and prominence of language that casually refers to male genitals as signifiers of power and authority (e.g., having balls, getting it up). Roth suggested that lesbians instead adopt a term rooted in the female body to refer to potency, power, and sexual prowess, and proposed the term "engorged lesbian clitoris" or "engorged clitoris" to replace phallic imagery. For example, instead of using a term like balls, one might say "he didn't have the 'engorged clitoris' to take up my challenge" (Roth, 2004, p. 185). This change in the language of dominance and desire would enhance a stable, conscious, and potent sense of self among lesbians (Roth, 2004).

Heteronormative language also affects how sexual and gender identity is performed in conversations. Kitzinger's (2005) analysis of conversations from heterosexual British and American people illustrated how people routinely produce themselves and each other as heterosexual. Conversants automatically created a normative heterosexual world in their speech through the use of heterosexual joking, banter, and the discussion of heterosexual activity without explicitly announcing their heterosexuality. Individuals also displayed their own heterosexuality and their assumptions of a heterosexual world by talking regularly about heterosexual relationships, including discussing marriage-related topics and using the terms husband, wife, and in-laws, in a "taken-for-granted normative default way" (Kitzinger, 2005, p. 229). Perhaps most interesting, however, was that speakers commonly used the pronouns "he" and

"she" as a method for referring to just one member of a couple and for distinguishing one member from another—a feat of language that cannot be used to refer to same-sex couples.

Kitzinger (2005) noted that, in these conversations, "cointeractants are not actively 'being heterosexual' or flaunting their heterosexuality—but are simply getting on with the business of their lives, treating their own and others' heterosexuality as entirely unremarkable, ordinary, taken-for-granted and displaying it incidentally in the course of some other action in which they are engaged" (p. 255).

What does this taken-for-granted heterosexual language mean for lesbians? To start, it demonstrates that same-sex couples are excluded from a vast range of interactional and conversational activities. Second, the pervasiveness of heterosexual self-display in these conversations suggests that anyone who does not reveal him or herself as heterosexual in conversation is unusual. Someone who explicitly identifies herself as lesbian is highly unusual and she is likely to be accused of flaunting her sexuality. Finally, even if a woman does not identify herself as a lesbian, the absence of heterosexual talk by or about her may nonetheless signify that she is not heterosexual. In fact, the absence of heterosexual talk may spark other's so-called gaydar (i.e., the ability of LGBT individuals to identify one another based on thin slices of information).

The remedy to the invisibility of lesbian sexuality, according to Kulick (2000), is to move away from a focus on sexual identity (i.e., from the labeling of individuals as lesbian, gay, bisexual, or transgender) to a focus on desire. Although people differ in their desires and in the manner in which they signal those desires, the desire for intimacy, erotic fulfillment, and recognition are common to all. The vast spectrum of sexual needs and behaviors should be understood as available to everyone rather than being associated with particular sexual identities.

GENDER ROLES

Interest in the study of lesbian-specific genders, such as butch and femme, recently has increased (e.g., Levitt & Hiestand, 2005; Payne, 2010; Wright, 2008), although these roles continue to be controversial among lesbians (Rifkin, 2002). Historically, butch and femme roles were associated with the 1950s working-class lesbians (Faderman, 1991). Butch lesbians were expected to appear and behave in a stereotypically masculine manner, while femme lesbians were expected to align their performance and appearance with female gender stereotypes (e.g., Lapovsky-Kennedy & Davis, 1993). During the 1970s, many white lesbian feminists rejected these roles as reinforcing heterosexist values and instead favored more androgynous self-presentations (e.g., no makeup, short hair, comfortable shoes, pants). In the 1980s, there was a resurgence of butch-femme roles

among some white urban lesbian communities, partly in reaction to the dogma of the 1970s. Contemporary interest in butch-femme roles has focused on gender expression as a performance that some lesbians choose (Butler, 1990), and researchers have been exploring what functions they serve (Levitt & Hiestand, 2005) as well as how to measure them (Lehavot, King, & Simoni, 2011).

Butch-femme roles are not widely endorsed by white, middle-class lesbians, but a substantial minority of lesbians subscribe to the roles somewhat. In a survey of mostly white lesbian readers of *The Advocate* magazine, Lever (1995) reported that about half the readers rated themselves and their partner as being in the middle of a seven-point scale that ranged from very femme/feminine to very butch/masculine. Another 25 percent indicated that they were in a butch/femme pair, 17 percent said they were in a femme/femme pair, and 8 percent indicated being butch/butch.

Moore (2006) reported that black lesbians endorsed three patterns. About 34 percent were classified as gender blenders (self-presentations combined traditionally masculine and feminine elements, such as comfortable shoes and makeup). About half categorized themselves as femme women who preferred to wear dresses or skirts, form-fitting clothes, high-heeled shoes, and other typically feminine gear. About 18 percent were defined as transgressive women (more masculine self-presentations). The style a woman chose remained fairly stable over time and structured her social relationships with other lesbians.

Contemporary theorists have posited the concept of lesbian gender to describe the roles and performances of self-identified butch and femme lesbians. It is important to point out that these conceptions of lesbian genders do *not* parallel traditional masculinity and femininity. Two major disconnects between lesbian gender roles and heterosexual roles are in the areas of sexual behavior and economic dominance. Both empirical and anecdotal evidence indicates that butch-femme roles do not dictate a sexually aggressive and dominant role for butch lesbians and a passive, submissive role for femmes.

Lesbians who described themselves as butch or femme in the Lever (1995) study indicated that the roles were not related to who was the sexual aggressor in the relationship. Many femmes are aggressive and strong women who take responsibility for actively seeking the partner they desire, whereas butch lesbians emphasize their partners fulfillment in lovemaking rather then their own (Zimmerman, 2000). In addition, the saying "Butch on the street, femme in the sheets" challenges the myth of the sexually aggressive butch lesbian. In sexual interactions, lesbians who perceive themselves as masculine overall, nevertheless view themselves as more feminine when they are interacting sexually (Rosenzweig & Lebow, 1992). Similarly, studs, or black lesbians who embody masculinity in appearance

and mannerisms, do not follow the traditional male script that places the man's sexual desires ahead of the woman's (Lane-Steele, 2011). Instead, the femme's sexual pleasure is prioritized over the stud's. Some studs do not like to be sexually stimulated at all.

Among lesbians that subscribe to butch-femme roles, a major function of the roles is as a sexual signaling system. For instance, Levitt and Hiestand (2005) examined the meaning of butch and femme genders for 12 butch- and 12 femme-identified lesbians ranging in age from 23 to 62. Each woman was asked: "What does it mean for you to be butch or femme?" The content of these one-hour interviews led the authors to conclude that gender identities, such as butch, femme, or androgynous, helped these lesbian women identify and communicate their attraction to others and structure romantic and interpersonal interactions. Butch-femme flirting, in particular, entailed a process of recognizing and displaying gender difference and different forms of power that led to mutual validation of each other's sexual orientation and agency.

Levitt and Hiestand (2005) concluded that these gender identities created a positive system of sexuality for lesbians that validated their gender, recognized butch and femme power, and encapsulated political resistance through challenging traditional sexual and gender boundaries. Moore (2006) also reported that for African American lesbians, traditional patterns of power and subordination were not part of their physical gender roles. Black lesbians valued their own and their partner's self-sufficiency and autonomy.

Recently, Lehavot and colleagues (2011) created and validated a new scale assessing the multiple components of gender expression in lesbian and bisexual women without requiring participants to specify a gender identity (e.g., butch/femme). The Gender Expression Measure among Sexual Minority Women (GEM-SMW) includes three distinct factors, assessing appearance, gender roles, and emotional expression. Sample items include: "I often wear skirts and dresses" (appearance), "I enjoy activities that involve tools, such as car work or household repairs" (gender roles), and "I cry easily" (emotional expression). This measure successfully differentiates not only butch from femme women, but also androgynous women from those who do not identify with any of the gender identity terms. While the GEM-SMW is among the first gender expression instruments developed specifically for lesbian and bisexual women, it can be used with heterosexual women as well.

Another aspect of butch lesbian roles or lesbian masculinity that has been little explored pertains to how this type of gender performance can serve lesbians in work settings. For example, Wright (2008) used a qualitative approach to explore issues of gender and sexuality in a sample of 12 women firefighters in the United Kingdom (6 lesbian, 6 heterosexual). The U.K. fire service is male dominated and has been characterized as

homophobic, but nonetheless attracts both lesbian and heterosexual women firefighters (Wright, 2008). Semi-structured interviews with these women revealed many differences between the gender-based experiences of heterosexual and lesbian firefighters, though both were construed and treated on the basis of their sexuality.

In general, lesbian firefighters found it easier to be in the male-dominated fire service environment than heterosexual women firefighters. In fact, the representative of the Fire Brigades Union Gay and Lesbian Committee stated: "I believe that it's a lot easier [now] for a female to be in the job, especially if they are gay" (Wright, 2008, p. 108). Part of the reason for this advantage was due to the strict stereotypes applied to female firefighters in this domain; in the fire service, women firefighters are characterized either as masculine lesbians or as heterosexual, sexually predatory "fire tarts." Lesbians who came out to colleagues were, therefore, seen as fitting in more with the dominant culture and were treated "just like one of the lads" (Wright, 2008, p. 107). Lesbian firefighters were also able to avoid unwanted sexual attention by coming out. Indeed, some lesbians felt they had more stress-free relationships with their male colleagues in the absence of sexual tension, benefiting their overall performance and state of mind.

Lane-Steele (2011) also reported that "studs" (i.e., black lesbians who embody masculinity in their appearance and mannerisms) confirmed that they gained access to power and privileges by virtue of their masculine gender performance. Being "one of the boys" enabled studs to increase their position in the social hierarchy where men are in power. Essig (2008) described a similar benefit from her butch image and a penalty when that image changed. Before her pregnancies, men colleagues saw Essig as mannish but nonthreatening. She was treated as one of the boys: "I was slapped on the back, rubbed on the head, pushed along to more and more grants, more and more office space, more and more awards" (p. 117). However, after her female gender was brought to the forefront through her pregnancies, Essig lost her pseudo-masculine power and became the object of disgust and neglect. Her initial status never returned.

The concept and practice of butch-femme roles continue to be controversial within the lesbian community despite recent interest in understanding or measuring these roles. For instance, Rifkin (2002) argued that theorizing butch and femme lesbian-specific genders is ultimately undesirable. Equating heterosexual masculinity to butch lesbian gender and heterosexual femininity to femme lesbian gender reinforces the naturalization of heterogendered desires and relationships. An alternative is to recognize that masculinity exists across a range of sexual and gender identities. For instance, the woman-in-a-suit persona includes lesbians, female-to-male transsexuals, and heterosexual women, and represents various levels of female masculinity and gender subversion.

In sum, recent discussions of butch-femme roles have tended to focus on the performance of gender and to distinguish lesbian genders from traditional masculinity and femininity. Research also has addressed how the roles function as a sexual signal and in the workplace.

LESBIAN RELATIONSHIPS

Research on lesbian couples indicates that successful relationships share the same qualities as do well-functioning heterosexual relationships. Thus, many researchers have concluded that lesbians and gay men are more similar to heterosexual women and men than different (e.g., Kurdek, 2004a; Scrivner & Eldridge, 1995). This conclusion has been useful to support arguments that lesbian and gay couples deserve equal status and recognition. For example, regardless of sexual orientation, good relationships involve low costs and high rewards (Kurdek, 1998; Rusbult, 1983), interdependence (Kurdek, 1992), psychological intimacy (Mackey, Diemer, & O'Brien, 2004), a positive communication style (Julien, Chartrand, Simard, Bouthillier, & Begin, 2003), humor and affection (Gottman, Levenson, Gross et al., 2003), and enhanced images or positive illusions about the partner (Conley, Roesch, Peplau, & Gold, 2009). Stability in lesbian couples is related to similar qualities that hold heterosexual and gay men couples together, including a more positive expectancy of the interaction and higher empathy (Gottman, Levenson, Gross et al., 2003). Lesbian couples have similar dissolution rates and patterns as heterosexual cohabiting couples, as well (Blumstein & Schwartz, 1983; Kurdek, 1995, 1996).

Less emphasis, however, has been placed on how lesbian relationships are different from other couple types or benefit women in terms of women's subjectivity and negotiation of life stress. Perz and Ussher (2009) provided an interesting example of the benefit of being in a lesbian relationship concerning how premenstrual syndrome (PMS) was treated. Lesbians did not regard PMS as a medical illness or unspeakable pathology as was common in heterosexual women's accounts (Ussher, Perz, & Mooney-Summers, 2007). None of the lesbians used pathological or derogatory terms, such as *mad, loony tune, bitch,* or *Jekyll & Hyde,* to describe themselves premenstrually (Ussher et al., 2007), although heterosexual women commonly did so (Cosgrove & Riddle, 2003; Ussher, 2002). Unlike heterosexual women, lesbians felt no guilt or self-blame for PMS and reported few feelings of being out of control. PMS has been described as a culture-bound syndrome because it is not reported in non-Western cultures (Chrisler & Caplan, 2002). These findings suggest that a woman's relationship with her partner affects the construction of PMS as either pathological, as frequently happens in heterosexual relations, or results in acceptance, as in lesbian relationships.

Similarly, lesbians report more positive experiences of menopause than heterosexual women. Winterich (2003) reported that menopausal lesbians described being more free to act on their desires and openly discuss sex with their partners than heterosexual women. Husbands complained about their wives' menopausal symptoms, but none of the lesbian partners complained (Winterich, 2003).

A growing body of work indicates that lesbian relationships are distinct, positive, and beneficial for women, at least for the white lesbian couples that typically have been studied. Lesbian relationships are more satisfying than those of heterosexuals (Green, Bettinger, & Zacks, 1996; Kurdek, 2003; Metz, Rosser, & Strapko, 1994). Lesbian couples report more cohesion or connectedness than gay men or heterosexual couples (Green et al., 1996) and demonstrate a greater capacity for mutual empathy, empowerment, and authenticity in the relationships (Mencher, 1990). Lesbians are especially effective at working together harmoniously compared to other couple types (Roisman, Clausell, Holland, Fortuna, & Elieff, 2008). Lesbians exhibit greater egalitarianism as evidenced by highly flexible household arrangements and decision making (Connolly, 2005) and are more likely to share responsibility (Matthews et al., 2003; Schneider, 1986). Lesbians report stronger liking of their partners, more trust, and more equality (Kurdek, 2003). African American lesbians indicate that sharing an ethnicity with a partner creates a substantive common bond (Hall & Greene, 2002; Mays, Cochran, & Rhue, 1993). Lesbians are less concerned about their own or their partner's appearance and weight (Garnets & Peplau, 2006), and are free to wear comfortable shoes (Krakauer & Rose, 2002). Overall, lesbian relationships tend to be strong in the areas that predict satisfaction, including emotional competency (Metz et al., 1994); liking, trust, and equality (Kurdek, 2003); cohesion-flexibility (Green et al., 1996); and intimacy, equity, and autonomy (Schreurs & Buunk, 1996).

In terms of conflict resolution, lesbians are less likely than heterosexual couples to exhibit a pattern where one partner demands and the other withdraws and are more likely to suggest solutions and compromise (Kurdek, 2004a). Lesbians resolve conflict more effectively than heterosexual couples, even though they disagree on the same issues (Kurdek, 2004b). Lesbian couples also show more empathic attunement to their partners' nonverbal signals and consciously avoid expressions of contempt (Connolly & Sicola, 2006). Happy lesbian couples are more likely than other couple types to maintain a steady positive state in their communication, use more humor, and show more joy/excitement when discussing an area of conflict (Gottman, Levenson, Swanson, et al., 2003; Kurdek, 2004a).

Some researchers have concluded that the positive aspects of lesbian relationships are due to a "double dose of relationship-enhancing influences" that result from two women in a couple having similar gender roles (Kurdek, 2003, p. 416). However, gender stereotypy cannot fully account

for the success of lesbian relationships because lesbians tend to be less gender conforming than heterosexual women. Lesbians report having the freedom to desire or be desired in their relationships (Rose & Zand, 2002; Ussher & Mooney-Somers, 2000); in other words, to be outside the constraints of the heterosexual matrix (Butler, 1990). Although lesbians and heterosexual women are similar in terms of femininity scores, self-ratings of masculinity often differ (Lippa, 2002). Lesbians tend to rate themselves higher on qualities, such as independence, having a strong personality, making decisions easily, being competitive, and acting as a leader, and also showed more interest than heterosexual women in masculine activities and jobs (but less interest than heterosexual men; Lippa, 2002).

Lesbian relationships appear to include at least three defining features that are not gender typed, but that are linked instead to feminist beliefs: (a) a value of equality in relationships, (b) a concern for autonomy, and (c) the expectation to be economically self-supporting. For instance, equality in relationships is a value linked to feminism, not to femininity. Lesbians may be consistently more tacitly feminist than heterosexual women, partially accounting for the strength of this constellation of behaviors. Heterosexual women with feminist identification had greater egalitarian and assertive role expectations for relationships (Yoder, Perry, & Saal, 2007). Heterosexual women also report greater relationship quality, equality, stability, and sexual satisfaction to the extent that they perceived their male partner to be a feminist (Rudman & Phelan, 2007). Support for the idea of feminism as a mediating variable is provided by findings that lesbian and heterosexual women do not differ in masculinity when they are matched for feminist beliefs (Peters & Cantrell, 1993). Thus, feminist heterosexual women may be a more appropriate comparison group for lesbians than heterosexual women in general.

Lesbian couples generally have been found to maintain a high level of autonomy in their relationships, as well as a high level of intimacy. Autonomy refers to acting according to one's own values independent of the social environment or making decisions independent of partner pressure (Schreurs & Buunk, 1996). It also refers to having friends and interests outside of the relationship (Peplau, Cochran, Rook, & Padesky, 1978). Among lesbian couples, autonomy has been related to lesbian feminist ideology (Peplau et al., 1978) and has been found to be compatible with intimacy (e.g., Peplau et al., 1978; Schreurs & Buunk, 1996). In fact, Kurdek (1998) found that lesbian partners reported more autonomy as well as more intimacy in their relationships than did married couples. Moreover, for both lesbian and heterosexual women, sexual autonomy (i.e., sexual authenticity and freedom) is associated with greater sexual satisfaction (Sanchez, Moss-Racusin, Phelan, & Crocker, 2011).

The necessity of earning a livelihood is the third way in which lesbians differ from heterosexual women (Peplau & Huppin, 2008). Lesbians

expect to be financially self-supporting and providing for oneself is a common theme in lesbians' descriptions of their lives (Morgan & Brown, 1991). Not expecting to have a male provider may motivate lesbians to seek better paying nontraditional jobs, to pursue higher education, and to seek career opportunities. Evidence suggests that financial power imbalances are actively avoided in lesbian relationships, as is economic dependency for either partner (Burns, Burgoyne, & Clarke, 2008).

Most studies provide incomplete information about both same-sex and heterosexual couples' money management, because they typically use only a two-category measure that is most likely based on heterosexual marriage norms: pooling all resources together versus nonpooling. Using a four-category measure, Burns and colleagues (2008) studied a small sample of lesbian and gay couples, and reported that the majority of couples were committed to a system that provided each partner with access to some money, personal spending, and decision making. Most used a system of partial pooling. For couples with differing income levels, pooling often was done proportional to income, with the higher earning partner contributing a larger share to joint expenses. Unlike breadwinning men and dependent wives in heterosexual marriages, lower earning lesbian and gay men partners did not tend to do more housework.

Overall, the research to date suggests that lesbian relationships are and can be successful and happy. These findings must be qualified by several limitations. First, sampling issues may affect results. For instance, lesbians may be less likely to have children than heterosexual women and this may expand their career options. Thus, lesbians and heterosexual women should be matched in terms of whether or not they have children when studying occupational choice or commitment. Also, as noted earlier, white heterosexual women as a group may not be an appropriately matched sample to compare to white lesbians. Feminist beliefs may partly determine attitudes toward equality, autonomy, and work. However, feminist values may be a less influential factor in comparisons of black heterosexual and lesbian women. Black lesbians are more likely to have developed their same-sex desires outside the ideologies of lesbian feminism that have influenced white lesbians (Moore, 2011). In addition, many black heterosexual women grew up with a model of female economic independence in their mothers and female relatives. Their attitudes about economic independence may not be connected to feminist values.

Second, few studies have been done on ethnic minority or working-class lesbian couples. Occupational interests and self-ratings of masculinity may be affected by cultural values. Lippa and Tan (2001) found larger differences in the masculinity ratings of Hispanic American and Asian American lesbians versus heterosexual women than among white lesbian and heterosexual women. The authors speculated that the traditional gender roles prevalent in Hispanic and Asian cultures may not encourage the

more androgynous alternatives that are more accepted in white culture. Studies of working-class lesbians are similarly sparse and may require unique approaches. In a study of middle- and working-class lesbians in England, McDermott (2004) found that the working-class women were less confident and more nervous in the interview and had a difficult time trusting that their stories were important or interesting. The middle-class and university-educated women spoke with greater ease and certainty and more easily elaborated on their lives. McDermott (2004) advised that the power dynamics in interviews with working-class lesbians must be closely attended to so that they feel empowered to tell their story.

Third, lesbian relationships are not immune from problems. Lesbian couples, like heterosexual and gay male couples, tend to disagree about similar topics, such as finances, affection, sex, criticism, and household tasks (reviewed by Peplau & Fingerhut, 2007). Hall and Greene (2002) also described differences among African American lesbian couples in social class backgrounds that brought them into therapy. Conflicts arose from clashes between the working- and middle-class values of the two partners over whether to pay for middle-class vacations, to stay with relatives versus in a hotel when visiting family, or to pursue a higher education. Additionally, some lesbians engage in domestic violence in a pattern that is similar to escalating violence in heterosexual relations (Kelly & Johnson, 2008; West, 2002). These issues and the unique contribution of discrimination and minority stress to relationship problems are being studied (e.g., Balsam, Molina, Beadnell, Simoni, & Walters, 2011; Mohr & Daly, 2008).

In sum, despite the many positive features of the average lesbian relationship, lesbian relationships are as unique and varied as heterosexual relationships, and research and theory on sexuality should recognize this variation.

INTERNET COMMUNITIES

Internet chat rooms, search engines, online personal advertisements, and the like have recently permitted lesbian women, many of whom were otherwise isolated, to find communities of similarly identified women and to share about various issues, such as sexuality, sexual activity and health, and sexual discrimination. On the Internet, women can remain anonymous if they choose to, permitting them to gain education and experience without the fear of being "outed" in their local communities or to prejudiced individuals.

Xenasubtexttalk, an interesting online community, was created by three lesbians in 1998, to provide a space for fans to discuss the lesbian subtext woven throughout the television series, *Xena Warrior Princess.* Online postings, examined by Hanmer (2003), revealed that women members and visitors engaged with other fans about how they came to discover

their same-sex desire and how they related to Xena, the heroine protagonist of the show. Computer-mediated interviews with participants also revealed that watching the show and participating in the Xenasubtexttalk community influenced many women to embrace their lesbian sexuality for the first time. Thus, the show and Internet community offered women the opportunity to explore their own and others' sexual narratives in a safe environment.

Media outlets also can help lesbians to unite and to challenge dominant practices. Henrickson (2007) examined the use of the Internet for constructing lesbian, gay, and bisexual (LGB) communities and facilitating sexual contact among community members in New Zealand. Participants (1,023 women and 1,233 men) were asked how they made contact with LGB communities and how they used the Internet to hook-up (i.e., to find sexual partners or relationships). The Internet was the third most frequently used means of making initial contact with the LGB community, following contact through friends or school or job. For immigrant men and women living in New Zealand, the Internet was used even more frequently as the first point of contact. Lesbian and bisexual women who were married to and living with a man were proportionately the highest users among women. About 23.3 percent of women used the Internet for hooking up.

Lesbians in British Columbia also were found to use the media as a means for negotiating multiple identities, communities, and social networks (Bryson, MacIntosh, Jordan, & Lin, 2006). Open-ended, in-depth interviews using a sample of 63 women who identified as "lesbian, gay, bisexual, dyke, queer and/or transgendered" revealed that participants commonly used media spaces and materials to construct and practice their identities as lesbians. The Internet was used to locate and belong to communities of "like others" (e.g., Asian queer women, queer folks living with mental health issues, members of the Xenaverse, fat dykes, leather dykes, etc.).

Overall, research indicates that the Internet is a major vehicle for connecting lesbians with lesbian communities and as a means to find sexual and relationship partners.

LESBIAN RELATIONSHIPS AND THE LEGALIZATION OF SAME-SEX MARRIAGE

Legal changes resulting in the availability of same-sex marriage have raised questions about what impact greater social acceptance will have on lesbian relationships. The legalization of same-sex marriage in some states also has made it possible to identify and survey lesbian couples such that research with this population is increasing. In general, surveys indicate that most lesbians endorsed the belief that legal recognition of same-sex marriage represents an aspect of legal equality for LGBT people that is a

positive change (e.g., Lannutti, 2005). The majority viewed it as marking the end of discriminatory practices and second-class citizenship.

The two greatest perceived benefits were financial, including health insurance for family members, tax breaks, recognition of joint property, and increased security for families in terms of making medical decisions and protecting the legal rights of couples, parents, and children. However, views of whether it will strengthen couples or the community were mixed. Some contended that it would provide validation for couples, and thus help to reduce internalized homophobia. Marriage also was expected to create barriers to dissolving relationships that would stabilize couples. Others anticipated that same-sex marriage would heal the relationship between the LGBT and heterosexual communities; heterosexuals will perceive same-sex couples to be more similar to themselves, which will in turn lead to greater acceptance. In contrast, others reported that its availability might create a fad among lesbians to get married without serious intent. Some argued that if legal marriage becomes the norm in the LGBT community, unmarried couples would be stigmatized or that as lesbian couples became assimilated into heterosexual norms, the community might lose its unique culture.

Research suggests that legal and social recognition may be associated with different outcomes. For example, Fingerhut and Maisel (2010) surveyed one member of couples from California who had made a formal legal or social commitment to a partner and compared them to those who had not. Legal recognition in the form of a domestic partnership was associated with making greater investments in the relationship, but was found to be unrelated to life and relationship satisfaction. Social recognition in the form of a public ceremony was associated with life and relationship satisfaction but not to investments. Causal associations could not be determined. Longitudinal research would be needed to understand if recognition leads to well-being, well-being leads to recognition, or whether both are caused by other variables.

Some feminists have been more skeptical about the likely impact of legal same-sex marriage. For instance, Ettelbrick (1999) argued that the marriage equality movement represented a fight for the right to conform and assimilate—to be just like heterosexuals. A goal of feminism, however, is to challenge the organization of society around heterosexual norms, such as marriage (Clarke, 2003). Marriage is rooted in patriarchal values and perpetuates the idea that the nuclear family is the best and most legitimate form of relationship; accordingly, it should be disputed. Otherwise, legal same-sex marriage will reinforce marriage as the gold standard for relationships and will marginalize lesbians who choose to remain single or couples that choose not to marry. In other words, as Clarke (2003) argued: "lesbians and gay men who want to be just like heterosexuals lack ambition" (p. 528).

Despite these concerns and criticisms, the trend toward legalizing same-sex marriage appears to be strong in the general population and within the LGBT community. Proponents of same-sex marriage frequently frame it as a straightforward civil rights issue, in that same-sex marriage would give LGBT people equal opportunity to participate fully in civil society (American Civil Liberties Union, 2011). In addition to expanding civil rights and reducing legal discrimination against LGBT people, legalizing same-sex marriage may have the added benefit, over time, of loosening the rigid, gender-based dictates of marital roles. For example, the current trend for families and married women to adopt patrilineal surnames may be reconsidered and relaxed once the field of marriage includes individuals who do not (indeed cannot) abide by this rule.

FUTURE DIRECTIONS FOR RESEARCH

A major limitation for understanding lesbians and lesbian couples is the general tendency for researchers to use heterosexual relations as the anchor position by which others are judged. Heterosexuality remains an unremarked norm for interpreting human experience (Kitzinger, 2001). Research concerning same-sex couples often centers around if and how lesbians and gay men are as capable of having as intimate and loving a relationship as heterosexuals. However, research reviewed here suggests that lesbian relationships "manage to endure without the benefit of institutional supports" (Kurdek, 2005, p. 253) and to embody certain relationships strengths. New directions for research might focus on what accounts for the strength of lesbian couples and if they might be a model for heterosexuals instead of vice versa.

If lesbian relationships were used as the anchor position or baseline, instead of as an alternative or counterpoint to heterosexual relationships, fruitful new research questions and perspectives might result. For instance, lesbians differ more from heterosexual couples in terms of equality than any other relationship variable examined (Kurdek, 2001). This suggests that heterosexual relations might benefit from more equality. Men's position of dominance in heterosexual relations has been linked to the finding that men derive more benefit from marriage than women, particularly in terms of health (e.g., Kiecolt-Glaser & Newton, 2001). Power-status differentials between husbands and wives may partly explain why spousal conflict has a greater negative impact on the physiology and health of wives. For instance, wives instructed to interact assertively with a dominant husband had elevated cardiovascular responses (Brown, Smith, & Benjamin, 1998). In contrast, lesbian relationships provide a model of equality in terms of interpersonal dominance, which is predictive of high levels of relationship quality (Markey & Markey, 2011), effective conflict resolution (e.g., Gottman, Levenson, Swanson, et al., 2003; Kurdek, 2004a),

and perhaps health as well. Finally, research has indeed shown that partner equality promotes relationship happiness and longevity in heterosexual couples (e.g., Cooke, 2006; Frisco & Williams, 2003). Thus, to the extent that lesbian relationships are good models of relationship equality they hold practical as well as theoretical value for all.

The expanding body of research on lesbian sexuality and relationships, especially comparative research with other couple types, indicates a maturing of the field in lesbian and gay studies, away from an earlier focus on gender identity, attitudes, and psychopathology and more toward normal development. This is a promising trend. However, a possible downfall of comparative research is that it will limit the questions asked and measures used to what applies equally to women and men and not what applies uniquely to women versus men. The risk also exists that, even within lesbian and gay psychology, men will become entrenched as the normative category. Lee and Crawford's (2007) analysis of research on lesbians and bisexual women from 1975 to 2001 indicates this is already the case: lesbians were indexed less than gay men and research on lesbians was more likely to be published in specialty journals, not the top psychology journals.

CONCLUSION

Much scientific progress has been made in the last 20 years toward better understanding lesbian lifestyle, identity, and sexual expression. Recent research has shown lesbian relationships to be distinct and cohesive entities with many positive and beneficial properties, such as mutual empowerment, mutual sexual gratification, autonomy, and effective conflict resolution. Butch-femme gender roles are now better understood as positive signaling and identification systems for attraction and expression rather than being exclusively tied to sexual dominance or subordination. And lesbians' unique use of language and Internet communities reveals how lesbian women continue to subvert heteronormative culture, challenging sexuality researchers to focus on desire and fulfillment rather than sexual categories or boundaries.

Progress has also been made in media portrayals of lesbian sexuality and in some social beliefs about lesbians. Images of lesbian sexuality in mainstream media have been increasing and are more positive now than in the past, although these images remain narrow. Lesbian media gives a more broad portrayal of lesbian sexuality and one that is imbued with agency. Endorsement of legalizing same-sex marriage has also been steadily increasing in the United States (Silver, 2011), with some polls now showing a majority in favor of the practice, though the consequences of legalizing same-sex marriage for lesbian women and gay men are still unknown.

Ultimately, however, the lion's share of work required to thoroughly understand the lives of lesbian women has yet to be done. In light of the vast amount of research on sex and gender that has been produced in the last decade (for a review, see Eagly, Eaton, Rose, Riger, & McHugh, 2012), very little has been focused on lesbians. Moreover, research on lesbian sexuality continues to focus on small samples of racially-homogenous "out" lesbians in networked lesbian communities (Rothblum, 1994). Larger samples of more racially and ethnically diverse lesbian women are needed to fully understand lesbian life and sexuality. Given that broad acceptance and visibility of lesbian sexuality is increasing, this large-scale research can and should be promptly pursued.

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Chapter 2

Bisexual Women's Sexuality

Mimi Hoang

Though a hot topic for many, discussing the sexuality of bisexual women in one chapter is challenging. Many complexities exist within the bisexual women's community, even in the definition of *bisexual* itself. If one were to ask 10 people on the street to define what being bisexual means, one might get 10 different answers. And though gay and lesbian communities have slowly gained more acceptance in the United States, bisexual men and women have received much less esteem or even acceptance. A myriad of unkind stereotypes run rampant in the media about bisexual people in general, including being confused, greedy, or promiscuous. For bisexual women in particular, TV and movies generally showcases them cheating on their partners, having threesomes, or eventually going gay or going straight. This, of course, lends to stereotypes about the unfaithful, slutty, or again, confused bisexual woman.

All these mixed messages and media untruths mar an honest, in-depth understanding of this community. It also doesn't help that these negative attitudes come from both the straight *and* gay world. When internalized, these fabricated stereotypes potentially damage the development

of strong, confident bisexual women, and ultimately, a vibrant bisexual women's community. Thus, to begin discussing bisexual women, the first step is defining bisexual identity. This chapter, then, starts with a more academic breakdown of terms before delving into the more tangible layers of sex and sexuality in bisexual women.

DEFINING BISEXUAL IDENTITY

Let's start with some theory. Alfred Kinsey in the 1940s broke ground on unconventional and nonheterosexual sexual behavior. Although people tend to focus on his data on homosexuality and not bisexuality, only 4 percent of the men and 3 percent of the women in his study were exclusively homosexual. His famous Kinsey scale also only measures sexual *behavior,* and though it implicitly put bisexual *behavior* on the map, it did not explicitly propose a *bisexual identity* category. The Klein Sexual Orientation Grid (KSOG) in the 1980s broke further ground on different dimensions of sexual orientation, including sexual attraction, romantic attraction, sexual behavior, fantasies, lifestyle, and self-identification. Many others since then have urged sexuality researchers to clearly define attraction, behavior, and self-identification as separate concepts (Garnets & Kimmel, 2003).

Bisexual Attractions

Let's talk first about bisexual attraction. Some say that bisexual attraction means having both sexual and romantic attractions to both men and women. In practice, this could mean a woman who has sexual and romantic feelings for men and women. The statements "I could have sex with or fall in love with either" or "I dig girls and boys" represent this. Some of them may eroticize men for certain qualities and women for other qualities. They may say, "I really like macho guys and girly girls" or on the reverse, "I'm mostly into effeminate men and tomboyish women." Others say that bisexual attraction is defined only as having sexual attractions to men and women. In practice, this could mean a woman who has sexual feelings for men and women, but has romantic feelings toward men only or women only. These women might say, "I find both sexy but only fall in love with men," and "I have the hots for both but my heart is with women."

Then, there are those bisexual women who do not define their attractions at all by the sex of their partner. For example, they may say, "I like artistic people who can cook" or "I'm attracted to masculine people in general." For them, "bisexuality is about the electricity and not the plumbing," or their proclivities may include relationships with transgender, transsexual, or nongender-conformist individuals. "I only like butch women and transmen" or "I like feminine folks, be that men, women, or someone in between" might be things you hear. Thus, the most comprehensive and

agreed upon definition among academics and the bisexual community itself is "sexual and/or romantic attraction to more than one sex/gender." Or a more contemporary way of putting this—"gender queer desire" (Ward, 2011).

Many academics and activists have discussed the possibility that there are more bisexual people than gay/lesbian people. Recent studies of adults (Laumann, Gagnon, Michael, & Michaels, 1994) and adolescents (French, Story, Remafedi, Resnick, & Blum, 1996; Garofalo, Wolf, Wissow, Woods, & Goodman, 1999) have in fact confirmed that individuals attracted to more than one sex outnumber those exclusively attracted to the same sex, especially among women. Thus, more bisexual people exist than most people think. But why, then, does this not seem to be public knowledge?

This is where the split between bisexual attractions, behaviors, and self-identifications comes into play. After all, not all these dimensions line up in each person. Research has often found discrepancies among the percentage of people who report bisexual attractions, report bisexual behaviors, and who identify as bisexual (Amestoy, 2001; Fox, 2003; Ketz & Israel, 2002; Rust, 2001). The profiles of the women discussed above are all about who they are attracted to, not who they actually have sex with or date, or what they call themselves in public. Despite the fact that these inconsistencies exist, research supports the view that *attractions are typically the most reliable way of measuring sexual orientation,* because behaviors and self-labeling are greatly affected by cultural norms and social opportunities (Diamond, 2008; Fox, 2003).

Bisexual Behaviors

It has been said that "Bisexuality is not an identity . . . but a narrative, a story" (Garber, 1995, p. 87), meaning that to truly understand a women's bisexuality means looking at her story over time, rather than only taking a snapshot at one point in time. Klein (1993) noted four bisexual behavior typologies: *sequential, concurrent, transitional,* and *historical. Sequential bisexuality* is when someone has sexual and/or romantic relationships with one person at a time. For example, a woman who has sex with a man, then dates a woman, then later dates a man, and later has a fling with a woman is exhibiting sequential bisexuality or *alternating bisexuality* or *serial monogamy.* This is probably the most common typology, though the media rarely ever portrays this type. *Concurrent bisexuality* describes a person who has sexual and/or romantic relationships with men and women at the same time. This would mean a woman who is dating a man and a woman at the same time. *Polyamory transitional bisexuality* describes a person moving from a heterosexual orientation to a gay/lesbian orientation. This would mean a woman who dates men, and then after a period of self-exploration, dates men and women for a while, and then in realizing that she is gay,

dates women only thereafter. *Historical bisexuality* is a person who currently lives a straight or gay/lesbian life, but in the past had relationships with men and women (e.g., a straight woman who currently only dates men, but in the past dated both men and women).

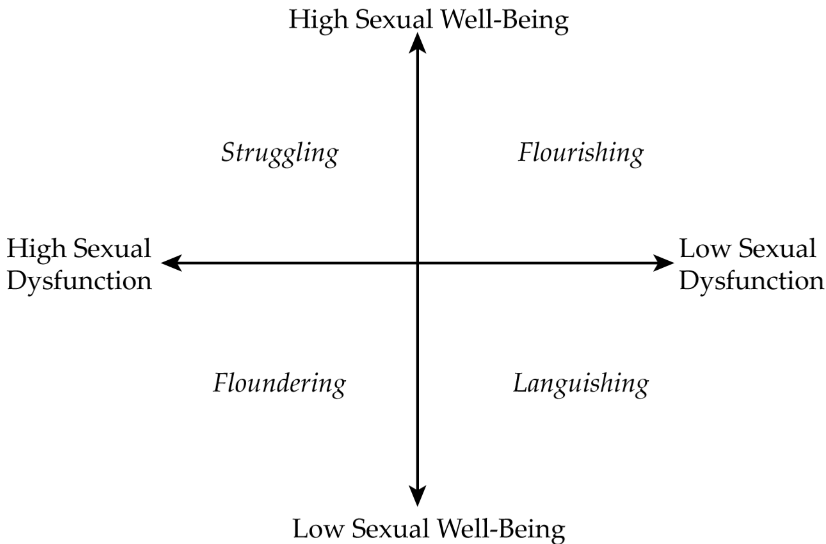
Klein (1993), Fox (2003), Ross (1991), and Little (1989) also describe other bisexual narratives. *Recreational* bisexuality is when a heterosexual-identified person has same-sex activity while using drugs and/or alcohol. An oft-cited example of this in mass media is a straight college woman who gets drunk and ends up having sex with her female best friend. Bisexual behavior could be deemed *temporary,* such as a gay-identified woman who has casual sex with men in between her relationships with women, or a woman who dates men except for one relationship with a woman. *Experimental* or *exploratory* bisexuality happens when a straight or gay woman has sex with another gender out of curiosity. *Motivational* bisexuals are straight women who have sex with women at the insistence of a male partner for his titillation. With the increase in one-man-and-two-women scenes in pornography for straight male audiences, motivational bisexuality seems to have become increasingly common in recent years.

Bisexuality that is *situational* or *circumstantial* is a heterosexual person who chooses same-sex partners only in situations where there is limited access to other-sex partners (e.g., a straight woman has sex with women in prison or in all-female harems). Someone who traverses into same-sex behavior for financial or career reasons (e.g., prostitution or pornography) may be called an *occupational* or *conditional* bisexual, whereas bisexuality that is dictated for some or all members of a society has been called *ritual* bisexuality, which has been documented for males, such as in ancient Greece or in Papua New Guinea.

Bisexual Self-Identifications

So, we now know that bisexual attractions and behaviors don't always match up. Next came bisexual self-identifications, which are no different. Horowitz and Newcomb (1999) found that 40–50 percent of people in their study had bisexual attractions, but only 1 percent actually called themselves bisexual. Even Rust's (2001) large-scale study on the bisexual population showed that out of the 917 bisexually attracted men and women, only 64 percent self-identified as bisexual. Others who are gay or lesbian may call themselves bisexual early on because doing so may seem safer. To help illustrate this, the Concentric Theory of Bisexuality (Hoang, 2009) shows that only some people who have bisexual attractions behave bisexually and that only some who behave bisexually self-identify as bisexual, with a small percentage who self-identify or behave bisexually not necessarily having bisexual attractions (Figure 2.1). As Diamond (2003) said it best, "Identity and orientation do not always coincide" (p. 354).

Figure 2.1 Concentric Theory of Bisexuality



Source: Hoang, 2009.

Although the term bisexual has been around for decades, its usage has been inconsistent and fraught with conflict. Because the term has the suffix sexual, some find it limiting only to sexual behavior. Others find it too clinical or archaic, akin to the term homosexual. Although the homosexual community has adopted the easier-on-the-ears gay and lesbian, the bisexual community has no parallel user-friendly term or at least one with consensus. In an attempt to de-emphasize the sexual aspect, many women simply use *bi.* Others who are exploring use the term *bicurious,* although some criticize this term as making bisexuality seem experimental or trendy (Bower, Gurevich, & Mathieson, 2002). Both of these terms, however, use bi, which assumes a binary view of gender (Berenson, 2002). The "two-ness" of *bi* also might assume that a bisexual person needs two relationships at the same time or has a 50/50 split on attraction. Over and over again, it seems that bisexual people are ambivalent about the term bisexual (Amestoy, 2001; Berenson, 2002; Bower et al., 2002; Fox, 2003; Rust, 2001).

Thus, you might hear many other terms, such as *pansexual* and *omnisexual,* for women who want a more encompassing definition that includes transgender people or attraction outside of gender lines or interest in the unconventional, such as group marriage or BDSM (bondage, domination, sadism, and masochism). Other terms circumvent bi and sexual altogether, such as *fluid* or *flexual.* Many younger individuals, women in particular,

have embraced the once derogatory *queer,* although *queer* is also utilized as an umbrella term for the general lesbian, gay, bisexual, and transgender (LGBT) community. Many bisexual women dating lesbians seem to gravitate toward *queer,* perhaps to seem more gay. This increased cohesiveness with the gay/lesbian community, however, can render bisexuality invisible (Bower et al., 2002).

Adding to the mix of self-identity labels are other creative creations. Some use compound labels, such as *lesbian-identified bisexual, bisexual lesbian,* or *bisexual queer,* or more individualized labels, such as *bi-dyke* and *heteroflexible* (Bower et al., 2002; Rust, 2001), and rebel against all mainstream categories. Some women also use *technical bisexual,* such as "I'm technically bisexual, but . . . ," which some say shows the dissonance between inward and outward identities (Rust, 2001). Still others mysteriously go unlabeled altogether (Diamond, 2008; Rust, 2001). Whether this is because of the cumbersome process of bouncing from gay to straight labels, the inadequacy of the mainstream lexicon, or their own sense of not belonging, remains unclear. However, one can guess that a person who goes unlabeled probably has some element of bisexuality in their experience.

Thus, describing the essence of bi women's identity is complex. In some ways, defining bi identity means defining sexual orientation as a whole, because based on conventional wisdom, there exist only two valid categories for women. Even traditional definitions of *lesbian* (attracted to the same sex) and *straight* (attracted to the other sex) seem to leave out or overlap with *bisexual* (attracted to more than one sex), being that they each already take up "half of the pie." This also makes unclear where the boundaries between *straight* and *lesbian* officially end and where *bisexual* begins. Thus, in defining the *bisexual* category, one perhaps needs to rethink *straight* (*exclusively or primarily* attracted to the other sex) and *lesbian* (*exclusively or primarily* attracted to the same sex).

Bisexual Identity Development

Now that we have an understanding about attraction, behavior, and self-identification, we can discuss the identity development process as a whole. This is important because most gay/lesbian identity development models portray a relatively smooth sequence of stages/phases moving from (a) first awareness of same-sex feelings, (b) first same-sex experiences and acceptance of gay/lesbian identity, (c) self-disclosure of gay/lesbian identity, and then (d) integration of gay/lesbian identity into the person's overall identity (Cass, 1979; Coleman, 1982; Sophie, 1986; Troiden, 1979). For a bisexual woman (or man), however, development of sexual identity involves a more multilayered process due to both same-sex and other-sex feelings, and how these feelings may or may not coincide with actual experiences or actual self-disclosure, as described in the previous subsection.

Bisexual identity development models for bisexual men and women, in fact, describe a more complex journey, composed of (a) awareness of other-sex feelings and same-sex feelings (not necessarily in that order), (b) experience of other-sex and same-sex relationships (not necessarily in that order), (c) acceptance of bisexual identity, (d) disclosure of a bisexual identity, and then (e) continued uncertainty of self-identification labels (though not attraction) due to lack of community resources, prejudice, and being in a monogamous relationship (Brown, 2002; Diamond, 2008; Weinberg, Williams, & Pryor, 1994). Thus, due to many external challenges and lack of bisexual validation, the final stage of identity development for bisexual people tends to be a type of identity maintenance rather than full integration like in the gay/lesbian models.

This last identity maintenance stage has been validated in Diamond's landmark 10-year longitudinal study on sexual minority women (2008), which found that despite external changes in who they dated or what they called themselves, most of the bisexually attracted women sustained their feelings for both sexes and even felt an increased certainty about their bisexual orientation. Thus, names changed but attractions didn't. This name-changing phenomenon was shown in another study where many bisexual women took on the identities of those around them and hid their bisexual orientation because of anti-bisexual prejudice, and only half expected to continue to identify as bisexual throughout their life (Wilson, 2008). Again, orientation and identity may diverge, but most bisexual women remain bisexual.

Building from these findings and theories, the idea of identity congruence has been proposed as a useful way to frame positive bisexual identity development (Hoang, 2006). That is, a woman with a congruent bisexual identity is a woman who is aligned in her attractions, sexual behaviors, social groups, and private and public self-identifications. Thus, a bisexual woman who is about equally attracted to men and women (e.g., a "KSOG 4") would have sex and/or relationships about equally with both men and women, socialize with gay and straight networks or bisexual networks, and acknowledge her bisexual identity both internally and externally. In other words, how she feels, acts, and calls herself would be in unison.

At what ages does all this process happen? Fox (1996) found that bisexual women tend to experience their first attractions to men in their early teens, their first sexual experiences with men in their mid-to-late teens, and first relationships with men in their late teens. He also noted that bisexual women had their first attractions to women in their mid-to-late teens and first sexual experiences and relationships with women in their early 20s. Thus, for bisexual women, other-sex experiences tend to happen earlier than same-sex experiences. Fox also noted that first self-identification as bisexual for women tends to happen in the early-to-mid 20sand first self-

disclosure as bisexual in the early-to-late 20s, although the averages seem to be getting younger in recent years. And though first self-disclosure may occur in early adulthood, as mentioned earlier, identity maintenance, for some, may continue throughout the lifespan.

Sex and Love

Now that the internal identity processes and some of the sociocultural forces that affect bisexual women have been discussed, readers will have a better understanding of the sexual and romantic lives of bisexual women. Not coincidentally, these topics, though more concrete, are no less complex. Sex and dating can already be complicated as a straight or lesbian woman, but add both same-sex and other-sex dimensions in the mix and things can become even more extraordinary and exciting, or sometimes just downright exhausting.

In general, bisexual women may have any of the sex and dating dilemmas as anyone of any sexual orientation, such as decisions about whether to have sex before marriage, sex within a committed relationship, sex with friends, sex with strangers, or no sex at all. These sexual decisions depend on her sexual values, which could range anywhere from very conservative to very liberal, as well as levels of sex drive, which could range from nil to very high. Safer sex is also something to navigate with male and female partners, which can be tricky in a society where sex is taboo and myths about safe sex abound.

A bisexual woman may be pining for a monogamous and domesticated life complete with white picket fence with a life partner, be it male or female. For a bisexual woman, who has found a male life partner, this may go as smoothly as any other heterosexual union. A bisexual female who has found a female life partner, however, unfortunately may not have the option of legal same-sex marriage depending on which U.S. state she lives in. Some women will have the option of domestic partnership status, whereas the rest will have to settle for legally unrecognized spiritual union. For some bisexual women, this lack of legal recognition, along with familial and social pressures, may be strong deterrents to finding a same-sex partner. She may also want children, which may be conceived "au naturel" or via artificial insemination, or adoption. But this domesticated dream is not for all; like many modern women, some bisexual women may want monogamy, but not marriage. This may mean exclusive long-term relationships with no legal binding in sight. Of course, these relationships could be delineated by sex/gender or not. For example, she may only date women but have flings with men or she may be completely gender blind in her dating agenda.

Alternatively, some bisexual women may want a polyamorous arrangement, which also is replete with multiple choices. One common poly

arrangement consists of having one primary partner with a sustained secondary partner (e.g., a husband and a girlfriend or a wife and a boyfriend). She may also want to share her secondary partner(s) with her primary partner (a V formation). If all partners are of equal status in a closed arrangement, then this would be called *polyfidelity* or *group marriage* (a triangle formation). Some bisexual women might want a primary partner with various short-term secondary partners (e.g., a serious girlfriend/boyfriend with casual girlfriends, boyfriends, or casual one-nighters) and both primary partners may also have secondary partners (e.g., she and her girlfriend may both date men outside of their relationship). Important to note is that healthy polyamory entails mutual agreement between partners and plenty of communication, such as when, how, and with whom any activities occur.

Due to societal stigma, many LGBT individuals use internet sites to find sex and relationships. The challenges of dating in a monosexist world can make the internet sites even more attractive to a bisexual woman where she can more closely manage her image or her audience. If she is using a singles advertisement, she may or may not want to communicate her bisexual identity upfront, although many dating sites are inherently monosexist, thereby forcing people to choose between "looking for men" and "looking for women." For bisexual woman who use internet dating sites, many use them for browsing/curiosity, some for seeking friendships, a fun dating relationship, a serious relationship, or sexual chatting, and a smaller percentage to test their sex appeal or to find a discreet affair, and interestingly, out of women who use internet dating sites, more bisexual women compared to lesbian or heterosexual women use them to explore their sexuality (Lever, Grov, Royce, & Gillespie, 2008).

As complex as the coming out and identity development process is, it can be easy to imagine that coming out to a sexual or romantic partner could be tricky as well. This is a question that bisexual women need to face in a dichotomous society where a woman is assumed either straight or gay depending on superficial factors, and where being bisexual is treated either as a sin, an illness, or a character flaw. Thus, a bisexual woman carries the burden of managing these impressions or boldly creating her own. She must decide whether to tell her male or female partner on the first date, before or after sexual activity, before or after becoming serious. With the boom of internet social media, a bisexual woman may be indirectly "outed" if she already has bisexual-related identifiers on her internet profile. Once in a romantic relationship, she may also need to communicate her definition of her bisexuality and whether this has any bearings on the relationship. Without role models for healthy bisexual relationships, these dynamics present a tough obstacle course for bisexual women, especially for a woman figuring out her bisexuality while in a committed relationship (Bradford, 2006).

Sexual identity formation could indeed have bearings on relationship behaviors. One study attempted to dispel the myth of the "inherently cheating bisexual woman" by looking at differences in identity processes and internalized biphobia. The study found that more congruent bisexual identities were correlated with less internalized biphobia and more bisexual pride (Hoang, 2006). Although this study did not find a significant relationship between infidelity and bisexual identity congruence or internalized biphobia, it did find that more than one-third of the women were faithful, which disputes the myth of the "inherently unfaithful bisexual woman." Moreover, a follow-up article with post hoc analyses did show that unfaithful bisexual women had higher levels of internalized biphobia than faithful bisexual women (Hoang, Holloway, & Mendoza, 2011). This applied to relationships with male and female partners and affairs with men and with women. Thus, internalized stigma seems to play a major role in identity development and relationships for bisexual women.

Contrary to myths about bisexual people being unable to have stable relationships, studies have also found increasing relationship commitment across life stage cohorts, with more bisexual people in middle and older adulthood describing themselves as married/partnered than as single (Brewster & Moradi, 2010). As bisexual people age, the tendency to identify as polyamorous also increases; one hypothesis for this being that the term *polyamory* implies relationship commitment (albeit to more than one person at a time), which is less characteristic for emerging adults, most of whom are single or casually dating (Brewster & Moradi, 2010).

Sex and Love with Heterosexual Men

As discussed previously, bisexual women's first sexual and romantic relationships tend to be with men, though this is not always the case. Data on percentages of bisexual women's relationships with men versus women is scarce, although one study showed that bisexual women had more exclusive relationships with men (Hoang, 2006) and another study showed bisexual women having slightly more sex with male partners (Brewster & Moradi, 2010). The authors caution sociopolitical reasons for this rather than internal reasons, due to the fact that other-sex relationships are more socially acceptable and women face the pressure to marry in our society. Also, many people might be defining sex to mean penile intercourse (Brewster & Moradi, 2010). One might also take into account gender role conventions and the fact that men are socialized to be more sexually aggressive than women, or the lower numbers of gay/lesbian meeting places (e.g., gay bars, groups) versus heterosexual meeting places (everywhere else), or that statistically there could be more heterosexual men than lesbian women. This is somewhat reflected in a study showing that half of

adolescent bisexual women date both men and women, 23 percent date men only, and 14 percent date women only (Elze, 2002).

In understanding the relationship dynamics between bisexual women and heterosexual men, it is important to look at heterosexual people's attitudes toward bisexuality. Many studies seem to show similar results that heterosexual people think bisexual people are sexually promiscuous, unfaithful, spread STIs/AIDS to heterosexual people, and are less well-adjusted than heterosexual and even gay/lesbian people (Eliason, 1997; Spalding & Peplau, 1997). Although little research exists on heterosexual men's attitudes, specifically toward bisexual women, many movies have featured the wife or girlfriend who cheats on her male partner with another woman, such as *Henry and June, High Art,* or *Imagine Me and You.* Many TV talk shows also seem to dramatize the woman-cheating-on-a-man-with-another-woman scenario. Not coincidentally, the cheating partner is inevitably the bisexual partner, with the same-sex lover on the side, which conflates bisexuality with infidelity and sets up the other-sex relationship as the "good" relationship and the same-sex relationship as the "bad" one (Ochs, 1996).

After the advent of *Girls Gone Wild* videos in the late 1990s eroticizing drunken young heterosexual women kissing other girls while men cheer them on, TV shows seem to be joining the trend to include some girl-on-girl kissing between supposedly heterosexual females, such as *Sex and the City, Friends,* and *Desperate Housewives.* All of this has fostered the fetishization of bisexual or bicurious women by heterosexual men. Popular in today's society is the idea that the ultimate male fantasy is two women having sex (Bower et al., 2002). Of course, many mainstream images of this fantasy show two ultrafeminine, by-all-appearances-heterosexual women. Perhaps, not coincidentally, adult films targeting heterosexual male audiences often start with a brief girl-on-girl scene followed by a male joining, implying that the same-sex portion was purely a warm-up activity to prepare for the central guy-on-girl finish (Ochs, 1996). The underlying assumption here is that the penis rules in the bedroom.

Then, it is foreseeable that this straight male fetish trickles into the everyday world. Women who act on or disclose their bisexuality often get unwanted attention or pressure from straight men who assume that the woman has a higher sex drive, has broader sexual interests, has an interest in swinging, or threesomes with another woman. Thus, some bisexual women who want to be taken more seriously may choose not to disclose upfront, or they may downplay it, intellectualize it, or become defensive about it. Others who buy into the fetishization may play into the slutty image, flaunt their bodies and sexualities, and fuel this sexualized attention. Bisexual women may also encounter increased STI (sexually transmitted infection) risk as a result of disclosing her bisexual desires, because telling a male partner often opens them up to even more sexual partners

because the men then encourage it (Champion, Wilford, Shain, & Piper, 2005). For instance, Burleson (2005) found that many bisexual women, but not men, in other-sex relationships were allowed or encouraged by romantic partners to explore their same-sex attractions.

Despite these fetishes, many bisexual women may still gravitate toward relationships with men because of society's overall stigma against gay/lesbian sexualities. Some may purposefully try to avoid getting too close or serious with women so that they can lead a straight life and earn their family's or community's acceptance. Interestingly, a study on bisexual women's infidelity showed that they were unfaithful more often in their exclusive relationships with male partners than with female partners (Hoang, 2006), although the participants also had more exclusive relationships with men overall. The explanation could be due to the uncertainty of settling down with a man if the bisexual woman has not reconciled her bisexual desires, especially if she is being pressured. The bisexual woman with an incongruent sexual identity might publicly have boyfriends while having discreet encounters with women, the reverse of men "on the downlow" who publicly have girlfriends but have secret encounters with men. Both are maintaining a heterosexual facade. Perhaps, not coincidentally, this mimics the heterosexual facade that many gay and lesbian people used to (and perhaps still) uphold when they got married or took other-sex partners to the prom.

Being with a man, and therefore a heterosexual relationship, may also be challenging for bisexual women who have many LGBT friends or a strong identification with the LGBT community. They may feel their own queer identity being muted or questioned by outward heterosexual behavior (Bradford, 2006). Some bisexual women in this situation may try to compensate by amplifying their LGBT or queer identity. They may try to "look more queer" or be more outspoken about LGBT issues. One study found that bisexual women partnered with men were more likely to be "out" about being bisexual to their gay/lesbian friends than bisexual women partnered with women (Gregory, 2009). Thus, being with men is not necessarily always the easier path.

Sex and Love with Lesbian Women

Bisexual women, though not always the case, may discover or come to terms with their same-sex attractions after they negotiate their other-sex attractions. Some explanations for this could range from the obvious societal stigma of LGB sexualities or lack of exposure to LGB culture and terminology. Some bisexual girls/women may not even hear the term bisexual until after they hear gay and lesbian, so they may not be aware of this third option. Young girls/women are also socialized to be ignorant, passive, or discreet about their own sexual interests, thus boys/men may

confront them about sex before other girls/women do or before they even confront themselves. They may assume that having crushes on boys must automatically make them heterosexual, thus foreclosing any other sexual identity exploration. Even for girls/women who are aware of their same-sex feelings, they may not know which other girls/women would similarly be interested until someone discloses something obvious or if it's within an LGBT context. Whereas bisexual women can meet a slew of available men at your average bar, park, or movie theater, Burleson (2005) found that most bisexual women meet female partners through friends, work, or LGBT community events.

Interestingly, although bisexual women may on average deal with their straight side before their gay side, Brewster and Moaradi (2010) found that many bisexual women have slightly stronger same-sex physical and emotional attraction than other-sex physical and emotional attraction (whereas bisexual men show the reverse pattern, meaning that both seem slightly more attracted to women). This would possibly weaken the myth that "bisexual women are actually really straight" (and that "bisexual men are actually really gay"), although sociopolitical forces could be making it more acceptable to eroticize or romanticize women. In today's world, it just seems more acceptable to say "women are beautiful" than "men are beautiful."

Roles and expectations may differ in having sex with women versus men. In the movie "Kissing Jessica Stein," the seemingly evolved bisexual love interest named Helen states that being with a woman is different than being with a man because "her lips are softer, her body softer" and that it's "nonthreatening but very exciting." Thus, the assumed sexual power dynamics between men and women are not necessarily assumed between two women. The nonthreatening component of sex between women could also be problematic, however, in misperceptions about STI risk. Champion and colleagues' 2005 study found that a group of bisexual minority women believed that STI risk does not exist between women, because it's not "real sex," or that STI risk is only associated with men, so sex with lesbians is safer than sex with a man. They also assumed that sex with a lesbian woman was safer than with a bisexual woman because of the bisexual woman's history with men, even though some lesbian-identified women still have sex with men. Some of the women in the study also believed that *receiving* oral sex from a woman was safer than *performing* oral sex on a woman or that no risk was associated with sharing sex toys. Several reported being afraid to suggest using protection with other women because it might imply that she was unfaithful or "dirty" (Champion et al., 2005). Although this study used a very small sample of women, it is understandable how many women (and men) could fall prey to these myths considering general stereotypes about safe sex in our society.

Bisexual women in sexual and romantic relationships with lesbian women could experience any of the same joys that two lesbian women face, such as commonalities in gender role socialization, versatility of sexual or gender roles, and more mutual or sensual sexual pleasuring. But, as described by Bradford (2006), they may experience all the same challenges too, such as experiences of homophobia and internalized homophobia, social rejection, lack of legal rights, or outright physical danger. Some bisexual women's families make it very clear that their support is dependent on which way they go, which is an outright homophobic stance and an assumption of choice. The experience of trying to conceive with a same-sex partner can also be fraught with difficulties due to family negativity or prejudice and discrimination in the fertility industry, and create undue psychological strain (Yager, Brennan, Steele, Epstein, & Ross, 2010).

Challenges may also come from within the relationship as well. Many bisexual women in same-sex relationships also face pressure to identify as lesbian from their partners or lesbian community (Ochs, 1996). And although women partnered with females seem more likely to disclose their bisexual identity to their families and straight friends than women partnered with men (Gregory, 2009), perhaps because it's harder for them to hide their sexual minority status, even their own families may then pressure them to identify as lesbian because it seems easier to comprehend (Bradford, 2006). Their partners may also associate the self-identification as bisexual as some kind of indicator of lack of commitment or interest, and ask the impossible question, "You're with me now; why do you still need to call yourself bisexual?"

This may trigger many issues of biphobia, homophobia, and sexism, as their lesbian partner's concerns may have many assumptions or implications about the bisexual partner's sexual identity development, internalized homophobia, or sense of feminism. Again, stereotypes of the bicurious but heterosexual-leaning female come to the forefront, making the lesbian partner fear the worst—that their bisexual partner will ultimately leave them for a man. These urban myths seem quite powerful and pervasive, to the point that some lesbian women won't consider even dating a bisexual woman and will state the highly prejudiced "No bisexuals" on their singles advertisements. Challenging this typical lesbian fear is the finding that the rate of infidelity for bisexual women in exclusive relationships with women was very low, and in fact lower for relationships with women than with men (Hoang, 2006). Moreover, some lesbian women have a penchant for bisexual women who, on average, may look and act more feminine than lesbian women or who may be less politically militant than lesbian women. Summed up in one lesbian's statement, "I like bi women because they like you for who you are, not how you identify."

Sex and Love with Bisexual or Transgender Individuals

With all of the sociopolitical trials and tribulations in dating heterosexual men and lesbian women, it could be expected that some bisexual women may seek other bisexual men and women to date. And although not much has been written on bisexual-women-dating-other-bisexuals phenomenon, it seems like a promising option. A bisexual woman would definitely find comfort in dating another bisexual person with similarities in sexual identity, attractions to both men and women, and experiences of biphobia. Dating another bisexual can mean not having to explain yourself all the time.

Some bisexual women may be able to find other bisexual partners at bisexual-specific groups and events or at LGBT general groups and events. For those who are interested in sexual kink and more unconventional sexual activities, many BDSM community groups have a large number of bisexual members, though it is also important to note that BDSM is an interest for straight, gay, and lesbian individuals alike. Some may find them through their own friendship networks, although one study shows that few bisexuals are friends with other bisexuals (Galupo, 2006). This could possibly be a result of lack of access to local bisexual communities or their own internalized biphobia. If a bisexual woman still has shame about her bisexuality, she may avoid other bisexual women or associating with the bisexual community in general. Another theory is that some bisexual women may not be interested in feminine women, and therefore may prefer more masculine lesbian women. There does seem to be a niche, however, for women who prefer bisexual men, perhaps because they seem more sensitive to women and issues of sexism.

For those interested in using the internet to find sex and love, LGBT sites that are explicitly bisexual-positive (not just bisexual-inclusive) are a potential way to find another bisexual profile. Moreover, there are legitimate internet dating sites that specifically cater to bisexuals-seeking-bisexuals. Unfortunately, other supposed bisexual dating sites may play into the hypersexual bisexual stereotype and mainly promote hook-ups, threesomes, cybersex, or even infidelity.

Bisexual individuals may be more open to dating transsexual or transgender individuals than straight or gay individuals, perhaps because of shared openness to the gray area between male and female and between gay and straight. Although transphobia can exist in any community, a bisexual woman might be more apt to base attraction on chemistry rather than anatomy. A shared experience and history with sex and gender oppression may also create a common bond, as well as the shared alienation from many gay and lesbian communities, the would-be safe space for sexual and gender minorities. Anecdotally, some bisexual women have been known to date butch lesbians and transgender men. Some transgender women have also

found themselves maybe not coincidentally in relationships with bisexual women, perhaps because it was more acceptable for the trans woman to date women when they were presenting themselves as male.

Culture and Community

As can be seen, identity development, sex, and dating for bisexual women is not as easy or glamorous as mainstream TV shows like *The O.C.* might portray, or as straight and gay/lesbian folks might stereotype. These processes for bisexual women are fraught with many pressures and challenges which fly in the face of popular beliefs that "being a bisexual woman is trendy" or even that "women's sexuality is more fluid than men's," which all curiously sound like shifty come-on lines and ignore the broader social, political, and historical forces of patriarchy, sexism, and misogyny. The sociopolitical forces from the dominant heterosexual and queer discourses also inevitably impact the cultural development of the bisexual women's community and bisexual community in general.

Community Isolation and Confusion

An activist slogan from the gay and lesbian movement from the 1980s was "Silence Equals Death." The aim was to break the silence about the oppression of gay and lesbian people and give voice to the oppressed. It also coincides with the mentality that coming out of the closet was something to strive for. Even jokes about "earning your toaster oven" for helping gay people come out speak to this belief of liberation via self-disclosure and authentic living. This idea has also been endorsed in the clinical realm, with many studies showing that less internalized homophobia is associated with more developed gay and lesbian identities (Mildner, 2001; Rowen & Malcom, 2002) and relationship and health benefits (Henderson, 2001; Meyer, 2003). Research on the bisexual community echoes this sentiment—less internalized biphobia is associated with more cohesive bisexual identities and less infidelity (Hoang, 2006; Hoang et al., 2011).

So, how does this apply to the current bisexual community? As discussed above, the identity process for bisexual individuals can be a more winding and treacherous journey than for gay men and lesbian women. Many bisexual women have difficulty achieving a solidified bisexual identity where they feel, think, and act in a harmonious way. This is due in part to the dichotomous world of only two valid "check boxes" for sexual orientation. Yoshino (2000) argues that this gay/straight dichotomy is a purposeful and systemic erasure of bisexual as a viable category. So, how can a bisexual woman find answers when the answers keep disappearing?

A young bisexually attracted woman may try to find camaraderie with straight women when she first has other-sex experiences. Sharing sexual

and relationship stories about men can be key in building bonds with heterosexual women (Galupo, 2006). If she discloses her same-sex feelings or experiences, however, she risks social rejection from this circle. So, she may then seek community with lesbian women. She may not only at first find kinship with their experiences of injustice and rejoice in their celebration of womanhood, but she may also then suffer distrust and hostility from them if she discloses her underlying desires for men.

Many bisexual women, rather than face social outcasting from two communities, may consciously or unconsciously downplay their bisexual orientation in the gay/lesbian community. Some, because they may have built a full-fledged romantic, platonic, and professional life in the gay/lesbian community, unwittingly foreclose on further identity exploration and may not "come out" as bisexual until later in their adulthood. Some have been known to say that they fear reentering the world of men after enjoying the close-knit woman-centered bonds of lesbianhood. Some are fully aware of their bisexual nature, but publicly identify as *lesbian* or *queer* in order to sustain their place in the gay/lesbian community or to preserve their activist identity, assuming that identifying as bisexual is not political enough. Some, as mentioned previously, try to drop sexual identity labels altogether. If silence equals death, then all these self-imposed acts of repression, concealment, and un-naming, combined with society's acts of denial, devaluing, and erasure, are surely keeping the bisexual community barely breathing.

But what about other bisexual women? The sad reality is that some may never meet another out-as-bisexual woman in their local area. If a somewhat-out-as-bisexual woman by chance finds another somewhat-out-as-bisexual woman, she may rejoice in this or she may not. Studies on bisexual women's friendship patterns have shown that bisexual women tend to look for those of the same sex and same race/ethnicity, but not necessarily of the same sexual orientation. A fascinating finding is that if they did show a preference for sexual orientation, half of them preferred lesbian friends over bisexual ones (Galupo, 2006). Rust (1995) questions whether this is not only due to lack of access, but also to issues of biphobia and internalized biphobia.

Whether for better or worse, it appears that many bisexual women settle into the community that matches their current relationship profile. So, if they've settled down with a man, then they may settle down in the mainstream heterosexual world. If they've settled down with a woman, then it's the gay/lesbian community. If they're into polyamory, then it may be the poly community. If they're not into settling down, then they may continue floating depending on their current inclination. Many bisexual women, whether due to external or internal reasons, end up having a mixture of bisexual, gay, lesbian, and straight network of friends, a kind of patchwork family (Bradford, 2006).

Organizing and Activism

But what about bisexual communities? Bisexual women, if lucky enough, may live in geographical areas that are well-populated and progressive enough to have a bisexual-specific group. Many LGBT community centers may have bisexual conversation/support groups that may hold weekly, biweekly, or monthly meetings for bisexual, bicurious, and bi-friendly individuals to converse on bi topics in a safe space. Due to the structured and confidential nature of these groups, this may be an optimal starting point for many bisexual women beginning their bisexual identity exploration.

Many urban areas, such as New York, San Francisco, Boston, and Los Angeles, also have self-sustaining bisexual social and networking groups, some cogender and some specifically for bisexual men or bisexual women. These organizations may hold meetings in a local coffee shop or "mobile" events in various locations for a multitude of social gatherings. Other social groups that are purposefully inclusive of bisexual individuals may be polyamory groups, BDSM groups, or other alternative sexuality or cultural groups (e.g., transgender groups, nudist groups, pagan groups). The current trend seems to be a waning of support-type groups and a multiplying of social-type groups, which may be a sign that more bisexual men and women are more certain about their identities and looking for fun and friendship rather than a place to figure themselves out.

Some geographical areas may have such extensive resources as to have nonprofit status and office space, such as the established Bi Resource Center in Boston or the developing Los Angeles Bi Task Force, or other durable and dynamic activist groups, such as the New York Area Bisexual Network and the Bisexual Organizing Project of Minneapolis. These organizations feature physical and virtual bisexual resource collections and coordinate educational programming or promote bisexual visibility at LGBT events. Some groups aim to promote bisexual cultural arts. Interestingly, many of the more visible and active leaders are bisexual women, and more specifically, bisexual women over 30. This validates Brewster and Moradi's findings (2010) that women in young and middle adulthood tend to exhibit more "outness" than those in merging adulthood and that community involvement seems to increase as bisexual women mature.

For bisexual women not residing near these metropolitan areas, they may turn to other media to find bisexual connection. Bisexual blogs and websites are now growing in stability, as well as TV and radio shows focusing on bisexual community topics. National and international conferences are also an additional way to network and socialize with other like-minded individuals, and may be the only option for bisexual people living in less bi-friendly areas. Other social media savvy bisexual women may find social connectedness and activism via many bisexual-oriented internet groups, forums, and chatrooms.

Many bisexual organizers and activists are trying to gain status within bigger LGBT organizations by gaining leadership positions in traditionally gay or lesbian-dominated LGBT organizations or other more mainstream professional associations. Even well-known celebrities are coming out publicly as bisexual, such as movie and TV actress Anna Paquin and cutting-edge pop icon and LGBT activist Lady Gaga. All of these individual and national movements, both near and far, are hopefully helping to fight the stigma about being bisexual and promoting strength and solidarity for bisexual women everywhere.

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Chapter 3

Trans Women and "Interpretive Intimacy": Some Initial Reflections

Talia Mae Bettcher

> Our activity has no rules, though it is certainly intentional activity and we both understand what we are doing. The playfulness that gives meaning to our activity includes uncertainty, but in this case the uncertainty is an *openness to surprise*. . . . Rules may fail to explain what we are doing. We are not important, we are not fixed in particular constructions of ourselves, which is part of saying that we are *open to self-construction.* (Lugones, 1987, p. 16)

My aim in this paper is to chart and theorize some of the prevalent challenges that many trans women face in negotiating their sexualities in a world that is not always friendly to them. For example, because trans women are not ordinarily viewed as "one kind of woman among many," a man who has an orientation to women isn't expected to be straightforwardly attracted to (at least some) trans women as well. On the contrary, attraction to a trans woman may lead to worries that he is really gay (or bisexual). To be sure, there are indeed men who are specifically attracted

to trans women *as trans.* But this raises its own worries; in particular, there is a concern among some trans women about being fetishized. Some of these types of attractions may serve to undermine trans women *as women.*

The point is that trans women face some important challenges in negotiating the desires of others, in seeking out intimate relations, and in understanding the nature of their own sexualities. Before attempting to understand the sexuality of trans women, then it would seem to be important (as a first step) to get a better sense of these challenges. In this chapter, I undertake this task both as a trans woman who has experienced these challenges and as a philosopher theorizing them. Specifically, this chapter is an extension of previous theoretical work stemming primarily from my own experience as a trans woman and my knowledge of other trans women I've met through my life travels, as well as grassroots community activism.

This chapter will tend to focus primarily on trans individuals who were assigned male at birth but who now self-identify either as women or as trans women (I will use the expression trans women to refer to them). I will leave it open whether these individuals avail themselves to (or wish to avail themselves to) various medical technologies, including hormone therapy, genital reconstruction surgery, breast augmentation surgery, facial feminization, and so forth. In focusing on trans women, I do not discuss (non-trans) women who are in intimate relations with trans men, nor do I discuss some of the specific issues that trans men may face when viewed as women. A comprehensive account of transgender sexuality and women would need to take both into consideration.

The starting point of my theorizing is that we ought to accept the self-identity claims of all trans people as presumptively valid and true without requesting justification as a condition of acceptance.[1] This is important because one of the things that makes it particularly difficult to understand the sexuality of trans people is the fact that it has seemed necessary to frame trans people *as trans people* within some type of theoretical framework. The reason for this is the starting assumption that trans people are aberrant or at least in need of explanation (usually an etiological one). For example, Gender Identity Disorder is used as diagnostic category in both the American Psychiatric Association's DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders) and the World Health Organization's ICD-10 (International Classification of Diseases and Related Health Problems). Once trans people are understood as possessing a kind of identity disorder (whereby gender identity is misaligned with physical body), any subsequent discussions of trans sexuality filtered through that framework are going to be shaped accordingly. The more general problem is that this type of project is distracting. It tends to take up so much space that it forces out other types of inquiry; because one is so busy looking to provide a theoretical frame of reference that will render trans people intelligible, the question about trans sexuality either disappears or becomes

part of the theoretical frame itself. For example, some theoretical accounts (e.g., Bailey, 2003) have included sexuality as a crucial part of an etiological account of trans women specifically. In my view, such accounts fail to respect the self-identities of trans people and thereby prevent the possibility of actually learning about their sexuality.

A consequence of my starting point that we ought to accept the self-identity claims of trans people as presumptively valid and true is that one may not always immediately understand what self-identifying terms mean when a trans person uses it. For example, the fact that a trans woman self-identifies as a woman does not entail that she has had genital reconstruction surgery or even that she wants to have that surgery. On the contrary, a trans woman may take her body as a typical example of the body of a *trans* woman, and therefore of a *woman.*

This is a departure from common ways of framing trans people (the "wrong body model" and the "transgender model"). In the wrong body model, transsexuality is construed as a misalignment between gender identity and sexed body where the identity is innate and determines one's *real* sex. It's on the basis of this identity that one affirms that one has always *really* belonged to a particular sex where the morphological body is viewed as "wrong" and in need of surgical alteration.[2] In the transgender model, trans people experience oppression and violence because they challenge the view that there exists two nontraversible mutually exclusive categories in which all individuals belong. Their so-called "beyond the binary" status is seen as the source of conflict and hostility.[3]

Both accounts ironically tend to invalidate the self-identities of at least some trans people, because they do not start with the view that all trans self-identity claims should be presumptively accepted as valid.[4] For example, not all trans people self-identify as beyond the binary. Many see themselves as men and women. Yet, not all of these trans men and women see their bodies as wrong, either. Some trans women are not interested in genital reconstruction surgery, despite the fact that they see themselves as women (or trans women). In the "wrong body" account, such individuals won't count as women since they do not undergo surgical transformation and since they do not *want* to undergo such transformation. That said, these women may not see their bodies as in-between or beyond the binary, if they believe that their bodies are fairly typical for a trans woman and that a trans woman is a kind of woman. Neither account really does justice to such self-identities, then.

Instead of understanding trans people as standing in conflict with a gender binary, I adopt the more general view that (many) trans people tend to oppose the meanings of mainstream gender terms and practices.[5] I understand this conflict in terms of the contrast between dominant or mainstream culture and subcultural formations. In this view, a trans person can count as "a man" according to dominant cultural practices, while

counting as a woman in trans-friendlier subcultural contexts. Consider somebody who lives as a woman, sees herself as a woman, has been sustained in a subculture that respects her gender identity, and then finds that she is subject to violence on the grounds that she is "really male." The invalidation is not merely the invalidation of an individual self-identity, but an entire life that has been lived in relation to others in a different world.[6] This conflict is one that's deeply bound up with the distribution of power and the capacity to enforce a way of life and a way of seeing the world, regardless of the personal costs.

INTERPRETIVE INTIMACY AND SEXUAL DESIRE

Sexual/affectional orientation is generally taken to involve attraction to people of particular genders (i.e., *gynephilic* meaning woman loving and *androphilic* meaning man loving). Trans people may be thought to challenge the simplicity of this conception because they point to ways in which the features that typically align for men and women come apart. There are two different ways in which this happens. First, some trans people have bodies that may be read as mixed. For example, some trans women take feminizing hormones (growing breasts) but do not have vaginoplasty. Such a woman would have a mixture of bodily properties—a female-appearing body with a penis. If we take sexual attraction as targeting sexed bodies, then these mixed bodies are going to yield complications in understanding gyne- and androphilic desires in a straightforward way. Second, even in cases in which a trans person does not have a body that may be read as mixed, they may have a gender presentation that is taken as incongruent with their sexed body. Again, we have the possibility that the gender presentation and expression might matter more in the attraction or it might be that the sexed body matters more (or both matter in different ways).

In trying to re-understand sexual attraction within the context of trans people, however, it is important to keep in mind the centrality of respecting the self-identities of trans people and how they make sense of their own bodies. This already requires that we reassess the view that there is mixture or incongruence at all, in the above cases. The question we need to consider is actually quite different than what this "fragmentation" suggests. It is this: How can we make sense of sexual desire in light of the alternative interpretations that trans people use to undergird their self-identities? How can we do so in a way that respects trans self-identities?

To begin, it is important to understand that some trans people feel uncomfortable with sex-differentiated parts of their bodies when those parts are thought not to agree with their gendered sense of self. For example, a trans woman might feel uncomfortable with her penis and finds this to be invalidating of her womanhood. The interesting fact is that those body parts most likely to be a source of discomfort to trans people (genitals,

breasts) are also those that are put into social play in only very few situations—sexual situations being among the most common and important. This can obviously lead to challenges when negotiating sexual activity (particularly when sexual scripts centralize those body parts). Ironically, it is precisely such situations that provide trans people with the opportunity to reinterpret their bodies and to do so in an intersubjective way (at the very least, since they are the very few occasions in which these parts are involved). What gives sexual interaction such a powerful capacity for reinterpretation is, in part, the fact that in a sexual context, fantasy and role-play are permitted to an extent that is not normally acceptable in mundane public interactions. That is, within a sexual context, there is an element of *playfulness* that opens the doors of possibility, paying less attention to the constraints of social reality.

C. Jacob Hale (1997) discusses different types of strategies (retooling or recoding the body) that trans people might employ. One example involves the use of inanimate objects (such as dildos) in a way that allows them to "take on some of the phenomenological characteristics of erogenous body parts" (Hale, 1997, p. 230). Another involves renaming the body part itself. For example, what might be called a vagina can be called (in a leatherdyke context) a "boyhole" or a "fuckhole." Similarly, what might be called a penis in mainstream discourse can be called a "clit" instead. The point of these practices, according to Hale, is to "disrupt the dominant cultural meanings of . . . genitals [or other body parts] and to reconfigure those meanings" (Hale, 1997, p. 230).

There are many different kinds of such practices and it will be worth mentioning a few more. First, during intimate physical contact, there might be a "transfer" of body parts between partners. For example, if a trans woman (with a penis) is having penetrative intercourse with a non-trans woman, it is possible for the partners to erotically reunderstand the penis as belonging to the latter and the vagina to the former and the penetration as running in the opposite direction. Second (and this is perhaps a limiting case), it is possible to simply exclude the body part from any sexual role in the encounter and to effectively pretend it isn't there. While this may seem not to be a case of recoding, I think there is a sense in which it might count. Certainly, in order to perform this exclusion, it is likely that standard sexual scripts about what counts as typical sexual activity and how it is supposed to be performed may need to be rewritten. Third (and this one has consequences outside of the sexual situation), one might understand one's gender identity (as a woman, say) to accord perfectly with one's body (including a penis). That is, by recognizing trans women as women, one could understand one's penis as entirely congruent with one's womanhood. This would involve a reconfiguration of genitals (as they are related to the concept of a woman) and also the very concept of woman itself. This last move opens up notable possibilities. For example,

it could make sense for a trans woman to engage in active penetrative intercourse with her penis without this activity invalidating her *trans* womanhood. The social meaning of the activity and its relation to womanhood will have been reinterpreted.

Then, as I understand it, trans bodily dysphoria is an interpretative affair that pertains to social meanings attributed to body parts, rather than body parts taken as entirely independent of social meaning. While this might suggest that trans people would be better off trying to alter the meaning of their bodies rather than changing their bodies outright, it is also important (as Hale notes) to recognize that there are individual limits for trans people on how much reinterpretation is psychologically possible. In some cases, there may be no choice but to either forgo sex altogether, have sex in such a way that excludes the body part as much as possible from the situation, or have sex that is to some degree unpleasant. In other cases, sexual reinterpretation may indeed be possible—and largely facilitated within a sexual arena.

Recognizing that trans bodily dysphoria concerns the social meaning of body parts brings out the possibility that a trans person may experience bodily dysphoria under one interpretation of their body and may also be free from such dysphoria under a different interpretation (rather than by having one body part as opposed to another). Which interpretation is operative, then, is going to make all the difference in the world in terms of a trans person's comfort and ability to express herself intimately. Indeed, the issue does not merely concern comfort but emotional safety—certain interpretations can undermine her self-identity altogether.

Which interpretation is operative in the situation is going to depend on multiple factors, including the interpretation being used by the partner and also the interpretation being used by the trans person herself. It may be that each person has a different interpretation. Perhaps the partner has an invalidating interpretation, while the trans woman has a validating one. Given that invalidating interpretations tend to be supported by mainstream conception of trans people, it is likely that type of interpretation will possess more social force and hold sway. That said, it is not always obvious what interpretation is operative for a partner—this is not something that always comes out immediately. The discrepancy might be discovered later or never at all. At any rate, an element of trust (or distrust) can be part of the experience. Indeed, it is fair to say that there is a unique kind of vulnerability for trans people which may involve being intimate or exposed in ways that open oneself up for invalidating interpretations. This vulnerability takes place amidst questions, such as: "How does this person understand this region of my body? What does it mean to them? What do they want with it? Who am I to them?"

This is also suggestive of a particular kind of intimacy, namely a trans vulnerability that has been heard or interpreted in a way that is validating.

In other words, an invalidating discrepancy in bodily interpretation can be seen as a failure of intimacy and a lack of discrepancy can be seen as an achievement of intimacy. I say "achievement" because the negotiation of a shared interpretation goes against the grain of mainstream social meaning attributed to the body. This achievement of intimacy could involve the conscious participation in sexual activities that recode. And it need not always be initiated by the trans person herself. That is, in cases of a trusting relationship, it may be possible for a partner of a trans person to help her recode her body in a way that she might not have thought possible. In other cases, there might be a less clear vision of a positive bodily interpretation and sexual activity might be more exploratory—provisionally searching for healthier ways of understanding. The point is that there is a way of understanding these particular cases of intimacy around the interpretation of trans bodies as intimacies of meaning.

In this context, the nature of the partner's sexual attraction can play a role in literally helping recode a trans person's body. Consider a case in which a partner is attracted to a trans woman in a way that does not include *all* of the trans woman's body (because it is seen as incompatible wither her status as a woman). Attractions of this type are informed by mainstream gender interpretations of the body, and as such they may be invalidating. But consider a case in which a partner is attracted to a trans woman as a woman, but who also finds that that she or he is attracted to everything about her (or at least is sexually interested in engaging with all of her parts). Here, the desire can be sensitive to the trans woman's own self-interpretation. It starts with an initial attraction, but it is open and flexible. This kind of desire has the capacity to play a role (perhaps a fundamental role) in recoding a body according to an interpretation and helping undo trans bodily dysphoria. In light of this, we can distinguish two different types of gynephilic attractions—those which can play a role in achieving interpretive intimacy and those that cannot.

For the rest of the paper, I want to understand some of the specific social challenges that trans women face in achieving a validating interpretive intimacy. In particular, I want to look at some of the social forces that work to shut down the possibility of interpretive intimacy. This will include objectifying sexual desire (i.e., desire that is structured by transphobic interpretations and which foreclose interpretive intimacy). And, my hope is that this will help illuminate what needs to be done in order to make such intimacy less elusive.

REALITY ENFORCEMENT AND THE FORECLOSURE OF INTERPRETIVE INTIMACY

One of the most important features of mainstream gender practice, in my view, is the fact that public gender presentation is expected to align

with privately concealed genital status. Indeed, as I have argued elsewhere, public gender presentation can be seen to euphemistically communicate or symbolically represent genital status (Bettcher, 2006). This means that everybody is literally communicating their private genital status on a regular basis in public. To see that this is an abusive practice, consider the following: It is typically inappropriate to ask somebody explicitly about their genitals (imagine asking your coworker, "Do you have a penis or a vagina?"). To do so would be a boundary transgression (and a form of sexual harassment). The reason for this is that genitals (and information about genitals) are generally deemed personal (i.e., private). This means that even the euphemistic or coded transference of such information can be boundary violating (since the information is *still* private). Yet, in my view, gender presentation systematically communicates genital status and refusal to engage in this practice can lead to extreme violence (as we shall see below). So, we have a system that mandates boundary violation under threat of violence. That's an abusive system (Bettcher, 2009).

In my view, trans people can be understood to opt out of this system. By this, I mean two things. First, trans people present themselves in such a way that they can be taken to "misalign" gender presentation with their sexed body.[7] So, in a way, they refuse to disclose genital status through gender presentation, and hence flout the communicative mandate to declare genital status. Second, trans people understand what they are doing in a way that diverges somewhat from mainstream conceptions. Typically, a trans woman will see herself as a *woman* rather than really a man. Doing this requires not only understanding gender categories in ways that may depart from mainstream conceptions (which link gender category to genital status), but it may also require reunderstanding the very practice of gender presentation itself. For example, in some trans subcultural contexts, gender presentation is simply *not* taken to communicate genital status. Rather, it is generally taken to indicate and express a person's self-identity (as a woman, as a man, etc.), and more or less how the person wants to be interacted with. Beyond this, it may involve reunderstanding sexed bodies as well. As we have seen, body parts that are taken as male in mainstream contexts may be coded in different ways in trans-specific contexts. And, gender boundaries on intimacy may be altered (bodies understood as subject to gendered female and male boundaries in a mainstream context are subject to differential boundaries on intimacy. For example, there is a boundary on female toplessness but not male toplessness). My claim is that these can be altered by trans people (at least in certain contexts).

Because trans people opt out of this system, they can be subjected to what I call "reality enforcement." Reality enforcement is the mechanism by which acquiescence to the mandate to communicate genital status is enforced. This involves, first, the invalidation of trans self-identity

through the imposition of a gender category from without (e.g., "That's a man"). Second, because of the representational function of gender presentation, the "misaligned" presentation of trans people is taken as a kind of mere appearance (e.g., "*Really* a man merely *disguised* as a woman"). In cases where the trans person is "discovered" to be trans, she may be represented as having engaged in deception (i.e., as having misrepresented her genital status through her gender presentation).[8] In cases where she is already disclosed as trans, she may be presented as engaging in a kind of pretense. Either way, the trans person is delegitimized through an appearance/reality contrast (and hence subjected to a double bind) and held morally accountable for her actions. Finally, because of the central role of private genital status in fixing terms like woman and female, trans people are subjected to sexual violence through tactics of overt genital verification (to determine what they are "really"). In less extreme cases, they may be subject to inappropriate questions, such as "Have you had the surgery?" or "Are you a woman or a man?" or statements about "anatomical sex," which euphemistically discuss private information about genital status. The reason for this is obvious—it involves the effort to reenforce the cultural mandate to symbolically declare genital status that trans people have effectively opted out of. This last feature is particularly important, in that it points to a very distinctive form of sexual violence and/or boundary violation specific to trans people that is essentially bound up with identity invalidation itself (i.e., determining the reality of a person's sex through genital verification). This obviously is not inconsequential when considering trans people entering potentially intimate (and exposing) sexual situations, and then confronting invalidating interpretations of this type.[9]

Importantly, for our purposes, reality enforcement can concern sexual identity as well as gender identity. For sexual identity categories are, like gender categories, descriptors taken up by individuals and deployed within narrative self-conceptions to help confer intelligibly on their lives and on who they are (sometimes by staking a political stance or a community affiliation). While sexual identity labels categorize sexual/affectional desires and practices, they need not always correspond exactly with an individual's actual desires and practices (sometimes apparently contradictory practices are even left out of the self-conception). More importantly, these categories can serve a role in offering positive narrative interpretations that run against mainstream invalidation.

This is particularly important in light of the close connection between gender and sexual identity categories. Besides indicating the sex of the object of attraction, sexual identity categories tend to indicate the sex of the subject possessing that attraction. This is because sexual orientation is framed in terms of a distinction between same-sex and opposite-sex attractions (i.e., in terms of whether the subject and object are the same sex or opposite sexes). For example, "lesbian" indicates both a gynephilic orientation and the sex

of the person possessing that orientation (woman), as well as the fact that subject and object belong to the same sex. The consequence of this overlap between gender and sexual identity categories with regard to their role in narrative self-conception is that reality enforcement often concerns both.

For example, while a trans woman may self-identify as a heterosexual woman, she may be viewed as a gay man. That is, her sexual identity can also be invalidated insofar as she is taken to have a same-sex orientation. Again, this means that there will be a contest of interpretations. Her sex life (her desires, activities, etc.) will be viewed as "gay" by the enforcer, while she may see her sex life according to a very different interpretation. The consequence of this is that her recoding activities are not recognized for what they are. Instead, all her activities are interpreted in an invalidating way. In such a case, not only is there no interpretive intimacy, but also the very possibility of it is foreclosed.

Second, the appearance/reality contrast now applies to orientation as well. She is seen not just as really a man disguised as a woman, but really a *gay* man, disguised as a *straight* woman.[10] Thus *straight* orientation (of a woman) is now the misleading appearance and *gay* orientation (of a man) is the hidden reality where homosexual desire is read off from the revealed "body" (i.e., the penis). But once orientation is added to the equation, a *motive* for "pretending" to be a woman is immediately forthcoming (namely, to seduce unsuspecting straight men into having sex with them, i.e., sexual predation), and this has the consequence of erasing the importance of her own gender identity as the actual motive for her gender presentation. As a consequence, interpretive intimacy is foreclosed in another way: because there is no room for her own gender identity, there is no way to so much as access her ways of self-understanding.

Finally, in this case, the trans person herself is subject to a form of sexual violence (or at least harassment) involved in genitally determining that this person is "really a man." Far from interpretive intimacy, we have a very trans specific form of sexual boundary violation. Ironically, this can be obscured when the trans women herself is viewed as a sexual predator (a gay may try to seduce straight men by passing himself off as a woman).

Likewise, a trans woman who sees herself as lesbian may have her sexual self-identity invalidated by being represented as a straight man trying to pass himself off as a woman. Again, there will be a contest of interpretation over the nature of her desire and the meaning of her sexual activities (thereby erasing the possibility of sexual recoding and foreclosing the possibility of interpretative intimacy). This time, her apparent orientation (lesbian) will be taken to hide her true orientation (heterosexual). And, if there is any motive imputed in this case, it will be one in which she is read as a man who is trying to gain access to women's private space (restrooms, etc.), in order to commit acts of sexual violence or, minimally, to violate women's privacy boundaries for some type of sexual gratification (once again,

removing the capacity of her own gender identity to confer an intelligibility on her desire and activities). Finally, the attribution of the intent to violate boundaries is precisely the cover that hides the trans-specific boundary violation to which she is subject—a violation that occurs in place of interpretive intimacy. The point is that, because reality enforcement also concerns sexual identity, there is a way in which interpretive intimacy is made extraordinarily challenging and elusive.

THE SEXUALIZATION OF TRANS WOMEN

Reality enforcement goes to the heart of passing (and being read) as a daily issue of concern for many trans people. In my view, gender presentation is taken to communicate genital status, so "to pass as a (non-trans) woman" is to successfully communicate that one is "anatomically female." This issue of passing (and its connection to reality enforcement) is particularly pronounced in the cases in which trans people (particularly trans women) are dating or getting to know somebody in such a way that might lead to sexual intimacy. If the other person doesn't know, at what point (if any) does the trans person disclose? And, of course, the issue of interpretation in disclosure is crucial. After all, there is a difference between disclosing that one is a trans woman (on the one hand) and "really a man" (on the other). That said, when a trans woman says that she is a trans woman, this can be understood to mean "I am really a man," precisely because her very words are understood in a different way. There's a double bind here where trans people who are "out" about who they are may find that the potential partners they are interested in are not interested in them because they are seen as really women or really men.

It is precisely in sexualized or potentially sexualized cases that, however, one sees the most extreme manifestations of the reality enforcement. For example, Schilt and Westbrook (2009) found in a study of newspaper reports about homicides of people "described as doing gender so as to possibly be seen as a gender other than the one they were assigned at birth" that in 56 percent of cases, the reporters "depict violence as resulting from private, sexual interactions in which the perpetrator feels 'tricked' into homosexuality by 'gender deceivers'" (p. 452). Similarly, Schilt and Westbrook (2009) find in their study of trans men in the workplace that while women can, in most cases, accept trans men as men, "in sexualized situations, women frame trans men as deceptive—tricking women into seemingly heterosexual relationships without the necessary biological marker of manhood" (p. 450). The point is that many trans people (particularly trans women seeking men) face difficulties (often *great risk*) in negotiating sexuality, and in developing and maintaining intimate relationships that most non-trans people do not. Indeed, disclosing one's trans status may often lead to violence just as easily as discovery.

In light of this, we can begin to understand ways in which trans women are sexualized in nonintimate ways. Consider that women can be subject to unwanted sexual advances and are sometimes double binded in their options for addressing such situations. For example, some female gender presentations can be construed as reflections of sexual character ("promiscuous") or at least of sexual interest (regardless of the woman's own actual character and feelings). More generally, there is this phenomenon of coded or euphemistic nonverbal communication in heterosexual dating ritual that leaves women vulnerable to tactics of sexual manipulation, as well as blaming the victim in case of rape. For example, the very gesture of (a man) buying a drink (for a woman) and the responsive gesture of receiving it has obvious, albeit vague, communicative import. Even a man's sheer approach and initiation of a seemingly innocuous and frivolous conversation can have coded meaning.

Such behavior is often regulated by gender norms that leave women subject to risk no matter what they do. For example, terminating the coded interaction too abruptly may indicate that she is unfriendly or "bitchy." Besides this, consider that the aesthetic norms according to which many women are held accountable are precisely sexualized norms (i.e., to be considered an attractive women involves sexualizing oneself as a woman)—that is, to present oneself in a way that can be misconstrued as communicating sexual interest. In this way, women can be subject to difficult double binds: either violate gendered norms of conduct or else find oneself implicated in a nonverbal communicative exchange that has as its aim unwanted sexual interaction.

There is an interesting analogy here between the way female gender presentation is taken to communicate sexual interest or character (regardless of the woman's actual intention) and the way gender presentation in general is taken to communicate genital status (regardless of the intentions of trans people). Indeed, as I have argued elsewhere, both phenomena are aspects of the same system (Bettcher, 2007). One way to understand this is to see social negotiations of sexual intimacy (or distance) as generally euphemistic in nature and as essentially gendered within a heterosexual framework. The reason that it becomes important to know a person's genital status is to know how, exactly, to negotiate the closeness/distance with a given person, to know with whom to aim for sexual relations, and, from an institutional point of view, to regulate intimacy through sex-segregation (in restroom, changing-rooms, congregate housing, etc.).

In light of this, it is unsurprising that trans women who pass as "woman" (i.e., who pass as anatomically female) are vulnerable to the binds described above in ways that are more complicated in placing her at risk of being exposed as "really a man pretending to be a woman." When she finds herself in a sexualized context (or one that is leading there), it is

highly likely that if exposed, the trans woman will be viewed as "really a man, trying to seduce unsuspecting straight men." This risk of exposure and violence creates a pressure to maintain a certain form of presentation and conduct that maintains the nonverbal exchange. That is, trying to terminate the sexual interaction may actually lead to exposure. However, as the nonverbal communicative exchange continues, it is likely that she will also become more and more an object of sexual interest, and therefore scrutiny (increasing the chances of being read as really a man). Moreover, the longer the exchange continues, the greater the risk for extreme violence, since the man's own sexual desire is increasingly implicated as the path to intimacy is further traversed (Bettcher, 2006).

The problem is that the gendered communicative negotiation of a gradual path to sexual intimacy is constructed in such a way that is generally vague, nonexplicit, and nonverbalized. And, it is preset in such a way that the path is highly dangerous for trans women. Consequently, there is no room for the verbal explicitness that is sometimes needed in the aim for an interpretive intimacy. On the contrary, the pathway leads inevitably to a "shocking discovery" that, far from facilitating such intimacy, is the exemplar of trans-specific boundary violation. One way to put the point is to say that trans women do not have access to the standard, heterosexual communicative resources (as problematic as they are) for negotiating interpersonal closeness in the direction of sexual intimacy.

The situation is even more complex, however, since trans women who are "out" as trans may still find themselves subject to sexualization in very distinctive ways. This, too, however, is a function of the appearance/reality contrast. Consider cases in which a man is attracted to a trans woman *because she is trans.* Typically, this can play out as the outright eroticization of reality enforcement itself. For example, some men are attracted to feminine men or feminized men who are functionally women. In such a case, he may see through a trans woman's gender appearance to "the deeper reality" and this interplay (male filtered through female) may itself constitute the object of desire. Or consider sexual attraction to a "she-male" or a "chick with a dick." In this case, the eroticism may well involve the desire on the part of the man to provide oral sex for or to receive anal sex from this fantastic being. In such a case, however, the object of attraction is an impossible object whose existence is made manifest only in sexual fantasy. (I am imagining an analogy to a centaur or Pegasus). I say that this "creature" is "fantastic and impossible" since, according to the rules of reality enforcement, she would be viewed as "really a man with breasts, pretending to be a woman." In the fantasy, however, she is seen either as a woman (who has a penis) or else as something in between man and woman. This exception to reality enforcement is permitted because sexual fantasy (and the enactment thereof) allows for a kind of socially acceptable context of

play or pretense in which the typical strictures of reality can be set aside. In this type of eroticism, a trans woman becomes something that cannot exist in reality and that has no substance as a person.

Besides such cases of trans-specific desire, the salience of sexualized female gender presentation and its central place in heterosexual gynephilic attraction makes it unsurprising that *almost any* non-trans men (who are identified as straight) can find themselves attracted to trans women, regardless of the fact that they view them as "really men." This can cause an obvious cognitive dissonance: "I see myself as straight, and yet I have sexual attraction to somebody who is 'really a man.' Am I gay?" There is an irony here, however, in that if the attraction to the trans woman is an attraction to her insofar as she *looks like a woman,* it is hard to see that the attraction itself is androphilic (or gay). Moreover, there is a way in which a trans woman's penis can be entirely irrelevant to a sexual encounter (in case she provides oral sex or receives anal sex). Indeed, if the trans woman herself feels uncomfortable with her penis and wishes to engage in the retooling tactic of "exclusion," there can be agreement on both sides about this.[11] Rather than playing a role in sexual attraction, the "it's a man" part of the dissonance functions within the context of a social concern about loss of status through being viewed by peers as really gay.

Unsurprisingly it is not an uncommon experience among trans women to find men who are willing to maintain sexual relations with them while relegating them to the status of "dirty secret." Such relegation places a trans woman in a social context that is walled off from the rest of her partner's life. In such cases, we will have a clear failure of interpretive sexual intimacy. This is obviously the case in which the eroticism is literally structured by the appearance/reality contrast. However, this is also true when it is not. Suppose, for example, the trans woman is uncomfortable with her penis and uses the tactic of exclusion. This works well for her partner, since the visible presence of her penis would threaten his self-identity. There is, nonetheless, a fundamental interpretational disagreement between her and her partner about the basis for that exclusion: While she wants to work around it because it makes her feel uncomfortable (and she experiences it as invalidating), the partner actually wants to avoid it because it reminds him that the person he is with is "really a man only pretending to be a woman." This is an example of a failure in interpretive intimacy.

In all these cases, there is obviously something that can be called trans-specific objectification. It involves sexual desire that is either structured or enabled by the appearance/reality contrast coupled with a complete foreclosure of interpretive intimacy; instead, there is a trans-specific boundary violation. This type of objectification is, in my view, closely bound up with the stereotypic representation of trans women as perpetually sexually interested and available "whores." Such a representation can be seen

to arise, in part, as a consequence of the juxtaposition between desire for a culturally constructed (hetero) sexualized "sex-inviting" feminine appearance/gender presentation on the one hand and invalidation as really a gay man trying to seduce straight men on the other. In other words, while attraction to a trans woman is effectively gynephilic, the invalidating "it's really a gay man" is used as a way to erase a trans woman's subjectivity (and gender identity) by reducing her motivations to deceptive and predatory homosexual desire. This sexualization is only confirmed and augmented by the way the gender presentation itself is sexualized and construed as sex-inviting. In this way, she becomes nothing but a highly sexualized being (a predatory gay may be disguised by a sexualized, provocative gender presentation). However, once we have the involvement of objectification desire and the consequent relegation of trans woman to "dirty secret," trans women are literally forced to inhabit the stereotype. In this way, the representation serves as a cover for the actual objectification that is occurring.

SEXUAL IDENTITY AND INTERPRETIVE INTIMACY

In this last section, I want to discuss what I consider as one of the main obstacles to interpretive intimacy—namely, the self-identity of the potential partner and their own vulnerability to reality enforcement. For the interesting fact is that, in cases of potential sexual intimacy, reality enforcement expands in its invalidating capacity by applying to the sexual identity of the partner (or potential partner) and the relationship itself.

Consider a trans woman who is in a relationship with a non-trans lesbian identified woman. Both may see their desires as gynephilic and both may see the nature of their sexual/affection activities as lesbian and the relationship itself as lesbian. However, if the trans woman is not viewed as a woman at all, then the non-trans woman may find her own lesbian identity called into question. It might be worrying that she has some androphilic desire and that she is engaging in nonlesbian activities and that her sexual identity ought to be reassessed ("Is she bisexual now?"). The point is that, just as trans people may struggle with identity invalidation, so people who enter into authentic, loving relationships with trans people can find that their own (sexual) identities are invalidated. Indeed, the relationship itself can be invalidated by being construed as a heterosexual relationship. What is lost in this invalidation is not merely the fact that it is seen by its participants as lesbians, but also all the rich trans-specific meaning-making that characterizes the nature of the intimacy in a very fundamental way.

Recognizing this can help us understand how the self-identity of a potential partner can undermine the possibility of interpretative intimacy. In order to see this, it is important to pull apart homophobia and

reality enforcement. To be sure, reality enforcement is often intersected with extreme homophobia and heterosexism: The (non-trans) man reacts in the way that he does because he does not want to be seen as having gay attractions or engaging in same-sex sexuality. But it would be a mistake to reduce such cases to homophobia. These instances of homophobia are predicated on the prior view that trans women are "really men." And reality enforcement can operate independently of this homophobia. For example, some lesbians trans women find that some non-trans lesbian women are unwilling to be sexually or emotionally intimate with them precisely because the latter view the former as "really straight men." And, non-trans gay men may not be interested in gay trans men because they view them as "really women." While reality enforcement lies at the root of this disinterest, there is no analogous homophobia involved.

Whether homophobia is involved or not, however, there is concern to preserve sexual self-identity against possible invalidation. For example, because some men sees a trans woman as really a man, he may see her androphilic attraction to him as homosexual in nature and the potential sex activities open to the two as homosexual. Should the potential partner experience sexual attraction to this trans woman, while it might be seen as heterosexual desire by her, it may be seen as homosexual desire by him, thereby as invalidating of his own self-identity as a heterosexual man. Similarly, a non-trans lesbian woman, who sees a trans woman as really a man, may interpret the desire of a trans woman for her, and the potential sexual activities between them, as heterosexual. Should she herself experience sexual desire for the trans woman, it will then be read by her as androphilic in nature (thereby possibly as invalidating her own self-identity as a lesbian). In both cases, the sexual rejection of the trans women will be necessary, in part, to help preserve sexual self-identity against potential invalidation ("spill over," if you will, from reality enforcement itself). Of course, if the self-identity of a heterosexual man is supported by homophobic masculine ideals, then the potential invalidation of his own self-identity may cause shame and internalized loathing, in turn leading to externalized masculine violence against the object of his desire. But the basis for this is something prior to that.

What is striking about this potential "spill over" of reality enforcement is precisely that it is contingent on foreclosing the possibility of interpretive intimacy in the first place. For should a man who is worried about what his desires show him about his own sexual identity allow himself to engage in interpretive intimacy, it would be possible for him to recode his own sexual desire as well. That is, once he sees his partner as a woman (in a way that is informed by her own narrative self-understanding), he will be able to maintain his own self-identity as a heterosexual man. The requirement is an alternative understanding of what that means acquired

precisely through the negotiations of interpretive intimacy. In such a context, it is even possible that there is a corresponding change in the nature of his desire (from one structured by the appearance/reality contrast to something that is more interpretively open). The irony, then, is that a man with such a self-identity may resist intimacy with the trans woman he desires, when it is precisely a genuine intimacy that could transform him and allow him to engage in the interpretive intimacy necessary to genuinely see her as she sees herself.

Unfortunately, the pervasiveness of reality enforcement as a phenomenon can engender the desire of trans men and women to prove themselves real and to seek validation for this reality in the face of such reality enforcement, and sometimes this "push back" against invalidation can actually be quite harmful to trans people themselves (and to others as well). What this means is that trans women may settle for a situation that is invalidating to her and that lacks interpretive intimacy because it at least seems to hold the promise of validation. Indeed, she might stay in a relationship that is physically abusive or sexually objectifying in order to prove her "reality" as a woman. But it is also clear that some type of sexual intimacy may be necessary to help trans women negotiate their bodies in a way that is congruent with their self-identity. To the extent that even invalidating relationships can help achieve that (at least by offering sexual "pretense"), it may serve a necessary function. Such "validation" is costly, however, in that it actually plays into the very invalidation that she is resisting while also sacrificing the possibility of more open, meaning-making possibilities. It's the latter that is necessary in creating a world in which trans women can truly flourish.

NOTES

1. For a defense of this idea, see Bettcher (forthcoming, b).
2. For some examples of this type of view, see Rubin (2003, p. 150–151).
3. For classic formulations, see Stone (1991), Bornstein (1994), Feinberg (1998). I have presented the view in an overly simplified and homogeneous way.
4. For a defense of this, see Bettcher (forthcoming b).
5. For a defense of this, see Bettcher (forthcoming a).
6. The notion of "world" originates in the work of Lugones (1987).
7. I take this to be true even in cases when a trans person has undergone genital reconstruction surgery. For in cases of extreme transphobia, the neo-genitalia will be viewed as artificial and illegitimate and the trans person will be viewed in terms of birth genitalia.
8. For further discussion of trans women viewed as deceivers, see also Serano (2007).
9. For a more detailed account of the phenomenon of reality enforcement, see Bettcher (2007, 2009).
10. See Serano (2007, 2009).

11. The irony is even more pronounced in the case of attraction to trans women who have had vaginoplasty. In such a case, the man might still worry about his orientation because he is being sexually intimate with somebody who is still really a man or with somebody who once was a man.

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Part II

Diversity

Chapter 4

Sexuality and Sexual Health among Women with Physical Disabilities

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> I see my limitations as parameters; my normality, my sexuality, to be pushed right to the edge. If you are a sexually active disabled person, and comfortable with the sexual side of your life, it is remarkable how dull and unimaginative non-disabled people's sex lives can appear. (Shakespeare, Gillespie-Sells, & Davies, 1996, p. 60)

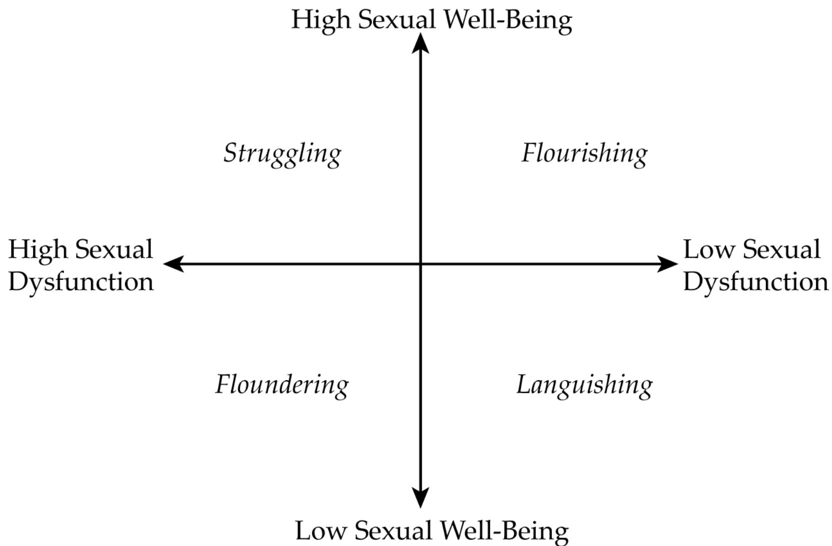
There are currently 27 million women in the United States living with a disability (Centers for Disease Control, 2011). Despite popular conception, these women have the same sexual needs as nondisabled peers (Mona et al., 2009; Mona & Gardos, 2000). Over the past decade, the behavioral health field has increasingly examined the sexual lives of individuals with physical disabilities (Mona et al., 2009; Mona, Gardos, & Brown, 1994; Nosek, Howland, Rintala, Young, & Chanpong, 2001). Yet, research in this area has historically focused on sexual *dysfunction*, particularly among men with spinal cord injuries, rather than examining sexual well-being and the sexual

lives of women with physical disabilities (Mona et al., 2009; Olkin, 1999). This focus on dysfunction fits with the Western historical emphasis on the medical model of disability, which is a pathology-oriented view that frames sexual experiences of women with disabilities (WWD) as biologically determined, with difference equating to deficit (Olkin & Pledger, 2003).

The view of disability as deficit based that is inherent in the medical model, coupled with society's emphasis on physical attractiveness, has led to a double-barreled taboo about disability and sexuality. In contrast, disability advocates have increasingly emphasized that disability is not only a natural part of human existence (Seelman & Sweeney, 1997), but also a profoundly social experience. The experience of disablement is predominantly the result of social, political, economic, and legal barriers, rather than simply a function of physiological status (Mona et al., 2009; Olkin & Pledger, 2003). The minority model of disability arises from this social framework and recognizes the disability community as its own cultural group, with similar experiences of prejudice, stigma, and discrimination as that of ethnic minority groups (Olkin, 1999). The minority model of disability, combined with an awareness and acknowledgment of the unique physiological and psychosocial experiences of WWD, allows for the most comprehensive understanding of sexuality and disability (Mona & Gardos, 2000).

As noted above, research on sexuality and sexual health for persons with and without disabilities has been predominantly viewed as the absence or presence of sexual dysfunction (Mona et al., 2011). This conceptualization has perpetuated the view of WWD as asexual or sexually limited, given the frequency of concerns that can impact WWDs sexual experiences (e.g., pain, mobility concerns, differences in blood flow, etc.; Olkin, 1999). A more comprehensive, sex-positive, and holistic approach to the conceptualization of sexual health was recently developed by Mona and colleagues (2011), and is known as the Complete State of Sexual Health Model (Figure 4.1). This model, adapted from a model of mental health proposed by Keyes and Lopez (2002), posits two distinct dimensions: sexual dysfunction and sexual well-being. These dimensions intersect to create four potential sexual health statuses: (a) *flourishing,* wherein a WWD is completely sexually healthy as she is high in sexual well-being and low on sexual dysfunction; (b) *languishing* or incompletely sexually healthy, as a WWD is low on sexual dysfunction but also low in sexual well-being; (c) *floundering* or completely sexually unhealthy, wherein a WWD is high in sexual dysfunction and low in sexual well-being; and (d) *struggling* or incompletely sexually unhealthy, as a WWD is high in sexual dysfunction and high in sexual well-being (Mona et al., 2011). This model was initially developed for use with the older adult population (Mona et al., 2011), but is readily applicable to WWD, particularly in light of the fact that more than 50 percent of women over the age of 65 are disabled (Centers for

Figure 4.1 The Complete State of Sexual Health



Source: Mona et al., 2011.

Disease Control, 2011). To date, this model has not been validated; however, it may provide a useful framework for understanding the sexual lives and experiences of WWD.

CULTURE AND DIVERSITY OF WWD

The minority model of disability, as noted above, acknowledges the unique cultural experiences of persons with disabilities (Olkin, 1999). Disability culture is bound by four common factors: fortification against oppression, unification, commitment, and recruitment (Greenwell & Hough, 2008). Like any cultural group, disability culture has an established set of ideals (e.g., acceptance of human differences, willingness to accept help and assume interdependence, appreciation for the absurd, etc.; Gill, 1991) that influence the sexual identities and sexual health of its community members (Mona et al., 2010). In comparison to the Western (often white) heteronormative and ableist ideals pervasive throughout the United States (Dune & Shuttleworth, 2009; Rembis, 2010), WWD who embrace disability cultural ideals may bring strengths to the sexual challenges they face (Mona et al., 2010). However, these ideals may not be embraced by every WWD, depending on a variety of factors, as disability and disability culture are not necessarily (or inevitably) central to one's self-concept (Peters, 2000). As with any cultural group, disability culture is not homogeneous

and the diversity within this group—whether in regard to nature of disability, social experiences, functional limitations, or age of onset—must be appreciated (Greenwell & Hough, 2008).

Additional cultural factors, such as gender, age, ethnicity, religion, sexual orientation, and socioeconomic status, uniquely interact with disability to affect sexual health and well-being among WWD (Mona et al., 2010). In one study of women from South Asia, Canada, and Jamaica, WWD reported that their disabilities further compounded their culture's discouragement of open discussion of sexuality (Center for Research on Women with Disabilities, 2011). In order to most comprehensively and sensitively promote sexual well-being among WWD, individuals must understand how a WWDs multiple identities interact to influence sexual identity and sexual relationships (Fraley, Mona, & Theodore, 2007). For example, it has been acknowledged that people with disabilities are often not accepted by the LGBT community and that "the disability community is not immune to homophobia" (Fraley et al., 2007, p. 17). Additionally, a WWDs religious identity may impact her view of premarital or extramarital sexual encounters, as well as her willingness to engage in masturbation or other sexual acts (Mona et al., 2010). Understanding how a woman's identities as a disabled person and as a member of the LGBT, religious, or other cultural community may intersect and the implications for her level of sexual well-being is critical in fully understanding the sexual concerns of WWD.

PSYCHOLOGICAL FACTORS ASSOCIATED WITH POSITIVE SEXUAL EXPRESSION

In addition to sociocultural factors, and often intertwined with them, are important psychological factors that contribute to the sexual experiences and sexual well-being of WWD. Psychological factors that play a role in sexual expression and sexual satisfaction include body image and sexual self-esteem. WWD may be vulnerable to decreased sexual satisfaction and poor overall sexual well-being, at least in part due to their higher risk for negative body image and poor sexual self-esteem relative to able-bodied women (Moin, Duvdevany, & Mazor, 2009).

For WWD, as for able-bodied women, the sexual self is often understood and expressed through an interpersonal lens (Leibowitz, 2003, as cited in Leibowitz & Stanton, 2007). The availability and presence of a partner is centrally important in the sexual well-being of WWD, more so than for men with disabilities and more so than are the specifics of the WWDs disability (Kedde & van Berlo, 2006). Although women's relational strengths are a valuable source of resilience for WWD (Schlesinger, 1996), a cascade of interconnected social and psychological factors can lead to problematic consequences of this relational focus for some WWD. For

example, Hassouneh-Phillips and McNeff (2005) developed a model of disabled women's risk for intimate partner abuse that incorporates societal devaluation of disability as the basis for poor body image, poor sexual self-esteem, higher value placed on nondisabled male partners, and reduced access to intimate partnerships. All these elements combine with a preference to be partnered and lead to relational decisions that favor relationship maintenance as a priority over avoiding or escaping abuse, as discussed in detail below

Researchers have found consistent evidence for the importance of body esteem and sexual self-esteem to the well-being of PWD. For example, Taleporos and McCabe (2002) studied 748 PWD and 448 able-bodied men and women, finding that general self-esteem was predicted by sexual self-esteem, body esteem, and sexual satisfaction, with body esteem being particularly important for WWD. Body esteem and sexual satisfaction were also predictors of depressive symptomatology. These relationships were more consistent and stronger predictors of general self-esteem for PWD than for able-bodied participants. Factors, such as body esteem and sexual esteem, may contribute to a WWDs overall sense of sexual well-being, according to the Complete State of Sexual Health Model, independent of her level of sexual dysfunction.

Body Image

Body image or body esteem is defined as an evaluative judgment about one's physical self (Mayer & Eisenberg, 1988, as cited in Hassouneh-Phillips & McNeff, 2005). Researchers have found that WWD are at risk for negative body image (Moin et al., 2009). Body image has implications for depression and psychosocial functioning among WWD (Benrud-Larson et al., 2003), as well as for sexual well-being (Taleporos & McCabe, 2001).

Taleporos and McCabe (2001) present qualitative data on the impact of physical disability on body esteem and argue that body image among PWD may be undermined by social feedback and internalization of the societal devaluation of disabled bodies. For a WWD who has a positive body image, careful regulation of exposure to social devaluation may be needed to preserve this positive self-view, as illustrated in the following quote:

> I strongly disagree with avoiding mirrors—I have heaps of them and love prancing around in front of them, but I do avoid looking in strangers' eyes as I'm going along in crowds and so forth, because I'm so scared of seeing their reactions to my body. From a young age I felt that this was the worst thing about my life—people's expressions of disgust, pity, horror, curiosity—so I learnt to not look into people's faces as I went along and I still don't. It takes enormous

> courage on my part to meet the gaze of strangers. (Taleporos & McCabe, 2001, p. 293)

WWD may have internalized ableist cultural beliefs about conventional standards of beauty and body image as well as their relationship to sexual value. Heterosexual and bisexual WWD may be sensitive to their male partners' desire for having a conventionally good-looking female partner, even if they themselves are comfortable with their bodies. Taleporos and McCabe (2002) quote a participant who captures this concern:

> I actually find my short arm and leg reasonably sexy. They're soft and fleshy with minimal scarring and I get quite entranced looking at myself naked because I find my form really interesting. But I do have a kind of terror with each new sexual partner, and actually also with those I'm in relationships with, that they'll find my arm and leg disgusting. Sometimes I've kind of obscured my stumps by all sorts of circuitous means so that my lover/s can't see them, or they're less apparent, which really stuffs my head up. (p. 305)

Negative body image and devaluation of disabled bodies are not exclusively self-directed among WWD, however. The internalization of ableist societal standards of attractiveness and desirability may also affect how heterosexual WWD view potential male partners. Hassouneh-Phillips and McNeff (2005) found that WWD sometimes expressed a preference for young, athletic, good-looking, nondisabled male partners. Similarly, male partners who have bodily characteristics that are seen as interfering with connection or pleasure may be rejected, as illustrated in the following quote describing the importance of penis size for sensation in a woman with a spinal cord injury:

> If they're big enough I can feel them because of the pressure. And if they're tiny you can't feel them . . . I guess you kind of turn into one of those type people, hey dude, do you have a . . . big package? So it's like an application for a job. (Liebowitz & Stanton, 2007, p. 48)

The centrality of bodily and physical aspects of sexuality for WWD vary and may be fluid or changeable over time. Many women eventually redefine sexuality as being more holistic, mental, and relational post injury (Leibowitz & Stanton, 2007). However, even when the scope or domains in which sexuality is defined expand markedly, physical aspects of sexuality may remain important (Leibowitz & Stanton, 2007), including for some heterosexual women the option to engage in penile-vaginal intercourse, which may be seen as inherently pleasurable (Mona et al.,

2009) or may be a signal about the viability of the relationship for the male partner (Hassouneh-Phillips & McNeff, 2005).

Sexual Self-Esteem

Sexual self-esteem (sometimes simply called sexual esteem) can be understood as a sense of oneself as a sexual being, including self-evaluation of both attractiveness and competence (Mayers, Heller, & Heller, 2003). Another, similar, definition of sexual self-esteem is an overall evaluation of one's sexual self, including emotional, cognitive, and behavioral facets of sexuality (Mayers et al., 2003; Zeanah & Schwarz, 1996, as cited in Oattes & Offman, 2007). Sexual self-esteem is an important and unique factor in sexual well-being. Although it is related to general or global self-esteem, sexual self-esteem has been found to be a better predictor of healthy sexual communication than global self-esteem (Oattes & Offman, 2007) and to contribute to sexual satisfaction partially through its influence on sexual assertiveness (Ménard & Offman, 2009). In addition, sexual self-esteem has been found to be an important predictor of sexual adjustment, beyond the effects of severity of spinal cord injury and beyond the effects of psychological variables, such as optimism, control, meaning, and general self-esteem (Mona et al., 2000).

Disability experiences can negatively affect self-esteem (Moin et al., 2009), although some PWD keep the role of disability in perspective. As one PWD noted:

> I feel that it can be too easy to blame everything on my disability—that the cute girl or guy I have a crush on rejects me just because I'm disabled. I'm beginning to realize that other factors come into play, that very few people . . . have "perfect bodies"—and that I may be rejected for quite separate reasons other than my body. This realization has cheered me up immensely, but I still find myself slipping into "poor cripple me" mode sometimes, especially when I can't get these folk I desire. (Taleporos & McCabe, 2001, p. 141)

THE SOCIAL CONSTRUCTION OF DISABILITY

Creating and sustaining a flourishing social and intimate life in the current sociocultural environment presents many challenges for WWD. WWD are exposed to the powerful and persistent messages of society that restrict definitions of beauty, sexuality, and virility while perpetuating the myth of asexuality that has been mistakenly attached to disability (Milligan & Neufeldt, 2001; Nosek et al., 2001; Olkin, 1999). These fallacies are part of the socially created disablement that complicates the pursuit of

social goals by WWD, such as dating, intimacy, and the establishment and maintenance of healthy long-term relationships.

Asexuality and Other Societal Myths about WWD

Olkin (1999) described the myth of asexuality for WWD as including beliefs about the lack of a basic sex drive, being functionally incapable of sex, and not having the ability to act in a sexually appropriate manner. Accompanying the myth of asexuality is the widespread belief that people without disabilities (PWOD) do not find WWD desirable as partners and that they are settling for less if they choose to pursue a relationship with someone with a disability (Chen, Brodwin, Cardoso, & Chan, 2002; Miller, Chen, Glover-Graf, & Kranz, 2009; Olkin, 1999).

Many WWDs describe feeling neutral about sex, not feeling like a woman, having sex minimized or dismissed by family and friends, and understanding that others think they should not seek intimacy (Esmail, Darry, Walter, & Knupp, 2010; Milligan & Neufelt, 2001; Nosek et al., 2001). Parents, siblings, friends, school staff, healthcare providers, and other professionals may all contribute to the development of these sexual beliefs (Esmail et al., 2010; Milligan & Neufelt, 2001; Rintala et al., 1997). Although the people delivering negative messages about sexuality may be well-meaning, with intentions that may include protecting WWDs' personal safety, emotional well-being, and so forth, these messages may result in harm. Specifically, invalidation of the sexual self may result in mistaken beliefs about the self and others and inhibit seeking and attaining fulfilling sexual and intimate experiences. Empowering WWDs to become aware of the sources of these internalized beliefs and subsequent self-limiting behaviors may be an initial step toward reclaiming their sexuality and building a healthy sexual self-esteem.

Dating and Intimacy for WWD

Establishing dating and intimate relationships is very challenging for many WWD, especially given the decreased opportunities to meet potential partners they report (Nosek et al., 2001; Rintala et al., 1997). Many WWD do have satisfying dating and long-term relationships, but they report more difficulties with establishing these relationships, often start dating at a later age, and are less likely to be perceived as a potential dating partner by PWODs (Howland & Rintala, 2001; Miller et al., 2009; Nosek et al., 2001; Rintala et al., 1997). The National Study of Women with Physical Disabilities studied the experiences of 475 WWD and 406 women without disabilities (WWODs). The WWD in the sample were largely white (82%) and well-educated (53% had college degrees), and 59 percent had onset of disability prior to the age of 18 (Nosek et al., 2001). The study revealed that

WWD, when compared to WWOD, had lower satisfaction with dating opportunities and more perceived societal and personal constraints on their ability to attract potential dating partners. They also found that friendships were less likely to evolve into romantic relationships for WWD (Nosek et al., 2001).

WWD attribute the experience of limited opportunities for dating to several possible sources. These include stigma and other societal values that compromise the intentions of possible partners as well as their own internalized ableism, as discussed above (Howland & Rintala, 2001; Nosek et al., 2001). Additionally, WWD have reported the experience of being categorized as just friends, which may occur during initial flirting and contact as soon as physical signs of disability become apparent or when disclosure of disability occurs. Some WWD have discussed having several male friends in high school, college, and other situations, but never being seen as a potential partner. The myth of asexuality, in the form of a misconception that WWDs cannot or do not want to engage in sexual activities, contributes to the phenomenon of being dismissed as a potential sexual partner (Howland & Rintala, 2001). WWD often describe fearing rejection, which results in a hesitancy to initiate contact in social situations or to pursue a dating relationship with a friend. Women have described the look of sympathy after disclosure or when the person sees their chair, brace, or other assistive device. A poignant account was related in Howland and Rintala's (2001) qualitative study on dating behaviors of WWD. A woman with cerebral palsy described her experiences with finding a potential date at a bar:

> You can have that eye contact, and they'll smile and everything and then come by, and they see the crutches, and then you can see the face just "whoosh," or they'll walk by and they'll see the crutches and just keep on walking, and I mean that hurts worse than anything else, so I don't know where I'm supposed to go or what I'm supposed to do. (p. 51)

This perception of being dismissed as a potential romantic or sexual partner is borne out by studies on the willingness of PWOD to engage in dating and marriage relationships with WWD (Chen et al., 2002; Miller et al., 2009). These studies have demonstrated that PWOD are more likely to engage as acquaintances or friends and are less willing to engage in a dating relationship or partnership with WWD, a reluctance which is influenced by the severity of disability (Chen et al., 2002; Miller et al., 2009). This is likely exacerbated by societal ideals of beauty, ableism, and lack of accurate understanding of disability and sexual intimacy (Esmail et al., 2010). These studies may be limited in their generalizability, as they have been conducted primarily with college student samples and are self-report

studies that may be susceptible to social desirability; however, they are consistent with studies of the experiences of WWDs. In addition, as noted above, some WWD hold internalized ableist views of physical attractiveness, as many WWD report a preference for dating nondisabled partners (Hassouneh-Phillips & McNeff, 2005; Howland & Rintala, 2001). Intimate partner relationships with disabled partners may be viewed less favorably for a variety of reasons. As one woman described:

> I have had one person with a disability that I have had a sexual relationship with, and I really would be more involved with him but he didn't have arms. And I realized, I went with this guy and it kind of got serious. And I had to tell him—to cut him off, and said, you know we can't continue because I like arms, I mean, that is something I, I like to be held and stuff. (Hassouneh-Phillips & McNeff, 2005, p. 235)

Other potential reasons for limited opportunities to date are a direct result of the way in which parents and siblings dealt with potential dating relationships. Parents who encouraged their daughters, expressed positive expectations for dating and marriage, and helped them feel attractive, primed them for more positive expectations and experiences. Conversely, WWDs whose parents and siblings were overprotective and conveyed a negative or neutral view of their daughter's or sister's dating and intimate life tended to negatively affect their potential for dating relationships (Howland & Rintala, 2001; Nosek et al., 2001). Practical issues may further complicate parental involvement in dating. For example, women described being driven to and accompanied on dates by their parents, even at older ages, to ensure accessible transportation and assistance with activities (e.g., transferring into bed or other sexual positions; Howland & Rintala, 2001).

With specific regard to sexual experiences, WWDs have reported that factors, such as communication and trust, affect their likelihood of engaging in and sustaining sexual relationships. The National Study on Women with Physical Disabilities reported that WWDs had comparable desire for sexual relationships, but were less likely than WWODs to be sexually active (Nosek et al., 2001). Challenges to sexual relationships include communication about potential physical characteristics that affect sexual activities (e.g., managing catheters, accommodating breathing difficulties, optimizing positioning, and adapting to limitations in physical strength). Finding a sexual partner who is comfortable with the "body stuff" and openly communicates has been reported as a potential challenge for many (Howland & Rintala, 2001, p. 57).

Trust is often foremost on a woman's agenda when considering the decision to become sexual with a partner (Howland & Rintala, 2001; Nosek

et al., 2001). WWD are more vulnerable to exploitation than WWOD. Concerns include being left in the middle of a date without adequate transportation, being betrayed by a date if that person discloses information about them to others, or being able to count on a partner during intimacy to avoid hurting them or to exercise care with assistive devices.

Coercive and Abusive Experiences and Relationships

Research has shown that abusive relationships occur at similar rates in women with and without physical disabilities (62% of women reported some form of abuse); however, WWDs have fewer options for escaping or resolving the abusive relationship than WWODs (Nosek et al., 2001). This may be partially due to lack of access to adequate services and programs for domestic violence and abuse (Chang et al., 2003; Nosek et al., 2001). Factors associated with increased risk of abuse include younger age, higher education, decreased mobility, social isolation, and depression (Nosek, Hughes, Talyor, & Taylor, 2006). Coercive and abusive relationships can arise from being the object of a partner who seeks out vulnerable partners and from choosing less desirable partners due to lack of experience or fear that no one else will accept you (Howland & Rintala, 2001). These individuals may be interested only in being gratified sexually or may have monetary motives, and they may sustain the relationship by telling the WWD that she is unlikely to find another person who would be willing to be with her (Howland & Rintala, 2001). WWD have various reasons for staying in abusive relationships, including loneliness, coercion by their partner, and fear of losing custody of their children (Nosek et al., 2001).

Many WWD rely on personal assistance services (PAS; e.g., caregiving) in order to accomplish many activities of daily living, such as bathing and dressing. These services, which are most commonly provided by family and friends, can place WWD uniquely at risk for abuse. In one study, women with physical disabilities noted that the intimate nature of PAS often leads to confusion over physical and social boundaries (Saxton et al., 2001). These blurred boundaries may result in inappropriate touching, unwanted sexual contact, or confusion about the appropriateness of an assistance provider's actions.

Marriage and Long-Term Relationships for WWD

WWD often have fulfilling long-term relationships that may involve giving birth to and raising children. However, these relationships can be more difficult to establish and maintain, which is understandable given the complexities involved in dating relationships, as mentioned above. According to studies on partnerships and parenting, WWDs are less likely

to be married than their male counterparts (Kreuter, 2000), and compared with WWOD are less likely to be married, more likely to marry later, more likely to be divorced, and less likely to have their children living with them (Nosek et al., 2001; Rintala et al., 1997). There is a paucity of research studies investigating partnerships and parenting in WWDs, particularly in nonheterosexual partnerships, and further research to illuminate the factors associated with fulfilling experiences as a parent and partner is warranted.

SEXUAL EXPRESSION AMONG WWD

Sexuality and intimacy involve a complex interplay between physical, psychological, and spiritual feelings, and behavior and experiences. As we have noted, for many WWD, disability status is relevant to sexual experiences; however, it is imperative to note that the impact of disability on sexuality is not always negative and does not necessarily inhibit the potential for sexual enjoyment (Chance, 2002). A willingness to expand the sexual repertoire beyond a limited focus on penile-vaginal intercourse may increase WWDs opportunities for sexual pleasure, and subsequently their sexual well-being (Chance, 2002; Mona et al., 2009, 2011). This can be done by defining sexual intimacy as mutual pleasure and enjoyment. Additionally, a willingness to experiment, alone and/or with a partner, may help women connect with their sensuality and sexuality. One woman, in a study of sexuality after spinal cord injury, described her experience,

> You get out and you get your baby oil, and you put the baby oil on, and you mix it with the water and it bonds with your skin, and you're smooth and you're silky and you're soft, and that's it. That's probably how I've managed to be without a man for so long, huh? I have another insight! I need to stay out of the shower and get me a man! (Leibowitz & Stanton, 2007, p. 50)

Despite opportunities for sexual well-being, many WWD experience differences in sexual functioning compared to WWOD, as described below.

Arousal and Orgasm

Challenges in sexual functioning can occur throughout the sexual response cycle in WWD. Many of these challenges are related to the nature of the woman's disability. For example, women with spinal cord injuries' experience of physiological arousal (e.g., vaginal lubrication, swelling of the clitoris, etc.) varies based on their level of injury (Basson, Brotto, Laan, Redmond, & Utian, 2005; Mona et al., 2009). Many WWD, however, find that with increased experimentation they are able to identify additional

erogenous zones that will promote arousal if stimulated (Chance, 2002). As one woman noted:

> It [sexual experimentation] helped me to have more of an open mind and not be as scared to try different things as I was before . . . I have found that if you have more of an open mind about the sexuality thing then the sex is gonna be better *for* you than if you have just a one set mind. And . . . even though you can't physically feel something if you keep on doing it then eventually . . . you may not feel it in that exact *place*, but you'll still get the same effect, which is actually kind of weird. But as long as you have your mind open . . . it makes it just ten times better. (Leibowitz & Stanton, 2007, p. 51)

As vaginal lubrication is controlled through multiple pathways in the central nervous system, women are able to achieve both psychogenic lubrication—that originates in the brain—and reflex lubrication, which can be aided through direct stimulation (Anderson, Borisoff, Johnson, Stiens, & Elliott, 2007). In order to promote psychogenic lubrication, it may be beneficial to set the stage for an intimate encounter though a sexually stimulating environment and engaging in fantasy and prolonged foreplay. Reflex lubrication can be addressed by engaging in oral or manual stimulation of the genitals and/or the use of a water soluble lubricant.

It is a common misperception that WWD, particularly those with a disability that results in diminished genital sensation, are unable to achieve orgasm (Chance, 2002; Mona et al., 2009). In fact, the brain is the most important organ in achieving orgasm (Sipski, Alexander, & Rosen, 2001), and WWD—especially those with a disability affecting the central nervous system—may experience a disruption in the neural pathways responsible for orgasm (Sipski & Alexander, 1993). As one woman with a spinal cord injury noted, when describing her sexual life post injury:

> I did realize that the sexual part of it starts in the head, you know, because I didn't have a lot of feeling, to touch, but this man was very patient with me. It was just companionship, and loving, and I found out that there was so much pleasure in my just thinking about it, and you know, it was a lot of mental other than physical. (Leibowitz & Stanton, 2007, p. 49)

Increasing cerebral stimulation through fantasy and role-playing, audiovisual erotic materials, and introducing new sexual games may help with achieving an orgasm, as multiple senses are receiving pleasurable messages (Sipski et al., 2001). If sensation is decreased in the genitals, increasing stimulation to other erogenous zones, such as the lips, ears, breasts, shoulders, back, and the area just above paralysis in women with

a spinal cord injury can help with the orgasmic response (Redelman, 2009). Participating in Tantric sex can be useful for WWD as it deemphasizes the goal of climax and promotes the idea of being present and fully aware of a woman's positive sexual emotions while simultaneously sharing this positive sexual energy with herself and her partner (Mona et al., 2009).

Mobility

Many WWD experience limitations in mobility that must be accounted for in order to promote overall sexual well-being. Spasticity, mobility limitations, contractures, and areas hypersensitive to touch are among the conditions that may affect mobility when engaging in acts of sexual expression (Abdel-Nasser & Ali, 2006). Trying varied positions for intercourse to determine what is most comfortable may empower and help WWD expand their sexual repertoire and identify opportunities for optimal pleasure. Ergonomic sex toys, feathers, and remote control vibrating devices are all useful in enhancing the sexual experiences of women who have mobility difficulties. In some cases, PAS can be incorporated into sexual activities to facilitate a sexual encounter. This facilitation may take the form of helping a WWD undress, providing aid in positioning for both partner sex and masturbation, or assisting with direct physical stimulation (Earle, 1999). While a comprehensive discussion on the role of PAS in facilitating sexual expression is beyond the scope of this chapter, readers are referred to Mona (2003) for more information. Additionally, cushion wedges, sex swings, and body slings can be integrated into the sexual lives of women to aid with varying levels of mobility.

Pain

WWD may experience pain during sexual activities stemming from organic or nonorganic difficulties or a combination of the two. Painful sexual encounters may result from contraction of vaginal and pelvic floor muscles and/or skin and connective tissue that has scarring or is not flexible (Pacik, 2011). Use of a catheter during sex, decreased vaginal lubrication, and infections may also be sources of pain. A woman who repeatedly experiences painful intercourse may lose her ability to attend to pleasurable sensations due to fear or anxiety of pain, and may subsequently respond by contracting the vaginal and pelvic floor muscles in anticipation of pain (Foote, 2002). This serves to reinforce and perpetuate the pain, decrease vaginal lubrication, and often ultimately results in a reduced sex drive. For women who wear a catheter, some choose to tape the external tube to the side of their leg, while others liberally apply lubricant and trust that it will remain in place. Painful intercourse or masturbation can also

be managed by scheduling sexual activities when symptoms are not occurring, experimenting with sexual positions and activities that minimize pain, and communicating with a partner or PAS regarding what does and does not cause pain, as well as engaging in other erotic activities that do not necessitate intercourse (e.g., skin-to-skin contact, kissing, etc.; Welner, 1997). Also, hormonal treatment, such as estrogen therapy in peri- and postmenopausal WWD may help increase vaginal lubrication and reduce vaginal dryness (The North American Menopause Society, 2004), and thereby reduce pain during sexual intercourse.

REPRODUCTIVE HEALTH FOR WWD

Despite the fact that WWD can have flourishing sex lives, research has indicated that these women experience substantial barriers to receiving adequate reproductive healthcare (Jackson & Mott, 2007; McRee, Haydon, & Halpern, 2010; Schopp, Sanford, Hagglund, Gay, & Coatney, 2002). Accessibility of gynecological and sexual healthcare is not only hindered by environmental/structural issues (Schopp et al., 2002), but also attitudinal and informational barriers (Walter, Nosek, & Langdon, 2001). Healthcare providers' lack of knowledge about disability and/or sexual healthcare for this population may lead to misconceptions and insensitivities about patient needs. Several studies have indicated that WWD have at times been denied sexual healthcare, particularly surrounding issues such as pregnancy (Drainoni et al., 2006; Schopp et al., 2002). When care is provided, it is not uncommon for offices and hospitals to have architectural barriers or inappropriate instruments, including a lack of height adjustable examination tables that would facilitate transfers (Schopp et al., 2002).

These barriers are not surprising when we consider the disparities in our understanding of reproductive healthcare for WWD. A recent PubMed (a leading database for medical journals) search for "women's reproductive health" yielded 5,798 articles. On that same date, a search for "women's reproductive health AND disability" found only 62 articles, many of which were focused on women with intellectual disabilities and/or were conducted outside the United States. There are many potential reasons for the failure of the medical community to appropriately address the reproductive healthcare of WWD. Long after the eugenics movement had seemingly fallen out of favor in the United States due to its association with the Nazi movement, WWD were subjected to inappropriate treatment by healthcare providers due to the misperception that these women were not capable of or should not be allowed to have children (Waxman, 1994). WWD have been coerced into medically unnecessary hysterectomies, involuntary sterilizations and abortions, and "clandestine" use of DepoProvera (Waxman, 1994, p. 160). Currently, younger women with

severe disabilities are significantly more likely to have had hysterectomies than their able-bodied counterparts (Center for Research on Women with Disabilities, 2011). It is clear that healthcare providers must strive to improve the sexual healthcare of WWD.

Women's Health

While WWD have the same reproductive healthcare needs as WWOD, this population receives preventive care, such as pap smears, at lower rates than their nondisabled counterparts (Drew & Short, 2010; Phillips & Phillips, 2006). In one study, reasons for nonadherence to recommended pelvic examinations included difficulty getting on the examination table, lack of knowledgeable physicians, structural barriers in the office, costs associated with examinations, transportation difficulties, and a belief that pelvic exams were unnecessary because of their disability (Center for Research on Women with Disabilities, 2011). Whatever the reason for lowered rates of preventative healthcare, it is clear that traditional screening practices may need to be altered to accommodate WWD. The prototypical 15-minute appointment may not be appropriate for WWD, as they may require more time to undress for the exam, or additional time during the exam due to necessary changes in positioning to alleviate pain (Piotrowski & Snell, 2007). The addition of a thorough clinical breast examination to a gynecological examination may be necessary, as altered sensation in the fingers, weakness, or rigidity may make it difficult for a woman to conduct breast self-examination (Piotrowski & Snell, 2007).

Sexually Transmitted Infections and Safe Sex Practices

Given the perception of WWD as asexual beings, it is not uncommon for counseling regarding safe sex practices to be overlooked, particularly during adolescence (Piotrowski & Snell, 2007). Despite this misperception, in one recent study, 22 percent of WWD reported a history of gonorrhea, syphilis, Chlamydia, or trichonomas (Center for Research on Women with Disabilities, 2011), and WWD have contracted sexually transmitted infections (STIs) at similar rates to their able-bodied peers (Piotrowski & Snell, 2007). Healthcare providers need to pay particular attention to their patients' functional limitations, as muscle rigidity, spasms, or weakness may make it difficult for these women to effectively use traditional barrier methods (Mona et al., 2009). Additionally, hormone-based contraceptives may be more risky for WWD than their nondisabled counterparts, as these pregnancy prevention strategies are associated with blood clots (e.g., estrogen- and progestin-based pills), osteoporosis (e.g., progesterone-only

medications), and infection (e.g., intrauterine devices; Piotrowski & Snell, 2007).

Pregnancy and Motherhood

WWD perhaps most frequently face overt discrimination with regard to pregnancy and motherhood. Perceptions that WWD should not procreate have led to undue emphasis on prenatal screening, conveying that if a fetal abnormality is found the proper course of action would be to abort the fetus in order to prevent another disabled individual (Walsh-Gallagher, Sinclair, & Conkey, 2011). These anti-disability sentiments, coupled with societal ableism that questions the mother's ability to rear her child, have resulted in many WWD being counseled against having children (Prilleltensky, 2003). When WWD do become pregnant, they are frequently faced with continued barriers in the medical system. Healthcare providers are often uninformed about the interaction between pregnancy and disability, with one study indicating that future primary care physicians grossly overstate the health risks associated with pregnancy among women with spinal cord injuries (Oshima, Kirschner, Heinemann, & Semik, 1998). While WWD are at higher risk for urinary tract infections, anemia, early labor, and other complications, research has indicated that many are able to conceive and carry a fetus to term if provided with adequate healthcare (Schopp et al., 2002).

Structural barriers continue to remain for pregnant WWD. In a large national study, 56 percent of WWD reported that their healthcare facility was unable to accommodate their disability-related needs at the time of delivery (Nosek et al., 2001). Physicians' offices additionally need to have wheelchair-accessible scales in order to properly weigh expectant mothers as part of their prenatal care (Morrison, George, & Mosqueda, 2008).

Despite the fact that there are approximately eight million families with one or both parents living with a disability in the United States (Rembis, 2010), WWD are often faced by significant prejudice regarding their ability to parent. In one study, a woman recounted her experience of hospital staff not teaching her how to bathe and dress her newborn, and instead providing her with the "unhelpful help" of doing the task themselves (Thomas, 2001, p. 254). Many new mothers also experience social service liaisons as hypervigilent of their parenting skills and are concerned that their children may be taken away from them (Walsh-Gallagher et al., 2011). And, as mentioned, WWD are more likely than their nondisabled counterparts to stay in a conflictual or unhealthy marriage due to concerns surrounding custody (Nosek et al., 2001). Despite these biases and prejudices, many WWD are more than capable of successfully raising their child by

creatively adapting equipment and procedures to meet the needs of their newborn (Prilleltensky, 2003).

CONCLUSIONS

It is evident that WWD are capable of having thriving sexual lives when social, environmental, and attitudinal obstacles are lowered. Recognizing the unique social, psychological, and physiological factors of this diverse group of women is critical in understanding the nature of their sexual experiences. Further work is needed to address society's ableist viewpoints that often limit our perception of WWD as sexual beings. The Complete State of Sexual Health Model allows for a sex-positive approach to sexual health for WWD, as it focuses on the interplay between WWDs sexual well-being, often marked and colored by their social and psychological experiences, and the physiological factors of disability that may lead to limitations in sexual expression. Disability is an often neglected experience in our society and healthy sexuality for WWD is often underemphasized as well. Thus, many are unaware of the possibilities for positive quality of life among WWD. This chapter has provided an overview of sexuality as experienced by WWD that can help illuminate the experiences of this population, and we call on readers to continuously examine their own culturally based beliefs about women, sexuality, and disability.

AUTHORS' NOTE

The authors acknowledge that there is an increasingly extensive literature base on the sexual lives of women with intellectual disabilities. This chapter, however, focuses exclusively on the sexual lives of women with physical disabilities, in order to most comprehensively address the nature of their sexual experiences.

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Chapter 5

Constructions of Sexuality for First Nation Women in Atlantic Canada: Results from a Qualitative Study

Allison Reeves and Charlotte Reading

Since the colonization of North America by Europeans, systemic racism, dispossession, and threats to cultural identity in the Indigenous[1] communities of North America has led to many social and health problems that were, prior to contact, largely unknown (Gunn Allen, 1986; Moffitt, 2004; Paul, 2000; Steenbeek, 2004). Within the context of various health and social inequities, sexual health concerns in particular present a greater burden for Indigenous women than for the mainstream population in Canada (Benoit, 2001; Benoit, Carroll, & Chaudhry, 2003; Calzavara, Bullock, Myers, Marshall, & Cockerill, 1999; Moffitt, 2004). In order for sexual health programs to provide accessible and appropriate services for Indigenous women, information about determinants affecting sexual health must be considered (Serrant-Green, 2005). Currently, there is a profound deficit of research in the area of sexual health among Indigenous women. The existing literature typically explores maternal health, fetal alcohol syndrome, and infant mortality, and in general, pathologizes the sexual health of Indigenous women (Dion Stout, Kipling, & Stout, 2001; Serrant-Green, 2005; Steenbeek, 2004). This literature largely fails to consider the

political, historical, and social contexts from which the sexual health status of Indigenous women emerges. In addition, the lack of qualitative studies leaves us with little understanding of the experiences, knowledge, and perceptions of Indigenous women around sexuality. This chapter offers an overview of sexual health determinants and outcomes among Indigenous women in Canada and describes results from a qualitative research study that examined the neocolonial cultural construction of young adult First Nation women's sexuality in Atlantic Canada.

A REVIEW OF TERMS: SEXUALITY AND SEXUAL HEALTH

The World Health Organization (WHO) defines sexuality as the knowledge, attitudes, beliefs, and values we have toward sexual health (2006). Sexuality encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction, and is influenced by the interaction of biological, psychological, social, economic, political, cultural, historical, religious, and spiritual factors (Boyce, Doherty, Fortin, & MacKinnon, 2003). Sexual health can also be conceptualized as our sexual practices and behaviors, which ultimately lead to sexual health outcomes (WHO, 2006). Sexual health concerns itself with several sexually related issues, including sexually transmitted infections (STIs), pregnancy, infertility, sexual well-being, sexual satisfaction, and sexual violence (Oakley, 1996). Recent definitions of sexual health and healthy sexuality have attempted to capture the wholistic[2] nature of these dimensions of human experience by integrating emotional, physical, cognitive, and social aspects of sexuality (Jackson, 1996). Sexual behavior has been conceptualized as social behavior, as sexuality and sexual norms emerge from discourse regarding sexual relations between and among people, the institution of marriage, and cultural meanings of love (Oakley, 1996). Ideologies informing our sexuality are also culturally constructed, transform over time, and vary by historical period and geography (McKay, 2004).

DETERMINANTS OF WOMEN'S SEXUAL HEALTH

Sexual health and sexuality are widely acknowledged to be influenced by many of the determinants of health, including socioeconomic status, sociocultural contexts, education, and biology (Blackwood, 2000; Boyce et al., 2003; Jackson, 1996; Langille, Curtis, Hughes, & Murphy, 2003). For instance, a 2010 WHO report on the social determinants of sexual health indicates that young adolescent women living in poor households are more likely to have children than adolescent women from wealthier homes. This report also states that education (especially for young women) plays an important role in reducing the number of pregnancies among

adolescent and young adult women. In addition, socioeconomic status and education also affect access to contraception as well as access to safe abortion services, and gender norms within a given culture can influence women's ability to negotiate safer sex practices (WHO, 2010). These are but a few examples linking social determinants to sexual health outcomes.

Personal coping skills and health practices are also linked to sexual health (Boyce et al., 2003), as individuals with emotional and mental health challenges frequently engage in more risky sexual behaviors (Boyce et al., 2003; Health Canada, 1999). A lack of social and emotional support for young women has also been associated with risky sexual health behavior and depression (Boyce et al., 2003). Similarly, self-esteem can influence one's behavior regarding the impulsivity of sexual activity and one's ability to resist peer pressure and make independent decisions (Health Canada, 1999). Finally, unequal and gendered power and status in a relationship can limit control in making healthy sexual choices (Health Canada, 1999; Laws & Schwartz, 1977).

Sexual Scripts: The Social Construction of Female Sexuality (1977) is a landmark document by Laws and Schwartz that focuses on the female perspective of sexuality. They refer to the notion of sexual scripts, which relate to sexual behaviors, rules, and expectations sanctioned by one's social group. They suggest that a woman's sexual identity is comprised of her personal experiences, the sexual scripts of her social group, her social position, and her cultural worldview. Although human beings are often unaware of the distinct characteristics of their social environment, it is in fact this environment that equips its cultural members to understand, judge, and make sexual-related decisions (Blackwood, 2000; Laws & Schwartz, 1977).

Culture also plays a principal role in constructing sexuality, as it is the symbolism of culture through which desires, meanings, and behaviors surrounding sexuality are learned and expressed (Jackson, 1996). Although innate human behaviors associated with sex and sexuality exist, it is through socially learned meanings that an individual's sexual self becomes manifest and follows sexual scripts. The various features of our lives, such as culture, religion, ethnicity, class, gender, family, and community, all combine to create sexual meaning (Blackwood, 2000).

In North America, gender represents the primary construct through which sexuality is defined, as gender often dictates how sexual behavior and sexual roles ought to be embodied and enacted (Oakley, 1996). In Western cultures, two genders are generally recognized and accepted (male and female), with clearly defined social roles for each. Differences in anatomy, the function of hormones, sexual behaviors, and cultural learning processes comprise the distinguishing characteristics between male and female sexuality in Western cultures (Oakley, 1996). Interestingly, only the first two items on this list are not affected by cultural constructs, illustrating that gender roles are in fact socially defined. However, it is important

to recognize that not all cultures embrace similar sexual scripts. As Jackson (1996) points out: "The idea that female's sexuality is qualitatively different from the male's is not universal in all cultures" (p. 37). Examples demonstrating different cultural views on sexuality between traditional Indigenous scripts and Western scripts are discussed in the following section.

A HISTORICAL LENS ON SEXUAL CONSTRUCTS FOR EURO-WESTERN AND INDIGENOUS WOMEN

In many Euro-Western cultures, women have historically been regarded as dependent, passive, and submissive (Connell, 2005). In terms of sexual function, women have been viewed as experiencing long arousal periods, less sexual fulfillment, and an inferior sex drive, in addition to suffering from romantic idealism (Oakley, 1996). In Victorian times, affluent women were denied their sexuality, and were therefore not permitted to express sexual desires, although they were expected to "submit" to fulfilling men's sexual needs. Today, contemporary women are perceived through a social lens that fashions female sexuality as a commodity (Welles, 2005). Although modern-day female sexuality is more public than throughout history, the contemporary image of female sexuality is not necessarily always positive for women. In Western cultures, females are often viewed as the sexual objects of male desire, a view highly supported by the media as well as those who might make a profit from this commercial enterprise.

As a result of both historic and contemporary misrepresentations of female sexuality, North American women have been encouraged to prioritize their physical attractiveness, rather than to develop agency with respect to their sexual lives (Welles, 2005). Many Western heterosexual women go to great lengths to achieve a cultural ideal of physical attractiveness, through diet, exercise, stylish depilatory habits and dress, for example. Women undertake these activities in order to fulfill their role as object of male desire. Unfortunately, this type of fulfillment is rarely consistent with sexual satisfaction, as little attention is paid to women's sexual desires or needs (Blackwood, 2000). Optimistically, as Western cultures become increasingly more accepting of sexual diversity, including same-sex relationships, beliefs and norms regarding sexuality will continue to evolve. However, the adaptation of these new models of sexuality can oftentimes be exceedingly slow.

Within the limited historical record of sexual customs and gender relations among ancient Indigenous groups, it is currently understood that few Indigenous societies in North America were patriarchal prior to 1600 (Dickason, 2002; Gunn Allen, 1986; Sacks, 1976). In fact, according to Gunn Allen (1986), several Indigenous groups were women-centered and shared myths of female creators, such as Thought Woman, the eldest God, whose thoughts preceded creation and from whom all else was born. Many Indigenous values included principles of diversity, positive sexuality, equality, and the values of strong, decisive females and nurturing among males (Bear Hawk

Cohen, 2003; Gunn Allen, 1986; Kinnon & Swanson, 2002). By today's Western standards, Indigenous cultures were quite forward thinking in terms of their treatment of women (who are not portrayed to be passive and helpless, as is the case in many Western historical portrayals of women) and acceptance of diversity (namely Two Spirit people and same-sex relationships, in which partners were often respected members of Indigenous societies) (Devries & Free, 2010; Dickason, 2002; Gunn Allen, 1986; Paul 2000). Indeed, women's roles were quite diverse in precolonial North America and women typically held positions of authority within society. For example, Iroquois women often held political power within their communities (Moore, 2002), and among the Tlingit and the Haida, a matrilineal clan system was maintained and property was transferred through the female line (Dickason, 2002). Women were also spiritually respected as the givers of life (Carter, 1997; Waldram, Harring, & Young, 1995) and were considered to have strong powers when menstruating or after menopause. Because of these powers, women were often the focus of many ceremonies (Fiske, 1996). Women were also healers, who understood the therapeutic power of plants and sacred medicines (Kinnon & Swanson, 2002), and as such had a primary role as a powerful life force within the natural, social, and spiritual realms.

With respect to sexuality specifically, available historical records suggest that sex was considered a gift from the Creator, it was believed to contribute to pleasure, well-being, and strong families, and not limited to the physical realm but involved the emotions, mind, and spirit (Gunn Allen, 1986; Kinnon & Swanson, 2002). Women's sexual health education and promotion included teachings on herbal medicines, pregnancy, and birth control from the grandmothers, as well as coming of age ceremonies to celebrate transitions into adulthood (Fiske, 1996). Children were taught about their bodies, men had knowledge of childbirth, and there was often openness around sexuality (Kinnon & Swanson, 2002). Among most cultures, women were respected, rarely abused, and rape was unusual or completely unheard of in certain communities (Bohn, 2003; Paul, 2000; Pearce at al., 2008). To mistreat a woman often incurred harsh punishments (Dickason, 2002) and strong social taboos against inappropriate behavior, such as violence against women, helped to improve reproductive health and secure healthy relationships (Kinnon & Swanson, 2002). Finally, coming of age ceremonies and rites of passage played an integral role in honoring a young person's transition into adulthood and sexual maturity (Yee, 2008).

SEXUAL HEALTH AMONG CONTEMPORARY INDIGENOUS WOMEN IN CANADA

Social inequities that can lead to a disproportionate burden of sexual health challenges represent a major concern for Indigenous women in Canada (Hoffman-Goetz, Friedman, & Clark, 2005; Public Health Agency of Canada, 2007; Steenbeek, 2004). The following statistics present trends

on sexual health challenges and vary by region, population, and group, and do not presume to tell the story of every Indigenous woman living in Canada. This discussion simply highlights a number of sexual health concerns that affect Indigenous women today.

With respect to STIs, several research studies indicate that STIs appear to be of particular concern for Indigenous peoples. For instance, the reported rates of *Chlamydia* and gonorrhea in Canada remain highest among First Nation and Inuit adolescents in many communities, ranging from 4 to 10 times higher than in mainstream populations (Hoffman-Goetz et al., 2005; Jolly, Moffatt, Fast, & Brunham, 2005; Steenbeek, 2004). If left untreated, *Chlamydia* and gonorrhea, which are often asymptomatic, can lead to pelvic inflammatory disease, chronic pelvic pain, tubal infertility, and ectopic pregnancies (Public Health Agency of Canada, 2008). The Human Papillomavirus (HPV), which is the most common precursor to cervical cancer, is currently *not* more predominant among Indigenous women than among non-Indigenous women (Young, Kliewer, Blanchard, & Mayer, 2000). However, Papanicolaou (Pap) test screening, which is an effective method of diagnosing and addressing HPV prior to its development into cancer (Healey et al., 2001), is not undertaken as frequently by Indigenous women. A study from Manitoba found that Indigenous women were far less likely than non-Indigenous women to have at least one Pap test in the previous three years (Young et al., 2000). This study also found that Indigenous women had 3.6 times the age standardized rate of invasive cervical cancer as compared to non-Indigenous women.

HIV/AIDS represents an area of particular concern for Indigenous communities as the numbers of HIV/AIDS cases in Indigenous populations are increasing. Currently, Indigenous peoples make up 3.8 percent of the Canadian population, yet have represented almost 24 percent of new HIV and 12 percent of new AIDS cases since 2002 (Devries & Free, 2010), with Indigenous women being almost three times more likely to contract HIV than non-Indigenous women in Canada[3] (Native Women's Association of Canada, n.d.). Additionally, the Canadian Aboriginal AIDS Network indicates that Indigenous youth account for one in every four HIV positive test among all Canadian youth, despite representing a small proportion of Canadian's young population[4] (NWAC, n.d.). Interestingly, a study on condom use in 11 Ontario reserve communities found avoidance of pregnancy, rather than concern over contracting STIs and HIV, to be the reason individuals elected to use condoms (Calzavara et al., 1998). This study found that, within the previous year, the majority of the 658 survey responses (61%) had never used a condom. As well, among those who had been sexually active during the previous year, as many as 9 percent had not heard of AIDS (Calzavara et al., 1999). The authors suggest that HIV can spread rapidly, as those who partner both outside and within the community act as sexual pathways for the virus; therefore,

individuals living within reserve communities are not insulated from exposure to HIV (1999).

IN CONTEXT: SEXUALITY AND SEXUAL HEALTH FOR INDIGENOUS WOMEN

It is important to contextualize these present-day sexual health trends through an historical lens, in order to highlight the changes brought on by the colonial oppression of Indigenous peoples. We have briefly reviewed what is written by Indigenous scholars about traditional gender relations and sexuality; we now consider the impacts of colonization on the sexual scripts and sexual health of Indigenous women.

In addition to the literal colonization of the Americas, European settlers brought with them a set of beliefs, which often did not include the positive sexuality and acceptance of diversity that Indigenous peoples valued. Through centuries of European domination, the residential school system, intercultural marriages, sexual norms and behaviors among Indigenous peoples changed dramatically. These changes began in early colonial times, when tensions arose between settlers and Indigenous peoples due to differences in norms and values. As a result of assimilationist policies and practices, Indigenous groups and European settlers became more involved in each other's lives. Sarah Carter's book, *Capturing Women: The Manipulation of Cultural Imagery in Canada's Prairie West,* explores early relationships between the Indigenous and non-Indigenous people in Canada's West. Despite the fact that Indigenous women were often preyed on and sexually abused by colonizers, they were still seen as corrupting and immoral for the most part (Carter, 1997). In fact, many colonizers saw their white brothers as being seduced by the Indian woman's offer to engage in licentious acts and that, because of these "lewd" women, the character of the men in Canada had been assaulted (Carter, 1997, p. 183). Still, not every Euro-Canadian accepted the derogatory image of First Nation women, and some recognized the positive role women played as midwives to early immigrants, as teachers about Indigenous plants, as medicine women, and as spiritual leaders, as well as other crucial roles in both Indigenous and non-Indigenous communities (Anderson, 2011; Coates, 2004; Fiske, 1996).

Over time, Western religion slowly became a part of the lives of many Indigenous women. Catholicism, for example, is noted as being especially fervent about "saving Indigenous people from sin." Indigenous traditions were denounced and replaced by a religious form of social control, including harsh discipline and punishment, teachings on sexual sin, and fear of eternal damnation (Fiske, 1996). Instead of a girl's first menstruation being cause for celebration within the community, Catholicism taught of Eve's "original sin" and of its connection to the pain of childbirth and the "pollution" of menstruation (Million, 2000).

Toward the end of the 19th century, the Canadian government, along with four Christian denominations, implemented residential schooling in Canada (Million, 2000). The governing institutions sought to rid the children of tribal community lifestyles—in a sense, to "individualize" them in order to socialize them as Canadian citizens (Fiske, 1996). In these schools, rules enforced the suppression of sexual desire and tactics, such as whipping, confinement, and humiliation, were used to instill fear of sexual wrongdoing (Moffitt, 2004). Ironically, sexual abuse of girls and boys was widespread within many of these schools, and children often endured years of physical, mental, emotional, and sexual abuse. Unfortunately, many children who grew up in this system went on to adopt parenting skills they had learned, and thus the cycle of abuse often continued (Moffitt, 2004).

In summary, the powerful forces of colonization brought with them a patriarchal ideology, which was especially devastating to women's power within relationships, families, and entire communities. Within the context of racialized patriarchy, it became increasingly difficult for Indigenous women to achieve healthy sexual practices in their relationships. This shift in sexual construction, combined with negative health determinants, such as poverty, has resulted in challenging sexual health issues for many Indigenous women today, including high rates of STIs, cervical cancer, sexual violence, and HIV (Moffitt, 2004).

INTRODUCTION TO THE RESEARCH STUDY

The literature clearly demonstrates a number of sexual health concerns among First Nation and other Indigenous women. However, there is little information emerging from current health research about conceptualizations and experiences of First Nation women regarding sexuality within physical, emotional, cognitive, spiritual, and relational dimensions. Additionally, little is known about how these concepts are affected by social and cultural norms and influences. Yet, the evidence is clear that determinants of health, social contexts, and meaning making related to sexuality affect sexual health outcomes (Benoit et al., 2003; Browne & Fiske, 2001; Tookenay, 1996). Therefore, in order to understand these health outcomes within the appropriate context, this study focused specifically on the current social construction of sexual health, including sexual scripts, among First Nation women in Atlantic Canada.

METHODS

The aim of this project was to explore the role of culture in relation to sexual scripts in formulating beliefs, values, and ultimately experiences around sexuality for young adult First Nation women in Atlantic Canada.

The research questions guiding this study were: (1) How are the multiple dimensions of sexuality (physical, emotional, cognitive, spiritual, and relational) conceptualized and articulated by young adult First Nation women, and (2) How do young adult First Nation women perceive the influence of Western and Indigenous values, norms, and contexts on their sexuality?

To address these research questions, semi-structured, qualitative interviews were conducted with 11 First Nation women between the ages of 18 and 30 in Atlantic Canada. This project utilized a qualitative methodology, which focuses on understanding human and social actions in their natural setting and which creates knowledge that is intentionally value laden, subjective, and situated in particular cultural, social, and historical contexts (McGrath & Johnson, 2003; Pinnegar & Daynes, 2007). This methodology was chosen purposefully, as it recognizes that sexual scripts for First Nation women are continuously undergoing transformations across time and between and within communities as cultures change and blend. This project was supported by an Indigenous community organization and ethical approval was secured from both a university ethics board, as well as from the Mi'kmaq Ethics Watch and the local First Nation Band authority. Measures were taken to protect the confidentiality and privacy of young women who participated; specifically, pseudonyms have been used to protect their identities. The 11 women who participated in this study were identified as heterosexual or bisexual and were living or had grown up in a reserve community.

Techniques used to analyze the data were borrowed from grounded theory; coding the data into thematic groups was inductive and considered frameworks, such as constructivism, critical social theory, feminist theory, and Indigenous theories (Campbell & Wasco, 2000; Guba & Lincoln, 1994; Kovach, 2005). This integrated approach to data analysis is considered appropriate for qualitative research with Indigenous peoples, as the combination offers a wholistic and critical lens through which to explore historical, political, cultural, economic, ethnic, and gender values, and their contribution to current social reality (Guba & Lincoln, 1994). Following qualitative analysis protocols, trends were categorized according to emergent themes.

FINDINGS

The findings have been presented as a summary of women's responses to questions about the physical, emotional, relational, spiritual, and cognitive dimensions of sexuality. Much of what the women shared refers to the multidimensionality of sexuality, the dimensions of which intersect and interrelate with each other. This section, therefore, represents a general fit of categories, keeping in mind the overlap between these wholistic dimensions of sexuality.

The Physical Dimension

With respect to the physical aspects of sexuality, participants expressed considerable knowledge about reproduction, contraception, and the risks associated with STIs, for which they described employing protective measures. In fact, several women demonstrated remarkable empowerment around negotiating safer sex.

Jo: I was chatting online and this guy—we were supposed to hook up, and I told him, "Okay—I'll meet you. I'll be at your house, make sure you have a condom!", I told him . . . I'm like, "Fucking put a condom on or I'm not sleeping with you!"

Many of the participants talked about their own experiences with STIs:

Linda: Yeah, ever since that guy that I slept with who gave me Chlamydia—if it's like 1 out of 2 people I sleep with has Chlamydia, like, that's bad!

Michelle: I guess if you're young and stupid I guess, and not using condoms and getting . . . I caught something before, I think that's why I'm so obsessed with using condoms. I had Chlamydia before! And I was like, Oh my god! I'm going to die! I didn't know what it really was! But yeah—and then, yeah, [the nurse said] "It's just an infection", and "Blah blah blah-take these antibiotics" . . . and now I always get checked.

Although participants did not necessarily view teenage pregnancy as negative, the information they received about it was typically couched within the vernacular of risk and error.

Susan: About the risks, like, [mom] told us that she had a teenage pregnancy, that she, um, she didn't want us to kind of—not mistakes, the same mistakes, but she wanted us to have choices, because she wasn't spoken to about it and she found out the wrong way, and grew up too fast.

Janice: We talked about it but we kind of more talked about the negative cause, well, she was not trying to scare us but like, I have, there's four of us in the family and I'm the oldest. So she's always, you know, pregnancy is not a bad thing but on a reserve you see a lot more of that than you would in a non-Aboriginal place and she didn't want it.

Not all the women described the physicality of sex in negative terms. In fact, some talked about a growing appreciation and comfort with their sexuality.

Linda: I don't know . . . I guess I've become more open to it, you know? . . . Explore what I want to do—do what I want to do.

Janice: . . . kind of like the whole experimenting thing. Now that I'm older and been in a relationship, I know what I kind of want—like, I know what I want!

However, women also spoke about times where sex was physically unsatisfying and unfulfilling, especially during their earlier sexual experiences:

Kathleen:	Cause back then you never had an orgasm back then. I don't even know what it was . . . It was more like—If he would come, you know? . . . I never even thought about that until right now actually.
Jo:	I didn't know how to—I don't know; I'd just be like, okay get it over and done with—just try to satisfy them. I didn't do it for myself.

The preceding quotes suggest that at least some of the women in this study sought personal validation through sexual relationships and may have engaged in sexual activity to feel appreciated and valued, while perceiving the satisfaction of their own sexual desires to be less relevant. In fact, participants talked very little about exploring their own physical pleasure. These findings indicate these young First Nation women may not always fully recognize their own physical needs and desires.

The Emotional Dimension

Emotions played an important role in the construction and experience of sexuality among the participants of this study. For some of the women, the affection and attention shared between themselves and their partner made the sexual experience special.

Linda:	He made me feel good in lots of ways . . . he'd tell me, "I love you," and all that stuff.
Interviewer:	Did you tell him it back?
Linda:	Yeah- I did. I did.
Susan:	. . . kind of like, just a unique bond between two people that only you two know about—that's how I see it anyway.
Chris:	[Sex makes me] feel close and happy.

Others described emotional difficulties related to shame and embarrassment, which were often rooted in unequal gender roles and expectations.

Michelle:	Sometimes I feel guilty, like, why didn't I wait, you know?
Jo:	Sometimes I get disgusted too though . . . it depends . . . like, if I sleep with someone one night—and I don't really know them, I feel like, oh my god! . . . disgusting like, skanky or something.
Laura:	You don't value yourself, obviously. You believe that, you know . . . you don't believe that you should be treated better, you won't be comfortable with your own body, you won't care about your body and what you do to it . . .

Overall, these stories reveal that, in addition to concerns about contracting an infection or becoming pregnant, many of the women experience

a sense of discomfort and even shame associated with being expressly sexual.

Women also discussed concerns related to body image, which has been included in the emotional domain, as it represents feelings associated with self-esteem and self-worth. The majority of the women spoke about a desire to be the "ideal" female partner—a beautiful one:

Anna: I feel like [guys] only like me when I'm looking my best. Like one time, when I was with __________, I felt like I didn't have to wear make up really. Then he got mad at me one day, he's like, "You don't even fix yourself up anymore!" He went like that to me. And it made me feel really down about it, you know? So um, I like to look my best.

Jo: Like, sometimes I'm like, "Don't touch my stomach"—or . . . I'm like, "Pass me my clothes!" if I'm in the shower!

Linda: Sometimes I'm shy [being naked]. Sometimes I don't know why.

Interviewer: Is it important for you to have like, a perfect body?

Linda: Yeah—

Interviewer: Where did you get that idea from?

Linda: I don't know—I just want to have a good body.

Interviewer: Yeah. But how do you know what a good body is? Where did you get that idea from?

Linda: Um . . . like TV? Like, there's always these girls wearing um, bikinis, and I want to wear a bikini, but I can't cause I got this gut! . . . I'm working on it!

However, some women did speak about body image in more positive terms:

Janice: Like, it doesn't affect me, like, I'm built the way I'm built, and you know. And if I want to I could probably lose weight or, you know, gain more weight

These findings reveal that body image may be strongly linked to feelings of self-worth among these First Nation women and that it is often others who define these standards. Rather, the women are simply left struggling to fulfill oftentimes unrealistic sexual images. An intense focus on appearance among several of the women indicates that they might view their social value (i.e., beauty) as being linked to their sexual value (Potgieter & Khan, 2005).

The Relational Dimension

Women spoke enthusiastically about making connections with their sexual partners, either those about whom they cared deeply about and/or those with whom they shared enjoyable sexual experiences:

Laura: You get to share your true feelings to a person that you're having sex with.
Kathleen: Um, I can trust my boyfriend . . . we've been together for a long time—that's one good thing . . . it's easier like, we've been together forever, so I can tell him anything.
Susan: It's one thing to know a guy as a friend and stuff and it's another thing to be with them. And to me it's like, I don't know—It's almost like, like a secret I guess, but it's not—only you two know about that feeling, only you two know how each other are, and um, it's not like it could be explained to anybody else . . .

Nevertheless, while the women valued love and closeness, several of their relationships were plagued with instability and insecurity:

Linda: My boyfriend—my ex-boyfriend . . . he already had sex . . . cause we were the type we just kept breaking up, then going back together, then breaking up—and each time we broke up, god knows who he went to . . . "do" . . .
Laura: . . . maybe [. . .] you have sex with someone you think that loves you but maybe this person is just with you to have sex.
Janice: Yeah—the whole one night thing, is kind of get it done and over with. It seems like it's got to be fast! There's only so many hours in the day, right, and at night, right? So, it's like, get it done and then go!
Interviewer: So do you feel close with your partner or not really?
Janice: You know how like—you just hook up with someone, like, that's it. That's just how it is.
Anna: Especially from my boyfriend, it makes me feel more wanted. You know, he comes over just to have sex with me, that makes me feel wanted. I like that feeling that he wants me.
Interviewer: Would you like it more if he wanted to be with you, like, in a permanent relationship?
Anna: Yeah . . .
Linda: The guys I've been checking out—they're not mean to me; they haven't called me whore or slut or anything. But there were like 2 or 3 guys that did it to me. They'd ask me out . . . and then, I'm not attracted to them. And I'd try to find a nice way of saying no. I just don't want to be mean off the bat, like, "I don't like you" . . . so I was like, "Let's just be friends." Then there were like 2 or 3 people that told me, "Fuck you, you fucking slut!" It's just . . . I don't know—It's just the way some guys are.

The Spiritual Dimension

Questions about spirituality were also included in the interviews in an attempt to gauge whether sexuality had any spiritual significance. This

dimension not only represents a dimension of wholistic sexuality, it is also relevant to this particular population, as spirituality was often an important aspect of traditional Indigenous sexuality. However, as a result of the influence of early missionaries and residential schools, most of the women in this study belonged to a community that had been strongly influenced by Western religion, such as Christianity. Consequently, most women did not discuss traditional Indigenous spiritual practices and did not see a connection between sexuality and spirituality, as described in this statement by Janice: "I go to church, but like, no—that has nothing to do with our topic today." There were, however, religious undertones in some of the women's perceived social rules around sexuality (for instance, many were taught to wait until marriage to have sex). These beliefs are explored below in the cognitive dimension of sexuality.

The Cognitive Dimension

In as much as there exists no clearly defined boundary between the cognitive experience of sexuality and any other dimension, this section aims to summarize the participants' values, beliefs, and ideas about sexuality. Based on their responses, the women in this study appear to have been raised with a certain degree of negativity around sexuality, as something to be avoided as well as something that is secret and shameful:

Janice: When I was younger, I was like, 'I don't think you talk about it' . . .

In fact, the social repercussions for being excessively sexual in one's behavior as well as appearance were grave:

Interviewer: Do you think that people looked down on girls in skimpy outfits [. . .]?
Heather: The girls looked down on it but the boys didn't. A few of the girls they were like, "skanks!", "ho's!" . . .
Susan: The outlook of people dressing like that at home wasn't good.
Interviewer: What kinds of things did they say about people who dressed like that?
Susan: Just that they're whores . . . and they're gonna have kids young, and um, they're promiscuous, and that um, it wasn't a positive thing.

Women discussed having their sexuality policed by other women within their social circles, which often included stigma toward those women whose behavior was perceived to be promiscuous. Lateral aggression has been defined in instances like these as a competition for attention and power between members of a subordinate group (Currie, Kelly, & Pomeranz, 2007). In this example, it relates to young women competing for power

that is moderated by members of the dominant group—in this case, men. Ironically, women were often made to feel shame after having sex with a man who they felt was rewarded for the same behavior. Another quote demonstrates the value one woman placed on her virginity as well as her regret in relinquishing it under what she perceived to be the "wrong" circumstances:

Laura:	I was just like, you know, retaliating, like on myself. I was blaming myself, really.
Interviewer:	So why were you so devastated?
Laura:	Because I wanted to save my—I thought that he was . . .
Interviewer:	The one.
Laura:	Yeah . . . Yep. Because it meant a lot to me—and then just to have someone just take that and . . .
Interviewer:	Throw it away?
Laura:	Yep.

These passages reveal several themes related to the women's beliefs about sex. Messages such as "girls don't talk about sex," "people should be heterosexual," "virginity is precious," and "men will respect you if you withhold sex" were alluded to frequently in these discussions. These findings demonstrate that sex and sexuality are tied to self-worth for most of these young First Nation women, and that social punishment may arise should they step outside the bounds of what has been defined as acceptable sexual behavior. Ironically, women are expected to seek—and often legitimately want—male attention, yet pay a social and emotional price for engaging in "bad" behavior. Much of the pressure seems to be placed on women themselves to enforce gendered morality and women's responsibility for sexual outcomes.

What we see taking form around this discourse of sexuality are trends in power relations in heterosexual relationships for these women. Some women described sexual relationships where they shared a balance of power with their partners and acted as sexual subjects, articulating their needs around desire, satisfaction, and sexual safety. These women demonstrated a construction of sexuality that indicated a stronger connection with their sexual desires and needs, suggestive of higher self-esteem, agency, and an internal sense of validation. On the other hand, the women also described instances where they lacked power in sexual relationships, deferred to male control, and took on roles that positioned them as sexual objects in the encounter. In these cases, women demonstrated a disconnect from their sexual desires and needs, and did not feel safe (or able) to articulate these desires or to take sexual initiative. This trend is more consistent with female objectification and sexual exploitation common within a patriarchy, where female needs are often silenced or shamed.

DISCUSSION

The constructs of connected and disconnected sexuality emerge from the neocolonial culture in which the participants of this study live, work, and engage in sexual relationships. According to this small study, contemporary Indigenous women in these geographic regions largely understand sexuality through a Western lens that is greatly influenced by Euro-Christian patriarchal systems, dominant gender roles, and the mass media. The messages, structures, and processes produced by these systems are value laden and relate to diminished self-esteem, gendered sexual ownership, the immorality of sex, sexual women as promiscuous (ironically, this message is generally coupled with the portrayal of highly sexualized females in the media), and the repression of female sexual desires. In a world where tensions around ethnicity, westernization, globalization, assimilation, and feminism abound, these young First Nation women are left struggling to develop agency and a healthy sexuality in a culture where sexuality is at once confusing, shameful, and highly coveted by the men around them. According to these findings, Western scripts have deeply shaped these women's sexuality and gender roles, by placing them into subordinate roles, removing their authority, and generally contributing to the colonization of Indigenous women's sexuality. Likewise, Western standards of a hegemonic masculinity (which values dominance, strength, and aggression, among others; Connell, 1987) have become prominent for many Indigenous men who are involved in the lives of Indigenous women (Brownridge, 2003). Males, like females, follow the values and norms of their peer group, which are informed by the larger society through media and other forums. Sadly, women sometimes display lateral aggression toward one another as they engage in a competition for male attention. Currie and colleagues (2007) suggest that, although women participate in "policing the boundaries of femininity," they do so through a "male gaze" (p. 32), which serves to perpetuate patriarchal norms.

Through colonization, Christian religions have become influential in the lives of Indigenous women like those who participated in this study. Many sexual constructions expressed by the participants include religious undertones, including sex-as-taboo, compulsory heterosexuality (Tolman, 1994), feelings of guilt after losing one's virginity, engaging in nonrelational sex, or contracting a STI. In his essay, *Suffering and Damage in Catholic Sexuality,* Patton (1988) argues that the psychological harm done by the misogynistic and homophobic belief systems of this institution are expressed in those affected by it through anger, shame, guilt, fear, anxiety, depression, and rage. He asserts that the church's "belief and practice of a philosophy hostile to erotic pleasure" (p. 131), which stresses self-denial and condemns nonprocreative sex, has caused many people great pain. Belief systems like these, which permeate society, can have an effect on

community, family, and individual values, roles, and beliefs about sexuality. Several Indigenous authors (e.g., Knockwood, 1992) have detailed the emotional and physical torment they endured at the hands of clergy in the Christian residential school system, which enforced a sexual ideology that suppressed sexual desire and instilled fears of sexual wrongdoing. Indeed, residential schooling was integral to colonizing the sexuality of Indigenous women and was a strong Western force which sought to wipe clean the lasting remnants of Indigenous sexual norms (Million, 2000). Within these institutions, Indigenous children were forced to learn Western "moral ways," and subsequently lost important and positive features of their own cultural knowledge (Fiske, 1996).

Shepard, O'Neil, and Guenette (2006) explore the current counseling needs of First Nation women and note that residential school survivors have experienced considerable trauma, related not only to the kind of emotional abuse that Patton (1988) refers to, but also to the sexual and physical abuse these young children suffered at the hands of their religious guardians. Many residential school survivors subsequently shut down emotionally and experienced life-long challenges related to the development of sexually intimate relationships (Shepard et al., 2006). According to these authors, emotional ties have been broken across generations, and therefore information sharing, including the transmission of cultural knowledge, has been further punctuated.

Like their elders before them who experienced the residential school system, many of these young women have been made to feel as if the consequences of sexual behavior (e.g., STIs, pregnancy) are uniquely female burdens (i.e., women as responsible for providing contraception and raising children). Over the last several hundred years, religion has not only negatively impacted the construction and experience of sexuality among Indigenous women, but has also been used to reinforce patriarchy and the oppression of women, by suggesting that women are not only the property of men, but also that the pleasure of women must be controlled and only used for reproductive purposes (Leeming, 2003). Fornaro (1985) agrees: "Women are everywhere subordinate in religion" (p. 296).

This ideology is far removed from traditional Indigenous sexual practices, which valued equality and celebrated sex; yet, they correspond with current Western notions about women's sexuality, which characterize men as active sexual subjects with a natural sexual desire, while women are the objects of this desire (and also in need of protection from it) (Connell, 2005; Weekes, 2002). Despite some similarities, the additional burdens of racism, discrimination, systemic poverty, isolation, abuse, lack of resources, and countless other challenges stemming from a colonial legacy result in Indigenous women facing a steeper slope to sexual well-being than non-Indigenous women.

Nevertheless, positive narratives of resiliency and sexual satisfaction also emerged from this study. For instance, despite findings that position women as sexual objects rather than subjects, some participants described sex and sexuality in positive terms, noting strong physical and emotional enjoyment from sex. Others described strategies that they employ in order to have their voice heard within relationships and to exercise agency, including the negotiation of safer sex practices. Participants also shared various ways in which they are challenging patriarchy, pursuing an education and providing stable homes for their children. They have career aspirations and recognize education as being an important first step in enjoying a life free of dependence on others. These findings reveal that many of the young women who participated in this study recognize the need to gain control over and stability in their lives, even against substantial historical and current social obstacles.

CONCLUSIONS

In order to support the development and preservation of young Indigenous women's sexual agency, to combat patriarchal undertones, and to promote a connected sexuality, sexual health promotion programs offered to this population must integrate female-positive messages about sexuality in the curriculum. While young Indigenous women are made aware of negative sexual health outcomes, such as STIs and unintended pregnancy, they are not given similar opportunities to learn about their unique sexuality or the tools to combat sexual commodification and develop sexual agency. Instruction should not pathologize sex, but rather include topics, such as mutual respect, intimacy and sexual satisfaction, so that young women are equipped to make informed and empowered decisions about sex. Welles (2005) notes that, in order to balance feelings of sexual shame and embarrassment, sex-positive attitudes toward female sexual desire must be encouraged.

The concept of "cultural continuity" has been described as a mitigating factor against youth suicide in First Nation communities in British Columbia (Chandler & Lalonde, 1998). These authors note that cultural continuity exists when one has an understanding of one's place in a particular cultural history, and thus feels a connection with one's culture. This connection creates an opportunity for individuals to contribute to their culture's future. Cultural continuity has applicability and relevance to many aspects of Indigenous women's sexual health. The participants of this study had little knowledge of women's sexual agency and sexual satisfaction among their ancestors. Health promotion efforts within Indigenous communities that actively work to restore traditional cultural practices (i.e., the moon lodge) may, therefore, create a sense of cultural continuity for women as well as alter sexual self-perceptions, ultimately increasing young women's self-esteem, agency, and empowerment within sexual relationships.

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Chapter 6

Latina Sexualities

Yvette G. Flores

As the kitchen filled with smoke from the two wood-burning stoves, a cacophony of laughter rose in response to Daisy's statement to one of the women who was helping prepare the meal: *Cuidado con el fuego. Son dos hornos, así te puedes calentar adelante y atrás.* ("Be careful of the fires," Daisy cautioned. "There are two stoves; that way your front and back can be heated.") "Careful when you get home, your husband may not be able to handle you!" another woman responded. As we all laughed, I wondered what made such camaraderie possible. I had met the women who cooked our meals, two elders from the town, three years before. During my previous visits, we had been respectful, yet distant. We had talked about children, losses, and recipes; we had chatted about life and my travels. Never before had sexual innuendo filled the conversation. Was the levity this time the result of our being together *in* the kitchen? Had *confianza* (trust) grown over the years? Was the shared experience of cooking a meal for others a bridge across our class and racial differences? We were a group comprised of two young working-class origin Latinas from the United States who identified as Chicanas, a white middle-class *Tica*

(Costa Rican woman), a well-known chef who was learning to cook the traditional way, two indigenous elders, a mestiza *Tica,* and I, a mixed-race European-looking *Centroamericana* university professor, all heterosexuals, all cooking and laughing together, and talking about sex.

This experience reminded me of earlier times while I was growing up in Costa Rica. No one talked directly to the children about our sexuality or about sex. In a predominantly matriarchal family, where my grandfather was the presumed authority but the women ruled, women were the transmitters of the culture and those who socialized the girls to become "good women"—by their admonitions more than their example. We heard plenty of jokes while growing up, unintelligible innuendo that the older children deciphered for the younger ones.

The women in my family taught us by example that a good woman was respectful of men, nurturing of children, and silent about "private things." They cautioned the girls about the dangers of not being respected. We overhead stories, by way of gossip, about women who had made mistakes, and consequently had to pay for their loss of restraint by raising children alone. Thus, sexuality was equated with sex, which in turn was linked to pregnancy and lifelong hardship. Such troubles were rooted in loss of restraint; the men were not blamed for pregnancies as women were believed responsible because *they* had lost control.

The message was clear; directly and indirectly the next generation of women in my family learned that a woman's body was a dangerous thing; she could lose control; she could become pregnant. She had to be protected. And given the few men in the family, the women had to do the protecting by instilling fear and controlling the behavior of the girls.

When the girls in my family reached adolescence, an older, married female cousin told us that a mother could always tell when a girl lost her virginity by how she walked. In terror of the dire consequences one might face if such a thing were to happen, we all observed how we walked and practiced "the virgin walk," just in case. My mother never talked to me about sex; all she ever said was that there were two types of women: women who married and women who let men use their bodies for their own pleasure. The patriarchal message was delivered before my first menses. Thus, just like many women of my generation, nativity, and class background, at home I learned that sex was a dirty act, and that being female I had to fear men and what they could do to me. I learned nothing about healthy sexuality from the women in the family.

Once I became an adolescent in the United States, I learned that my gender, sex, and class made me a target for men's desire. I came to fear my own body and the attention it drew. I learned to downplay my sensuality. The eroticized and objectified stereotypes of Latinas as sultry, "hot," exotic, voluptuous creatures that pervaded the media, resembled my mother's definition of dangerous *bad* women. I did not want to be seen that way.

Well into my adulthood, I continued to note the silence surrounding women's sexuality. Even in my training as a clinical psychologist in the 1970s, sexuality was not discussed. In my subsequent training as a family and couple's therapist, we discussed sexual dysfunctions but never sexuality, although we did have to read Masters and Johnson (1966). I once dared ask (perhaps naively): "What is healthy sexuality; to what are we comparing these 'dysfunctions?'" The blank stares from my peers and professor silenced me once again. One colleague finally stated, without intending to be offensive, "You are Latina; you should know . . . you people are naturally sexual." In that moment, I finally understood the silence surrounding sexuality I encountered for most of my life. It was not safe to draw attention to matters of sexuality. As Moraga (1981) and other Chicana lesbian feminists have noted, to address sexuality one must also name the other sites of oppression resulting from colonization—gender, race, class, sex. One cannot understand or even name the sexuality of women of color without contextualizing their experience as objectified others (Martin-Junquera, 2005). To discuss sexuality, particularly a woman of color's sexuality, is intrinsically a political act that challenges patriarchal scripts and violates cultural rules. Latina sexuality, as well as that of other women of color, has been talked about, written about, and studied mostly by others. It is primarily in Chicana literature and particularly in the writings of lesbian authors that women's sexuality began to be explored and silence was broken (see Anzaldúa, 1987; Castillo, 1995; Moraga, 1983; Perez, 1991, 1993).

As I grew older, I also discovered that the silence regarding sexuality during my childhood was due in part to my age. Latinas do talk a lot about sex and sexuality in their own safe spaces—*en sus sitios y en sus lenguas* ("In their sites and in their own discourses") as noted by Emma Perez (1991)—away from the gaze of men and others who might judge and label them, and away from impressionable children. Once I was considered old enough, my aunts talked with me about their lives as sexual beings—their joys, pleasures, and sorrows—and shared the wisdom acquired with age. One of my *tías,* who emerged as the respected family matriarch after the death of her father and the declining health of mine, told her daughters and me: "In this life a woman needs two men, one to support her and one to entertain her." In absolute surprise, I asked her why she had not told us that before, saving her daughters and me a lifetime of guilt and marital unhappiness. She replied: "Those are the things one learns with time. No one teaches us that we have the right to enjoy our bodies for ourselves. We could not teach you what we did not know." I *noted* with some shock that my women friends and I, all highly educated women, rarely talked openly about sex. When one of us did, the rest laughed uncomfortably and labeled her *loca* (crazy). It was apparent that many of my women friends and I had internalized the narrative that only crazy women would openly and directly talk about such things.

Thus, I began to wonder, along with other scholars (Hurtado, 2003; Zavella, 2003), what knowledge about sexuality was held by contemporary Latinas and Chicanas who had acquired more freedom and mobility due to education or life experience. Were they better able to prepare the next generation of women and men or were they teaching the same cultural scripts with which I had been raised and with which, to a lesser extent, I had regrettably raised my own daughter and son?

In this chapter, I review the extant social science information on Latina sexualities and explore the impact of traditional socialization and dominant views about sexuality on women's lives through case vignettes, psychotherapy client narratives, and the stories of research participants.

SEXUALITY THROUGH THE LENS OF SOCIAL SCIENCE

The social science literature on Chicana and Latina sexuality is limited and recent.[1] Psychologists Aida Hurtado (2003) and Lisa Aronson Fontes (2001) and anthropologist Patricia Zavella (1997, 2003) have studied the sexuality of Chicanas and Latinas; clinical psychologist Oliva Espin (1997) and educational psychologist and novelist Carla Trujillo (1991, 1998, 2003) have written extensively about the sexuality of Latina and Chicana lesbians, respectively. They have provided the theoretical framework for my own investigation of Latina and Chicana sexuality (Flores, 2006). Their qualitative studies of *mujeres* of various national, generational, and socioeconomic backgrounds illustrate the persistent influence of patriarchal narratives about women's bodies and dangerous behaviors on women's relationships to their sexuality and their sexual partners.

According to the American Psychological Association (2010), sexuality encompasses an individual's sex, gender identity and expression, and sexual orientation. Moreover, social scientists (Flores, in press; Hurtado, 2003; Zavella, 2003) argue that how a person comes of age sexually is greatly influenced by his or her cultural upbringing. Latino men and women often receive different messages and rules about sexuality and sexual expression. From childhood, gender and sexuality are interconnected, such that girls tend to receive stronger pronouncements about modesty, virginity, and proper conduct than do boys (Zavella, 1997). Chicana and Latina social scientists have tried to answer several important questions: What does it mean to be a woman in contemporary Latino/Mexicano/Chicano families? How do stereotyping and cultural ideals influence the embodiment of gender and sexuality among Latinas and Chicanas? What is the impact of rigid lines of sexual propriety on the emotional, psychological, physical, and sexual well-being of Chicanas? When, where, and how do women feel it is safe to talk about sex?

Zavella's (2003) study of Mexicanas and Chicanas in Santa Cruz, California, highlights the impact of patriarchal scripts and cultural messages on women's adult sexuality and sexual behavior. She found that, despite nativity, both immigrant and U.S.-born Mexican-origin women often were shamed by their parents, particularly their mother, for their sexual inquisitiveness. Parents rarely spoke to them about sex or directly expressed their expectations about "proper conduct." Generally, the messages were indirect and conveyed through innuendo and *moralejas,* stories about the negative outcomes of undesired behaviors.

Furthermore, the women interviewed by Zavella received strong messages of what Caridad Souza (2001) refers to as "that puta thing that just doesn't go away":

> Specific gender and gender ideologies governed my behavior as a young girl and adolescent in this community. The label puta (whore) was used in this Latino community for girls and young women to uphold the rigid lines of sexual propriety.(Souza, 2001, p. 119)

Academic discussions regarding women's sexuality often focus on sexual behaviors and practices. Fontes (2001) quotes physician and feminist sexologist Teifer (2001) by noting that "traditional views of women's sexuality, including that implied in the DSM-IV, support a dishwasher view of sexuality. That is, when you push the 'start button' the woman should cycle painlessly through desire, arousal, and orgasm" (Fontes, 2001, p. 33–34). This view of female sexuality is a legacy of Masters and Johnson's research in the 1960s and 1970s, which has been critiqued extensively by feminists (see Teifer, 2001) for its focus on heterosexual penetrative sex and its assumption that female sexuality is analogous to that of males. Furthermore, Teifer (2001), among others, has highlighted that for most women, unlike men, sexual desire is associated with emotional intimacy and relational concerns. The gender socialization of women, including Latinas, accentuates the importance of sexual expression *within* a relationship. Sexual behavior outside the context of an intimate (and loving) relationship elicits "that puta thing," which Latinas are warned to avoid. Thus, many Latinas must contend with oppressive narratives within the family and cultural community and objectification from the dominant group without significant support or alternative narratives to counter the stereotypes with which they are bombarded.

PROBLEMATIZING THE SEXUALITY OF LATINO MEN AND WOMEN

Most of the social and psychological literature on Latina sexuality focuses on their reproductive patterns, specifically the high rates of teen pregnancy

and the high fertility of Mexican and Chicana women. Therefore, Latina sexuality is cast as intrinsically problematic and invariably is associated with reproductive health issues (Biggs, Brindis, Ralph, & Santelli, 2010). Teen pregnancy is indeed an important public health concern, given the association of early pregnancy with poverty and multiple health disparities, including increased risk for substance use and abuse by adolescent sons of single parent women who were teen mothers (Gil & Vega, 2010). Moreover, while Latina teen pregnancy rates decreased slightly in the past decade, Latina (and especially Chicana) teen pregnancy rates remain the highest of all ethnic groups. According to the National Campaign to Prevent Teen Pregnancy (2006, cited in Biggs et al., 2010), 51 percent of Latinas will have at least one pregnancy during their adolescence and one in five sexually active Latino adolescent males will cause a pregnancy. Biggs and colleagues (2010) also found that both male and female Latina/o teens considered teen pregnancy a positive event, even if unplanned. For some teens, reproduction fills a void and offers them the chance to feel important and needed. The high value of maternity among some Latinos may create a strong connection between reproduction and sexuality for teens.

Furthermore, the age of first sexual activity has decreased among Latino and Latina teens, from late teens to as young as 16½ as the average age for first intercourse. However, 11 percent of Latino boys reported having sex prior to age 13 (Aguirre-Molina & Betancourt, 2010). Biggs and colleagues (2010) also found that most Latino males described their first sexual experience as desired; Latinas did not. For many young women, the first sexual encounter is one where they often felt coerced by their boyfriends or partners (Biggs et al., 2010; Flores, 2006).

The sexual behavior of Latinas/os also becomes a public health concern due to their low rates of contraceptive use, in particular the low frequency of condom use by males during their first intercourse, which is predictive of later condom use (Biggs et al., 2010). Likewise, the risk of sexually transmitted infections (STIs), and HIV/AIDS in particular, is associated with lack of condom use. The disproportionate rates of HIV infection among Latina/o adults call for increased education regarding reproductive health among the youth, as many were likely infected during adolescence. U.S.-born Latinos account for 41 percent of the estimated AIDS cases among this population, and those born in Puerto Rico and Mexico each constitute 22 percent of cases (Biggs et al., 2010).

The sexual behavior of Latinas and Latinos is associated with a number of risk factors; in particular, lack of family cohesion, limited communication about sexuality, poverty, family disintegration, and lack of access to reproductive health education and services. Lack of family communication about sexuality and reproductive health is a significant problem among Latino families. Clearly, a combination of structural, community, and family factors influence attitudes about sexuality and sexual behaviors.

However, adherence to cultural practices, parental education beyond high school, and communication about sexuality with parents emerge as important protective factors (Biggs et al., 2010; Flores, 2006).

In my study of adolescent negotiation of healthy decisions (Flores, 2006), Latina respondents desired that their parents, especially their mother, initiate conversations about sexuality and womanhood. Girls wanted to connect with their mothers through authentic dialogue, not merely through lectures and *regaños* (scolding). Olivia (a 14-year-old participant) stated: "Mom should start the conversation. She is the adult; but I think she feels awkward and nervous to talk to me about such things. I wish she could be more comfortable with herself so she could talk to me about what she expects."[2] Olivia's mother, as my aunt, perhaps could not teach what she had not learned yet. Other scholars have found that many mothers do speak directly to their daughters about sexuality and sexual behavior, and when they do, the girls are able to handle pressure from peers to engage in high-risk behaviors before they are ready (see Ayala, 2006; Brady, Tschann, Ellen, & Flores, 2009; Guzman, Arruda, & Feria, 2006; Romo, Kouyoumdjian, Nadeem, & Sigman, 2006).

LATINA GENDER SOCIALIZATION: COMING OF AGE

As stated earlier, most Latina girls are socialized to follow cultural norms that will help them become proper young women. Modesty, restraint, and proper behavior are emphasized (Hurtado, 2003; Zavella, 2003). While there are class variations as to how these lessons are delivered, the focus is on preserving virginity to ensure the family honor. Most Latinas indicated that there was little discussion at home about the two big "Ms"—menstruation and masturbation. Even less discussion occurred about sexual desire and sexuality. Many Latina college students and psychotherapy clients in my practice associated sexuality in adolescence and young adulthood with guilt and shame. Even well-educated women had difficulty discussing their concerns about sexuality and sexual desire; they were embarrassed and worried about what I might think of them if they talked about their sexual fantasies, desires, and practices.

The end of childhood is marked by the onset of menses. Many Latinas describe reaching this developmental milestone unprepared (see Hurtado, 2003). Unless they had received information at school in health classes, many had little information about menstruation. Some of my respondents and therapy clients noted that they had seen pads and tampons in the family medicine cabinet, but had been hesitant to ask what they were for since their mother seemed uncomfortable discussing anything related to the body. Susana, a 15-year-old respondent, reported that her mother took her and her sister to the supermarket when her sister turned 13 and she

was 12. Their mother filled the cart with pads. Once they were home, she gave each girl a box, a small box of pain medication, and told them: "You will soon learn what it means to be a woman; your tummy will hurt; you will think your insides are tearing apart, and then you will bleed. That will happen every month until you get married. After marriage, when you get pregnant, the bleeding will stop for a while. But the pain never goes away. So if it hurts a lot, take a pill or two." Susana added that she and her sister sat in stunned silence. Each month thereafter they checked with each other to see if "it" had happened yet.

As with Hurtado's (2003) respondents, many of my clients, research participants, and students experienced shame associated with menstruation. Maternal admonitions, about hiding the evidence, disposing of it properly, and not telling the men (father or brothers) about having their periods, left them feeling that menstruation was another burden of womanhood and something else to bring them shame.

With the physical changes that accompany puberty, young women often begin to receive conflicting messages about their appearance. Some middle-class origin women reported their mothers becoming preoccupied about weight and attractiveness. While the message of purity and virginity was delivered, the young women also were reminded that being attractive—looking good, being thin, and highlighting European features—was most desirable. In her essay, "La Macha," Cherrie Moraga (1981) discusses the privilege that came with her skin color and Anglo features, characteristics her Mexican mother reified. Arroba (2001), in her discussion of women's sexuality in Costa Rica, notes that the United Statesian preoccupation with weight, appearance, and body image has impacted women throughout Latin America, such that eating disorders and exercise and diet programs as well as plastic surgery have become routine among the more affluent classes. The implicit message for heterosexual women is that in order to get and keep a man she has to look good. The underlying cultural message is that getting a man is what women *should* want.

Some young women in Hurtado's (2003) study reported that their fathers began to treat them differently after they became *señoritas.* Many experienced their fathers' more guarded and, at times, seemingly disdainful attitude toward them as a painful loss. Older Latinas reflected on their father's behavior as signaling their own grief and loss of the little girl, now a young woman, who would soon leave the home to follow another man. Now older, these women felt compassion for their fathers who themselves had been impacted adversely by patriarchal notions and practices. The loss of closeness and intimacy with their father marked for many women the beginning of troubled and troubling relationships with men.

> I felt that my father did not love me anymore because my body had changed. How could I feel good about my womanhood when it

caused me the loss of my father's love? I don't think I ever got over that. (Julia, age 27, second-generation Chicana college student)

Not all Latinas experience the onset of menses as traumatic. Some Chicanas recounted how their mothers talked to them about the menses as a symbol of their entry into womanhood and emulated indigenous rituals practiced before the Conquest, where the community gathered to celebrate girls' coming of age. These mothers brought their daughters flowers, gathered with other Chicanas to give blessings to the new woman in their midst. For these young women, menstruation marked an entry into the world of women, as their bodies were blessed and celebratory prayers were sung. Most of these women credited such entry into womanhood with the comfort with their bodies and sexuality they experienced throughout their lives:

I thought I was going to have a Quince, but mom said no, we were going to do something different. She gathered all of her *comadres.* I was dressed in a long peasant dress my *abuelita* made me; my hair was braided and I walked barefooted into the hall. I discovered that they had put rose petals on the ground. I walked on rose petals!!! Then they blessed me and sang and gave me gifts. My dad laughed and said mom was crazy, but I know he enjoyed it as well. It was the best day of my life.

COMING OF AGE RITUALS

The Quinceañera, or Quince, the coming of age ritual practiced by many Chicana/o and Latina/o families, has been studied extensively by anthropologists, sociologists, and Chicano scholars and critiqued by Chicana feminists (see Cantú, 2002; Davalos, 1997). As a ritual, the Quince is meant to acknowledge a girl's coming of age—the beginning of her adulthood—as well as her purity, as exemplified by her wearing white. Some refer to it as a wedding rehearsal (Zavella, 2003). In traditional Mexican culture, among the wealthier classes, the Quince also served as an announcement to potential suitors that the girl was available for marriage. For contemporary Chicano families, particularly those who have not held strong cultural ties to Mexico, the ritual may be practiced less frequently and may have more of a social than a religious/cultural meaning. However, in one of my undergraduate Chicana/o studies classes, 98 percent of the U.S.-born Latinas had celebrated their Quince in a traditional manner.

The importance of the ritual varies by nativity, class, and level of acculturation. Nevertheless, the anticipation of a girl's coming of age often is fraught with anxiety for parents and girls alike. For the parents, it may

signify that the daughter is growing up and likely to begin dating. As Zavella (2003) found in her study, most respondents indicated the Quince as the marker set by parents to allow dating, even though many later changed the age to 16 or 17. For the girl, it may simply represent a big party or a symbol that connects her to her parent's culture. Elena, a 14-year-old middle school respondent in one of my studies (Flores, 2006) viewed it this way:

> My parents want to have a big *pachanga* (party) and have spent way too much money on this event. I really do not want to have it. I have had to learn the waltz, which is ridiculous to me. The waltz has nothing to do with my *cultura.* I also feel a lot of guilt because the white dress signifies virginity and I am no longer a virgin. Of course, my parents do not know that.

Elena was distressed by this situation; thus, she spoke to her high school counselor. Elena also was upset that her older brother did not have to go through what she termed "the circus" and was free to date. Elena had been seeing her boyfriend secretly and was not using condoms; she was afraid her mother would find them, since her mother regularly searched her room, backpack, and purse. Elena feared that if her parents found out about her sexual activity, she would fall from the pedestal and become a *puta* in her family's eyes. She believed that even her brother would turn against her if he found out that she was sexually active. In this family, standards of purity were upheld for the daughters, but not the sons.

Chicano males are often placed in the position of being the guardians of their sisters' virtue and the enforcers of patriarchal authority. Many adult Latinas have described being resentful of brothers who acted as their guardians and protectors and had freedom and privileges they did not, particularly in terms of performance of household chores and dating practices (Hurtado, 2003).

DEALING WITH CONTRADICTIONS

Chicanas often describe their coming of age as sexual beings as experiences fraught with contradictions. As women of color, they are frequently objectified as exotic, lascivious, and hot. Simultaneously, they are stereotyped as barefoot, pregnant, dark, and low class. Their families may impose ideals of purity and virginity that may be difficult (or undesirable) for young women to attain since they are bombarded with sexual images in the media. Stereotyped images of how a Latina is supposed to look and act can have a deleterious impact on self-image, self-esteem, and contribute to unhealthy behaviors, such as dieting and disordered eating (Chamorro & Flores-Ortiz, 2000/2003)

A number of studies find that Chicana adolescents experience stress as a result of voiced and unvoiced parental expectations about their sexuality. Young women often express a desire for their parents to discuss these issues openly (Ayala, 2006; Flores, 2006). The lack of "talking about sex" (Zavella, 2003), along with rigid gender socialization, increases the risk for Chicanas to engage in high-risk practices that can affect their health as a result of STIs and diseases, such as cervical cancer and HIV/AIDS (Castañeda, 2000).

Moreover, Zavella (2003) found that young adult and more mature Chicanas and Mexican immigrant women used particular metaphors to describe their experience of sexuality and sexual exploration—playing with fire, hot, passionate, boiling, a fire that was difficult to control. As adolescents, the women feared not being in control of their sexuality or being controlled by desire. These metaphors reflect in part the objectification and stereotyping Chicanas encounter in their everyday experience. They also reflect the perception of sexuality, embedded in cultural scripts, as dangerous and potentially hurtful to women.

Hurtado (2003) found that most of her college student respondents had grown up with silence surrounding sexuality and experienced guilt over sexual behavior prior to marriage. Even the daughters of professional women were socialized with traditional scripts. Few of my adolescent respondents had been told about masturbation, either at home or school. Many girls in my studies confided that they had learned about masturbation by reading their mother's romance novels. An adolescent therapy client, Rosita, the daughter of a psychoanalyst, laughed that she learned more about sex from reading her father's books by Sigmund Freud than from her parents or sex education class. In fact, she and her girlfriends spent hours in her father's study reading his books to learn about sex and desire. Regrettably, they also were learning about penis envy. Rosita wanted to discuss Freud's ideas about sexuality in therapy with me, a feminist Latina therapist, since neither of her parents appeared willing to hold such conversations.

Adult Latinas often complain that even their priests expect them to be sex machines or disregard their lack of desire or discomfort in order to please their partners, even when they have histories of sexual abuse (Fontes, 2001). On the other hand, Latinas who are comfortable with their sexuality often intimidate male partners who feel jealous and want to know who taught them to enjoy sex.

Chicanas at midlife often struggle with balancing obligations between parents and children and creating a space for their own desires, including sexual expression and the enjoyment of sex without concerns about reproduction (Flores-Ortiz, 1997). Cultural nicknames spouses use for each other, such as *viejo/vieja* (old man/old woman), as terms of endearment do not convey messages of sexual vibrancy. Chicanas, in my practice, often

complain that when they finally arrive at a point in life where they can be more sexually free, our youth-oriented culture renders them less attractive. These women also struggle with the expectations of age-appropriate propriety, which they internalized when younger. While generational, age, and class differences do exist in women's relationships to their sexuality, invariably, regardless of their age, women encounter "that puta thing" and preoccupation about how others perceive them.

Likewise, middle-aged Chicanas often complain about becoming invisible. "There seems to be an assumption that I am sexless since I became a grandmother," stated Ana, a 57-year-old, recently divorced, second-generation Chicana. "My children expect me to be *an abuelita,* in the style of my own mother who sacrificed her sexuality first for the children and then the grandchildren. My son told me that if I start dating, he will have to go into therapy." He worried that she would be viewed as a wanton woman by his friends. To allay his concerns, she offered to help pay for his psychotherapy.

Furthermore, cultural expectations that women should be protected by men are stressful for women who do not have male partners due to divorce or separation. Julieta, a 47-year-old second-generation Chicana psychotherapy client was told by her older brothers that she should move in with her parents after her husband left her. "It is not safe for a woman to live alone," they stated. While she was appreciative of their concern, she had no intention of returning to her parents' home; however, she felt conflicted between her own desire for continued independence and the traditional cultural script.

Women's bodies, at times, become the battleground of conflicting desires and expectations or the map where violence is recorded (Flores-Ortiz, 2003). Many adult Chicanas in my clinical practice experienced shaming from their parents as attention was called to their bodies (being too thin, too fat, having large breasts or wide hips, or being "thick") while being told to cover up. Others discussed how women in their families were taught to be "sexy good girls," who could show but not allow a touch lest men would not respect them. *Hay que anunciar para vender; pero si das a probar, nadie te lo va a comprar.* ("You have to advertise to sell; but if you give free samples, no one will buy.") This was a saying many of my Chicana clients heard while growing up. They came to see their bodies as commodities to be exchanged for financial security. Few recalled being taught to appreciate or care for their bodies for their own enjoyment.

The focus on women's sexuality as a commodity has historical roots from the time of the Conquest. Pre-Colombian women in the Americas were taught to cherish their bodies and their own rights over themselves; sexuality was often connected directly to spirit and heart (Castillo, 1995). Thereafter, the rape of indigenous women and the birth of the Mestizo in many instances were used against women; as if they had willingly given

themselves to the conqueror, rather than being the victims of rape and genocide. Their rape was recast as an example of women's treachery. The raped indigenous woman was blamed for the conquest and the downfall of Mexico. This historical trauma has impacted the relationship of men and women over generations. The shame of the conquest and the original rape of indigenous women has been passed down to *las hijas de Malinche.*[3]

As a result, men often distrust women because they are socialized to believe that women are by nature manipulative and deceitful. Men also are socialized to desire and fear a woman's sexuality and, therefore, are encouraged to contain and control it, presumably for her own good. Such cultural scripts promote secrecy and silence regarding sexuality, as well as gender oppression and sexual violence (Flores-Ortiz, 2003). Throughout their lives, Chicanas and Latinas encounter contradictive and disparaging messages about their gender, sexuality, and ethnicity that can wound their hearts and spirits.

LATINA LESBIANS

Implicit in the gender socialization of Chicanas and Latinas is an expectation of heterosexuality. Sexual identity formation in and of itself may be fraught with conflict, given the pervasive heteronormative cultural messages. Furthermore, the process of gay/lesbian identity formation may be more complex for immigrants and individuals who are members of particular religious groups (Espin, 1997).

Latina lesbian authors (Espin, 1997; Trujillo, 1991, 1998, 2003; among others) have described the silences, admonitions, and warnings they faced in childhood and adolescence regarding sexuality in general and homosexuality in particular. Their developing sexual identity had to be hidden for fear of rejection by the family. Very religious families equated lesbianism with damnation and often expressed concerns that any discussion about sexuality or sex would lead their daughters into a life of sin.

Lesbian and bisexual women in Zavella's (2003) study recounted how their parents never talked about sexuality, and if homosexuality was ever mentioned, it was in denigrating and pejorative terms. Carla Trujillo's (1991) anthology describes the challenges faced by "the girls our mothers warned us about"—the tomboys who might become lesbians and the promiscuous girls who would never find a good man to marry them. As Hardy and Laszloffy (2005) document, such experiences of devaluation impact the self-esteem and emotional well-being of gay and lesbian youth and may lead to depression and even suicide.

Oliva Espin (1997), Virginia Cass (1979), and Eduardo Morales (1990), among others, posit that unlike heterosexuals, gays and lesbians must contend with a unique psychological aspect of sexuality, the *coming out* process. Heterosexuals do not need to announce their sexual orientation.

It is assumed and celebrated, as in the ritual of the Quinceañera. Moreover, coming out is not a onetime event; it is a lifelong process which differs depending on the type of relationship (e.g., family, friends, coworkers, etc.). It involves a reoccurrence of the different stages of identity formation and potential reexperiencing of the conflicts these stages represent.

As a result of the racism and discrimination Chicanas and Latinas routinely encounter, the support of family and community is essential for psychological survival. Often, there are generational (and regional) differences in how Latina lesbians come out. In more progressive and accepting communities, gay youth may have safe spaces and groups (e.g., in junior and senior high school), and therefore may be more prepared to be out when they go to college or enter the workforce. They also may have support to deal with the family crisis or possible rejection that may occur once there is a disclosure about their sexual orientation. In communities, settings, or families that are intolerant, youth may be forced to hide their sexual orientation as it would be unsafe to disclose it.

Latina and Chicana lesbians face particular issues—already marginalized and othered as women *and* persons of color—where they must confront another source of discrimination and marginalization based on their sexual orientation and expression. Often gay and lesbian Latina/os and Chicana/os feel they must choose between their cultural and sexual community. This is a forced and untenable choice that can result in feelings of devaluation, despair, depression, and ultimately suicide. The stress experienced as a result of devaluation may be managed in maladaptive ways through the use of alcohol, drugs, or high-risk sexual practices (see Diaz, 1998). It can also be addressed in constructive ways if family, peer, or community support is available (Flores, in press).

An essential aspect of adolescent development is the integration of gender, ethnic, racial, and sexual identities. The majority of identity development models focus on one aspect of this process. There remains a lack of analysis of how young people make sense of their multiple identities and attain a sense of self that is as complex as their experience. Morales' (1990) model of sexual identity formation for Latina/o gays and lesbians incorporates the dual minority status of being gay and of color. While Morales' model is helpful in understanding the coming out process, it does not address the gender oppression faced by lesbians of color, within and outside the LGBT communities.

Latino cultures, with the emphasis on reproduction and parenting, often may not consider normal an individual who does not marry someone of the opposite sex; family members may tolerate homosexuality, but may not want anyone outside the immediate family to know for fear of *el que dirán* ("what will people say"). Thus, Latinas and Chicanas may need to hide an essential aspect of their identity to remain connected to their family (Espin, 1997; Morales, 1990).

Latina lesbians and gay Latinos are a minority within the European American gay and lesbian community and may not be able to fully experience their multiple identities. This, in turn, can impact their emotional and spiritual well-being. Heterosexual Latinas/os may stereotype, discriminate, and otherwise render invisible Latino lesbians as a function of heterosexual privilege, homophobia, or religious/cultural values. The end result of such soul wounding may be depression and/or substance abuse (Flores, in press). A supportive social system is essential to counter family rejection and society devaluation when it occurs, and to promote and maintain emotional, physical, and spiritual balance among LGBTQ Chicanas and Latinas.

TRANSGENDERED CHICANAS

Little information is available regarding the challenges encountered by transgendered Latina/os and Chicana/os. By their very existence, transgendered men and women challenge cultural notions of femaleness/maleness and stereotypes about gender. As Anzaldúa (1987) has argued, queer Latinas and Latinos contest fundamental cultural notions of sexuality; transgendered Latina/os must fight for the right to be human beings, along with challenging dual cultural constructions of gender and sexuality. The family can play a central role in supporting transgendered Latina/os' search for physical, emotional, and spiritual wholeness.

When family support is absent, the risk for mental health problems increases. Rosa was 32 when we met. She was an immigrant from Guatemala who had come to the United States with the hopes of obtaining sex reassignment surgery. The eldest child and only son of a well-to-do family, Rosa had been shunned by them when she told them she wanted to become a woman. Baptized as Gilberto, she had insisted the family call her Rosa from the time she was 7 years old. Her parents began sending her to various psychiatrists and psychologists from the time she was 10. Her father begged and pleaded—how could he wish to become a woman when he had all the privilege of his gender, his class, his family name? At age 22, Rosa asked her parents to send her to the United States. Embarrassed by her behavior (wearing dresses, insisting on being treated as a woman), the father relented. Ultimately, Rosa was able to have the desired surgeries and treatments. When we met at a conference, she pleaded that I tell my colleagues about her story and the need for psychologists to support transgendered Latinas and Latinos.

NEGOTIATING CULTURAL, ETHNIC, AND SEXUAL IDENTITIES

Many immigrant and second-generation Chicanos associate alternative lifestyles with the dominant European American culture and perceive

children who do not adhere to traditional gender roles and behaviors as over-acculturated or somehow lost to the culture of origin. In such cases, family members and LGBTQ Chicanas and Latinas can experience psychological and emotional distress. On the other hand, embracing one's sexuality can be liberating, freeing, and health promoting (Anzaldúa, 1987; Diaz & Ayala, 1999; Espin, 1997; Martin-Junquera, 2005; Moraga 1981, 1983). From living in the borderlands of multiple marginalizations, Latinas can embrace the new *mestizaje* that Anzaldúa (1987) described in her writings. Anzaldúa posited that by contesting the oppressive legacies and practices of patriarchal cultures a new consciousness would emerge. In turn, a decolonized spiritually grounded culture would be created.

Lorena is a 27-year-old health professional. From the time she was a small child, she knew she was a lesbian. Her mother, a single working-class Puerto Rican, supported her sexual identification. In fact, most of her large extended family accepted her unconditionally. Lorena recounted that she had some trepidation when she came out to her "very Catholic" grandmother. Instead of rejection, she found love. Her grandmother stated: "mi'jita you are going to find lots of people who are going to put you down 'cause you are dark and a woman, 'cause you come from poor folk, 'cause you are gay. So you better be strong; but know this, we all got your back." Her grandmother's political astuteness and her mother's support carried Lorena through multiple challenges.

Jocelyn, a second-generation Mexican American, is and always has been bisexual. She and her partner, a bisexual Chicano, live a "straight life" as a couple for the benefit of their parents and because they profoundly love each other. They met as children; their families lived in the same neighborhood. They attended the same schools and in junior high confided their mutual attraction *and* their attraction to same-sex individuals. Jocelyn stated: "I found in Larry my soul mate. He understands my desire to love both men and women. There is no jealousy, no competition. We are best friends; we are lovers; we are each other's mirror. Someday perhaps we can explain this to our families." Both Larry and Jocelyn have faced ostracism from the white gay community and from queer Latina/os who want them to commit to a solely gay and lesbian identity. Larry and Jocelyn say that they do not care about what others think. They grew up along the U.S.-Mexico border. Living in the borderlands is familiar. Jocelyn stated: "I am bilingual, bicultural, binational, so of course I am bisexual. It is only natural."

SEXUAL VIOLENCE

The silences regarding sexuality prevalent in Chicano/Latino families are also reflected in the frequent denial of sexual violence when it occurs. Chicanas and Latinas experience high rates of intrafamily and domestic

violence, including incest and spousal rape (Flores-Ortiz, 1997, 2003, 2005). Women victims of sexual abuse often feel they should have been able to avoid or prevent the abuse, even if they were children when it occurred. Julia was abused by her uncle and later by a friend of the family. She began cutting as an adolescent and struggled with eating disorders. When she first went to college, she experienced a date rape. While she obtained counseling after the rape, she did not disclose the childhood sexual victimization. She did not want that information to "be held against" her. Julia feared that a sexual abuse history would lead her counselor to think that she had "asked for it" (Flores, in press).

In my earlier work (Flores-Ortiz, 1997, 2003), I have discussed the spirit wounding and psychological trauma experienced by survivors of sexual violence. The healing of such trauma requires multiple interventions (van der Kolk, 1994), because sexual violence affects the body, mind, heart, and spirit of those who are victimized. One aspect of healing that is most challenging is the reconnection of heart, mind, and body. Many sexual abuse survivors disconnect from their bodies; at times they despise their bodies because of the battlefield it became (Flores-Ortiz, 1997, 2003). When the body has been defiled, the individual feels dirty. A touch, a look, a sound, or smell can trigger memories of the abuse and PTSD symptomatology. While some individuals are able to repress conscious memory of the abuse, the body remembers. Consequently, sexual dysfunction, avoidance of relationships, lack of pleasure in one's body, or increased high-risk sexual behaviors are common sequelae of sexual abuse and sexual violence (Flores, in press; Flores-Ortiz, 2003).

Many of my Chicana and Latina clients who are survivors of sexual violence carry deep spiritual wounds. The intergenerational trauma of the conquest is encoded in their psyche. When they experience sexual violence in their lives, they often connect to the histories of their female ancestors who endured the same (Flores, in press). *Soy una más, soy una más,* cried Nicole after a date rape. The police officer, who spoke no Spanish, did not understand. "I am one more, I am one more," she said. She later told me: "No one understands, Chicanas we are connected by a history of misogyny. From the beginning we have been prey to men who try to control us, who sexualize us, who fight battles against other men on our bodies. No one understands what that feels like, to be so unprotected, to be such prey."

The devastation experienced after sexual violence is reflected in depression, anxiety, panic, *susto.* Many survivors disconnect from their bodies in order to cope and repress memories of the abuse. As indicated in my earlier writings (see Flores-Ortiz, 2003), attacks against aspects of the self-blamed for calling attention to the victimized woman are common. For example, cutting one's hair or gaining weight may be unconscious ways to punish the body, which is being blamed for the assault. Disordered eating and substance abuse often are sequelae of physical and sexual violations.

Having internalized disparaging narratives of devaluation as a result of being sexual, even if it was against their will, many women blame themselves for the sexual violence they experienced.

CONCLUSIONS

A central aspect of mental health in both Western and Mestizo/Chicano/Latino traditions is the integration of body, mind, and spirit (Flores, in press). Enjoyment of one's sexuality is an important component of physical and emotional well-being. For Chicanas and Latinas, such enjoyment is nuanced by cultural rules and dominant culture views about them as a people. As with other facets of mental health, family, community, and individual factors contribute to well-being or pain.

Well into the first decade of the 21st century, we find that many Latinas continue to be socialized with patriarchal scripts which silence desire, create shame, and fail to instill entitlement to healthy sexuality. While many adult Chicanas and Latinas benefited from the civil rights movements of the last four decades and came to appreciate their gender, sexuality, and sexual expression, many paid a price for taking control of their bodies and choosing to live and to love openly and in defiance of traditional cultural norms (Espin, 1997; Flores-Ortiz, 2005; Souza, 2001; Trujillo, 1991; Zavella, 1997, 2003). Clearly, the entitlement to honor, respect, enjoy, and celebrate one's sexuality must be nurtured in the home. Likewise, healthy sexual identity development must be facilitated by the family and community. Respect for human integrity should include valuing human sexuality. The schools can play a key role in preventing sexual violence and promoting healthy sexuality, and so can family and community activism to abet stereotyped and sexualized images of Chicanas and Latinas.

In the meantime, Latinas continue to laugh, joke and talk about sex in safe spaces—in their own *sitios* and in their own *lenguas* (Perez, 1991), whether it is in the kitchen of a remote indigenous village, or the living room or kitchen of a *comadre*'s home, on a therapist's couch, or in a college classroom. And we encourage the next generation of scholars to continue to investigate, to ask questions, and to document the sexuality of Latinas of all social classes and national origins.

NOTES

1. The term Latina/o is used to refer to immigrants and U.S.-born children of immigrants from Central and South America. The term Chicana is used to refer to U.S.-born Mexican origin people. In some instances, the term Chicana is used by those who identify with the Chicano Movement and the Civil Rights struggles of the 1960s. Latino often is used to include both men and women. I prefer to use the

Latina/o designation to avoid sexist language. When used solely in the masculine or feminine form, the noun is referring specifically to either men or women.

2. Unless otherwise specified, all quotes are derived from unpublished therapy or research transcripts.

3. Malinche or Malintzin was a young princess who was given to Cortez as translator and interpreter. She became his lover and has been maligned as the symbolic mother of Mestizos. To be a Malinche means to be treacherous, to betray one's man, and culture. For a Chicana feminist reformulation of Malintzin, see Alicia Gaspar del Alba. (1994). Malinche's rights. In R. Gonzalez (Ed.), *Currents from the dancing river: Contemporary Latino fiction, nonfiction, and poetry* (pp. 261–267). New York: Harcourt Brace.

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Chapter 7

Sexuality, Identity, and Culture among Asian/Asian American Sexual Minority Women: New Research

Connie S. Chan and Allyson L. Baughman

> Identity is more than what I call myself, it is *who* I am—those aspects of me that are my own choosing and those aspects attributed to me. Who I am is constant, but can also change based on my surroundings. You could say that my identity is in flux.
>
> —An Asian woman who identifies as a lesbian

In this chapter, we explore the intersections of cultural and sexual identities or culture and sexuality for Asian sexual minority women. We examine the ways in which culture affects an understanding of one's sexual identity. We explore whether blending different identities make acceptance of a sexual minority (lesbian, gay, or bisexual—LGB) identity easier or harder. We look at the factors which influence cultural perspectives of sexuality and identity among Asian and Asian American women.

Much of the research on racial and sexual identity focuses on the conflicts and stresses that multiple identities create (Dworkin, 2001; Fukuyama & Ferguson, 2000; Greene, 1994). In addition to these stresses, we address whether there are positive aspects of having multiple, even overlapping,

minority statuses. We ask: can having an obvious racial minority identity status facilitate the acceptance of a sexual minority status?

MODELS OF ADAPTATION AND ACCULTURATION

Ethnic minority individuals in this country can be considered to have two cultures—their home or native culture, along with the hegemonic American culture. Individuals are constantly integrating the two different cultures in their lives. As such, we adopt the notion that cultural identity can be considered fluid, constantly in flux, and in motion. In the same way, we consider that, for some sexual minority women, sexual identity can also be perceived as being fluid. Sometimes, this is captured in the sense of having a bisexual identity. Others consider this to be a fluid sexual identity and not a dichotomized one of either having a heterosexual (straight) or homosexual (lesbian or gay) identity.

Having to be fluent in two cultures (at home and in society) may create a sense of flexibility that facilitates fluidity in other aspects of identity, including sexuality and sexual behaviors, as well as having a comfort with a continuum of sexual desire.

How applicable are models of sexual identity formation which assume sexual identity to be dichotomous? These traditional models assume that individuals move along a set continuum of identity development from self-awareness to positive integration of one's sexual identity to one's sense of self (Cass, 1979; Troiden, 1993). Several researchers have questioned whether these lesbian and gay identity models are applicable to non-Western cultures and/or to racial and ethnic minority group members within the United States (Chan, 1994; Greene, 1994; Loiacano, 1993; Morales, 1989).

More recently, a number of studies have addressed new models of understanding the intersections of being both LGBT *and* Asian or Asian American, defining some common characteristics of this group. In their study of East Asians LGB immigrants, Kimmel and Yi (2004) described how "discovering that one has an affectional, erotic, or sexual attraction to others of one's own sex has profoundly different meaning in China, Korea, and Japan than it does in the U.S., even for Asian Americans" (p. 144). They describe how these countries have had a long history for same-sex behavior that has been documented among males and also for females. However, during the 19th and 20th centuries, tolerant attitudes were largely replaced by Western ideas that same-sex attraction was abnormal (Kimmel & Yi, 2004). The belief that sexuality is a very private aspect of one's life is prevalent in Asian culture. Many Asians may continue to fulfill familial roles and responsibilities, such as wife or husband and mother or father, while at the same time have strong erotic feelings and sexual encounters with same-sex partners in private (Chan, 1994).

CONFUCIAN BELIEFS AFFECT SAME-SEX IDENTIFICATION

The Confucian principles of filial piety—duty to one's parents and family—requires that one maintains "face," or public image and representation. While each country has its own historical context for tolerance or prohibition of same-sex sexual behavior, in general this behavior was tolerated as long as it was expressed privately and as long as one continued to fulfill Confucian family obligations of wife and mother, for women (Chan, 1994, 1997; Kimmel & Yi, 2004).

Rather than being perceived as an individual, one's actions are representative of one's family and community. As a result, many Asian individuals keep their sexual relationships private to avoid bringing shame to one's family by taking on a social role outside of the norm (as being openly lesbian, gay, or bisexual would be). Even though their same-sex relationships may be similar in nature to those who are openly LGB in identity, they may be less likely to identify openly as LGB individuals. In their study of more than 400 lesbians in Hong Kong and China, Chow and Cheng (2010) found that many experienced shame, internalized stigma, self-devaluation, and were reluctant to disclose their lesbian identity to their parents. They speculated that similar identity and disclosure issues would be common to first- and second-generation Chinese American lesbians in the United States and elsewhere outside of Hong Kong and China, due to entrenched (and inherited) cultural attitudes.

But times seem to be changing in Asia. Kimmel and Yi (2004) report that there is a gay, lesbian, and bisexual community emerging in Asia, as they describe respondents who are open about their sexual identity and activity, have a same-sex lover, and sometimes live with them. Chow and Cheng (2010) studied an exclusively Hong Kong and Chinese sample and recognized that younger age groups have generally more tolerant attitudes toward same-sex orientation than do older cohorts in their study. With greater ease of travel, a two-way flow of information and media images through the internet, some lesbian, gay, and bisexual Asians have become more open about their sexual behavior and orientation. Along with this trend, other studies have shown that the younger the cohort, the more open and accepting they are toward a LGB identity (Carlson, 2002).

RELIGION AND RELIGIOUS ATTITUDES TOWARD LGB IDENTITIES FOR ASIANS AND ASIAN AMERICANS

Research has consistently demonstrated that many religious beliefs and religious prohibitions toward same-sex behavior have traditionally

played an important role in prejudice against LGB individuals. Many religious orientations are predictive of homophobic or homonegative attitudes. In general, gay, lesbian, and bisexual people who are very religious are more likely to feel negatively about their sexuality than gay, lesbian, and bisexual people for whom religion is unimportant (Tozer & Hayes, 2004). Other researchers have found that holding religious beliefs, including religious guilt, rejection by the church community, and the fear of eternal damnation, is correlated with a desire to seek conversion therapy (to change their same-sex orientations; Shidlo & Schroeder, 2002).

It should be noted that the religious beliefs described above are from the Judeo-Christian religions, which do not form the foundations of the primary religious and philosophical beliefs in the East Asian countries of China, Japan, and Korea. The primary religious and philosophical beliefs of Confucianism and Taoism in China do not have prohibitions regarding same-sex sexual attraction and behavior, but do prescribe gendered roles within the family (such as wife, mother, daughter). In Japan, where the dominant religious beliefs are Buddhism and Shinto, there are no religious or legal prohibitions against homosexual behavior. So, while same-sex sexual relationships may not be encouraged, neither are they as strongly prohibited as in Judeo-Christian religions. Korea provides an interesting example by which to examine these religious issues. South Korea has a strong and widespread Christian following due to Christian missionaries promulgating Protestant and Catholic religious beliefs in the 20th century. Of the three cultures (Japanese, Chinese, and Korean), Korea has the most socially conservative views in support of traditional marriage and against homosexual behaviors. It is speculated that the strong Christian influence in South Korea is directly responsible for the relatively stronger conservative views against same-sex relationships (Kimmel & Yi, 2004).

Unlike the United States, homosexual relations have never been overtly criminalized in the East Asian countries (except in the Korean military, where same-sex sexual behavior is illegal). It could be postulated that in the United States, where religious prohibitions against homosexuality are still very strong, not only do laws and restrictions against homosexuality follow, but also moral beliefs laid the foundation for prejudice and discrimination against LGB individuals. In the East Asian countries, the religious foundation for prejudice against homosexuality is not as dominant. It is replaced by the strong Confucian cultural beliefs regarding family honor, proscribed gendered and social roles, and the all-important concept of saving face and not bringing shame to one's family. These prescriptive behaviors can result in East Asian women seeking to downplay their sexual orientation/identity and seeking instead to fulfill familial responsibilities of procreation and acceptable social roles of wife and mother.

DUAL IDENTITIES: LESBIAN, BISEXUAL, OR GAY AND ASIAN/ASIAN AMERICAN

Much has been written about dual and triple identities—one's sexual orientation, one's racial/ethnic identity, and one's gendered identity—positing that it can create a kind of "triple jeopardy or triple oppression" among lesbians of color (Greene, 1994). As most identity development models have been based on a single social identity, such as racial or ethnic identity, *or* sexual orientation identity, they are of limited applicability when addressing LGB individuals' multiple and layered identities. Identity theories and models have attempted to address multiple identities among culturally diverse populations, including the visibility or invisibility of identity and the saliency of identity in any given situation (Fukuyama & Ferguson, 2000; Greene, 1994; Morales, 1989). These models stress that an individual may be more comfortable or open in identification with a racial, cultural, or sexual identity, or even all three at once, depending on the situational context. For example, McCarn and Fassinger's Model of Multidimensional Identity includes having BOTH the identity of being a member in a group (being part of the LGB or the Asian American community), as well as developing one's individual sexual identity for lesbians (McCarn & Fassinger, 1996). However, even as these integrative multiple identity models have been proposed to address layers of identities, including LGB identities, there has been very limited research with LGB people of color, especially Asian and Asian American populations. Moreover, much of the research has examined sexual identity as dichotomous (either lesbian/gay or heterosexual) and has either ignored bisexuality or that sexual identities can be fluid. Others have suggested that bisexual identity development is more complex than lesbian/gay identity development and is influenced by a host of factors, including ethnicity, culture, sexual behaviors, and gender, among others (Fox, 1996).

ACCULTURATION INTO AMERICAN CULTURE AS A FACTOR IN THE DEGREE OF OPENNESS ABOUT A SEXUAL MINORITY IDENTITY FOR ASIAN WOMEN

Asians perceive and experience their sexuality and sexual behaviors as being within the private realm, not a public role or identity to be shared. As a result, they are often invisible within the LGB community and may not personally adopt a LGB identity, even if they have same-sex partners or have emotional and physical intimacy and desire for same-sex relationships. Increasingly, however, more Asians are identifying themselves as LGB as they have more exposure to the openness of Western cultures or as they have become more acculturated in the United States. It has been sug-

gested that the Asian immigrants who chose to emigrate to countries, such as the United States, Canada, and Australia, may be in fact seeking a more open and accepting environment for being LGB and to be less constrained within the gendered and familial roles in East Asia (Kimmel & Yi, 2004).

OUR 2011 STUDY OF ASIAN AND ASIAN AMERICAN SEXUAL MINORITY WOMEN

Our 2011 study is described below. In conducting this study, we have attempted to better understand whether factors, such as religious background, country of origin (particularly whether participants were born in Asia or the United States), experience with discrimination, specific sexual identities (bisexual, queer, lesbian), and the separation or integration of sexual and racial/ethnic identities influenced key aspects of sexual identity, such as internalized negativity. Internalized negativity is arguably one of the most researched aspects of sexual identity. Previous studies have demonstrated a relationship between it and psychological distress (Szymanski & Sung, 2010), as well as other negative consequences, such as substance abuse and risky sexual behaviors (Szymanski, Kashubeck-West, & Meyer, 2008).

COMPARISON OF ASIAN AND ASIAN AMERICAN SEXUAL MINORITY WOMEN AND WOMEN OF OTHER RACE/ETHNICITIES

Do aspects of sexual identity differ among women of different races and ethnicities? To our knowledge, there are currently no studies examining this question. There are some studies which have begun to examine the needs and experiences of LGBT people of color (Balsam, Molina, Beadnell, Simoni, and Walters, 2011). However, additional research in this area is greatly needed. This study will explore aspects of sexual identity among Asian and Asian American sexual minority women as well as compare aspects of their sexual identity with women of other race/ethnicities.

METHODS

Participants

The sample comprised 48 Asian and Asian American sexual minority women who completed an online survey. Approximately one-third of the sample identified as queer (31%), one-third as gay/lesbian (31%), and one-third as bisexual (38%). The majority of respondents identified as Asian American (56%) and 21 percent of participants identified as Asian.

Participants ranged in age from 21 to 56 with a mean average age of 31 years. Approximately two-thirds of the sample (67%) was born in

the United States and 33% were born outside the United States. Of the participants born outside the United States, the average individual was 11-years-old when she moved to the United States. The study sample was well-educated. Ninety-six percent of respondents reported having a college degree and 100 percent reported at least some college education.

Measures

The survey consisted of 28 items. The questions were a combination of existing scales, modified questions, and original items.

Demographic Information: The survey collected demographic information from the respondents, including age, race/ethnicity, nativity, education, and sexual identity. Demographic characteristics, such as race, age, and education, were collected using original items. Sexual identity was measured by two questions. One question asked was: "What is your sexual identity?" Response choices consisted of bisexual, gay, lesbian, or queer. Participants were also asked to mark their sexual identity on a scale from 1 to 10 with 1 = exclusively heterosexual relationships and 10 = exclusively homosexual relationships.

Religiosity: Religious experience was assessed with three questions. Participants were asked: "In general, when you were growing up, how often did you attend or participate in religious services or activities?" Response choices to this question consisted of more than once a week, once a week, 10–20 times per year, 5–9 times per year, less than 5 times per year, and not at all. Participants were also asked to name the religion or religions with which they were affiliated growing up. Response options to this question included non-Christian (Buddhist, Hindu, Muslim) and Christian (Baptist, Catholic, Episcopalian, Mormon, Protestant, Unitarian) religions. Participants could also write-in any other religion. Finally, participants were asked to rate how their religious experiences influenced the development of their sexual identities, with responses ranging from very negative to very positive.

Aspects of sexual identity: Aspects of sexual identity were assessed using Mohr and Fassinger's Lesbian, Gay, and Bisexual Identity Scale (LGBIS). LGBIS is a measure designed to assess six dimensions of LGB identity that have been discussed in the clinical and theoretical literature. The LGBIS is a slightly reworded version of the Lesbian and Gay Identity Scale, which is fully described in Mohr and Fassinger (2000). The scale measures the qualities of internalized negativity, need for privacy, need for acceptance, identity confusion, difficult process, and superiority using a seven-point Likert scale from strongly disagree to strongly agree. We chose to use this scale to measure aspects of sexual identity because the scale has good reported reliability and validity (Mohr & Fassinger, 2000; Sheets & Mohr, 2009), and it has been frequently used and cited in LGBT research.

Examples of subscale items: An example of an item from the internalized negativity subscale is: "I wish I were heterosexual." An example from the need for privacy subscale is: "My private sexual behavior is nobody's business." An example from the need for acceptance subscale is: "I often wonder whether others judge me for my sexual orientation." An example from the identity confusion subscale is: "I'm not totally sure what my sexual orientation is." An example from the difficult process subscale is: "Coming out to my friends and family has been a very lengthy process." An example from the superiority subscale is: "I look down on heterosexuals" (Mohr & Fassinger, 2000).

Dual Identity: The concept of dual identity was assessed using modified questions from an unpublished survey of African American MSM (men who have sex with men). The questions asked about aspects of the development of both sexual and racial identity, including which required the most energy, which was more important, and which the respondent got the most satisfaction from. The integration of sexual and racial/ethnic identity was assessed with three questions. Respondents were asked their perception about the integration of their sexual and racial/ethnic identities, as well as whether the separation or integration was stressful or helpful (e.g., participants were asked: "How much do you feel there is a split between your sexual identity and your race/ethnicity?").

Discrimination: Discrimination due to race/ethnicity and sexual identity were also measured using original items. Participants were asked if they experienced oppression due to their race/ethnicity or sexual identity with responses on a Likert scale from never to a great deal.

Procedure

An Internet-based survey was used to collect the data. The Internet has been a useful tool for collecting data from lesbian, gay, and bisexual samples (Moradi, Mohr, Worthington, & Fassinger, 2009). Even if such persons are not "out" broadly, they may feel comfortable being out online because the Internet provides privacy and anonymity. Additionally, Riggle, Rostosky, and Reedy (2005) discussed that sexual minority-specific electronic mailing lists and online message boards may be good recruitment venues because lesbian, gay, bisexual, and queer-identified individuals tend to view the Internet as a safe place to connect with other sexual minority individuals. Participants were recruited via an email announcement of the study sent to the contact person of various Asian American LGBT organizations (found through Internet searches), and university Asian studies and women's studies programs. The contact person was asked to distribute the research announcement to their clients, colleagues, and students. Potential participants used a hyperlink to access the survey website. After reading the informed consent, participants completed the survey anonymously.

RESULTS

Nearly one-third of the sample (28%) reported not participating in or attending religious services when growing up. A similar proportion (30%) reported rare attendance of less than five times per year. However, a substantial percentage (22%) of respondents reported attending religious services once or more per week while growing up. Women who identified as queer in the survey were more likely to report not attending religious services compared to bisexual and lesbian women (40% vs. 22% and 21%, respectively). Many religions were reported by respondents, with the top four being Catholic (25%), Buddhist (19%), Protestant (13%), and Baptist (10%).

Women who reported an affiliated religion were grouped into Christian (e.g., Catholic, Protestant) and non-Christian categories (e.g., Buddhist, Hindu). Table 7.1 describes the aspects of sexual identity measured on the LGBIS by type of religion. Women affiliated with a Christian religion growing up had a *significantly greater need* for acceptance of their sexual identity compared to women affiliated with non-Christian religion ($p < .10$). Women affiliated with a Christian religion growing up also reported a *significantly more difficult* process of sexual identity development compared to women affiliated with a non-Christian religion ($p < .01$).

Women were also grouped by participation in religion when growing up. Women who participated in or attended religious services five or more times per year were classified as active in religion, and women who participated in or attended religious services less than five times per year were classified as not active. Table 7.2 shows the aspects of sexual identity by activeness in religion. Women active in religion growing up reported a significantly greater need for privacy, and a significantly more difficult process with the development of their sexual identity compared to women who were not active in religion growing up. Women who were active in religion had a greater need for acceptance as well, although this result was only marginally significant ($p < .10$).

Aspects of sexual identity were compared across the various sexual identities of women in the study: bisexual, queer, and gay/lesbian. Table 7.3

Table 7.1 Religion and aspects of sexual identity from the LGBIS scale*

	Total Mean (SD)	Christian Mean (SD)	Non-Christian Mean (SD)	*p*-value
Internalized negativity	2.0 (0.95)	2.1 (0.99)	1.9 (0.93)	
Need for privacy	4.4 (1.5)	4.6 (1.7)	4.2 (1.3)	
Need for acceptance	3.3 (1.2)	3.7 (1.3)	3.0 (1.1)	0.08
Identity confusion	2.3 (1.3)	2.3 (1.3)	2.3 (1.3)	
Difficult process	3.5 (1.5)	4.3 (1.4)	3.1 (1.3)	0.01
Superiority	2.7 (1.5)	2.8 (1.4)	2.5 (1.6)	

*Subscales are scored from 0 to 7, with 7 being the highest level.

Table 7.2 Religious activity and aspects of sexual identity from the LGBIS scale*

	Total Mean (SD)	Active in religion Mean (SD)	Not active Mean (SD)	*p*-value
Internalized negativity	2.0 (0.95)	2.2 (1.1)	1.9 (0.9)	
Need for privacy	4.4 (1.5)	4.8 (1.8)	4.1 (1.0)	0.09
Need for acceptance	3.3 (1.2)	3.7 (1.3)	3.1 (1.2)	0.10
Identity confusion	2.3 (1.3)	2.2 (1.1)	2.5 (1.4)	
Difficult process	3.5 (1.5)	4.3 (1.5)	3.1 (1.2)	0.01
Superiority	2.7 (1.5)	2.6 (1.4)	2.7 (1.6)	

*Subscales are scored from 0 to 7, with 7 being the highest level.

Table 7.3 Sexual identity and aspects of sexual identity from the LGBIS scale*

	Total Mean (SD)	Bisexual Mean (SD)	Queer Mean (SD)	Gay/Lesbian Mean (SD)	*p*-value
Internalized negativity	2.0 (0.94)	2.3 (0.80)	1.5 (0.86)	2.3 (0.99)	0.04
Need for privacy	4.4 (1.4)	4.5 (1.4)	4.3 (1.4)	4.5 (1.5)	
Need for acceptance	3.4 (1.2)	3.3 (1.1)	3.5 (1.1)	3.3 (1.6)	
Identity confusion	2.4 (1.3)	2.5 (1.6)	2.7 (1.1)	1.9 (1.0)	
Difficult process	3.6 (1.4)	3.8 (1.5)	3.9 (1.5)	3.1 (1.2)	
Superiority	2.6 (1.4)	2.4 (1.6)	3.1 (1.5)	2.4 (1.3)	

*Subscales are scored from 0 to 7, with 7 being the highest level.

describes the differences in aspects of sexual identity for bisexual, queer, and gay/lesbian Asian and Asian American women in this study. There were significant differences in internalized negativity among the three sexual identities ($p < .05$). The results suggest that women identifying as bisexual or lesbian had greater levels of internalized negativity compared to women identifying as queer in this study. There were no other significant differences among the groups.

Aspects of sexual identity were compared across the nativity of survey respondents. Table 7.4 describes the differences in aspects of sexuality for women who were native (U.S.) born versus foreign born. Women who were foreign born had *significantly greater internalized negativity* compared to respondents who were native born ($p < .05$).

In response to the question "How much do you feel there is a split between your sexual identity and race/ethnicity?" about half of the total sample reported that these two identities were integrated. More than 70 percent of queer women (71%) and about 44 percent of bisexual or lesbian women reported that the two identities were integrated. Aspects of sexual identity were compared among women who reported that their sexual and racial identities were integrated and women who reported that they were separate. Table 7.5 shows the findings. Women who reported a separation

Table 7.4 Nativity and aspects of sexual identity from the LGBIS scale*

	Total Mean (SD)	Native-Born Mean (SD)	Foreign-Born Mean (SD)	*p*-value
Internalized negativity	2.0 (0.94)	1.8 (0.83)	2.5 (1.0.)	0.02
Need for privacy	4.4 (1.4)	4.3 (1.5)	4.6 (1.3)	
Need for acceptance	3.4 (1.2)	3.3 (1.1)	3.5 (1.5)	
Identity confusion	2.4 (1.3)	2.4 (1.2)	2.4 (1.6)	
Difficult process	3.6 (1.4)	3.7 (1.6)	3.6 (1.3)	
Superiority	2.6 (1.4)	2.8 (1.5)	2.4 (1.3)	

*Subscales are scored from 0 to 7, with 7 being the highest level.

Table 7.5 Integration or separation of sexual identity and race/ethnicity and aspects of sexual identity from the LGBIS scale*

	Total Mean (SD)	Integrated Mean (SD)	Separated Mean (SD)	*p*-value
Internalized negativity	2.0 (0.95)	1.7 (0.80)	2.3 (1.0.)	0.03
Need for privacy	4.4 (1.5)	4.0 (1.4)	4.8 (1.4)	0.10
Need for acceptance	3.3 (1.2)	3.2 (1.2)	3.5 (1.3)	
Identity confusion	2.3 (1.3)	2.2 (1.2)	2.4 (1.4)	
Difficult process	3.5 (1.5)	3.3 (1.6)	3.7 (1.4)	
Superiority	2.7 (1.5)	2.5 (1.4)	2.8 (1.7)	

*Subscales are scored from 0 to 7, with 7 being the highest level.

between their sexual identity and race/ethnicity had *significantly higher internalized negativity* compared to women for whom these identities were integrated ($p < .05$). Women who reported a separation between their sexual identity and race/ethnicity had a greater need for privacy compared to women for whom these identities were integrated, although this was only marginally significant ($p = .10$).

Although there are no current large-scale studies of Asian American sexual minority women, we compared the findings in this study on the LGBIS scale to other published studies. In order to attempt to compare aspects of sexual identity between LGB Asian and Asian American women and women of other race and ethnicities, a literature search was performed for studies which used the LGBIS scale. Nine studies were identified. Five of the nine studies were excluded because the reported scores for the LGBIS scale were for men and women combined, and therefore not comparable. The remaining four studies addressed majority white populations of LGB women (Balsam & Mohr, 2007; Boehmer, Clark, Timm, Glickman, & Sullivan, 2011; Mohr & Fassinger, 2000, 2006).

The Asian and Asian American women who participated in our 2011 survey reported greater internalized negativity, need for privacy, need for acceptance, difficult process, and superiority compared to the primarily

white women in the other studies (Balsam & Mohr, 2007; Boehmer et al., 2011; Mohr & Fassinger, 2000, 2006).

DISCUSSION

What's in a Name?: The Social Construction of Identity for Asian and Asian American Sexual Minority Women

Currently, the impact of particular sexual identities is not well-understood. Does it matter if one identifies as queer or lesbian, for example? In addition to personal meaning, sexual identities can have political or other social qualities, particularly in relation to the gay rights movement. Our survey of sexual minority Asian and Asian American women suggests that specific identities do matter, and that they may be socially or culturally constructed. Of the women participating in the survey, one-third self-identified as bisexual, one-third as gay/lesbian, and one-third as queer. Women in the study who identified as queer had significantly lower internalized negativity compared to women who identified as bisexual or gay/lesbian. Our findings, then, suggest that sexual identity does influence important aspects of sexual identity, such as internalized negativity and the need for privacy. Interestingly, none of the women identifying as queer were born outside of the United States. This may indicate that a queer identity might be a U.S. or Western construct. It is also possible that the adoption of a queer identity is age related, with younger women being more likely to identify as queer compared to bisexual or gay/lesbian. The women in the survey who identified as queer were an average of 2–3 years younger than women identifying as bisexual or gay/lesbian; however, this is not a substantial age difference. Studies are needed to understand the origins of sexual identities and the extent to which they are socially constructed.

The findings of this survey suggest that there are differences in important aspects of sexual identity, such as internalized negativity, the need for privacy, the need for acceptance, and difficulty of the process among Asian and Asian American sexual minority women. Women who identified as queer in the study had significantly less internalized negativity compared to other sexual minority women. The identities that Asian American sexual minority women choose (bisexual, queer, gay/lesbian) appear to make a significant difference in aspects of their sexual identity and overall well-being.

Religion also appears to be related to aspects of sexual identity, although the findings of this study do not suggest a clear picture. The majority of the study sample reported attending or participating in religion. Being affiliated with a Christian religion compared to a non-Christian

religion and being active in religion compared to not active were both associated with greater need for acceptance and a more difficult process of developing a sexual identity among the women in this sample. We do not know whether there is an interaction between religious participation and the type of religion (Christian/non-Christian), however. The sample size of this study was too small to stratify by both religion and level of participation. As outlined in the earlier part of the chapter, non-Christian religions are typically more accepting of nonheterosexual identities. Understanding the impact of different religions on the development of a sexual identity, among Asian women in particular, would be a valuable goal for future research. Of note, the proportion of women who reported attending or participating in religion was lowest for women who identified as queer (60%). The reasons for this are not known; however, it could be a function of culture. It could also be connected to nativity because the women in this study who identified as queer were all native to the United States. This study suggests that there are significant relationships between religiosity during childhood and the need for privacy, the need for acceptance, and how difficult the process of developing a sexual identity is for sexual minority Asian American women.

The study sample was about one-third foreign born. Although the average foreign born woman in the study had lived in the United States for about 20 years, differences were noted in aspects of sexual identity. Specifically, foreign-born women reported much higher internalized negativity compared to U.S.-born women. There was a relationship between sexual identity and nativity, in that more than 70 percent of foreign-born women identified as lesbian, much fewer as bisexual (29%), and none (0%) as queer. The reasons for this finding and its influence on internalized negativity are not currently known.

The separation or integration of the dual identities of race/ethnicity and sexual identity also influence aspects of sexual identity. Women in the study who identified as bisexual or lesbian reported a higher prevalence of race/ethnicity and sexual identity being separate than women who identified as queer (57% vs. 27%, respectively). Women who reported that their race/ethnicity and sexual identities were separate had a higher internalized negativity and a greater need for privacy compared to women who reported that these identities were integrated.

Experiencing oppression due to race/ethnicity and sexual identity was found to be prevalent among sexual minority Asian American women. The vast majority (84%) of women in this study reported experiencing oppression at some point due to BOTH their race/ethnicity and sexual identity. Sexual minority Asian American women who reported oppression due to race alone had a greater need for privacy than women who reported never experiencing oppression due to race/ethnicity. Sexual minority Asian American women who reported oppression due to sexual identity

alone had a greater need for privacy, a greater need for acceptance, and a greater difficulty with the process of developing a sexual identity than women who reported never experiencing oppression due to sexual identity. In contrast, sexual minority Asian American women who reported experiencing oppression due to race and sexual identity had less internalized negativity compared to women who never experienced oppression. It could be that experiencing multiple oppressions might increase an individual's resiliency which may lead to lower internalized negative feelings about sexual identity.

The finding that Asian sexual minority women may have a greater need for privacy may not be surprising considering the value of privacy in Asian cultures. Greater internalized negativity scores may also be related to minority distress. Recently, LGB Asian Americans scored higher on a measure of minority stress than black and Latino LGB individuals (Balsam et al., 2011). These types of stressors may intersect and interact in different ways depending on racial and sexual identity (Balsam et al., 2011). Of note, our study found that sexual minority Asian American women who reported experiencing oppression due to race and sexual identity had less internalized negativity compared to women who never experienced oppression. We hypothesize that experiencing oppression might increase an individual's resiliency which may lead to lower internalized negative feelings about sexual identity.

Specific studies with larger samples of sexual minority Asian and Asian American women are sorely needed. This population represents many countries, languages, religions, and cultures. The development of a sexual identity for Asian and Asian American women, therefore, may or may not be the same as in other populations. Future studies will help understand this substantial and important part of the population. In addition, further research is needed to untangle and understand the unique ways in which different types of stressors interact, particularly within Asian/Asian American sexual minority women and among other women of color.

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Chapter 8

Counseling African American Women: Let's Talk about Sex!

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In the absence of clear, specific literature, this article provides information about the sexuality of African American women and identifies culturally relevant practices counselors may use to gain understanding of and respond to sex-related issues (i.e., development, identity, and activity) of African American women. Implications for counselors and recommendations for broaching sexual matters are discussed.

Sexuality of African American women has been largely examined and described in the context of risky sexual behaviors. There have been few studies focused on the meaning African American women place on their sexuality and on their sexual decision making (Rouse-Arnette & Dilworth, 2006). In addition to the focus on risk, Wyatt and Riederle (1994) urged researchers to examine sexual decision making, suggesting that to design effective prevention and intervention strategies, researchers need to examine women's sexual practices, knowledge about sex, and comfort in discussing sex. Such an examination would of necessity include the social, ethnic, cultural, economic, religious, and relationship factors in which sexual decision making is embedded. The purposes of this article are to

provide information about the sexuality of African American women and to identify culturally relevant practices counselors may use to gain understanding of and respond to the sexual concerns of African American clients. In this article, the term *African American woman* (women, respectively) is used, but we acknowledge that this term is not the only representation used to identify this group.

SEXUAL RISK TAKING

In 1994, Wyatt identified three phases for the future research on human sexuality. First, researchers need to focus on knowledge about sex and sexual knowledge acquisition as well as sexual socialization. Second, the circumstances under which sexual risk taking occurs and its consequences should be identified and used in the formulation of conceptualization and the development of research questions. Third, research should be aimed at understanding the interventions that minimize sexual risk taking.

There are several reasons that counselors and health professionals need to achieve a better understanding of women's sexual practices, particularly those of minority women (Quadagno, Sly, Harrison, Eberstein, & Soler, 1998). Current data indicate that rates of HIV infection and AIDS are rising faster among women than among men and that a disproportionate amount of the increase among women is concentrated among African Americans and Hispanics. In 2000, African Americans made up 52 percent of HIV infection cases and 38 percent of individuals diagnosed with AIDS (Centers for Disease Control and Prevention, 2001; Robinson, Scheltema, & Cherry, 2005). In a study to examine sexual risk behaviors among low-income African American women, Robinson et al. (2005) found that women who reported having sexual difficulties were also more likely to report having multiple concurrent partners, and their partners had multiple concurrent partners, thus increasing their risk for HIV. African American women are also at increased risk for other sexually transmitted diseases, early unintended pregnancies, and abortions (Wyatt, 1997).

Adolescents represent one of the fastest growing risk groups for HIV in the United States. African American adolescents, with girls having higher rates than boys, make up the greatest portion of AIDS cases among adolescents (Aronowitz, Rennells, & Todd, 2006). Unfortunately, little is known about how risk behaviors develop during adolescence. Aronowitz et al. (2006) found that the community in which girls live influences the extent and type of exposure to sexual content as well as the level of support that exists to monitor exposure and sexual behavior. Adolescent females are often unaware of the dangers associated with risky sexual activity and rely on messages from society to inform their sexual practices and form ideas about their sexuality (Burson, 1998). To develop prevention and

interventions that lead to decreased risk, one must understand the development of sexuality in a cultural context.

AFRICAN AMERICAN WOMEN'S SEXUALITY

Although it has been necessary in helping intervention specialists identify groups at increased risk for sexually transmitted disease, the research focus on risk has largely ignored other aspects of African American women's sexuality. Specifically, the role of emotional states, attitudes, values, and beliefs on understanding sexuality and decision making must be explored in the sociocultural and historical contexts in which views of African American women's sexuality has been formed.

Sex in preslavery Africa was viewed as natural and sanctioned as a part of marriage (Wyatt, 1997). In the world of slavery, however, African women had no rights over their bodies, and sex became something to dread. Women who were slaves submitted to sexual demands to avoid punishment or other reprisals. Wyatt (1997) observed that African American women's sexual development takes place in "sometimes deafening silence about her sexuality or in the midst of negative messages and expectations about her inability to control it" (p. 3). Both of these circumstances can be traced to slavery when African women were forbidden the practice of rituals and customs previously used to socialize girls into womanhood. As well, African women who were afforded little to no privacy with regard to their bodies were often labeled as exhibitionists. Women who survived slavery learned to behave submissively, did not discuss sexual abuses, and learned to live with a quiet dignity, resigned to the abuses they endured (Jackson & Greene, 2000; Wyatt, 1997). Freedom from slavery gave rise to a sexual conservatism in African American families that included limited sexual information as one way to regain control of children's sexual development. This conservatism is still evident in some families.

Messages that African American women receive during childhood about sexuality may include that (a) nudity is unacceptable, (b) masturbation is sinful and taboo, (c) homosexuality is not acceptable, (d) intercourse before marriage is wrong, and (e) sexual abuse often involves strangers (Jackson & Greene, 2000; Wyatt, 1997). Phrases often heard during childhood and adolescence include the following: "Good girls don't do it," "No man is going to buy the cow if he can get the milk for free," "Good girls who do it, lie about it," and "Heifers who calve are permanently tainted meat." This line of thought has its roots embedded in the collective experiences of African American women, reaching as far back as the era of slavery and stretching on to the overwhelmingly Christian influenced era of civil rights (Dyson, 1999; Jackson & Greene, 2000; Mitchem, 2004; Stephens & Phillips, 2005). Such phrases are indicative of views held by older generations of African American women (Allen, 1995).

Consistent with this view is the idea that African American women should remain chaste and should repress any notions of sexuality, simultaneously treating the subject of sex as something sleazy, immoral, and taboo (Allen, 1995; Jackson & Greene, 2000; Norment, 1998). Girls and women who engage in sexual acts do not discuss it with others (Allen, 1995; Dyson, 1999). The traditional view asserts that the African American women should wait for Mr. Right and then take their places as wives and mothers, putting off other dreams and ambitions (Norment, 1998). African American women have been viewed historically in terms of childbearing, with no acknowledgement of sexuality (Dyson, 1999). Sex education grounded in this traditional view has proliferated through many generations within the African American community (Allen, 1995; Dyson, 1999). Contrasted with the sexual conservatism that still exists in many African American families is the stereotype of African American women as promiscuous (Wyatt, 1997). Stories of wild-hipped sirens who seduced their slave masters away from god-fearing wives to contemporary portrayals of strippers and whores by rappers are examples of the negative images of African American women that have persisted over time (Allen, 1995; Mitchem, 2004).

Stephens and Phillips (2005) recently examined sexual scripts from a sociohistorical perspective. From this perspective, a total of 12 images were identified that influence the development of sexual identities among African American adolescent women. The Jezebel, mammy, welfare mother, and matriarch were identified as foundational images for framing African women's sexuality (Jackson & Greene, 2000; Stephens & Phillips, 2005). The Jezebel is described as a young, promiscuous, oversexed woman with light skin, long hair, and a shapely body. She achieves sexual gratification and personal satisfaction only by pleasing men (Stephens & Phillips, 2005).

By contrast the mammy is portrayed as asexual, dark skinned, and overweight, putting the needs of her master's family before her own family's (Stephens & Phillips, 2005). Another foundational image described by Stephens and Phillips (2005) is that of the welfare mother. This image portrays African American women as uncontrollable breeders of unwanted children who become socioeconomic burdens to society. The final foundational image, the matriarch, was formed in the 1960s. This depiction of African American women is one of controlling, disdainful, and contemptuous females who do not need a man beyond reasons of childbearing and who were seizing power over the African American family causing the downfall of its men within American society (Stephens & Phillips, 2005). These historical foundational sexual scripts can be seen in today's sexual scripts of African American women.

Stephens and Phillips (2005) identified an additional eight sexual scripts that African American youth culture has embraced. These sexual scripts include the diva, gold digger, freak, dyke, gangster bitch, sister savior,

earth mother, and baby mama. The diva is described as a toned down Jezebel, with a sultry or tempting sexuality, who sees herself as worthy of being adored. Divas value attention over substance in relationships and are seen as high maintenance. The gold digger is described as using sex as a commodity to obtain material and economic goods. The foundational sexual script of the gold digger is linked to the hypersexed Jezebel and the financially dependent welfare mother (Stephens & Phillips, 2005).

The sexual script of the freak is seen as someone who is sexually aggressive and uninhibited. Linked to the foundational Jezebel, freaks project a good girl image but use sex to control their partners and to fulfill their own sexual needs (Stephens & Phillips, 2005). The dyke is often characterized as a woman who resists the sexual advances of men. There is a belief that the dyke was hurt emotionally or physically by a man resulting in her trying to get back at him by taking on masculine traits and having sexual interactions with women only. The dyke finds her foundational script in the asexual mammy and the emasculating matriarch (Stephens & Phillips, 2005). Aggression and emotional strength best describe the gangster bitch. A survivor by nature, the gangster bitch does not expect long-term love but uses her sexuality to release stress, please men, and more importantly, to show loyalty (Stephens & Phillips, 2005). The sister savior and earth mother sexual scripts are described as unique in that both exclude male definitions within their sexual scripts. Stephens and Phillips (2005) described their sexuality as resting on a higher plane based in a spiritual and communal framework. Sister savior has her roots in the church and its teachings on sexual morality. This script dictates a strict adherence to the teachings of the bible. God's word is seen as the only legitimate source about human sexuality, resulting in demure, obedient, and conservative views toward sexuality (Stephens & Phillips, 2005).

The earth mother, by contrast, is described as having a more developed sexual identity and sense of self. She is characterized by her political and spiritual consciousness, her Afro-centric nature, and her acceptance of diverse definitions of beauty. The earth mother projects self-empowerment and rejects exploitation based on race and sex (Stephens & Phillips, 2005). Finally, the baby mama is seen as a potential outcome for any of the previously described scripts. Stephens and Phillips (2005) described this script as all encompassing of the foundational scripts of the Jezebel, mammy, welfare mother, and matriarch images. The baby mama's script is enacted once a child is born. Viewed by some as a respected role, the baby-mama script is seen as the symbol of an African American girl moving into womanhood. Also linked to this script is the belief that having a child is evidence of her love for the father, thus strengthening their bond (Stephens & Phillips, 2005).

As African American women have become more assertive, independent, and self-determining, they are redefining their own sexualities in

terms of healthy self-concepts, imaging beauty within their own bodies, and within a spiritual context (Dyson, 1999; Mitchem, 2004). The more traditional perspective is changing as African American women find themselves more socioeconomically empowered, assertive, independent, and driven (Allen, 1995; Dyson, 1999; Norment, 1998). The African American woman in contemporary society is charting her own direction in life: remaining interested in a love life, but not dependent on one (Norment, 1998; Roberts, 1996). Phrases such as "good girls don't do it" are being replaced with "I gotta get mine," "I want to date and enjoy sex," and "My spirituality is a part of my sexuality" (Dyson, 1999; Roberts, 1996). Rather than waiting for a Mr. Right to take care of them, women are making their own money and decisions. They want Mr. Right to be a partner who respects and supports their dreams and aspirations (Allen, 1995; Norment, 1998; Roberts, 1996). The traditional view that women must repress sexuality or subvert their sexual needs in the service of a relationship helped women survive when they were raised only to marry (Wyatt, 1997). However, in society at this time, African American women are no longer served well by turning over control of their lives to a partner. Instead, they make choices that both honor their culture and traditions and protect them from unwanted outcomes (e.g., sexually transmitted disease).

To respond to the sexual issues African American women may present in therapy, counselors need to acknowledge the existence of the aforementioned stereotypes and the historical and cultural contexts in which they developed (Jackson & Greene, 2000). Counselors also need to convey their understanding to clients of the ways such stereotypes and attendant sexual scripting may have influenced their clients' sexual development. In addition, it is essential that counselors consider the pressures imposed by families, in an effort to regain control of their daughters' sexual development in postslavery America, to maintain a dignified silence about sexual beliefs and practices. The counselor's challenge is to promote discussion of sexual matters in a safe, nonthreatening, and culturally relevant way that speaks of understanding, not expectation, about sex. The following sections offer specific suggestions about ways to meet this challenge.

COUNSELING AFRICAN AMERICAN WOMEN

Although there has been little emphasis in the professional counseling literature regarding African American women's sexuality, a great deal of attention has been directed to African American women's health and mental health in general, including seeking and accessing services (Ivey, 2006; Jackson & Greene, 2000; Matthews & Hughs, 2001; Neese, Schover, Klein, Zippe, & Kupelian, 2003; Neighbors, 1986; Neighbors & Jackson, 1996; Paniagua, 2005; Parham, 2002; Williams, 1999), dynamics of the helping process, guidelines for practice, prevalent issues faced, and counseling needs

(Bridges, Selvedge, & Matthews, 2003, DiClemente et al., 2004). Counselors who provide services need to be familiar with these topics to work most effectively with African American women (Caldwell, 1996; Constantine & Sue, 2006; Cross, 1995). Counseling African American women must include strategies that are congruent with cultural characteristics and values (i.e., groupness, heritage, communalism, fluid time orientation, cooperation interdependence, egalitarianism, emotional expressiveness, respect for elders and nature, and spirituality; Bradley & Sanders, 2003; Paniagua, 2005; Parham, 2002; Smith & Wermeling, 2007; Williams, 2005).

The unique and diverse worldview of African American women requires that counselors consider, understand, and attend to identities, constraints, and a cultural context that accompany presenting problems (Bingham, 1992; Williams, 2005). Issues such as stigmatization, marginalization, oppression, and internalized racism may emerge in counseling and have the potential to impact the counselor–client relationship (Williams, 2005). Some of the elements of a culturally responsive approach to counseling African American women include (a) emphasis on egalitarian relationships, (b) open discourse about feelings of discrimination and racism, (c) the establishment of trust, and (d) client understanding of the counseling process (Howell & McEvatt, 2005; Sue & Sue, 2008). In addition, emphasis on positive assets of the client (family, community resources, and church/spirituality; Frame, Williams, & Green, 1999; Paniagua, 2005; Parham, 2002; Walker, 2002; Williams & Frame, 1999); external factors related to the presenting problem, like social, political, economic, and historical factors (Huffman, Myers, Tingle, & Bond, 2005); gaining an awareness of cultural knowledge during presession preparation; collaboration in defining goals; and collaboratively determining interventions are also viewed as inclusive counseling practices (Bradley & Sanders, 2003; Sue & Sue, 2008).

An example of one cultural characteristic and dimension of identity discussed in the cross-cultural literature is spirituality. The use of religion and spirituality is traditionally relied on heavily within the African American community as a whole (Neighbors & Jackson, 1996; Paniagua, 2005; Parham, 2002; Watlington & Murphy, 2006). Spiritual reliance is linked to religion being a vehicle for African Americans to speak of the issues of oppression, liberation, love, hope, and justice (Watlington & Murphy, 2006). The literature calls attention to the importance of religious involvement to African Americans, who are described as likely to pray, practice religious rituals, and attend religious services (Musgrave, Allen, & Allen, 2002). Spirituality within the African American community does not have a single definition but incorporates tenets of several definitions. Banks and Parks (2004) identified four themes of spirituality that included (a) finding meaning in life through self-transcendence, (b) the experience of spirituality as a physical embodiment of the spirit, (c) recognition and value of the interconnectedness between relationships among all life forms, and

(d) relationships as the context for developing spirituality (Banks & Parks, 2004). Other definitions of spirituality refer to an inner quality that facilitates connectedness with the self, other people, and nature. An aspect common among African Americans is that spirituality is a focus on the acknowledgement of and relationship with a supreme being (Musgrave et al., 2002; Parham, 2002).

Historically, African American women have used spirituality to cope with sexual abuse during slavery, health and social issues (i.e., domestic abuse, breast cancer), and to decrease anxiety and daily stress (Gibson & Smith-Hendricks, 2006; Musgrave et al., 2002; Watlington & Murphy, 2006). Today African American women continue to use components of their spirituality to manage personal woes, and daily frustrations and stress (Taylor, 2003). Sex-related issues of African American women are connected to spiritual values, beliefs, and constraints. Banks and Parks (2004) found that spirituality directly and indirectly influenced African American women's decision making and behavior as they relate to family, health, and community interactions. It was also noted that spiritual relationships with other African American women were highly valued. These findings suggest that recognizing and incorporating spirituality in counseling provide African American women a vehicle for discussing sex-related issues in a culturally relevant context.

In addition to the considerations presented above, Day-Vines et al. (2007) provided a useful guide for talking about topics of race, ethnicity, and culture in the counseling process. We believe that the descriptions of the ways that counselors talk to their clients about race may also be a helpful formulation for counselors to use when broaching the topic of sex. Broaching is a way to talk about difference. Described as a therapeutic behavior, counselors demonstrate an "ongoing attitude of openness with a genuine commitment to continually invite the client to explore issues of diversity" and use "the counseling relationship as a vehicle for navigating a discussion concerning issues of difference related to race, ethnicity and culture" (Day-Vines et al., 2007, p. 402). Their conceptual framework includes a continuum of five broaching styles: (a) avoidant, (b) isolating, (c) continuing/incongruent, (d) integrated/congruent, and (e) infusing. Using the last three styles, we have adapted the model to include broaching sexual topics as well as those intended by Day-Vines et al. and to help counselors identify ways that they may become more effective in addressing the sexuality needs of African American women (see Tables 8.1, 8.2, and 8.3). We list the characteristics, corresponding attitudes and behaviors, and possible outcomes. We also include examples consistent with Moore and Madison-Colmore's (2005) History, Empowerment, Rapport, and Spirituality (HERS) model, a useful starting tool for conceptualizing a framework for counseling and talking about sex. The HERS model and the broaching model are congruent with others (i.e., pathology model,

Table 8.1 Application of continuing/incongruent broaching style in counseling African American women

Counselor/Counseling	Description
Characteristic	Counselor is open to discussions of sex but lacks necessary skills.
Attitude	Sees the need to discuss cultural factors in counseling about issues of sexuality.
Behavior	Recognition of the need to discuss in a cultural context does not translate into counseling process. Example: learning about the client's herstory both in study and from inviting the client's voice.
Potential outcome	Sexual issues may be discussed, but important emphasis on cultural context may be ignored.

Source: Adapted from a model proposed by Day-Vines et al. (2007) and Moore and Madison-Colmore (2005).

Table 8.2 Application of integrated/congruent broaching style in counseling African American women

Counselor/Counseling	Description
Characteristic	Counselor encourages a discussion and interpretation of sexual behavior and decision making in the context of culture.
Attitude	Views broaching sex in a cultural context as essential to developing a strong working relationship.
Behavior	Recognizes the intersection between culture, race, and sex and discusses these effectively with client. Example: empowers the client to talk about issues of identity and sex by establishing trust and rapport (e.g., How do you identify . . . as an African American woman, Black female, etc.?).
Potential outcome	Counselors are likely to establish trusting relationship based on mutual, demonstrated understanding of the cultural conflicts around sex experienced by African American women.

Source: Adapted from a model proposed by Day-Vines et al. (2007) and Moore and Madison-Colmore (2005).

structural-functional model, emergent model, the Afro-centric model, and integrated feminist and psychodynamic models) that suggest that counselors go on to address specific issues of the client (Moore & Madison-Colmore, 2005). We offer these examples not as a template but as a starting point for discussing sex with African American women.

Table 8.3 Application of infusing broaching style in counseling African American women

Counselor/Counseling	Description
Characteristic	Counselor believes broaching sex in a sociopolitical, historical context is important.
Attitude	Views broaching sexuality in the context of culture as an essential part of combating oppression and promoting healthy decisions.
Behavior	Incorporates discussion of culturally contextualized experience into all counseling practice. Example: broaches issues surrounding spirituality and client's sexuality (if relevant for the client).
Potential outcome	Clients may achieve an understanding of the values that underlie sexual choices, the roots of these values, and the values that do and do not serve them well in terms of sexuality and sexual decision making.

Source: Adapted from a model proposed by Day-Vines et al. (2007) and Moore and Madison-Colmore (2005).

In keeping with Day-Vines et al. (2007) model, counselors who broach issues of sexual practices and sexual concerns in counseling demonstrate an awareness of both the individual and cultural context of the client's experiences. Counselor awareness should communicate an understanding of the connection "between the client's problems, possible sociopolitical realities," and intersecting identities (p. 405). Counselors with a broaching style at the integrated/congruent and infusing end of the continuum translates an appreciation of the client's worldview into counseling strategies and interventions, not doing so in a stereotypic manner. In addition, counselors operate as change agents and advocate for systemic change. Day-Vines et al. (2007) model invites the voice of African American women in counseling to talk and explore their issues of sexuality.

Establishing trust is noted as an important therapeutic element essential for counseling African American women. Trust can be established by not minimizing and compartmentalizing client histories, attitudes, beliefs about sex but rather by contextualizing the problem holistically (Williams, 2005). Another way to establish trust is by addressing client concerns and expectations in talking about sex in counseling (Constantine & Greer, 2003). Because African American women may regard counselors as part of a system that invalidates them (i.e., having *cultural mistrust* or *healthy cultural paranoia,* terms used by Constantine & Greer, 2003; Paniagua, 2005), counselors can establish trust by using culturally relevant frameworks to

create effective counseling interventions. More specifically, due to negative connotations that can accompany sex scripts and cultural mistrust of counselors, clients cannot be expected to come in and talk about issues considered taboo. Counselors can get at this information by effectively broaching these topics in a way (i.e., integrated congruent and infusing) that communicates counselors understand the cultural context of the experience of African American women. Consequently, effective broaching styles provide counselors with a mechanism for addressing barriers in counseling like counselor and client difficulty in talking about sexual issues. Effective broaching can therefore assist in overcoming barriers and address perceptions of sex, self, and others in an appropriate cultural context. In talking about sex, trustworthy broaching in counseling is multidimensional and requires counselors to apply cultural competence skills (Day-Vines et al., 2007; Sue & Sue, 2008).

RECOMMENDATIONS FOR COUNSELORS

From our discussion, several recommendations emerge for best practice. First, counseling practice is informed by counselors' knowledge of scripts and stereotypes that indeed exist about African American women and their awareness of the sociohistorical context in which these scripts developed. Second, counselors demonstrate their understanding of each clients' sexual identify development. Third, counselors develop and use culturally relevant practices to engage with clients, recognizing barriers that impede African American women's willingness to access counseling and engage in active discussion about taboo subjects (i.e., sex, sexuality) once in the counseling process. Counselors can seek to overcome such barriers by using multicultural competence skills and the technique of broaching. Counselors should examine and be aware of their own attitudes and beliefs about sex-related issues. Gaining self-awareness is a vital first step in developing expertise and for broaching these issues in practice. Finally, counselors use their knowledge and understanding of both clients and culturally competent practices to intervene effectively.

Additional recommendations for counseling practice include counselor development of both self-awareness and understanding of how the cultural context of the client intersects with the client's view of their own sexual identity and how that identity has developed. Talking about how the client sees herself, how the client believes others view her, and her perceptions of that view can promote client reflection and has the potential to trigger the change process. Talking about spirituality is an essential element to keep counseling culturally relevant (Moore & Madison-Colmore, 2005) and can help foster counselor understanding of the cultural-historical views of African American women's sexuality (Jackson & Greene, 2000;

Wyatt, 1997). Spirituality and religious beliefs and activity (e.g., prayer and meditation) are noted as an important part of the existence of African American women as a means of coping and for deriving meaning for life (Jackson & Greene, 2000; Moore & Madison-Colmore, 2005; Neighbors & Jackson, 1996; Paniagua, 2005; Parham, 2002). As a result, relative connections between sex-related issues and African American women's spirituality should be further explored. It is imperative for counselors to ask about the role spirituality has in the life of a client in general as well as if and how it is related to client's sex issues (i.e., development, identity, and activity). This should be accomplished while not assuming that spirituality is a significant life dimension for all clients (Jackson & Greene, 2000; Moore & Madison-Colmore, 2005). Reluctance to broach these issues may result in unsuccessful outcomes in counseling (Moore & Madison-Colmore, 2005).

Counselors might consider adopting an integrated/congruent broaching style that is moving toward an infusing broaching style to accomplish best practice (e.g., using awareness and understanding to apply appropriate interventions and strategies in counseling). Adopting an effective broaching style enables counselors to elicit client information about sex in a culturally relevant, individually contextualized way. Willingness to broach sensitive topics in this way communicates interest and cultural understanding to the client in ways that support the development of trust and rapport.

Appropriate strategies and therapeutic interventions may also include connecting with clients (a) using ritual, music, poetry, and prose; (b) using appropriate clinical assessment instruments and understanding client strengths; (c) facilitating awareness by helping clients understand their language and pain; (d) setting goals by examining culturally centered theoretical assumptions and restoring balance; (e) helping the client to take action and instigating change by empowering the client; and finally (f) accepting feedback and being accountable by examining congruence between goals and outcomes (Parham, 2002).

Group counseling (Bradley & Sanders, 2003; Jackson & Greene, 2000; Smith & Wermeling, 2007; Vaz, 2005; Yaeger, 2001) is also noted as an ideal modality for exploring issues of sex with African American women. Group counseling is a useful way to tap into the social and cultural resources of African American women clients. By fostering groupness (a cultural value), and "sisterhood," the group process offers a way for counselors to gain "additional insight about the client" for counseling clients about sex (Bradley & Sanders, 2003, p. 188). The environment of a group can foster support and a sense of universality among group members. Group counseling may foster feelings of safety for discussing and exploring personal and sex-related issues (Smith & Wermeling, 2007). Group work is an effective tool for empowering African American women psychologically, socially, and spiritually (Smith & Wermeling, 2007). A group counseling approach that has been noted as beneficial for counseling African American women is the reflecting

team approach (Vaz, 2005). Vaz (2005) described group counseling process wherein group members act as consultants and rotate counseling focus from client to client, session to session. The approach provides each member the opportunity to speak in the group on multiple occasions (Vaz, 2005). Another group strategy summarized and reviewed by Yaeger (2001) is the Images of Me group (p. 350). Postulated by Pack-Brown, Whittington-Clark, and Parker (1998), the Images of Me group draws on existential and cognitive behavioral approaches to group work. Focusing on "one's reason for being, the unavoidable exigencies of life in an unpredictable world," the Images of Me group uses "the power of the individual to alter her way of thinking to influence her sense of well-being and ultimately her mental health" (Yaeger, 2001, p. 350). The book also offers useful culturally responsive exercises counselors can use in group work (Pack-Brown et al., 1998) for broaching and addressing sex issues in counseling African American women.

CONCLUSION

In conclusion, African American women have unique needs surrounding sex that should be addressed by both counselors and researchers. The very limited discourse on African American women's sex issues and counseling is unfortunate, given the impact of sex-related issues on humanity. We have drawn from existing professional literature to offer suggestions about ways to create a climate where discussions of sexuality are not only possible but probable. Strategies we propose for talking about issues of sex in a culturally holistic and historically relevant way are grounded in the broaching work of Day-Vines et al. (2007) coupled with the important findings of other experts in culturally competent counseling. We believe that counselors who adopt one of the three styles on which we elaborated, with a goal of achieving the infusing style, will have the potential to have deep and meaningful discussions about sex with African American women.

NOTE

1. Chippewa M. Thomas, Tylon M. Crook, and Debra C. Cobia, *The Family Journal, 17*(1), pp. 69–76, © 2009 by SAGE Publications. Reprinted by permission of SAGE Publications.

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Part III

Sexuality and Health

Chapter 9

The Experience and Construction of Changes to Women's Sexuality after Breast Cancer[1]

Jane M. Ussher, Emilee Gilbert, and Janette Perz

Breast cancer is the most common cancer in women and the second leading cause of cancer deaths in women globally (World Health Organization, 2009). It is now recognized that changes to sexual well-being can be the most problematic aspect of life post–breast cancer, with the impact lasting for many years after successful treatment (Andersen, 2009; Bertero & Wilmoth, 2007), often associated with serious physical and emotional side effects (Langellier & Sullivan, 1998). Indeed, research has shown that when compared with healthy same-aged women, women with breast cancer experience lower levels of sexual satisfaction and have more difficulty maintaining their sexual life (Speer et al., 2005). Until recently, research examining the impact of breast cancer on sexuality was primarily conducted from a positivist-realist paradigm (Wilmoth, 2001), privileging the physical and material aspects of women's experience, and focusing on levels of sexual "dysfunction" post–breast cancer, where functional sexuality is conceptualized as penile/vaginal intercourse (Fobair et al., 2006). Recent research has shown, however, that engaging in sexual intercourse may not

be positioned as women's primary focus of sexual adjustment and satisfaction after a breast cancer diagnosis, and engagement in sexual intercourse does not necessarily equate to sexual satisfaction (Wilmoth, 2001). Moreover, the primary focus on the physical effects of breast cancer or breast cancer treatment on sexual behavior assumes that a woman's experience of sexuality is limited to its corporeal dimensions, negating the influence of the social construction of sexuality and illness (Meyerowitz, Desmond, Rowland, Wyatt, & Ganz, 1999) and the ways in which the meaning of sex is negotiated by individuals and within relationships (Gilbert, Ussher, & Perz, 2010a).

As a counterpoint to the primacy of positivism and realism, research from a social constructionist paradigm has provided insight into women's lived experiences of changes to sexuality after breast cancer (Archibald, Lemieux, Byers, Tamlyn, & Worth, 2006), and the ways in which sociocultural discourses shape the experience and interpretation of sexuality (Young, 1992). As Judith Butler (1990) has argued, our understanding of sexual subjectivity is confined within a heterosexual matrix, within which masculinity and femininity are performed through engagement in normative sexual practices, described as the "coital imperative" (Gavey, McPhillips, & Braun, 1999), with failure to perform coitus positioned as dysfunction and other practices as not "real sex" (Few, 1997). These social and cultural discourses teach us about what is normal and abnormal, and profoundly impact on how we come to construct our understanding of sexuality, and explain why many heterosexual couples who cannot physically engage in sexual intercourse following diagnosis and treatment of cancer, cease all expression of sexual intimacy. However, within a social constructionist paradigm, intrapsychic and intersubjective aspects of women's experiences are often ignored, and the physical body is either positioned as the passive object of cultural constructions or it is absent from explorations of lived experiences of sexuality after breast cancer. In other words, the physical dimension of illness can get neglected by social constructionists who tend to explore the constructions and meanings ascribed to symptoms rather than the materiality of the illness, the functioning of the body, and the impact this has on a person's life (Ussher, 2008).

In order to address the limitations of both realism and constructionism, this chapter will adopt a material-discursive-intrapsychic perspective (Ussher, 2000), which acknowledges the materiality of sexual changes following breast cancer, women's intrapsychic experience of such changes within a relational context, and the influence of the discursive construction of femininity and sexuality. In this vein, we will review the available research on breast cancer and sexuality, and then examine a recently completed Australian study of sexual well-being after breast cancer as an illustrative case example.

Materiality: Changes to the Body and Sexual Functioning following Diagnosis and Treatment

Research with Western women has found that embodied changes and disturbances to sexual functioning frequently reported following the diagnosis and treatment of breast cancer include: dyspareunia (Speer et al., 2005); fatigue (Fobair et al., 2006); vaginal dryness (Ganz, Greendale, Petersen, Kahn, & Bower, 2003; Ganz, Rowland, Desmond, Meyerowitz, & Wyatt, 1998); decreased sexual interest or desire (Avis, Crawford, & Manuel, 2004); decreased sexual arousal (Knobf, 2001); numbness in previously sensitive breasts (Wilmoth, 2001); difficulty achieving orgasm (Fobair et al., 2006; Speer et al., 2005); and lack of sexual pleasure (Meyerowitz et al., 1999). Research in non-Western cultures has yielded similar results, with diminished sexual desire, decreased orgasm, vaginal dryness, coital pain, decreased sexual activity, deterioration of the sexual relationship, a loss of interest in their sexual partner, sexual dissatisfaction, reported by Iranian, Turkish, and Chinese women after breast cancer (Alicikus et al., 2009; Can et al., 2008; Garrusi & Faezee, 2008; Zee et al., 2008).

A considerable amount of research has investigated the relationship between breast cancer treatment and changes to sexual well-being, with women who undergo chemotherapy being reported to be at higher risk of reporting sexual difficulties after treatment than those who have not received such treatment (Avis et al., 2004; Ganz, Desmond, Belin, Meyerowitz, & Rowland, 1999; Ganz et al., 1998; Thors, Broeckel, & Jacobsen, 2001). Chemotherapy is also associated with problems of arousal, lubrication, orgasm, and sexual pain (Alder et al., 2008), issues that are particularly common shortly after treatment (Burwell, Case, Kaelin, & Avis, 2006). However, whilst research has found that radiation is associated with feeling medically invaded (Langellier & Sullivan, 1998), it is not as likely to be associated with decreased sexual desire as chemotherapy (Takahashi et al., 2008). Yet, the impact of chemically induced menopause (CIM) on sexuality has also been associated with decreased sexual desire; pain during intercourse; vaginal dryness; decreased sexual arousal; a severe or complete loss of pleasurable sexual sensations; and decreased frequency or intensity of orgasms (Archibald et al., 2006).

The combination of loss of sexual function, premature menopause, and the associated symptoms of vaginal dryness tends to be particularly severe (Ganz et al., 1998), and can be devastating for young women who may also be concerned with loss of reproductive opportunity (Ganz et al., 2003). However, the evidence of a link between hormonal treatment with tamoxifen, an estrogen antagonist, and sexual functioning is somewhat contentious. Ganz and colleagues (1998) found no difference in sexual functioning between women treated with or without tamoxifen, whilst Mortimer and colleagues (1999) found that some women treated with

tamoxifen complained of pain, burning, or discomfort with intercourse, vaginal tightness, hot flashes, and negative feelings during intercourse. There has also been much recent research examining the impact of breast cancer surgery on the sexual functioning of women, though the results are mixed. Some have found that women who received breast-conserving surgery report fewer problems associated with sexual interest than women who had a mastectomy (Ganz et al., 1999; Markopoulos et al., 2009), and that women who have had a mastectomy experience difficulty relaxing and enjoying sex, difficulty reaching orgasm (Burwell et al., 2006), as well as a decreased frequency of sex post-surgery (Takahashi et al., 2008). However, others provide little evidence of a link between type of surgical treatment and sexual functioning (Rogers & Kristjansen, 2002; Thors et al., 2001).

Intrapsychic Experiences: Emotions and Body Image

Whilst some women experience the changes to their sexuality after breast cancer positively (Archibald et al., 2006; Ganz et al., 1998; Langellier & Sullivan, 1998), the majority of evidence shows that women with breast cancer experience a range of serious negative emotional changes as a result of disturbances to their sexuality, including fear of loss of fertility, negative body image, feelings of sexual unattractiveness (Bertero & Wilmoth, 2007), loss of femininity (Wilmoth, 2001), depression, and anxiety (Garrusi & Faezee, 2008), as well as alterations to their sexual self-concept (Wilmoth, 2001). Having to adjust to the removal of the breast or to the alteration in appearance of the breast, loss of body hair, loss of menstruation and childbearing capacity, feeling old before their time (Wilmoth, 2001), concern about weight gain or loss, and a partner's difficulty understanding a woman's feelings (Fobair et al., 2006) can exacerbate these negative emotional changes. Although some researchers have argued that such changes are more prevalent in women with preexisting anxiety, depression, or sexual dysfunction (Can et al., 2008; Fobair et al., 2006), the potential emotional impact of disturbances to sexuality is an issue for a large proportion of women with breast cancer. Women who report negative changes to their sexuality can also report worrying about what causes these sexual changes, how long the changes will last, the extent to which the changes may impact on their intimate relationship, and how they can cope with the sexual changes (Gilbert et al., 2010b).

Although the physical pain of breast cancer and treatment diminishes with time, the experience of emotional pain may persist as women grieve the loss of their breast or feel as though a part of them has died (Langellier & Sullivan, 1998). In this vein, breasts are often positioned as such a significant part of women's sense of self that those who undergo a mastectomy feel like "half a woman" (Manderson & Stirling, 2007). Research also shows

that the strongest consistent predictor of sexual problems after breast cancer is lower perceived sexual attractiveness (Burwell et al., 2006), and that women who have a poor body image after breast cancer have lower rates of sexual satisfaction and are more dissatisfied with their sexual relationship than those with a positive body image (Speer et al., 2005). Overall, however, it is suggested that body image and sexuality are most significantly affected by breast cancer during the first year of survivorship, and that body image is more likely to be affected by mastectomy compared to breast-conserving treatment or breast reconstruction (Fobair et al., 2006; Ganz et al., 1998). For example, studies have shown that mastectomy patients are more likely than women who have received breast-conserving surgery or reconstruction to dislike their appearance without clothes (Alicikus et al., 2009), avoid looking at themselves in mirrors (Langellier & Sullivan, 1998), and feel embarrassed, ugly, or self-conscious (Manderson & Stirling, 2007). Women who receive breast-conserving surgery also report fewer problems with dressing, body image, and being naked than women who have had a mastectomy (Markopoulos et al., 2009).

Sociocultural and Discursive Constructs: The Construction and Experience of Breasts and Sexuality

Research that has taken a social constructionist approach to the issue of sexuality and breast cancer has been largely concerned with the ways in which sociocultural and medico-scientific discourses shape a woman's construction and experience of her illness and her body. For example, Langellier and Sullivan (1998) examined how these discourses are embedded in women's breast talk, and found that women talk about four different but highly interrelated types of breasts. The medicalized breast constructed as a physical body part with disease; the functional breast constructed as a symbol of women's emotional abilities to nurture others; the gendered breast constructed as a symbol of femininity, beauty, and sexual desirability; and the sexualized breast which incorporates the look and feel of the breast. These types of breasts are positioned in women's talk as belonging not only to themselves, but also to their children, husbands, and lovers. This is exemplified in Thomas-MacLean's (2005) interview study, where women who had undergone a mastectomy described feeling a loss of bodily symmetry post–breast cancer surgery that led them to manage appearances or hide their "deformity" from others. Women have also reported wearing prosthesis to appear normal to those in public, and to avoid being viewed as asymmetrical or less than whole by husbands, male partners, or children (Manderson & Stirling, 2007). It has been argued that this is because within patriarchal culture there is a focus on the breast as "daily visible and tangible signifier" of a woman's femininity for both herself and for others (Young, 1992, p. 215). A particular type of breast

is both privileged and normalized—the breast that is round, firm, and not sagging or medically mutilated. The woman with breast cancer is thus potentially positioned outside normal femininity (Spence, 1995), which can have serious implications for women's sense of self, body image, psychological well-being, and sexuality.

Equally, when an individual is diagnosed with cancer and comes to be seen as ill, a different set of norms emerge for "acceptable" behavior within their illness state (Wellard, 1998, p. 53), including the notion that people with cancer have either limited sexual needs or are asexual (D'Ardenne, 2004). Schildrick (2005) has argued that people with a disability or serious illness are disqualified from normative discourses of sexuality, as "proper" sexuality is associated only with able-bodied, healthy, and usually young individuals, which "legitimates a denial of sexual desire and pleasure" (p. 334). This disqualification and denial is also associated with the prominence of the "coital imperative" in medical, social, and legal discourse (Gavey et al., 1999, p. 37), wherein individuals who cannot perform sexual intercourse *properly* are positioned as dysfunctional (Tiefer, 1996, 2001). It is thus not surprising that intercourse has been found to be strongly connected with feelings of acceptance, intimacy, and love, and absence of intercourse with feelings of self-doubt (Gavey et al., 1999). However, as Schildrick comments: "'Proper' sexuality is inevitably contested by those whose atypical morphology literally frustrates the performance of conventional paradigms and normative certainties" (2005, p. 332) in their renegotiation of sex outside the coital imperative.

At the same time, for intimate partners who are also the carer of a person with cancer, renegotiating a sexual relationship may be particularly problematic, given the discursive construction of the good carer and the social construction of appropriate or taboo sexual conduct for those in the role of carer. Carers may come to consider their partner purely as a patient and as dependent on them for their basic needs—needs that are often antithetical to the expression of sexuality within the relationship (Gilbert, Ussher, & Hawkins, 2009). For example, Manderson (2005) found that people with a stoma and their carer find it difficult to sexualize a body on which there is now attached a bag containing in a very visual way urinary fluid and defecation. Similarly, in the study we present below, a number of women with breast cancer reported that their partners were disgusted by, and could no longer sexualize, their breasts.

Relationship Context and Sexual Renegotiation

One of the most important and consistent predictors of sexual health in women with breast cancer is the quality of their partnered relationship (Archibald et al., 2006; Ganz et al., 1999; Garrusi & Faezee, 2008). In fact, the quality of a woman's relationship is a stronger predictor of

sexual satisfaction, sexual functioning, and sexual desire after breast cancer than the physical or chemical damage to the body after treatment (Alder et al., 2008; Speer et al., 2005; Zee et al., 2008). Research has shown that if women can renegotiate their sexual practices when the type of sex they had precancer is no longer desirable or possible, they are more able to manage the changes to their sexual relationship (Gilbert et al., 2010a). The inability to renegotiate sexuality and intimacy post-cancer has been reported to be associated with difficulties in communicating about sexual matters (Arrington, 2003; Foy & Rose, 2001; Holmberg, Scott, Alexy, & Fife, 2001), often for fear of creating feelings of guilt in the person with cancer (Kuyper & Wester, 1998). However, there is a distinct lack of research that examines sexuality after cancer from a relational perspective. This negates the ways in which the experience of sexuality is shaped by the relationship context, including how a woman positions her partner post-cancer, how the partner positions the woman post-cancer, whether sex is positioned as a taboo in the context of cancer, and whether sex is openly communicated about.

CHANGES TO SEXUAL WELL-BEING AFTER BREAST CANCER: A STUDY OF AUSTRALIAN WOMEN

In order to illustrate the material-discursive-intrapsychic experience and construction of changes to sexuality after breast cancer, we now present a case example, drawing on the findings of a recent research study conducted with Australian women. The purpose of this study was to examine the lived experience of sexual well-being and couple intimacy in a large sample of individuals with breast cancer living in Australia, using a mixed method approach.

Study Outline and Participants

The participants were 1,999 individuals drawn from the membership of a national organization for Australians affected by breast cancer, Breast Cancer Network Australia (BCNA). Participants ranged from 18 to 84 years, with an average age of 54.1. The sample was predominately female (99.8%), self-identified as Anglo-Australian (89.1%), and had further tertiary education and/or training (60.7%). The majority of participants were partnered (85.3%), heterosexual (98.0%), and had children (84.2%). On average, it had been 3.9 years since participants received their diagnosis of breast cancer, with 74.6 percent having been diagnosed with early-stage breast cancer. At the time of this study, 45.6 percent had finished their treatment and 45.5 percent were still receiving treatment. Menstruation had ceased for 77.8 percent of the sample, who described themselves as postmenopausal.

The study involved a survey which was available for online completion for a 14-day period in December 2010, involving a combination of closed and open-ended items. In the quantitative analysis presented below, percentages for frequency data were calculated on the number of participants who completed each item, rounded up for readability. For items with multiple options, percentages do not total 100, as participants could choose more than one response. Thematic analysis (Braun & Clarke, 2006) was used to analyze the open-ended responses. This involved independent reading of responses to each question by two members of the research team, in order to ascertain the major themes that emerged, and to develop a coding frame, based on notions of consistency, commonality, and the function and effects of specific themes. Demographic information is provided for longer quotes, which is omitted to enhance readability from shorter quotes.

In the analysis presented below, we examine accounts of changes to sexual well-being and relationships; what was perceived to cause such changes; avenues of coping; and impact on partners.

The Impact of Breast Cancer on Sexual Well-Being and Relationships

In answer to a question on the impact of breast cancer or breast cancer treatment on sexual well-being, the majority of the 1,956 participants reported a decrease in frequency of sex (78%), energy for sex (76%), sexual arousal (74%), feeling desirable (73%), interest in sex (71%), sexual pleasure (64%), satisfaction with sex (62%), and intimacy (60%) (Table 9.1). No change was reported by the majority of participants in the areas of "partner interested in sex" (64%) and "communication with partner about sex-

Table 9.1 The impact of breast cancer or breast cancer treatment on sexual well-being (N = 1956)

	Percentage (*n*)		
Area	Decreased	No change	Increased
Frequency of sex	77.9% (1427)	20.3% (372)	1.8% (33)
Energy for sex	76.0% (1379)	22.4% (407)	1.5% (28)
Sexual arousal	73.6% (1344)	24.2% (442)	2.2% (40)
Feeling desirable	73.4% (1385)	25.1% (473)	1.6% (30)
Interest in sex	71.4% (1308)	26.1% (479)	2.5% (45)
Sexual pleasure	64.2% (1151)	33.8% (607)	2.0% (36)
Satisfaction with sex	61.9% (1096)	35.6% (630)	2.5% (44)
Intimacy	60.4% (1090)	34.5% (623)	5.1% (93)
Communication with partner about sexual needs	42.4% (746)	50.5% (889)	7.2% (126)
Partner interest in sex	32.4% (565)	64.3% (1120)	3.3% (58)

ual needs" (51%); however, a considerable proportion of the sample also reported decreases in these areas. Only 7 percent of the sample noted an increase in the area of "communication with partner about sexual needs," this being the largest recorded increase.

Of the 1,956 participants who described which aspects of breast cancer or breast cancer treatment were perceived to have affected sexual well-being (Table 9.2), the most frequent responses were: tiredness (71%), vaginal dryness (63%), hot flushes (51%), and feeling unattractive (51%).

When asked what had been tried to deal with changes to sexual well-being after the onset of breast cancer, the most common response, reported

Table 9.2 Aspects of breast cancer or breast cancer treatment that have affected sexual well-being (N = 1956)

Item	Percentage (*n*)
Tiredness	71.0% (1387)
Vaginal dryness	63.3% (1237)
Hot flushes	51.2% (1000)
Feeling unattractive	50.8% (993)
Weight gain	48.8% (953)
Difficulty being aroused	45.8% (894)
Feeling uncomfortable exposing my body	44.0% (860)
Medication side effects	39.0% (762)
Loss of confidence in myself	38.4% (751)
Depression/anxiety	37.8% (738)
Change in size or shape of breast	37.6% (734)
Difficulty reaching orgasm	35.9% (701)
Loss of sensation	35.8% (700)
Reduced nipple sensation	35.4% (692)
Pain during intercourse	33.4% (653)
Anxiety about sex	28.6% (558)
Early menopause	28.1% (550)
Appearance changes (e.g., hair loss)	27.0% (527)
Pain in upper body	26.9% (525)
Relationship changes	22.8% (446)
Fear	21.4% (418)
Loss of identity	17.0% (332)
Anger	16.3% (319)
Lymphodema	16.3% (318)
Guilt	12.6% (246)
Feelings of shame	10.2% (200)
Other[a]	36.9% (722)
Erectile difficulties (for men with breast cancer)	100.0% (5)

[a] Each less than 10 percent—increased sensitivity (9.9%, *n* = 193); thrush (8.4%, *n* = 164); vaginal discharge (8.0%, n = 157); irregular menstruation (6.1%, *n* = 120); weight loss (3.9%, *n* = 76); more energy (0.6%, *n* = 12).

by 61 percent of the 1,598 respondents, was talking to partner/husband, followed by lubricant (57%), exercise (45%), reading information booklets/leaflets (31%), talking to a health professional (26%), antidepressants (20%), psychotherapy/counseling (16%), sex aids (14%), medications (11%), and books (11%).

The majority of the 1,999 respondents reported that breast cancer had affected their sexual relationship, with 24 percent saying it was affected *dramatically,* 26 percent *considerably,* 32 percent *somewhat,* and only 15 percent *not at all.* Of the 1,348 participants who answered a question asking whether their partner had experienced any negative consequences as a result of their breast cancer, the most common reports were: fear of hurting me during sex (52%), lack of interest in sex (37%), difficulties in communication (34%), tiredness (28%), and change in role (seeing me as a patient; 20%). The pattern of these proportions in all the above items did not differ according to age, relationship status, sexual orientation, or current stage of cancer treatment.

More than 400 participants (n = 413) responded to an item inquiring into the influence of cancer on their ability to enter into a new relationship, with 57 percent indicating that it had an impact. The most frequently identified issues were related to feelings around appearance and the perceptions of others with *body image/attractiveness concerns* noted by 77 percent of the subsample, followed by *lack of confidence* (67%), *not feeling desirable* (65%), and *fear of rejection* (47%). Of these concerns, *not feeling desirable* and *fear of rejection* were more commonly reported by women seeking new heterosexual relationships (64% and 46%, respectively) compared to women seeking a new same-sex relationship (14% and 0%, respectively). The most common physical effects reported were *fatigue* (47%), *vaginal dryness* (43%), and *upper body or other pain* (23%).

The Subjective Experience of Changes to Sexual Well-Being after Breast Cancer

All 1,259 participants were women who provided answers to an open-ended question asking about subjective experience of changes to sexual well-being after breast cancer. The most common responses were related to (1) negative emotional consequences, (2) physical changes, (3) feeling unattractive or lacking femininity, (4) reconciliation of self to changes, (5) concerns about impact on partner or relationship, (6) and partner support and relationship improvement.

Negative Emotional Consequences: Devastation, Depression, and Sadness

More than a third of the participants (n = 439) described negative emotional consequences of changes to sexual well-being post–breast cancer.

The most commonly reported feelings were *devastating* and *depressing,* with other descriptors including *confusing, disturbing, soul destroying, shocking and unexpected, frustrating, traumatic,* and *demoralizing.* For the majority of women, these feelings were associated with a loss of interest in sex, or not experiencing pleasure during sex, as is illustrated by the following accounts: "I find that I have no desire for sex. When I have sex I find that it was not enjoyable which then made me feel guilty" (47-year-old woman, locally advanced breast cancer, 2 years post-diagnosis); "Very upsetting. I love my husband very much and our relationship is very good. My physical body does not arouse or respond like it used to" (51-year-old woman, early breast cancer, 3 years post-diagnosis); "It's very upsetting but I have no interest in sex at all, couldn't care if I never have sex again!!!" (49-year-old woman, early breast cancer, 2 years post-diagnosis).

A significant proportion of women reported sadness and loss as a result of sexual changes, with one saying: "I feel a sense of loss, as if part of me has died," and another saying "I felt like my heart had been ripped out. Very empty." Many women also told us that they "miss the sexual aspect of my life":

> I feel as if an integral part of my life is no longer well within my reach. Although I am getting older and therefore might be expected to lose interest in sex to a certain degree, sex has been an important component of my life until I started receiving treatment for breast cancer. I worry about my loss of interest in sex and I miss the sexual aspect of my life. (65-year-old woman, early breast cancer, 3 years post-diagnosis)

A substantial number of women told us that they experienced feelings of loss because of the changes in their relationship with their partner, feeling that a door was being closed, and that they could not always discuss it: "Sad as I love my husband dearly, but this has changed our intimate relationship" (46-year-old woman, early breast cancer, 5 years post-diagnosis). The "totally unexpected" nature of changes to sexual well-being were also a source of distress for many participants, who told us that they had been given no information about what to expect: "Terrible! I am young and had not expected the side effects sexually that come from menopause and treatments. . . . very sad" (26-year-old woman, early breast cancer, 3 years post-diagnosis); "Devastating. A complete shock, no one tells you that it ruins your sex life" (61-year-old woman, secondary breast cancer, 3 years post-diagnosis); "It was totally unexpected as nobody seemed to mention sexual dysfunction as a result of treatment. It made me feel that I had lost something very precious. I just wanted to be normal again" (56-year-old woman, early breast cancer, 3 years post-diagnosis).

Physical Changes to Sexual Well-Being: Painful Sex and Absence of Desire

Approximately one quarter of respondents (n = 249) described the changes to sexual well-being after breast cancer in terms of physical changes, including vaginal dryness; absence of sexual desire, arousal or orgasm; and absence of breast sensitivity or breast tenderness: "Enjoy the sexual experience but very conscious of my breast and the fact they have no feeling. Weight put on the breast can be painful" (48-year-old woman, early breast cancer, 2 years post-diagnosis); "Main problem is lack of interest and vaginal dryness. Husband VERY supportive but doesn't initiate sex as often because he doesn't want to be pushy as he knows I just can't be bothered a lot of the time" (50-year-old woman, early breast cancer, 3 years post-diagnosis); "Due to not having an oestrogen my vagina has basically closed up shrunk in other words. . . . I have a prolapse as well which doesn't help" (55-year-old woman, locally advanced breast cancer, 3 years post-diagnosis).

Vaginal dryness or vaginal prolapse can lead to painful coital sex. This was an experience commonly reported by women, which can sometimes lead to avoidance of sex: "Sexual intercourse is very painful. We can get pleasure from mutual masturbation but penetration for me is very, very painful. It is almost like my husband is wearing a condom with cut glass attached to it" (65-year-old woman, early breast cancer, 6 years post-diagnosis); "I do not lubricate, the skin external and internal to the vagina is very delicate tearing easily. So sex is now painful for me regardless of the type of lubricants we use" (31-year-old woman, locally advanced breast cancer, 3 years post-diagnosis). A number of women gave accounts of dealing with these physical changes by renegotiating coital sexual activity after breast cancer, primarily through the use of lubricants. In some instances, this was positioned positively as an effective solution. "Breast cancer diagnosed Oct 2008. Met new partner (widower) Jan 09 and commenced sexual relationship Feb 09. No probs except dryness due to Arimidex (use lubricant)" (67-year-old woman, early breast cancer, 3 years post-diagnosis).

In other instances, lubrication was described as messy and as interrupting the spontaneity of sex: "The only way to have sex is with lubrication which is messy and I find it extremely frustrating and annoying for not only me but for my husband as the first thing I reach for is my bottle of lubricant" (38-year-old woman, early breast cancer, 9 years post-diagnosis). Masturbation was also described as a solution, with one 75-year-old woman with locally advanced breast cancer, 1-year post-diagnosis telling us: "As a still attractive older woman no sexual partner means masturbation an option on occasion." These accounts of renegotiation were in the minority, however, with the majority of women reporting that they had ceased sexual activity or endured uncomfortable or painful sex to please

their partner. As one woman commented: "There is physical and emotional pain involved in having sex—I worry that I only doing it to keep him happy, not at all for myself."

Women also reported that the physical consequences of cancer or cancer treatment, including tiredness, nausea, feeling sore or uncomfortable, as well as weight gain, had an impact on their sexual well-being: "Forced menopause and feeling overweight impact on feeling 'sexy', and less desirable" (48-year-old woman, early breast cancer, 3 years post-diagnosis); "Sex is the last thing on your mind when your chest hurts, you lose all your hair, you are tired and feel very unattractive—you just want to survive and get through" (35-year-old woman, secondary breast cancer, 2 years post-diagnosis).

In contrast, a very small number of women reported increased sexual pleasure or desire, increased libido, or reported that sex was a way of feeling real and alive during treatment: "I went from not feeling a desirable woman, to feeling the more sexually interested and excited I have ever been" (50-year-old woman, early breast cancer, 2 years post-diagnosis); "I am shocked that my libido has increased" (35-year-old woman, early breast cancer, 2 years post-diagnosis). These cases may be in the minority, but they suggest that detrimental effects of breast cancer on sexual well-being cannot be assumed to be the case for all women.

Feeling Unattractive and Lacking in Femininity: I Am Not Really a Woman Anymore

Approximately one-fifth of the respondents (n = 212) reported feeling unattractive or lacking in femininity after breast cancer, and as a consequence, told us that they felt that this had an impact on their sexual well-being. Thus, women described themselves as being distressed because of "negative feelings about my body," or because "I don't feel attractive at all anymore."

> When first diagnosed, I was alone so sex not important, now it is naturally more important, and having no breasts now sometimes makes me feel less feminine considering my fiancé was always a "boob" man. (41-year-old woman, early breast cancer, 6 years post-diagnosis)

Other women provided more pejorative comments about themselves, feeling *old and ugly, maimed, grotesque, mutilated, a freak, damaged goods, like an old has-been, undesirable, deformed,* feelings that were associated with breast scars, reconstruction, hair loss, and weight gain: "I feel my body is not my own. I do not like my 'fake' breasts. I feel old now and ugly" (55-year-old woman, early breast cancer, 3 years post-diagnosis); "I hate to look at myself. I can't look in the mirror. I can't even touch myself to see if the lump is still there. I can't stand to be looked at or touched. A hug is

all I can bear" (48-year-old woman, locally advanced breast cancer, 1-year post-diagnosis). These feelings led many women to hide their bodies from their partner, saying: "I don't want my husband to see or touch my breast," or "I don't feel like exposing my breast and have partner touching it and seeing it." Many women also reported feeling "like I was a different person," "my femininity was ripped off overnight," "not really a woman," "less womanly," "less of a person," or "an inadequate partner":

> Horrible!! I'm 28 and have been married for 9 months and have had sex probably 4 times in that time . . . I used to enjoy it very much and now have no physical pleasure from it and barely ever do it. This has impacted on my identity as a woman and as a wife, has made me consider my partner having an affair because I am not able to satisfy him sexually. (29-year-old woman, early breast cancer, 1-year post-diagnosis)

In some instances, this feeling was associated with partner rejection, which confirmed the woman's fears, as is illustrated in the following accounts: "Husband avoided my reconstructed breast, which made me feel it wasn't a 'normal' thing" (58-year-old woman, early breast cancer, 2 years post-diagnosis); "Devastating, don't feel like a whole person anymore, partner won't look at chest anymore so sex is just not worth it" (48-year-old woman, early breast cancer, 2 years post-diagnosis); "He says I have 'mutilated my body.' It isn't a pretty sight, and I don't like it either, but I'm stuck with it" (48-year-old woman, locally advanced breast cancer, 2 years post-diagnosis). In contrast, other women described partner support as alleviating their fears about being unattractive or deformed, or of their partner helping to address their lack of confidence in body image: "Took time for me to accept myself as I am. My partner, to his credit, loves me how I am." (53-year-old woman, early breast cancer, diagnosed 1996).

> Initially, I felt that I was unattractive, even deformed. I worried that my husband wouldn't love my body as before. He tells me over and over that he loves me even more now so . . . I have to get over it and just believe him. (60-year-old woman, early breast cancer, 1-year post-diagnosis)

However, partner support or acceptance did not always alleviate women's negative feelings about their body or femininity, as illustrated in the following accounts: "I know it is me and not my husband as he has been wonderful telling me constantly that in his eyes I am still the same to him. But I feel ugly with these scars" (68-year-old woman, locally advanced breast cancer, 2 years post-diagnosis); "Although my husband says he has no problem with my body as it now. . . . I have a problem with it! . . . I

just can't get passed [*sic*] this feeling. This affects our intimacy greatly!" (47-year-old woman, early breast cancer, 2 years post-diagnosis).

No Change or Reconciling Self to Changes in Sexual Well-Being: It Really Hasn't Worried Me

Approximately one-tenth of the participants ($n = 123$) described having experienced no change in sexual well-being or having reconciled themselves to such changes since the diagnosis of breast cancer: "No change after breast cancer diagnosis"; "It really hasn't worried me all that much"; "It has not really changed me. I feel the same"; "Not very important for me"; "This is something we have both come to terms with and manage accordingly"; "I was too tired to care." Others positioned changes in sexual well-being as temporary and looked forward to improvements in the future: "I hope I will 'get back to normal' after I finish treatment. I feel the need to conserve my energy for healing at this time" (40-year-old woman, early breast cancer, 1-year post-diagnosis).

At the same time, for a small number of participants, the cessation of sexual activity was welcomed: "Now I have a reason to say no"; "In some ways a relief"; "Being over 70 and never very partial to sex it was fine"; "Couldn't care less whether I had sex ever again." For other women, sex was positioned as unimportant or as less important than other aspects of health since the diagnosis of breast cancer, which meant that changes to sexual well-being were accepted: "Other things seem more important and my partner has been so caring that sex seems quite unimportant"; "Find I am focused on how my health is rather than sex"; "Too many other things to worry about because of the absolute shock of the diagnosis and the treatment process." A few women commented that sex had never been important: "Sex was never an issue with us and haven't done so for about over 20 years prior to diagnosis and we are very happy"; "After so many years of marriage we have become very good friends, so sex is not that important"; "Did not have sex before and not having it now"; "The need for sex was no longer part of my life."

Concerns about Impact on Partner or Relationship: Letting My Partner Down

For approximately one-fifth of the sample ($n = 190$), the impact of changes in sexual well-being for their partner was their major concern. Thus, a 52-year-old woman with locally advanced breast cancer, 3 years post-diagnosis, told us: "It made me feel as though I was neglecting my husband but I just don't feel the same about sex as I use to." Other women described their concern as "Letting my partner down"; "I know he would like more from me"; "I feel he is missing out"; or "I feel terrible about this and the impact it has on my partner."

> I'd say I've had less than 5 orgasms in 12 months and I am not even bothered which is not how I use to be. I worry about how my partner must feel as I struggle to appear interested when we have sex. We are close but I know he would like more from me. (34-year-old woman, early breast cancer, 1-year post-diagnosis)

Approximately 10 percent of respondents (*n* = 126) told us that their relationship had experienced difficulty or broken down as a result of changes to their sexual well-being after breast cancer. Comments included: "It was all very difficult, and placed a big strain on my relationship"; "My husband had affairs behind my back . . . our marriage is all but finished although we are still together"; "Devastating and almost ended my marriage"; "Ex-husband made me feel like a leper"; "The diagnosis brought about the end of my marriage"; "I did not realize the impact on my marriage until it was too late"; "My husband did not react well and subsequently left." A number of women also told us that existing relationship difficulties had been exacerbated by the occurrence of breast cancer: "He does not seem interested anymore in sex at all. It had been a bit of a problem previous to my diagnosis and has got much worse since"; "My diagnosis just exacerbated problems that already existed in my marriage. A noncommunicative relationship just got worse."

The majority of respondents attributed these relationship changes or breakdown to their own disinterest in sex: "I went from a high libido to no libido or interest at all, my husband replaced me in less than 2 months"; "It is very frustrating for my partner, my interest in sex has declined, therefore creating tension in the marriage"; "Prediagnosis sex was fun but now I have no desire. My relationship with husband is strained and stressed. He still wants sex but I am not aroused." For other women, these relationship changes were attributed to their partner becoming their "carer," "brother," or "housemate," and thus no longer their lover: "I feel the relationship with my husband has become like housemates rather than husband and wife"; "My partner is now my carer—and I think it is this fact which has altered our sexual relationship." Difficulties in communication were also described as causing relationship tension: "Devastating, had good relationship before, very loving, as soon as I had the first operation he didn't communicate at all"; "Very hard to come to terms with since my partner isn't good at communicating and in denial about my health issues"; "Devastating, communication became very strained for the first time in our relationship."

Partner Support and Relationship Improvement: We're Closer Now

A small proportion of women, approximately one-tenth, described feeling closer or experiencing greater intimacy with their partner since the

diagnosis of breast cancer: "Whilst the act of sex has decreased the intimacy between us has increased in other ways"; "Our relationship has moved to another level of loving without sex"; "I actually feel more secure in my relationship post-diagnosis"; "The BC experience has brought us together and improved intimacy considerably"; "We stopped taking our sex life for granted and made an effort to maintain intimacy and our sex life."

Breast cancer was also described as offering an opportunity to renegotiate intimacy in order to meet a woman's needs, often addressing needs that had been there prior to breast cancer. One woman described this as "freedom" from sex, whilst another described increased "communication, flirtiness and warmth" which resulted in a richer relationship with her husband, with whom she had developed "a deep unspoken bond that is much richer than the earlier sexual moments." Better communication since diagnosis was also reported by a number of women participants: "Much closer to partner and more open"; "We communicate our needs much better than before my diagnosis"; "I found that we communicated better regarding issues during treatment and since." Having a supportive partner who accepted the changes the woman was experiencing and who exerted "no pressure" for sex or was "willing to wait until I'm willing" was also described as a "the most important thing" by a number of women:

> At diagnosis we were both so devastated and I felt that I would never be able to have sex again but as time goes on and acceptance happens our sex life has improved thanks mainly to my partner's attitude that he loves me and does not find anything different about me. (65-year-old woman, early breast cancer, 1-year post-diagnosis)

Having a secure relationship before breast cancer was described as important for a number of women, allowing the couple to cope with changes in sexual desire or activity: "We are very secure in our relationship and agreed that intercourse was not high on the list of needs. Support, sharing conversations and just being together was more important" (54-year-old woman, early breast cancer, 2 years post-diagnosis). Equally, a number of women described new relationships developing since diagnosis and treatment for breast cancer, sometimes after a previous relationship had ended post-cancer: "I have found a very considerate amazing beautiful partner. I also still feel sexy and whole and goddess like"; "Marriage breakdown prior to diagnosis—no sexual relationship for six months or more—new relationship after treatment finished."

> When I was first diagnosed, I went through a terrible time of feeling undesirable, fearing disfigurement and seeking affirmation. I felt very needy. I sought reassurance and was firmly rejected. Although upsetting at the time, this was paradoxically helpful in forcing me to

> face up to my future independently and take ownership of what was happening to me. The effect of the surgery was much less disfiguring than I'd feared, and my confidence has returned. I've since had an affirming sexual relationship. (62-year-old woman, early breast cancer, 1-year post-diagnosis)

These accounts suggest that relationship difficulty or breakdown does not mean the end of sexual relationships for women with breast cancer, as new relationships can develop and can be rewarding, both emotionally and sexually.

CONCLUSION

The findings presented in this study of Australian women support and extend previous research, which reports significant changes in sexual well-being after diagnosis and treatment for breast cancer. In a previous survey of 863 women that examined self-reported changes to sexual functioning after breast cancer, it was found that one-third reported that cancer had a negative impact on their sexuality (Meyerowitz et al., 1999). In this study, the largest study of sexual well-being in the context of breast cancer published to date (see Gilbert et al., 2010a), the proportion was far greater, suggesting that one-third may be a significant underestimate. Decreases in frequency of sex, sexual arousal, interest and desire, as well as in sexual pleasure, satisfaction, and intimacy, were attributed to a range of factors, including tiredness and pain, psychological distress and body image, and medically induced menopausal changes, such as vaginal dryness, hot flushes, and weight gain. However, accounts of material changes to the body and relationships, as well as intrapsychic consequences, cannot be separated from discursive constructions of illness, femininity, and (hetero)sexuality, which give meaning to the experience of sexual well-being after breast cancer: a material-discursive-intrapsychic interaction (Ussher, 2005). For example, the focus on vaginal dryness experienced by women with breast cancer as a major cause of sexual difficulty, and the paucity of accounts of renegotiating sexual activity when coital sex was painful or difficult, illustrates the dominance of the coital imperative in the construction and experience of heterosexuality (Gavey et al., 1999). Challenging the coital imperative through the exploration of noncoital sexual practices should thus be central to professional advice and support for individuals with breast cancer.

Whilst some individuals experience the changes to their sexuality after breast cancer positively (Archibald et al., 2006; Ganz et al., 1998; Langellier & Sullivan, 1998), the majority of evidence shows that people with breast cancer experience a range of serious negative emotional changes as a result of disturbances to their sexuality, confirmed and elaborated on by the findings of this study. Having to adjust to the removal of their

breast or to the alteration in appearance of the breast, loss of body hair, feeling old before their time (Wilmoth, 2001), concern about weight gain or loss, and a partner's greater difficulty understanding one's feelings (Fobair et al., 2006) can exacerbate these negative emotional changes, as was found in this study. As Archibald and colleagues (2006) showed in their interview study with 30 women with breast cancer, 62 percent of those who reported experiencing negative changes to their sexual well-being also reported that the changes had an adverse impact on them emotionally. These women were worried about what was causing sexual changes, how long the changes would last, the extent to which the changes would impact on their intimate relationship, how they could cope with the sexual changes, as well as feeling that their sexual pleasure or functioning was no longer under their control, and guilt over how the sexual changes would affect their relationship with their partner. The findings of this study confirm these reports in a larger sample of individuals with breast cancer and provide further insight into the nature of these effects.

Partners play a key role in women's experiences of the changed body after breast cancer, illustrating the intersubjective nature of the construction and experience of sexuality in the context of breast cancer—the importance of relationship context and partner reaction, as well as the complexity of the woman's own response. Whilst partner rejection was consistently associated with women's feelings of negativity about the body or femininity, partner support did not always alleviate these negative feelings. The way the woman felt about herself and her ability to accept the changes to her body also impacted on the way she positioned her body after breast cancer, allowing her to still feel like a sexual woman, or conversely, to feel "neutered," as one participant described herself. At the same time, accounts of relationship change after breast cancer confirm previous research reports that the diagnosis of cancer can change the relational dynamics between people with cancer and their life partners, which can have an impact on their ability to cope (Ussher, Wong, & Perz, 2011). It has been reported that partners of people with cancer assume new roles in the household (Ben-Zur, Gilbar, & Lev, 2001), in addition to providing physical and emotional support, which can have an impact on the sexual relationship (Gilbert et al., 2009). Couples living with cancer have also reported communication problems (Zahlis & Shandis, 1991) or increased conflict (Badr & Carmack Taylor, 2006), and in some instances have attributed relationship breakdown to cancer (Kornblith, Anderson, & Cella, 1990), as was found in this study. Conversely, it has been argued that couples living with cancer are no more likely to separate than couples in the general community (Schover, 2004), and that cancer could have had a positive effect on couple relationships (Badr & Carmack Taylor, 2006), bringing people with cancer and their partners closer together (Dorval et al., 2005) through creating greater intimacy (Manne et al., 2004). These

conflicting findings have led Hagedoorn, Sanderman, Bolks, Tuinstra, and Coyne (2008) to conclude that, in their meta-analysis of distress in couples coping with cancer, further research is needed on "just how much cancer intrudes upon and organizes the daily lives of couples confronted with the disease" (p. 24). The findings of this study make a substantial contribution to addressing this plea, through exploring both negative and positive accounts of the impact of cancer on sexual relationships.

Whilst the experiences of partners are often neglected in research on sexuality and intimacy post-cancer (Reichers, 2004), there is growing acknowledgement of their unmet needs in this area (De Groot et al., 2005). Reported disruptions include decreases in their own sex drive; fear of initiating sex with their partner; difficulty regaining a level of "normality" within the sexual relationship; and feeling unwanted and unattractive because of cessation of sex (Harden et al., 2002; Hawkins et al., 2009a; Sanders, Pedro, Bantum, & Galbraith, 2006). Many of these findings have been confirmed and extended by the findings of this study, which reported on partner experiences from the perspective of the person with breast cancer. This reinforces the need to include partners, as well as people with cancer, in future research in cancer and sexuality. At the same time, the accounts of individuals who are not in a relationship highlights the importance of sexual well-being for those with breast cancer who are currently single and the need for support, if requested, to alleviate fears or concerns about entering a new relationship. Sexuality is not only a relational issue; changes in sexual well-being and in sexual desire and arousal can also have an impact on those who are not in a relationship.

The research reviewed in this chapter and the findings outlined in this study are of significance to clinicians, as sexual well-being is central to psychological well-being and quality of life (World Health Organization, 1995), and sexual intimacy has been found to make the experience of cancer more manageable and assist in the recovery process (Schultz & Van de Wiel, 2003). Health professionals can play an important role in ameliorating concerns surrounding sexual well-being after breast cancer (Can et al., 2008), offering specific suggestions related to sexual enhancement products (Herbenick, Reece, Hollub, Satinsky, & Dodge, 2008), emotional adjustment to sexual changes (Archibald et al., 2006), as well as information for partners (Gilbert et al., 2009). However, the finding that only 25 percent of participants in this study had discussed sexual well-being with a health professional, despite the high levels of distress reported, is a matter of concern. This appears to confirm previous findings that few health professionals engage in discussions of sexual well-being with people with cancer, even in areas where it might be expected, such as breast cancer (Hawkins et al., 2009b; Hordern & Street, 2007). Further education and training of health professionals is also required, in order that they will

be able to advise couples affected by breast cancer on issues of sexual well-being and address unmet needs in this arena.

In conclusion, the analysis in this chapter has demonstrated that there is compelling evidence that breast cancer can have a significant impact on a woman's sexuality, both physically and psychologically, influenced by the discursive construction of "normal" sexuality and femininity, as well as a woman's relationship context. Whilst each of these areas has been considered separately, reflecting the existing research in this field, it is important to acknowledge that they are irrevocably connected. The physical body cannot be conceptualized independently from women's intrapsychic negotiation, her relational context, and the discursive constructions of sexuality and femininity in a particular sociocultural context: a material-discursive-intrapsychic interaction.

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NOTE

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Chapter 10

HIV/AIDS and Women's Sexuality

Donna Castañeda and Duvia Lara Ledesma

I (Donna Castañeda) began working on HIV/AIDS issues in the early 1990s, and from that time I recall conversations with my highly educated male colleagues in which I was informed, with quite a tone of authority on such matters, that vaginal sex was not as risky as anal sex, because the vagina was "made" for intercourse while the anal tract was not. My colleagues could make such assertions because from the beginning of the HIV/AIDS epidemic the virus was so strongly linked to gay men and, somewhat later, to injection drug use that heterosexual transmission of the virus, and therefore, women's vulnerability to it, was neglected (see Higgins, Hoffman, & Dworkin, 2010). This contributed to women's virtual invisibility in the epidemic from the start; thus, even those involved in HIV/AIDS research had difficulty imagining women as being at risk for infection. Up to that point, the number of women with the disease was still small relative to men, and the presence of women in the overall thinking about HIV/AIDS continued to be minimal and one dimensional. Women were viewed primarily as vectors of the disease, transmitting it to unsuspecting others, such as their newborn babies and those with whom they had sexual contact. As the focus

on heterosexual transmission grew, women began to be added on to discussions about HIV/AIDS and were not as invisible as they had been in the first decade of the epidemic, but they were not central to the understanding of it (Amaro, 1995; Amaro, Raj, & Reed, 2001; Strebel, 1995; Welch, Cline, & McKenzie, 1996). Finally, in 1992, when the Centers for Disease Control and Prevention expanded its case definition of HIV infection to include symptoms associated with the virus in women, such as invasive cervical cancer (December, 1992), an immediate increase in the number of women diagnosed with HIV/AIDS, and therefore finally eligible for publicly funded treatment, occurred. Likewise, women's greater biological vulnerability to HIV infection became apparent (Amfar, 2011a; European Study Group on Heterosexual Transmission of HIV, 1992; Nicolosi et al., 1994; O'Brien et al., 1994), although researchers now realize that even biological vulnerabilities intersect with social, cultural, and political practices to influence women's risk for HIV infection (Chersich & Rees, 2008).

Today, the situation with respect to HIV/AIDS and women has shifted dramatically as the proportion of women with HIV/AIDS increased rapidly in the United States and globally over the last two decades. Now, women are considered pivotal to understanding and responding to HIV/AIDS, such that Michel Sidibé, executive director of the Joint United Nations Programme on HIV/AIDS (June, 2010) could say: "This epidemic unfortunately remains an epidemic of women." Along with this change has come greater recognition of the contextualized nature of women's vulnerability to HIV/AIDS (Higgins et al., 2010; Teti, Bowleg, & Lloyd, 2010) and the limitations of previous approaches that assigned greatest importance to individual behavior, attitudes, cognitions, and knowledge (Amaro, 1995; Amaro et al., 2001; Katz, 2002). An emphasis on contextual understandings from the interpersonal and relational context up to the larger political, economic, and cultural contexts that affect women's risk for HIV is helping to reshape and reframe approaches to understanding HIV prevention and care for women (Bredström, 2006; Castañeda, 2000; Larios et al., 2009; Susser, 2009).

Despite the increased centrality of women's experience with HIV/AIDS, and that, as the voluminous literature on HIV/AIDS attests, women's risk for HIV is played out to a large extent in their sexual lives, a greater understanding of women's sexuality itself has not occurred. The notion of women as sexual beings who experience desire, pleasure, and agency in their sexual lives or how women themselves view and define this dimension of their lives is startlingly minimal. This is the case with regard to all women and HIV discourse, whether referring to heterosexual, lesbian, bisexual, or trans women and sexuality (e.g., Bockting, Robinson, Forberg, & Scheltema, 2005; Melendez & Pinto, 2007). Furthermore, while women are now considered front and center in relation to the HIV/AIDS pandemic, how they are positioned within the overall social, cultural,

and political discourses surrounding HIV continues to be fraught with paradox and ambivalence about blame, guilt, needs, and their role in the overall pandemic (for a discussion see Gurevich, Mathieson, Bower, & Dhayanandhan, 2007). Add to this the silence, evasiveness, contradictions, and lack of information surrounding women's sexuality generally and its relatively low priority in HIV/AIDS research, and one can see that we are not yet well-positioned to advance understandings of women's sexuality concerns and experiences.

The purpose of this chapter is to describe the importance of considering more explicitly and seriously women's sexuality in HIV/AIDS. In this effort, We first examine the scope of HIV/AIDS among women worldwide and in the United States. We then provide a working definition of sexuality and distinguish it from the related, but conceptually distinct, terms of sexual health and reproductive health, as these concepts, while important and clearly intertwined with sexuality, at times actually obscure understandings of women's sexuality. We then review the research on sexuality, women, and HIV/AIDS. We go over more fully the contextual and intersectional approaches to understanding HIV/AIDS, sexuality, and women, and we end by explaining why understanding women's sexuality is essential to reducing women's risk for HIV.

THE GLOBAL SCOPE OF HIV/AIDS AND WOMEN

Since the beginning of the HIV pandemic in the early 1980s, more than 60 million people have contracted HIV and nearly 30 million have died of HIV-related causes (AmfAR, 2011b). In 2010, a total of 34 million persons worldwide were living with HIV, of which 16.8 million were women. An estimated 2.7 million persons were newly infected that year, and 1.8 million persons died from AIDS in 2010 alone (World Health Organization, n.d.). Nonetheless, the rate of new infections with HIV began to decline in the late 1990s and this decline is continuing. Although not all countries worldwide show this pattern, the majority of them do and the decline is especially noteworthy in some high prevalence countries, such as South Africa, Botswana, United Republic of Tanzania, Zambia, and Zimbabwe, which have shown significant declines in HIV prevalence among young women and men (Global Health Report, 2010). Likewise, the estimated mortality due to AIDS has declined overall, with declines in mortality beginning in the mid-1990s in North America and Central and Western Europe after introduction of antiretroviral therapy in these regions, followed by declines in sub-Saharan Africa and the Caribbean beginning in 2005 with the introduction of antiretroviral therapy. In other regions, such as Asia and Central and South America, mortality due to AIDS has stabilized, but not declined (Global Health Report, 2010).

Worldwide, at approximately 52 percent, a little more than half of all persons living with HIV are women and girls; in two regions, the

Caribbean and sub-Saharan Africa, women and girls outnumber men and boys in prevalence of those living with HIV. In fact, in the highest HIV prevalence region in the world, sub-Saharan Africa, women aged 15–24 are more likely to become infected with HIV than men, and women are as much as eight times more likely to be living with HIV than men in the same age group (Global Health Report, 2010). Furthermore, in 2009, HIV/AIDS was the leading cause of death and disease for women around the world (AmfAR, 2011a).

In North America, women account for 26 percent of persons living with HIV, while in Western and Central Europe they make up 29 percent of those living with HIV/AIDS. In the United States, specifically, women account for one in four new AIDS diagnoses and deaths (AmfAR, 2011a) and an estimated 290,000 women are living with HIV/AIDS in the United States (Centers for Disease Control and Prevention, 2011). The incidence of HIV among women has remained relatively stable since the early 1990s (HIV/AIDS Policy, 2011). Women of color remain most at risk for HIV infection—while African American women and Latinas make up 26 percent of all women in the United States, they account for 82 percent of AIDS cases among women (AmfAR, 2011a). In fact, in 2009, the estimated rate of new HIV infection for African American women was 15 times greater than among white women and the estimated rate of new HIV infection among Latinas was four and a half times the rate among white women (Centers for Disease Control and Prevention, 2011).

While the prevalence of HIV/AIDS among women and girls may vary across geographic regions, women share a common source of risk for HIV and that is heterosexual sex. The vast majority of women in the United States contracted the disease through heterosexual sex, similar to the situation of women around the world (Centers for Disease Control and Prevention, 2011).

DEFINITION OF WOMEN'S SEXUALITY

In a discussion about women's sexuality and HIV, a clarification of the term "women's sexuality" is helpful to make. While no universal definition of sexuality exists and how sexuality is defined, constructed, managed, and acted out by women varies historically and cross-culturally, an important premise in any understanding of women's sexuality is that it is very much embedded within and grows out of political struggles, gender relations, and cultural meanings surrounding femininity and legal and social definitions of human rights (see Castañeda & Ulibarri, 2010, for a discussion). Sexuality is a personal psychological, emotional, and physical experience, but how women learn about, understand, approach, and enact their sexuality cannot be separated from the larger sociocultural context of their lives. Sexuality has been primarily viewed as a natural and

immutable aspect of life, and the biomedical model, along with studies of specific sexual behaviors, has been the prevailing framework governing the study of women's sexuality (see Amaro, Navarro, Conron, & Raj, 2002, for a discussion). On the other hand, globalization, whether through economic, technological, or cultural processes, has led to exposure to and engagement with a much wider array of cultural constructions surrounding sexual and relational intimacy, thus highlighting the limitations of the standard sexuality frameworks (Obermeyer, 2000; Padilla, Hirsch, Muñoz-Laboy, Sember, & Parker, 2007; Parker et al., 2004). Influenced by these larger globalization processes, as well as feminist thinking and writing about women's sexuality generally in the last two decades (for reviews, see A New View of Women's Sexual Problems, 2004; Tavris, 2008; Tiefer, 2010; Tolman & McClelland, 2011), the definitions of sexuality have expanded to include not only behavioral and biological aspects, but also recognition of the multiplicity of factors that may influence sexuality (Promotion of Sexual Health: Recommendations for Action, 2000). This change can be seen in the working definition of sexuality developed by the Pan American Health Organization, World Health Organization, and World Association of Sexology that is useful to present here:

> Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors. (Promotion of Sexual Health: Recommendations for Action, 2000)

This definition does not overtly incorporate gender-related concerns, such as compared to men, the greater subordination of women and efforts at control of women's sexuality that are seen worldwide. It includes the suggestion of diversity in gender identity and sexual orientation, but it does not include the notion of compulsory heterosexuality (see Castañeda & Burns-Glover, 2005; Rich, 1983) that constrains women's sexual options, even in what are considered sexually liberal countries and societies. Nevertheless, the above definition represents a broadened perspective on sexuality that stems from greater global and cross-cultural engagement, not just by researchers, corporations, and government entities, but also by ordinary women as they traverse geographic, cultural, and political boundaries due to a myriad of reasons, such as economic necessity, family reasons, or political conflict and oppression. It also implies, at least indirectly,

the notion of an individual's *right* to positive sexuality—an important and progressive advance in the thinking about sexuality.

Another term that has emerged within the larger sexuality discourse, particularly in response to the HIV/AIDS pandemic, and that must be distinguished from sexuality, is sexual health. It is related to the concept of sexuality—in fact, for women sexuality and health always intersect in numerous direct and indirect ways—but cannot be conflated with or substituted for it. Sexual health for women refers not just to the absence of sexual dysfunction and sexual diseases, such as HIV/AIDS or other sexually transmitted diseases, nor does it refer narrowly to positive reproductive health, such as healthy pregnancy, childbirth, and contraceptive use. It includes these dimensions, but it also incorporates the notion of an overarching well-being experienced when a person has the ability to freely, responsibly, and safely express their sexual desires without the fear of coercion, discrimination, or violence (Promotion of Sexual Health: Recommendations for Action, 2000; Sexual Health-A New Focus for WHO, 2004). The sexual health concept is situated within the larger domain of public health, and as such a consequence and necessary component of the notion of sexual health is education services about sexuality, reproductive biology, fertility control, and protection against sexually transmitted diseases (e.g., Robinson, Bockting, Simon Rosser, Miner, & Coleman, 2002). Because of the growing understanding among social scientists, program planners, and international health advocates that gender inequality is at the heart of women's vulnerability to sexual health problems (Raimondo, 2005), such as their risk for HIV/AIDS and sexual victimization, these services must be provided in a manner that increases women's autonomy, freedom of choice, and supports and empowers them to confront hostile, oppressive, or demeaning gender arrangements and ideologies in their social and personal environments (Ruklos Hampton, McWatters, Jeffery, & Smith, 2006; Undie, Crichton, & Zulu, 2007).

In summary, women's sexuality is multifaceted and broadly defined, and necessarily refers to more than just individual biological functioning, reproductive health, or absence of sexually transmitted diseases. It includes the potential for sexual pleasure and the erotic, however that may be defined by individual women. Sexual health, a related concept, refers to the ability and opportunity to live out one's sexual and reproductive life in ways that ensure health and safety. As a concept, it is linked to provision of sexual education and sexual and reproductive health services for women.

WOMEN'S SEXUALITY AND HIV/AIDS

Research on HIV and women's sexuality indicates that after an HIV diagnosis, if a partner is available, women typically continue to engage in sexual

behavior. Although some women may opt for celibacy, whether out of choice or lack of a sexual partner, the majority continue their sexual life, at least to some extent (Bell, Richardson, Wall, & Goldmeier, 2006; Bova & Durante, 2003). Nonetheless, women's experience of sexuality often changes with a diagnosis of HIV infection. Women may be more likely than men to suffer from negative changes in their sexual lives (Kelly, Lohan, Alderdice, & Spence, 2011), but other research demonstrates that women show variability in how HIV influences their sexuality. For instance, a study by Denis and Hong (2003) that compared a sample of HIV-positive women to women who did not have HIV found that the women with HIV showed decreased sexual functioning across a range of sexual variables, including interest in sex, sexual activity, sexual satisfaction, sexual relationships, orgasm, sexual problems, and they scored significantly lower in the overall sexual functioning measure. Of these variables, lack of sexual interest and difficulty having orgasms stood out, with HIV-positive women scoring significantly lower in frequency, intensity, and ease of orgasm, and lower interest in and satisfaction with sexual function than women who were not HIV positive (Denis & Hong, 2003).

On the other hand, in their study of 101 HIV-positive women, Bova and Durante (2003) found that 90 percent of women in their sample reported continuing to be sexually active after their HIV diagnosis. The reported quality of sexuality for 52 percent of the participants remained the same or even improved. A combination of factors were related to better sexual functioning in this group, including less severe HIV-related symptoms, better mental health, a more positive meaning attributed to life with HIV, a better quality of life, and absence of injection drug use (Bova & Durante, 2003). Similarly, Rose, Peake, Ennis, Perira, and Antoni (2005) found that in a study of 21 women with both HIV and HPV (human papillomavirus) that mental health, in this case, depression, as well as intrusive thoughts, and reduced quality of sleep were associated with lower sexual quality of life, although further analyses found that depression mediated the relationship between intrusive thoughts and sexual quality of life. Unlike the Bova and Durante study, in this study somatic symptoms were not related to sexual quality of life (Rose et al., 2005)

Siegel, Schrimshaw, and Lekas (2006) investigated the role of treatment availability—whether women were living with HIV in the era before the availability of highly active antiretro-viral therapy (HAART) or were living with HIV in the era after HAART treatment became available—on sexual activity, sexual interest, and feelings of attractiveness. Siegel and colleagues (2006) found that women in both samples reported similar changes in their sexual lives; in other words, the introduction of HAART and the concomitant shift to viewing HIV as a chronic condition to be medically managed, rather than a life-threatening disease, did not appear to make a difference in how women's sexual lives were affected. Approximately one-third of

women in both groups reported one or more changes in their sexual lives, such as diminished pleasure in sex, a loss of interest in sex, and a diminished sense of sexual attractiveness to potential partners.

Florence and colleagues (2004) examined the prevalence and correlates of female sexual dysfunction among HIV-positive women in Europe and found that a quarter of the women in the study reported moderate-to-severe sexual dysfunction after diagnosis of HIV infection, and this decline was found among both those receiving and not receiving antiretroviral treatment, similar to the results found by Siegel and colleagues (2006). They also did not find that lypodystrophy (fat accumulation in the waist, neck, breasts/fat reduction in face, buttocks, or limbs), a possible side effect of antiretroviral treatment, was related to reported sexual dysfunction. On the other hand, Florence and colleagues (2004) found that psychological distress, as defined by depression, irritability, and anxiety, was significantly related to sexual dysfunction in their sample. Florence and colleagues (2004) argue that for HIV-positive women psychological factors are more salient in the sexual dysfunction they may experience along with the diagnosis of HIV itself, rather than the effects of antiretroviral treatment.

Bell and colleagues (2006) reviewed clinical notes on a small sample of women seen at a dedicated women's HIV clinic (34 women), and results revealed that approximately half reported sexual problem or dissatisfaction with sex in the last 12 months. The two most common problems women reported were lack of sexual desire and lack of orgasm, although some women mentioned pelvic pain, fear of HIV transmission to a partner, and that an HIV diagnosis made one afraid to have sex. Although Bell and colleagues (2006) acknowledge the potential for organic causes of women's sexual problems, including the effects of antiretroviral treatment, they indicate that for their sample "there is the sense that their sexual problems reported are highly contextual rather than organic in nature" (p. 708). Interestingly, another aspect of this study was a survey of physicians at HIV clinic centers in the United Kingdom. Results showed that 61 percent rarely or never asked women HIV clients about their sexual functioning.

While HIV treatment and degree of disease symptomology have not been associated with problems in sexual functioning among HIV-positive women in some studies, other research has found that sexual dysfunction is related to HAART adherence, greater HIV-related symptoms, and worsening of viro-immunological parameters (e.g., Bova & Durante, 2003; Trotta et al., 2008). In fact, this is true for both women and men, and in addition, particular side effects of HAART are implicated in sexual dysfunction, with self-reported abnormal fat accumulation significantly related to moderate-to-severe self-reported sexual dysfunction among women and men (Trotta et al., 2008). Unlike other research, Trotta and colleagues did not find mental health status to be implicated in moderate-to-severe sexual dysfunction.

The research on HIV and women's sexuality has tended to focus on dysfunction, deficits, and decline across a range of sexuality-related dimensions, such as sexual behavior, interest, satisfaction, and so forth; but other studies have attempted to take a more in-depth, qualitative approach to determine the meanings behind the problems associated with sexuality among women who are HIV positive, as well as the strategies women use to develop and maintain sexual intimacy and satisfaction in their relationships. For example, Maticka-Tyndale, Adam, and Cohen (2002) interviewed 35 HIV-positive individuals who were also receiving combination antiretroviral therapy about their experience with sexual intimacy after an HIV diagnosis. Although only four of the participants were women, participant responses were identified by gender and women's individual responses could be examined. In this case, women (as did men) referred to an initial response to an HIV diagnosis of refraining from sex with a relationship partner due to fear of transmitting the virus, but as time went on, use of protected sex practices increased and the sexual relationship improved. Other themes expressed by single women were a concern about whether they would ever find a partner who would be accepting of their diagnosis, questions about how to navigate disclosure of their HIV status, and the fears and risks inherent in that situation if they did. This study emphasized that changes in sexual behavior and individual approaches to these changes varied across participants, but that sexual intimacy was an ongoing concern for individuals living with HIV.

Other qualitative research has revealed similar results in that women experience anxiety due to fear of infecting a partner, being reinfected themselves, or acquiring another type of sexually transmitted disease. Women even indicate that safe sex practices, such as use of condoms, are stressful due to fears of condoms breaking, coming off, or having small holes in them (Siegel et al., 2006). Women refer to sadness at the loss of spontaneity they experience in their sexual lives and how certain sexual activities, such as oral sex, must be foregone. As one woman expressed:

> It's hard, it's—a sexual relationship—is hard when so many precautions have to be taken . . . Hard in that you are missing out on things that other people have. You know, in regards to oral sex or sensations. Or they don't have to worry about fluids and other things. (Siegel et al., 2006, p. 443)

In a semi-structured interview study of sexuality issues among 20 Canadian women living with HIV, the themes that emerged, parallel to the findings from quantitative studies, indicated a decline in sexuality related to an HIV diagnosis (Gurevich et al., 2007). These themes include notions of diminished spontaneity, foreclosed (provisional) sexual freedom, foreclosed power (feeling diminished in relation to a partner due to HIV-positive

status), foreclosed flirtation, inciting violence (with disclosure to a sexual partner), (un)natural sex, responsibility imperatives, muted/mutated sexuality, and diminished intimacy. Gurevich and her colleagues demonstrate that, taken together, women's HIV and sexuality experiences reflect a discourse on self-regulation and self-disciplining, with a focus on responsibility for and protecting others, rather than on their own sexual needs. Such self-regulation/self-discipline limits women's possibilities for sexual and erotic exploration, desire, sexual playfulness, intimacy, and even their potential for power and equality in a sexual relationship. In addition, for women, disclosure and power differentials due to HIV status as well as other signifiers, such as gender, socioeconomic status, age, and so forth, have the potential to incite violence against them (Gurevich et al., 2007).

The study by Gurevich and her colleagues (2007) is important because it not only documents the complex and multiple burdens women must negotiate with respect to their sexuality and HIV, but it also goes beyond previous research in that it situates women's HIV and sexuality experience within a matrix of historical and current forces that simultaneously maintain these burdens. These forces include those that dominate the discourse on women and HIV, such as women as conduits or vectors of transmission of HIV; the relative neglect of research on women's sexuality, sexual health, and mental health concerns; and that women continue to have a standing within HIV/AIDS communities, at least in the west, that is "precarious and paradoxical" (Gurevich et al., 2007, pp. 13), particularly with respect to their sexuality. As one woman in the Gurevich and colleagues study expresses this:

> It is quite remarkable how the men, by and large here [AIDS Committee of Toronto], are out, you know, out there fucking a lot, and the women in here are straight women, some lesbians, but most of the straight women who work here are women who don't have a very vibrant, out there, active sex life or sexuality . . . I see a lot of very ghostly, straight women around here. (p. 13)

THE RELATIONSHIP CONTEXT, SEXUALITY, AND HIV

Women's ongoing relationships present a special arena of concern and difficulty with regard to sexuality and HIV that is worth noting separately. Close relationships can provide emotional support and attachment, safety and security, companionship, a social and community identity, and at least the potential for economic security. In fact, relationships can have a powerful effect on how women living with HIV see themselves and can provide the sustenance to transcend an illness identity and thrive as a person. As one woman expresses it:

> But [partner] gives me so much confidence. It is amazing how he makes me feel. I feel 90% of the way I feel today is because of [partner]. Because I know, you have moments and you are looking at yourself and you think "oh my god, I am dirty, I am sick. I can infect somebody." You know what I mean. . . . And [partner] healed all those fears, completely, because the way he is being. (HIV-positive woman; Kelly et al., 2011, p. 821)

But HIV-positive women in ongoing relationships, particularly with men, are often confronted with the need to renegotiate many elements of the relationship, including sexual intimacy, particularly if they are in a serodiscordant relationship. They must contend with the stigma still associated in much of the world with a positive HIV diagnosis and that stigma can intrude in the relationship, thereby limiting sexual communication and comfort. Likewise, one or both partners may potentially experience alienation due to differing serostatus which can contribute to sexual adjustments difficulties (van der Straten, Vernon, Knight, Gomez, & Padian, 1998). Interestingly, often seronegative partners in a relationship are the ones that have to push for greater sexual activity and are willing to take more sexual risks, as desire for sexuality on the part of the HIV partner often diminishes (van der Straten et al., 1998).

Another concern that emerges in heterosexual relationships, where one or both partners are HIV positive, is that couples may feel the desire to have children. This is especially the case with the advent of antiretroviral therapies, the concomitant lengthening of lifespan, and the reconceptualization of living with HIV as similar to living with a chronic illness that can be managed. Furthermore, recent research demonstrates that viral load suppression of HIV-positive persons can lead to a much reduced risk for sexual transmission of the virus (Anglemyer, Rutherford, Baggaley, Egger, & Siegfried, 2011) and mother-to-child transmission of HIV is also much reduced with the combined use of ART (antiretroviral therapy), Cesarean section before labor begins or rupture of membranes, and complete avoidance of breast feeding (Sturt, Dokubo, & Sint, 2010). Where these interventions are available, the risk for mother-to-child transmission is as low as one to two percent (Sturt et al., 2010). Couples may feel that having children, unlike in the earlier HIV era, is now an option and the desire to have children may influence sexual behavior in these relationships (Venkatesh, 2011).

Another key concern in relationships is transmission of the virus to the partner or reinfection of the self or partner. However, research demonstrates that in relationships where one or both partners is HIV positive, individuals experience and act out their sexual lives based on a complex and intersecting set of meanings and decisions that are personally relevant to them. These include balancing biomedical information about risk, viral

load, and transmission with concern for protecting the partner; personal and interpersonal sexual desire and pleasure; desire to please a partner; attitudes toward condom use in committed relationships; desires to conceive a child; a desire to return to heteronormalcy among heterosexual couples, and an overall concern for sustaining the relationship (Kelly et al., 2011). Along with these assessments, women in relationships with men must often grapple with implicit gender role expectations and power differentials that place them at a disadvantage in attempts to redefine sexuality in the relationship. In relationships, women's options surrounding sexuality may be constrained by economic need, fear of violence from a partner, concern for children who may be present, social and cultural expectations of women to be caretakers in the family, obligations to submit to a partner's sexual desires, as well as their love of and desire to stay with a partner (Chersich & Rees, 2008; D'Cruz, 2012; Pulerwitz, Amaro, De Jong, Gormaker, & Rudd, 2002). In other words, sexuality for women in relationships where one or both partners is HIV positive represents more than simply calculating risk—it involves balancing multiple relational dimensions that may or may not be related to risk for HIV.

Because sexuality for couples where one or both partners is HIV positive necessarily implicates relationship elements, such as intimacy, commitment, communication styles, power imbalances, desire for children, and gender roles and inequalities, interventions to reduce risk for HIV transmission tend to be more effective if they contain a couple, compared to individual only, focus (Burton, Darbes, & Operario, 2010; Operario, Nemoto, Iwamoto, & Moore, 2011). An important concern is to develop interventions that are sensitive to the varying cultural and economic contexts in which HIV-positive women live, norms and attitudes surrounding extra-relationship sexual partners, women's role as the caretakers in the family, and overall couple functioning. Couple-focused interventions for women in differing societies, cultures, or countries who are living with a partner in either an HIV discordant or concordant relationship may take a much different form due to the differing institutional, medical, and family support options available to them (e.g., D'Cruz, 2005; Gupta, 2000).

UNDERSTANDING WOMEN'S SEXUALITY TO REDUCE HIV/AIDS AMONG WOMEN

Unlike today, when a great deal of HIV/AIDS research is done across multiple cultures and in differing regions of the world, early on much of the HIV/AIDS-related research was done in the west, where individual-level variables, such as cognitions, attitudes, intentions, and so on, were considered key to understanding and changing risk behaviors, and thereby reducing the spread of HIV (see Amaro et al., 2001; Gupta, 2000; Katz, 2002; Logan, Cole, & Leukefeld, 2002). These approaches presumed

that choices and decisions about behavior were equally available to all individuals regardless of factors such as gender, social class, ethnic or cultural group, sexual orientation, or sexual identity. Likewise, the discourse on HIV/AIDS, women, and sexuality has been embedded in the language of biology, medicine, and epidemiology (see Amaro et al., 2001). Recognition that women's risk for HIV was linked to a much larger set of variables, many of which exist at the interpersonal, social, and cultural levels, in other words, the intersectionality of women's risk for HIV, only gradually emerged. Currently, however, a much clearer understanding exists that multiple factors influence women's risk for HIV through their sexual lives, and that these factors are not distributed across or experienced similarly or equally by women and men. One of the most critical of these elements in understanding women's sexuality and its relationship to HIV is the notion of power. As Gupta (2000) articulately expresses this idea:

> we talk about the components of sexuality as the Ps of sexuality—practices, partners, pleasure/pressure/pain, and procreation. The first two refer to aspects of behavior—how one has sex and with whom; while the others refers to the underlying motives. But we have learned . . . there is an additional P of sexuality and this is the most important—power. (p. 2)

Gupta (2000) goes on to state that power is inherent in any sexual interaction and determines how all the other Ps of sexuality are expressed and experienced, which partner's sexual pleasure is the prioritized, as well as when, how, and with whom sex will occur.

Along with this increased understanding of the contextual and intersectional nature of women's risk for HIV has been a concomitant growth in the last 15–20 years in the understanding of and approach to the study of women's sexuality. Whereas sexuality has been primarily viewed as a natural and immutable aspect of life and the biomedical model, along with studies of specific sexual behaviors, has been the prevailing framework governing the study of women's sexuality (see Amaro et al., 2002, for a discussion), a fuller understanding of the social and cultural embeddedness of sexuality itself has been articulated (for examples, see Blackwood & Wieringa 1999; Correa & Parker, 2004; Parker et al., 2004). In fact, the HIV/AIDS pandemic itself, the focus on sexual diversity that grew out of it, and the resulting women's and lesbian, bisexual, gay, transgender, and queer movements that grew in developing countries in the wake of HIV/AIDS, along with the intersection of other multiple streams of separate and interwoven social change activities and events, has contributed to more nuanced and complex frameworks through which women's sexuality is currently viewed. These social change activities and events include the feminist, lesbian and gay, women's health, and civil rights movements

that began in the 1960s and 1970s in Western countries; the transnational women's health and reproductive rights movements and development work that emerged in the 1980s and 1990s and the concomitant advocacy to prioritize women's reproductive rights, particularly by international women's NGOs (nongovernmental organizations); and the activism to incorporate into human rights convention reports language supporting sexual health, sexual rights, and gender equality (Mongrovejo, 1999; Parker, 2007; Parker et al., 2004; Petchesky, 2003; Tiefer, 2002; Weeks, 2007). It is also due to the rapid pace of globalization in the last quarter century that has led to fundamental changes in national and international economies, political systems and institutions, media, work, family life, and most importantly, in conceptualizations of gender relations, identity, and sexualities (Carnoy & Castells, 2001; Hirsch, 2007; Weeks, 2007).

Taken together, these events and activities have provided new vocabularies, concepts, and spaces for a more informed analysis of sexual life overall and, in particular, the sexual life of women (Parker, 2007). What is missing in this discourse is the connection of newer understandings of *women's* sexuality to their risk for and experience living with HIV and that better understanding of women's sexuality may be key to prevention of HIV among them. The concept of sexuality as a healthy and normal arena of one's life and that it may have important positive emotional and psychological implications for women's lives does not appear prominently in HIV discourses today. Certainly, the idea that promoting a positive sexuality for women, one that includes sexual pleasure as an important goal and right for women, is difficult to find.

As it stands, within the context of HIV/AIDS, women's sexuality is problematized; it is primarily viewed as a source of vulnerability, risk, and danger for them as well as their partners, rather than as a fundamental aspect of their lives. Furthermore, only a limited number of sexual behaviors are focused on with respect to HIV (i.e., those that fall into the safe and unsafe sexual behavior categories), and they are often studied in ways that isolates them from the larger context of women's sexual and relational lives. Women are primarily portrayed as victims of sexuality, although the woman as victim narrative that is prevalent even in feminist accounts of women's risk for HIV is being questioned, particularly as it relates to the notion of women's universal lack of agency and empowerment with regard to sexual relationships with men (e.g., Higgins et al., 2010; Susser, 2009). Women may not necessarily be well served by the woman as victim narrative and it may obscure as much as it reveals about women's sexuality needs in the context of HIV. Women everywhere and always have been able to find spaces, margins, or interstices where they have been able to act out their power, influence, and agency, even in the realm of their sexual lives (e.g., Muise, 2011; Schatz, 2005) The path to fully understand women's sexuality and HIV is one that is fraught with the tension to consider this reality on the one hand,

as well as the reality of women's inequality in virtually every society across the globe on the other hand (e.g., Teti et al., 2010; Thege, 2009).

The notion of promoting positive sexuality for women may seem trivial in contrast to the daunting problems of poverty, abuse, and oppression that women experience worldwide. For example, simply being female is one of the primary risks for STIs (sexually transmitted infections) worldwide (Celentano et al., 2010). Nonetheless, as Bay-Cheng (2010) explains, women's sexuality is "constructed through oppressive norms and conditions founded on gender, heteronormativity, class, and race" (p. 97), and these intersecting systems of gender oppression and inequality are the source of women's vulnerability to HIV as well as to other negative consequences of sexuality, such as STIs, unwanted pregnancy, infections, and sexual violence, rather than their sexuality. In fact, women's oppression is demonstrated when women's rights to erotic pleasure and reproductive choices are routinely curtailed and violated once they have been diagnosed with HIV (Welbourn, 2006). They are overtly or implicitly pressured to end, reduce, or regulate their sexual lives, refrain from having children, and denied information about possibilities for pleasure, even from basic information about anatomy and reproductive health (Gurevich et al., 2007; Kelly et al., 2011; Welbourn, 2006). Sexuality itself, however, is not the cause of these violations and restrictions; rather, when women's right to a positive sexuality is promoted, it can be a source of strength and meaning for women instead of a site of danger or vulnerability (Bay-Cheng, 2010). When women's sexual needs are valued and promoted, they then have the ability to make decisions about "the Ps of sexuality—practices, partners, pleasure/pressure/pain, and procreation" (Gupta, 2000, p. 2), and therefore are best positioned to carry out their sexual lives in ways that reduce their risk for HIV, as well as other negative sexual consequences. The promotion of a positive sexuality for women necessarily includes questioning the social and political structures, systems, and processes that sustain gender inequality and injustice, the true sources of women's vulnerability to HIV/AIDS. As Palesa Beverley Ditsie eloquently stated in 1995 at the United Nations Fourth World Conference on Women, "no woman can determine the direction of her own life without the ability to determine her sexuality" (as cited in Wieringa & Blackwood, 1999, p. 26).

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Chapter 11

Childbearing and Women's Sexuality: Moving beyond Avoidance and Myth

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During pregnancy and the postpartum period (conceptualized here as the first year after birthing), women's sexuality can be challenged in myriad ways. Consideration of the influence of childbearing on women's sexuality illuminates many interesting complexities about sexuality, including variation in experiences and behavior, the role of psychosocial and cultural influences on sexuality, and the importance of intimacy, flexibility, and communication within a sexual relationship. Some authors view the challenges presented by pregnancy and the postpartum period through the lens of sexual dysfunction (Abdool, Thakar, & Sultan, 2009; Bitzer & Alder, 2000; Murtagh, 2010) or distress (Gianotten, 2007). Others, such as ourselves, view pregnancy and the postpartum period as normative transitional events that challenge couples to make adjustments in their sexual lives and behavior (Foux, 2008; Kleinplatz, 2001; von Sydow, 1999). Both types of scholars frequently note that couples' needs for resources and support during this potentially vulnerable time are often unmet (Barrett et al., 2000; Lewis & Black, 2006). It is likely that social taboos and embarrassment serve as barriers to both clients and providers in their attempts to discuss sexual issues.

The literature on this topic, particularly within the discipline of psychology, is scarce and limited. According to Kleinplatz (2001), "both medical and mental health professionals tend to medicalize and simultaneously de-sexualize these events" (p. 127). She goes on to argue that such widely shared beliefs and imperatives about women's sexuality as separate from reproduction, pregnancy, and motherhood may contribute to the dearth of literature on childbearing and sexuality. Furthermore, the literature available focuses almost exclusively on European American, middle-class, heterosexual, married women. Rarely are husbands, women of color, lower income women, lesbians, single mothers, or adolescent girls surveyed about their sexual experiences during (their partner's) pregnancy and the postpartum period. In this chapter, we review this limited literature to describe the extent to which women's sexual activities may vary across pregnancy and the postpartum period, as well as the physical, psychological, and social factors that influence women's sexual experiences. We consider the implications of this body of work for improving women's sexual experiences during the pregnancy and the postpartum period, for predominantly their firstborn children.

Sexuality and Pregnancy

Women's sexual behavior varies a great deal across the three trimesters of pregnancy and the first year postpartum, yet typical patterns have emerged in the literature. The findings from most studies suggest that there is a slight decline in the frequency of sexual behavior in the first trimester, a great deal of variability in the second trimester, and a decrease in frequency of sexual behavior in the third trimester (Adams, 1988; Bitzer & Alder, 2000; De Judicibus & McCabe, 2002; Hyde, DeLamater, Plant, & Byrd, 1996; Murtagh, 2010; Wannakosit & Phupong, 2010). From her extensive review of the literature, von Sydow (1999) found that approximately 10 percent of women abstain from sexual intercourse throughout the entire pregnancy.

In the first trimester, physical symptoms, such as extreme fatigue, nausea, breast tenderness, and psychological concerns, such as fear of harming the baby, can hinder women's sexual desire and activities (Foux, 2008; Gianotten, 2007; Murtagh, 2010; Pauleta, Pereira, & Graca, 2010). There is more variability in women's sexual behavior during the second trimester than in any other (von Sydow, 1999). Increases in women's sexual desire, satisfaction, and frequency of sexual activity may occur due to physiological factors, such as decreased fatigue and nausea and increases in vaginal vasocongestion and lubrication (Gianotten, 2007; Murtagh, 2010). Finally, in the third trimester, fatigue and physical discomfort can lead to decreased sexual activity (Bartellas, Crane, Daley, Bennett, & Hutchens, 2000; De Judicibus & McCabe, 2002; Gianotten, 2007) Interestingly, some

women may not report lower levels of sexual satisfaction, despite these decreases in sexual activity (Pauleta et al., 2010).

There are very few studies that examine psychosocial factors that influence women's sexual behavior during pregnancy. The two primary issues that surface from this literature concern fears of harming the fetus and the domain of body image. Research has consistently shown that couples are concerned that sexual activity may harm the fetus or induce preterm labor, and this fear contributes to a decline in sexual activity (Bitzer & Alder, 2000; Gianotten, 2007; Hyde et al., 1996; Maurizio et al., 2010; Pauleta et al., 2010). From her review of the literature, von Sydow (1999) concluded that fear of harming the baby inhibits sexuality during pregnancy for between 25 percent and 50 percent of women and 25 percent of men. Within normal and healthy pregnancies, sexual intercourse has not been found to contribute to preterm labor or fetal harm (Bitzer & Alder, 2000; Sayle, Savitz, Thorp, Hertz-Picciotto, & Wilcox, 2001). Women with complicated pregnancies or a history of miscarriage may be at risk for adverse outcomes as a result of sexual activity (Bitzer & Adler, 2000; Gianotten, 2007; Sayle et al., 2001), but these are beyond the scope of this chapter. Clearly, couples' misconceptions about the risk of sexual intercourse can have an unnecessarily detrimental effect on their sexual relationship and create anxiety and stress. Health care providers and counselors should discuss these issues with their clients and provide them with accurate information and support, so that they can make more informed decisions about sexual activity during pregnancy.

Pregnant women's body image and men's reactions to their partners' pregnant bodies are complex, multifaceted, and multiply determined (Draper, 2003). The visibly pregnant body is an emblem of femininity and is increasingly glamorized and commercialized in popular culture (Tropp, 2006). Yet, it is simultaneously threatening because it challenges the boundaries of sexuality and reproduction, private and public, self and other, animal and human (Draper, 2003; Goldenberg, Goplen, Cox, & Arndt, 2007). This paradox creates a confusing context for women's body image, feelings of attractiveness, and sexuality during pregnancy. Pauleta and colleagues (2010) found that, in the third trimester, 41 percent of their participants reported feeling less attractive, but most did not feel as though their partners were less interested in sexual activity. Women's self-confidence in later stages of their pregnancies may be negatively influenced by feelings of self-consciousness (Gokyildiz & Beji, 2005), both of which may hinder women's sexuality and sexual expression, especially with partners who may hold negative or conflicted feelings toward women's pregnant bodies. Earlier research (Bogren, 1991) has found that men report lower levels of interest in sex with their wives in the last trimester of pregnancy compared with the other trimesters. Draper (2003) reported that the men in her study had varied reactions to their partners' changing

bodies, but that their narratives often revealed a great deal of tension and confusion revolving around the shift from wives as predominantly sexual/intimate partners to potential mothers. Gianotten (2007) noted that some women believe that their pregnancy increases their attractiveness and some find that it detracts from their attractiveness, and that similar variability exists for partners. What may cause distress or conflict is a discrepancy in such views between a pregnant woman and her partner (Gianotten, 2007).

A neglected construct in this literature is the role that attitudes toward sexuality may play in shaping couples' sexual behavior during pregnancy. For example, Fisher and Gray (1988) proposed that individuals with an erotophilic view of sexuality (e.g., a positive, responsive, open approach to sexual behavior) would be more comfortable communicating about and experimenting with adjustments in sexual practices and positions than individuals with an erotophobic view (e.g., avoidant, negative approach). In their study of a sample of young married couples, Fisher and Gray (1988) found that husbands' and wives' scores on the measure of this construct were strongly correlated, but that wives' scores shared a stronger relationship with sexual outcomes than husbands' scores. Specifically, erotophilic pregnant women reported higher levels of interest in sex, more frequent sexual behavior, and higher levels of sexual satisfaction than erotophobic pregnant women.

Finally, there are several interesting issues to consider regarding sexuality and labor and birthing. Some progressive childbirth educators and midwives recognize that labor and birthing can be extremely sensual and even sexual events for women and their partners (Gaskin, 2007; Kitzinger, 1984). According to these sources, nipple stimulation and sexual intercourse can potentially induce labor, and clitoral stimulation and perineal massage can reduce pain during labor. In fact, some women report orgasmic sensations (figurative and literal) during labor and birthing. Acknowledgement of women's sexual sensations and experiences surrounding birth itself may challenge potentially harmful assumptions about the need to separate sexuality from maternity, and validate women's experiences of maternal events as sexually stimulating (Kleinplatz, 2001).

Postpartum Period

As is the case with pregnancy, women's sexual activities and experiences vary a great deal in the first 12 months after the birth of their infants, although general patterns do emerge. Many different factors influence women's sexuality in the postpartum period, including issues related to physical recovery, emotional adjustment, multiple roles, relationship satisfaction, childhood sexual abuse (CSA) experiences, and breastfeeding. Researchers have generally neglected these issues, and yet, scholarship in this area could go a long way toward informing effective psychoeducational

interventions designed to optimize women's sexuality during this potentially vulnerable transition period.

Women's sexual behavior is especially challenged in the immediate postpartum period, typically defined as the first six weeks after birthing. Factors, such as perineal and vaginal discomfort, lochia (vaginal discharge that can occur in the first six weeks), fatigue, changes in body image, breastfeeding, postpartum affect, and religious practices, can all influence women's sexual desire, arousal, and experiences in the immediate postpartum period (Abdool et al., 2009; Al Bustan, El Tomi, Faiwalla, & Manav, 1995). Clearly, there is wide variability in women's readiness to resume sexual intercourse and other sexual behaviors, and women are sometimes encouraged to follow their own timelines (http://www.mayoclinic.com/health/sex-after-pregnancy/PR00146).

Various obstetric issues have been found to influence women's sexuality in the first few months after giving birth. Among a sample of primiparous women experiencing a vaginal delivery (Andrews, Thakar, Sultan, & Jones, 2008), 92 percent reported pain in the perineal area, particularly if they experienced tearing or episiotomy. However, most women reported both resolution of perineal pain and resumption of sexual intercourse within two months of birthing, regardless of levels of genital trauma. Likewise, Rogers, Borders, Leeman, and Albers (2009) did not find large differences in sexual functioning or dyspareunia (painful intercourse) between women with minimal genital trauma and those with extensive tearing that required sutures. Chang, Chen, Lin, Chao, and Lai (2011) examined the impact of episiotomy on Taiwanese women's pain and sexual functioning at various points during the postpartum period. Women who experienced an episiotomy reported higher levels of perineal pain at six weeks postpartum than women who did not undergo an episiotomy. The two groups did not differ significantly in sexual functioning at two weeks and three months postpartum. It is possible that women are engaging in sexual intercourse despite perineal pain. There were no significant differences in the timing of first sexual intercourse among German women who had experienced an injury-free vaginal birth, a vaginal birth with episiotomy or lacerations, an operative vaginal birth, or a Cesarean section (Buhling et al., 2006), and most women had resumed intercourse by eight weeks postpartum and reported enjoying intercourse within three months postpartum, regardless of mode of delivery. A search of empirical articles concerning the impact of mode of delivery on women's sexuality in the postpartum period, published between 1990 and 2003, yielded only six articles that were relevant and met inclusion criteria (Hicks, Goodall, Quattrone, & Lydon-Rochelle, 2004). From these, Hicks and colleagues (2004) concluded that the evidence to suggest a negative impact of operative vaginal deliveries on women's postpartum sexuality is more conclusive than that regarding Cesarean delivery. It is possible that concerns about

the negative impact of a vaginal birth on women's sexual functioning may encourage women to elect a Cesarean delivery (Handa, 2006). Women need accurate information about the relationship, or lack thereof, between obstetric factors and long-term sexual functioning.

Another interesting and underexplored issue concerns the impact of birthing on women's genital appearance. Research has shown that young women's insecurities about the appearance of their external genitalia has negative implications for their sexual satisfaction and experiences (Schick, Calabrese, Rima, & Zucker, 2010). Likewise, there is a growing trend toward altering vulvas and vaginas through cosmetic surgery to achieve the "ideal" or "designer" vagina (Braun, 2005). In addition to aging and other reasons, women may cite childbirth as a primary reason for sagging, asymmetrical, or otherwise *imperfect* genitalia (Braun, 2009). As this trend becomes more popular and accessible, is it possible that women may avoid a vaginal birth and/or seek out this surgery to *restore* their genitalia to a pre-childbirth state? Although, perhaps, medically warranted for some women, the popularity of this trend reflects the increasing commodification and sexualization of women's genitalia. It seems reminiscent of the infamous "husband's stitch," when women were given extra sutures after an episiotomy, supposedly to restore their vaginas to a virginal state for their husbands' pleasure.

After the immediate postpartum period, most women resume fairly regular sexual activity, but many continue to experience sexual difficulties and challenges. De Judicibus and McCabe (2002) found that, at three months postpartum, many of their participants reported dyspareunia (i.e., painful sexual intercourse) and low levels of sexual desire. Factors that had a negative impact on women's sexual activity and satisfaction at three months included depression, fatigue, breastfeeding, and lower levels of relationship satisfaction. Hyde and colleagues (1996) found that, on average, at both 4 months and 12 months postpartum, most of the heterosexual women and men in their sample reported having sexual intercourse approximately five times per month. Their levels of sexual satisfaction dropped significantly in the first month postpartum, but gradually increased during the first year postpartum. In a later study (Hyde, DeLatamer, & Hewitt, 1998), they found that women's role satisfaction as opposed to the mere occupation of multiple roles had a positive influence on their postpartum sexual experiences.

There is very little research available on the relationship between women's sexuality and postpartum depression (PPD), which can be experienced by approximately 13 percent of new mothers (O'Hara & Swain, 1996). Lewis and Black (2006) noted that PPD may be associated with lowered levels of interest in sexual activity, and De Judicibus and McCabe (2002) found that depression at three months postpartum was associated with lower levels of frequency of sexual activity. This relationship is surely

bidirectional, as Nicolson (1999) argued that women's depression during the postpartum period is largely a normative form of grieving that occurs as a result of a series of losses they experience during the transition to motherhood, including losses in the area of sexuality and related domains of appearance and femininity. Alder and Bancroft (1988) found that breastfeeding women, at three months postpartum, reported both more depression and higher levels of impairment in their sexuality than women who were not breastfeeding. The relationship between women's sexuality and psychological well-being in the postpartum period is a complex, multidimensional one and is likely influenced by many different factors.

For many different reasons, breastfeeding can impact postpartum women's sexuality. However, the relationship between breastfeeding and women's sexuality is complicated due to the myriad variables that can influence both women's sexuality and breastfeeding behavior (Avery, Duckett, & Frantzich, 2000). Breastfeeding women reported a wide range of experiences with respect to the impact of breastfeeding on their sexuality within the first 12 months postpartum (Avery et al., 2000). However, a sizeable literature suggests that, compared with women who bottle-feed their infants, breastfeeding women experience difficulties with vaginal lubrication, dyspareunia, lower levels of sexual desire and activity, and less satisfying sexual experiences (Avery et al., 2000; De Judicibus & McCabe, 2002; Hyde et al., 1996; Lamarre, Paterson, & Gorzalka, 2003; von Sydow, 1999). These challenges are more pronounced for women who breastfeed for longer periods of time (LaMarre et al., 2003). In addition to the pain and discomfort women experience during breastfeeding in the early postpartum period (Kelleher, 2006), women may continue to have sensitive breasts and nipples, which may render stimulation of the breasts during sexual encounters unpleasant or uncomfortable (Convery & Spatz, 2009; Lewis & Black, 2006). Women may also experience sexual arousal while breastfeeding (Kleinplatz, 2001) and partners may express jealousy about the intimacy shared between their wives' and their infants (Lewis & Black, 2006).

The false dichotomy between motherhood and sexuality (Kleinplatz, 2001; Weisskopf, 1980) and conflicting cultural messages about the roles of women's breasts (Rodriguez-Garcia & Frazier, 1995; Young, 2010) may influence both women's breastfeeding experiences and sexuality in the postpartum period. Yet, few researchers have investigated the impact of these messages, particularly the sexualization of breasts, on women's breastfeeding behavior and experiences (Morse, 1989). For example, pregnant women have concerns about the impact of breastfeeding on their breast size, shape, and sexuality (Johnston-Robledo & Fred, 2008), and some have found that body image concerns may dissuade women from breastfeeding (Barnes, Stein, Smith, & Pollock, 1997). Fisher and Gray (1988) found that erotophobic women were less likely than erotophilic

women to breastfeed their new infants. It is common for breastfeeding women's breasts to leak milk during and after orgasm (Lewis & Black, 2006; von Sydow, 1999). Depending on their sexual attitudes and comfort levels, couples may either find this erotic or embarrassing. Given taboos surrounding breastfeeding and sexuality, the new sexual challenges posed by breastfeeding can be difficult for couples to adjust to and discuss.

Men have been found to share negative perceptions of breastfeeding partners and/or potential partners as well as concerns about the impact of their partners'/potential partners' breastfeeding on their sexual relations (Henderson, McMillan, Green, & Renfrew, 2011; Ward, Merriwether, & Caruthers, 2006). The authors (Henderson et al., 2011; Ward et al., 2006) attributed these concerns, among other things, to embarrassment, the sexualization of women's breasts, and masculine ideologies. Clearly, fathers' attitudes about the complex relationships among breastfeeding, sexual attractiveness, and sexual activity could play a powerful role in women's comfort level with sexual activity during the postpartum period. Contrary to what we might expect, Avery and colleagues (2000) found that the women in their large sample believed breastfeeding to have a slightly positive impact on their sexual relationship, and they did not experience difficulty embracing their breasts as both a source of sexual pleasure and infant sustenance. Although it is likely that women who are more comfortable with their bodies and sexuality may be more likely to breastfeed their infants, it is also possible that the experience of breastfeeding may have a positive impact on women's body image and sexuality (Al Bustan et al., 1995).

Childhood Sexual Abuse

Women with childhood sexual abuse (CSA) histories may find the embodied experiences of pregnancy, birthing, and breastfeeding to be especially challenging (Bohn & Holz, 1996; Johnston-Robledo & Barnack, 2004; Klaus, 2010). Despite the prevalence of CSA experiences among childbearing women, obstetricians may be unaware of these challenges, and thus unprepared to assist women (Leeners, Richter-Appelt, Imthurn, & Rath, 2006). In their comprehensive review of this literature, Leeners and colleagues (2006) noted that there is little published empirical work on this topic, and much of it is methodologically flawed. This limited body of work (Leeners et al., 2006) suggests that pregnancy for women with CSA histories may involve more physical complaints, psychological vulnerabilities (e.g., anxiety, stress, depression), increased high-risk behaviors (e.g., substance abuse), and weight gain than that found among women without CSA histories. Survivors may also be uncomfortable in childbirth preparation classes, where they are asked to lie on their backs in front of other individuals with whom they are not acquainted. Although the

literature does not suggest a relationship between CSA and complications during labor, some women report that birthing triggers or even uncovers painful memories of CSA experiences. Johnston-Robledo and Barnack (2004) reviewed literature supporting the possibility that birthing for women with CSA histories can be extremely traumatizing. Birthing and CSA share a number of similarities (Bohn & Holz, 1996). Thus, women with CSA histories may also find that routine procedures and experiences during labor and birthing, such as vaginal examinations, painful pelvic sensations, a lack of control, and exposure of their bodies, may be threatening (Radosti, 1999; Rhodes & Hutchinson, 1994) because they mirror the dynamics of sexual abuse (Bohn & Holz, 1996). Some scholars have found that survivors of CSA are at a higher risk for PPD than other women (Leeners et al., 2006; Records & Rice, 2005), and that CSA may actually have a negative impact on the thyroid health of women with PPD (Plaza et al., 2010). Finally, it is possible that breastfeeding presents unique challenges to survivors of CSA, especially for adolescent mothers (Bowman, 2007). CSA survivors may find breastfeeding difficult due to discomfort touching their breasts, body shame, complexities about the sexual arousal they may feel during breastfeeding, confusion about the dual role of breasts, and feelings of exposure while breastfeeding in public (Bohn & Holz, 1996; Coles, 2009; Leeners et al., 2006). Despite these difficulties, Prentice and colleagues (2002) found that survivors of CSA were more likely to initiate breastfeeding and persist longer than women without CSA histories. Findings from qualitative research suggest that, for CSA survivors, breastfeeding may involve positive experiences, such as enhanced mother-baby relationship (Coles, 2009) and actually facilitate the psychological healing process (Wood & Van Esterik, 2010). Clearly, more research on the impact of CSA on women's maternity experiences is warranted.

Implications for Research and Intervention

Sexual intimacy during pregnancy, which could encompass a wide variety of pleasurable sexual activities, can help women and their partners remain close and cope with challenges they may face throughout the course of pregnancy and early parenting. Furthermore, some scholars have argued that various forms of sexual dysfunction for women and their partners originate during pregnancy and postpartum (Abdool et al., 2009; Gianotten, 2007) Thus, it is important that they have the resources they need to optimize their sexual functioning and relationships during this potentially vulnerable time. Prenatal visits with obstetricians and/or midwives during pregnancy can provide women and their partners with opportunities to discuss their sexual health and concerns. Yet, it appears as though healthcare providers in general (Hinchliff, Gott, Galena, & Elford, 2004) and prenatal care providers in particular (Polomeno, 1997)

avoid discussions of sexual health with their patients. Given the avoidance of sexuality issues in maternity care, it is clear that the concerns of prospective and new parents are not addressed. Pastore, Owens, and Raymond (2007) assessed first-time parents' concerns about sexuality among two samples of women and men—one was assessed at 4 months postpartum and the other at 12. At four months postpartum, common concerns included issues regarding birth control and resumption of sexual intercourse (e.g., timing and impact of physical recovery). At 12 months, both women and men were concerned about discrepancies in desire and changes in the woman's body image. As a result, women may rely on less reliable sources to address their concerns and obtain information about sexual issues relevant to childbearing (Murtagh, 2010).

The dearth of psychological research on the impact of childbearing on women' sexuality is striking. Without a sizeable body of knowledge about this complex topic, it is difficult to determine how best to optimize women's experiences. This neglect reflects and perpetuates dated and potentially harmful assumptions about women's bodies and sexuality (Kleinplatz, 2001). The extant empirical research on this topic is often based on homogenous samples, is flawed by various measurement issues (e.g., retrospective designs, varied terminology, limited assessment tools), and framed within a medicalized or deficit model of women's sexuality. The research of Hyde and colleagues (1996), which was longitudinal, prospective, and addressed multiple aspects of women's sexuality, is an exemplary exception. Feminist research on the impact of pregnancy, obstetric issues, breastfeeding, CSA, PPD, and many other childbearing issues is warranted. Longitudinal, multivariate research on diverse women's sexuality across the entire childbearing spectrum would both legitimize this topic in the literature and inform efforts to educate and support women and their partners.

A comprehensive sexual health assessment during an early prenatal care or counseling session may facilitate dialogue about maternity and sexuality, and identify any areas of sexual health in need of attention or discussion (Murtagh, 2010). Health care providers could also provide women and their partners with accurate information about sexual activity as well as ideas regarding alternative forms of sexual expression during pregnancy and the postpartum period, so that they do not avoid sexual activity or physical intimacy (Maurizio et al., 2010). These topics could be addressed in a childbirth preparation class as well (Foux, 2008). Wannakosit and Phupong (2010) investigated the impact of a sexual education group on the sexual behavior of couples during pregnancy. Although they did not find that the group members' sexuality was different from a control group, they argued for the importance of this resource as well as the need for research to determine its effectiveness. Lee and Yen (2007) conducted a similar study on women exposed to a postpartum sexual health program

in Taiwan. They found that, compared with women in a postpartum health program that did not address sexuality topics, the women in the experimental condition reported increased sexual health knowledge and sexual efficacy both three days and eight weeks after the program. This type of programming may also be employed to provide women and their partners with critical information about contraceptive choices after birthing as well (Lee, Tsai, Tsou, & Chen, 2011).

Clearly, there is a need for mental health providers and maternity caregivers to work collaboratively to address both normative and clinical issues that may arise concerning pregnancy, childbirth, postpartum adjustment, and breastfeeding (Convery & Spatz, 2009; Johnston-Robledo & Barnack, 2004; Murtagh, 2010). Individuals with underlying sexual dysfunction, complicated pregnancies, dissatisfying relationships, mental illness, and CSA histories may be especially vulnerable to distress and in need of support services concerning their sexuality and intimate relationships during pregnancy and/or the postpartum period (Abdool et al., 2009; Johnston-Robledo & Barnack, 2004; Klaus, 2010; Miller, 1997). Couples, particularly those anticipating the conception or birth of their first child, may benefit from psychotherapy immediately before and during pregnancy to strengthen their relationship. Research has consistently shown that women in satisfying relationships report more satisfying sexual experiences during pregnancy (De Judicibus & McCabe, 2002; von Sydow (1999). Couples in satisfying relationships may have the intimacy, trust, comfort level, and communication skills necessary to remain flexible and honest regarding sexuality issues during pregnancy and the first postpartum year. On the contrary, women's lowered levels of sexual desire and activity may contribute to men's infidelity, especially in the context of unhappy marriages (Whisman, Coop Gordon, & Chatav, 2007). Couples who struggle in their relationships may benefit from counseling and other kinds of intervention, to both assist their transition to parenthood and provide them with suggestions for ways to minimize the risk of infidelity (Whisman et al., 2007). Couples may also need assistance coping with fluctuations in their sexual activity across pregnancy and the postpartum period and with discrepancies in desire and comfort levels that may occur (Bitzer & Alder, 2000).

In sum, women's sexuality is impacted in profound and underexplored ways by pregnancy, childbirth, postpartum issues, and breastfeeding. Continued neglect of these complexities, on the part of researchers, educators, mental health providers, and maternity caregivers, does women and their partners a great disservice and perpetuates harmful assumptions about women's sexuality. Kleinplatz (2001) argued that the desexualization of women's reproductive experiences obstructs opportunities to explore and embrace the full range of women's embodied sexual experiences. We hope that this chapter will inspire scholars, practitioners, educators, and everyday women to challenge traditional ideas about women's sexuality and

childbearing, and thereby help prospective and new mothers reach their full potential as sexual beings.

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Part IV

Sexuality, Mental Health, and Therapy

Chapter 12

Defining and Diagnosing Women's Sexual Problems

Cynthia A. Graham and John Bancroft

In recent years, the definition and diagnosis of sexual problems in women is a topic that has generated considerable debate and controversy (e.g., Binik, Brotto, Graham, & Segraves, 2010; Brotto, Graham, Binik, & Segraves, 2011; DeRogatis et al., 2010). Although there are currently no approved pharmacological treatments for female sexual problems in North America, a number of drugs, both hormonal and centrally acting agents, are being evaluated, amidst widespread concerns about the medicalization of female sexual dysfunction (Moynihan, 2003; Tiefer, 1996). This subject is also timely because the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is currently undergoing revision. Publication of DSM-5 is expected in 2013, but the proposed diagnostic categories have been made available and these include some major changes in how female sexual disorders are defined and diagnosed (Binik, 2010; Brotto, 2010; Graham, 2010).

The classification and diagnosis of sexual disorders in women is challenging; in part, because there is a lack of agreement amongst researchers and clinicians about what constitutes sexual dysfunction. Underlying

this, there is a lack of understanding about the nature of nonproblematic sexual desire and arousal in women (Bancroft & Graham, 2011; Levine, 2002; Meana, 2010). Whether a particular sexual behavior or response is considered functional or dysfunctional depends to a large extent on social and cultural expectations (Leiblum, 2006). Epidemiological surveys have revealed widely varying prevalence rates for sexual dysfunction across different countries (Fugl-Meyer & Fugl-Meyer, 2006; Laumann et al., 2005). Definitions of sexual problems also show considerable change across time. For example, whereas in the previous century sexual desire in women was considered a sign of mental disturbance, low sexual interest is now regarded as a clinical symptom requiring treatment (Hartmann, Heiser, Rüffer-Hesse, & Kloth, 2002; Leiblum, 2006).

The aim of this chapter is to highlight some key issues in the conceptualization of sexual problems in women. First, we provide a brief overview of how definitions of sexual problems in women have evolved over the last few decades. We then discuss four central issues relevant to defining and diagnosing sexual problems in women—the marked variability of women's sexuality, the boundary between "normal" and "dysfunctional" sexuality, the inclusion of distress in definitions of sexual disorders, and the role of relationship and partner variables. Finally, we end the chapter with a discussion of the DSM-5 proposals for female sexual disorders that have been put forward, highlighting the major changes from the current DSM-IV-TR classification (APA, 2000).

DEFINING AND DIAGNOSING SEXUAL PROBLEMS IN WOMEN: HISTORICAL ASPECTS

As noted above, there have been major changes in the definition of female sexual problems over the last 50 years. Currently, the two most widely used classification systems are the DSM-IV-TR (APA, 2000) and the International Statistical Classification of Diseases and Related Health Problems (ICD-10) (World Health Organization, 1992); the ICD-10 is also currently undergoing revision. In the first edition of DSM (APA, 1952), the concept of sexual deviation appeared, but the term sexual dysfunction was not used. In 1980, the concept of "psychosexual dysfunction" was introduced in the third edition of the DSM (APA, 1980), the term "psychosexual" reflecting the widespread view at the time that psychological factors were of fundamental importance in the etiology of sexual problems. Psychosexual dysfunctions were defined as "inhibitions in sexual desire or the psycho-physiological changes that characterize the sexual response cycle" (APA, 1980, p. 261). The sexual response cycle referred to the human sexual response cycle (HSRC) put forward by Masters and Johnson (1966), who conceptualized sexual response as a universal, linear series of phases—excitement, arousal, orgasm, and resolution. This model

was later expanded to include sexual desire as a necessary separate phase of the cycle (Kaplan, 1974; Lief, 1977). The HSRC became the framework for classifying sexual problems in the DSM, with problems in sexual functioning occurring at any one or more of the phases. In the most recent edition of DSM-IV-TR (APA, 2000), this basic structure was maintained, but there was a shift away from the idea that sexual disorders were caused primarily by psychological inhibition. Psychosexual disorders were characterized by "disturbance in sexual desire and in the psychophysiological changes that characterize the sexual response cycle" (APA, 2000, p. 493). In addition to the main categories of female sexual disorder (desire, arousal, orgasm, and pain), DSM-IV-TR also contains three additional categories: sexual dysfunction due to a general medical condition, substance-induced sexual dysfunction, and sexual dysfunction not otherwise specified.

The DSM-IV-TR diagnostic criteria for one of the most common sexual problems in women, hypoactive sexual desire disorder (HSDD), are identical to those applied to men. In addition to the presence of marked distress or interpersonal difficulty, HSDD is defined by one criterion: "persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity" (APA, 2000, p. 498). For the arousal disorders, there are separate male and female categories: female sexual arousal disorder (FSAD) and male erectile disorder (ED). However, as for ED, the monosymptomatic criterion for FSAD concerns only genital changes: "Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement" (APA, 2000, p. 502). Interestingly, DSM-III-R (APA, 1987) had included lack of subjective excitement and pleasure as well as impaired genital response in the diagnostic criteria for both sexes, but this was removed from the DSM-IV-TR criteria. The rationale for this change was that the subjective feelings criterion was overly vague and that subjective and genital changes showed poor concordance (Segraves, 1996).

There has been longstanding dissatisfaction with the DSM-IV-TR classification system of sexual dysfunction, particularly regarding the female sexual disorders (Tiefer, 1991). Some of the major problems identified include the lack of any duration or severity criteria, an inadequate acknowledgement of partner and relationship factors, an overemphasis on genital response, and an assumption that women's sexual problems should be conceptualized in a similar way to men's (Segraves, Balon, & Clayton, 2007; Tiefer, 1991). Regarding the DSM focus on genital indicators of sexual arousal, findings from psychophysiological studies in women with and without DSM diagnoses of FSAD have demonstrated that women with arousal problems are not less genitally responsive to visual sexual stimuli than women without such problems (Brotto, Basson, & Gorzalka, 2004; Laan, van Driel, & van Lunsen, 2008); impaired genital responsiveness is therefore not a valid diagnostic criterion for sexual arousal

disorder (Laan et al., 2008). What differentiates women with and without sexual arousal problems are the subjective aspects of sexual arousal (Brotto et al., 2004).

One of the most fundamental criticisms of the DSM has been that the HSRCs discrete phases of sexual response do not represent the ways that sexual arousal and desire are experienced by women (Hartmann et al., 2002). There is strong evidence of a high degree of comorbidity between FSAD and other sexual disorders, particularly HSDD (Basson et al., 2003; Fugl-Meyer & Fugl-Meyer, 2002; Laumann, Paik, & Rosen, 1999; Rosen, Taylor, Leiblum, & Bachmann, 1993). Given the evidence for high comorbidity and the elevated rates of mental health problems in women with sexual problems, Hartmann and colleagues (2002) suggested that rather than simply expanding and revising DSM criteria and the traditional HSRC classification system, women's sexual problems would be better conceptualized as a "global inhibition of sexual response, together with a history of mood disorder, specific personality factors and an elevated level of psychological stress" (p. 79).

Research has found a mismatch between clinical diagnoses of sexual dysfunction and women's own perceptions that they have a sexual problem (King, Holt, & Nazareth, 2007). King and colleagues compared ICD-10 diagnoses of sexual disorder in women attending U.K. general practices with participants' own perceptions that they had a sexual problem. Among the 401 participants, 38 percent had at least one diagnosis of sexual dysfunction, but only 18 percent of women received a diagnosis and also perceived this as a problem. The greatest discordance was found for sexual arousal disorder and lack or loss of sexual desire; agreement between clinical diagnosis and women's perception of a problem was highest for dyspareunia and vaginismus. Interestingly, 20 percent of the women were assigned a diagnosis of sexual dysfunction, but did not feel that they had a sexual problem, and 19 percent received no clinical diagnosis, but perceived that they *did* have a sexual problem. King and colleagues (2007) concluded that the current diagnostic classification systems miss "a significant proportion of women who are distressed by what they regard as sexual difficulties but which do not fit a diagnostic classification" (p. 287).

In response to the above shortcomings of the DSM and ICD classification systems, there have been several proposals for revised definitions and diagnostic criteria since DSM-IV-TR (Basson et al., 2000, 2003; Brotto, Bitzer, Laan, Leiblum, & Luria, 2010; The Working Group for a New View of Women's Sexual Problems, 2001). However, with the exception of the New View classification system, these revised criteria have preserved the basic structure of the DSM, with separate disorders linked to discrete phases of the HSRC. There has also been criticism that these proposals have emerged from "top-down" consensus agreement by experts (Bancroft, Graham, & McCord, 2001; King et al., 2007; Mitchell & Graham, 2008)

and that there has been a reluctance to make fundamental changes or to "return to the drawing board" (Mitchell & Graham, 2008).

In addition to recommendations for revised criteria, alternative models of female sexual response have also been proposed (Basson, 2000; Laan & Both, 2008; Tiefer, 2001; for review, see Hayes, 2010). Basson (2000), for example, proposed that women usually engage in sexual activity motivated by nonsexual factors, such as desire for emotional closeness with a partner, rather than because of any intrinsic sexual desire. The Incentive Motivation Model (Both, Everaerd, & Laan, 2007; Laan & Both, 2008) has also challenged the traditional notion that sexual desire is the first stage in a sequence of sexual response, but sees it as an awareness of sexual arousal that has already occurred in response to a sexual stimulus, but that the woman was not aware of.

Only two published studies have directly compared different models of female sexual response (Giles & McCabe, 2009; Sand & Fisher, 2007). The findings from both studies suggested that there is no one universal model of sexual response that fits all women. Sand and Fisher (2007) investigated three different models—Kaplan (1974), Masters and Johnson (1966), and Basson (2000)—in a sample of American women and found that similar proportions of women endorsed each of these three models, but with the Basson model being more relevant to those with sexual problems.

KEY ISSUES IN CONCEPTUALIZING SEXUAL PROBLEMS IN WOMEN

The Varied Nature of Women's Sexuality

There is now considerable evidence of marked variability of women's sexual experiences and expression. There is, for example, substantial variability in sexual response across women of different ages, sexual orientation, and cultural background (for a review, see Bancroft & Graham, 2011). Women vary considerably in the age at which they first experience orgasm, the consistency with which they are able to reach orgasm, and the importance they attach to orgasm (Graham, 2010). Baumeister (2000) reviewed the literature on gender differences in sexuality and concluded that women's sexuality is more malleable than that of men's in response to sociocultural and situational factors. This is consistent with the fact that this variability of women's sexuality became more apparent as the sociocultural repression of women's sexuality lessened during the course of the 20th century.

As suggested by studies evaluating different models of sexual response, women are also likely to vary in the pattern of arousal they typically experience in a sexual context (Bancroft & Graham, 2011). Recent qualitative research has highlighted this heterogeneity in women's sexual response.

Many women do not report experiencing sexual desire, arousal, and orgasm as discrete phases, have difficulty differentiating sexual desire from subjective arousal, and do not report a uniform linear progression from desire to arousal to orgasm (Brotto et al., 2009; Carvalheira, Brotto, & Leal, 2010; Goldhammer & McCabe, 2011; Graham, Sanders, Milhausen, & McBride, 2004). Despite the DSM focus on deficient (or absent) sexual fantasies as the hallmark feature of HSDD in women, research suggests that many women report that they do not often experience sexual fantasies and do not regard fantasies as an important marker of their sexual desire (Brotto, 2010). Moreover, studies have indicated that there are a multitude of triggers or cues for sexual desire and arousal (McCall & Meston, 2006; Meana, 2010), and these vary both within and across individual women.

This variability may underlie the limited success of pharmacological treatment for women's sexual problems, and also explain the disjunction between clinical diagnoses of sexual disorders and women's own perceptions that they have a sexual problem (King et al., 2007).

The Boundary between "Normal" and "Dysfunctional" Sexuality

It is becoming increasingly clear that, until we have established a valid method for categorizing these variable aspects of "normal" women's sexuality, we will have difficulty in developing and evaluating methods of treatment for what can meaningfully be called "dysfunctional" sexuality. Distinguishing between psychiatric disorder and normal distress/variation has been a long-standing challenge in the mental health field generally (Wakefield, 2011). In the area of sexual dysfunction, we have two interacting challenges: the recognition of the varieties of "normal" sexual function in women, and the identification of transient problems in sexual functioning, which may be understandable, and even adaptive, reactions to current stressors of various kinds. The need to avoid inappropriate pathologizing in both respects is becoming increasingly recognized (Graham & Bancroft, 2006; Mitchell & Graham, 2008). Wakefield (2007) discussed the potential harmful consequences of misclassification of problems of living as mental disorders, including stigma, inappropriate treatment, and inappropriate selection of research participants.

Epidemiological studies have demonstrated that transient, short-term sexual problems are very common, but more persistent problems much less so (Hayes, Dennerstein, Bennett, & Fairley, 2008; Mercer et al., 2003). In a U.K. national probability sample survey, 53.8 percent of the female respondents reported at least one sexual problem lasting a minimum of one month in the past year, but this figure dropped to 15.6 percent for problems lasting at least six months in the past year (Mercer et al., 2003). Hayes and colleagues (2008) found that prevalence rates of sexual dysfunction are highly affected not only by the duration of sexual difficulty,

but also by the length of time over which women are asked to recall sexual difficulties.

We also know that sexual problems are often related to other problems in a woman's life (e.g., mental health problems, relationship difficulties, or significant life stresses; Bancroft, Loftus, & Long, 2003). Reduced sexual interest, for example, often appears to be an adaptation to stress or an unhappy relationship (King et al., 2007). Although clinicians would routinely assess these factors, they are not included in any diagnostic criteria for sexual disorders.

Another issue is that although the DSM text states that a diagnosis of FSAD should not be given if the problems in arousal are "due to sexual stimulation that is not adequate in focus, intensity, and duration" (APA, 2000, p. 501), in both clinical and research practice the adequacy of sexual stimulation is difficult to assess. Epidemiological surveys of the prevalence of sexual arousal disorders have not included assessment of this variable and it is indeed difficult to see how this could be done in a large-scale survey.

In view of the evidence that transient sexual problems are very common, and to avoid labeling short-term adaptive reactions to problems in a woman's life as sexual "dysfunction," it seems important to specify some level of symptoms that are required for a diagnosis, in addition to being a significant change from what had previously been considered "normal" by each woman. Currently, for a DSM-IV-TR diagnosis of any sexual disorder, there are no specific duration or severity criteria, but the symptoms are required to be persistent or recurrent. According to the DSM text, whether a diagnosis is given should also depend on the judgment of the clinician, "taking into account such factors as age and experience of the individual, frequency and chronicity of the symptom, subjective distress, and effect on other areas of functioning" (APA, 2000, p. 494). Some authors have advocated the use of more precise severity and duration criteria in DSM diagnostic criteria, suggesting a duration criterion of six months and the presence of symptoms on 75 percent or more of sexual encounters (Balon, 2008; Balon, Segraves, & Clayton, 2007; Segraves et al., 2007). Although logically it seems that more precise criteria for severity and/or duration of problems would set the threshold higher for making a diagnosis, the difficulty here is that adoption of any specific duration or proportion of occasions will be somewhat arbitrary, given the lack of empirical data on the natural history of sexual problems. For example, we have little basis on which to recommend whether symptoms experienced on 75 percent or on 90 percent of sexual encounters should be the appropriate cut-off. One other possible indicator of severity might be how often an individual avoids sexual encounters because of the problem. This approach was used by Mercer and colleagues (2003) in their U.K. survey of sexual function problems. Among women aged 16–44 years, who reported having had a

recent sexual problem, 62.4 percent of them avoided sex because of their sexual difficulties.

The Inclusion of Distress in Definitions of Sexual Disorders

Although marked distress or interpersonal difficulty is an essential criterion for any DSM diagnosis of a sexual disorder, early epidemiological studies did not assess respondents' distress about sexual difficulties (Fugl-Meyer & Fugl-Meyer, 1999; Laumann et al., 1999, 2005). More recent surveys that have included distress (Bancroft et al., 2003; Oberg, Fugl-Meyer, & Fugl-Meyer, 2004; Shifren, Monz, Russo, Segreti, & Johannes, 2008; Witting et al., 2008), show prevalence estimates drop, usually by at least half, when distress about the sexual problem is assessed (Brotto et al., 2010; Hayes, 2008).

Whether distress should be an essential criterion for a diagnosis of sexual dysfunction is, however, a complex issue and one that has provoked considerable debate (Althof, 2001; Bancroft et al., 2003; Mitchell & Graham, 2008). For example, it is clear that some women who have sexual problems are not distressed by them and that others are very distressed, although they do not meet criteria for any sexual disorder. Clinically, it is clearly very important to assess distress, and anyone who is not distressed or troubled is unlikely to seek treatment (although this may occur when the sexual partner is distressed about the problem). We also need to keep in mind the ill-understood interaction between distress and sexual desire. Nevertheless, as with other clinical diagnoses, it may be appropriate to establish the diagnosis and separately assess the extent to which the woman is distressed by the problem. With this approach, distress would not be a criterion of the diagnosis, but would be recorded as clinically relevant.

In recent years, a number of self-report measures of sexual distress have been developed(e.g., the personal distress scale [DeRogatis et al., 2004] and the female sexual distress scale [DeRogatis, Rosen, Leiblum, Burnett, & Heiman, 2002]), in part, because of their use in clinical trials of pharmacological treatments for female sexual problems. It is important to consider, however, how little we know about what it is that women are distressed about. Hayes (2008) defined sexual distress as "negative and distressing feelings that a woman may experience about her *level of sexual function*" (p. 216; our emphasis). However, the evidence to date suggests that women are less distressed about their level of sexual function and more distressed about their relationship status or the quality of their relationship (Bancroft et al., 2003; Rosen et al., 2009). Witting and colleagues (2008) investigated sexual function and sexual distress in a population-based Finnish sample of 5,463 women. All partner compatibility items (e.g., amount of foreplay, interest in sex, and communication about sexual matters) were significantly associated with distress and with most of the sexual dysfunctions. Women most often

reported having "too little foreplay" and "partner is more interested." In a national U.S. survey of heterosexual women, 14.7 percent reported marked distress about their own sexuality; 19.8 percent about their relationship; and 24.4 percent about one or both of these variables. The best predictors of distress, however, were general emotional well-being and relationship with partner (and not aspects of sexual functioning, such as lubrication and orgasm; Bancroft et al., 2003).

In summary, we still have little understanding of the determinants of sexual satisfaction and of sexual distress. Some research has suggested that while sexual problems may be more common in older women, distress about sexual problems decreases with age (e.g., Leiblum, Koochaki, Rodenberg, Barton, & Rosen, 2006; Shifren et al., 2000), and again we understand little about why this is the case.

Partner/Relational Issues

The DSM-IV-TR restricts the diagnosis of a mental disorder by definition to individuals; mental disorder is defined as "a clinically significant behavioral or psychological syndrome or pattern that occurs *in an individual* and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom." One of the frequent criticisms of the DSM classification of sexual disorders has been that there is little acknowledgment of the fact that sexual activity usually occurs in an interpersonal context (Leiblum, 2006; Mitchell & Graham, 2008). Relationship factors (both partner factors and the interaction between partners) are often fundamental to the etiology and the experience of sexual difficulties (Dennerstein, Lehert, & Burger, 2005; Goldhammer & McCabe, 2011; Witting et al., 2008). Recent studies have also highlighted the importance of sexual problems of male partners for the sexual experience of women (Dean et al., 2009; Rubio-Aurioles et al., 2009).

Despite this, the emphasis in definitions of sexual disorders has been firmly on the individual. Discrepancy in sexual desire between partners is perhaps one of the most common clinical presentations; yet, this symptom is not included in any of the diagnostic criteria. Although DSM-IV-TR includes relational processes as "other conditions that may be a focus of clinical attention," there are no criteria provided for these and they seem to be seldom used in clinical diagnoses (Beach, Wamboldt, Kaslow, Heyman, & Reiss, 2006).

While it is important to avoid pathologizing individuals on the basis of their relationship context, and discrepancies in desire should not entail the partner with the lower level of desire being labeled as "dysfunctional" (Segraves et al., 2007), it does seem that individual-focused diagnoses risk

neglecting "couple-level" problems. A systemic approach to sexual desire problems was proposed by Clement (2002), who questioned whether we should conceptualize sexual desire as the property of an individual, or as "an emergent function of the structural matching of partners" (p. 243). Outside the area of sexual dysfunction, some have argued that DSM-5 should include categories for specific relational disorders, such as parent-child relational problems and partner relational problems (First, 2006; Heyman et al., 2009). Perhaps, because of the DSMs long-standing focus on the physical aspects of sexual functioning and the HSRC (Tiefer, 2001), few in the sexual dysfunction field have advocated for inclusion of sexual relationship disorders. Another less radical option for better incorporating relational processes into diagnostic criteria is the use of specifiers, discussed in the next section.

DSM-5 PROPOSALS FOR FEMALE SEXUAL DISORDERS

As mentioned above, proposals for the fifth edition of DSM have now been put forward and these include significant revision to the definition and classification of female sexual disorders (for a full listing of the proposed revisions for all of the DSM disorders, see http://www.dsm5.org/Pages/Default.aspx). We focus here on the key differences between the new definition and diagnostic criteria for one specific female sexual disorder—sexual interest/arousal disorder (SIAD)—and the current DSM-IV classification of sexual arousal and desire disorders.

For DSM-5, the Sexual and Gender Identity Disorders Work Group have proposed that FSAD and HSDD for women be replaced with a new diagnostic category, SIAD. The rationale for merging the desire and arousal disorders was presented in two published literature reviews on HSDD and FSAD (Brotto, 2010; Graham, 2010). These reviews concluded that there was substantial overlap between problems with sexual desire and problems with sexual arousal, as evidenced by significant comorbidity between HSDD and FSAD (Fugl-Meyer & Fugl-Meyer, 2002; Laumann et al., 1999; Rosen et al., 1993), high correlations between the desire and arousal domains on psychometric measures of sexual functioning (Brotto et al., 2011), and lack of evidence that desire and arousal are experienced by women as discrete phases of sexual response (Beck, Bozman, & Qualtrough, 1991; Brotto et al., 2011; Carvalheira et al., 2010; Graham et al., 2004).

Another major change proposed for DSM-5 is that an expanded set of polythetic criteria for the new disorder, SIAD, replaces the monothetic criteria for HSDD and FSAD in the DSM-IV-TR. To better reflect the symptoms experienced by women who present for treatment with sexual problems, the new criteria include a reduced focus on genital symptoms and on sexual fantasies as being the only indicator of sexual desire in women. There is an increased emphasis on reduced subjective sexual excitement/pleasure

and on the inability to respond sexually to any internal or external cues as being central to the diagnosis. The polythetic criteria also reflect the research evidence that there is a great deal of heterogeneity across women's experiences of sexual arousal and no one "model" of female sexual response fits all women.

Another important difference between the proposed criteria for DSM-5 and the current DSM criteria is that specific duration and severity criteria are included; for a diagnosis of SIAD to be made, symptoms must have been present for at least six months and be experienced on all or almost all sexual encounters. This threshold was based on the findings, discussed earlier, where the prevalence of symptoms occurring for shorter time periods and on fewer occasions (Hayes, et al., 2008; Mercer et al., 2003; Oberg et al., 2004) was markedly higher than the prevalence of symptoms occurring more frequently and/or for longer durations.

In the DSM-IV-TR (APA, 2000), there are subtypes to indicate "the onset, context, and etiological factors associated with the Sexual Dysfunctions" (p. 494); these are lifelong versus acquired; generalized versus situational; and due to psychological factors versus due to combined factors. A major recommendation in the proposed criteria for SIAD is to include the use of specifiers that may be relevant to etiology and/or to decisions about treatment. Specifiers are typically used to "describe the course of the disorder or to highlight prominent symptoms" or to "indicate associated behavioral patterns of clinical interest" (Beach et al., 2006). For SIAD, the specifiers include: partner factors (e.g., partner's sexual problems, partner's health status); relationship factors (e.g., poor communication, relationship discord, discrepancies in desire for sexual activity); individual vulnerability factors (e.g., poor body image, history of abuse experience) or psychiatric comorbidity (e.g., depression or anxiety); and cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity, with medical factors relevant to prognosis, course, or treatment. These specifiers were chosen based on empirical evidence that these factors are important determinants of women's experience of sexual problems. Several of these specifiers (e.g., cultural/religious factors) warrant much greater attention and it is hoped that inclusion of these in the diagnostic criteria will stimulate future research, as well as aid clinical assessment and decision making.

CONCLUSIONS AND RECOMMENDATIONS

The lack of any major revisions in the structure and major criteria of DSM classification of sexual disorders has been variously attributed to the emphasis on the reliability of diagnostic criteria, leading to outcome measures which have high interrater reliability but low or nonassessed validity (Bancroft et al., 2001), on the goal of achieving congruence between

DSM and ICD systems (Segraves et al., 2007), and on the need to maintain "continuity in research and clinical ractice" (DeRogatis, Clayton, Rosen, Sand, & Pyke, 2011, p. 218).

As this review has highlighted, there is still much work to be done to provide an empirical basis for such a classification system. There is, for example, relatively little good qualitative research on women's experiences of sexual problems (Goldhammer & McCabe, 2011). As discussed earlier, we understand little about why some women report having distressing sexual problems, but do not fit any diagnostic category, and why others meet diagnostic criteria for a sexual disorder, but report no distress about the problem. Research such as that suggested by King and colleagues (2007), where women assigned clinical diagnoses in a research setting might be interviewed about what is (and what is not) distressing about their sexual problems, would be valuable. Similarly, qualitative interviews with women who report being distressed by their sexual functioning/experiences, but would not receive a clinical diagnosis, should be carried out. As most researchers select female participants for studies on the basis of DSM or ICD diagnostic criteria, the likelihood is that our findings relate only to a subset of women with sexual problems (and perhaps the minority). For example, research on sexual arousal problems has focused on women with an inadequate lubrication-swelling response of sexual excitement (APA, 2000), the DSM-IV-TR criterion for FSAD, although in clinical practice very few women present with this symptom alone (Bancroft et al., 2001), and this symptom does not appear to be one that many women feel distressed about (Bancroft et al., 2003).

The impending DSM-5 diagnostic system for sexual dysfunction may well provide a step in the right direction. However, we should keep in mind that the current DSM process has helped to uncover the need for research in various aspects of female sexuality. It is striking how recently we have started to grapple with the fundamental aspects of women's sexuality. This process must continue, and hopefully by the time we get to DSM-6 we will be in a much better position to conceptualize and categorize sexual dysfunction in women.

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Chapter 13

Playing with Power: Women and Gender in BDSM Sexualities

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In this chapter, I examine psychological research and theory on the sexual practices that fall under the umbrella of BDSM (a multipurpose acronym referring to bondage and discipline, dominance and submission, sadism and masochism, consensual sadomasochism, fetish, and kink). After providing definitions and descriptions of the roles and sexual practices involved, I turn to theoretical perspectives on BDSM practice. Throughout, I highlight issues relevant to women's involvement in these practices, given that women have traditionally been discouraged from engaging in such nontraditional practices. Because of gender socialization in childhood that teaches girls to eschew interest in sexuality (with messages such as "good girls don't want/have sex"), and femininity ideologies that encourage women to pursue sex only in the context of romantic relationships (Phillips, 2000), some women find that there are explicit and implicit social pressures pushing them toward more traditional, mainstream practices. This chapter concludes with recommendations for future research on women who engage in BDSM and other nontraditional sexual practices.

DEFINITIONS, ROLES, AND SEXUAL PRACTICES

BSDM refers to a wide range of consensual sexual activities loosely grouped into the categories bondage and discipline, dominance and submission, sadism and masochism (or sadomasochism), leather, fetish, and kink.[1] Ethnographic researchers (Scott, 1980; Weinberg, Williams, & Moser, 1984) have found that one of the key defining features of BDSM is an appearance of dominance and submission (one partner having control over another obedient partner). Thus, BDSM can be seen as a sexual activity in which power (dominance and submission) is eroticized and power is expressed through sexuality. The sexual practices involved are often considered nontraditional because they are not genitally focused; that is, although they may produce sexual arousal in participants, they do so through bodily and psychological practices that heighten each participant's sense of power or powerlessness.

Roles and Identities

BDSM practitioners use specific terminology to self-identify their preferred roles and preferred ways of interacting with others. These roles are grouped into three primary categories. First are those practitioners who prefer to be in control or providing stimulation; terms referring to this role include sadist, dominant, top, or master/mistress. Second are those practitioners who prefer to be under their partner's control or receiving stimulation; terms referring to this role include masochist, submissive, bottom, or slave. Finally, switches or versatiles are those who are interested in both roles, varying between dominance and submission at different times or with different people (see Moser & Kleinplatz, 2007, for elaboration on roles and definitions).

Breslow, Evans, and Langley (1985) found no gender differences in role preference; around one-third of men and women preferred the dominant role, around one-quarter of men and one-third of women preferred to switch, and 40 percent of women and 42 percent of men preferred the submissive role. Thus, there was a slight preference among both genders for submission. However, other studies that have included men and women have found greater representation of men in the dominant role (Cross & Matheson, 2006; Ernulf & Innala, 1995; Yost, 2007) and greater representation of women in the submissive role (Dancer, Kleinplatz, & Moser, 2006; Ernulf & Innala, 1995; Yost, 2007), which would be consistent with traditional understandings of gender roles.

Some BDSM activists claim that identifying as a sadomasochist (or as a dominant, submissive, switch, etc.) is similar to identifying as a lesbian, gay man, or bisexual, in that BDSM is an identity that defines their sexuality and defines their preferred manner of interacting with a sexual partner (Kamel, 1983; Taylor & Ussher, 2001).

BDSM Practices

There are a plurality of practices that fall under the rubric of BDSM (see Table 13.1), with most individuals having a set of preferred practices in which they regularly engage. Generally, a BDSM interaction (referred to as a "scene" or as "play") begins with some negotiation, where participants set limits for the upcoming encounter. Limit setting involves a discussion of preferred activities as well as those activities that are absolutely unacceptable (termed "hard limits") and those that are undesirable but could be carefully incorporated (termed "soft limits"; Moser & Kleinplatz, 2007). Sometimes partners agree in advance on a "safeword," a term that, when used, will stop all activity and will allow the participants to interact outside of the dominant/submissive roles; when partners have been involved for long periods of time, safewords might not be employed (Moser, 1998). Individuals involved in long-term power play (such as full-time owner-slave relationships, in which the partners attempt to live continually as a dominant/submissive couple) eschew safewords altogether, as they do not fit conceptually with the relationship dynamic (Dancer et al., 2006).

There is some evidence of a developmental trajectory to the BDSM behaviors; Santtila, Sandnabba, Alison, and Nordling (2002) reported that BDSM behavior follows a similar script as that of normative heterosexual behaviors, in which less intense activities precede more intense activities (e.g., kissing generally precedes intercourse). In their analysis of BDSM behaviors, the authors found a clear structure indicating a cumulative scale, such that participants who had engaged in more intense behaviors were likely to have engaged in less intense behaviors as well. They speculate that these findings could reflect either a developmental process over the course of a lifetime (a person first tries spanking, and then months or years later tries the more intense activity of whipping), or a script that has been acted out in a single BDSM encounter (early in the evening, a person is "warmed up" through a spanking, and then later that night the intensity is increased to a whipping). The authors conclude that sadomasochistic sex is similar to normative heterosexual sex in this progression of intensity.

Detailed explanation of BDSM practices is available elsewhere in the academic literature (Moser & Kleinplatz, 2007; see also Alison, Santtila, Sandnabba, & Nordling, 2001), with a vast array of descriptive and how-to manuals readily available in the popular press (Conway, 2000; Easton & Hardy, 2001, 2003; Midori, 2005; Miller & Devon, 1995; Varrin, 2000; Warren, 2000; Wiseman, 1996). In order to focus attention in this chapter on women, gender, and power, I direct the interested reader to these sources.

The Role of Consent

Although some of the sexual practices involved in BDSM, particularly the painful activities, may share physical characteristics with instances of

Table 13.1 BDSM-related activities

Bondage and discipline

- Bondage/restraints (rope, handcuffs, chains, hoods; restricting movement or decorative)
- Devices to prevent sexual access (chastity belts, gags, butt plugs)
- Furniture or structures designed for bondage (crosses in the shape of a T or X, cages)
- Japanese bondage (highly decorative and intricate)
- Sensory deprivation (blindfolds, hoods, gags)
- Physical discipline (spanking, paddling, caning)
- Psychological discipline (denial of privileges, standing in corner)

Dominance and submission

- Depersonalization (animal play, furniture play)
- Foot worship
- Forced homosexuality or heterosexual (against the submissive's sexual orientation)
- Gorean relationships (ritualized male-dominant and female-submissive style, based on novels by John Norman)
- Humiliation
- Protocols (kneeling, stylized forms of address [e.g., "My Lord"], collars, and other symbols of ownership, use of contracts)
- Role plays (master/mistress and slave, teacher and student, adult and child)

Sadism and masochism, or sadomasochism

- Application of ice or heat
- Clothespins and clamps (sometimes with weights attached)
- Genitorture (cockbinding, cunt torture)
- Impact play (spanking, whipping, flogging, paddling)

Fetishes

- Eroticizing items (leather, latex, corsets, stockings)
- Eroticizing body parts (feet, hands)

Edge play (activities that carry greater risk)

- Blood play (cutting, use of knives, needles for temporary piercing)
- Electricity play (using medical stimulation units (TENS) or violet wand)
- Erotic asphyxiation (breath control)
- Fire play
- Permanent body modification (cutting, piercing, branding)
- Mummification and suspension bondage
- Water sports (urination, enemas, catheters)

Note: The organizational structure presented here draws on groupings made by Downing (2007), Ernulf and Innala (1995), and Moser and Kleinplatz (2007). The same activity can be experienced differently depending on the context and the participants; for example, spanking might serve the purpose of discipline, humiliation, or pain depending on how it is administered and the participants' roles and expectations for the scene. Thus, these groupings are not absolute, and there is a great deal of cross-over.

nonconsensual sexual violence (such as rape or sexual coercion), it is important to note the many ways in which BDSM practices differ from those crimes. The primary difference is consent—all participants in a BDSM encounter are willing to so participate (Taylor & Ussher, 2001; Weinberg et al., 1984). Another distinguishing feature separating BDSM from nonconsensual violence is that of meaning: "People within S/M scenes enter into such contracts for the pleasure (however broadly conceived) that they may experience. That is, the participants themselves mutually define the meanings of the acts that are perpetrated" (Langdridge, 2007, 89–90). Thus, BDSM is distinct from nonconsensual sexual violence, because BDSM practitioners freely choose activities and imbue these activities with psychological meanings that involve personal pleasure.

WHO PARTICIPATES IN BDSM?

Early research conducted by Kinsey found that over half of men and women responded erotically to being bitten, and 12 percent of women but 22 percent of men respond erotically to stories with sadomasochistic themes (Kinsey, Pomeroy, Martin, & Gebhard, 1953). In a national study in the United States, 11 percent of women and 14 percent of men reported having engaged in sadomasochism and 11 percent of both sexes reported having engaged in dominance/bondage (Janus & Janus, 1993), but this sample was not representative of the national population. In a study of 347 lesbian and bisexual women attending LGBT community events in New York City, almost one-half had engaged in any "kinky behavior," with the most commonly reported activity being bondage (Tomassilli, Golub, Bimbi, & Parsons, 2009).

The only representative survey available (conducted with Australian adults) found that 2 percent of sexually active men and 1.4 percent of sexually active women had engaged in BDSM activity with a partner in the past year (Richters, Grulich, de Visser, Smith, & Rissel, 2003), but no representative data are available for a U.S. population.

Prevalence research is especially difficult to conduct because, due to perceptions of societal disapproval, a BDSM identity is frequently kept hidden from others. As many as 72 percent of a group of BDSM-identified individuals surveyed by the National Coalition for Sexual Freedom (an organization promoting BDSM activism) reported that they kept their BDSM identities a secret (National Coalition for Sexual Freedom, 1998), and thus most research has relied on convenience samples that cannot speak to rates of involvement.

When examining the demographics of empirical studies that used convenience samples, some trends have emerged. Samples generally include more men than women and are predominantly white (Dancer et al, 2006; Moser & Levitt, 1987; Plante, 2006; Weinberg, 2006). Participants tend to be

more highly educated and have a higher income than the general public, and are highly sexually experienced and sexually liberal in their attitudes (Breslow et al., 1985; Eve & Renslow, 1980; Lindemann, 2011; Moser & Levitt, 1987). Thus, it appears that interest in BDSM is more widespread among these segments of the U.S. population, although without a representative survey, it is impossible to draw conclusions about prevalence. Of course, higher socioeconomic status may simply reflect a sampling bias, in which people with higher SES are likely to volunteer for research studies, have more leisure time to attend BDSM group meetings (where much of this research is conducted), and are more likely to use the Internet (where other research is often conducted). Similarly, greater representation of men than women may be due to men being more likely to be open about nontraditional sexualities or to be more likely to participate in the organizations that have been studied.

Given that BDSM sexuality is relatively uncommon, several researchers have been interested in whether people involved in BDSM are psychologically healthy. In the nationally representative survey in Australia, Richters and colleagues (2008) found no association between BDSM involvement and a history of sexual assault, psychological distress, nor sexual difficulties. Using convenience samples, several studies of men (Damon, 2002; Spengler, 1977), women (Levitt, Moser, & Jamison, 1994), and mixed-gender samples (Cross & Matheson, 2006; Moser & Levitt, 1987; Sandnabba, Santtila, Alison, & Nordling, 2002) showed that BDSM practitioners evidence rates of psychological health and maladjustment at rates comparable to the general population. For example, Connolly (2006) reported no differences between a BDSM sample and the general population on depression, anxiety, or obsessive–compulsive disorder. Through carefully reasoned considerations of the existing data, several clinical psychologists, psychiatrists, sociologists, and sex therapists emphatically argue that BDSM ought to be considered a normal variant of human sexuality, rather than a pathology (Baggaley, 2005; Henkin, 2007; Kleinplatz & Moser, 2005, 2007; Williams, 2006).

Research on Women in BDSM

The earliest research on BDSM solicited responses from men only, based on the assumption that the only women who practiced BDSM were prostitutes and only participating in BDSM for financial reasons (Spengler, 1977). Later research proved this assumption to be incorrect in two ways. First, research with women who provide BDSM for money (variously called S/M professionals, professional dominatrices, pro-dommes) has found that many also engage in BDSM in their own personal lives (Lindemann, 2010; Sisson & Moser, 2005). In other words, providing professional BDSM services does not preclude a woman from being

personally interested in BDSM practice; in fact, 90 percent of the BDSM professionals in the study conducted by Sisson and Moser (2005) reported that their professional practice positively impacted their personal BDSM life, and 83 percent indicated that it positively impacted their personal BDSM identity.

Second, the assumption proved incorrect once researchers began to study BDSM in more depth and simply observed women's involvement. Gosselin, Wilson, and Barrett (1991) recruited 87 women from the United Kingdom, Europe, America, and Scandinavia, and Levitt and colleagues (1994) recruited 34 women in the United States. In both samples, women tended to identify as heterosexual rather than bisexual or lesbian, and as submissive rather than dominant or versatile. Participants in Levitt and colleagues' study reported that they first came out about their BDSM interests at around 23 years of age, 80 percent were happy with their BDSM orientation, and the most common activities enjoyed were bondage, spanking, oral sex, and the master-slave script.

Gosselin and colleagues (1991) reported results from personality measures, finding that women involved in BDSM were more extraverted, stable, and psychotic (referring to a tendency to be reckless or to have fluctuating emotionality), but less neurotic (referring to nervousness), than control women. They had lower scores on a measure of the tendency to lie and elevated lesbianism scores. These female BDSM practitioners reported more frequent and more varied sexual fantasies than control women. The authors concluded that women involved in BDSM are more sexually adventurous and nonconformist than control women. In addition, the BDSM women's pattern of high psychoticism, low neuroticism, and high libido reflected, in the authors' opinions, a sexual pattern more commonly found in stereotypical men.

Some research studies have included men and women to focus on gender comparisons. Breslow and colleagues (1986) reported on a sample of 130 male and 52 female BDSM practitioners. Men recognized their BDSM interests at an earlier age than women did. Approximately two-thirds of the men reported an interest in BDSM since childhood, whereas two-thirds of the women reported having been introduced to BDSM by a partner. Regarding specific behaviors, men and women were equally interested in humiliation, spanking, masturbation, and master-slave relationships. Women were slightly more interested in bondage, erotic lingerie, and oral sex, whereas men were slightly more interested in pain, whipping, enemas, and anal sex.

THEORETICAL PERSPECTIVES; OR, WHY ARE PEOPLE INVOLVED IN BDSM?

Several theoretical perspectives on BDSM have been proposed; however, many have little-to-no empirical support. For example, the earliest

theories pathologized BDSM practice, considering it to be either indicative of psychological disease (a mental illness) or associated with immorality, sexual violence, and crime (Freud, 1961a, 1961b, 1938/1995; Stekel, 1929/1953). These psychodynamic theories, which assumed BDSM always to be a marker of illness, are generally inadequate to explain BDSM because they were based on an incredibly small number of clinical cases—individuals seeking psychotherapy, who are presumably not representative of BDSM practitioners as a whole—and because the theorists were writing about behaviors and characteristics (such as self-defeating personality) that differ greatly from consensual BDSM (Breslow, 1989; Taylor, 1997). In addition, these theories have largely been debunked based on empirical research finding no evidence of heightened psychopathology among BDSM practitioners (see review above).

Another theory with little empirical support was the radical feminist perspective (see Linden, Pagano, Russell, & Starr, 1982). These theorists claimed that BDSM is a form of sexual aggression, in which one partner inflicts pain on an unwilling partner. These radical feminists argued that BDSM replicated unhealthy patriarchal relationships and encouraged violence against women; ultimately, they concluded that BDSM was an antifeminist endeavor because of its reliance on violent and sexist imagery. Within this perspective was a theory of BDSM practice: individuals who are drawn to BDSM practice are psychologically similar to individuals who engage in rape or other nonconsensual (and illegal) sexual violence (Russell, 1982). However, in an examination of support for feminist values and endorsement of egalitarian roles for women, Cross and Matheson (2006) found that BDSM practitioners espoused largely feminist and women-supportive attitudes and beliefs, and their attitudes did not differ from a control group of non-BDSM practitioners. Thus, these researchers concluded that the radical feminist theory of BDSM as antifeminist was not empirically supported.

Within the social psychological literature, Baumeister (1988, 1989) proposed a theory of masochism in particular. He posited that masochism is a way of relieving an individual of higher level self-awareness, by causing one to focus on lower level awareness of the self as a body. Baumeister compares masochism to other methods of escaping the self, such as distance running, alcohol use, or meditation. He argues that in order to escape the pressures of higher level self-awareness, people engage in a number of different diversions as a way of dealing with everyday stress; masochism is one of these methods. On the other hand, Baumeister theorized that sadism is an attempt to strengthen one's self-awareness, since the BDSM top orchestrates and controls the encounter. The top, in this theory, engages in BDSM in order to bolster a sense of control that he or she is perhaps lacking in day-to-day life.

In a modest test of this theory, Cross and Matheson (2006) found that masochists did not display heightened levels of escapist behaviors compared to other groups, and sadists did not display evidence of attempting to compensate for low levels of control in daily life. However, several other theories (e.g., Langdridge, 2007; Lindemann, 2010) make similar arguments involving a decrease in self-awareness during BDSM scenes; so, Baumeister's theory remains quite influential on the field of research.

Empirically Supported Theories

More recent theories have begun considering BDSM practices as a normal sexual variation and focused on understanding the phenomenological experience or the social context in which BDSM practice takes place. These newer theories have been supported by empirical research, and are therefore considered here in more detail. It is important to note that, because there is great diversity in BDSM practices, no single theory will be capable of explaining all experiences. Rather, multiple theoretical perspectives can help illuminate different aspects of BDSM and the varied meanings that BDSM practice has for practitioners.

Power Exchange

Theory from a variety of sources suggests that BDSM is regularly understood by participants to be an eroticization of power or an eroticized exchange of power. In interviews and field studies, various researchers have found that BDSM practitioners engaged in a variety of activities that highlight the role of power (Scott, 1980; Weinberg et al., 1984). Weinberg and Kamel (1995) observed that "at the very core of sadomasochism is not pain but the idea of control—dominance and submission" (p. 19). Califia, a BDSM practitioner, in the Popular Press book *Sensuous Magic,* used the definition "a temporary, consensual transfer of control from the bottom to the top for the duration of an S/M scene or an S/M relationship" (1994, p. 237). Weinberg (1987) further noted that the majority of BDSM behaviors, such as pain, bondage, and humiliation, are designed to emphasize the sexual power exchange (see also Langdridge & Butt, 2005).

Other sources of information on the power eroticization in BDSM comes from practitioners themselves. Brame, Brame, and Jacobs (1993), based on interviews with more than 100 BDSM practitioners, noted: "The power exchange between lovers is a fundamental source of erotic excitement, shared by equals, and often an intellectually enlightening experience" (p. 71). Similarly, Taylor and Ussher (2001) found that one of the four definitional themes that participants highlighted was an unequal distribution of power. For some participants, power was fixed, with one

partner always in control. For others, power was fluid and shifted within relationships and within scenes. Power was generally expressed through physical stimulation or psychological stimulation. Califia explained: "The basic dynamic of S/M is the power dichotomy, not pain" (1979/2000, p. 165). Another BDSM practitioner, Lucy (1987), sums up power eroticization in BDSM stating: "In a sexual context sadist & masochist are roles that define erotic poles of power & have meaning of passion trust & intensity that flow from a fully consensual situation" (p. 30). Indeed, Cross and Matheson's multistudy examination (2006) utilizing observations and interviews in BDSM-focused chat rooms, found support for the characterization of BDSM as an erotic power exchange.

Power, of course, carries multiple meanings. Interpersonal power, for instance, refers to the ability to encourage someone to do something that they would not have otherwise done (Johnson, 1976). Feminist scholars have sometimes termed this "power over," which refers to controlling or dominating another person, and in Western societies this type of power is often seen as quite negative, particularly in the context of a sexual or romantic relationship. On the other hand, a sense of personal power, involving control over one's self, is highly valued in Western societies. This kind of personal power has been described by feminists as "power for oneself" (Miller, 1976), "empowerment" (Moglen, 1983), "power within" (Smith & Douglas, 1990), and "power to" (Yoder & Kahn, 1992). I would argue that the power that is eroticized in BDSM is not "power over," but rather is better conceptualized as "power-to" or "power-with."

Power-to

Power-to has been used to describe one's ability to determine one's own destiny. There is ample evidence that all participants in BDSM scenes determine the general course of the interaction, and so in a small sense, their destiny. Communication and negotiation prior to a BDSM scene is common, and one important aspect of that communication is limit setting or defining activities that are unacceptable (Taylor & Ussher, 2001). A BDSM practitioner, Truscott (1991), explained the importance of this communication between participants in an BDSM scene:

> The starting point of all BDSM relationships, then, is talk of the most intimate kind. The talk is about what S/M play gets the potential partners off; who will assume which role; whether other people may be included (and if so, who); what each person's limits are; whether or not "safe words" are allowed or required, and if so, what they are; the health of the partners (which may limit or prohibit specific activities); what safer sex precautions are required; what activities or roles raise painful apparitions from the past and need to be avoided

for now; and, more mundanely, whether one of the other has to leave for work at five the next morning.

Except for the last point, traditional relationships don't usually begin with this intimate a discussion. Most couples never talk openly about what they want and what they are prepared to give in their sexual relationships. . . .

It is this, the negotiation preparatory to the new S/M relationship, that is the most important gift of contemporary consensual sadomasochism to the larger society. (pp. 18–19)

Weinberg (1994) reported that the most realistic description of what occurs in a BDSM scene is that both the dominant and the submissive are actively involved in its development. He further noted that often the action in a scene is collaboratively scripted, so it is inaccurate to say that one participant has power and the other does not. In this sense, all participants in a BDSM scene have "power-to." One of Taylor and Ussher's (2001) participants explained: "Fundamentally both parties should be in control . . . to talk about who is ultimately in charge is to avoid the mechanics of what's actually going on" (p. 299).

Power-with

"Power-with" or empowerment has been described as a process in which "power is something to share, something to use for the enhancement of others" (Miller & Cummins, 1992, p. 416–417). BDSM practitioners have stated that it is "power-with" or a sharing of power that characterizes BDSM (Easton & Liszt, 1995a; 1995b). Many BDSM practitioners' descriptions of scenes highlight the flow or exchange of power between or among participants; there is no evidence that power is seen as a static entity belonging solely to the dominant partner. Taylor and Ussher's (2001) participants stated: "It's a power exchange . . . symbolic, not real," and "We play with the power thing . . . it's like a sex toy . . . I'll have it for a while then she'll have it" (p. 299). One of Kamel and Weinberg's (1995) participants remarked: "Her submission fed my dominance and vice versa" (p. 90), to explain the flow of energy between participants. BDSM practitioner Lucy (1987) wrote: "The power & erotic exchange always flows full circle. If it doesn't then it's not satisfying & the satisfaction of all concerned is a prime goal in S/M" (p. 31).

Understanding Pain

The initial response of many people on hearing about BDSM practices focuses on the ostensible pain involved. Representations of BDSM in the media almost exclusively highlight painful stimuli (Wilkinson, 2009),

erroneously leading outsiders to believe that BDSM always involves pain. As the set of activities listed in Table 13.1 demonstrate though, many BDSM activities are completely devoid of pain.

Still, other activities are or have the potential to be painful. This raises the question of how BDSM practitioners understand pain and how they could desire to include painful activities in their sexual lives, when most people understand pain to be something one ought to avoid. There are, of course, many situations in which people willingly submit to pain that are not considered deviant or in need of explanation—the pain of childbirth without medication, for example, is embraced by many women who believe that pain-relieving drugs might harm the fetus; playing through pain in sports is celebrated, as athletes sacrifice in order to win the game. Yet, purposefully seeking out pain during a sexual encounter is more difficult to comprehend. Biological research has shown that the pleasure and the pain centers of the brain are very close, and that when sexually aroused, a person's tolerance for pain increases, and that the experience of pain leads to the production of euphoria-inducing endorphins (Sack & Miller, 1975), all of which might help us understand how pain and pleasure can be related on a physiological level. However, sociological or psychological research can more fully illuminate the lived experience of the merging of pain with pleasure.

Langdridge (2007) provides a useful theoretical argument for understanding the integration of pain into sexuality that takes place in some BDSM. He draws on the analysis of torture provided by Scarry (1985) in *The Body in Pain* to show some effects that pain within a BDSM scene might have on the recipient. First, because pain is felt as both internal (one's own body) and external (imposed by the one giving the pain), painful BDSM practices cause a psychological breakdown of the boundary between the self and the other. Because this occurs in a context of safety, wherein the bottom fully trusts the top to avoid true bodily harm, this potentially frightening psychological breakdown of boundaries is experienced positively.

Second, Langdridge (2007) draws on Scarry's theory of the breakdown of language during a painful experience. Pain destroys language, which destroys the sense of agency and even the consciousness (the sense of self, of thought, and of emotions) of the person in pain. Again, because in BDSM this is occurring in a well-controlled scene and because the destruction is temporary, Langdridge argues that this can be experienced as peaceful.

Using ethnographic interviewing, Newmahr (2010) uncovered several narratives that BDSM practitioners used to explain their use of pain within sexuality. Some practitioners explained that the sensations experienced during ostensibly painful activities are not, in fact, felt as pain by the recipient. Instead, some practitioners are able to transform the sensations of pain into something pleasurable; this transformation is instantaneous and

nearly outside the consciousness of the bottom, and so the sensation being administered by the top, which others might feel as pain, is instead felt as something pleasurable. Pain, in this perspective, isn't experienced at all.

Other participants in Newmahr's (2010) study explained that they did feel the sensations as pain, but that they were willing to feel such pain in the service of a larger goal. For instance, many bottoms chose to experience pain when it served to enhance the feelings of dominance and submission in the relationship; enduring pain became a way to show devotion to one's top and to deeply feel the act of submission. Female bottoms tended to rely on a "sacrificial" discourse (Newmahr, 2010, p. 401) more than male bottoms, who instead used what Newmahr called a "hypermasculine narrative of pain ('no pain, no gain')" (2010, p. 402). Male bottoms, too, felt the sensations as pain, but were motivated to prove their own strength by being able to withstand that pain. This difference can be easily heard in a quote from a female participant, who said: "I'm feeling the pain and it feels horrible, but that's good because it's like this gift I'm giving you" (Newmahr, 2010, p. 402), whereas a male participant stated: "The thing that I got out of it most was a pure sense of accomplishment and of—a kind of victory, really. It felt like I'd just [been in] some incredibly tough battle, you know, and won" (Newmahr, 2010, p. 404).

Finally, a small number of Newmahr's (2010) participants rejected the idea of pain as aversive (implied in the two discourses previously discussed), and instead explained that they do feel pain, and they like that feeling that "pain hurts, but the hurt also feels good" (Newmahr, 2010, p. 404). Newmahr noted that participants found it difficult to articulate how pain can feel like pain but still be enjoyable and desirable, given the limitations of a language that implies that pain is always unwanted. Participants who framed pain in this positive way tended to identify specifically with the labels *sadist* and *masochist,* so as to highlight their particular relationship with enjoyable pain.

Theater and Fantasy

Another theoretical position on BDSM derives from sociological work. T. S. Weinberg has written extensively on the ways sociological concepts can be used to study BDSM. Drawing on Goffman's theories (1974), Weinberg (1978) argues that one central feature of BDSM is a theatrical frame. Weinberg claims that BDSM activities occur within a theatrical frame, in which participants transform what appears to be violence into pleasurable play through "keying" the behavior. Various keys are employed by BDSM practitioners that give meaning to BDSM behaviors that is different from the meaning those behaviors normally have.

Ethnographic research describing typical scenes has supported this concept of a theatrical frame (Moser, 1998; Plante, 2006). Specific BDSM

keys involve collaborative limit setting (the "victim" and the "aggressor" decide in advance the activities that will take place), scripting (BDSM practitioners often decide on a sequence of events that will take place in the scene, which allows for everything to work out well in the end), and the fact that the submissive partner exerts some measure of control over the scene (despite the appearance that the dominant partner is fully in control). Additionally, Moser (1998) described the setting up of specific space in which BDSM encounters take place, and the ways in which participants set aside other space for interacting in everyday roles (such as kitchens and social spaces away from BDSM scenes), which fits with Weinberg's theory in that the latter could be considered akin to the "backstage."

I have argued elsewhere (Yost, 2007) that a central definition of BDSM is fantasy. Weinberg's (1978) theatrical analogy considers BDSM as "constructed performance," and it seems apparent that fantasy is one of the psychological mechanisms that enables this theatrical frame to operate. In other words, BDSM practitioners sometimes engage in sexual fantasy to transform a scene of dominance and submission into a personally meaningful and sexually pleasurable experience. My argument draws on the work of Terry Hoople (1996), who theorized that BDSM practitioners attempt to actualize a fantasy relationship through BDSM practices. For example, she states that no one involved in BDSM simulates real, actual slavery; instead, participants in BDSM actualize a very stylized and historically inaccurate version of slavery, which is an eroticized version. In other words, practitioners create a fantasy of dominance and submission that is sexually arousing, and then act out that fantasy in their BDSM encounters.

Newmahr's (2010) ethnographic results caution against taking this set of theories too far, however. She notes that scenes are more similar to improvisational theater, in that individual scenes are generally spontaneous and not completely scripted out, although they do occur within the bounds of general rules. That is, although negotiation and planning is often undertaken in advance, the specific activities and sequence of activities are not usually scripted; rather, they emerge as the players involved feel moved to do so. Additionally, Newmahr expresses concern that using the language of "roles" and "role play" diminishes the lived experience of people involved in BDSM, who often do not experience a feeling of pretense when engaged in BDSM nor do they experience their interactions as performances for the benefit of an audience.

Thus, although the theatrical theory is helpful in laying out some aspects of the context around BDSM practice, the analogy only goes so far until butting up against clear differences between acting and BDSM as experienced by practitioners. Similarly, although fantasy may sometimes help BDSM practitioners eroticize the activities in which they are engaging, BDSM is an embodied practice and it would be inappropriate to lose sight of the role of the body in understanding BDSM (Hart, 1998; Hornsby, 1999).

BDSM as Transformative

Several theorists have claimed that BDSM practices can be understood as transformative or capable of transforming the individual self of those who so engage. It is argued that BDSM involves such intense, psychologically relevant emotions that the person involved is bound to experience a shift in their understanding of themselves. Some theorists espousing this view note the many ways in which BDSM is seen by practitioners as similar to psychotherapy (Barker, Gupta, & Iantaffi, 2007; Lindemann, 2011). For instance, the professional dominatrices interviewed by Lindemann (2011) regularly referred to themselves as therapists providing help to their clients; they explained that they provide a safe space in which clients can be their true selves (i.e., be open about their sexual proclivities), they allow clients to fully express their identities, and they often allow clients to relive past victimization in the BDSM encounter (by setting up scenarios similar to past experiences of rape, embarrassment, or abandonment). The professional dominatrices in this study felt that their clients began a process of transformative healing through the careful, structured, and safe BDSM scene. BDSM was also used by clients as a way to atone for past wrongdoings, with the BDSM scene resulting in absolving the clients of guilt, because they have been punished for their transgressions (Lindemann, 2011).

Other theorists have emphasized the transformative power of BDSM but focused on its similarity to religious experience rather than therapy. Several observers have commented on BDSM practitioners' understanding of their practice in terms of a spiritual journey (Beckmann, 2007; Comfort, 1978; Rubin, 1991). This journey is characterized by a "decentering" of the self (Beckmann, 2007, p. 104) or a "dividing" of the self (splitting the "self" from the body; Langdridge, 2005), which ultimately results in an expansion of one's self-awareness through the BDSM practice. The written accounts of several BDSM activists validate this theoretical perspective (see Califia, 1994; Easton & Hardy, 2003; Foucault, cited in Miller, 1994; Thompson, 1991). For example, Baldwin (1991) stated: "It is little wonder that we sometimes refer to them as religious experiences, because that's what they can feel like . . . Because the element of ecstatic transformation was so common to these experiences, they felt spiritual to many of us" (p. 172).

After the body-focused processes of depersonalization or pain (Langdridge, 2005) or after the psychological process of feeling intense shame or humiliation (Lindemann, 2011), the BDSM practitioner arrives post-scene feeling whole and complete.

Barker and colleagues' (2007) analysis of four public BDSM narratives, along with their analysis of the authors' own experiences, similarly point to the multiple ways in which BDSM can exert transformative power. They conclude:

> It seems that there is not one "healing narrative" of BDSM but several, using different languages to suggest that BDSM may take a person on a journey from physical ill health to healing, from psychological problems to confidence and happiness, from abuse to positive relationships, from feeling powerless in the face of illness and/or disability to self-control, from painful self-injury to sexual pleasure and from trauma and shame towards enlightenment and transcendence. (Barker et al., 2007, p. 205)

Interestingly, Beckmann (2007) argues that this transformative experience is likely to be experienced only by those in the bottom or submissive role. She argues that topping or dominating, with the need to retain control, to guide the experience, and to ensure the safety of all activities is incompatible with the "letting go" that a transcendental state requires.

Gender Theorized within BDSM

Because of cultural scripts that associate dominance with masculinity and submission with femininity (Morgan, 1975), it is perhaps not surprising that researchers and theorists concerned with BDSM have often highlighted gender issues and the association between BDSM and feminism. For instance, one quantitative study found no differences between BDSM practitioners and controls on measures of feminist attitudes and measures of support for egalitarian roles between men and women (Cross & Matheson, 2006).

Qualitative research provides further evidence of the alignment between feminism and BDSM practice. For instance, Taylor and Ussher (2001) found that BDSM was understood as "dissidence" by participants, and this dissidence focused on the rejection or the reversal of gender roles. The participants described BDSM as "deliberately, consciously antithetical to a sexual hegemonic, namely patriarchal heterosexuality" (Taylor & Ussher, 2001, p. 302). My own research has shown that the sexual fantasies of BDSM practitioners often do not follow traditional gendered roles (where men are dominant and women are submissive); rather, BDSM practitioners who identify with the dominant role tend to have dominance fantasies in which they provide pleasure to a partner, and practitioners who identify with the submissive role have submission fantasies in which they receive pleasure (Yost, 2007). In other words, traditional gender roles were trumped by the BDSM role for those practitioners who identify exclusively as dominants or submissives. Finally, female participants in focus groups led by Ritchie and Barker (2005) explicitly stated that BDSM was a feminist practice for them. These women argued that BDSM encourages freedom of expression around gender, with little-to-no expectation that men will be traditionally masculine and women will be traditionally

feminine. In addition, these participants stressed that choice (being free to choose whether to be dominant or submissive) made BDSM a feminist enterprise.

Other scholars have theorized that BDSM allows participants to expand their definitions of gender. Smith (2005) argued that BDSMs divorcing of dominance from masculinity and submission from femininity meant that this community can redefine gendered power dynamics in more expansive ways. In particular, dominants embody a dependency and nurturance that is not traditionally associated with masculinity and submissives embody a strength and self-determination that is not traditionally associated with femininity. Thus, masculinity becomes imbued with nurturance, male care, and intimacy, whereas femininity is expanded to include autonomy. Bauer's (2007) research suggests that this kind of "expansion of gender concepts" is particularly common in queer BDSM communities (p. 182).

There is an abundance of evidence from BDSM practitioners that the BDSM culture defies gender roles. Califia, for example, has written about the gender transgressions that take place in BDSM. Califia (1979/2000) wrote: "BDSM is so threatening to the established order . . . BDSM roles are not related to gender or sexual orientation or race or class. My own needs dictate which role I will adopt" (p. 166). Califia argues that, although the larger culture assumes that men will be dominant and women will be submissive, in BDSM the dominant or submissive roles are freely chosen, without regard to traditional gender expectations of the broader culture. Interviews and ethnographic research has expanded this point to show the ways in which BDSM practitioners do not just play with the traditional association between male/dominant and female/submissive; many also engage in "gender play" as well, seeing the BDSM scene as a place where individuals can express and perform a variety of gendered personas depending on the situation and one's partner (Hale, 1997). A participant in Bauer's study explained this as follows:

> In leather space people have a lot more freedom to explore their own gender(s). For instance, if I'm role playing I could be a girl one day and a boy the other day. Because people are into role playing and taking on different personas in the leather community, it opens up the possibilities for exploring gender. These gender explorations may allow people to discover something about themselves, like "you know what, wow, I really like living as a boy, maybe I wanna do that for now, but maybe not for my whole life." And leather space is a place where that possibility can be acknowledged. (Femmeboy, a participant quoted by Bauer, 2007, p. 181)

It is important to note that these latter examples (Bauer, Califia, Hale) all derive from lesbian, dyke, or queer BDSM communities. It is possible

(perhaps even probable) that heterosexual communities provide less opportunity for the kind of gender play described here. That is, the queer community is already open to nontraditional gender expressions, which may facilitate the gender play prevalent in queer BDSM scenes.

FUTURE DIRECTIONS

Women's participation in the alternative sexual practices of BDSM have been understudied relative to men's participation. Thus, there are many open questions about these nontraditional sexualities. Information on women's process of becoming involved in BDSM, women's process of "coming out" (for those who choose to do so), and how women integrate BDSM practice into existing relationship patterns would be interesting. Whereas lesbian or dyke BDSM communities have been studied by several researchers, relatively less scholarly work has considered the experience of heterosexual women (particularly submissives). Correlates of BDSM identity for women has also received little attention; that is, what sexuality- or gender-related attitudes and beliefs are associated with involvement in BDSM? Future research with BDSM-identified women and within BDSM communities can lead us toward a fuller understanding of the diversity that exists within women's sexual lives.

NOTE

1. Although I will use the more expansive acronym, BDSM, other scholars have chosen SM, S/M, or D/s to refer to similar phenomena; the differences between these terms are subtle and not relevant to the literature reviewed in this chapter. When directly quoting, I have retained the original author's acronym of choice.

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Chapter 14

Restoring Sexuality: Women's Sexuality in the Aftermath of Trauma

Thema Bryant-Davis and Nardos Bellete

Women who have experienced interpersonal trauma may experience a number of sexual consequences, ranging from increased risk for infection, pregnancy, difficulty with intimacy, and revictimization. These challenges, as well as other social and psychological challenges, may occur among lesbian, bisexual, and heterosexual women (Robohm, Litzenberger, & Pearlman, 2003; interpersonal traumas may include sexual assault, child abuse, intimate partner abuse, community violence, war, sexual harassment, hate crimes, and societal trauma [oppression]). The consequences of these violations can be pervasive and severe. There are, however, a number of strategies that have been utilized to empower women as they seek to reclaim their well-being, including their sexuality. Rivera (2002) notes that most treatment regimens for trauma survivors include some focus on enhancing client's capacity to create a healthy adult sexuality, with the goal of replacing rigid, maladaptive beliefs and behaviors, rooted in patterns of oppressive sexuality, with those that enable them to develop a mature and satisfying life.

In the immediate aftermath of sexual assault, survivors may experience bruises, pregnancy, and sexually transmitted infections. In addition to problems with general physical health, those who have experienced sexual abuse or assault may experience difficulties with sexual functioning. Intimate activity may trigger traumatic flashbacks, which can lead to emotional dysregulation, dissociation, and avoidance (Derenne & Roberts, 2010). Sexual violence survivors additionally often report feeling numb, dazed, and too vulnerable to seek treatment (Derenne & Roberts, 2010).

Childhood sexual abuse, physical abuse, and neglect can also affect a woman's sexuality in adulthood. The capacity to utilize others as a form of self-soothing is determined by early attachments and also is critical to one's response to developmental stresses (Schwartz & Galperin, 2002). The quality of early attachments strongly affects the capacity for adult intimacy. Early trauma and dissociative reactions have systematic effects on arousal, desire, and pair-bonding (Schwartz & Galperin, 2002). Hall (2008) notes that the pathway from childhood abuse to adulthood sexual difficulties can be based on learning unhealthy sexual patterns of behavior and cognition, as well as anxiety about being "normal" sexually, power imbalance in the sexual relationship, stress (because of the consequences of low socioeconomic status), and limited access to both quality health care and sexual information.

For women with direct exposure to trauma, the effects can undoubtedly cause emotional suffering. This point has been extensively covered in the psychological literature and there is a growing body of research on the impact of interpersonal trauma on a woman's intimate relationships. In fact, scientific literature supports observations made on the ability of trauma symptomatology to drastically alter a woman's ability to relate to others. While the trauma survivor may develop hypervigilance, altered cognitive functioning or blunted emotionality, symptoms typically seen in posttraumatic stress disorder (PTSD), these issues can have a "ripple effect" that can influence interactions with partners, family, friends, coworkers, and various others (International Society of Traumatic Stress Studies [ISTSS] Fact Sheet, 2003). It is also possible that members of the trauma survivor's support network, including their romantic partner, may experience vicarious trauma, pain, or anxiety in the management of their own psychological crisis. Therefore, as the field of psychology expands its definition and treatment of trauma, care must be taken to also widen the scope from the treatment of the individual toward the treatment of their social system (D'Ardenne & Morrod, 2003). In a 2005 conference, Shalev supported this view, stating: "Trauma should not be seen as affecting individuals but as affecting humans in their context."

It is well-established that women with sexual trauma and childhood sexual abuse can develop considerable difficulties in intimacy and sexual functioning in adulthood (De Silva, 2001; Goff, 2006). Females may

develop avoidance of intimacy, issues with trust and openness, loss of sexual desire, sexual phobias, vaginismus, and anorgasmia (Mills & Turnbull, 2004). Survivors of intimate partner violence (IPV) often report symptoms of suicidal ideation, inability to establish intimacy and trust, grief, shame, and social isolation (D'Ardenne & Balakrishna, 2001). Women who were accident victims and had developed PTSD were also found to have similar issues in their intimate relationships, including reduced sexual desire, inability to relax during sex, and anorgasmia (De Silva, 1999). Women affected by combat trauma were included in an extensive literature review by Busuttil and Busuttil (2001) on the psychological impact on families with prolonged separations due to life-threatening situations. Results showed that trauma survivors and partners experienced difficulties with the reunification and reintegration process.

After female genital mutilation, newly immigrated women may experience shame once exposed to the new expectations of a more sexual culture through media outlets or their peers. Once aware of their differences in genital appearance, which can accompany a lack of sexual enjoyment due to circumcision, these women may respond with feelings of inadequacy, anger, guilt, and lowered self-esteem (Whitehorn, Ayonrinde, & Maingay, 2002). Wilson and Kurtz (2000) studied the impact of PTSD on couple relationships where outcomes demonstrated significant deleterious effects on survivors, their partners, and their relationship, regardless of the circumstances of traumatic events in female participants.

Trauma has also been found to affect women's sexual attitudes. Interestingly, Broman (2003) found that experiences of trauma among women, but not among men, resulted in more accepting ideas in certain domains of sexuality. Specifically, women who had experienced negative life events, such as trauma, were more accepting of pornography and were more accepting of having a gay or lesbian family member or friend.

FACTORS AFFECTING REACTIONS TO TRAUMA

Processes of psychological traumatization can be viewed through conditional factors that persist before, during, and after the impact of trauma. Pretraumatic factors consist of personal and family history of psychiatric illness, socioeconomic status (lower groups at higher risk), and gender (women are at greater risk). Peritraumatic factors contain the specific type of trauma, the level of perceived danger, and early-on depression and/or sustained dissociation (Shalev, 2000). Although many different types of trauma can affect women's personal relationships, some events are more likely to affect their intimate relationships than others. Some of these common traumatic life events include: death of a loved one (especially when unexpected), diagnosis of cancer, miscarriage, sexual assault, intimate partner violence, criminal acts, disclosure of an affair, brain injury,

torture or incarceration, exposure to war or terrorist attacks, near-death experiences (such as drowning), natural disasters, and diagnosis of HIV or other potentially lethal illnesses (Mills & Turnbull, 2004). While this is a list of the most common traumatic events that may create "ripple effects" around the exposed individual, therapists must use their discretion as to how their clients' relationships may be affected. Finally, posttraumatic factors include issues involving one's level of social support, economic resources, extent of loss, and secondary stressors.

CRITERIA AND CLASSIFICATIONS OF INTIMACY

When identifying healthy and committed partner relations, Schwartz (2001) characterized them through the following criteria:

- Communicating openly, spontaneously, and nondefensively
- Responding with empathy
- Negotiating conflicts through accommodation and compromise
- Affirming each other's vulnerabilities
- Enjoying physical contact ranging from affection to sex
- Creating a unique identity from their mutual developmental history through shared experiences
- Respecting and supporting each other's evolution as individuals (acceptance of differences in interests, friendships, careers, hobbies, etc.)
- Providing support for each other during crisis
- Contributing to mutually shared goals and responsibilities
- Playing together openly and spontaneously
- Remaining monogamous and faithful to each other

Mills and Turnbull (2001, 2004) cite two broad categories to describe intimacy. Intrapsychic intimacy is characterized by the individual's achievement of sufficient self-knowledge and self-acceptance that subsequently promote a willingness to share one's thoughts and feelings with another. Specifically, it measures the capacity of an individual to know the self, which may then represent an individual's capacity to develop intimate relationships. Resilience and vulnerability are characteristics included in intrapsychic intimacy. Interpersonal intimacy, on the other hand, is viewed as the result of an interaction that occurs between people who share something meaningful with one another. Anxiety, blunted emotions, and anger or irritability, all features of common diagnoses following trauma, may all impair interpersonal intimacy and further damage the relationship.

INCREASED RISK OF SEXUALLY TRANSMITTED DISEASES

Experiences of sexual abuse and assault increase the risk for sexually transmitted infections (STIs). There is also a greater risk for the transmission of disease in the context of IPV. For women, IPV is unfortunately quite prevalent. IPV is defined as a partner's willful intimidation, assault, battery, sexual assault, and/or other abusive behavior over another. IPV is an underreported crime, with approximately only one-fifth of rapes, one-fourth of physical assaults, and one-half of stalking against women ever reported to authorities (National Coalition Against Domestic Violence, 2007). It is also estimated that 1.3 million women are assaulted by their intimate partners each year and one in four women assaulted by a partner during their lifetime (National Coalition Against Domestic Violence, 2007). Women between the ages of 20 and 24 are at greatest risk for IPV. Incident rates for women in lesbian relationships are estimated to be equal or greater than that of heterosexual women (Greenwood et al., 2002; Tjaden & Thoennes, 2000). In fact, IPV affects individuals in every community, despite one's age, race, nationality, economic status, religion, or educational background. IPV includes emotional abuse and controlling behaviors that encapsulate the systemic pattern of dominance by the perpetrator.

In a review of the literature, Campbell (2002) found multiple health consequences for which abused women are at higher risk. These include gynecological issues, including vaginal, anal, and urethral trauma after forced sexual activity (Campbell, 2002), and increased risk for sexually transmitted infections including HIV (Coker, 2007). Coker (2007) also found correlations between IPV survivors and later behaviors, including sexual risk taking (e.g., inconsistent condom use and nonmonogamous partners), unplanned pregnancy or induced abortion, sexual dysfunction, and STIs.

Additional trauma resulting from the vulnerability and susceptibility to STIs is a real threat for those exposed to interpersonal trauma. STI risk, including that of HIV/AIDS, is possible directly through transmission during forced unprotected sex with a partner or indirectly through the victim's inability to negotiate for safer sex (Heintz & Melendez, 2006). This difficulty in negotiating safer sex may stem from several factors that include the associated power dynamics, fear of violence, and lower self-efficacy. Furthermore, a victim's preoccupation with the essential task of guarding against physical and emotional harm may overshadow the ability to attend to concerns about safer sex.

RISK FOR REVICTIMIZATION

Women who were sexually abused as children are at increased risk for sexual assault during adulthood. There are a number of pathways that

have been proposed to explain the connection between childhood and adulthood victimization. Theorists have pointed to the following factors as contributors to increased risk for sexual assault, one of which is that the family of origin may be characterized by conflict and a lack of support, increasing the risk of an adolescent seeking to escape the family, even if this includes involvement with an abusive partner and/or a delinquent, drug-using subculture. A child sexual abuse (CSA) survivor with an insecure attachment style, especially if the style reflects a negative attitude toward self and a positive view of others, may be more vulnerable to abusive partners. Given that a certain percentage of persons are sexually aggressive, the more persons that a woman dates, the greater her chances of encountering a sexually aggressive partner. Some sexual assault survivors face difficulties maintaining healthy relationships, which may then result in them encountering multiple partners. Child sex abuse may increase the risk of revictimization of survivors due to the posttrauma feelings of powerlessness, lack of control, loss of value, and difficulty coping (Gold, Sinclair, & Balge, 1999). Researchers have confirmed that among adult survivors of childhood sexual abuse, psychological distress (depression and anxiety) and the use of sexual intimacy to relieve distress increased one's risk for sexual revictimization (Orcutt, Cooper, & Garcia, 2005).

For adult survivors of sexual assault, researchers have found that lack of acknowledgment of the assault can increase the risk for revictimization. Specifically, women who do not label the sexual violation as an assault are more likely to engage in high alcohol consumption and continue to socially engage with the offender. Both these factors increase the likelihood that one will experience an attempted sexual assault (Littleton, Axsom, & Grills-Taquechel, 2009).

When examining revictimization, it is important to examine not only the psychological challenges facing survivors, but also the ecological factors. Sexual assault occurs within a social context, and while positive social support can serve as a protective factor, negative social dynamics can increase survivors' risk for further abuse. In terms of sexual assault survivors risk for revictimization, researchers have found the mediating role of silence and fear of stigmatization. Specifically, when sexual assault survivors do not disclose the assault due to fear of social stigma, they are at increased risk for revictimization (Miller, Canales, Amacker, Backstrom, & Gidycz, 2011). This silence can increase isolation and shame, while decreasing the possibility of posttraumatic growth, leaving survivors distressed and vulnerable to further violation. Survivors' fear of social stigma is based in the reality that many persons endorse rape myths that blame victims for the violation. Specifically, researchers have found that non-supportive responses to disclosures of assault, including victim-blaming statements by those in one's support network, can increase the risk for revictimization (Mason, Ullman, Long, Long, & Srarzynski, 2009).

While some research has been done on women exposed to single-incident traumas, particularly IPV, relatively few studies have focused on women who experience abuse by multiple partners. However, studies have found that a substantial number of abused women have been in previous abusive relationships; rates range from 27 percent in a community sample (Bogat, Levendosky, Theran, von Eye, & Davidson, 2003), 41 percent in a combined community-shelter sample (Kemp, Green, Hovanitz, & Rawlings,1995), 49 percent in a national probability sample (Woffordt, Mihalic, & Menard, 1994), 56 percent in a service-seeking sample (Coolidge & Anderson, 2002), to 59 percent in another combined community-shelter sample (McCloskey, 1997). Furthermore, women who reported experiencing CSA or physical abuse have been found to be two to three times more likely to experience IPV in adulthood (Coid et al., 2001; Whitfield, Anda, Dube, & Felitti, 2003). A longitudinal study also found that women who witnessed IPV as a child were three times more likely to be at risk for IPV in adulthood (Ehrensaft et al., 2003).

Multiple traumas can also inflict significant psychological distress and devastate a woman's overall health. Studies indicate that most negative mental health outcomes associated with a history of IPV (e.g., PTSD, depression, anxiety, somatic complaints) appear attributable to those that experienced abuse by multiple partners versus a single partner, with women in single abusive relationships not differing significantly from nonabused controls (Bogat et al., 2003; Coolidge & Anderson, 2002; Messman-Moore, Long, & Siegfried, 2000). Overall, many abused women tend to exhibit greater levels and prevalence rates of Axis I and Axis II psychopathology (Coolidge & Anderson, 2002).

RISK FACTORS FOR REVICTIMIZATION

Child maltreatment, specifically CSA, physical abuse, and neglect, influence a child's socioemotional development and can increase the likelihood of further trauma (Finkelhor, Ormrod, & Turner, 2007). The emergence of dissociation and borderline personality traits are two such factors that can increase the risk for revictimization. It is theorized that dissociation may allow the victim an opportunity to compartmentalize their perceptions of their abuser (Liotti, 1992), and may interfere with the victim's inability to attend to danger cues that differentiate threatening and nonthreatening behaviors due to derealization or depersonalization (Noll, Horowitz, Bonanno, Trickett, & Putnam, 2003; Wöller, 2005). Borderline personality traits have also been suggested as a predictor of multiple adult abusive relationships, as a review of literature suggests that from 50 percent to 81 percent of clients diagnosed with borderline personality disorder report a history of trauma (Brand, 2003). Coolidge and Anderson (2002) also found a significantly higher rate of two Axis I disorders, specifically PTSD

and depression symptomatology. Family dynamics, such as neglect, parent-child role reversal, and disorganized/insecure attachment, have also been cited as risk factors to many abused women (Alexander, 2009; Cyr, Euser, Bakermans-Kranenburg, & Van Ijzendoorn, 2010).

Specific characteristics of multiple abused women have also been cited in the literature. Women in multiple abusive relationships were found to have higher rates and greater levels of dependent, paranoid, and self-defeating personalities than women in nonabused and single abused groups (Coolidge & Anderson, 2002). Greenwald (2002) suggested that women who were abused multiple times in childhood later exhibited several conduct problem behaviors, including lack of empathy, impulsivity, anger, acting-out, and resistance to treatment. Experts also posit that the history of child trauma can establish disturbances in four developmental domains: regulation of affect and emotion, biological dysregulation and somatization, issues with impulse control, and difficulties in the development of the self and interpersonal relationships (Herman, 1992; Putnam, 1997). A national study found women who were impoverished, single or recently divorced, or had an educational level below that of their mother or female caregiver have an additional increased risk for revictimization (Byrne et al., 1999). Women who experience chronic symptoms and pathology are then placed in a vicious cycle wherein violence, mental illness, and poverty increase the risk for further victimization, mental illness, and poverty (Brand, 2003).

RISK FOR BECOMING AN OFFENDER

Although the majority of sex offenders are males, there are a number of women who become perpetrators of sexual violence and interpersonal abuse. The development of these behaviors has been linked to a history of CSA, emotional distress, use of dysfunctional sexual fantasies as a means of relief from the distress, and a lack of healthy coping strategies (Maniglio, 2011).

TREATMENT INTERVENTION AND PREVENTION

Disclosure of experiences with sexual trauma or abuse should be introduced by health care professionals in an open and nonjudgmental manner during routine medical care (Derenne & Roberts, 2010). Current findings emphasize the importance of inquiring about a woman's trauma history within introductions to therapy and service provider settings. Failing to do so may overlook significant issues for treatment that exist in abused women, especially multiple abused women, which may include characteristics and behaviors that create enduring vulnerabilities to further violence. Therefore, early identification of trauma victims and the scope

of their symptomatology are imperative for identification of high-risk factors.

It should also be noted that many couples enter couples therapy with sexual secrets. These secrets may include sexual trauma and may impede treatment until they are shared and discussed (McCarthy, 2002). McCarthy's (2002) estimate, based on 4,000 sexual histories, is that 75–85 percent of clients have not shared sexually sensitive or past sexual material with their spouses. While a client may not wish to share some of these experiences with her or his spouse, it is imperative that the therapist meets with the couple separately for the first or second session, so that an extensive sexual history can be gathered from each spouse without fear of judgment. Some common past sexual secrets are shameful or disappointing first intercourse, CSA or incest, guilt over masturbation or fantasies, confusion about same-sex experiences, negative body image, and contracting STIs. While concurrent individual therapy is recommended for clients with abuse and trauma, it is important to bring these topics into couple therapy, because these past experiences can have a significant impact on the emotional intimacy and sexual functioning of the couple.

A meta-analysis of 17 controlled treatment studies found that 62 percent of those with PTSD who received treatment improved compared to 38 percent of those who were not treated (Sherman, 1998). After treatment, 48 percent of participants who initially met full criteria for PTSD no longer did so, with moderate improvement maintained at the three-month follow up. Given that a significant portion of participants displayed chronic PTSD symptoms, these data are especially significant. In a review of the most common treatments for posttraumatic symptomatology cognitive behavioral therapy was among the most researched, and includes exposure therapy, stress inoculation training, relaxation training, thought stopping, cognitive restructuring, role-playing, and covert modeling (Brand, 2003). Cognitive techniques particularly aim to reduce the anxiety and depressive symptoms by training clients to modify dysfunctional thinking patterns associated with trauma. Although psychodynamic concepts, such as the use of the therapeutic alliance, hypnotherapy, and transference-countertransference, have been suggested to be efficacious, relatively few empirical findings exist to support this (Herman, 1992; Wilson, Friedman, & Lindy, 2001).

Pharmacotherapy has proven effective in a variety of populations, with most researchers recommending psychotropic medication in the context of psychotherapy. By far, the most recommended are serotonin reuptake inhibitors (SSRIs) that have shown to improve depression, anxiety, insomnia, and dissociative symptoms. On the other hand, monoamine oxidase inhibitors (MAOIs) and tricyclic antidepressants (TCAs) have shown more efficacy in the treatment of intrusive symptoms (Brady & Back, 2002). Combinations of medications that include mood stabilizers and atypical

antipsychotics may also be warranted and generally show promise within comprehensive treatment settings (Brand, 2003).

There is a need for disparate treatment interventions for individuals with complex trauma versus those with simple posttraumatic symptomatology. In fact, complex PTSD has been shown to be less responsive to treatment, with as many as 25 percent of clients with complex posttraumatic symptoms dropping out of treatment and only one-third eventually completing treatment with clear benefits (Brand, 2003). Cloitre, Koenen, Cohen, and Han (2002) advocate a two-stage treatment, wherein the first stage consists of techniques to contain traumatic material and affect. Stage one may include medication management and the strengthening of the therapeutic alliance to assist clients in managing their intense emotions, impulses, and symptoms; interpersonal skills would also be included in stage one. After clients have shown increased regulation and interpersonal skills, traditional trauma therapies (e.g., exposure or stress inoculation training) can be implemented.

Most of all, trauma survivors require a compassionate therapist with the ability to manage the often intense trauma-based dynamics that occur within treatment. Therapists must assist clients in their need to feel validated, respected, and empowered to break the reenactment of humiliation and powerlessness that accompany trauma and form a maladaptive narrative (Herman, 1992). Many trauma survivors come to therapy with a myriad of issues, frequent emotional crises, high levels of distress, seemingly chaotic lives, and often a history of treatment failure. In these situations, if the therapist is adept in validating their experiences and making sense of their presenting problems through response patterns to trauma, the client is liable to respond with greater hope for success in treatment as well as an increased motivation for change (Brand, 2003). Likewise, when clients are taught that their symptoms were once adaptive responses to trauma that are no longer useful, or begin to understand the meaning behind their previously misinterpreted behaviors, this can relieve the client because they are not as "crazy" or "damaged" as they once believed themselves to be.

While much treatment focuses on helping women engage in healthier behaviors, it is also important to address the thinking of survivors. More specifically, Blain, Galovski, and Peterson (2011) found that intervening to improve survivors' post-assault appraisals of the self may help to reduce the impact of interpersonal trauma on women's sexual functioning. Additional cognitions that need to be explored include the schema of self-intimacy, self-safety, self-trust, other intimacy, other safety, and other trust (Wright, Collinsworth, & Fitzgerald, 2010). Through cognitive therapy, survivors are able to challenge and change beliefs about their trauma histories and emerge with different beliefs about themselves, others, and the future that allow them to respond differently to future interpersonal encounters (Jacobs, 2002).

Risk reduction treatment for survivors should include psychoeducation, communication skills, exposure therapy for trauma, substance abuse treatment, and healthy dating techniques. Healthy dating includes psychoeducation concerning healthy versus unhealthy relationships, decision making regarding sexual activity, sexually transmitted infection/disease prevention, ongoing communication, identification of risky people and situations, as well as preparation for addressing risk (Danielson et al., 2010). One program to prevent revictimization among sexual assault survivors makes use of group therapy that provides psychoeducation, examining common cognitions and emotions following rape and challenging common myths about sexual assault and sexual assault survivors. The program also includes social problem solving, assertiveness, and personal risk-assessment components. Participants consider the factors that contribute to their individual revictimization risk and determine individualized solutions, including the use of positive coping strategies (Mouilso, Calhoun, & Gidycz, 2011).

Short-term psychodynamic sex therapy with trauma survivors includes identifying the internal conflicts, emotions, and defenses of the survivor (Bianchi-Demicheli & Zutter, 2005). Dynamic work can also include dream work and analysis. Additional strategies can include training on sexual responsiveness, hypnotherapy, behavior sex therapy, couples therapy, relaxation training, medication, and group therapy. Additional strategies that have been explored in the literature include expressive art therapy, journaling, crisis counseling, spirituality, social support, and eye movement desensitization and reprocessing (Bryant-Davis, 2011).

Effective treatment must take into account the cultural context of survivors, including but not limited to their sexual orientation, race, ethnicity, socioeconomic status, religion, and ability status (Bryant-Davis, 2007). An ecological framework is also recommended that attends to family systems, workplace issues, school environment, and neighborhood (Danielson et al., 2010). Therapy addressing posttrauma issues, including sexual issues, need to be sensitive to the needs of lesbian, bisexual, and transgender clients. Clients need a therapeutic context in which their expressions of gender identity and sexual orientation are acknowledged and clearly supported, so that their psychotherapy process will enable them to live freely and fully, rather than reinforcing the marginalization they experienced as abused children and as adults who practice sexualities, which are not widely accepted and fully supported in our society (Rivera, 2002).

IMPLICATIONS FOR FUTURE STUDY

Over the years, researchers and counselors have attempted to identify and understand challenges faced by trauma survivors, including challenges related to their sexuality. In the beginning, theories explained the

phenomena through the irrational behaviors of abused women (e.g., Deutsch, 1944; Freud, 1920/1961a, 1924/1961b), which effectively blamed women for their own victimization. Current theories of women exposed to trauma have become less victim blaming. Nevertheless, further work must be done in this area to expound on evidence-based treatment modalities for women of various backgrounds, with particular attention to healing and restoring the sexuality of survivors. These modalities must attend to the cultural context of survivors on multiple levels (Bryant-Davis, 2007). Furthermore, implications for therapist readiness and competency must be explored with proposals on how to fill-in the necessary gaps in training. Traumatic experiences can lead to numerous challenges regarding one's sexuality, but there are multiple pathways to assist and empower survivors in the journey toward restoration and holistic well-being.

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Chapter 15

Gaining Intimate Citizenship: Sexuality and Women with Enduring Mental Illness

Joanna Davison

Sexuality is a complex and important aspect of a person's health and mental wellness. However, for women with experiences of enduring mental illness (schizophrenia, bipolar, depression, and personality disorder), very few studies have specifically explored this area of well-being. This chapter outlines the literature related to the sexuality of women with enduring mental illness, including the contextual factors that impact on these women's behaviors. Discussion on the notion of intimate citizenship and the sexual rights of this group of women is outlined, and concludes with recommendations for how mental health professionals can create a culture that supports the realization of intimate citizenship for women with enduring mental illness.

SEXUALITY

Sexuality is a fundamental aspect of being human. The World Health Organization (WHO) (2004) defines sexuality as central to life and encompassing aspects, such as gender identities and roles, sexual orientation,

eroticism, pleasure, intimacy, and reproduction. Few (1997) suggest that there is not one single definition of sexuality, but rather diverse sexualities. Sexuality not only is more than sexual activity and sexual behaviors, but also encompasses common mental health issues, such as self-identity, and the ability to form trusting relationships with others in social and intimate ways (Park Dorsay & Forchuk, 1994). While sexuality is an important feature of one's identity, there is limited research specifically related to the sexuality of women with experiences of enduring mental illness. Studies that do examine the sexuality of women with enduring mental illness are generally mixed gender, and from a feminist perspective, this lack of differentiation between the genders of the participants raises concerns, as it suggests that gender has no effect on the data being collected. A generic description disregards the powerful influence of social- and cultural-based gender differences that impact on a person's life and the experience of mental illness (Ritsher, Coursey, & Farrell, 1997). In other words, women's experiences are defined through men's experiences. For example, the role of relationships and intimacy are viewed as central to women's sexuality (Kaschak & Tiefer, 2001). However, within mixed gender sexuality studies, the focus of the research is generally on sexual behaviors and activities, and only a few studies of people with enduring mental illness consider sexuality within a broader relational context (McCann, 2000; Volman & Landeen, 2007). As such, key aspects of women's sexuality are generally invisible, hidden, and rendered meaningless.

Studies about the sexuality of women with enduring mental illness focus primarily on the women's individual sexual behaviors, and find that compared with the general population, this group of women is seen to engage in risky sexual behaviors, such as unprotected sexual intercourse, multiple partners, sex trading, and sexual coercion (Cournos et al., 1994; Meade & Sikkema, 2007); have higher rates of HIV and sexually transmitted infections (Davidson et al., 2001; Randolph et al., 2006); and higher rates of abortion (Coverdale, Turbott, & Roberts, 1997) and sexual dysfunction (Wallace, 2001).

HIV rates for women with enduring mental illness range from 5.3 percent to 20 percent (Cournos & McKinnnon, 1997) and, although within the general Western population HIV infection rates are generally greater for men than women, among people with mental illness the gender difference is reportedly smaller (Carey, Weinhardt, & Carey, 1995). Davidson and colleagues (2001) also suggest that due to low condom use among women with enduring mental illness and sexual activity with multiple sexual partners, women are at greater risk of HIV than men with the similar mental health experiences.

While the studies clearly highlight the sexual risk behaviors of women with enduring mental illness, the focus of the studies is the women's individual behaviors and such an approach does not consider the contextual

factors that influence the individual behaviors. According to the WHO (2004), sexuality is expressed on a personal level, but is influenced and shaped by wider social, economic, cultural, legal, religious, historical, and political structures. To gain a better understanding of the sexuality of women with enduring mental illness, it is critical to move beyond the individual and examine those factors that influence these sexual behaviors. These include the impact of abuse, gender socialization, sexual coercion, poverty, the experience of mental illness, stigmatizing attitudes, eugenics, reproduction, psychiatric medications, and heteronormativity. The following sections outline these factors.

CONTEXTUAL FACTORS

Abuse

The experience of abuse and violence influences sexual risk behaviors (Collins, 2001). Women with enduring mental illness report higher rates of sexual abuse than nondiagnosed women, with abuse rates ranging from 50 percent to 75 percent (Rosenberg, Goodman, Thompson, & Mueser, 1999; Weinhardt, Bickman, & Carey, 1999) and experience repeated victimization, with Bengtsson-Tops and Tops (2007) finding that 63 percent of women with enduring mental illness had been exposed to more than one episode of abuse. The association between childhood sexual abuse and high-risk sexual behavior is attributed to the long-term emotional consequences of sexual abuse on interpersonal relationships (Meade & Sikkema, 2007). Common behavioral responses arising from the experience of sexual abuse include passivity and subservience and feelings of powerlessness (Plumb, 2005; Williams, 2005). The long-term mental health implications of sexual abuse are also associated with a variety of psychiatric symptoms, including schizophrenia, depression, anxiety, borderline personality disorder, and substance use disorders (Brand, 2002; Rosenberg, Lu, Mueser, Jankowski, & Cournos, 2007), and increased severity of psychological disturbance (Read, 1998). Consequently, the experience of abuse negatively impacts on the woman's ability to voice her sexual needs, her sense of power, and also her mental well-being.

Gender Socialization

While abuse is experienced on a personal level, power imbalances underpin this experience. Williams (2005) argues that gender inequalities provide opportunities for serious abuses of power, as women are positioned to meet the needs, including sexual needs, of men. Sexist socialization can cast men as having uncontrollable sexual urges and the initiators of sexual activity and women as passive recipients (Jackson & Scott, 1996).

Negotiation around condom use can then be difficult when a woman has little control or power within a relationship. Similarly, a woman may risk violence or abuse when requesting a partner to use a condom (Few, 1997).

Hooks (2000) argues that for a woman to be assertive she risks being seen as unfeminine, as female gender socialization encourages women to deny their feelings and emotions. Gender socialization can then make it difficult for women to take a position of agency and assertiveness. Javed and Gerrard (2004) note that gender roles can lock women in the relatively powerless position of "other." It then becomes an easier and more rewarding option to be compliant, rather than resist the gender roles by being self-assertive (Javed & Gerrard, 2004). Suppressing such feelings and emotions can lead to depression and a diminished sense of self-worth. For women with enduring mental illness, the subordinating effect of abuse and female socialization can then interlock and impact on a woman's ability to articulate her own sexual desires and to prioritize her safety in high-risk sexual situations.

Sexual Coercion

Women with enduring mental illness also report high rates of sexual coercion, with between one-third and up to three-quarters of women reporting a history of sexual coercion (Chandra, Deepthivarma, Carey, Carey, & Shalinianat, 2003). Sexual coercion refers to sexual behavior occurring because of threats of physical force, emotional abuse, or financial incentives (Weinhardt et al., 1999). This includes coercion into unwanted sexual intercourse and rape (Coverdale et al., 1997; Goodman, Rosenberg, Mueser, & Drake, 1997; Lombardo & Pohl, 1997). Sexual coercion poses a serious threat to the sexual and mental health of these women, for two reasons. First, sexual coercion and forced sex may result in vaginal and anal tearing, pelvic inflammatory disease, genitourinary problems, STIs, and HIV. Second, exposure to these episodes may impact on the women's mental health and exacerbate their experiences of mental illness (Weinhardt et al., 1999). Under these circumstances the women often have few options to manage their risk for infections, as a higher priority is their physical and emotional safety (Collins, 2001).

Poverty

Women with enduring mental illness are also often poverty stricken (Collins, 2001). The long-term impact of an enduring mental illness generally results in limited employment and economic dependence on government subsidies. As a result of not being able to meet their basic needs, women will engage in sex trading or exchanging sex for money or goods (Meade & Sikkema, 2007). This places women at great risk, as sex trading

often occurs with unfamiliar partners and the women have limited ability to afford safe sex measures, such as condom use (McKinnon, Carey, & Cournos, 1997; Weinhardt et al., 1999). Therefore, the women may engage in risky behaviors as a result of their socioeconomic position rather than because of their mental health. In other words, poverty may drive women into high-risk sexual activities.

The practice of women with enduring mental illness engaging in sex trading for cigarettes while in psychiatric hospitals has also been reported (Davison, 2008). Davison (2008) noted that in these situations staff tended to overlook such activities. By staff failing to respond to such practices, it could be argued that they and the hospital system condone, albeit covertly, the economic exploitation of women's sexuality. The need for women with enduring mental illness to exchange sex for cigarettes both reflects the limited economic opportunities available to them and the commodification of their sexuality, and the response of staff could be seen as supporting these systems. Economic, institutional, and individual practices not only influence and shape the women's sexuality, but also contribute to the stigma associated with this group of women.

Mental Illness

The impact of a person's mental illness has also been linked with engaging in sexually risky behaviors. Mania in women with a bipolar condition often results in an increase in sexual impulsivity and risk-taking behaviors, while cognitive impairments either from schizophrenia or substance abuse also affect judgments and negotiation skills within sexual relationships (Collins, 2001; Davidson et al., 2001). The consequences of such behaviors can add to the mental distress the women may be experiencing.

Exacerbation of a woman's mental distress may at times necessitate admission into a psychiatric hospital. Unfortunately, events of sexual harassment are not uncommon within psychiatric units, with many women reporting sexual abuse or intimidation while being hospitalized and feeling unprotected by staff (Glenister, 1997; Harris, 1997; Ramsey-Klawsnik et al., 2006). The current trend toward integrated male and female wards may actually be undermining the safety of the women, especially as mixed gender wards increase the likelihood of abuse occurring (Grant, 2003), and the women are particularly vulnerable in these settings.

Contributing to this vulnerability is that the process of being diagnosed with a mental illness and then hospitalized promotes within the person a degree of passivity (Romme, 2009). Therefore, the institutional practice of mixed gender units coupled with other factors, such as the passivity and subordinating effects of sexual abuse, gender socialization, and the medicalizing of mental distress, can then intersect to influence the sexuality experiences of women with enduring mental illness.

Stigma

The sexuality of people with enduring mental illness is often seen as problematic and pathologized (Deegan, 1999). Media representations of people with enduring mental illness as dangerous and violent have been identified as contributing to these attitudes (Cook, 2000). Cook (2000) argues that media stereotypes create stigma and fear, which act to control the sexual expression of people with experiences of mental illness. For people who experience mental illness, these beliefs become internalized, resulting in the person repressing their sexuality or worrying too much about their normalcy (Cook, 2000, p.199). Self-stigmatizing beliefs then impact on the formation of close permanent relationships (Thornicroft, Brohan, Rose, Satorius, & Indigo Study Group, 2009) and increase the likelihood of engaging in more casual sexual relationships and having multiple sexual partners. For stigmatized societal groups, the condom can symbolize the barriers in society that make it difficult to form intimate relationships (Joff, 1997). As such, condomless sexual activity is seen as overcoming the stigma, as it symbolizes trust and acceptance. The experience of stigma can influence not only a person's social identity and mental health, but also the way a person will engage with others (Ryan, Carryer, & Patterson, 2003). For women with enduring mental illness, the marginalization that arises from stigma impacts on their sexual relationships and also their ability to engage in safe sexual activities.

The stereotyping and discrimination associated with mental illness influences how women with enduring mental illness express their sexuality. However, several studies suggest poor sexual health knowledge and limited access to primary health care services, as further explanations for people with enduring mental illness engaging in risky sexual activities (Grassi, Pavanti, Cardelli, Ferri, & Peron, 1999; Lyon & Parker, 2003). Lyon and Parker (2003), in their study of women with mental illness, found that many of the women knew very little about contraception and preventive health care. It could be argued that the women are responsible for their poor sexual health knowledge; however, other factors influence that knowledge. Sexual health education is often delivered at a primary health care level, but women with enduring mental illness often receive inadequate health care in these settings (Van Den Tillart, Kurtz, & Cash, 2009) and where payment is required, due to limited income, the cost of accessing primary health care can then become a barrier (Cook, 2000).

As such, mental health professionals are in the best position to provide sexual health information. Unfortunately, although studies have found that people with enduring mental illness will openly discuss sexual issues (McCann, 2000; Volman & Landeen, 2007), mental health professionals often report feeling uncomfortable when discussing sexuality with their clients, and as a result ignore or seldom inquire about this aspect of their

client's lives (Cort, Attenborough, & Watson, 2001; McCann, 2003; Pyke, Rabin, Phillips, Moffs, & Balbirnie, 2002; Quinn, Happell, & Browne, 2011). The reasons for staff's reluctance to engage in discussion of sexual issues with clients include a lack of education around sexual health issues and concerns about professional roles and boundaries (Collins, 2006; Pyke et al., 2002). Such reluctance illustrates how at an institutional level mental health services can then maintain and reinforce socially held stigmatizing beliefs.

Other ways mental health professionals both reflect and uphold societal attitudes that contribute to negative stereotyping of people with experiences of mental illness is by viewing the sexual activity of this group of people as inappropriate, likely to slow recovery, and therefore to be discouraged, or else consider the person as asexual (Buckley & Wiechers, 1999; Dobal & Torkelson, 2004). Such attitudes not only contribute to the marginalization and sense of "other" that people with mental illness experience, but also create barriers to accessing sexual health education and support.

Eugenics

Historical factors also have tended to pathologies the sexual expression of people with enduring mental illness. Eugenic ideologies underpinned many of these beliefs and practices (Deegan, 1999). Between 1900 and 1940, eugenic theories developed as a worldwide movement and was based on the belief that emotional, mental, and social traits were genetically inherited (Allen, 1997). Society could, therefore, be protected from the types of people defined as socially "unfit" by ensuring their heredity defects were not passed on (Taylor, 2005). Eugenics appealed to many intellectuals, scientists, and conservative thinkers, as it sought to improve the human race by ensuring only the fittest reproduced and discouraged the "unfit" or worthless members of society from having children.

Psychiatrists especially embraced eugenic theories, as eugenics positioned the cause of psychiatric illness within a genetically inherited framework (Schulze, Fangerau, & Propping, 2004). Therefore, psychiatry became established within a biological context like other areas of general medicine. This organic explanation provided psychiatry the legitimate body of knowledge it needed to raise its standing within the medical profession (Schulze et al., 2004). With the support of psychiatrists and others, the eugenic movement was able to enact its ideologies through legislation. Such legislation saw the forced sterilization of thousands of people, including psychiatric patients (Schulze et al., 2004; Sharav, 2005).

However, while support for eugenic ideologies waned, it could be argued that eugenic thought has remained in more subtle forms. For example, up until 1992 in New Zealand, it was illegal to have sexual intercourse

with a mentally disordered female (Mental Health Act, 1969), and within psychiatric settings women were illegally administered hormonal contraceptives without their consent (Egan, Siegert, & Fairley, 1993). Universally, preventing pregnancy among women with mental illness still remains a key priority for mental health providers (Collins, 2001; Davison, 2008). Such legislation, practices, and priorities imply an underlying concern about this group of women having children and becoming mothers.

Within psychiatry, the role of genetics and genetic susceptibility are still seen as the prominent cause of mental illness (Schulze et al., 2004). Deegan (1999) suggests that concerns about the inheritable nature of genes contribute to the construction of sexuality of people with enduring mental illness as problematic. Furthermore, Krumm and Becker (2006) propose that the reluctance of mental health professionals to engage in discussions, specifically concerning family planning issues, can be seen as a legacy of past eugenic policies. Eugenic ideology and psychiatry both contribute to the negative construction and stigma associated with the sexuality of people with enduring mental illness.

Reproduction

Compared to nondiagnosed women, women with enduring mental illness have higher rates of unplanned pregnancies and abortion (Coverdale et al., 1997; Miller & Finnerty, 1996). Reasons offered for high abortion rates included contraceptive failure, lack of social support, and pressure from health professionals due to concerns about a woman's ability to raise her children. The teratogenic risks or risks to fetal development associated with certain psychiatric medications have also been attributed to women terminating their pregnancies (Viguera, Cohen, Bouffard, Whitfield, & Baldessarini, 2002). While one option to avoid the teratogenic risks is to stop the medication, the impact of discontinuation was often a recurrence of illness symptoms. Accordingly, the fear of becoming unwell was another reason women chose not to proceed with a pregnancy (Viguera et al., 2002).

However, when women chose to proceed with their pregnancy, they were more likely to have to give up their children for others to rear (Coverdale et al., 1997; Miller & Finnerty, 1996). The loss of their children often intensified the emotional and mental distress and sadness the women experienced (Dipple, Smith, Andrews, & Evans, 2002; Sands, Koppleman, & Soloman, 2004).

For women with enduring mental illness, pregnancy is seen as problematic and suggests the result of some individual failing, such as noncompliance with contraception. This is despite the fact that changes in antipsychotic medication regimes, from older or typical antipsychotic medications which have side effects that have a contraceptive effect to newer atypical antipsychotic medications which have less side effects, have resulted in unplanned pregnancies (Gregorie & Pearson, 2002).

Concerns about this group of women becoming pregnant also overlook the larger social context in which pregnancy occurs. For example, motherhood and having children are often seen as the ultimate goal for women (Abbott, Wallace, & Tyler, 2005). For women with enduring mental illness to enter into this position of motherhood is to regain a place of normalcy that is often lost on being diagnosed as mentally ill. Motherhood enables the woman to enter into socially accepted roles and to shift away from the location of "other." The rearing of a child gives both status and a purpose to the women's lives (Davison, 2008). Not being able to enter into this position only intensifies the "othering" process and sense of marginalization.

Medication

Within psychiatry, one of the main treatments for the experience of mental illness is the use of psychotropic medication. Such medications have significant side effects, including sexual dysfunction and weight gain. Reported rates of sexual dysfunction in women on conventional neuroleptics range from 30 percent to 93 percent (Wallace, 2001). Sexual difficulties surrounding desire, arousal, and orgasm were the main problems reported. However, Kaschak and Tiefer (2001) argue the cause of sexual dysfunction for women is not solely a biomedical factor, but rather the intersection of sociocultural, political, economic, psychological, and relational factors. This suggests that while medication may be contributing to the women's experiences of sexual dysfunction, other wider factors will also influence the women's sexual behaviors.

Weight gain is another common side effect of psychotropic medication (McDevitt, Snyder, Miller, & Wilbur, 2006) and is seen as the stigmata of mental illness (Schulze & Angermeyer, 2003). Women report that the weight gained from medication not only affected their self-image and relationships with others, but also contributed to a sense of social exclusion and marginalization (McCann & Clarke, 2005; Schulze & Angermeyer, 2003). The impact of weight gain on notions of self-esteem and self-worth is particularly relevant for women, as within society a woman's appearance is often considered the main area of power available to her (Caplan & Cosgrove, 2004). Powerful negative assumptions are also assigned to bodies considered overweight, as the person is generally seen as a failure and out of control (Ryan & Carryer, 2000). As a result, Davison and Huntington (2010) suggest that psychiatry and the use of medication both contribute to and increase the stigma that women with enduring mental illness experience.

Heteronormativity

Western sexuality is shaped by heteronormatvity or the idea that a loving, lasting couple is essentially heterosexual (Plummer, 1995). Up until

1973, homosexuality was defined as a mental disorder within the Diagnostic and Statistical Manual of Mental Disorders (DSM; Klinger, 2002). The decision to delete homosexuality from the DSM occurred as a result of political pressure that challenged the pathologizing definitions of homosexuality (Weeks, 1985). Although removed from the DSM, attitudes did not change overnight, as the power and dominance of heteronormativity continued to force many women to hide and conceal their lesbian identity with significant mental health consequences (Meyer, 2003).

Hellman (1996) suggests lesbians with enduring mental illness may be doubly disadvantaged, as they face both the stigma of being lesbian and of having a mental illness. Lesbians describe this as a double "coming out" process—coming out as a lesbian and as a mental health consumer (Davison & Huntington, 2010). Lesbians continue to be disproportionately exposed to prejudice and discrimination, including within their use of mental health services (Owen & Khalil, 2007). Homophobic and heterosexist attitudes exist in mental health services, with one study finding 30 percent of lesbian women experiencing some form of discrimination from mental health staff (Welch, Collings, & Howden-Chapman, 2000). The most common anti-lesbian experiences reported were the mental health staff's failing to recognize the impact of living in a homophobic society. Particular areas identified included a lack of recognition and understanding of the conflict around disclosure of one's sexuality, the legal rights of partners, and relationship and family difficulties (Welch et al., 2000). This suggests that while staff may not have been overtly homophobic, the more subtle forms of discrimination and heterosexism, which renders lesbians invisible and silenced (McEvoy, 2000), were still apparent. The experience of heterosexism within the mental health system raises issues about the power of the mental health system to shape and maintain normative structures, such as heteronormativity.

IDENTITY

As noted, most studies on the sexuality of women with enduring mental illness are focused on individual sexual activities and position the women's sexuality as problematic. However, when sexuality was examined within the broader context of identity, sexuality was identified as an important aspect of a person's sense of self and well-being (Davison, 2008; Volman & Landeen, 2007). Davison and Huntington's (2010) study on the sexuality experiences of women with enduring mental illness found that, while women reported that their sexuality was an important aspect of their identity, several powerful systems controlled and influenced how the women expressed their sexuality. These included the effects of female socialization, stigma, and heteronormativity, which interlocked to affect the women's sense of identity, mental well-being, and connection with

others (Davison & Huntington, 2010). The women also made suggestions for how staff and services could better address their sexuality experiences (Davison, 2008). These suggestions could be seen as a rejection of their psychiatric identity and the reconstruction of a positive affirming identity. To facilitate discussions about sexuality, the women stressed the need to be able to trust staff, and for staff to be accepting and affirming of the women and their lifestyle, and to recognize and value the importance of intimate sexual relationships (Davison, 2008). Acknowledging the role of relationships in women's lives is especially important, as relational aspects are considered central to women's sexuality (Kaschak & Tiefer, 2001). Underpinning this need is a requirement from staff to accept the women and their identity as sexual subjects.

INTIMATE CITIZENSHIP

Society constructs people who experience mental illness as being "other," subhuman, and inferior (Beresford, 2005; Johnstone, 2001). The position of "other" is one of having no voice. A sense of subordination and marginalization arises from the position of "other" in society. The "othering" process associated with the experience of mental illness separates the women from society. The women's sexual behaviors are seen as arising from some individual failing and, from a medical perspective, as arising from a brain disease. Williams (2005) argues that psychiatry with its focus on diagnosis and individual pathology detracts from external causes that may be contributing to the person's behavior. Using solely the medical lens to examine sexual behaviors overlooks those wider contextual influences and only contributes to the experience of stigma. The labeling process also means that health professionals, and the wider society, do not need to examine their role in creating a culture that stigmatizes and marginalizes the sexuality of women with enduring mental illness.

Pilgrim (2005) states that the social exclusion and marginalization that arise from stigma limit a person's active participation in society and their access to citizenship entitlements. "Intimate citizenship," a term coined by Plummer (1995), is a person's right to sexual expression, intimacy, and desire. For women with enduring mental illness, this means the right to intimacy and expression of sexual identity. Recognizing intimate citizenship means the stories of those whose sexuality has been pathologized, such as those of women with experience of mental illness, can then be heard.

For women with enduring mental illness to access this sphere of citizenship, mental health services need to create a culture in which the women's sexual stories can be heard and a culture that is responsive to the sexuality experiences of this group of women. The desire for love, closeness, and acceptance is a fundamental human need, and as such, the expression of sexuality and engaging in intimate relationships are considered key

aspects in a person's recovery from mental illness (Watkins, 2003). Therefore, to enhance the women's ability to recover from their mental health experiences, mental health staff need to recognize the value of intimacy and loving relationships and to uphold the notion of sexual rights. Creating this culture requires service providers to look beyond the individual behaviors and to examine the women's patterns of behavior within the wider contextual factors, such as the impact of gender socialization and stigma associated with the experience of mental illness. Psychiatry's role in maintaining and upholding such behaviors also needs to be explored. Undertaking this process will help challenge and counter the negative constructions associated with the women's sexuality and enhance access into this sphere of citizenship.

CONCLUSION

Sexuality is an important aspect of a person's life and well-being. Yet, the sexuality of women with experiences of enduring mental illness is viewed in a stigmatizing and often discriminatory way. Many experiences interlock to shape and influence how these women express their sexuality, including practices within mental health services. One way mental health services can break down the stigmatizing attitudes and experiences that separate women with enduring mental illness from the rest of society is to view intimate citizenship as a central aspect of recovery. Doing this will create a culture within mental health services that is supportive of the women's sexuality and sexual expression, and enhance the women's ability to claim a subject position of intimate citizen.

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Chapter 16

Women's Sexuality: From Problems to Possibilities

Debra Mollen and Jennifer Mootz

In 2007, *New York Times* reporter Stephanie Rosenbloom wrote an article about the proliferation of the word *vajayjay,* a euphemism for the word *vagina* popularized collectively by Oprah Winfrey, *Grey's Anatomy,* and the Urban Dictionary. A few years earlier, feminist psychologist Harriet Lerner (2004) theorized that women's conspicuous avoidance of the word *vulva* and the erroneous interchanging of *vagina* for *vulva* were endemic problems that needed correction. She noted: "When we feel prohibited from speaking clearly, we also can't think clearly" (p. 164). What can we learn about women's sexuality from these two references? What are the individual and cultural implications when one of the most revered, influential women in the world employs a puerile expression to avoid the anatomically correct name for her genitals? What happens to women when we lack language for our experiences? Given this cultural backdrop, what is the nature of women's sexual problems and how can we treat them effectively?

In this chapter, we begin by examining the major categories of sexual disorders, including diagnostic criteria, particularly for those disorders that most often affect women. Next, we review information on prevalence

rates in order to ascertain how many women may be impacted by sexual problems, and provide information and explanations regarding what accounts for discrepancies in the reporting of sexual problems. We then offer a critical perspective in order to shed further light on the construct of desire, genital and subjective arousal, sexuality and shame, the quandary of inaccurate and incomplete language, and the cultural images and proscriptions that impact women's sexuality. We conclude the chapter by delineating strategies for treatment, both those at the individual and couples' therapy level as well as those on global, systemic, and social justice strata, all of which are of critical importance in the quest for women to experience joyful, healthy, and satisfying sexuality.

WOMEN'S SEXUAL PROBLEMS: A MEDICAL PERSPECTIVE

In 1998, the pharmaceutical company Pfizer introduced the drug sildenafil (Viagra). Since that time, physicians have prescribed Viagra to more than 17 million men in the United States, making it a lucrative medication. In 2001 alone, Pfizer reported sales of US$1.5 billion (Moynihan, 2003). Particularly because of the success in treating erectile dysfunction in men with medications like sildenafil, medically oriented researchers and physicians, often in conjunction with pharmaceutical companies, have made substantial efforts to define women's sexual problems from a medical perspective (Moynihan, 2003).

The *Diagnostic and Statistical Manual of Mental Disorders,* text revision (DSM-IV-TR; American Psychiatric Association [APA], 2000), categorizes sexual disorders into four domains: sexual dysfunctions, paraphilias, gender identity disorders, and sexual disorder not otherwise specified. Of these, this chapter will focus on sexual dysfunctions, since the majority of women who seek psychotherapy because of sexual problems present with issues consistent with sexual dysfunctions (Laumann, Paik, & Rosen, 1999; Laumann et al., 2005)

The taxonomy of sexual dysfunctions was primarily constructed from Masters and Johnson's (1966) conceptualization of the human sexual response cycle. In 1966, Masters and Johnson observed 700 women's and men's sexual responses and posited that the participants' responses could be categorized into a linear sequence: excitement, plateau, orgasm, and resolution; they termed this response set the human sexual response cycle. Later, Kaplan (1979), a psychotherapist, critiqued Masters and Johnson's model and introduced the component of desire. Shortly after Kaplan's contribution, the 1980 revision of the DSM-III (APA, 1980) grouped sexual problems according to four arenas: desire, arousal, orgasm, and pain. This conceptualization of sexual dysfunctions is based on Masters and Johnson's (1966) and Kaplan's (1979) findings and has remained consistent throughout the

ensuing revision of the DSM-IV-TR (APA, 2000). Though not without its challengers, the initial understanding of sexual dysfunction has persisted for more than four decades.

According to the DSM-IV-TR: "A sexual dysfunction is characterized by a disturbance in the processes that characterize the sexual response cycle or by pain associated with sexual intercourse" (APA, 2000, p. 535). Although pain is not a component of the human sexual response cycle, clinicians added this dimension because some clients reported experiencing pain on sexual contact (Brotto & Klein, 2007). In the DSM-IV-TR, sexual dysfunctions are delineated into seven areas: sexual desire disorders, sexual arousal disorders, orgasmic disorders, sexual pain disorders, sexual dysfunction due to a general medical condition, substance-induced sexual dysfunction, and sexual dysfunction not otherwise specified. All the disorders are characterized by three criteria: a definitional criterion that is specific to each disorder; a second criterion, which states that "the disturbance causes marked distress or interpersonal difficulty" (APA, 2000, p. 541); and a third criterion, which states that the disorder "is not better accounted for by another Axis I disorder and is not due exclusively to the direct physiological effects of a substance or a general medical condition" (APA, 2000, p. 541). Moreover, each area of dysfunction can be conceptualized using these groups of specifiers: lifelong or acquired type, generalized or situational type, and due to psychological factors or due to combined factors (APA, 2000).

In the DSM-IV-TR (APA, 2000), sexual desire disorders include hypoactive sexual desire disorder (HSDD) and sexual aversion disorder (SAD). The defining criterion for HSDD is that a woman must experience "persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity" (APA, 2000, p. 541). Most often, HSDD develops in conjunction with other psychological or interpersonal difficulties, typically after a person has had a period of sufficient sexual interest (APA, 2000). SAD, on the other hand, is marked by an active avoidance of genital contact with a sexual partner.

Female sexual arousal disorder (FSAD) and erectile dysfunction constitute the sexual arousal disorders. FSAD "is a persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement" (APA, 2000, p. 543). FSAD often occurs simultaneously with HSDD and orgasmic disorders.

The orgasmic disorders consist of the female orgasmic disorder (FOD), male orgasmic disorder, and premature ejaculation. FOD is defined as "a persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase" (APA, 2000, p. 547). The APA acknowledged that women demonstrate immense diversity according to the type, level, and frequency of stimulation needed to experience orgasm. Hence, APA

recommends that the clinician rely on her or his best judgment when considering a diagnosis of FOD and take into account contextual factors, like experience, age, and the adequacy of the stimulation.

The sexual pain disorders include dyspareunia, which can affect women or men, and vaginismus, a disorder specific to women. Dyspareunia is described as "genital pain that is associated with sexual intercourse" (APA, 2000, p. 554). Vaginismus is characterized by recurring involuntary contraction of the perineal muscles surrounding the vagina when penetration is attempted. The contractions can range from mild to severe, and if severe enough, will prevent penetration, including coitus.

PREVALENCE

Laumann and colleagues (1999) analyzed data garnered from the National Health and Social Life Survey (NHSLS) to determine the prevalence of sexual problems among women and men. For the NHSLS, researchers interviewed 1,749 women and 1,410 men, aged from 18 to 59, for 90 minutes each regarding several dimensions of sexual dysfunction, including: lack of desire, arousal problems, climax problems, anxiety regarding performance, climaxing too quickly, physical pain, and not finding sexual encounters pleasurable. In analyzing the data from these interviews, Laumann and colleagues (1999) concluded that more women than men experienced sexual dysfunctions (43% and 31%, respectively). Although Laumann and colleagues (1999) were careful to admonish that the data gathered in the NHSLS do not constitute clinical diagnoses, 43 percent is still a strikingly high percentage of women with sexual problems. When considering specific types of sexual problems, 22 percent to 43 percent of women reported having low sexual desire (Laumann et al., 1999, 2005), 18 percent to 41 percent reported an inability to orgasm (Laumann et al., 2005), 14 percent reported problems with arousal (Laumann et al., 1999), and 7 percent reported problems with sexual pain (Laumann et al., 1999).

Sexual problems correlate with demographic and cultural variables. For instance, in the Global Study of Sexual Attitudes and Behaviors (GSSAB), which assessed sexual problems in women and men throughout seven geographic regions (Southeast Asia, East Asia, Middle East, Central/South America, non-European West, Southern Europe, and Northern Europe), Laumann and colleagues (2005) found that women in the Middle East and Southeast Asia experienced more sexual problems overall than did women residing in other regions of the world. Moreover, a curious gender paradox was evidenced such that women's sexual problems, with the exception of lubrication problems, decrease with increasing age while the reverse holds true for men: increasing age correlates with a lack of interest in sex, inability to orgasm, and trouble maintaining an erection (Laumann et al., 1999, 2005). In Laumann and colleagues' (1999)

analysis of data collected in the United States, nonmarried women reported more sexual anxiety and problems with climaxing than married women. More highly educated women experienced fewer sexual problems overall. Regarding ethnicity, black women reported lower sexual desire and less pleasure than white women, white women reported more problems with sexual pain than black women, and Latina women reported fewer sexual problems than both black and white women. Furthermore, sexual problems were related to physical, emotional, and stress-related troubles. Women who experienced less life satisfaction and happiness also reported having more sexual problems. Women whose households underwent economic deterioration reported greater sexual problems as well. Finally, women who had been sexually assaulted, either as children or adults, reported more difficulty with physical arousal (Laumann et al., 1999).

Sexual problems among women are also significantly affected by attitudes, anxiety, and relationships. In a study about sexual dysfunction that included 186 women, McCabe (2005) found that "negative attitudes toward sex impede the development of sexual intimacy" and that "the women who experienced the most relationship problems showed the highest level of breakdown in their sexual response by showing a lack of desire" (p. 386). For these reasons, it is of critical importance that researchers and therapists consider contextual information when assessing and treating women who meet diagnostic criteria for sexual dysfunctions and disorders.

As we noted earlier, in order for a woman to meet the criteria for a clinical diagnosis within the spectrum of sexual dysfunctions, she must also exhibit marked distress about her sexual problem. Neither the NHSLS nor the GSSAB assessed for levels of distress. To address this missing piece of the prevalence puzzle, Bancroft, Loftus, and Long (2003) looked specifically at the prevalence of women's distress about sexual problems. They conducted a national telephone survey with 987 white and black women between the ages of 20 and 65-years-old. They attempted to differentiate distress into two types: relational distress (concern about relational problems arising from sexual problems) and self-focused distress (concern about one's inability to experience sexual pleasure or perception of oneself as a sexual being). Overall, Bancroft and colleagues (2003) determined that 24.4 percent of women experienced distress related to their sexual practices. The strongest predictors of distress were negative emotions during sexual interactions and other emotional problems. Notably, the number of women distressed about their sexuality constitutes nearly half of the 43 percent to 44 percent of women who experience sexual difficulties, as determined in the earlier study in which researchers did not account for distress (Bancroft et al., 2003; Laumann et al., 1999).

A CRITICAL PERSPECTIVE OF THE PROBLEM

Perhaps the most challenging component in the treatment of women's sexual problems is that there is little understanding of how women's healthy sexuality might best be conceptualized. Disciplines which have constructed the definitions for women's (un)healthy sexual functioning (e.g., sexology, psychology, and psychiatry) are rooted in patriarchy and models of healthy sexuality are androcentric (Meana, 2010; Nicolson & Burr, 2003; Wood, Koch, & Mansfield, 2006). For instance, Freud infamously and erroneously contended that the clitoral orgasm is inferior to the vaginal orgasm, which he deemed as the more mature orgasm (Freud, 1930). Women who preferred the clitoral orgasm were said to suffer from penis envy and frigidity. Consequently, several women sought treatment for being frigid (Koedt, 1970). Grave conceptual errors such as these laid the framework for more than a century of misunderstanding, misrepresenting, and mistreating women's sexual problems.

Fortunately, researchers have begun to formulate alternative models of women's sexuality that include new definitions of mechanisms involved in sexual experiences (e.g., Basson, 2000, 2002, 2003; Kaschak & Tiefer, 2002). Qualitative research has further elucidated how healthy sexuality is constructed by women themselves (e.g., Mollen & Stabb, 2010). Still, practitioners should remain mindful that research on women's sexuality is in its infancy (Bancroft & Graham, 2011) and that our forebears' influence persists today.

What Constitutes Desire?

To meet the criteria for a diagnosis of HSDD, women must report low levels of desire, which is defined in the DSM-IV-TR as deficient or absent sexual fantasies (APA, 2000). Several researchers have critically examined this definition (e.g., Bancroft & Graham, 2011; Basson, 2000; Brotto, 2010; Meana, 2010). In essence, using sexual fantasies as a criterion to define desire may be problematic for assessing desire in women. The frequency of women engaging in sexual fantasy may not parallel that of men for a host of sociopolitical reasons. For example, desire denotes agency and women are not socialized to express sexual agency. Because of this, Brotto (2010) suggested that it may be more relevant to assess the intensity of women's desire rather than the frequency. Additionally, there are cross-cultural variations in subjective reports of desire (Laumann et al., 1999, 2005). For instance, women who are more acculturated to the dominant U.S. culture report higher levels of desire (Brotto, 2010).

Another perplexing aspect of desire is that women often report that feeling desired increases their state of arousal or desire for their partners. For instance, Strassberg and Lockerd (1998) explored the content of

women's fantasies and found that 50 percent of women participants fantasized about being desired in the role of a performer or stripper (as cited in Meana, 2010). Bancroft and Graham (2011) suggested that both women and men have a basic pattern of sexuality, with a woman's basic pattern beginning when a man finds her sexually attractive or desirable and culminates in her choice to be sexual with her partner. Basson (2000, 2003) created a model of women's desire in which she contended that women's desire and motivations for sexual activity are more complex than the human sexual response cycle allows. According to Basson (2000), a significant motivator for women to engage in sexual activity is relational intimacy. Thus, she classified women's desire as either spontaneous or responsive. Spontaneous desire refers to self-initiated fantasies and yearning for sexual activity; it is linear and parallels the construction of desire in the DSM-IV-TR (APA, 2000). Responsive desire is circular, wherein a woman's partner initiates sexual activity, the woman responds to this initiation favorably, and exhibits desire in response to her partner's stimulation. Basson (2000) asserted that women's responsive desire is often fueled by relational motivations including desire for love, intimacy, or effort toward relationship maintenance. Basson (2000) recommended dividing HSDD into three subtypes. In the first subtype, women exhibit spontaneous desire, but have low motivation to act on this desire. In the second subtype, women lack both spontaneous and response desire. And third, women experience spontaneous desire, but have difficulty physiologically responding to sexual cues.

Meana (2010) questioned Basson's distinction between spontaneous and responsive desire. Drawing on the motivational model (Laan & Everaerd, 1995), she reasoned that spontaneous desire is never spontaneous. It always occurs in response to some sexual stimulus, which could be processed consciously or subconsciously, the latter of which gives the illusion that sexual thoughts or fantasies are not triggered, but self-initiated. Meana (2010) reasoned that the spontaneous and responsive dichotomy might better be conceptualized as a continuum of response. Moreover, a distinction might be made between healthy and unhealthy sexual functioning, such that the spontaneous or linear model of desire more appropriately characterizes healthy functioning, while a responsive model is more indicative of women who exhibit sexual problems. Meana proposed eliminating the distinction between these two types of desire.

Another model of desire, the dual control model of sexual response, defines desire from a primarily neurobiological perspective (Bancroft & Graham, 2011). In this representation, a person's sexual response is a result of the interplay between excitatory and inhibitory neurological mechanisms, which are shaped by genetics and early learning experiences. Bancroft and Graham (2011) purported that women's inhibitory and excitatory systems differ. Hence, the dual control model accounts for individual variability (which is especially relevant for women). Inhibition normally serves as

an adaptive mechanism, prohibiting risky sexual behavior or situations. However, in women with low desire, the inhibitory system may be overactivated, the excitatory system could be underactivated, or both overactivation of the inhibitory system and underactivation of the excitatory system could occur in conjunction (Clayton, 2010).

We offer that Bancroft and Graham's (2011) proposed pattern, which is similar to Basson's (2000, 2003) conceptualization of responsive desire, overemphasizes neurobiology and underemphasizes the sociopolitical and historical explanations for why women's excitatory and inhibitory systems are so overwhelmingly dysfunctional. We caution that the basic pattern of these models is problematic because they uphold traditional stereotypes of women, such that women are initially passive regarding sexuality and simultaneously imbued with the decision-making responsibility for sexual activity. The basic pattern is also problematic in that it is inherently heterosexist. Alternative perspectives that incorporate gender socialization provide important contextual considerations regarding women and desire. Leiblum (2002) noted that women's potential for sexual pleasure is likely greater than men's (due to the possibility of multiple orgasms without a refractory period), but that strong cultural proscriptions impede the unencumbered expression of desire.

Genital and Subjective Arousal

The DSM-IV-TR categorizes desire and arousal disorders discretely (APA, 2000), which does not accurately reflect women's understanding and experiencing of their own sexual processes. First, there is discordance between women's reports of subjective arousal and measurements of genital arousal (Bancroft & Graham, 2011; Basson, 2002; Laan, Everaerd, Bellen, & Hanewald, 1994), and subjective arousal is difficult to differentiate from desire. For example, Laan and colleagues (1994) measured 47 women's vasocongestive responses and subjective arousal when viewing women-made and man-made erotica. The women-produced erotica included more dialogue and context, softer lighting, and less genital focus, and was generally intended to be more women friendly. They found that there were no differences between the two groups in the women's vasocongestive responses. However, there was a significant difference between women's reported affect and subjective arousal. Women who viewed women-produced erotica experienced more positive affect and greater subjective arousal. Conversely, women who viewed the man-made erotica reported increased negative affect and low subjective arousal, in opposition to their biological response.

We can only speculate as to why incongruity exists between subjective and genital arousal. Some researchers have proposed that women have an automated biological response to sexual stimuli (Bancroft & Graham,

2011), and yet most women are denied sexual agency, which may well translate to a disconnection between subjective and genital arousal. There are also methodological complications in the assessment of arousal. For instance, researchers tend to assess arousal by measuring vaginal blood flow or vaginal pulse amplitude (VPA). However, vaginal lubrication and VPA do not correlate well to subjective awareness of arousal (Bancroft & Graham, 2011), a disjunction that reflects a profound and persistent misunderstanding about women's sexuality—that the clitoris is women's primary sex organ which is both homologous and analogous to the penis. Unfortunately, few studies measure the tumescence of the clitoris and labia (Bancroft & Graham, 2011). Methodological explanations aside, the discordance between women's subjective and genital arousal is in many ways not surprising, given the sociocultural context in which women's desire and arousal occur.

SEXUALITY AND SHAME

Fine and McClelland (2006) cautioned that many people erroneously equate the sexualization of girls and women with empowerment, and that girls and women are provided the license to be sexy, but not sexual. Certainly, being desired is largely a passive construct, which could be why some researchers (e.g., Meana, 2010) draw on Fredrickson and Roberts' (1997) objectification theory when considering the phenomenon of being desired. According to objectification theory, women are continually subjected to the objectifying gaze, interpersonally and through media. Because of the objectifying gaze, women begin to see themselves through the eyes of the other and take on an observer's perspective of their own bodies, which leads to habitual monitoring, one form of which is termed body surveillance. Women experience bodily shame when they scrutinize themselves and determine that their bodies do not meet ideal societal standards.

In a summary of 10 years of research conducted on aspects of objectification theory, Moradi and Huang (2008) reported that body surveillance and body shame are negatively related to psychological well-being and self-esteem, and may result in depressive symptoms. Relatedly, increased self-objectification is related to less interest in genital contact. Furthermore, women who reported greater levels of self-objectification were less likely to demonstrate sexual agency, had fewer sexual experiences overall, and had more regret following sexual experiences (Moradi & Huang, 2008). Steer and Tiggemann (2008) looked specifically at the role of objectification theory in women's sexual functioning and determined that self-objectification and body surveillance increased body shame and appearance anxiety, both of which led to increased self-consciousness, which resulted in decreased sexual functioning. Calogero and Thompson (2009)

found that increased endorsement of appearance ideals depicted in the media yields more body monitoring and body shame and less sexual satisfaction among women. Additionally, Mercurio and Landry (2008) found that body shame and self-objectification are significantly and negatively related to women's satisfaction with their lives as a whole.

Experiencing body shame and shame around menstruation has tangible, potentially dangerous consequences. Schooler, Ward, Merriwether, and Caruthers (2005) studied 199 young women and found a relationship among body shame, menstrual shame, and sex, such that those women who reported more body and menstrual shame also reported engaging in sex less often and exhibiting less sexual assertiveness when they did. Body and menstrual shame were also specifically related to condom use self-efficacy, such that those women who reported greater shame were less likely to be comfortable discussing issues of safe sex and purchasing contraception.

Several other researchers have reported troublesome findings regarding various correlates of sexuality and shame among girls and women. In a study of adolescent girls, for example, Impett, Schooler, and Tolman (2006) found that girls who engaged in more body objectification were less likely to use condoms and that those who ascribed to more traditional femininity ideals were less likely to evidence sexual self-efficacy, including finding enjoyment in sex and exhibiting sexual agency. Impett and Tolman (2006) reported that among their sample of 116 girls who were seniors in high school, although many reported generally feeling positively about their sexual experiences, fewer than half endorsed liking how their bodies felt during sex. Braun and Kitzinger (2001, p. 272) noted that women may worry that their vaginas are either too tight or too loose, remarking that there is pressure to see "women's 'natural' bodies as flawed, imperfect, and perfectible . . . [creating] another site of dissatisfaction, another area for (heterosexual) women to be concerned about." In their qualitative study of bad hook-up scripts, Littleton, Tabernik, Canales, and Backstrom (2009) found that one-third of their sample of 109 college women named remorse and shame likely consequences of a bad hook-up. Relatedly, Lunceford (2010) wrote about the shame that accompanies many women on college campuses as they walk home after engaging in (casual) sex, particularly as they are subject to disapproving stares and chastising comments. Taken together, the results of these studies indicate that experiences of shame may be more ubiquitous than exceptional among girls and women, and that such experiences have deleterious, enduring effects on women's sexuality.

INACCURATE AND INADEQUATE LANGUAGE

Undoubtedly, dialogue about women's sexuality is hampered by a lack of coherent and accurate language. Historically and currently, there has

been a tendency to define women's sexuality in the context of a reproductive framework. Ogletree and Ginsburg (2000) conducted several surveys to assess people's knowledge of sexual anatomy. In one of their surveys, they asked 209 participants about the sexual anatomy terminology that they learned while growing up. Out of the 209 participants, 208 learned the term penis and 198 learned the term vagina. Zero participants reported learning the term vulva or clitoris. Ogletree and Ginsburg (2000) concluded that the vagina is the term most often used for women's genitals, which is problematic because if women think of the vagina as their primary sexual organ, they are likely detached from the clitoris, the main source of sexual pleasure among women. Waskul, Vannini, and Weisen (2007) situated the clitoris in a symbolic purgatory that exists between women's sensual experiences of their clitoris and the moment when they gain symbolic meaning (i.e., language) for their sensual experiences. They examined the written reports of 15 participants to determine how women make meaning during this linguistic progression. Their participants revealed a general sense of both silence and ignorance about the clitoris, both educationally and from parents. Likewise, Wade, Kremer, and Brown (2005) surveyed 833 students to investigate the relationship between clitoral knowledge and orgasmic frequency. They found that the sources which correlated with the most accurate information about the clitoris were the least likely to be accessed (e.g., self-exploration). They also found that knowledge did not relate to frequency of sexual orgasm, indicating that social measures beyond education are needed. Researchers have referred to the silence around the clitoris as the *whatchamacallit* problem (Lerner, 2004), symbolic castration (Wade et al., 2005), and symbolic clitoridectomy (Waskul et al., 2007).

The lack of accurate language may also induce worry and shame in girls. Lerner (2004) contended that when girls' experiences of their bodies do not correspond to information that they receive from their environments about their bodies, shame and anxiety erupt. She poignantly recounted a client's experience whose father touched her vulva. When the client encryptedly presented this information to her therapist as a friend's experience, the therapist asked whether the father touched the girl's vagina. The therapist's language confused the client who never mentioned the abuse again. In Waskul and colleagues' (2007) study, several of their participants experienced worry that something was wrong with them on the sensual discovery of their clitoris. One four-year-old, for instance, fretted that she had a penis. Certainly, linguistic omission denotes stigmatization, and it follows logically that women might well internalize this message.

Another recurring theme in the studies conducted on sexual anatomy and language is that many women learn about their bodies from their male sexual partners (Wade et al., 2005; Waskul et al., 2007). For instance, a participant in Waskul and colleagues' (2007) study remarked: "The first time I found out the name of the clitoris I was about sixteen. My boyfriend

sort of told me what it was" (p. 165). In Ogletree and Ginsburg's (2000) study, men possessed more accurate information about women's sexual processes than did the women in the study. For example, women were more likely than men to state that the inside wall of the vagina is the locus of most pleasure for women. (It is not; it is the clitoris.) The lack of accurate language and the means by which language and knowledge is acquired yields a problematic paradox, such that women are dependent on men for knowledge of their bodies, discouraged from being sexual agents, and yet, as noted earlier, simultaneously imbued with the responsibility for (hetero)sexual activity.

While inaccurate language contributes to women's confusion about their sexuality, increases worry, shame, and anxiety, and indicates that women's sexuality does not belong to them, arguably the most powerful message surrounding women's sexuality is that women's sexual pleasure remains taboo. While some limited perspectives offer that women are permitted sexual pleasure in conjunction with (but not at the expense of) their male partners' pleasure (Braun, Gavey, & McPhillips, 2003), powerful cultural and societal messages continue to dissuade women from experiencing their full range of sexual agency and pleasure.

CULTURAL IMAGES AND THE BROADER SOCIAL DISCOURSE OF WOMEN'S SEXUALITY

Simultaneously, while society perpetuates a lack of language around women's organs of sexual pleasure, ample language exists to control girls' and women's sexuality. In *Slut!,* Leora Tanenbaum (2000) assembled a table of positive and negative expressions for sexually active men and women, which vividly illustrates this point. There are 12 positive items for sexually active men (e.g., stud, player, Don Juan); for women, there are 2 (i.e., hot and sexy). In contrast, the list includes 3 negative items for sexually active men (e.g., womanizer, wolf); for women, there are 28 (e.g., slut, whore, tramp, ho, bitch). The positive connotations for men's sexuality coupled with the negative perspective on women's sexuality highlights the sexual double standard: the idea that men can and should enjoy sexual activity and that women not only should not, but perhaps even cannot. Importantly, the consequences for women who are perceived as not meeting their prescribed sexual standard range from social ostracization and isolation to violence and, in some cases, even death. For instance, recently a police officer in Toronto suggested that women "avoid dressing like sluts in order to not be victimized" (Romo, 2011, p. 1). Fortunately, an international movement called SlutWalk has erupted in response to this police officer's suggestion. Yet, the police officer's suggestion is indicative of the dominant culture's message that women who do not observe their sexual script deserve for men to assault them.

In addition to the sexual double standard, the broader social discourse sends conflicting messages to girls and women based chiefly on their relationship status. Unmarried girls, in particular, are taught the problem-focused perspective of sexuality, which is a focus on outcomes, such as pregnancy and sexually transmitted infections (STIs; Bay-Cheng, 2010; Clarke, 2009; Fine & McClelland, 2006). In this framework, girls are situated primarily as victims of male desire and charged with the sexual gatekeeper role. In an examination of the Abstinence Only Until Marriage (AOUM) curriculum, Fine and McClelland (2006) ascertained that the take-home message for girls is that any sexual activity outside a heterosexual marriage is abnormal, risky, and shameful.

To illuminate social messages about sexuality that magazines transmit to teenage girls, Clarke (2009) analyzed the content of several popular magazines. According to Clarke, most messages are based on risk and fear: fear around pregnancy, emotional risk, betrayal by the boys (the messages are overtly heterosexist), and STIs. Furthermore, the messages were heavily medicalized. Clarke also examined magazines' messages intended for midlife women, which she discovered altered somewhat from the messages delivered to teens. Magazine articles framed sex as women's responsibility in marriage and as something that women could use to barter for desired returns from their partner. Moreover, married women's reluctance to participate in sexual activity is often attributed to their male partners' unwanted sexual behaviors, including masturbation and pornography viewing habits. The only somewhat positive message sent to midlife women was that sexual activity can have health benefits, indicating the tendency to medicalize midlife women's sexuality as it does with teenage girls.

Of course, the accompanying implicit message to the one that frames sexual activity outside marriage as negative is that all sexual activity within a marital relationship is normal, safe, and, while still not necessarily pleasurable, ideal. Although once the sexual gatekeeper, when women marry, society dictates that they acquire the role of relationship maintainer. Since, according to social scripts, men enjoy sex, women should provide men with penile-vaginal sexual intercourse to ensure their partner's contentment, both in general and within the relationship. More recently, women's pleasure has been gradually more integrated into heterosexual sexual scripts, though, as some researchers have noted, women still report experiencing orgasm at rates significantly lower than men's (Wade et al., 2005) and women's pleasure often becomes entangled with an emphasis on men's ability to ensure their partners orgasm. Perhaps because of this conflation, Muehlenhard and Shippee (2010) found that significantly more women than men in their study reported faking orgasm, and that while men's chief reasons for faking orgasm had to do with sex taking too long, the reason women most often faked orgasm was to avoid hurting their partners' feelings.

TOWARD A FUTURE OF SOLUTIONS AND POSSIBILITIES

Taken together, the literature we have reviewed in the preparation of this chapter is sobering and dismaying. However, we operate from the premise that, equipped with the extant knowledge, we can offer several suggestions for how to initiate change in individual, cultural, and global spheres. Such change, if it is to be meaningful and sustained, will require the enduring, intentional efforts on the parts of psychologists and other mental health practitioners, as well as women and their partners.

1. Consider sexuality a key facet of multiculturalism and address it specifically in therapy. As we have illustrated, experiences related to sexuality vary considerably and intersect significantly with race/ethnicity, gender, age, sexual orientation, religion, and (dis)ability (Bay-Cheng, 2010). As such, sexuality ought to be considered a critical component of therapy and psychologists should initiate discussions about sexuality and include such considerations in conceptualization, assessment, and treatment planning.
2. Normalize women's sexual experiences, including their concerns and joys. When issues related to sexuality—including sexual expression, intimacy, and biological and reproductive functioning—are steeped in secrecy and embarrassment, secrecy and shame persist. Therapists can make an indelible positive impact by quelling women's fears about sexuality, speaking openly, frankly, and comfortably about sex, and encouraging their clients to do the same.
3. Use accurate, specific language when speaking with women about sexuality. Euphemisms (e.g., "sleeping with" instead of "being sexual with"), inaccurate terminology (e.g., vagina for vulva), and emotive language (e.g., purity or chastity rather than virginity) obfuscate thoughtful dialogue about sexuality and render confusion, miscommunication, and missed opportunities for clarification, connection, and understanding (Lerner, 2004; Waskul et al., 2007).
4. Encourage couples to explore their sexual scripts and assist them in expanding their scripting beyond current norms, if needed. The predominant sexual script, similar to the medical model, is linear and limiting, beginning with kissing and caressing, moving to genital contact (manual and oral), and culminating with intercourse. Sex is completed when the man orgasms. The emphasis on the man's orgasm through penetration is referred to as the coital imperative (Braun et al., 2003). For instance, a participant in Braun and colleagues' study explained: "A pattern for us seems to be, we've sort of worked it out, um what usually happens is we'll sort of you know kiss and cuddle and touch each other and stuff and then often like he'll give me oral

sex and I'll have an orgasm and then we'll have penetrative sex and he'll have an orgasm and that's the way it works" (p. 242–243). Although more modern versions of sexual scripting require women to orgasm within this sequence, women may feel obligated to orgasm, may feel pressured to fake orgasm to please their partners, and if they do orgasm, obligated to reciprocate their orgasm by participating in penile-vaginal intercourse (PVI; Braun et al., 2003; Muehlenhard & Shippee, 2010; Nicolson & Burr, 2003). Women report a desire for greater fluidity during sexual activity, and as they age, tend to define sexual activity beyond PVI (Meadows, 1997; Mollen & Stabb, 2010; Nicolson & Burr, 2003). We encourage a sexual landscape that would "allow individuals to create their own unique content and ordering [in sex] and . . . appreciate the changes in the existence, order, and salience of the components over the lifetime" (Iasenza, 2001, p. 45).

5. Employ a positive perspective. Recognize that sexuality can be a source of pleasure, connection, richness, and joy. Avoid the tendency to pathologize women's concerns, recalling that many women may report decreased desire but not distress.
6. Contextualize women's sexuality. Recognize that medical perspectives are often limited as they fail to take into account media influences, personal and collective histories, political influences, and cultural considerations.
7. Give women ownership over their sexuality. Recognize that for many women—both for those who report overt trauma histories and those who do not—sexuality and its concomitant functions may have been relegated to others' influence and control. Furthermore, research has shown that both women and men place more importance on men's sexual pleasure than on women's (Nicolson & Burr, 2003). Discussions about sexual agency and encouraging women to explore sexuality and its meaning in their lives are fruitful places to begin.
8. Work with couples on striving for egalitarian relationships in which power and pleasure are shared. Several researchers have noted that relationships that are balanced provide a number of benefits to both partners in heterosexual couples. In their study of 289 adults, Rudman and Phelan (2007) found that having a feminist partner yielded better relationship quality and stability. Moreover, men with feminist partners also reported greater sexual satisfaction. In her comprehensive review, Steil (2001) noted that those relationships characterized by equality are characterized by more affection, intimacy, and greater relationship satisfaction generally and sexual satisfaction specifically.
9. Generally, avoid polarizing women and men. In contrast to much of the popular press that glorifies gender difference, most research reveals tremendous similarities between women and men (Hyde, 2005). Impett and Peplau (2006) reviewed a wide array of relationship

research and concluded that "men and women are remarkably similar—both fall in love, form enduring attachments, suffer the pain of loneliness, and benefit from social support" (p. 287). Simultaneously, it is important to acknowledge and discuss the ways pleasure has been compulsory for men, and co-opted and relegated for women.

While the above recommendations are intended to inform treatment practices for psychologists and other mental health practitioners, we recognize that, in its traditional form of individual and couples' counseling, therapy alone is insufficient for initiating and sustaining comprehensive, meaningful change. We also wish to close our chapter with ideas that, though ambitious in scope, stand to make influential, widespread influence on future generations of girls and women.

1. We echo Tiefer (1996) who compelled women to strive for a reclaiming of body competence. Girls and women are acculturated such that tremendous emphasis continues to be placed on our bodies as valued primarily for their appearance (American Psychological Association, 2007), which is a prescription for self-objectification, habitual body monitoring, and appearance anxiety. We encourage women to find ways to experience their bodies as competent and capable, as entities able to move, construct, dance, feel joy, and create and respond to pleasure.
2. We suggest that women explore the possibilities of pleasure through masturbation. As Bay-Cheng (2010) so eloquently stated: "Desire and pleasure must be embraced as inalienable rights and vital components of human thriving, not as luxuries afforded to a fortunate few" (p.100). Furthermore, given research that has linked masturbation to improved sexual health (Coleman, 2002), more enjoyment of an array of sexual practices (Bancroft & Graham, 2011), and better body image (among white women; Shulman & Horne, 2003), we would be remiss not to encourage women to cultivate a sense of healthy entitlement to their own pleasure.
3. Ending the pandemic of men's violence against women is imperative if we are ever to achieve a world in which sexual equality is a reality. Girls and women—and boys and men—need healthy, safe places to live and work. Physical, sexual, emotional, financial, and spiritual abuse undermine one's sense of safety and prohibit healthy sexual development.
4. Ensure that sexuality education is enduring across all phases of the lifespan and is comprehensive and accurate in all its forms. In spite of the dismal outcomes of abstinence-only education and related virginity pledges, (Brücker & Bearman, 2005; Perrin & DeJoy, 2003), we still lack sexuality education that yields responsible, informed, thoughtful, astute adolescents and adults.

5. Vigorously support policies that promote equality for all citizens, including the Equal Pay Act, paid maternity and paternity leave, reproductive justice, marriage equality, and health care. Such policies hold the potential to eradicate racist, sexist, heterosexist, and classist practices that continue to exploit and affect disempowered and disenfranchised members of society. As Bay-Cheng (2010) noted, ensuring equality in legislation and policy helps create a culture in which romantic and sexual relationships are based not on a sense of compelled obligation but rather equality and choice.

CONCLUSION

In this chapter, we have elucidated the nature of women's sexual problems, including offering reasons for discrepancies in prevalence rates and in the construct of desire. We examined and dismantled ideas about genital and subjective arousal, sexuality and shame, language, and cultural messages that devalue women's sexuality. Finally, we offered several suggestions for enhancing psychological treatment for women and for more global awareness and change.

We recognize that women's sexual concerns and complaints rest on centuries of inequality and misogyny, and that fostering enduring change will require sustained, consistent efforts at the individual, sociocultural, political, national, and international levels. Yet, we are left encouraged by a vision for change and the hope that such change is full of possibility and promise.

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Part V

Violence and Women's Sexuality

Chapter 17

Abusive Relationships and Women's Sexuality

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Over the course of a lifetime, one out of every three women will be raped, beaten, or otherwise abused (Heise, Ellsberg, & Gottemoeller, 1999). It is projected that every nine seconds a woman is physically assaulted (Finkelhor, Hotaling, Lewis, & Smith, 1990). Additionally, it is estimated that every hour 78 women are forcibly raped and that 25 percent of all women will be sexually assaulted before they turn 18 (Kilpatrick, Edmunds, & Seymour, 1992). While these statistics can be shocking, the situation is, in reality, much worse considering that many abusive acts are never reported and remain hidden from family and friends (Lundberg-Love & Marmion, 2006).

In response to the increasing awareness of abuse, much research has been conducted to examine the relationship between such victimization and the psychosocial functioning of adults. Historically, however, limited research has focused on the effect that different types of abuse can have on women's sexuality (Meston, Heiman, & Trapnell, 1999). Hence, the purpose of this chapter is to provide a review of the research that has investigated the impact of physical, sexual, and emotional abuse on women's sexuality.

WHAT IS SEXUALITY?

To understand the effect of abuse on female sexuality, we must first define what constitutes sexuality or sexual health. Sexual health is a combination of the social, intellectual, emotional, and physical aspects of sexuality that positively enrich the individual and enhance individual personality, interpersonal communication, and love (World Health Organization, 1975). Sexual health plays an intricate role in mental and physical health and involves a variety of experiences which include cultural, cognitive, social, psychological, and biological experiences (Clayton, 2003). In order to understand the effects of abuse on women's sexuality, a holistic approach is necessary, one that describes the effects of abuse on multiple areas of functioning.

PHYSICAL ABUSE AND SEXUALITY

"When you've been beaten in several relationships . . . you lose part of yourself . . . When you then enter into a relationship where you are respected and accepted, you feel you don't deserve it" (Træen & Sorensen, 2008, p. 385). Physical abuse can involve a wide range of behaviors that includes shoving, slapping, throwing things, punching, and beating an individual; thus, physical abuse can be defined as any act designed to hurt, injure, endanger, or cause physical pain to another person (Berry, 1998).

Recent studies have suggested that women are up to six times more likely than men to be victims of physical abuse (Goldsmith & Vera, 2000). Consequently, physical abuse has been associated with a number of sequelae that can have a detrimental impact on a woman's interpersonal relationships and her sexual functioning.

Physical abuse has been associated with subsequent psychological distress (mental health issues), pervasive fear, interpersonal problems, feelings of self-blame, lower self-esteem, and a greater risk for the development of substance abuse problems. Additionally, women who have been physically abused may report learned helplessness, problematic partner selection (attraction to men who are violent), difficulty making long-term relationship commitments, an inability to engage in meaningful sexual relationships, an increase in risky sexual behavior (inconsistent condom use, multiple sex partners, exposure to sexually transmitted diseases), and a greater risk for future revictimization (Cavanaugh et al., 2011; Drapeau & Perry, 2004; Holiman & Schilit, 1991; Lundberg-Love & Marmion, 2006; Meston, Rellini, & Heiman, 2006; Wilson & Widom, 2011).

Recent studies have shown that women who have been physically abused tend to be at a greater risk to engage in risky sexual behaviors (Cavanaugh, Hansen, & Sullivan, 2010; Meston et al., 2006). Cavanaugh and colleagues (2010) administered a series of self-report questionnaires to understand the relationship between the severe effects of physical abuse

that can result in posttraumatic stress disorder (PTSD) and subsequent sexual risk behavior in a sample of 137 women. The authors found that women who had developed PTSD as a result of the abuse were four times more likely to have engaged in high-risk sexual behaviors than nonabused women. Moreover, survivors of physical abuse with concomitant addiction issues were at an even greater risk of engaging in high-risk sexual behaviors, such as infrequent condom use and sex with multiple partners (Deliramich & Gray, 2008; Wilson & Widom, 2011).

Researchers agree that women who have been physically abused also experience various types of psychological distress. This distress can manifest itself in many ways, but is usually associated with anxiety, fear, and depression (Cavanaugh et al., 2011; Lundberg-Love & Marmion, 2006). Plichta and Falik (2001) used a series of self-report measures to examine the relationship between physical abuse and subsequent mental health problems in a sample of 1,821 women. The authors concluded that women who had been physically abused had a greater likelihood to report depressive symptoms, as measured by the Center for Epidemiologic Studies-Depression Scale (CES-D; Radloff, 1977), and to subsequently be diagnosed with an anxiety or depressive disorder than nonabused women.

Furthermore, women who are currently in an abusive relationship can often develop a form of learned helplessness, in which they believe there is no way to escape from the abuse they are experiencing. Many women begin to express feelings that they somehow brought this situation on themselves and that the abuse was their fault (Lundberg-Love & Marmion, 2006; Walker, 1979). Such feelings of self-blame and learned helplessness have a detrimental effect on a woman's self-esteem (Holiman & Schilit, 1991). For example, Meston and colleagues (1999) administered the Rosenberg Self Esteem Scale (Rosenberg, 1965), to assess levels of self-esteem in women who had suffered from abuse. Their results suggested that women who had been physically abused tended to have lower self-esteem scores than nonabused women. Moreover, the frequency of physical abuse was robustly correlated with low self-esteem scores, in that a higher frequency of physical abuse was related to lower self-esteem scores.

Additional research has indicated that some women who have been physically abused in the past may be attracted to abusive men in the future (Drapeau & Perry, 2004). For example, one woman reported that after having been physically abused, she felt unattractive, inferior, and incompetent. When she subsequently entered into a healthy relationship with mutual respect and acceptance, she believed that she did not deserve such a relationship (Træen & Sorensen, 2008). This woman's story illustrates how a woman's experience of being physically abused can result in low self-esteem and is a risk factor for entering a future relationship with an abusive partner.

Such a finding could explain why some women who do become involved in multiple violent and abusive relationships experience lower

relationship quality and satisfaction than nonabused women (Sciangula & Morry, 2009; Woodin, 2011). Similarly, low levels of self-esteem reported by women who have been physically abused may contribute to future relationship dissatisfaction (Lundberg-Love & Marmion, 2006; Sciangula & Morry, 2009).

The same woman above discussed that she sometimes felt unhappy in her current, nonabusive relationship. She felt unworthy of the love of a man who would not beat her and reported lacking a desire for sexual intimacy in the relationship (Træen & Sorensen, 2008). Her description of the lack of desire for her nonabusive partner and her own feelings that she was not worthy of someone who would not beat her could be related to particular researchers' suggestions that some women who have been physically abused may develop self-defeating tendencies that can ensnare them in abusive relationships (Drapeau & Perry, 2004; Walker, 1979). Drapeau and Perry (2004) further suggested that women who are abused at an early age may become conditioned to seek out physically abusive relationships in the future. Thus, some women may experience difficulty when breaking free from the cycle of abuse and transitioning to a nonabusive relationship.

Walker (1979) first described what she termed the "cycle of abuse" that has been found to be present in more than two-thirds of physically abusive relationships. The cycle is divided into three stages that begin after an initial loving relationship. The first stage is the "tension building stage," wherein tension increases between the abuser and the victim (Walker, 1979, p. 55). The second stage is the "acute battering incident," in which the tension reaches a climax and the abuser physically harms the victim (Walker, 1979, p. 59). After the abuse, the final stage of the cycle occurs, wherein the abuser professes remorse and shows "loving contrition" and there is a noticeable absence of tension (Walker, 1979, p. 59). During this time, the victim may be showered with gifts and promises that the abuse will never happen again. Unfortunately, the victim is also reminded of all the wonderful characteristics of the abuser which leads the woman to forgive the past abuse. However, after a period of time, the tension will build again and the cycle will repeat itself until the victim breaks free from the abusive relationship. Walker (1979) was the first researcher who tried to explain how a woman could become entrapped in an abusive relationship that could lead to multiple abusive experiences. This cycle of abuse can help us understand how women who have been physically abused can be revictimized.

Consequently, Widom, Czaja, and Dutton (2008) utilized the Lifetime Trauma and Victimization History (Widom, Dutton, Czaja, & Dumont, 2005) to lend support to the idea that women who have been physically abused tend to be at a greater risk for revictimization. This instrument uses a structured interview to detect the physical abuse history of women

and the frequency of subsequent revictimization. The researchers found that physically abused women were clearly at a greater risk for future victimization than nonabused women. Thus, women who have been physically abused not only have to face the consequences of their initial abuse, but may also have to deal with the possibility of future revictimization.

SEXUAL ABUSE AND SEXUALITY

"I didn't feel that it was my fault that he did it. But I was ashamed because I couldn't stop it. After the episode I started to hide . . . to prevent the situation from happening (again)" (Træen & Sorensen, 2008, p. 380). Sexual abuse can be defined as any sexual act in which an individual is forced to engage against her will. It includes sexual experiences that a partner finds coercive, unpleasant, frightening, or violent. It can also involve forcing a partner to have sex without protection from disease or impregnation. In short, forcing a woman to have any sexual interaction that leaves her feeling demeaned or violated can be considered sexual abuse (Berry, 1998).

Over the past several decades, much research has been conducted that examined the relationship between sexual abuse and its impact on female sexuality. It is important to note that each woman's experience of sexual abuse may be unique, and thus has the potential to lead to an array of possible sequelae (Lundberg-Love & Marmion, 2006). Therefore, we first list many of the possible behavioral effects of sexual abuse and then elaborate on them throughout the section.

Sexual abuse has been associated with low self-esteem, lower levels of social support, lower scores on self-reports of feeling romantic or passionate, reduced sexual contact, satisfaction, and pleasure in sexual activities for at least one year after the abuse, subsequent sexual dysfunction that can last for years, lower ratings of self-reported health, higher rates of future risky sexual behaviors (early sexual contact, inconsistent condom use, prostitution), a greater risk for contracting sexually transmitted diseases, higher levels of interpersonal sexual behavior (greater frequency of intercourse, more sexual partners, a greater variety of sexual experiences, and multiple ongoing sexual relationships), higher levels of intrapersonal sexual behavior (more liberal sexual attitudes, higher frequency of masturbation, more unrestricted sexual fantasies), a greater risk for mental health problems (depression, anxiety, PTSD), higher levels of suicidal ideation, a higher risk of suicide, and a greater risk for subsequent sexual victimization (Briere & Runtz, 1986; Golding, Wilsnack, & Cooper, 2002; Meston et al., 1999, 2006; Roller, Martsolf, Drauker, & Ross, 2009; Van Berlo & Ensink, 2000; Widom et al., 2008).

In a qualitative study of women who have suffered from abusive relationships, Træen and Sorensen (2008) examined patterns found in the attitudes and feelings of women who have been abused. One such pattern

that was identified in most of the interviewees was that each woman felt shame regarding her abusive experience and tended to believe that it was somehow her fault that the abuse occurred. Clearly, such feelings of shame and regret can reduce a woman's self-esteem (McAlpine & Shanks, 2010). Hannah, one participant in this study who was currently in a nonabusive relationship, explained to her interviewer that after her abusive experience she felt unattractive and had little sexual desire. Furthermore, she felt as though she did not deserve to be in the current relationship she was in because her nonabusive partner deserved so much more than she could offer. She also felt guilty regarding her lack of desire and expressed difficulty moving beyond the profound sense of shame associated with her abuse. At the conclusion of the interview, Hannah described herself as someone who had struggled with low self-esteem and believed that she did not deserve the love of another individual (Træen & Sorensen, 2008).

Hannah's experience exemplifies the struggle that many sexually abused women have with low self-esteem. Many of the women espouse feelings of being unclean after their sexual assault. Indeed, after sexual assault, many women express a desire to bathe or shower. Moreover, Fairbrother and Rachamn (2004) reported that many sexually abused women felt as if they were "mentally polluted." In their study, they defined this unfortunate phenomenon as a mental sensation associated with feeling morally unclean or dirty in the absence of any actual contamination. The study used a semi-structured interview in which they found that 60 percent of their participants experienced such feelings. Several expressed that they felt compelled to physically clean themselves after recounting the experience of their abuse. Others expressed having these feelings after engaging in healthy sexual activity subsequent to their abuse. Furthermore, one woman reported feeling dirty and needed to wash herself after feeling sexually attracted to a man (Fairbrother & Rachman, 2004). Clearly, the belief that an abused woman feels contaminated as a result of the sexual abuse necessarily reduces self-esteem and can significantly affect the quality of her future relationships with men (Sciangula & Morry, 2009).

Additionally, women who have been sexually abused tend to have lower levels of social support than nonabused women (Lundberg-Love & Marmion, 2006). In fact, in a meta-analysis of the results of six general population studies, Golding and colleagues (2002) found that abused women were more likely to remain unmarried, become divorced or separated from the marriages in which they do enter, have fewer friends, and to have less frequent contact with those with whom they are close, and consequently report receiving less emotional support from their friends, relatives, and spouse. In one case study, Dianna, a woman who was sexually abused when she was 16, explained that she felt a need to suppress and hide her sexual abuse. Furthermore, she described how since she lived in a small town, she was afraid of the consequences of revealing her

abuse. She said that if she told anyone, the entire town would have found out, everyone would hate her due to her disclosure, and she would lose her friends (Træen & Sorensen, 2008).

Not surprisingly, however, Dianna's embarrassment and desire to hide her abuse from her friends led her to become increasingly isolated. As a result, she could not receive the emotional support that might have been provided by her family and friends. Hence, many women who have been sexually abused have experiences similar to Dianna's in which their fear of others' reactions usurps the social support they otherwise could have received (Del Castillo & Wright, 2009; Golding et al., 2002).

In 2006, Meston and colleagues conducted a study evaluating the effects of early sexual abuse on later sexual functioning. In this study, women completed self-report questionnaires regarding their current sexual experiences. The results indicated that there was a significant correlation between early sexual abuse and adult negative sexual affect. The majority of the women in this study reported having felt fear, anger, or outright disgust during sexual activity within the past two years. Furthermore, the women in this study obtained very low scores on Andersen and Cyranowski's (1994) Sexual Self-Schema Scale, which provides a subjective report of the perception of oneself as a sexual being. Women who reported early sexual abuse tended to view themselves as less romantic and passionate when compared to the responses from nonabused women. The authors concluded that the negative sexual affect experienced by many sexually abused women exacerbates their capacities to feel romantic and passionate (Meston et al., 2006).

Additionally, the development of negative sexual affect that can emerge in some survivors of sexual abuse often results in women reporting lower levels of satisfaction and pleasure in sexual activities. Van Berlo and Ensink (2000) reviewed a number of studies examining the sexual functioning of individuals subsequent to their sexual abuse. They found that the frequency of sexual contact decreased after sexual abuse. Furthermore, women who were abused tended to report decreased satisfaction and pleasure in sexual activities for up to one year post abuse. Victims of abuse suffered from sexual problems, such as fear and arousal and desire dysfunctions. Hence, negative sexual affect may underlie the reduced sexual contact, satisfaction, and pleasure reported by sexually abused women.

In the Træen and Sorensen (2008) study, Dianna, an interviewee, explained how she was sexually abused by a friend of her brother while sleeping. After the abuse, she began to experience problems with reduced sexual desire and aversion to sexual activities. She explained how in subsequent romantic situations when she was sleeping next to a partner and, in an effort to be romantic or funny, her partner would begin to touch her intimately and "it would make her crazy." She just wanted "him to get out" as it would trigger memories of her previous abuse. She stated

that at the beginning of her relationships she usually could force herself to ignore the sexual aversion that she felt. However, as the relationship progressed, the problems of low desire would increase and she would be unable to "go along with things" any longer (Træen & Sorensen, 2008, p. 381). In Dianna's case, it is clear how the aversive feelings associated with being sexually abused can be related to feelings of being less romantic and passionate. It can also explain how pleasure or satisfaction that should come from sexual activity can be compromised and how the experience of being sexually abused can "poison the experience of intimacy" and defile that which should have been most beautiful (Lundberg-Love & Marmion, 2006, p. 69).

While many individuals experience negative sexual affect and lower levels of sexual activity after an incident of sexual abuse, there is also evidence to support that, later in life, some women tend to become more sexually active when compared to their nonabused counterparts (Van Berlo & Ensink, 2000). Meston and colleagues (1999) examined the relationship between early abuse and the later interpersonal and intrapersonal sexual activities of sexually abused women and compared them to those of a control group. They found that women who had been sexually abused early in life tended to report having more interpersonal sexual experience. For example, the women who had been sexually abused reported more experience with intercourse, a greater frequency of intercourse, a greater variety of sexual experiences (broader range of sexual activities), and higher levels of unrestricted sexual behavior (number of partners, engaging in one-night stands, brief sexual relationships, and multiple ongoing sexual relationships). They also found that the sexually abused women had higher levels of intrapersonal sexual behaviors in that they had more liberal sexual attitudes, more unrestricted sexual fantasies, a greater variety of sexual fantasies, and a greater frequency of masturbation than their nonabused counterparts. Interestingly, despite the fact that the women in this study reported a greater level of sexual activity, they also reported having a lower sexual drive than nonabused women (Meston et al., 1999).

Roller and colleagues (2009) administered an unstructured interview to evaluate women who had been prescreened for early sexual abuse. As a part of the interview, women were asked to describe their experience with abuse, how it had affected their lives, and how they were currently coping with the experience. The researchers analyzed the recordings from these interviews, and grouped incidents and experiences together to form a body of empirical evidence which suggested that there were many experiences common to sexual abuse survivors. As such, survivors were found to be more likely to later participate in high-risk sexual behaviors. Many of the participants in the study defined themselves as promiscuous, due to the number of sexual partners they have had and the frequency with

which they had sex with partners they barely knew. Others reported having frequent, unprotected sex and sex with multiple partners. Many also reported having contracted sexually transmitted diseases as a result of their risky sexual behaviors (Haydon, Hussey, & Halpern, 2011).

Some researchers have suggested that increased sexual activities and high-risk sexual behaviors may be related to an effort to feel loved and bolster an already damaged self-esteem (Lemieux & Byers, 2008; Lundberg-Love & Marmion, 2006). One woman, who had more than 30 sexual partners in her lifetime, indicated that she felt depressed, dirty, and unattractive, and consequently did not like herself very much. With respect to her sexuality, she described herself as being cold, unemotional, and unsexy. While she depicted herself as someone who had little sexual drive, she admitted to engaging in sexual acts that she found distasteful as a means "to receive affirmation of her worth from others" (Træen & Sorensen, 2008, p. 381). As such, her experience exemplifies the manner in which some individuals who have been sexually abused may engage in sex as a means to experience feeling adequate and loved.

Plichta and Falik (2001) have described the impact of sexual violence on women's health. They used an existing survey of 1,800 women to compare the lasting impact sexual violence had on women's health. Within the surveys, women were asked questions that evaluated their physical well-being and given a subscale of the CES-D depression scale to detect symptoms of anxiety and depression (Radolf, 1977). Additionally, they were asked to report whether they had ever been diagnosed with a mental health disorder or if they were currently taking any medication for anxiety or depression. The authors found that women who had been sexually abused reported lower levels of physical well-being and tended to be at a greater risk for mental health problems when compared to nonabused women. Hence, women who have been sexually abused tended to score higher on scales of depression and anxiety than a control group. Furthermore, they reported higher levels of suicidal ideation and were at a greater risk for suicide than nonabused women (Briere & Runtz, 1986; Lundberg-Love & Marmion, 2006).

Women with histories of sexual abuse also may report symptoms of PTSD (posttraumatic stress disorder) (Schwecke, 2009). Symptoms of PTSD can include pervasive flashbacks, intrusive thoughts and memories, and nightmares. Other researchers have reported that survivors may have difficulty regulating their affect and suffer from extreme emotional states, negative alterations in their self-concept and concept of others, an exaggerated startle response, chronic hyperarousal, excessive vigilance, and control and trust issues that can last throughout a lifetime without clinical intervention (Lundberg-Love & Marmion, 2006). Thus, the effects of sexual abuse can significantly impact a woman's life through the pervasive effects of PTSD.

Perhaps, the most robust finding amongst the preponderance of research studies is that women who were abused at an early age tend be at a greater risk than nonabused women for subsequent sexual revictimization (Lundberg-Love & Marmion, 2006; Widom et al., 2008). In fact, recent studies have shown that women who are abused at an early age are two to three times more likely to be revictimized in later adulthood (Barnes, Noll, Putnam, & Trickett, 2009). Due to this alarming statistic, numerous studies have tried to understand the link between prior victimization and subsequent victimization.

Noll and Grych (2011) described a model representing a three-step process (read-react-respond) to understand how women who have been sexually abused respond to sexual pressure or coercion. They suggest that sexual abuse survivors have alterations in the process by which they view and understand a sexually coercive situation, how their bodies respond physiologically to that threat, and how they respond behaviorally to that threat. This model incorporates many factors that play a role in such responses and examines sexual attitudes, attachment styles, means of decoding emotional cues, the effects of alcohol and drug use, the "fight or flight" biological stress responses, and the cognitive and behavioral mechanisms underlying their response to sexual pressure and coercion (Noll & Grych, 2011). This model is a positive step in understanding how abusive experiences can shape a woman's psyche to be perhaps more vulnerable to subsequent sexual abuse. Furthermore, it integrates the effects that sexual abuse can have on both a woman's intrapersonal and interpersonal functioning into a holistic scheme that can explain the risk for future experiences with abuse (Noll & Grych, 2011).

Clearly, the effects of sexual abuse are numerous and impact a wide range of female sexual functioning. Although this is not meant to be a comprehensive list of the means by which abuse can affect a woman's future relationships, it does outline many of the ways that women may respond to sexual abuse. Additionally, we know that certain factors can mitigate the effects of sexual abuse in a woman's life. These factors include the time frame of the disclosure of the abuse, others' reactions to that disclosure, the level of social support received after disclosure, the age of the abused individual, and the individual's premorbid level of self-esteem (Gries et al., 2000; Sachs-Ericsson et al., 2010). As such, it is clear that the earlier an intervention can be made and the more that positive support that can be provided, the better the outcome for the sexual health of women who have been sexually abused.

EMOTIONAL ABUSE AND SEXUALITY

"The yelling I could take . . . the beating I could take . . . the pain and blood I could take . . . but when he would tell me that he didn't love me

and that I was worthless, I felt myself dying inside" (Lundberg-Love & Marmion, 2006, p. 15). Emotional abuse can be defined as any attempt by an individual to belittle, embarrass, demean, ridicule, shame, insult, or otherwise emotionally hurt another person. It involves calling a person names, withholding affection, attention, or money, and forbidding relationships that promote positive socialization. It also includes performing destructive acts, threatening children, pets, or other family members. In short, it is anything designed to cause emotional distress to another person (Berry, 1998).

A number of recent studies have examined the effect of emotional abuse on interpersonal relationships. These studies have found significant evidence that supports a link between emotional abuse and the following sequelae: lingering terror, pervasive flashbacks, a greater fear of intimacy, low self-esteem, poor interpersonal skills, hostility, aggression, lower levels of self-reported relationship quality, and increased levels of conflict in all interpersonal relationships (Berzenski & Yates, 2010; Messman-Moore & Coates, 2007; Paradis & Boucher, 2010; Queen, Nurse, Brackley, & Williams, 2009; Reyome, 2010).

The results from these studies tend to paint a stark picture for the sexual well-being of women who have suffered from emotional abuse. In a phenomenological study performed by Queen and colleagues (2009), researchers used an unstructured interview to examine the impact of emotional abuse on women in intimate partner relationships. The principal investigators found that many women who had suffered from severe forms of emotional abuse often reported having pervasive flashbacks and a sense of lingering terror from their experience. An interview with Johanna, a participant within their study, exemplifies the lingering terror that often pervades the lives of women who have been emotionally abused. In her interview, Johanna explained the heartbreak she felt when her ex-husband brutally shot and killed four of her beloved pets. She explained that on a subsequent occasion, with no provocation, he silently put a gun to her head while she was cleaning the house. He never said a word to her as he pulled the gun down and then placed it back on her head when she attempted to move away. The expected shot never came, but the damage had already been done. Shortly after that experience, she packed up her things and left her husband for good. At the conclusion of the interview, she discussed how although her ex-husband had been dead for several years, she still felt no relief. While he could no longer threaten her with physical harm, the experience of her animals being shot and the gun being placed to her head was fresh in her mind and still continues to worry and incite fear in her.

Johanna's example clearly illustrates how the lingering terror associated with emotional abuse can have a significant impact on the healthy development of subsequent relationships. These same researchers found

that women who have had such experiences tended to have difficulty coping with situations that trigger memories of the prior incidents. For example, some women could not bear to live in certain types of houses or hear certain types of noises associated with their abuse, as such stimuli would provoke flashbacks and reignite feelings of fear (Queen et al., 2009).

Clearly, the experiences and feelings described in the previous paragraph do not foster comfort in future relationships. Davis, Petretic-Jackson, and Ling (2001) found that individuals who have been emotionally abused tend to have a greater fear of intimate relationships. They used the Fear of Intimacy Scale developed by Descutner and Thelen (1991) to determine the relative fear an individual has regarding intimate relationships. Emotionally abused women scored significantly higher on this scale than did nonabused women. Although not all emotionally abused women report lingering terrors and pervasive flashbacks, all victims describe it is as a negative experience that erodes their self-esteem (Gross & Keller, 1992). Romeo (2000) described a relationship between early emotional abuse and later low self-esteem that is caused by a lack of positive interactions. Consequently, when an abused individual receives a consistent barrage of negative criticism she tends to question whether she is fundamentally flawed, and thus undeserving of love and affection (Messman-Moore & Coates, 2007).

In a sample of college students who reported a history of early emotional abuse, Petretic-Jackson and colleagues (1993) reported that such individuals were significantly more likely to feel less lovable and likable on a self-report scale measuring self-esteem when compared to a control sample of nonabused individuals. Hence, it appears that as a woman's self-esteem decreases and the number of negative interactions with others mounts, her individual self-concept changes and she begins to feel that she is unworthy of respect, friendship, love, and affection (Romeo, 2000).

Additionally, it has been posited that women who have been emotionally abused are also more likely to participate in high-risk sexual behaviors (Lundberg-Love & Marmion, 2006). Lemieux and Byers (2008) have suggested that such behavior may result from a desire to feel some degree of control over their lives or as an attempt to prove their self-worth. As previously noted, women who have been emotionally abused may feel unloved, and thus may seek out sex as a means to bolster their flailing self-esteem. One woman who participated in the Træen and Sorensen (2008) study described sex as the source of life. She explained how when she was in the moment she felt as though she was in touch with her inner queen and that when she went back to her everyday life she felt as though she lost the intimate connection with her body. Another woman who had suffered from emotional abuse explained that, after her parents divorced, she lived with her mother and was frequently denigrated by many of her mother's new sexual partners. Eventually, some of them made sexual advances toward the young woman which resulted in risky sexual behavior

to counteract the feelings of worthlessness brought on by emotional abuse (Lundberg-Love & Marmion, 2006).

Reyome (2010) has reviewed a number of studies and concluded that many of the interpersonal problems that women with histories of emotional abuse face are associated with the development of poor interpersonal skills. Berzenski and Yates (2010) suggested that poor coping skills correlated with increased levels of intimate partner violence. They examined the relationship between abuse and relationship violence in 2,169 undergraduate students, using a portion of the Conflict Tactics Scale (Straus, 1979). This scale was used to detect the frequency and type of relationship violence among the participants. The authors found that early emotional abuse, as compared to other types of abuse, robustly predicted later relationship violence and victimization.

Messman-Moore and Coates (2007) published a study that established a link between early emotional abuse and subsequent interpersonal difficulties. Participants were categorized depending on the type of abuse they had experienced. Then, the Young Schema Questionnaire-Short Form (Young, Klosko, & Weishaar, 2003) was administered to assess any early maladaptive schemas that may have developed as a result of their abusive experience. Finally, the participants completed the Inventory of Interpersonal Problems (Horowitz, Alden, Wiggins, & Pincus, 2000), a self-report measure designed to detect interpersonal difficulties. The authors reported that individuals who were emotionally abused were more likely to experience higher levels of conflict within their romantic relationships, work or school associations, and even their friendships. Additionally, they found that certain women who suffered from emotional abuse tended to develop maladaptive beliefs or schemas from an early age that put them at risk for future adult interpersonal conflict. The authors suggested that because one of the consequences associated with childhood trauma is difficulty trusting others, emotional abuse led some women to believe that others cannot be trusted to provide adequate emotional support.

According to Paradis and Boucher (2010), individuals who have suffered emotional abuse may appear to be more distant and cold in their interpersonal relationships as compared to nonabused women. The researchers administered the Inventory of Interpersonal Problems in Couple Relationships (Paradis & Boucher, 2007), which used a five-point Likert scale to detect maladaptive patterns in interpersonal behaviors. The authors concluded that women with a history of emotional abuse tended to be more distant and cold in their relationships, which could potentially be a result of the development of maladaptive schemas associated with emotional abuse.

Undeniably, the effects of emotional abuse are vast and cannot fully be described in one chapter. Additionally, it is important to note that there is no prototypical example of the effect of emotional abuse, as it can

comprise many groupings of the variations discussed here (Lundberg-Love & Marmion, 2006). As such, this chapter has attempted to examine many of the common effects of emotional abuse and the manner in which they can affect interpersonal relationships, and thereby sexuality.

Furthermore, many researchers believe that emotional abuse is far more prevalent than other types of abuse, as it tends to be highly comorbid with all other forms of abuse (Abowitz, Knox, & Zusman, 2010). While a great deal of research has focused on the relationship between the individual types of abuse and their respective sequelae, it is important to note that there is overlap between the effects of emotional abuse and other types of abuse because they often occur simultaneously (Meston et al., 1999).

Interestingly, a common theme in recent research is that individuals who have suffered from emotional abuse tend to describe their experience as debilitating and distressful as those who have suffered from physical or sexual abuse (Lundberg-Love & Marmion, 2006). Furthermore, emotional abuse is sometimes more difficult to detect and treat than other types of abuse; the scars left behind by this type of abuse are imprinted on the psyche, as opposed to the body, and words can hurt forever.

CONCLUSION

"I don't even know how to tell the story . . . it's like the frog that ends up boiling because he didn't realize the heat was being turned up a little bit, a little bit, and a little bit more. Finally, before he knew it, he was boiled. That's how it felt" (Queen et al., 2009, p. 237). Clearly, the effects of each individual type of abuse can have a definitive and lasting impact on a woman's sexuality. While many of the consequences of the various types of abuse may be similar, each woman's experience of abuse is unique (Queen et al., 2009). Some women may recover from their abuse sooner than others. But many women suffer for decades without therapeutic intervention. The purpose of this chapter was to identify the effects of the various types of abuse (physical, sexual, and emotional) and discuss how such effects can impact sexuality. Overall, we have found that women who have experienced any type of abuse are more likely to report lower self-esteem, greater problems with respect to the quality of their subsequent relationships, and often develop anxiety or depressive disorders. Indeed, there is a high degree of comorbidity among the sequelae associated with physical, sexual, and emotional abuse (Dong et al., 2004; Meston et al., 1999). When one attempts to understand the impact of abusive experiences on women's lives, one must recognize that the effects are intertwined and can have multiplicative effects.

In conclusion, while we have discussed many of the negative sequelae associated with abuse, we need to recall that therapeutic intervention can greatly improve the life of an abuse survivor. Although the path may be

different for each individual, recovery, hope, and a positive future is possible for any woman who has been victimized and worth the effort (Lundberg-Love & Marmion, 2006). One particular client asked her therapist if recovery was really possible. The therapist responded:

> Absolutely. It is like living in color instead of black and white. It is about fully participating in life instead of going through the motions. It is about moving from feeling powerless to feeling powerful. It is about becoming whole again rather than being defined by the experience of abuse. But most of all, it is about being free, at last. (Lundberg-Love & Marmion, 2006, p. 84)

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Chapter 18

Constructing Women as Sexy: Implications for Coercive Sexuality and Rape

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RAPE CULTURE

Rape is a prevalent and persistent phenomenon that profoundly impacts the lives of women and girls in the United States (Watson, Kovack, & McHugh, 2011). Recently released research from the Centers for Disease Control indicated that women in the United States have a one in five chance of being raped, and such rates of sexual violence represent significant expenditures in health care costs (Centers for Disease Control, 2011). Previous reports, including the National Violence Against Women Survey (Tjaden & Thoennes, 1998) and the National College Health Risk Survey (Brener, McMahon, Warren, & Douglas, 1999), have consistently concluded that about 20 percent of women are victims of rape or attempted rape during their lifetimes. The consistency of such findings over time has been interpreted as documenting the persistence of rape (Rozee, 2003).

Although rape and sexual violence against women are universal phenomena, there are cultural variations in rape rates. Cross-cultural research on rape has found that incidence rates vary and this is directly correlated

to the cultural context (Sanday, 1981). Such studies have revealed the existence of "rape prone" cultures, or environments that support beliefs conducive to rape and increase risk factors related to sexual violence. Among industrialized and Western cultures, the rates of rape are relatively high in the United States (Scully & Marolla, 1998), leading some to label United States a rape-prone culture (e.g., Griffin, 1979; Sanday, 1981).

SEXUALITY AS SOCIALLY CONSTRUCTED

The emphasis on cultural ideologies that support sexual aggression and violence is an important component of the feminist analysis of rape. Feminist authors have argued that an understanding of the experience of rape requires an analysis of the cultural context in which rape is consistently committed at high rates. For example, Rozee (2003) argues that the persistence and prevalence of rape may best be explained by examining our cultural constructions and attitudes toward rape. Feminist theory stresses that rape is both socially produced and socially legitimated. Our conceptions of rape, and our cultural attitudes toward male and female sexuality, may contribute to the prevalence of rape and impact our reactions to rapists and victims (Ullman, 2010). Gavey (2005) documents how feminist research and activism have contributed to our recognition of rape as an epidemic problem, and how cultural norms and sexual scripts contribute to this epidemic. Similarly, Rozee (2003) argues that rape, and in particular date rape, is persistent because on some level forced and nonconsensual sex is permissible; she refers to it as "normative rape." Here, we take a similar social constructionist perspective, examining the ways in which our cultural norms and social constructions of gender and sexuality and our cultural scripts for heterosexual interactions contribute to multiple forms of sexual violence.

In our culture, we tend to think of sex as natural (i.e., as a biological imperative or an inherent drive). However, some theorists, including feminists, have argued that sex is NOT a natural act (e.g., Tiefer, 1995), and have adopted the social constructionist (e.g., Foucault, 1980) position that sexual practice, identities, and concepts are products of social practices. Within the social construction position, there is an emphasis on language, labels, and constructs, based on shared meanings and reflecting (often unexamined) assumptions about the phenomena (McHugh & Cosgrove, 2004). The social constructionist does not attempt to reveal reality, but instead is interested in how reality is constructed through interactions and language. For example, the meaning of a behavior or an experience is established through the way we label it, talk about it, and evaluate it. Sexual attitudes, behaviors, and identities are thus viewed as culturally constructed and regulated through social practices and discourses. For example, the social constructionist perspective might seek to understand

which acts are labeled as sex and why (Peterson & Muehlenhard, 2004; Tiefer, 1995).

Conceptions of rape have changed over time and remain contested today; everyone is not in agreement about what constitutes rape. Even within the criminal justice system, rape is legally defined by each state (in the United States). Although rape is the term most often used, the Centers for Disease Control and the World Health Organization prefer the term "sexual violence," which refers to "any type of sexual contact or behavior that occurs without the explicit consent of the recipient to the unwanted sexual activity." Our focus is not on rape (as legally defined), but instead on sexual violence as experienced by women. Therefore, our emphasis in on experiences that may not meet legal thresholds as a crime, but do have a detrimental impact on an individual's well-being. The social constructionist perspective compels us to critically consider constructs, language, labels, and discourses (McHugh & Cosgrove, 2002). Subsequently, we examine the process by which a sexual interaction is understood or labeled as rape, and challenge the construction of sexual experiences as being "(just) sex" versus rape (Gavey, 2005). In the gray area between forcible rape and fully consensual sex, there are a whole range of experiences involving ambiguity, negotiation, intimidation, stress, and confusion. Following Kelley (1987), we reject the binary construction of women's sexual experiences as violent or nonviolent and view sexual interactions as occurring along a continuum (e.g., from choice, to pressure, to coercion, to force). The labels and meanings attached to women's (unwanted) sexual experiences by the women themselves, and by others, are grounded in cultural norms and constructs, including sexual scripts, the construction of male and female sexuality, and conceptions/myths about rape. Importantly, the name or labels given to an experience of unwanted sex has an impact on the reaction of the victim and the reaction of other individuals and agencies to the victim.

THE SEXUAL DOUBLE STANDARD

The sexual double standard is defined as the practice of judging the sexual behaviors of men and women by two very different standards. In general, the sexual double standard refers to cultural practices, in which sexual behaviors that are condoned or rewarded when performed by men are negatively evaluated when committed by women (i.e., women are chastised and stigmatized for similar behaviors; Kreager & Staff, 2009). The sexual double standard is based on the belief that men and women's sexuality is inherently different; men are believed to have a biologically based sexual drive, whereas women are viewed as less sexual and more interested in relationships relative to men. Although public perceptions and popular trade books, such as *Slut!* (Tanenbaum, 2000) and *Fast Girls*

(White, 2002), support the existence of a double standard, scientific research has not consistently documented the sexual double standard as a set of attitudes that are widely held (Crawford & Popp, 2003).

A variety of qualitative approaches have been employed to study the operation of a double standard. Aubrey (2004) examined teenage television programming and found that females in the television shows were more often punished for sexual acts (e.g., rumor spreading, contracting sexually transmitted infections) than were males. Eder, Evans, and Parker (1995) observed teenagers in their natural environment—middle school—to examine daily behaviors consistent with the sexual double standard. They observed such behaviors as boys pointing at girls during sexual education when the teacher's back was turned, but taking bows when male sexuality was being discussed. They also observed that girls were policing each other's sexuality and clothing choices, and girls who were deemed "sluts" were excluded from the groups.

McHugh and colleagues (2009) examined the sexual double standard as a cultural practice. Students in class and in focus groups described slut bashing, the derogation of girls and women using sexualized negative terms. Results confirmed widespread derogation of girls and women as sluts, with no comparable negativity attached to sexually active boys and men. Slut is a derogatory term applied not only to express negativity toward the sexual behavior and appearance of girls and women, but is also used as a weapon to relationally aggress against girls and women. Slut bashing can have long-term effects for the targets who suffer from social isolation and poor self-image. More importantly, the use of the term slut sends a message to other girls/women to restrict their sexual expression. Various qualitative studies have documented the application of negative labels for sexual norm violations of girls and women. Slut bashing is one example demonstrating the continuing application of the sexual double standard. The sexual double standard, in which we criticize sexual activity by women and applaud the sexual prowess of men, contributes to our rape-prone culture. Research revealed that the sexual double standard was the most important variable in explaining rape-supportive attitudes (Sierra, Santos-Iglesias, Gutierrez-Quintanilla, Bermudez, & Buela-Casal, 2010).

SEXUAL SCRIPTS

One approach to understanding social constructions of male and female sexuality is to examine sexual interactions in relation to sexual scripts (Simon & Gagnon, 1984, 1986). Scripts are cognitive models used to interpret, guide, evaluate, and remember social interactions. Cultural scripts are collective guides that outline the norms, values, and practices to be relied on in particular situations by members of a shared culture

(Eaton & Rose, 2011). This cognitive approach to social interactions has been applied to sexual interactions (e.g., Eaton & Rose, 2011; Rose & Frieze, 1993). Sexual scripts are culturally produced guides that describe what actions will occur (in a sexual encounter) and in what order. Just as in a movie script, individuals are assigned roles to play, and there are lines (i.e., discourses) and actions associated with the scene.

In a script theory approach, culturally prescribed scripts assign the role of gatekeeper to women and the role of initiator and/or predator to men. Women are viewed as responsible for vetoing or limiting the sexual actions (i.e., saying no), whereas men are assigned a role of persistence or aggression (Byers, 1996; LaPlante, McCormick, & Branigan, 1980). The male role in the cultural sexual script involves pursuit and persistence. Males are viewed as having uncontrollable sexual responses to provocation, thereby reducing their culpability for inappropriate or offensive sexual behaviors. The cultural script emphasizes the importance of male pleasure. Our cultural script for women emphasizes waiting to be chosen or actively encouraging male attention based on sexual attractiveness. Women's roles also require them to restrict and resist the sexual advances of men. Women are viewed as desiring love and affection, as opposed to sexual pleasure, and women are expected to engage in sexual behavior only in the context of affection and love.

It is believed that the sexual double standard is often passed down throughout generations through the use of sexual scripts. These sexual scripts include beliefs such as "a man always wants sex and is ready for it," "sex is for men," "women shouldn't talk about sex," and "for women, sex is good in committed relationships, but bad when casual" (Kimmel, 2007).

American culture has a gendered notion of sex, typically defining penetration as the key element in heterosexual sex. The traditional sexual script for heterosexual interactions situates men as initiators of sexual activity and women as the reactors or "gatekeepers," responsible for controlling the pace and limiting the access of men (Brooks, 1995; Tiefer, 1995). This heterosexual script positions men and women as adversaries (Castañeda & Burns-Glover, 2004), which sets the stage for coerced sex and rape. In the script, sexual interactions are like a competitive game, in which the man uses multiple strategies to persuade the woman to engage in sex and the woman uses multiple strategies to avoid sexual intercourse.

Feminists have argued that these sexual scripts encourage the use of persistence, manipulation, and coercion by men to obtain sex, and assign responsibility for resisting and restricting male sexual behavior to women. Initially, Muehlenhard and McCoy (1991) demonstrated that sexual double standards and the sexual script resulted in women expressing token resistance or scripted refusal (i.e., women were inhibited from saying yes to sexual interactions). This type of exchange also fosters an environment of sexual victimization, by blurring the distinction between sex and sexual

coercion/rape (Gavey, 2005). This perspective—in which female resistance is dismissed as merely being a part of women's role in the script—plays a role in sexual victimization, by suggesting to men that such resistance is not genuine protest. Some feminist theorists have argued that it is for this reason that acquaintance rape is not considered by many to be real rape (Brownmiller, 1975; Griffin, 1979).

Script theory suggests that forced sexual activity may not be labeled as rape because it conforms to scripts for "normal" sexual interactions. In a study conducted by Littleton and Axsom (2003), when participants described a rape script and a seduction script, both scripts tended to involve the use of manipulative tactics on the part of the man to obtain sex and the woman engaging in sexual activity that she did not want. Alternatively, Ryan (1988) reports that the seduction scripts students wrote differed significantly from rape scripts they composed; the students' rape scripts described forcible rape at the hands of a stranger. In a related study, Kahn, Mathie, and Torgler (1994) reported that women students who were raped (by legal standards), but did not acknowledge it, were those who possessed stereotypical rape scripts of violent stranger rape. They did not construct their experience of unwanted sex as rape. In other research, where undergraduates responded to a sexual situation/script, half the women student respondents felt that unwanted intercourse obtained through pressure was acceptable behavior, and they even thought the acquaintance rapist/man might fall in love with them (Lewin, 1985). This research confirms Gavey's (2005) contention that women construe acquaintance rape (i.e., unwanted sexual intercourse performed under pressure) as normative. Similarly, college men may not identify acquaintance rape as rape. According to Check and Malamuth (1983), men may believe that a woman is only saying no because the woman is acting according to the double standard. Koss, Leonard, Beezley, and Oros (1985) found that 12 percent of their male respondents reported engaging in sexual behavior that qualified as rape, but the respondents said that it was definitely not rape. Krahe, Scheinberger-Olwig, and Kolpin (2000) found a strong link between men's beliefs that women engage in token resistance and reported aggression against female partners.

RAPE MYTHS AND VICTIM BLAME

Feminists identified problematic misconceptions about rape in the 1970s. Identified through media analysis and interviews with individuals, rape myths were exposed as mistaken and stereotypic beliefs that were strongly ingrained, widespread, and disadvantageous to women. Rape myths are persistent social beliefs that can be defined as "descriptive or prescriptive beliefs about rape (i.e., about its causes, context, consequences, perpetrators, victims, and their interaction) that serve to

deny, trivialize, or justify sexual violence exerted by men against women" (Bohner et al., 1998, p. 14). A feminist project has been to challenge widely held rape myths using empirical research (Ward, 1995). Edwards, Turchik, Dardis, Reynolds, and Gidycz (2011) reviewed three decades of research on rape myths, recording the persistence of rape myths and focusing on the role of media, religion, and other institutions in perpetuating rape mythology. There are a number of rape myths, but typical myths fall into a few broad categories, including the stranger rape myth, myths about the rapist, and women-blaming rape myths. The gist of all the rape myths is that women, not men, are responsible for rape.

The stranger rape myth, also known as the "real rape" stereotype, is the idea that an unfamiliar (black) man jumps out of an alley and forcibly assaults a white, middle-class, conservatively dressed woman—a woman who hasn't consumed alcohol or engaged in other "questionable" behaviors (Ullman, 2010). This woman is described as fighting back, kicking and screaming, but failing in her attempt to get away. As a result, she is raped. This situation is typically regarded as the only one in which a victim is blameless, and for this reason, this type of myth is extremely problematic. This stereotype delegitimizes rape situations that do not fit this perfect mold; in effect, opening the door for victim blaming and fostering other attitudes consistent with a rape-prone culture. This stereotype also serves to perpetuate false beliefs that phenomenas, such as date rape and marital rapes, do not exist, whereas in fact 84 percent of individuals who are raped know their attacker on some level (Warshaw, 1988). Still, individuals tend to believe that rape occurs in dark alleys by a stranger with a weapon, even though less than one-third of all sexual assaults are committed by strangers (Tjaden & Thoennes, 2000).

Myths about who the rapist is are also based on inaccurate stereotypes. Individuals envision the black male stranger in the alley as the perpetrator of rape, although research has demonstrated that actual rape is most likely to be committed by acquaintances and intimate partners of the same race as the victim (Koss, 1985). Rape myths also tend to point to psychopaths as the perpetrators of rape. But survey research shows that we cannot tell the difference between men who are rapists and men who are not, as reflected by physical appearance, personality measures, or other psychological tests (Field, 1978; Payne, Lonsway, & Fitzgerald, 1999). Men who sexually aggress against women may hold certain cultural beliefs more than nonaggressing males. For example, sexually aggressive men and rapists are more likely to believe in rape myths and to blame victims for provoking rape (Field, 1978; Malamuth & Check, 1985). Another myth about the rapist relates to the sexual double standard—the rapist, like other men, is seen as being unable to control his sexual urges. Belief in this myth absolves men of responsibility for their behavior, often casting the blame on the victims of rape instead.

Women-blaming myths are myths about the women who are victims of rape. In our society, we often blame the victims of rape both overtly and covertly (e.g., by asking "did you fight back?" or "what was she wearing?"). These myths are directly related to the stereotype of a rape victim. For example, a characteristic of women that is often questioned in cases of rape is sexual purity. Believers of "the purity myth," (Valenti, 2009) argue that this sexual double standard serves as a basis by which women's worth is judged, such that women who are not pure (i.e., not virgins) are considered less moral than those who are pure. It is thought that this double standard serves to contribute to violence against women and victim blaming, by creating a dichotomy between "good" and "bad" women, suggesting that "good women" (i.e., those who are chaste) are not deserving of rape, but those who are sexually active may be at least partially to blame (Valenti, 2009). All women/victim-blaming myths are based on the idea that rape is precipitated or even provoked by women due to their appearance, their behavior, and so forth. Women-blaming myths may also accuse women of deriving pleasure from the rape. Examples of this type of myth include: "Many women find being forced to have sex very arousing," "Many women secretly desire to be raped," and "Although most women wouldn't admit it, they generally find being physically forced into sex a real 'turn-on.'"

Despite decades of research exposing these beliefs as misconceptions, research continues to document that rape myths are still widely held (Edwards et al., 2011). Research by Ward (1988) indicated that only one-third of students disagreed that rape is provoked by women's appearance and two-thirds of respondents agreed that women going out alone put themselves in a position to be raped. Ward also found that less than one-half of students thought that men were responsible for rape, rather than women. Why do rape myths persist, when such perspectives have been shown to be invalid and harmful? Rape myths are an extension of sexual scripts and incorporate the sexual double standard.

Rape myths persist as a cognitive schema that allows men and women to distance themselves from being perpetrators and victims of rape and helps individuals to maintain belief in a just world (Bohner, Eyssel, Pina, Siebler, & Viki, 2009; Bohner, Jarvis, Eyssel, & Siebler, 2005; Bohner, Siebler, & Schmelcher, 2006). Bohner and his colleagues (2005) demonstrated that rape myth acceptance served as a buffer for women; women reported lower levels of anxiety when confronting the issue of sexual violence when they subscribed to rape myths. Rape myths functioned differently for male students. Rape myths helped the male respondents to rationalize and justify their own experiences as sexual aggressors. Responding to rape by blaming victims, in effect, denies the reality that all women are susceptible to sexual violence (Kopper, 1996). Rape myths provide individuals and institutions with a false sense of safety based on the belief that

rape can be avoided through clothing and behavioral choices. Rape myths may also reassure men that their own sexually aggressive behaviors are not rape (Ryan, 2011).

Rape myths contribute to the persistence of rape by impacting the victim's recognition of rape and her likeliness of reporting the incident to police or other authorities. Victims of acquaintance rape are less likely to report their experience to the authorities than victims of stranger rape (McGregor, Weibe, Marion, & Livingstone, 2000). Kahn and his colleagues (1994) examined differences in scripts of acknowledged and unacknowledged rape victims (i.e., women who have an experience that fits the definition of rape but do not label their experience as rape). Unacknowledged rape victims had a rape script that involved a violent attack by a stranger, whereas acknowledged rape victims had scripts that included acquaintance rape. Peterson & Muehlehard (2011) reviewed research documenting that many young women who have been raped (by legal standards or accepted definitions) do not label their experiences of unwanted sex as rape because the characteristics of the incident did not *match* their rape scripts. For example, based on qualitative research with 30 women, Phillips (2000) concluded that women experienced a profound lack of fit between their own complex lived experiences and societal notions of victimization. Peterson and Muehlehard (2011) present a match and motivation model for women labeling their sexual experiences as rape. In addition to considering the match between their experiences of unwanted sex and rape, women also reflect on the anticipated consequences of labeling the experience as rape. Women's motivations for not labeling the incident as rape and for not reporting it included reluctance to label the perpetrator as a rapist and to avoid being labeled themselves as rape victims. Other research indicates that women cannot avoid the negative impact of rape by not acknowledging it. Women who experienced acquaintance rape had similar negative long-term effects regardless of whether they acknowledged/labeled the incident as rape (Kahn, Jackson, Kully, Badger, & Halvorsen, 2003).

Victim-blaming reactions from others have been referred to as secondary victimization (Campbell & Raja, 1999), and secondary victimization is a common experience of rape victims (Ullman, 2010). Blaming responses take one of two forms, according to Ullman (2010). Overt blaming involves explicit statements, such as "It was your fault." Implicit blaming typically occurs by questioning the victim about her activities, her decisions, and so on. Research indicates that victims are blamed by both informal and formal networks. Agency personnel who are supposed to provide assistance or support to rape victims, such as police, physicians, pastors, and psychologists, frequently engage in victim-blaming responses (Ullman, 2010). At minimal, one-fourth and as many as three-fourths of survivors receive negative social reactions from someone in their support network

(Campbell, Ahrens, Sefl, Wasco, & Barnes, 2001). Ahrens (2006) reports that negative reactions received from friends and families reinforced victims' feelings of self-blame, and reactions from professionals led to victims questioning the advisability of disclosure. Krahe (1991) reports that police officers frequently adopt a traditional view of male and female sexual interaction. Their rape script involved violent force, a stranger assailant, and an outdoor context. The police officers viewed acquaintance rape that involved low levels of force as dubious.

Survivors of sexual assault often experience silencing, a process that can occur both before and after rape disclosures. This silencing of victims not only causes a reexperiencing of the trauma (Ullman, 2010), but it also places women in the silent, subservient position in society. Policies and practices within the criminal justice and mental health systems are often guided by misconceptions about rape (Ullman, 2010). In a recent study of incarcerated women who reflected on their own sexual victimization, Heath, Lynch, Fritch, McArthus, and Smith (2011) analyzed the narratives women provided regarding silence about the incident. The women respondents who remained silent about their rape experience reported rape myths and often questioned whether the interaction was rape. They also blamed themselves and doubted whether others would believe them. The authors concluded that the prevalence of rape myths among these women played a role in women's willingness to disclose. Therefore, victim blaming discourages women from reporting their sexual assault to the criminal justice system.

Rape is the most underreported crime. Failure to report rape undermines the potential of the police and criminal justice system to prevent rape. The underreporting and underprosecution of rape, which are both impacted by rape myths, send a message to the perpetrators and to the general public that there are no real consequences for committing acts of sexual aggression (Heath et al., 2011). We underestimate the prevalence of rape when victims decide not to disclose the experience. Ironically, the prevalence rates should counteract our tendency to victim blame. When rape is a normative experience, the tendency should be to look for larger, more structural explanations. Blaming individuals for common events violates common sense. Thus victim-blaming rape myths contribute to the underreporting of rape; failure to acknowledge the prevalence of rape is supported by, and in turn supports our misunderstanding of the reality of rape.

Widely held research has indicated that belief in rape mythology is related to other attitudes and behaviors. In a study conducted by Suarez and Gadalla (2010), men were found to have displayed a significantly higher endorsement of rape myth acceptance than women. Rape myth acceptance was strongly associated with hostile attitudes and behaviors toward women, which was tested by allowing men the opportunity to

administer a loud painful sound to a woman who was pretending to be another participant. In an early study, Burt (1980) found that tolerance of interpersonal violence was the strongest predictor of rape myth endorsement. Subsequent research has indicated that gender role stereotyping and endorsement of adversarial sexual beliefs are associated with rape myth acceptance. For example, Quackenbush (1989) reported associations among the following: masculinity, tolerance for interpersonal aggression, adversarial sexual beliefs, and rape myth acceptance. The linkage of rape attitudes with adversarial, exploitative sexual beliefs and the tolerance for less violent forms of sexual coercion supports the feminist position that rape is the extreme on the continuum of male domination of women (Ward, 1995).

Rape myths are not only harmful because they may lead to victim blame or underreporting of rape, but they are also dangerous in that they may increase the prevalence of rape. Both rape tolerance and rape myth acceptance have been empirically linked with attitudes condoning male dominance, the perception of women as sex objects, and the reported likelihood of raping (i.e., rape proclivity; Malamuth, Sockloski, Koss, & Tanaka, 1991). Research that has surveyed rapists found that convicted rapists subscribe to rape myths more than nonraping men (Malamuth & Check, 1985). A 1980 study conducted by Malamuth, Haber, and Feshbach found that college men reporting likelihood to rape (if there was no chance of punishment) indicated more tolerance for rape and endorsed a series of rape myths. Other research on samples of nonconvicted males generally reveals a strong relationship between self-reported rape proclivity and acceptance of rape myths (e.g., Bohner et al., 2005, 2006; Chapleau & Oswald, 2010; Chiroro, 2004; Malamuth, 1981; Malamuth & Check, 1985; Tieger, 1981). Consistent with the high levels of reported date rape on college campuses, the research on rape proclivity confirms that a large percentage of college men view sexual coercion and nonconsensual sex as being within their behavioral repertoire. The research also confirms the connection between rape mythology and the perpetration of sexual aggression.

Thus, culturally held misconceptions about rape have obvious deleterious effects on society and rape victims in particular. Rape myths are extremely problematic because they can lead to an individual not reporting when they are raped, professionals that ask blaming questions, juries not convicting rapists, family and friends who imply the victim is at fault, and/or a man's increased likelihood to rape, because he does not perceive sexual coercion and forced sex of an acquaintance as "rape" under the standards of our culture. Rape myths also underlie our cultural approaches to rape prevention, which emphasize what women should do to avoid rape rather than how to control or curb male sexual aggression (Rozee, 2003).

THE SEXUALIZATION AND OBJECTIFICATION OF GIRLS AND WOMEN

A report released by the American Psychological Association (Zurbriggen et al., 2005) documented that the media has increasingly included sexualized images of girls and women over the past decades. Sexualization occurs when people value a woman or girl primarily for her sexual appeal or behavior; hold her to a narrow standard of beauty; equate her physical beauty with sexiness; view her as an object for sexual use; or inappropriately impose sexuality on her (Zurbriggen et al., 2005). The Task Force on the Sexualization of Girls reviewed research confirming that women more often than men are portrayed in a sexual manner (e.g., dressed in revealing clothing with bodily postures or facial expressions that imply sexual readiness) and are objectified (i.e., used as a decorative object or as body parts rather than a whole person). In addition, a narrow (and unrealistic) standard of physical beauty is heavily emphasized. In *The Purity Myth,* Jessica Valenti (2009) reveals the overt and hidden ways our society links a woman's worth to her sexuality rather than to values like honesty, kindness, and altruism. These are the models of femininity presented for young girls to study and emulate. Besides media, girls may receive sexualized messages from parents, teachers, and peers. Research documents that both male and female peers have been found to contribute to the sexualization of girls. Girls frequently police other girls regarding their conformity to standards of thinness and sexiness (Eder et al., 1995) and boys sexually objectify and harass girls (Hill & Kearl, 2011). In short, "Sex-specific sociocultural messages tirelessly target adolescent girls and women's bodies" (Fredrickson, Roberts, Handler, Nilsen, & O'Barr, 2011, p. 689).

The APA identified the sexualization of women and girls as harmful to girls' self-image and as posing a potential mental health risk to both girls and women. The APA report reviewed existing evidence and concluded that sexualization has negative effects in a variety of domains, including cognitive functioning, physical and mental health, and healthy sexual development (Zurbriggen et al., 2005). Sexualization encourages girls to construct their own sexuality in terms of appearing sexy to attract the attention and approval of boys and men. Sexualization also encourages boys to appraise girls and women in terms of their appearance and sexual appeal. Men frequently demonstrate an entitlement to express their evaluation of female bodies and appearance not only in social situations, but also in the office and on the street (Sullivan, Lord, & McHugh, 2010).

The sexualization of girls and women exists on a continuum from sexualized evaluation to sexual violence. At all points on this continuum, women are treated as bodies. At one end of this spectrum of sexualization, women are most subtly evaluated through sexualized gazing or visual

inspection of their bodies. This type of gazing has the potential for sexual objectification. At the other end of the spectrum lies sexual violence (Fredrickson & Roberts, 2004).

The frequency of and blasé attitude toward the sexual objectification of women in American society seem to set the stage for a rape-prone culture. In a culture in which it is permissible to objectify women in everyday social encounters and through countless forms of visual media, it is not entirely surprising that sexual violence is minimized despite its prevalence. Objectification theory contends that all women are susceptible to sexual objectification, an experience that can negatively impact emotional and mental well-being. When a woman is sexually objectified, she is treated as an object, in particular a body or a collection of body parts, to be used and/or consumed by the viewer (Fredrickson & Roberts, 2004). This conveys the message that a woman's value lies in her physical appearance, as her worth is limited to the pleasure derived by her viewers from consumption of her appearance.

Sexual objectification exists in many forms, not the least of which is the sexually objectifying gaze. In American society, the objectification of women is so inescapable that a sexualizing gaze can be found in social encounters, media depicting social encounters, and various types of visual media (e.g., film, advertisements, magazines, and pornography) that place the focus on women's bodies and body parts (Fredrickson & Roberts, 2004).

The existence of sexualized gazing in social encounters is supported by empirical data that has found that women are gazed at more often than men. Research confirms that men direct more nonreciprocated gazes toward women, and such gazing by men is often accompanied by sexually evaluative commentary (Fredrickson & Roberts, 2004). Similarly, certain forms of street harassment (e.g., a man commenting on a woman's breasts as she walks by) consist of this type of sexualized gazing. Although empirical data on this topic is limited, results from various surveys indicate that most women have experienced harassment by male strangers in public at least once in their lifetime and may experience such harassment as often as every day (Sullivan et al., 2010). Researchers have found that stranger harassment is positively related to women's fear and perceived risk of rape, highlighting just a couple of the negative effects of sexualized gazing on women.

Women do not even have to leave their homes or engage in social activities to experience objectification, since the sexualized gaze is ever-present throughout the media, a phenomenon that is well-documented. For instance, one study compared body exposure of men and women in print advertisements and found that women's bodies were exposed four times as often as men's bodies (Plous & Neptune, 1997). Another study reported that more than half of the advertisements in a popular U.S. women's

magazine portrayed women as objects (Lindner, 2004). These and other kinds of objectification in the media have been linked to permissive attitudes toward the objectification of women, rape-supportive attitudes, and the acceptance of rape myths (Stankiewicz & Rosselli, 2008).

Whatever its form, sexual objectification serves to dehumanize women, leaving them more susceptible targets for sexual violence. This may be because it is easier to demand or force a woman into a sexual act if she is viewed as a commodity or a piece of property (Friedman & Valenti, 2008; Kilbourne, 1999). In fact, empirical studies suggest that sexual objectification is a key component of sexual violence. For instance, research has revealed that women whose appearances are considered to be "provocative" are thought to provoke their own rape (Beneke, 1982). The role of objectification in sexual violence is also exemplified by many individuals' accusatory responses to women who are victims of rape (e.g., questions such as "What was she wearing?" which focus on the victim's appearance; Ullman, 2010).

Because American society is so saturated with the objectification of women, it is likely to affect most girls and women to some degree, regardless of age, socioeconomic status, sexuality, ethnicity, and so forth, though the experience may be somewhat unique to each individual or subgroup. What these individual women and groups of women have in common, however, is the shared experience of being vulnerable to sexual objectification. Research has shown that being subject to this type of scrutiny leads women to keep constant vigil of their appearance, having internalized the message from society that their worth lies in their physical appearance. This is a phenomenon described by objectification theory as self-objectification. Self-objectification often leads women to feel shame and/or anxiety if they believe that their appearance does not measure up to the standards set by society. Furthermore, self-objectification has been shown to relate to the experience of depression and disordered eating among women, as well as women's fear of and perceived risk of rape (Fredrickson & Roberts, 2004; Rudman & Fairchild, 2007).

EMBRACING SEXUALIZATION

Refuting the belief that rape is the result of provocation by women, challenging the derogation of women's sexual expression, and defending their right to sexy attire, women around the globe have staged slut walks (Stampler, 2011). Slut walks began in Montreal in response to a police officer's comment that to remain safe "women should avoid dressing like sluts." Subsequently, masses of women (and men) have staged protests in cities and on campuses around the world. The walks have attracted media attention and controversy. Participants protest against explaining or excusing rape by referring to any aspect of a woman's appearance (Valenti,

2011). Others state that they "are tired of being oppressed by slut-shaming; of being judged by our sexuality and feeling unsafe as a result" (Powers, 2011). The rallies protest both victim blaming and slut bashing, and they challenge the use of the word (slut) as a weapon against women and as a justification for their victimization. Slut walk defenders say that they're being ironic and that it's supposed to be funny that women are turning a word used to dehumanize them into a badge of pride. According to cofounders of the original Slut Walk, Sonya Barnett and Heather Jarvis, "Being in charge of our sexual lives should not mean that we are opening ourselves to an expectation of violence" (Adelman, 2011).

These demonstrations may be seen as consistent with the perspective attributed to Third Wave feminists that women can perform femininity without accepting second place status (e.g., Wolf, 1997). Wearing makeup and short skirts is seen as a personal choice. Alternatively, the sexy attire of young women may be viewed as acceptance of fashion directives without sufficient reflection on the meaning or consequences of one's appearance. For some women, dressing sexy is a way of expressing themselves as sexual beings (e.g., Peterson, 2010). Others contend that this is women's sense of female sexuality as seen through the lens of a dominant discourse that centers on male desire and the male gaze (e.g., Gill, 2003). In cultural constructions, women are cast in the role of sexual object and now women cast themselves in that role as a way to "feel" sexual.

Researchers have examined the phenomena sometimes labeled as self-sexualization. In Gill's (2003) analysis, self-objectification is disguised as sexual subjectivity and interpreted by some women as empowering. Nowatzki and Morry (2009) demonstrated that hyperfemininity, defined as adherence to feminine norms and endorsement of sexual adversarial positions and not self-objectification, was empirically correlated with self-sexualizing behaviors in college women. Questions about the meaning and consequences of young women dressing in provocative attire or acting in sexually emboldened ways remain contested within society and with the academic and feminist community (e.g., Lamb, 2010; Lamb & Peterson, 2012; Peterson, 2010; Smolak & Murnen, 2011). Feminist theorists support the importance of women, including young women, expressing themselves as sexual agents, but do not necessarily agree with women's choices to position themselves as objects of male desires.

CONTEMPORARY SEXUAL SCRIPTS

Similarly, college women may view traditional dating scripts as gendered and favor newer forms of making sexual connections as more gender neutral. Hooking up is the new script for male and female relations on college campuses according to Bogle (2009). Hook-ups are defined as sexual encounters "usually occurring on only one occasion between two

people who are strangers or brief acquaintances" (e.g., Paul & Hayes, 2002, p. 640; Paul, McManus, & Hayes, 2000). Although hook-up and one-night stand often are used interchangeably to refer to a casual sexual relationship that is limited to a single occasion, others indicate that repeated hook-ups frequently occur (England, Shafer & Fogarty, 2007). Hooking up refers to the casual nature of the connection (i.e., the lack of commitment or affectionate ties). Furthermore, not all hook-ups involve intercourse, and some do not involve any sexual acts beyond making out (England et al., 2007). Though some researchers have argued that hooking up has become even more frequent than dating on college campuses (e.g., Bogle, 2009; Bradshaw, Kahn, & Saville, 2010; Glen & Marquardt, 2001), other studies have found that students greatly overestimate how often hook-ups occur within the general student culture (Holman & Sillars, 2011; Lambert, Kahn, & Apple, 2003). Some research has indicated that hooking up is more likely to involve white and more affluent students who consume alcohol; students of color are less likely to engage in hooking up (Owen, Rhoades, Stanley, & Fincham, 2010). Holman and Sillars (2011) found that even among predominantly white students in the northwestern United States, only about one-third of participants reported experience with two or more sexual hook-ups, yet most respondents believed that the typical student had two or more hook-ups.

Other researchers have addressed an additional script for relationship encounters, referred to as hanging out. Hanging out occurs when women and men "spend loosely organized, undefined time together, without making their interest in one another explicit" (Glenn & Marquardt, 2001, p. 5). A recent series of studies of a Hispanic young adult population indicated that, in contrast to research suggesting that hooking up has become more popular than dating on college campuses (e.g., Bogle, 2009; Bradshaw et al., 2010; Glen & Marquardt, 2001), traditional first dates were found to be the most common interpersonal script for young Hispanic adults (Eaton & Rose, 2011), hanging out emerged as the second most popular script, and few respondents reported hooking up.

College students believed that hook-ups were gender neutral in that they could be initiated by men or women (Paul & Hayes, 2002). However, other research suggests that men continue to initiate and to dominate in hook-up sexual interactions (England et al., 2007) and the priority remains on male pleasure. Men are more likely to experience orgasm when the hook-up involves oral sex or intercourse. Hook-ups, like other sexual encounters, are based on our cultural constructions of male and female sexuality, including the double standard (Bogle, 2009; England et al., 2007).

The reference to women returning from an (unplanned) evening of sleeping over as the "walk of shame" is an explicit example of the double standard. Women are viewed as shamed when engaging in hook-ups whereas men are not (Pearlson & McHugh, 2010). When asked about their feelings after a hook-up, regret was the most common feeling reported to

Paul and Hayes (2002), and women were more likely than men to report feeling regretful or disappointed. Men were more likely to report satisfaction. Women respondents also reported ruminating about the experience and experiencing shame and self-doubt. Similarly, Eshbaugh and Gute (2008) found that hook-ups, especially those involving intercourse, were associated with regret for college women. Bradshaw and colleagues (2010) reported that women preferred traditional dates to hook-ups, possibly because of the sexual double standard.

Traditional sexual and relationship scripts incorporate gender roles and the double standard and provide the foundation for coercive sex and rape. Do the newer scripts of hanging out or hooking up represent a movement toward gender equality and more consensual sex? Bogle (2009) argues that hooking up represents the adoption of an androcentric (i.e., male oriented) approach to sex. A single sexual interaction without strings, affection, or intimacy resembles the stereotypic male orientation. Does this represent the liberation of women? Is sexual freedom commensurate with adopting a male approach to sex? Or is Gavey (2005) accurate in her assessment that the issues of consent and coercion remain problematic in such sexual encounters? Are women engaging in just sex or is their ability to consent complicated by cultural constructions of male and female sexuality? Powell (2010) concludes that "contemporary young people must negotiate a tension when it comes to sexuality-between messages of sex as danger or risk and messages promoting young people's engagement in an exaggerated raunch culture" (p. 17).

WOMEN'S SEXUALITY AS IMPACTED BY RAPE

The reality of men's sexual aggression impacts women's sense of themselves as sexual beings. One of the few things about sexuality we are willing to teach young girls is the possibility of bad touch and to avoid interactions with strangers. Girls are often restricted in their movements by our desire to protect them from boys and men. This cultural perspective emphasizes virginity and purity for women and implicitly acknowledges a more bestial sexuality in boys and men. As girls develop into sexual beings in adolescence, they are increasingly warned about men and the dangers of sexuality. In teaching girls about the potential of men to rape them, we are also teaching them to fear men, men's sexual overtures, and, in general, sexual interactions with men. We are teaching them to expect and tolerate male sexual aggression. Women are taught to fear and avoid rape, but at the same time they learn to view male sexual persistence, pressure, and coercion as normative. In this sense, rape and coerced sex are a key element in girls and women's understanding of both male and female sexuality.

Rozee (2003) has critiqued rape prevention programs that focus primarily on what women can do to avoid rape. For example, women are

advised to not walk alone or frequent certain locations. This approach to prevention confirms the rape myth perspective that rape is the result of what women do or do not do. These programs also convey the notion that men are inherently sexual, irresponsible, and uncontrollable. The message is that we cannot control the sexual aggression of men; we can only try to avoid it. As Rozee (2003) points out, these programs do not prevent rape, but merely support rape myths and sexual scripts. A multivariate study by Norris and Kaniasty (1992) found that precautionary behaviors of women had no preventive impact on the subsequent occurrence of crime. More importantly, this form of rape prevention contributes to women's fear and anxiety and limits their movement and activity. Fear of rape keeps women in their place—at home, following social conventions.

This presents a dilemma for parents and for society. Some men and boys are dangerous and do engage in coercive sexual interactions and forcible rape. At the same time, our cultural construction of male sexuality encourages men to act on their urges and to see adversarial sexual interactions as "natural." Our cultural view encourages men to persist and to overcome or ignore female resistance, and societally we often view women, not men, as responsible for avoiding rape. Our current messages about rape contribute to rape persistence by teaching men and women rape myths, victim blame, sexual scripts, and a sexual double standard that form the foundation for coerced sexual interactions.

CONCLUSIONS

Rape is a social tradition that reflects and perpetuates male domination (Brownmiller, 1975). Rape is about power (Griffin, 1979). Rape is a function of the degree to which women are socially, politically, and economically disadvantaged relative to men. Rape both results from and maintains sexual inequality. Russell (1982) contends that social attitudes, norms, and values and traditions of inequality result in rape-supportive cultures. Our ideas about men, women, and their sexual interactions not only underlie rape and sexual coercion, they also impact our attempts to prevent and intervene in sexual assault.

Even as we attempt to repair the damage of sexual violence at the individual level, we must shift our focus to challenging the sexual double standard, modifying our sexual scripts, and revealing the nontruth of rape myths (Rozee, 2003; Watson et al., 2011). Rape prevention begins with recognizing the prevalence of rape and acknowledging the profound impact that rape has on the lives of victims, as well as the lives of all girls and women (Watson et al., 2011). From a feminist perspective, rape prevention involves the critical examination and challenge of gender roles and gender inequality. Thus, an alternative approach to rape prevention might emphasize changing our sexual scripts, challenging the sexual double

standard, and criticizing rape myths (Gavey, 2005; Watson et al., 2011). Reducing the prevalence of rape and sexual violence requires changing our cultural constructions of gender, sexuality, intimate relationships, and equality, and eliminating social institutions and social practices that incorporate and maintain male dominance and gender inequality. Most importantly, rape prevention ultimately needs to address and modify the sexually aggressive scripts/behavior of men.

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Chapter 19

Sex Trafficking, Sexual Exploitation, and Women's Sexuality

Nancy M. Sidun and Jill Betz Bloom

Her desperate parents sold Maya, born in Nepal, to an agent for US$55 on the promise she would have a good job at a carpet factory. This would allow her to send money home monthly. The night Maya left her home, the agent resold her to a *dalal* (trafficker) who took her across the border by foot into India. When they arrived in Mumbai a few days later, the *dalal* sold Maya to a *malik* (brothel boss). The *malik* told Maya that she owed him 35,000 Indian rupees (US$780), and that she was to repay her debt by having sex. Maya refused, and the *malik* raped her and did not feed her until she agreed to perform sex with as many men as it would take to repay her debt. For two years, she was kept in a bungalow where she was forced to have sex with 20 men each day. After those two years, she was sold to another *malik*. She did not live in a bungalow this time, but was kept in a *pinjara* (cage) with one other woman. After two more years, Maya managed to escape and fled to a shelter. She was tested for HIV at the shelter; the results were positive. The staff helped her get in contact with her father; however, he told her not to come home as she would only bring shame to the family and could never be married since she had HIV (Kara, 2009).

Maya's story is emblematic of the hundreds of thousands of women and children trafficked globally for sexual exploitation. The exploding epidemic of trafficking of women and children for the purposes of sexual exploitation is the most common form of trafficking, and is the focus of this chapter.

The chapter begins with an overview of the definition and scope of human trafficking, followed by a discussion of the structural and individual risk factors or vulnerabilities that predispose women and girls to sexual trafficking. We then turn to a more focused presentation of regional global trafficking patterns in order to illustrate the differences and commonalities that are contoured to the structural and individual vulnerabilities of women and girls. We conclude with a discussion of the consequences of sexual exploitation and trafficking for women and girls.

DEFINITION OF HUMAN TRAFFICKING

There has been considerable debate about the exact definition of "trafficking," however, in 2000, the United Nations Trafficking Protocol established a definition that is now generally accepted. The United Nation's definition is as follows:

> The recruitment, transportation, transfer, harboring, or receipt of persons, by means of the threat of use of force or other forms of coercion, of abduction, of fraud or deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation includes, at a minimum, the exploitation or the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery, servitude, or the removal of organs. (United Nations Office on Drugs and Crime, 2005, para. 1)

Severe forms of human trafficking are defined in the Victims of Trafficking and Violence Protection Act of 2000 (TVPA, P.L. 106-386) as:

> Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or . . . the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purposes of subjection to involuntary servitude, peonage, debt bondage, or slavery. (Sec. 103(8) of Div. A)

All international and national laws stress that these three key elements (i.e., fraud, coercion, force) are essential in the definition of human

trafficking (Jones, Engstrom, Hilliard, & Diaz, 2007). In the case of minors, there is a general agreement in much of the international community and within the United States that the trafficking term applies whether a child was taken forcibly or voluntarily (Siskin & Wyler, 2010).

Distinctions also exist between human trafficking and human smuggling. The difference is subtle but significant. Human smuggling usually involves a person who chooses to cross the border illegally, alone or with the assistance of an expert. When using an expert to assist them, the individuals knowingly give consent to that person to help them gain illegal entry into a foreign country. Smuggled persons are essentially on their own once they cross the border, whereas a trafficked person's ordeal is just beginning—the trafficker sells the victim to an exploiter or exploits the victims themselves. Trafficked persons are smuggled with coercion or fraud at the beginning and end of the process by being exploited (Kara, 2009). There are occasions when smuggled persons become trafficked persons if fraud, force, or deception become involved in their journey.

SCOPE OF THE PROBLEM

The United States fought the devastating Civil War more than 145 years ago to end slavery; however, today slavery is more widespread, with twice as many people enslaved than during the African slave trade (Bryant-Davis et al., 2011; Cockburn, 2003). Trafficking of persons for the intent of exploitation is both an international and a domestic offense that involves violations of labor, public health, and human rights standards (Siskin & Wyler, 2010). Human trafficking has acquired grave dimensions worldwide and is the most serious human rights violation in modern times (Hodge, 2008).

Due to the covert nature of trafficking, it is difficult to determine the exact number of people trafficked annually. Nonetheless, we know that the scale of human trafficking is monumental and increasing as both demand and supply are rising, with the growth most notable in the past two decades (Kara, 2009; Shelley, 2010).

In the age of globalization, organized trafficking operates as a transnational industry not restrained by national boundaries. Every continent of the world is now involved as a destination, transit, or origin/source of trafficked persons. To illustrate the scope of the problem, at least 120 nations are routinely pillaged by traffickers, and more than 130 nations are known destination countries (Thompson, 2008). Human smuggling and trafficking have been among the fastest growing forms of organized crime, due to current world conditions that have created an increased demand and supply (Nam, 2007; Orhant, 2002; Shelley, 2010). Mass migration in response to economic and political destabilization in many transitional and developing countries fuels the trafficking trade, as women are often forced to move from rural towns or villages to cities in order to survive.

This relocation of women, among other factors, insures that traffickers have a continuous supply of vulnerable women and girls (Parrot & Cummings, 2008). Also, due to enormous migration flows, trafficking is often hidden, and therefore remains undetected (Naim, 2006). Furthermore, globalization has fueled the ready supply of trafficked women and girls, as the demographic and economic disparities between the developing and developed world have increased. Globalization has also fostered a tremendous growth in regional tourism that has made travel possible for sex tourism in newly established hub countries. Additionally, the demand for trafficked and exploited labor has increased, as the global economy requires that producers remain competitive by generating cheap goods and services (Shelley, 2010).

This supply and demand has produced a thriving business for traffickers. Human trafficking tends to have low start-up costs, minimal risks for traffickers, high profits, and large demand (Shelley, 2010). The recent European Commission Report (2010) declared that humans are the most trafficked commodities in Europe, more than illegal drugs or arms. The selling of humans is a multibillion dollar business; estimates range from 10 to 30 billion dollars annually made by the illicit selling of persons (Nam, 2007; Thompson, 2008; United States Department of State [USDOS], 2005). People, unlike drugs, can be sold repeatedly, which makes women and children very lucrative merchandise (Hodge, 2008).

The U.S. government (USDOS, 2010) estimates that approximately from 600,000 to 800,000 women, children, and men are trafficked across global borders each year; at least 56 percent of those trafficked are women. If, however, one includes persons trafficked within countries, the official U.S. estimates are 2–4 million people who are trafficked annually (Siskin & Wyler, 2010). The United Nations estimates the same numbers; however, their figure is just for women who are trafficked each year (Murray, 2008). Other organizations that track data associated with human trafficking, such as the International Labour Organization (ILO), report that as many as 12.3 million adults and children are currently victims of forced labor, bonded labor, and forced prostitution throughout the world (International Labour Organization, 2011). The nonprofit organization Free the Slaves cites numbers as high as 27 million slaves worldwide (Bales, 2000, 2010).

The ILO (2005) estimates that nearly half of all victims (43%) are trafficked specifically for commercial sexual exploitation and 32 percent for labor exploitation. Of the women and girls trafficked to the United States, Hodge and Lietz (2007) report approximately 70 percent are trafficked for prostitution and other forms of commercial sexual exploitation.

It is frequently assumed that the trafficking of people means one is moved vast distances across continents; however, much of the exploitation occurs closer to one's home country. A significant, but largely undocumented,

amount of trafficking occurs within countries (Siskin & Wyler, 2010). According to the United Nations Office on Drugs and Crime (2009), domestic trafficking not only occurs in both geographically large and socioeconomically stratified countries, such as Brazil and India, but also among relatively small and wealthy countries, such as those in Europe.

VULNERABILITY FACTORS OF TRAFFICKED WOMEN AND GIRLS

Poverty, unemployment, and poor working conditions are among the driving forces behind much of men's and women's involvement in sex trafficking. As discussed earlier, women are more likely to be the trafficked commodity, and, as such, reflect the particular experience, position, and status of women worldwide. The U.S. Agency for International Development (USAID) reported: "Trafficking is inextricably linked to poverty. Wherever privation and economic hardship prevail, there will be those destitute and desperate enough to enter into the fraudulent employment schemes that are the most common systems in the world of trafficking" (Farr, 2005, p. 137).

Economic strife, social instability, misogyny, and abuse figure prominently in the personal and situational experiences of women and girls most vulnerable to sex trafficking. To most effectively illustrate the impact of these factors, the following discussion is divided into *structural vulnerabilities* and *personal* or *individual vulnerabilities.* Structural vulnerabilities refer to the larger situational factors that collectively affect those living in developing and transitional countries, such as war and political and economic instability, which, in turn, contribute to poverty, unemployment, and relocation. Structural vulnerabilities, too, reflect the social structural factors of social class, and forms of ethnic, racial, and religious discrimination in both developed and developing nations. Personal or individual vulnerabilities refer to the more immediate experiences of familial instability and physical and sexual abuse. While distinct in many respects, there is overlap between types of vulnerability, as well as a link between structural conditions and their effect on the personal.

STRUCTURAL VULNERABILITIES

Women's and girls' vulnerability to trafficking is rooted in their cultural and social structure, as well as in their status in the global marketplace (Farr, 2005). Globalization, in combination with the political and economic instability in various regions of the world, has contributed to the dramatic rise of trafficked girls and women in transitional and developing *source* countries to largely developed *destination* countries. What has become increasingly apparent is that globalization is resulting in the feminization of

poverty around the world. In both developed and developing nations, key vulnerability factors include political instability; a decrease in economic stability; a decrease in the status of women; and limited work and educational opportunities for women. These factors, in combination, contribute to the relocation and migration of women. Such structural factors also have led to the rise of complex organized crime syndicates, the demand side of trafficking, whose livelihood depends on the exploitation of desperate and vulnerable girls and women.

PERSONAL VULNERABILITIES

In her recently published book, *Girls Like Us,* which focuses on sex trafficking in the United States, Lloyd (2011), a survivor of the commercial sex industry turned activist, points out that "for girls who have experienced incest, sexual abuse or rape, the boundaries between love, sex and pain become blurred. Secrets are normal and shame is a constant" (p. 65). Lloyd goes on to note that the "lessons learned during sexual abuse are valuable ones for recruitment into the commercial sex industry" (p. 65). She cites figures that indicate that as much as 70–90 percent of sexually exploited girls and women in the United States were sexually abused before recruitment. Lloyd concludes that sexual abuse "lays the groundwork"—"the pimp, the trafficker" she writes, "doesn't need to do much training. It's already been done" (p. 65).

Despite differences in countries, cultures, and ethnicities, certain factors persist for sexually exploited and exploitable girls. Research has indicated that approximately 90 percent of trafficked and sexually exploited children (predominately girls) in the United States have experienced some form of abuse or neglect and are poor, runaways, or homeless, from abusive and neglectful homes, with some involvement in the foster care system (Estes & Weiner, 2002). Lloyd rightly cautions that to view individual risk factors as simply the result of dysfunctional families or childhoods riddled with neglect and abuse ignores the larger structural factors, such as socioeconomic conditions, war, and poverty. Neither family nor individual pathology adequately addresses the individual vulnerabilities of sexually exploited girls who grow into sexually exploited women. Importantly, Lloyd concludes, stating that we must ask: "What is the impact of poverty on these children?" "How do race and class factor into the equation?" "Beyond their family backgrounds, what is the story of their neighborhoods, their communities, their cities" (Lloyd, 2011, p. 34).

For girls and women in developing and transitional countries, specific vulnerability factors also include the lack of employment; illiteracy or minimal education; lack of training or technical skills; and public corruption, which individually or in combination reflect the push and pull factors that have contributed to the feminization of migration. Social inequality, poverty,

abuse, and limited work opportunities are the push factors that lead girls and women to leave their communities or countries of origin. A study in Colombia additionally identified a number of personal characteristics that are common among trafficking victims. These include "a tendency to take risks in order to fulfill one's goals, a focus on short-term rewards that may result from short-term risks, and a lack of familial support and/or strong social networks" (Ribando, 2007). The pull factor includes the hope of finding economic opportunity abroad (Guinn & Steiglich, 2003). Ribando (2007) additionally points out that these pull factors are fueled by television and on-line images of wealth in the United States and Europe.

REGIONAL SEX TRAFFICKING PATTERNS

Sex trafficking is an industry that is highly responsive to the shifting and unstable social and economic realities around the world. Women and girls are clearly vulnerable to and/or made vulnerable by a combination of circumstances; but so, too, are men affected by social and economic instability. For some, the trafficking of women is not only lucrative, but also a reaffirmation of traditionalist masculine power. In this respect, sexual trafficking of women by men very often "fits" cultural gender roles. It should also be noted that wars and militarized sites, too, fuel the male demand for a sex trade. Sex trafficking, therefore, must be understood dynamically; that is, it is driven by a country's level of human development and economic and gender status, which, in turn, is driven by global conditions, local customs, and history.

Clearly, there are commonalities in the type, function, and purpose of trafficking around the world. Yet, there are also differences that reflect the unique social and political realities of a country or region that determine the particular trafficking methods.

SEX TRAFFICKING IN ASIA

The greater part of the world's human trafficking victims live or originate in Asia and are trafficked to all regions of the world, especially other Asian countries, Europe, the Middle East, Australia, and North America (Shelley, 2010). The majority of profits for many Asian organized crime groups in China, Japan, and Southeast Asia, including India, involve human smuggling and trafficking, unlike their counterparts in Latin America, North America, and Western Europe, who profit more substantially from illegal drug trade (Shelley, 2010). Not all trafficking in Asia, however, is facilitated by organized crime; governmental officials in most regions of Asia also assume indispensable roles in perpetuating the trafficking industry.

Sex and labor slaves have been in existence for centuries, as debt bondage in Asia was as pervasive in the past as it is today; there are families

with multiple generations that have been in debt bondage unable to successfully free themselves (Picarelli, 2007). Intergenerational prostitution is particularly notable for India. A leading Indian antitrafficking activist, Ruchira Gupta, analyzed this happening, "when a woman's children and her children's children are also sold into prostitution, it becomes institutionalized . . . none of the mothers want their daughters to get into prostitution . . . but when they become older and disease-ridden . . . they push their daughters into prostitution, because otherwise they starve" (as cited in Shelley, 2010, p. 143).

Within many of the Asian cultures, men frequenting prostitutes is a deeply engrained and an accepted practice (Shelley, 2010); men buy sex to reinforce their masculinity and to exercise power over the weak and vulnerable (Huda, 2006). Although poverty, social disasters, and gender inequalities enable traffickers to secure young women and girls, it is the buying power of consumers for submissive women and children that make trafficking profitable (Huda, 2006).

Trafficking of children in Asia makes up a more significant proportion of overall trafficking than in other regions of the world (Shelley, 2010). For example, up to 20,000 Nepalese girls are trafficked to India each year and up to 30,000 of the 100,000 prostitutes in Mumbai are Nepalese girls (Kara, 2009). In many Indian cities, girls as young as eight or nine are being sold into sex work (Huda, 2006). This craving for younger and younger children is based on the false premises that if one has sex with a virgin they will avoid the risk of contracting HIV. This is not the case, as young girls are sold as "virgins" over and over, and due to their young age they are more vulnerable of contracting HIV since their genital tract is still not fully mature (Huda, 2006).

In some Asian countries, the increase in sex tourism has significantly increased the commercial sex industry (Huda, 2006); foreign governments also play a role in encouraging child sex tourism as they turn a blind eye to the sex tourism industry, thus allowing the industry to perpetuate child sexual exploitation to encourage tourism in their country in general (Nair, 2010).

In Asia, the sex industry has developed into a lucrative business that influences employment and national income and contributes significantly to the region's economic growth (Coalition Against Trafficking in Women [CATW], n.d.). There are no signs of this sex industry slowing down; in fact, even with the economic growth of China and India it appears to be growing. Also, with the breakdown of closed borders of communist countries of Asia, these countries have begun to receive tourists. Coupled with the development of Internet and computer technology in Asia, international sex trade and international proliferation of child pornography is flourishing (Shelley, 2010).

SEX TRAFFICKING IN THE UNITED STATES

In 2000, the U.S. Congress passed aggressive antitrafficking legislation, the Trafficking Victims Protection Act (TVPA). While it raised awareness of the trafficking problem, addressed prevention, facilitated prosecution, and offered resources to aid numerous victims of trafficking, a decade later human trafficking remains a significant problem in the United States. Reported cases of domestic human trafficking have been detailed in all 50 states, Washington, D.C., and some U.S. territories (Office of Safe and Drug-Free Schools [OSDFS], 2007).

Trafficking within the United States is unique among wealthy, industrialized countries; its sex trafficking victims are younger, more often born within the United States and more mobile. The United States also has many similarities to developing countries with regards to sex trafficking. For instance, the United States is a substantial source country for sex trafficking victims; a significant number of children are trafficked from the United States to other industrialized nations with large sex industries, such as Germany, Japan, and the Netherlands (Estes & Weiner, 2001). Also, like developing countries, many cities within the United States have become major sex tourism destinations, such as Atlanta, Chicago, Las Vegas, New York, San Francisco and, Washington, D.C., to name a few (Gates & Goodman, 2006; Shelley, 2010; Whitley, n.d.).

The Department of Justice estimates that 15,000 foreign nationals are trafficked into the United States each year. These foreign-born victims tend to be from Asia and Latin America, and frequently are forced to serve their own immigrant groups (Free the Slaves and Human Rights Center, 2004 [FTS and HRC]). The vast majority of persons trafficked for sexual exploitation in the United States are American born and young (Shelley, 2010; Sher, 2011). America is distinctive among the Western countries in this regard, as the majority of sexual trafficked victims in other developed economies are foreign born (Shelley, 2010).

The United States tends to be a country where the population is extremely mobile, much more so than their counterparts in Western Europe; trafficking patterns also reflect this mobility. For instance, Maria, trafficked from Mexico into the United States, recounts that she was transported every 15 days to another trailer in a nearby American city. This was to give the customers a variety of girls and also it kept her unaware of where she was in case she tried to escape (Bales & Trodd, 2008; Parrot & Cummings, 2008).

Estes and Weiner's (2001) groundbreaking study illuminated the gravity of North American youth being trafficked and sexually used and abused on American soil. They estimated that between 244,000 and 325,000 American children and youth are at risk of becoming victims of sexual exploitation, including child pornography, juvenile prostitution, and trafficking of children for sexual purposes. The average age of entry into the commercial

sex industry is 11–12-years-old (Frundt, n.d.b). Disproportionately, American-born victims of sexual trafficking are Hispanic and African American; however, all racial or ethnic groups are trafficked (Shelley, 2010; Sidun, 2012). There is, however, some evidence that sexually exploited youth are more at risk for being recruited if they are from a low socioeconomic status, much like their foreign counterparts (Lloyd, 2011).

Domestic sex traffickers, referred to as pimps, prey on young women and girls. Up to 90 percent of runaways are thought to end up as prostitutes, with a third being enticed into prostitution within 48 hours of running away (Frundt, n.d.a; Gates & Goodman, 2006). Traffickers target youth through telephone chat lines, social network sites, at clubs, on the street, and at malls, and also they have girls recruit other girls (OSDFS, 2007). Mostly, men are the traffickers; however, some women and juveniles, including older siblings, do engage in recruitment (Estes & Weiner, 2001).

The Polaris Project (2011a), a nonprofit antitrafficking organization in Washington D.C., clearly articulates the distinct types of the sex industries in the United States:

- *Residential brothels* are normally found in residential dwellings, such as houses, condos, and so forth. They are a commercial sex brothel, mostly comprised of women and children from Latin America to serve only Latino "johns." The victims commonly serve as many as 4 men per hour, totaling 48 men in a 12-hour day.
- *Hostess clubs* and *strip clubs* can have trafficked women who are U.S. citizens, undocumented immigrants, and/or foreign nationals; however, there are some clubs that exploit minors as well. They provide commercial sex to the club patrons by a pimp, employer, or another controller (Polaris Project, 2011b).
- *Escort services* can offer women or men, adults or minors, U.S. citizens or immigrants. Two forms of the escort services may involve commercial sex; out-call services where the victims go to the location of the "john" or in-call services where the "john" comes to the victim (Polaris Project, 2011c).
- Typically, the women that work at *brothels disguised as massage parlors* live on-site, where they are confined and forced into providing commercial sex from 6 to 10 men daily, 7 days a week. Almost all the 50 U.S. States have "massage parlors"; they can be found in office buildings, strip malls, and occasionally in residential homes (Polaris Project, 2011d).
- The most common place for domestically trafficked youth to work is as *street prostitutes,* where a pimp coerces them to provide commercial sexual services. Victims are expected to earn a nightly quota, ranging from US$500 to US$1,000, which the pimp keeps (Polaris Project, 2011e).

Last, sex trafficking at truck stops requires mention as a unique venue for trafficking in the United States. There are two forms of sex trafficking that occur at truck stops: pimp-controlled prostitution and massage parlors. Truck stops have their own slang and distinctive means of communication: pimps advertise victims over CB radios, johns search online trucker boards for where to purchase sex, johns signal their interest in sex by using their highlights or stickers on their windows, and victims canvass truck stops knocking on cab doors of the trucks. Frequently, brothels disguised as massage parlors will be situated close to truck stops and are advertised on billboards or signs at or near the truck stop (Polaris Project, 2011f).

SEX TRAFFICKING IN LATIN AMERICA

Human trafficking is a growing problem in Latin America and the Caribbean. Political instability and social unrest have created environments conducive to regional and international traffickers, and impoverished children throughout Latin America are most at risk. Along with Southeast Asia and the former Soviet Union, it is a primary source region for people trafficked to the United States.

The International Human Rights Law Institute (IHRLI) at DePaul University College of Law carried out an extensive study on trafficking in this region, and cited a number of factors that contribute to the difficulty in both analyzing and understanding trafficking in this part of the world (Guinn & Steiglich, 2003). Among the difficulties in gathering reliable information, the violence, trauma, and stigma associated with trafficking were paramount. Also noted were the institutional disincentives that criminalize rather than protect victims; the cultural norms of sex and gender that sanction subordinate roles of women; and the lack of reliable information from consulates and health care providers.

Definitional difficulties, that is, agreement on what constitutes trafficking, included the lack of clarity around agency and the consent of women and the variations for children's status as minors versus adult. For example, in some countries, children aged 12–14 are considered adult, whereas in other countries the age of consent is 18 Also, the legality of prostitution and commercial sexual activity in some countries raises definitional questions (Guinn & Steiglich, 2003). As in other regions, a debate continues to circulate around the relationship between prostitution and trafficking. Some hold that all forms of prostitution, legal or illegal, should be defined as trafficking, arguing that prostitution is not sex work and that it is violence against women because it gives men permission to buy women on demand (Raymond, 2004). Those who disagree argue that giving prostitutes some degree of legitimacy lessens the risk that women will be exposed to trafficking (Feingold, 2005). Other opponents to the definitional link of prostitution with trafficking, including European and Latin

American countries that have legalized prostitution, caution that such a broadened definition of trafficking would limit international consensus and their ability to work together to combat trafficking (Ribando, 2007).

The role of organized crime in this region, largely associated with drug trafficking, has also obscured or diverted attention from sex trafficking. Alien smuggling and forced-labor trafficking have been significantly more visible than sex trafficking of women and girls in Mexico, Central America, and South America (Farr, 2005). Nevertheless, as noted in a U.S. Intelligence Report, despite there being less information about crime groups that traffic in women does not mean that they are not involved (Richard, 1999).

There is a strong correlation between trafficking and migration in this region. Central America, for example, was found to have the highest out-migration rate in the world. The increase in irregular and/or undocumented migration puts migrants at a high risk for abuse by traffickers and alien smugglers (Ribando, 2007).

The majority of victims are trafficked for prostitution, though many are used for pornography and stripping. Girls more often are trafficked within their countries, whereas women tend to be trafficked internationally, sometimes with the consent of their families and husbands. It has also been reported that intraregional trafficking is also common, given the relatively open borders in the Caribbean along with lax enforcement of entertainment visa and work permit rules, legalized prostitution, and the sex tourism industry (Ribando, 2007). The most recent trafficking problems occur at border crossings throughout Mexico and Central America, especially the Mexico-Guatemala border, when undocumented women, unable to get to the United States, resort to or are forced into prostitution. For example, Tecun Uman, a Guatemalan town near the Mexican border, has as many as 80 brothels with more than 1,000 women working as prostitutes (Ribando, 2007).

In Latin America, it is regional gangs, such as the Mara Salvatrucha (MS-13) that are increasingly involved in trafficking drugs, arms, and people (Ribando, 2007). It has also been argued that trafficking is a sort of "disorganized crime," where traffickers are individuals or small groups and not part of organized crime syndicates (Feingold, 2005).

SEX TRAFFICKING IN CENTRAL AND SOUTHEASTERN EUROPE AND FORMER RUSSIAN REPUBLICS

Central Europe (Czech Republic, Slovakia, Hungary, Poland), Southeastern Europe (the former Yugoslav nations), and the former Russian Republics are referred to as transitional states. Following the collapse of the Soviet Union in 1989, Central European and former Soviet countries experienced a notable political, social, and economic transition that proved to

be fertile ground for trafficking in distinct ways, where the former Soviet Republics quickly became the fastest growing trafficking source region.

The former Yugoslav nations, following the conflict between 1992 and 1995, too, experienced notable economic and social instability that fueled sexual trafficking.

Central Europe

The political and economic transition that took place following the collapse of the Soviet Union, and the instability that resulted, led many women to migrate to Western Europe, which, now open, offered escape and economic opportunity. At the same time, such reactions to social and economic instability make women especially vulnerable to the ploys of traffickers. Lured to Western Europe with false promises of employment or marriage, many women found themselves trapped and indentured into sex work.

Beginning in the late 1980s, the sex trafficking of Central European women became preferable to trafficking Asian women. Shorter distances for Western traffickers lessened both expenses and risks and increased profits. In addition, Central European women were more attractive to Western white male consumers because they fit white men's racial and gender expectations (Nikolic-Ristanovic, 2003).

Former Yugoslav Countries

The conflict in the former Yugoslavia in the 1990s was a boon to sex trafficking, in a number of ways. The large number of refugees became victim pools, and refugee and detention camps became breeding grounds for traffickers and organized crime in the region (Farr, 2005). A causal link, too, has been noted between armed conflicts and trafficking. Women's weakened position in the labor market—the feminization of poverty—results in increased migration, especially among younger women, who become easy prey for traffickers.

Nikolic-Ristanovic (2003) noted the impact of war and militarism on sex trafficking in Eastern Europe. She pointed out that the presence of military, regardless of war, had an impact on sex trafficking. "Although the impact of militarism on trafficking is not necessarily connected to war," she explained, "war may produce militarist cultural ideals about gender, which increase the vulnerability of women to socio-economic factors that lead to sex trafficking" (p. 1).

Women refugees were among the most affected in this region, specifically those living in Kosovo, where the Serbian campaign against ethnic Albanians in Kosovo and Bosnia-Herzegovina took place, resulting in their migration back to Albania to refugee camps. By the mid-2000s,

Bosnia-Herzegovina and other former Yugoslav states had developed thriving sex industries, "fueled by the demand from soldiers, rebel groups, peacekeeping troops, and foreign businessmen" (Farr, 2005, p. 111). The large numbers of poor, unemployed women in the former Yugoslavia refugee camps and bordering countries easily met this demand.

Vandenberg and Peratis (2002) noted the parallels between the trafficking of women in post-conflict Bosnia-Herzegovina and the rape and other forms of sexual violence women and girls experienced during the years of conflict in the early 1990s. The report goes on to state that the international post-conflict involvement likely contributed to the growth of trafficking. Local traffickers were rarely prosecuted and trafficking laws were not enforced. Police, it was reported, created false documents, visited brothels, and sometimes engaged directly in trafficking. So, too, did members of the UN police-monitoring force patronize clubs where trafficked women worked.

Former Russian States

The collapse of the Soviet Union affected the economic and social conditions of all countries in Central and Southeastern Europe, but the impact on the former Soviet Republics was particularly hard felt. For example, from 1991 to 1995, Russia's GDP declined by 34 percent (Farr, 2005). As the state-run economies of the republics moved to a market economy, a new dependence on global lending institutions eroded a sense of self-sufficiency. At the same time, the economic downturn fueled an already active underground criminal economy. Among the most lucrative of these criminal businesses is sex trafficking.

It is generally agreed that women were an important part of the industrial and professional labor market in the Soviet Union, and that in the post-Soviet period, the status of women worsened. Marsh (1996) argued that where there was ambivalence regarding gender equality during the Soviet era, by the mid-1990s, it became "clear that the economic crisis, nationalist revival and desire for de-Sovietization [had led], in most of the new states, to a notably conservative reaction against women" (p. 19). In 1993, TASS News Agency reported that the position of women "was deteriorating in all spheres of public life" (Marsh, 1996, p. 19). Eighty percent of those who lost jobs in the years immediately following the Soviet breakup were women. By the late 1990s, women were 60 percent of unemployed and 90 percent of the newly unemployed in Ukraine. The wage gap, too, greatly increased for women, from 70 percent of men's in 1989 to 40 percent of men's in 1995, and today ranging from 35 percent to 40 percent (Novikova, 2011).

The economic crisis, and specifically its effect on women, contributed to the rise of the former Soviet republics as source countries for the sex industry, fueled by the numbers of educated and uneducated women

desperate for work and or marriage. Lured by job advertisements or marriage agencies, women often found themselves abroad and experiencing various forms of abuse, prostitution, or trafficking. In Israel and Turkey, the name "Natasha" has become synonymous with prostitutes and victims of the sex trade (Malarek, 2003).

Hughes (2004) reported that some NGOs consider the bride trade to be a form of trafficking of women, because its operation "depends on an inequality of power between men and women" (p. 2). The profit for the marriage agencies is based on recruiting women from regions of poverty and high unemployment, and marketing the women to men based on sexual, racial, and ethnic stereotypes. The men seeking women from such agencies often express a desire for women who are interested in fulfilling traditional family roles, or as one man put it, Ukrainian and Russian women "have a European face and the patience of an Asian" (Stanley, as cited in Yakushko, 2009). When asked why women enter into such services, the responses included: for a better life, an aversion to native men, as well as a *Hollywood-ized* view of America (Yakushko, 2009). Hughes (2004) pointed out that although some women may find work, romance, or new opportunities, many become victims of sexual exploitation, violence, and trafficking. Cases of deception by traffickers for jobs abroad, as well as cases of women being abused or murdered after marrying a man arranged through a marriage agency, are well-documented.

CONCLUSIONS: THE CONSEQUENCES OF BEING SEX TRAFFICKED AND EXPLOITED

The emotional, physical, psychological, and social consequences for trafficked women and girls are grave. As the first Fellow on Human Trafficking at Harvard University, Siddharth Kara, so clearly articulates: "The contemporary sex trafficking industry involves the systemic rape, torture, enslavement, and murder of millions of women and children, whether directly through homicide or indirectly through sexually transmitted diseases and drugs . . . the fate of the world's sex slave remains terribly grim" (Kara, 2009, p. 150).

The health consequences for women and girls who were trafficked for the commercial sex industry are staggering. Seventy-one percent to one hundred percent were physically assaulted (Farley et al., 2003; Raymond, Hughes, & Gomez, 2001; Zimmerman et al., 2003, 2006). Eighty-nine percent reported that they had wanted to escape prostitution, but did not believe they had any other alternative for survival (Farley et al., 2003). One study exclusively conducted with Mexican young women who had been trafficked revealed similar results: in the week prior to their interviews 70 percent were beaten with an object, 100 percent were abused physically, 28 percent had been burned by cigarettes, 36 percent were threatened with being killed, and

22 percent had been raped by johns and/or their traffickers (Acharya, 2008). Additionally, those that reported they had been injured while they were trafficked, 57 percent stated that these injuries cause continual problems or pain (Zimmerman et al., 2006). Women and girls who have been trafficked for the commercial sex industry have the highest rates of rape and homicide of any group. Canada's Special Committee on Pornography and Prostitution revealed that women who prostituted had 40 times higher death rate than that of the general population (as cited in Farley, 2006, p. 107).

The copious physical health problems encountered by women and girls who have been sexually exploited are devastating. They include drug and alcohol addiction, physical injuries, gastrointestinal problems, dental problems, infectious diseases, chronic pain, malnutrition, sexually transmitted diseases, traumatic brain injuries, and reproductive health problems, such as pregnancy, infertility, and other diseases (Parrot & Cummings, 2008; Rafferty, 2008; Raymond et al., 2002; Williamson, Dutch, & Clawson, 2010; Zimmerman et al., 2003, 2006). Girls are particularly at risk for increased lacerations and bodily injuries as their bodies are not fully physically developed (Gates & Goodman, 2006).

Exposure to sexually transmitted infections, particularly HIV, needs special mention. Women and girls are twice as likely to become infected with HIV in heterosexual sex with a HIV-infected partner as men (Gates & Goodman, 2006; Kristof & WuDunn, 2009). While prevalence of HIV and STDs varies depending on geographic location, estimates still suggest that 23–80 percent of those trafficked for sexual exploitation will contract HIV (Silverman et al., 2006, 2008; Zimmerman et al., 2006). Women and girls' vulnerability to HIV infection is heightened due to their compromised agency. For example, women and girls are not allowed to refuse sex, and if they do refuse they are raped by their trafficker to "break them down," nor are they allowed to negotiate condom usage, and their mobility and access to preventive health care is restricted. Moreover, limited knowledge of STI/HIV and the use of substances as a coping strategy all contribute to likelihood of contracting HIV (Decker, McCauley, Phuengsamran, Jaynam, & Silverman, 2011; Huda, 2006).

Psychological trauma is an extremely common and predictable aftermath of interpersonal violence, particularly for sexually exploited women and girls who have endured prolonged captivity (Hossain, Zimmerman, Abas, Light, & Watts, 2010). Significant similarities exist between hostages, political prisoners, prisoners of concentration camps, battered women, and other victims of captivity, and women and girls that have been trafficked (Herman, 1997). These experiences of violence, including direct violence and threats, intimidation, and emotional manipulation from traffickers and pimps, can lead to multiple mental health problems, such as anxiety, depression, sleep disorders, confusion, disorientation, posttraumatic stress disorder (PTSD), phobias, panic attacks, hostility, and suicidal ideation

(Antonopoulou & Skoufalos, 2006; Bryant-Davis et al., 2011; Clawson, & Goldblatt Grace, 2007; Farley et al., 2003; Parrot & Cummings, 2008). Also, frequently reported psychological symptoms by trafficked women and girls are shame, grief, fear, distrust, hatred of men, self-blame, self-hatred, despair, and hopelessness (Clawson & Goldblatt Grace, 2007). Recent research identified three mental health outcomes for those that are trafficked for sexual exploitation: 55 percent met criteria for high levels of depression, 48 percent met criteria for high levels of anxiety, and 77 percent had possible PTSD (Hossain et al., 2010).

The horrific physical and psychological health consequences, which can persist years beyond escape from trafficking, are only some of the consequences of being trafficked for sexual exploitation; the social costs are very tangible and devastating. The stigma and discrimination these women and girls face once they are freed is extreme. Doctors without Borders has witnessed the rejection these women and girls have experienced by partners, families, and communities (as cited in Parrot & Cummings, 2008, p. 95). In traditional cultures, historically and today, when a woman is raped, the aggrieved party is not the woman but her husband or father. As wife or daughter, the woman becomes damaged goods and brings shame on her family. If not ostracized for the shame brought onto families, women and girls are often blamed and held responsible for their perceived rash behavior in reaction to the desperate circumstances that led them to be deceived by traffickers.

Trafficking also robs women and girls of their basic and universal rights to life, liberty, and the pursuit of happiness (USDOS, 2005), and it denies individuals, communities, and countries the chance to reach their full potential. We cannot turn a blind eye to this horrific human rights violation against women and girls; woman and girls are not sex objects, they are someone's daughter, sister, mother, wife, and fellow human being.

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COLLEEN CLEMENCY CORDES, PhD, is a counseling psychologist and clinical associate professor at the Nicholas A. Cummings Behavioral Health Program at Arizona State University, a doctoral program specifically aimed at training clinicians in integrated behavioral healthcare. She received her doctorate in Counseling Psychology from Arizona State University in 2009, and completed a postdoctoral fellowship in Primary Care Behavioral Health at the Edith Nourse Rogers Memorial Veterans Hospital in Bedford, Massachusetts, in 2010. She additionally received a certificate in Primary Care Behavioral Health from the University of Massachusetts Medical Center. Her work focuses on the intersection of medical, psychological, and behavioral health, and she has also been involved in training physicians to more efficiently and effectively engage their patients in whole health care.

DEBRA C. COBIA, EdD LPC, NCC, is an associate dean for Assessment and Research and a professor in the College of Education at the University of West Georgia, Carrollton, Georgia. Dr. Cobia directs the doctoral

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TYLON M. CROOK, PhD, NCC, is an assistant professor in the Department of Counseling at Xavier University, where he prepares master's level clinical mental health and professional school counselors. Dr. Crook's research interest includes advocacy competence among mental health and school counselors. He also has a research focus on multicultural self-efficacy among counselors and counselor educators-in-training. He holds an MSc degree in Counselor Education with emphasis in school and community counseling from Mississippi State University. He also holds a BSc degree in Educational Psychology from Mississippi State.

JOANNA DAVISON is a senior nurse lecturer in the School of Nursing, Northtec Polytechnic, Whangarei, New Zealand. Davison has more than 20 years of mental health nursing experience and has worked in inpatient mental health units alongside adults and young people. For more than eight years, Davison worked in a primary health care service, and it was in this setting that she gained an understanding that sexuality was an important component of a person's health and well-being and was able to integrate aspects of sexuality into her mental health nursing practice. In 2008, Davison completed her master's thesis which explored the sexuality experiences of women with enduring mental illness. She is very grateful for the women and the sharing of their stories, as the women made visible the unseen experiences that impact the expression of sexuality.

> He aha te mea nui o tea o?
> He tangata! He tangata! He tangata! (Maori saying)
> What is the greatest thing on earth?
> It is the people! It is the people! It is the people!

FLORENCE L. DENMARK, PhD, is an internationally recognized scholar, researcher, and policy maker. She received her PhD from the University of Pennsylvania in social psychology and has six honorary degrees. Denmark is the Robert Scott Pace distinguished research professor of psychology at Pace University in New York. She is a past president of the American Psychological Association (APA) and the International Council of Psychologists (ICP). She holds fellowship status in the APA and the Association for Psychological Science. She is also a Fellow of the Society for Experimental Social Psychology (SESP) and the New York Academy of Sciences. She has

received numerous national and international awards for her contributions to psychology. In 2011, at the APA convention, Denmark received the award for Outstanding Lifetime Contributions to Psychology. Denmark's most significant research and extensive publications have emphasized women's leadership and leadership styles, the interaction of status and gender, ageing women in cross-cultural perspective, and the history of women in psychology. Denmark was the main NGO representative to the United Nations for the American Psychological Association and is currently the main NGO representative for the International Council of Psychologists. She is the immediate past chair of the United Nations/New York NGO Committee on Ageing and serves on the executive committee of the UN NGO Committees on Ageing, Mental Health, and Family.

ASIA A. EATON is a research scientist at Florida International University, with a PhD in social psychology from the University of Chicago. Her research explores the relationship between social power and gender in the United States and the implications of enacting powerful roles and gender roles for individuals' attitudes and behaviors. Specifically, she is interested in the underlying reasons for men and women's different leadership trajectories and experiences, how social role occupation affects men and women's openness to persuasion, and how gender roles and social power structure the behavior and attitudes of adolescents and adults in intimate relationships.

YVETTE G. FLORES was born in Panama and raised in Costa Rica and South Central Los Angeles. She obtained her PhD in clinical psychology from the University of California, Berkeley, in 1982. Since then, she has been a professor at various schools of Professional Psychology, and since 1989, a ladder-rank professor at the University of California, Davis. Her research and writings focus on health and family psychology, in particular Latino mental health and the intersection of race/class/gender and colorism on immigrant and U.S.-born Latinas. Her primary research interests are related to migration, acculturation, and the prevention of intimate partner violence, eating disorders, and HIV infection among Latinos. She is a national and international consultant on issues of health, mental health, and migration.

JEANINE M. GALUSHA is a graduate student in the MS clinical neuropsychology program at the University of Texas at Tyler. Her academic goals include earning a doctorate in psychology and continuing research in dementia. She is a 2010 graduate of the University of Texas at Tyler, where she earned a BS in psychology and graduated Magna Cum Laude. While an undergraduate, she was accepted as a member of Psi Chi, the national honor society in psychology, and worked with several professors on various research projects.

ADAM D. GARLAND is an undergraduate student at the University of Texas at Tyler and is scheduled to graduate in 2012 with a BS in psychology. His academic goals include earning a doctorate in clinical psychology and pursuing research in childhood/adolescent disorders. His current research interests include anxiety, depression, childhood disorders, and the psychological effects of childhood trauma on adult victims. During his undergraduate career, he volunteered at various local mental health organizations and was accepted as a member of Psi Chi, the national honor society in psychology. Currently, he is a student affiliate of the American Psychological Association and is assisting in research under the tutelage of professors at the University of Texas at Tyler.

EMILEE GILBERT is a postdoctoral research fellow within the Health Services and Outcomes Research Group at the University of Western Sydney. Since graduating with her PhD in 2004, Gilbert has developed a program of research that focuses broadly on gendered health behaviors. She has expertise in a range of qualitative methodologies and has published papers that examine issues of sexuality in the context of cancer, as well as the meanings young women attach to cigarette smoking. She is currently involved in a number of large-scale funded projects that address sexuality and fertility for people with cancer and supervises a number of higher degree candidates in these areas. Gilbert has also lectured for a number of years in research methods, media and popular culture, psychology and health, and gender and sexualities.

CYNTHIA A. GRAHAM is a clinical psychologist who obtained her master's degree from the University of Glasgow in 1982 and her PhD from McGill University in 1990. From 1996 to 2004, she worked at Indiana University and the Kinsey Institute for Research in Sex, Gender, and Reproduction. From 2004 to 2010, she was a research tutor on the Oxford Doctoral Course in Clinical Psychology and a research fellow at Harris Manchester College, University of Oxford. She is currently a senior lecturer in the Department of Psychology at the University of Southampton and a research fellow at the Kinsey Institute and the Rural Center for AIDS/STD Prevention, Indiana University. Dr. Graham's research interests focus on: (1) the behavioral effects of hormonal contraceptives; (2) the relevance of sexual excitation and sexual inhibition to sexual health; (3) sexual problems; and (4) condom use errors and problems. She is editor-in-chief of the *Journal of Sex Research,* past president of the International Academy of Sex Research, and a member of the DSM-5 Workgroup for Sexual and Gender Identity Disorders.

MIMI HOANG, PhD, is a psychologist, educator, and activist, and has been a bisexual community organizer since 1999. Since then, she cofounded

and chaired the Los Angeles Bi Task Force, a nonprofit organization promoting education, advocacy, and cultural enrichment for the bi community and two bi social groups: Fluid UCLA and AMBI (A Meeting of Bi Individuals). Dr. Hoang also founded the Safe Zone Program at California State University, LA, and has advanced the development of two local bi discussion groups in the Los Angeles area. She has a published research article on bisexual identity congruence and internalized biphobia, and has spoken at multiple conferences, universities, and community agencies. Named one of the "Most Significant Women in the Bisexual Movement" by Mike Szymanski, veteran bi activist and author, Dr. Hoang continues to promote sexual orientation equality in community, clinical, and academic circles.

INGRID JOHNSTON-ROBLEDO, PhD, is currently an associate professor in the Psychology Department at SUNY, Fredonia, where she teaches courses on the Psychology of Women, Women's Health, and Human Sexuality. She is also the assistant dean of the College of Arts & Sciences. Her primary areas of expertise are women's reproductive and sexual health, with an emphasis on psychosocial aspects of menstruation, breastfeeding, postpartum adjustment, and motherhood. Much of her work focuses on the extent to which women's experiences with their reproductive and sexual health are limited by the internalization of cultural messages about their bodies. She is president-elect of the Society for Menstrual Cycle Research, serves on the executive committee for Division 35 of the American Psychological Association (Society for the Psychology of Women), and is a Fellow of the American Psychological Association.

DUVIA LARA LEDESMA is a graduate student in the MA General/Experimental Psychology program at the California State University, San Bernardino (CSUSB). Her research focuses on the translation of the Children's Sleep Habits Questionnaire, a parent questionnaire that assesses children's sleep problems, to a Spanish version. She is a research assistant at University Center for Developmental Disabilities at CSUSB, assisting with survey research with parents of children with autism and other developmental disabilities. She is seeking to pursue a doctorate in developmental psychology and continue her research with children with autism and other developmental disorders. She is a 2010 graduate from San Diego State University, where she earned a BA in psychology.

PAULA K. LUNDBERG-LOVE is a professor of psychology at the University of Texas at Tyler (UTT), where she teaches psychopharmacology, behavioral neuroscience, physiological psychology, sexual victimization, and family violence. Dr. Lundberg-Love is also a licensed professional counselor at Tyler Counseling and Assessment Center in Tyler, where she provides therapeutic services for victims of sexual assault, child sexual

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MAUREEN C. McHUGH, PhD, is a professor of psychology at Indiana University of Pennsylvania (IUP), where she teaches graduate and undergraduate courses in gender, sexuality, and diversity. Dr. McHugh is a reviewer for *Psychology of Women Quarterly,* on the editorial board for the *Journal of Violence,* and media editor for *Sex Roles.* She is the recipient of: a Pioneer Award for her early contributions to the field; the Christine Ladd Franklin Award for her contributions to feminist psychology; and the Florence Denmark Distinguished Mentoring Award for feminist mentoring from the Association for Women in Psychology (AWP). She has published journal articles and chapters in the area of feminist methods, violence against women, and gender differences, including chapters in many Psychology of Women texts and handbooks. Her current research interests include slut bashing, hookups, sexualization, and sexual violence, including street harassment, intimate partner violence, psychological abuse, sexual assault, and gender harassment.

DEBRA MOLLEN is a licensed psychologist, associate professor, and director of the Master's Program in Counseling Psychology, as well as affiliate faculty in the Department of Women's Studies, at Texas Woman's University. She earned her PhD in counseling psychology with a minor in Gender Studies from Indiana University. Debra teaches undergraduate and graduate coursework in multiculturalism, sexuality, the psychology of women, and professional development. She has conducted scholarship and published in the areas of women's sexuality; childfree women; multicultural counseling competence and pedagogy; and professional issues, such as training and early career concerns. In 2009, she was honored to be granted her institution's Mary Mason Lyon award recognizing faculty developing outstanding records of research, teaching, and service.

LINDA R. MONA, PhD, is a clinical psychologist who serves as the assistant director of Psychology Training at VA Long Beach Healthcare System. In this role, Dr. Mona participates in training interns and residents, in addition to providing clinical services focused on disability and mental health. She leads the VA Psychology Multicultural Counsel which guides the direction of national VA psychology diversity training. Through her consulting, Dr. Mona works with companies on strategies focused on infusing notions about disability into diversity in the work place. She challenges traditional

medical notions of disability and reframes this life experience from a multicultural lens. She has received numerous awards, including recognition by the American Psychological Association and the Veterans Health Administration. She has published more than 50 articles and delivered more than 100 workshops on disability. Dr. Mona's work has been featured on Oprah radio, Canadian Discovery Health, PBS, and *Self* magazine.

JENNIFER MOOTZ is a doctoral student in counseling psychology at Texas Woman's University. She has a bachelor's degree in phenomenological and existential psychology from the University of Dallas. She obtained a master's degree in social sciences from the Universiteit van Amsterdam, where she specialized in gender, sexuality, and ethnicity. Much of her research has been women focused, often from a cross-cultural perspective. For example, she has conducted research with women regarding bodily insecurity, sex workers about their experiences in the red-light district of Amsterdam, and Sudanese refugee women who have relocated to the United States. Additionally, she has taught several sections of an undergraduate Psychology of Women course. She serves as an intercultural trainer and consultant for clients who are relocating internationally. Finally, she is a program director at a nonprofit agency, which offers pre- and postvention support for those who are contemplating suicide or are otherwise in psychological crisis.

MICHELE A. PALUDI is the Elihu Root Peace Fund visiting professor of women's studies at Hamilton College for 2011–2012. She is the series editor for *Women's Psychology* and also *Women, Careers and Management* for Praeger. Dr. Paludi is the author/editor of 46 college textbooks, and more than 180 scholarly articles and conference presentations on sexual harassment, campus violence, psychology of women, gender, and workplace violence. Her book *Ivory Power: Sexual Harassment on Campus* (1990, SUNY Press) received the 1992 Myers Center Award for Outstanding Book on Human Rights in the United States. Dr. Paludi served as chair of the U.S. Department of Education's Subpanel on the Prevention of Violence, Sexual Harassment, and Alcohol and Other Drug Problems in Higher Education. She was one of six scholars in the United States to be selected for this subpanel. She also was a consultant to and a member of former New York State Governor Mario Cuomo's Task Force on Sexual Harassment. In addition, Dr. Paludi has held faculty positions at Franklin & Marshall College, Kent State University, Hunter College, Union College, and Union Graduate College, where she directs graduate certificate programs in human resource management and leadership and management. She teaches in the School of Management.

JANETTE PERZ has a PhD in psychology and is an associate professor in the Health Services and Outcomes Research Group at the University of

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CHARLOTTE READING is an associate professor in the School of Public Health and Social Policy, Faculty of Human and Social Development, University of Victoria. Dr. Reading has conducted research and published in the areas of Aboriginal health, Aboriginal HIV/AIDS, social determinants of Aboriginal health, cultural safety, cancer among Aboriginal peoples, Aboriginal ethics, and research capacity building as well as the sexual and reproductive health of Aboriginal women.

ALLISON REEVES is currently a PhD student in counseling psychology at the University of Toronto where she is focusing her dissertation work on Indigenous Healing in the area of sexual health for indigenous women. She completed her MA degree in health promotion at Dalhousie University where she looked at social constructions of sexuality for First Nation women in Atlantic Canada. She has also worked in India and West Africa, again with a focus on women's health.

SUZANNA M. ROSE, PhD, is executive director of the School of Integrated Science & Humanity and professor of Psychology & Women's Studies at Florida International University in Miami. She has published extensively on issues related to gender and sexuality, including personal relationships, friendship, lesbian issues, hate crime victimization, and women's academic career development and networks. She also has consulted with more than 30 universities nationally concerning strategies for recruiting and retaining science faculty.

SAMANTHA R. SCIARRILLO is a doctoral student in the clinical psychology program at Indiana University of Pennsylvania. She is the graduate assistant for the Women's Studies Program and a student representative to the Commission on the Status of Women at IUP. Her research and clinical interests are in sexuality and gender, and she is involved in a research project studying sexual scripts and the sexual double standard. She has presented on this research regionally and nationally.

NANCY M. SIDUN, PsyD, ABPP, ATR, is both a clinical psychologist and an art therapist. She currently is the supervising clinical psychologist for Kaiser Permanente-Hawaii and maintains a small independent practice, which focuses on women's issues. Dr. Sidun is the chair of the American

Psychological Association's Task Force on Trafficking of Women and Girls, and past chair of the former American Psychological Association, Division 52, International Psychology's Task Force on Human Trafficking. She has published and presented locally, nationally, and internationally on these issues especially as it relates to sexual exploitation of women and girls. Other interests include: international adoption, international women's issues, women's leadership, and white racial identity.

KIMBERLY SMITH, MA, is a doctoral student in clinical psychology at Pepperdine University, with a specialization in clinical neuropsychology. A cultural neuropsychologist in training, Smith's research focuses broadly on the neuropsychological correlates of trauma and the role of culture in the expression, diagnosis, and therapeutic treatment of neuropsychological disorders. Furthermore, Smith is dedicated to serving patients from diverse backgrounds struggling with severe mental illness from a psychosocial recovery perspective. Smith's leadership experiences include serving as a board of director on several community-based organizations and national appointments, including being elected for a two-year term as the American Psychological Association of Graduate Students (APAGS), Member-at-Large, Education, where she advocated for students' education and training needs across all subfields of psychology. Smith expects to advance the field of psychology to include diverse perspectives for those in leadership.

MAGGIE L. SYME, PhD, received her degree in counseling psychology from the University of Kansas in 2009. She completed her clinical postdoctoral training at VA Boston Healthcare System in 2010, with a specialty in Geropsychology and Neuropsychology. Her research includes sexual quality of life in older adults and cancer survivors, as well as community-based participatory research to address cancer health disparities. She is currently working toward a master's degree in Public Health with an emphasis in Epidemiology.

CHIPPEWA M. THOMAS, PhD, LPC, NCC, is an associate professor in the Department of Special Education, Rehabilitation, and Counseling at Auburn University, who as a counselor educator/supervisor prepares masters-level counseling students to work in the mental health work force as well as counselor educators/supervisors at the doctoral level. Dr. Thomas is also the director of Faculty Engagement out of the office of the vice president for University Outreach at Auburn University. Her research interests include counselor education programming and ethics in training; specifically gatekeeping, pedagogy, and multicultural counseling competence development and practice. She holds a master of education degree in Community Mental Health Counseling from Auburn University and bachelor's degree

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JANE M. USSHER is professor of Women's Health Psychology at the University of Western Sydney, Australia. She has published widely on the construction and lived experience of health, in particular women's mental health, the reproductive body, and sexuality. She is the editor of the Routledge *Women and Psychology* book series and is author of a number of books, including *The Psychology of the Female Body; Women's Madness: Misogyny or Mental Illness?; Fantasies of Femininity: Reframing the Boundaries of Sex; Managing the Monstrous Feminine: Regulating the Reproductive Body;* and *The Madness of Women: Myths and Experience.* She has also edited a number of books: *Gender Issues in Clinical Psychology; The Psychology of Women's Health and Health Care* (with Paula Nicolson); *Psychological Perspectives on Sexual Problems; Bodytalk: The Material and Discursive Regulation of Madness, Sexuality and Reproduction;* and *Women's Health: Contemporary International Perspectives.*

STEPHANIE A. WARES received her MS in Mental Health Counseling from Canisius College in Buffalo, NY, in 2006. In graduate school, she continued with her research in women's health, specifically on therapeutic potentials of combining a feminist perspective with Solution Focused Brief Therapy and Motivational Interviewing on diverse populations of women. She then continued her practical work as a mental health counselor and a lecturer at SUNY, Fredonia, where she taught courses in the Psychology of Women and Introduction to Counseling. She also applied her techniques to other areas of student need in academic counseling. She now works as an academic counselor and student social services coordinator at Northern Essex Community College, Haverhill, MA. She continues to focus her research on the benefits of applying therapeutic techniques (Feminist Perspective with Motivational Interviewing Skills) to everyday interactions with students with the intent of promoting empowerment and resiliency in a community college population.

BETH WATSON is a doctoral candidate in clinical psychology at Indiana University of Pennsylvania (IUP) and a teaching associate at IUP and Westmoreland Community College. Her clinical interests include sexuality and gender and forensic psychology. She has presented on sexual scripts and the sexual double standard regionally and at the Association for Women in Psychology (AWP), and has published previously on sexual assault (Watson, Kovach, & McHugh, 2010). She served as cochair of the Sex and Gender Conference at IUP in 2011. Her dissertation research examines the relation of the sexual double standard and rape myth acceptance to rape proclivity.

MEGAN R. YOST, PhD, is assistant professor of Psychology and Women's and Gender Studies at Dickinson College, where she teaches courses on the psychology of gender, the psychology of sexuality, qualitative research methods, and quantitative data analysis. Her research examines the gendered nature of human sexuality from a feminist, social psychological perspective. Her dissertation focused on gender dynamics and power relations within consensual sexual sadomasochism. Currently, she is interested in understanding the influence of gender on sexuality, preventing sexual violence, and examining people's lived experience related to sexual orientation and diverse sexual practices. Her research has appeared in *Psychology of Women Quarterly, Archives of Sexual Behavior, The Journal of Sex Research, Journal of Lesbian Studies,* and *Journal of Homosexuality.*