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Objectives

1. Describe the lifespan perspective of human sexuality.
2. Understand how sexual development begins during infancy and is influenced by parental behaviors.
4. Review the effect of sex education and the consequences of teen pregnancy.
5. Discuss the various trends in sexuality among singles, cohabitants, married couples, and divorced individuals.
6. Understand extradyadic sexual involvement and the various types of extramarital affairs.
7. Learn how sexuality changes in the middle and later years.
TRUTH OR FICTION?

T/F Overweight females are more likely to be sexually active than recommended-weight counterparts.

T/F National data on adolescents reveals that most are depressed and feel social rejection.

T/F Most very early sexual debuts (e.g., age 12) are nonconsensual.

T/F In one study of sexually active adolescents, over 15% reported wanting to get pregnant.

T/F Most teachers in public schools to use abstinence-only curriculum.

SEXUALLY IS NOT THE SAME IN ALL OF LIFE'S INNINGS. IN THIS CHAPTER WE TAKE THE LONG VIEW OF ONE'S SEXUALITY ACROSS TIME. WE BEGIN WITH SEXUALITY IN THE UTERUS AND CONTINUE WITH THE VARIOUS ISSUES INDIVIDUALS FACE.

9.1 Sexuality in Infancy and Childhood

A life-cycle view of sexuality emphasizes that early experiences are important influences in subsequent sexual development.
9.1a Infancy

Infancy is the first year of life following birth. Just as infants are born with digestive and respiratory systems, they also are born with a sexual response system that has already begun to function. Ultrasound on the pregnant woman has been used to document fetal erection of the penis. Such an erection confirms that, with the exception of the reproductive system (which will be delayed until puberty), all the human body systems begin functioning prenatally. Indeed, even in the uterus, boys often have penile erections and girls have clitoral erections or vaginal lubrication.

Because sexual pleasure is an unconditioned positive stimulus, infants are capable of learning associations via classical conditioning processes. Masturbation has been observed in both boys and girls as infants.

Because infants may learn to associate sexual pleasure with their bodies early, it is important for parents not to overreact. Parents who slap their infants for touching their own body parts and label such behaviors as “dirty” may teach their children to associate anxiety and guilt with sexuality. It is crucial to keep in mind that for babies to find pleasure in touching their bodies is developmentally normal. Of course, although parents should be careful to teach children that it is okay to touch themselves, there are societal restrictions such as when to do so (in private). There are also restrictions about touching others (with their consent) and having others touch them (again, with consent).

Although we can assume that touching the genitals results in pleasurable feelings, it is unlikely that infants attach sexual meaning to these experiences in the ways that adults do. It is also important to keep in mind that even though infants are capable of sexual responsiveness, they are not experiencing arousal in the same sense as a young adult. Pedophiles who claim that the child “wanted it” may not be mindful that infants and young children have not learned the social scripting of arousal and sexuality that come as the child gets older and moves toward reproductive age, maturity, and relationships.

9.1b Sexual Behaviors of Children

Childhood extends from age 2 to age 12 and involves physical, cognitive, social, and sexual development. Collecting data on the sexuality of children involves the observations of caretakers. Schoentjes and Deboutte (1999) analyzed data from a 7 page questionnaire completed by caregivers of 917 children ages 2–12 of Belgian or Dutch origin. Children who had been sexually abused were omitted from the analysis. Table 9-1 reveals selected sexual behaviors of various age groups. The researchers noted that the findings are similar to studies of U.S. children (Friedrich, Fisher, Broughton, Houston, & Shafran, 1998).

The selected behaviors in Table 9-1 can be sorted into various categories: exhibitionism, self-stimulation, other focused, gender role behavior, sexual anxiety, sexual interest, and voyeuristic behavior. Notice that the uninhibited behavior of 2- to 5-year-olds quickly abates as socialization takes place. For example, 30% of those children were observed touching their sex parts in public, but only 9% of 10- through 12-year-olds exhibit this behavior. Similarly, 21% of 2- to 5-year-olds touch the sex parts of others, but only 2% of those ages 10–12 years do.
### TABLE 9.1 | Sexual Behaviors of 917 Belgian/Dutch Children

|       |                                             | (n = 470) | D—6–9 yrs.  
|       |                                             | (n = 311) | E—10–12 yrs. 
|       |                                             | (n = 136) | F—Chi² P      |
|-------|---------------------------------------------|-----------|-------------|--------|
| 1.    | Touches sex parts in public                 | 30.0%     | 16.1%       | 8.8%   | <0.00001 |
| 2.    | Masturbates with hands                      | 9.2%      | 6.1%        | 5.2%   | NS      |
| 3.    | Masturbates with object                     | 3.2%      | 0.3%        | 1.5%   | <0.02   |
| 4.    | Touches other people’s sex parts            | 21.9%     | 7.7%        | 1.5%   | <0.00001|
| 5.    | Touches sex parts at home                   | 78.3%     | 56.0%       | 31.6%  | <0.00001|
| 6.    | Uses words that describe sex acts           | 3.6%      | 24.4%       | 27.9%  | <0.00001|
| 7.    | Pretends to be opposite sex when playing    | 13.8%     | 2.9%        | 1.5%   | <0.00001|
| 8.    | Puts objects in vagina/rectum               | 3.0%      | 0.3%        | 0.0%   | <0.005  |
| 9.    | Tries to look at people when they are nude  | 37.2%     | 28.9%       | 19.1%  | <0.001  |
| 10.   | Undresses self in front of others           | 62.6%     | 48.6%       | 27.2%  | <0.00001|
| 11.   | Kisses other children not in the family     | 63.4%     | 38.6%       | 23.5%  | <0.00001|
| 12.   | Shows sex parts to children                 | 13.2%     | 7.1%        | 2.2%   | <0.001  |
| 13.   | If boy, plays with girl’s toys; if girl, plays with boy’s toys | 59.4% | 38.3% | 20.6% | <0.00001|
| 14.   | Shy about undressing                       | 15.3%     | 30.2%       | 32.4%  | <0.00001|
| 15.   | Plays doctor                                | 53.0%     | 39.2%       | 15.4%  | <0.00001|

Take a moment to express your thoughts about the following question. A favorite game among preschool children is “doctor.” This game—which may be played between boys, between girls, or between boys and girls—involves one child assuming the role of patient and the other the role of doctor. The patient undresses, and the doctor examines the patient both by making a visual inspection and by touching his or her body, including the genitals. Some parents, believing such exploration is wrong, punish their children for playing “doctor.” Alternatively, parents might respond by saying something nonpunitive, such as, “It is interesting to find out how other people’s bodies look, isn’t it?” However, developmental psychologists suggest that parents should be concerned, and should intervene, if one child is unwilling or coerced into playing doctor, if the children are not the same age (within a couple of years), or if the activity is potentially harmful—such as inserting objects into themselves or each other. In such situations, parents might say something like, “Your body is wonderful, and it is natural that you are interested in your own body. But it is your body, and only you should touch yourself in private places.” What reactions do you recall your parents making to your early sexual behavior?

9.1c Barriers to Parents Talking to Their Children About Sex

Sexual socialization/sexuality education of children is a process by which knowledge, attitudes and values about sex are learned (Stone, Ingham, & Gibbins, 2013). Parents are typically regarded as the first and most important source of sexual socialization for their children. While children are continually learning from parents about sex (even though parents do not talk about sex), parents are concerned about what and when to talk with their children about sex. That they should say anything at all is accompanied by the fear that doing so will spark experimentation and destroy their child’s innocence/nonsexual state. Parents also may be tense when engaging in a conversation about sex due to their own inadequate socialization; and when they do bring up the subject, it is more often about reproduction than relationships. Nevertheless, there is strong evidence that there is a positive link between parental openness about sex and “young people’s confidence, competence, and sexual safety” (Stone, Ingham, & Gibbins, 2013).

Direct information from parents about the process of talking with their children about sex was collected from 20 parents of 44 children, ages 3–7, in five group discussions. The content of the discussions focused on “barriers to communication” (Stone, Ingham, & Gibbins, 2013). One barrier (referred to above) is the anxiety associated with the desire to protect the innocence of the child. One parent said it was just easier to lie: “I’ve completely avoided telling him what periods are, because he’s seen blood in the toilet when it hasn’t flushed properly and asked. I actually said to him, ‘Oh, I had some beetroot at lunchtime and it’s colored the water.’” Commenting on this statement, Stone and colleagues (2013) said, “Parents tended to express their fears through the potential of lost childhood and shielding their children from ‘corruption,’ noting that children are non-sexual and that they did not want prematurely to assist them to cross over into the ‘world of the grown-ups’. In particular, there were fears that children would start thinking and behaving in sexual ways that are regarded as being reserved for adulthood.”
Another barrier was the uncertainty regarding the best age, for the child, for the parent to be open about sexual information. “Some parents felt that children have little need for any sexuality education before age 8, whereas others had already discussed specific topics and dealt with issues in some detail.” Regardless of when, parents struggle with the words. One parent said, “I find it hard using the right words to explain, the right terminology that they can understand.” The result of parental struggle on timing and words is to be reactive—and wait till the child asks rather than be proactive with information about sexuality.

Fear of the reactions of other parents was a third barrier for parents in talking with their children about sex. An example is a parent who said:

I kind of worry, for instance there was an incident lately where (daughter) was convinced that babies come out of your belly button, and so I tried to explain to her like, no they don’t come out your belly button and she asked me, ‘Well how do they come out?’ and I said, ‘I squeezed you out of my foofee’. And then she was outside and she was talking to the next door neighbors’ kids, they were talking about how they’d had a little baby next door and (daughter) screamed out across three gardens, ‘My mummy squeezed me out of her foofee’ and I’m just thinking these kids are younger than (daughter) and I’m not sure that their parents want them to hear. You’ve got to consider other parents. (Stone, Inghamand, & Gibbins, 2013)

Parental discomfort was a fourth barrier to being open and honest about sex with their children. The parents generally felt inadequate in knowledge, skills, and delivery, and their discomfort was often based on their own parents’ inadequacies. One parent remarked: “I do get embarrassed talking about any of it because nothing was explained to me as a child and I never asked questions. … I think more than anything it’s knowing where to start and what to say and like getting yourself stuck into a deeper hole when you start answering the questions.”

Early and open communication with children about sexuality can have a positive impact in terms of sexual safety and outcomes (Stone, Inghamand, & Gibbins, 2013). Indeed, parent-child sexual communication is most effective when it is initiated prior to first intercourse (sexual debut). Parents who create the context with their children that talking about sex is normative have opportunities across time to provide information/teach lessons. Watching sexual content on TV, listening to sexual lyrics, and reacting to a child’s stories from school provide “teachable moments” to talk about sexuality. See the Un/Hushed weblink by Karen Rayne for information about how parents can talk with their teens about sex.

Harris and colleagues (2013) confirmed the value of positive parent-child relationships and communication on the sexual decisions and behavior of adolescents. They analyzed data from 134 adolescent African American males and revealed parent-child closeness was positively correlated with amount of parent-child sexual communication with both mothers and fathers. Such closeness was also associated with greater condom use, less permissive sexual attitudes, fewer sexual partners, and less unprotected sex. The findings emphasize the importance of the parent-child relationship and the role of parent-child communication between parents and sons. Of note is that the males noted greater communication with mothers than fathers.
Exposing Children to Parental Nudity

Some parents are concerned about the effects parental nudity may have on their children. “Will it traumatize my children or affect their sexual development negatively if I allow them to see me nude?” parents ask. Others are concerned that they may have already damaged their children because the children have walked in on the parents and observed them having intercourse. (This is known as the “primal scene.”) To what degree should parents be concerned about these issues?

Schoentjes and Deboutte (1999) reported 40% of children ages 6–9 and 13% of those 10–12 reported walking around the house without clothes. Of the effects of family nudity on children, Friedrich and colleagues (1998) noted that children so exposed reported higher levels of sexual behavior for children ages 2–12 (but within cultural limits). In general, children who grow up with parents who embrace “nudism” learn positive associations with their bodies. Harm in the form of negative feelings or guilt about one’s body would be a result of a parent shaming the child for being nude or for touching his or her own body.

9.2 Sexuality in Adolescence

Adolescence is defined as the developmental period between puberty and adulthood. It is a time when the individual transforms his or her image as a child into that of a young adult with a future adult life. Explorations with sexuality, including same sex sexual behavior, are a usual part of adolescent development (Cartaxo, Peixoto, Rolim, Neto, & deAbreu, 2013). In the United States and most cultures today, adolescence typically begins between the ages of 10 and 13 and ends between the ages of 18 and 22. Adolescence is a time when one becomes increasingly aware of one’s own sexuality and that of others.

9.2a Adolescence

Early adolescence (middle school or junior high school ages) includes the time of greatest pubertal change. Late adolescence (the mid to late teen years) involves identity exploration, interacting with romantic partners, and school performance with a career objective in mind. The most noticeable changes in adolescence are physical.

9.2b Physical Changes

The adolescent’s body undergoes rapid physiological and anatomical change. The term puberty comes from the Latin pubescere, which means to be covered with hair. Pubic hair and axillary (underarm) hair in young girls and pubic, axillary, and facial hair in young boys are evidence that the hypothalamus is triggering the pituitary gland.
to release gonadotropins into the bloodstream. These hormones cause the testes in
the male to increase testosterone production, as well as the ovaries in the female to
increase estrogen production.

Further physical changes in adolescence include the development of secondary
sex characteristics, such as breasts in the female and a deepened voice in the male. A
growth spurt also ensues, with girls preceding boys by about two years. Girls growing
taller than boys their age characterize this growth spurt. Genitals of the respective sexes
also enlarge (the penis and testes in the male and the labia in the female). Internally,
the prostate gland and seminal vesicles begin to function, making it possible for the
young adolescent male to ejaculate. (Sperm is present in the ejaculate at about age 14.)
First ejaculation usually occurs around age 13 or 14, but the timing is variable. The first
ejaculation is referred to as semenarche.

Girls experience their own internal changes. The uterus, cervix, and vaginal walls
respond to hormone changes to produce the first menstruation, or menarche. This
usually occurs between the ages of 12 and 13, but the timing is highly variable.

Adolescents are particularly concerned about the degree to which their bodies match
the cultural image and are unhappy when their bodies do not match that image. Girls
are more likely to be dissatisfied with their body image than boys. Since adolescent females are intent on matching
the cultural weight ideal for a female, what is the consequence of
being overweight on sexual decisions and behavior? Averett
and colleagues (2013) analyzed national data on adolescents
(National Longitudinal Survey of Adolescent Health) and
found that overweight or obese adolescent girls are less likely
than their recommended-weight counterparts to be sexually
active. However, overweight or obese girls are not less likely
to have sex under the influence of alcohol; and once they
have had vaginal intercourse, their consistency of condom
use is no different from that of their recommended-weight
peers. The most striking finding is that overweight or obese
girls are at least 15% more likely than their recommended-
weight peers to have ever had anal intercourse, regardless of
whether they have ever had vaginal sexual intercourse.

9.2c Psychological Changes

In addition to physical changes, psychological changes also occur in adolescence.
Psychological changes include moving from a state of childish dependence to a state
of relative independence, resolving sexual identity issues, and feeling secure that one
is normal. An example of adolescent ambivalence about growing up is the adolescent
female who has a bottle of blow bubbles and a bottle of perfume on her bedroom
dresser. Adolescents often want the freedom to play as children along with the freedom/
independence of an adult.

Risk taking is normative during adolescence. Sexting (sending sexually explicit
text or photos via cell phone) is an example of risk-taking behavior. Sexting is associated
with substance abuse and high-risk sexual behavior. Benotsch and colleagues (2013)
analyzed Internet questionnaire data on 763 young adults, 44% of whom reported
sexting. The researchers compared those who sex texted/sent photos with their non-
sexting counterparts. The “sexters” were more likely to report recent substance use and
high-risk sexual behaviors, such as unprotected sex and sex with multiple partners. Of
those who engaged in sexting, a considerable percentage (31.8%) reported having sex
with a new partner for the first time after sexting with that person.
Strassberg and colleagues (2013) found that 20% of their sample of 606 high school students in the Southwest reported they had sent a sexually explicit image of themselves via cell phone, whereas almost twice as many reported that they had received a sexually explicit picture via cell phone. Of those who received such a photo, 25% forwarded it to others; and of these who forwarded such a photo, 30% said that they were aware of potential serious legal consequences.

Temple and colleagues (2012) analyzed data from 948 public high school students on their dating and sexual behavior (including sexting). Of the sample, 28% reported having sent a naked picture of themselves through text or e-mail (sext), and 31% reported having asked someone for a sext. More than half (57%) had been asked to send a sext, with most being bothered by having been asked. Adolescents who engaged in sexting behaviors were more likely to have begun dating and to have had sex than those who did not sext (all P < .001). For girls, sexting was also associated with risky sexual behaviors (e.g., drinking alcohol, having multiple sexual partners, not using a condom). Walker and colleagues (2013) observed that girls often feel coerced by their partners to engage in sexting behavior. Doing so is a risky sexual behavior since the partner may put the nude photos on Facebook to intimidate the girl/punish her.

In spite of their quest for independence and risk taking, adolescents tend to be psychologically healthy. Jenkins and Vazsonyi (2013) studied national data on adolescents and found that, on average, all participants had low levels of depression, perceptions of social rejection that tended to decrease over time, high levels of self-esteem, and happiness that tended to increase over time. These data suggest that heterosexual adolescents transition well into adulthood with positive psychosocial outcomes.

A major focus of adolescent development is the exploration of how emotionally intimate and how sexually intimate of a relationship the adolescent wants (Short, Catallazzi, & Beitkopf, 2013). The adolescent in Sweden sometimes uses the friends-with-benefits context to explore the parameters of intimacy and sexuality (see Cultural Diversity).

Cultural Diversity

Adolescence is a time of emotional/sexual exploration in the U.S. and in other societies, as well. Erlandsson and colleagues (2013) interviewed Swedish adolescents (ages 16–18) involved in “friends-with-benefits” (FWB) relationships. The goal of involvement in a FWB relationship was exploration of physical and psychological intimacy, with no expectations or demands. The eight adolescents revealed that they were ambivalent about the legitimacy of the romantic feelings they had for their partner, used alcohol frequently, and rarely used contraception.

9.2d Sexual Debut of Adolescents

At what age do adolescents first have sexual intercourse and what are the outcomes? Based on analysis of 17,220 New York youth (ages 15 through 19), of those who reported ever having had sex, a quarter of the females and over half of the males (52%) had their first sexual intercourse before age 14 (Kaplan, Jones, Olson, & Yunzal-Butler, 2013). Finer and Philbin (2013) also identified early sexual debuts of adolescents and found
that the youngest (e.g., age 12) are often non-consensual. In another study of middle school children in ten states, 20% of the sixth graders and 42% of the eighth graders had engaged in sexual intercourse. Consistent with previous studies, males, minorities, and those who are not likely to complete high school are more likely to have engaged in higher frequencies of sexual behavior and high sexual risk behaviors (Moore, Barr, & Johnson, 2013; R-Almendarez & Wilson, 2013; Lyons, Manning, Giordano, & Longmore, 2013).

Early sexual debut is typically associated with high-risk sexual behavior—including alcohol/drug use, not using condoms, getting pregnant (or causing pregnancy), and violence in the form of being hit/slapped or otherwise hurt by a partner. Sexually active black and Hispanic students were significantly more likely to report early sex than white and API (Asian Pacific Islander) students (42.9% and 38.8%, respectively, versus 25.9% and 30.8%, respectively) (Kaplan, Jones, Olson, & Yunzal-Butler, 2013). In an effort to delay adolescent sexual debut, the researchers emphasized the following:

Evidence-based interventions in school and community settings must be accompanied by efforts to increase access to sexual and reproductive health services and environmental changes that support healthy relationships, including responsible decision making about sexual activity. Our findings provide strong support for the need to create social environments in schools and neighborhoods that support young people of all races/ethnicities to make healthy and informed decisions about their sexual and reproductive health. (p. 355)

First Sexual Intercourse Experience

The following is a description of a first intercourse experience of a student (name withheld by request) from the authors’ classes.

I was 15 and my partner was 16. I had two fears. The first was my fear of getting her pregnant the first time. The second was of “parking” in dark and desolate areas. Therefore, once we decided to have intercourse, we spent a boring evening waiting for my parents to go to sleep so we could move to the station wagon in the driveway.

After near hyperventilation in an attempt to fog the windows (to prevent others from seeing in), we commenced to prepare for the long-awaited event. In recognition of my first fear, I wore four prophylactics. She, out of fear, was not lubricating well; and needless to say, I couldn’t feel anything through four layers of latex.

We were able to climax, which I attribute solely to sheer emotional excitement, yet both of us were later able to admit that the experience was disappointing. We knew it could only get better.

Being Modern-Orthodox adds an additional challenge to the first sexual intercourse experience. Shalev and colleagues (2013) interviewed 36 newlywed men and women about their first intercourse experience. They were Modern-Orthodox (8% of the population) and may not have even held hands prior to the wedding. Both men and women associated the sexual intercourse with emotional and behavioral difficulties, which were rooted in the traditional nature of the religious Modern-Orthodox society in Israel. They had had no sex education, no previous interpersonal sexual experience, and no familiarity with their own bodies. They were in shock and in coping mode. In addition, they were adjusting to living with a person of the opposite sex and sharing the same space (i.e., bedroom, bathroom, etc.). They sought help on the Internet and discovered that their problems were common, given their limited experience and traditional religious upbringing.
Alcohol use (which impairs sexual decisions) in adolescence is common. Livingston and colleagues (2013) interviewed adolescent females (ages 14–17) to investigate the effect of alcohol on sexual choices. While reducing social anxiety and excusing unsanctioned sexual behavior were identified as advantages of using alcohol, the respondents also noted that it impaired their judgment and increased the chance of sexual regret and coercion. Hence, any educational/preventative attempt to delay sexual debut and increase responsible decision-making must include attention to decisions about alcohol use.

**Take a moment to answer the following questions.** What do you think is the ideal “first” sexual intercourse or sexual experience? What would be the nature of the relationship? How long would the partners have known each other? Would there be alcohol or not? How does your own reality differ from your answers?

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**Cultural Diversity**

In late 2013, France’s senate voted to ban beauty pageants for children under 16 in an effort to protect girls from being sexualized too early. Anyone who enters a child into such a contest would face up to 2 years in prison and €30,000 in fines. The senate approved the measure 197–146.

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**9.2e Teen Pregnancy**

The mention of a teenage mom may sometimes carry the implication that the mother did not want to get pregnant and is trying to cope with early motherhood; however, some sexually active adolescent females want to get pregnant. Cavazos-Rehg and colleagues (2013) discovered that 16% of their sample of teenage girls, ages 15–18, reported that they would be “a little pleased” or “very pleased” if they were to become pregnant. Factors associated with wanting to become pregnant included having had a prior pregnancy, being “older” in contrast to “being younger,” and having parents with a high school education or less.

Medical risks to teen mothers are greatest for younger teens. Although maternal mortality rates for adolescent women are low, they are twice the rate for adult women. The neonatal death rate for babies born to adolescent women is three times higher than for those born to those in their 20s and the risks of low birth weight and preterm birth are more than double. Access to prenatal care, poverty, unmarried status, smoking, and drug use are contributors to the health risks.

In addition to health risks, there are developmental and social complications of teen pregnancy as well. Unless supportive interventions are in place, these complications include interruption of the teen’s educational and vocational opportunities, separation or divorce from the child’s father, poverty, and repeat pregnancies. Children who are born to teen mothers do not fare as well as those born to adult mothers.
Plan B for Adolescents?

The over-the-counter morning after pill is available, without a prescription, to females of any age. **Plan B** (also sold as Next Choice and My Way) is a high dose progestin pill that acts to prevent ovulation or fertilization of an egg. Taking it 72 hours after unprotected sex, condom failure, or a missed period can reduce the chance of pregnancy by 89%. The morning after pill is most effective if taken 24 hours after exposure. Plan B is not the “abortion pill” (RU-486), which requires a prescription.

The argument for making Plan B,—which costs $40 to $60 for one pill and is available without a prescription—is that it will help to reduce pregnancy for the 1 in 5 adolescent females who report unprotected sexual intercourse. Ten percent of teens are forced to have sex, and Plan B provides the option of not becoming pregnant with a partner who used force. The argument against Plan B being available without a prescription is that some teens will be more willing to have sex since they can “take a pill in the morning.” In addition, some parents do not want their children to have the Plan B option since they feel it “encourages promiscuity.”

Content of Sex Education in Public Schools

Since sex education provided by parents is limited (Mauras, Grolnick, & Friendly, 2013), sex education is provided in most public school systems and is usually taught as part of another subject, such as health education, home economics, biology, or physical education. Because each state, rather than the federal government, is responsible for sex education in the public school system, there is considerable variation among the states in terms of the sex education offered. The prevailing model for sex education has been “abstinence only.” More recently, comprehensive sex education has involved abstinence plus information about condoms, HIV, STIs, etc. Three-fourths of the teachers in one study reported using the abstinence-only curricula (Einsenberg, Madsen, Oliphant, & Sieving, 2013).

How do teachers feel about teaching sex education? Einsenberg and colleagues (2013) analyzed data from 368 middle and high school sex education teachers in Minnesota. Almost two-thirds reported structural barriers; 45% were concerned about parent, student, or administrator response; and one-fourth reported restrictive policies. What is needed is more structural support for teachers to teach a wide variety of topics, not only abstinence, but contraception, STIs, sexual violence, sexual orientation, etc., as well. Agreement on the content of the curriculum becomes the problem. Some parents do not want their child exposed to any sex education since they fear liberal teachers will teach permissive values or that students will be prompted to become sexually active as a result of classroom instruction.

In response to more limited sex education programs, Planned Parenthood Los Angeles developed and launched a teen-centered sexuality education program based on critical thinking, human rights, gender equality, and access to health care. The program included...
a 12-session classroom sexuality education curriculum for ninth grade students, workshops for parents, a peer advocacy training program, and access to sexual health services (Marques & Ressa, 2013).

How effective is sex education when effectiveness is defined as “delaying early sexual debut of young adolescents”? Erkut and colleagues (2013) compared sixth graders exposed to a nine-lesson sex education program “Get Real: Comprehensive Sex Education That Works” with a control group. Participants were 548 boys and 675 girls who completed surveys in both sixth grade (baseline) and seventh grade (follow-up). 30% of those not exposed to the sex education program were more likely to initiate sex by follow-up when controlling for having had sex by sixth grade, demographic variables, and a tendency to give socially desirable responses.

Sex education is not just what happens in public schools in the U.S. Rogow and colleagues (2013) discussed sex education on a broad international scale. “It’s All One” is one such program with the theme of integrating gender and rights into sexuality education that is used in various countries. Hence, sex education is focused not on encouraging individuals to “use a condom” but to internalize empowerment and equality in dyadic relationships.

9.3 Sexuality in Adulthood

National DATA

By age 75, only 3.9% of American women and 3.5% of American men have never married (Statistical Abstract of the United States, 2012–2013, Table 57). Between the ages of 25 and 29, 47.8% of females and 62.2% of males are not married (Table 57).

9.3a Sexuality Among Singles

<table>
<thead>
<tr>
<th>TABLE 9-2</th>
<th>Reasons for Remaining Single</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefits of Singlehood</strong></td>
<td><strong>Limitations of Marriage</strong></td>
</tr>
<tr>
<td>Freedom, including sexual variety</td>
<td>Restrictions from spouse or children</td>
</tr>
<tr>
<td>Responsible for one’s self only</td>
<td>Responsible for spouse and children</td>
</tr>
<tr>
<td>Close friends of both sexes</td>
<td>Pressure to avoid other relationships</td>
</tr>
<tr>
<td>Spontaneous lifestyle</td>
<td>Routine, predictable sex/lifestyle</td>
</tr>
<tr>
<td>Feeling of self-sufficiency</td>
<td>Potential to feel dependent</td>
</tr>
<tr>
<td>Freedom to spend money as one wishes</td>
<td>Money spent in reference to spouse/children</td>
</tr>
<tr>
<td>Freedom to move as career dictates</td>
<td>Restrictions on career mobility</td>
</tr>
<tr>
<td>No control/influence from spouse</td>
<td>Potential to be controlled/influenced by spouse</td>
</tr>
<tr>
<td>No emotional or financial loss caused by divorce</td>
<td>Possibility of divorce</td>
</tr>
</tbody>
</table>
The primary advantage of remaining single is freedom and control over one’s life. This freedom translates into being available to have a variety of sex partners since there is no spouse to disappoint; and unless a couple is polyamorous, commitment means giving up other sex partners.

However, singles have intercourse less frequently than those who are married or living together. Not only may singles be having less sex and achieving less sexual satisfaction (Michael, Gagnon, Laumann, & Kolata, 1994), they may also be more vulnerable to engaging in high-risk sexual behavior. The following self-assessment allows you to determine the degree to which you engage in behavior that involves a high risk for HIV infection.

**Self-Assessment 9-1: Student Sexual Risks Scale (SSRS)**

The following self-assessment allows you to evaluate the degree to which you may be at risk for engaging in behavior that exposes you to HIV. Safer sex means sexual activity that reduces the risk of transmitting the AIDS virus. Using condoms is an example of safer sex. Unsafe, risky, or unprotected sex refers to sex without a condom, or to other sexual activity that might increase the risk of AIDS virus transmission. For each of the following items, check the response that best characterizes your belief:

A = Agree  U = Undecided  D = Disagree

1. If my partner wanted me to have unprotected sex, I would probably give in.  
   A  U  D
2. The proper use of a condom could enhance sexual pleasure.  
   A  U  D
3. I may have had sex with someone who was at risk for HIV/AIDS.  
   A  U  D
4. If I were going to have sex, I would take precautions to reduce my risk of HIV/AIDS.  
   A  U  D
5. Condoms ruin the natural sex act.  
   A  U  D
6. When I think that one of my friends might have sex on a date, I ask him/her if he/she has a condom.  
   A  U  D
7. I am at risk for HIV/AIDS.  
   A  U  D
8. I would try to use a condom when I had sex.  
   A  U  D
   A  U  D
10. My friends talk a lot about safer sex.  
    A  U  D
11. If my partner wanted me to participate in risky sex, and I said that we needed to be safer, we would still probably end up having unsafe sex.  
    A  U  D
12. Generally, I am in favor of using condoms.  
    A  U  D
13. I would avoid using condoms if at all possible.  
    A  U  D
14. If a friend knew that I might have sex on a date, he/she would ask me whether I was carrying a condom.
   A U D

15. There is a possibility that I have HIV/AIDS.
   A U D

16. If I had a date, I would probably not drink alcohol or use drugs.
   A U D

17. Safer sex reduces the mental pleasure of sex.
   A U D

18. If I thought that one of my friends had sex on a date, I would ask him/her if he/she used a condom.
   A U D

19. The idea of using a condom doesn’t appeal to me.
   A U D

20. Safer sex is a habit for me.
   A U D

21. If a friend knew that I had sex on a date, he/she wouldn’t care whether I had used a condom or not.
   A U D

22. If my partner wanted me to participate in risky sex, and I suggested a lower risk alternative, we would have the safer sex instead.
   A U D

23. The sensory aspects (smell, touch, etc.) of condoms make them unpleasant.
   A U D

24. I intend to follow “safer sex” guidelines within the next year.
   A U D

25. With condoms, you can’t really give yourself over to your partner.
   A U D

26. I am determined to practice safer sex.
   A U D

27. If my partner wanted me to have unprotected sex, and I made some excuse to use a condom, we would still end up having unprotected sex.
   A U D

28. If I had sex and I told my friends that I did not use condoms, they would be angry or disappointed.
   A U D

29. I think safer sex would get boring fast.
   A U D

30. My sexual experiences do not put me at risk for HIV/AIDS.
   A U D

31. Condoms are irritating.
   A U D

32. My friends and I encourage each other before dates to practice safer sex.
   A U D

33. When I socialize, I usually drink alcohol or use drugs.
   A U D

34. If I were going to have sex in the next year, I would use condoms.
   A U D

35. If a sexual partner didn’t want to use condoms, we would have sex without using condoms.
   A U D
36. People can get the same pleasure from safer sex as from unprotected sex.
   A  U  D

37. Using condoms interrupts sex play.
   A  U  D

38. It is a hassle to use condoms.
   A  U  D

**Scoring**

Begin by giving yourself eighty points. Subtract one point for every undecided response. Subtract two points every time that you disagreed with odd-numbered items or with item number 38. Subtract two points every time you agreed with even-numbered items 2 through 36.

**Interpreting Your Score**

Research shows that students who make higher scores on the SSRS are more likely to engage in risky sexual activities, such as having multiple sex partners and/or failing to consistently use condoms during sex. In contrast, students who practice safer sex tend to endorse more positive attitudes toward safer sex, and tend to have peer networks that encourage safer sexual practices. These students usually plan on making sexual activity safer, and they feel confident in their ability to negotiate safer sex even when a dating partner may press for riskier sex. Students who practice safer sex often refrain from using alcohol or drugs, which may impede negotiation of safer sex. They also often report having engaged in lower-risk activities in the past. How do you measure up?

**(Below 15) Lower Risk**

(Of 200 students surveyed by DeHart and Birkimer (1997), 16% were in this category.) Congratulations! Your score on the SSRS indicates that, relative to other students, your thoughts and behaviors are more supportive of safer sex. Is there any room for improvement in your score? If so, you may want to examine items for which you lost points and try to build safer sexual strengths in those areas. You can help protect others from HIV by educating your peers about making sexual activity safer.

**(15 to 37) Average Risk**

(Of 200 students surveyed by DeHart and Birkimer, 68% were in this category.) Your score on the SSRS is about average in comparison with those of other college students. Although you don’t fall into the higher-risk category, be aware that “average” people can get HIV, too. In fact, a recent study indicated that the rate of HIV among college students is 10 times that in the general heterosexual population. Thus, you may want to enhance your sexual safety by figuring out where you lost points and working toward safer sexual strengths in those areas.

**(38 and Above) Higher Risk**

(Of 200 students surveyed by DeHart and Birkimer, 16% were in this category.) Relative to other students, your score on the SSRS indicates that your thoughts and behaviors are less supportive of safer sex. Such high scores tend to be associated with greater HIV-risk behavior. Rather than simply giving in to riskier attitudes and behaviors, you may want to empower yourself and reduce your risk by critically examining areas for improvement. On which items did you lose points? Think about how you can strengthen your sexual safety in these areas. Reading more about safer sex can help, and sometimes colleges and health clinics offer courses or workshops on safer sex. You can get more information about resources in your area by contacting the CDC’s HIV/AIDS Information Line at 1-800-342-2437.

Source: DeHart, D. D., & Birkimer, J. C. (1997). The Student Sexual Risks Scale (modification of SRS for popular use; facilitates student self-administration, scoring, and normative interpretation). Developed for this text by Dana D. DeHart, College of Social Work at the University of South Carolina; John C. Birkimer, University of Louisville. Used by permission of Dana DeHart and John C. Birkimer.
9.3b Sexuality Among Cohabitants

Cohabitation, also known as living together, involves two adults—unrelated by blood or by law and involved in an emotional and sexual relationship—who sleep in the same residence at least 4 nights a week for 3 months. Willoughby and Carroll (2012) surveyed 1,036 young adult college students and found that the endorsement of cohabitation is strongly associated with having more sexual partners, being permissive in sexual attitudes, and being less religious. Cohabitants also tend to have a higher frequency of sex since the partners are often relatively new to each other.

Not all cohabitants are college students. Indeed, only 18% of all cohabitants are under the age of 25. The largest percentage (36%) are between the ages of 25 and 34 (Jayson, 2012). Reasons for the increase in cohabitation include career or educational commitments; increased tolerance of society, parents, and peers; improved birth control technology; desire for a stable emotional and sexual relationship without legal ties; avoiding loneliness; and greater disregard for convention (Kasearu, 2010).

The couple living in a cohabitation relationship precedes virtually all marriages in Sweden (Thomson, E. & Bernhardt, 2010); however, only 12% of first marriages in Italy are preceded by cohabitation (Kiernan, 2000). Italy is primarily Catholic, which helps to account for the low cohabitation rate. Religious affiliation is also associated with lower rates of cohabitation in the United States (Gault-Sherman & Draper, 2012).

9.3c Sexuality Among the Married

In spite of the perceived benefits of singlehood or cohabitation, marriage remains the lifestyle most Americans choose.

Marital sex is characterized by its social legitimacy, declining frequency, and superiority in terms of sexual and emotional satisfaction.

1. Social Legitimacy In our society, marital intercourse is the most legitimate form of sexual behavior. Premarital, extramarital, and homosexual intercourse do not enjoy as high a level of social approval as does marital sex. It is not only okay to have intercourse when married, it is expected. People assume that married couples make love and that something is wrong if they do not.
2. *Declining Frequency*  
Sexual intercourse between spouses occurs about six times a month, and declines in frequency as the spouses age. Pregnancy also decreases the frequency of sexual intercourse (Lee, Lin, Wan, & Liang, 2010). In addition to biological changes due to aging and pregnancy, satiation also contributes to the declining frequency of intercourse between spouses and partners in long-term relationships. Psychologists use the term **satiation** to refer to the repeated exposure of a particular stimulus (in this case, the partner), which results in the loss of its ability to reinforce. The 500th time that a person has intercourse with the same partner is not as new and exciting as the first few times.

A change in hormone levels may also be related to the decline in frequency of sexual intercourse between spouses. Testosterone levels (associated with interest in sex) are lower in men who are in committed or married relationships, as well as in women who are mothers (Barrett, et al., 2013).

Some spouses do not have intercourse at all. In a nationwide study of sexuality, 1% of husbands and 3% of wives reported that they had not had intercourse in the past 12 months (Michael, Gagnon, Laumann, & Kolata, 1994). Health, age, sexual orientation, stress, depression, and conflict were some of the reasons given for not having intercourse with one’s spouse. Such an arrangement may be accompanied by either limited or extensive affection.

3. *Sexual and Emotional Satisfaction*  
Despite declining frequency over time, marital sex remains a richly satisfying experience. Contrary to the popular belief that unattached singles have the best sex, married and pair-bonded adults enjoy the most satisfying sexual relationships. In the national sample referred to earlier, 88% of married people said they received great physical pleasure from their sexual lives, and almost 85% said they received great emotional satisfaction (Michael, Gagnon, Laumann, & Kolata, 1994). Individuals least likely to report being physically and emotionally pleased in their sexual relationships are those who are not married, not living with anyone, or not in a stable relationship with one person. Hence, the categories from most to least sexually satisfied are the marrieds, cohabitants, and the uninvolved.

### 9.3d Sexuality Among the Divorced

Of the almost 2 million people getting divorced annually, most will have intercourse within 1 year of being separated from their spouses. The meanings of intercourse for separated or divorced individuals vary. For many, intercourse is a way to reestablish—indeed, repair—their crippled self-esteem. Questions such as “What did I do wrong?” “Am I a failure?” and “Is there anybody out there who will love me again?” loom in the minds of the divorced. One way to feel loved, at least temporarily, is through sex. Being held by another and being told that it feels good give people some evidence that they are desirable.

Because divorced individuals are usually in their mid-30s or older, they may not be as sensitized to the danger of contracting HIV as are people in their 20s. Divorced individuals should always use a condom to lessen the risk of an STI, including HIV infection, and AIDS.
9.3e Extradyadic Sexual Involvement

About a one-fourth of husbands and 20% of wives have sex with someone outside the marriage at some time during their marriage (Russell, Baker, & McNulty, 2013).

Types of Extradyadic Encounters

The term extramarital affair refers to a spouse’s sexual involvement with someone outside the marriage. Affairs are of different types and include the following:

1. Brief encounter A spouse meets and hooks up with a stranger. In this case, the spouse is usually out of town, and alcohol is often involved.

2. Paid sex A spouse seeks sexual variety with a prostitute who will do whatever that spouse wants (e.g., former New York governor Eliot Spitzer). These encounters usually go undetected unless there is an STI, the person confesses, or the prostitute exposes the client.

3. Instrumental or utilitarian affair This is sex in exchange for a job or promotion, to get back at a spouse, to evoke jealousy, or to transition out of a marriage.

4. Coping mechanism Sex can be used to enhance one’s self-concept or feeling of sexual inadequacy, compensate for failure in business, cope with the death of a family member, or test one’s sexual orientation.

5. Paraphiliac affairs In these encounters, the on-the-side sex partner acts out sexual fantasies or participates in sexual practices that the spouse considers bizarre or abnormal, such as sexual masochism, sexual sadism, or transvestite fetishism.

6. Office romance Two individuals who work together may drift into an affair. David Petraeus (former CIA director) and John Edwards (former presidential candidate) became involved in affairs with women they met on the job.

7. Internet use Internet users now tops 1.6 billion people (Hertlein & Piercy, 2012). Although an extramarital affair does not exist, legally, unless two people (one being married) have intercourse, Internet use can be disruptive to a marriage or a couple’s relationship. While men and women agree that offline kissing, touching breasts/genitals, and sexual intercourse constitute infidelity they disagree about the degree to which online behaviors constitute cheating. Based on data collected by Hines (2012), men are less likely than women to view a partner emailing a person online for relationship advice (27% versus 51%), having a friendly conversation with someone in a chat room called “Married and Lonely” (64% versus 84%), and creating a pet name for a person he/she met in an Internet chat room (40% versus 70%) as cheating. Males also are less likely to view online pornography as cheating (27% versus 64%).

Computer friendships may evolve to feelings of intimacy; involve secrecy (one’s partner does not know the level of involvement); include sexual tension (even though there is no overt sex); and take time, attention, energy, and...
affection away from one’s partner. Cavaglion and Rashty (2010) noted the anguish embedded in 1,130 messages on self-help chat boards from female partners of males involved in cybersex relationships and pornographic websites. The females reported distress and feelings of ambivalent loss that had impact on the individual, couple, and their sexual relationship. Cramer and colleagues (2008) also noted that women become more upset when their man is emotionally unfaithful with another woman (although men become more upset when their partner is sexually unfaithful with another man). The Self-Assessment 9-2 section allows you to measure your attitude toward infidelity.

### Self-Assessment 9-2: Attitudes Toward Infidelity Scale

Infidelity can be defined as “unfaithfulness in a committed monogamous relationship.” Infidelity can affect anyone, regardless of race, color, or creed; it does not matter whether you are rich or attractive, where you live, or how old you are. The purpose of this survey is to gain a better understanding of what people think and how they feel about issues associated with infidelity. There are no right or wrong answers to any of these statements; we are interested in your honest reactions and opinions.

Please read each statement carefully, and respond by using the following scale:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<tbody>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Strongly Agree</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

1. ___ Being unfaithful never hurt anyone.
2. ___ Infidelity in a marital relationship is grounds for divorce.
3. ___ Infidelity is acceptable for retaliation of infidelity.
4. ___ It is natural for people to be unfaithful.
5. ___ Online/Internet behavior (for example, visiting sex chat rooms, porn sites) is an act of infidelity.
6. ___ Infidelity is morally wrong in all circumstances, regardless of the situation.
7. ___ Being unfaithful in a relationship is one of the most dishonorable things a person can do.
8. ___ Infidelity is unacceptable, under any circumstances, if the couple is married.
9. ___ I would not mind if my significant other had an affair as long as I did not know about it.
10. ___ It would be acceptable for me to have an affair, but not my significant other.
11. ___ I would have an affair if I knew my significant other would never find out.
12. ___ If I knew my significant other was guilty of infidelity, I would confront him/her.

### Scoring

Selecting a 1 reflects the least acceptance of infidelity; selecting a 7 reflects the greatest acceptance of infidelity. Before adding the numbers you selected, reverse the scores for item numbers 2, 5, 6, 7, 8, and 12. For example, if you responded to item 2 with a “6,” change this number to a “2”; if you responded with a “3,” change this number to “5,” and so on. After making these changes, add the numbers. The lower your total score (12 is the lowest possible), the less accepting you are of infidelity; the higher your total score (84 is the highest possible), the greater your acceptance of infidelity. A score of 48 places you at the midpoint between being very disapproving and very accepting of infidelity.
Scores of Other Students Who Completed the Scale

The scale was completed by 150 male and 136 female student volunteers at Valdosta State University. The average score on the scale was 27.85 (SD = 12.02). Their ages ranged from 18 to 49, with a mean age of 23.36 (SD = 5.13). The ethnic backgrounds of the sample consisted of 60.8% white, 28.3% African American, 2.4% Hispanic, 3.8% Asian, 0.3% American Indian, and 4.2% other. The college classification level of the sample included 11.5% freshmen, 18.2% sophomores, 20.6% juniors, 37.8% seniors, 7.7% graduate students, and 4.2% post baccalaureate. Male participants reported more positive attitudes toward infidelity (mean = 31.53; SD = 11.86) than did female participants (mean = 23.78; SD = 10.86; p <0.05). White participants had more negative attitudes toward infidelity (mean = 25.36; SD = 11.17) than did nonwhite participants (mean = 31.71; SD = 12.32; p <0.05). There were no significant differences in regard to college classification.

Source: “Attitudes toward Infidelity Scale” 2006 by Mark Whatley, Ph.D., Department of Psychology, Valdosta State University, Valdosta, Georgia 31698-0100. Used by permission. Other uses of this scale by written permission of Dr. Whatley only (mwhatley@valdosta.edu). Information on the reliability and validity of this scale is available from Dr. Whatley.

Extradyadic sexual involvement or extrarelational involvement refers to the sexual involvement of a pair-bonded individual with someone other than the partner. Extradyadic involvements are not uncommon. Of 1,099 undergraduate males, 21% agreed with the statement, “I have cheated on a partner I was involved with”; of 3,459 undergraduate females, 25% were cheated on by a partner they were involved with (Hall & Knox, 2013).

Diversity in Other Countries

Researcher Pam Druckerman (2007) wrote Lust in Translation, in which she reflects how affairs are viewed throughout the world. First, terms for having an affair vary. For the Dutch, it is called, “pinching the cat in the dark”; in Taiwan, it is called “a man standing in two boats”; and in England, “playing off sides.” Second, how an affair is regarded differs by culture. In America, the script for discovering a partner’s affair involves confronting the partner and ending the marriage. In France, the script does not involve confronting the partner and does not assume that the affair means the end of the marriage; rather, “letting time pass to let a partner go through the experience without pressure or comment” is the norm. In America, presidential candidate John Edwards’s disclosure of his affair with an office worker ended his political career.

Motivations for Extradyadic Sexual Encounters

Individuals in pair bonded relationships report a number of reasons why they become involved in a sexual encounter outside their relationship. The top three identified reasons, in an Internet sample of spouses, included sexual needs, emotional needs, and falling in love—with no differences between women and men (Omarzu, Miller, Shultz, & Timmerman, 2012). Other reasons for an affair include the following:

1. Variety, novelty, and excitement Most spouses struggle with the transition of moving from a context where one has multiple sexual partners to having only one sexual partner. Most spouses enter marriage having had numerous sexual partners. Traditional marriage scripts fidelity. Indeed, traditional wedding vows state, “Hold myself only unto you as long as we both should live.”
Table 9-3 identifies the lifestyle alternatives for resolving the transition from multiple to one sexual partner at marriage.

<table>
<thead>
<tr>
<th>TABLE 9-3</th>
<th>Sexual Lifestyle Alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monogamy</strong></td>
<td><strong>Cheating</strong></td>
</tr>
<tr>
<td>Spouse is only sex partner.</td>
<td>Husband and/or wife cheats.</td>
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</table>

Extradyadic sexual involvement may be motivated by the desire for variety, novelty, and excitement. One of the characteristics of sex in long-term, committed relationships is the tendency for sex to become routine. Early in a relationship, the partners cannot seem to have sex often enough. However, with constant availability, partners may achieve a level of satiation; and the attractiveness and excitement of sex with the primary partner seem to wane.

The **Coolidge effect** is a term used to describe this waning of sexual excitement and the effect of novelty and variety on sexual arousal:

One day President and Mrs. Coolidge were visiting a government farm. Soon after their arrival, they were taken off on separate tours. When Mrs. Coolidge passed the chicken pens, she paused to ask the man in charge if the rooster copulated more than once each day. “Dozens of times,” was the reply. “Please tell that to the President,” Mrs. Coolidge requested. When the President passed the pens and was told about the rooster, he asked, “Same hen every time?” “Oh no, Mr. President, a different one each time.” The President nodded slowly and then said, “Tell that to Mrs. Coolidge.” (Bermant, 1976, pp. 76–77)

Whether or not individuals are biologically wired for monogamy continues to be debated. Monogamy among mammals is rare (from 3% to 10%), and monogamy tends to be the exception more often than the rule (Morell, 1998). Pornography use, which involves viewing a variety of individuals in sexual contexts, is associated with extramarital sex (Wright, 2013). Even if such biological wiring for plurality of partners does exist, it is equally debated whether such wiring justifies non-monogamous behavior—or whether individuals are responsible for their decisions.

2. **Workplace friendships**  A common place for extramarital involvements to develop is the workplace (Merrill & Knox, 2010). Neuman (2008) noted that 4 in 10 of the affairs that men reported began with a woman they met at work. Coworkers share the same world 8 to 10 hours a day and over a period of time may develop good feelings for each other that eventually lead to a sexual relationship. Tabloid reports regularly reflect that romances develop between married actors making a movie together (e.g., Brad Pitt and Angelina Jolie met on a movie set). Arnold Schwarzenegger’s housekeeper was “at work” when she had sex with him (which produced their child and prompted the end of Schwarzenegger’s marriage upon disclosure 10 years later).
3. **Relationship dissatisfaction**  It is commonly believed that people who have affairs are not happy in their marriage. Spouses who feel misunderstood, unloved, and ignored sometimes turn to another who offers understanding, love, and attention. Neuman (2008) confirmed that being emotionally dissatisfied in one’s relationship is the primary culprit behind an affair.

4. **Sexual dissatisfaction**  Some spouses engage in extramarital sex because their partner is not interested in sex. Others may go outside the relationship because their partners will not engage in the sexual behaviors they want and enjoy. The unwillingness of the spouse to engage in oral sex, anal intercourse, or a variety of sexual positions sometimes results in the other spouse’s looking elsewhere for a more cooperative and willing sexual partner.

5. **Revenge**  Some extramarital sexual involvements are acts of revenge against one’s spouse for having an affair. When partners find out that their mate has had, or is having an affair, they are often hurt and angry. One response to this hurt and anger is to have an affair to get even with the unfaithful partner.

6. **Homosexuality**  Some individuals marry as a front for their homosexuality. Cole Porter, known for such songs as “I’ve Got You Under My Skin,” “Night and Day,” and “Every Time We Say Goodbye,” was a homosexual who feared no one would buy his music if his sexual orientation were known. He married Linda Lee Porter (alleged to be a lesbian), and their marriage lasted until Porter’s death 30 years later.

   Other gay individuals marry as a way of denying their homosexuality. These individuals are likely to feel unfulfilled in their marriage and may seek involvement in an extramarital homosexual relationship. Other individuals may marry and then discover later in life that they desire a homosexual relationship. Such individuals may feel that (1) they have been homosexual or bisexual all along, (2) their sexual orientation has changed from heterosexual to homosexual or bisexual, (3) they are unsure of their sexual orientation and want to explore a homosexual relationship, or (4) they are predominantly heterosexual but wish to experience a homosexual relationship for variety. The term **down low** typically refers to African American married men who have sex with men and hide this behavior from their spouse.

7. **Aging**  A frequent motive for intercourse outside marriage is the desire to return to the feeling of youth. Ageism, which is discrimination against the elderly, promotes the idea that being young is good and being old is bad. Sexual attractiveness is equated with youth, and having an affair may confirm to older partners that they are still sexually desirable. Also, people may try to recapture the love, excitement, adventure, and romance associated with youth by having an affair.

8. **Absence from partner**  One factor that may predispose a spouse to an affair is prolonged separation from the partner. Some wives whose husbands are away for military service report that the loneliness can become unbearable. Some husbands who are away say that remaining faithful is difficult. Partners in commuter relationships may also be vulnerable to extradyadic sexual relationships.

9. **High androgen levels**  Men who have high levels of androgen (male hormone) have an increased likelihood of extrapartner involvement (Fisher, et al., 2012a).
An Affair?

An affair has both negative and positive consequences. An affair may end the marriage. Allen and Atkins (2012) surveyed 16,090 U.S. individuals and found that more than half of the men and women who had engaged in extramarital sex were also separated or divorced from their spouse. Traeen and Thuen (2013) identified reasons for divorce in a sample of 1,001 Norwegians. Of those age 50 or older, infidelity was the top reason. More men (44%) than women (33%) reported infidelity.

Even if the marriage does not end, there is the potential to contract a sexually transmitted infection (HPV being the most common). The HIV epidemic has increased the concern over this possibility. Spouses who engage in extradyadic sex may not only contract a sexually transmitted infection but may also transmit the infection to their partners (and potentially their unborn offspring). In some cases, an affair may prove deadly.

Finally, spouses who have an affair risk the possibility of their partner finding out and going into a jealous rage. Jealousy may result in violence and even the death of the unfaithful spouse or the lover involved. Another possible tragic outcome of extramarital relationships is that a spouse who “cheats” or has been “cheated on” becomes depressed and commits suicide.

Partners who decide to avoid an affair might focus on the small choices that lead to a sexual encounter. Because an affair occurs in an identifiable sequence of behaviors (e.g., eye contact, flirting, sex references, touching, etc.) and contexts (e.g., away from spouse, presence of alcohol/drugs, etc.), the person can choose to avoid them. Avoiding intimate conversations and drinking with someone to whom you are attracted helps ensure that a sexual encounter will not occur. Not to make these choices (“not to decide is to decide”) is to increase the chance that extradyadic sex will occur.

There are some potential positive outcomes from an affair. Some spouses who have had an affair do not regret doing so. One woman, known to the authors, said that while her husband constantly criticized her, the man with whom she had had the extramarital relationship “needed me and made me feel loved and important again.” This woman eventually divorced her husband and said that she never regretted moving from an emotionally dead and abusive relationship to one in which she was loved and nurtured. In this case, the extramarital affair served as a bridge out of the marriage.

For some spouses who have an affair and stay married, the marriage may benefit. Some partners become more sensitive to the problems in their marriage. “For us,” one spouse said, “the affair helped us to look at our marriage, to know that we were in trouble, and to seek help.” Couples need not view the discovery of an affair as the end of their marriage; to the contrary, it can be a new beginning.

One husband said his wife had an affair because he was too busy with his work and did not spend enough time with her. Her affair taught him that she had alternatives—other men who would love her emotionally and sexually. To ensure that he did not lose his wife, he cut back on his work hours and spent more time with her.
Take a moment to answer the following question. The spouse who chooses to have an affair is often judged as being unfaithful to the vows of the marriage, as being deceitful to the partner, and as inflicting enormous pain on the partner (and children). What is often not considered is that when an affair is defined in terms of giving emotional energy, time, and economic resources to something or someone outside the primary relationship, other types of “affairs” may be equally devastating to one’s partner and relationship. Spouses who choose to devote their lives to their careers, parents, friends, or recreational interests may deprive the partner of significant amounts of emotional energy, time, money, and create a context in which the partner may choose to become involved with a person who provides more attention and interest. What relationships are you aware of in which a spouse felt neglected by the partner who was excessively focused on someone or something external to the marriage?

9.4 Sexuality in the Middle and Later Years

Middle age is commonly thought to occur between the ages of 40 and 60. Family life specialists define middle age as beginning when the last child leaves home and continuing until retirement or the death of either spouse. Middle age is a time of transition for women, men, and their sexuality. In general, beginning at age 50, there appears to be a gradual continuous decline in sexual interest and activity. The decline in sexual interest may also be due to the physiology of aging or age-related disease processes. A major change in the sexuality of women is the experience of going through menopause. For men, sexual changes are associated with a decrease in testosterone.

9.4a Women, Menopause and Hormone Replacement Therapy

Menopause is a primary physical event for middle-aged women. Defined as the permanent cessation of menstruation, menopause is caused by the gradual decline of estrogen produced by the ovaries. It occurs around age 50 for most women but may begin much earlier or later. Signs that the woman may be nearing menopause include decreased menstrual flow and a less predictable cycle. After 12 months with no period, the woman is said to be through menopause. However, a woman who is sexually involved with a man and does not want to risk a pregnancy should use some form of contraception until her periods have stopped for 2 years because she may not know until the second year whether periods have really ceased.

Although the term climacteric is often used synonymously with menopause, it refers to changes that both men and women experience. The term menopause refers only to the time when the menstrual flow permanently stops, whereas climacteric refers to the whole process of hormonal change induced by the ovaries or testes, pituitary gland, and hypothalamus. Reactions to such hormonal changes may include hot flashes, in which the woman feels a sudden rush of heat from the waist up. Hot flashes are often accompanied by an increased reddening of the skin surface and a drenching perspiration. Other symptoms may include heart palpitations, dizziness, irritability, headaches, backache, and weight gain.

For most women, the symptoms associated with decreasing levels of estrogen will stop within 1 year of their final period. Some women find estrogen replacement therapy (ERT) or hormone replacement therapy (HRT)—estrogen plus progestin—helpful to
control hot flashes, night sweats, and vaginal dryness. The use of hormone replacement therapy continues to be debated and researched. Davies and colleagues (2013) reported the collective thinking of the Society for Women’s Health research roundtable of 18 of the foremost experts within the field who discussed the collective evidence related to the risks and benefits of hormone therapy. Regarding the quality of life, the panel noted that HRT initiated in midlife women (around age 50) would significantly increase one’s quality of life. However, HRT started in later years would not significantly improve one’s quality of life or life expectancy. Details of the recommendations of the experts are provided in Table 9-4. Any woman considering using either estrogen or HRT for treatment of menopausal symptoms is encouraged to review her individual health history and medical goals with her health-care provider.

**Take a moment to answer the following questions.** How is the sexuality of aging women and men affected by cultural stereotypes and expectations? How might a generation of today’s young women, who have grown up in a sexually open and permissive era, differ when they become elderly (in terms of their sexuality) from elderly women of today who were reared in a more conservative, restrictive era?

### 9.4b Men and Testosterone Replacement Therapy

Some researchers suggest that men go through their own menopause because there is also a drop in sex hormones similar to that in women. However, the drop in testosterone is highly variable. In some men, the level can drop so low that men may experience depression, anxiety, hot flashes, decreased libido, difficulty achieving/maintaining an erection, and diminished memory. Yet other men experience no profound drop, and those who do may or may not respond to hormonal intervention.

Indeed, the changes most men experience as they age occur over a long period of time, and the depression and anxiety seem to be as much related to their life situation (for example, lack of career success) as to hormonal alterations. A middle-aged man who is not successful in his career is often forced to recognize that he will never achieve what he had hoped but instead will carry his unfulfilled dreams to the grave. This knowledge may be coupled with his awareness of diminishing sexual vigor. For the man who has been taught that masculinity is measured by career success and sexual prowess, middle age may be particularly difficult.

Nevertheless, “low testosterone level” and “testosterone replacement therapy” are frequent television advertisement phrases reflecting the $5 billion market promising renewed sexual energy, renewed mental clarity, an upbeat mood and erections. Testosterone is available in gels, patches or injections. The most reliable change is an improved libido for 80% of men.

There is disagreement among physicians, however, in regard to the risk of heart disease and prostate cancer. Most physicians agree that “testosterone does not instigate prostate cancer,” but they do not give testosterone to men who have prostate cancer. The range of testosterone levels is from 250 to 890. The FDA defines low testosterone level at 300, but some physicians will treat men with higher levels. The best advice to men considering testosterone replacement is to “consult with a physician who works with testosterone issues on a regular basis and ask a lot of questions” (Harvard Health Letter, 2013).
### TABLE 9.4 Consensus Clinical Statements on Hormone Replacement Therapy

<table>
<thead>
<tr>
<th>Clinical Recommendation</th>
<th>Vote</th>
<th>Difference from the USPTF recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall health benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. The benefit-risk profile of HT is more favorable for younger, newly menopausal, women.</td>
<td>Unanimous</td>
<td>The SWHR roundtable recommendation provides guidance on duration that is acceptable based on literature. USPTF did not address HT for symptom management.</td>
</tr>
<tr>
<td>2. In younger, symptomatic postmenopausal women, the benefits of E+P for at least 5 years outweigh the risks.</td>
<td>2 abstain</td>
<td>The SWHR Roundtable recommendation provides guidance on duration that is acceptable based on literature.</td>
</tr>
<tr>
<td>3. In younger, postmenopausal women with hysterectomy, the benefits of unopposed estrogen treatment for at least 10 years outweigh the risks.</td>
<td>Unanimous</td>
<td>The SWHR Roundtable recommendation provides risk information for younger individuals.</td>
</tr>
<tr>
<td>4. Patients with premature ovarian insufficiency benefit from hormone therapy and should be treated until at least the age of menopause, based on expert opinions and available observational data.</td>
<td>Unanimous</td>
<td>The SWHR Roundtable recommendation applies to women less than 50 years old.</td>
</tr>
<tr>
<td>5. There is consistent evidence that in early postmenopausal women, hormone therapy reduces total mortality.</td>
<td>5 opposed</td>
<td>The SWHR Roundtable recommendation provides guidance on total mortality and age difference with respect to the effects of HT initiation and effect.</td>
</tr>
<tr>
<td><strong>Quality of life</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Hormone therapy is the most effective treatment for vasomotor symptoms.</td>
<td>Unanimous</td>
<td></td>
</tr>
<tr>
<td>7. Hormone therapy provides a significant benefit on MS-QOL (HRQOL) in early postmenopausal women, mainly through the relief of symptoms, but treatment also may result in a global increase in sense of wellbeing (GQOL).</td>
<td>Unanimous</td>
<td>The SWHR Roundtable recommendation shows improvement in QOL for younger women.</td>
</tr>
<tr>
<td><strong>Osteoporosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Estrogen can be used for the prevention of osteoporosis (an FDA approved indication) in early postmenopausal women at increased risk of fracture. The optimal duration for treatment is not known. However, if HT is discontinued the benefits dissipate. Therefore, in patients at high risk for osteoporotic fractures, continued estrogen treatment or other alternative treatments should be considered.</td>
<td>2 abstain</td>
<td>The SWHR Roundtable recommendation advocates for the use of HT for the prevention of a chronic disease, osteoporosis.</td>
</tr>
<tr>
<td><strong>Breast cancer</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Available evidence suggests that unopposed estrogen appears not to increase the risk of breast cancer and may possibly reduce the risk in postmenopausal women with hysterectomy.</td>
<td>Unanimous</td>
<td></td>
</tr>
<tr>
<td><strong>Dementia</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. There is insufficient evidence to recommend hormone therapy after menopause for the prevention of dementia or enhancement of cognition.</td>
<td>Unanimous</td>
<td></td>
</tr>
<tr>
<td><strong>Vascular disease</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. HT in early postmenopausal women does not increase the risk for CHD, and may reduce it. However, there is insufficient evidence for the use of HT in the primary prevention of CHD.</td>
<td>1 opposed</td>
<td>The SWHR Roundtable recommendation provides guidance concerning CHD in younger women.</td>
</tr>
<tr>
<td>12. Hormone therapy should not be used for the secondary prevention of CHD or stroke.</td>
<td>3 abstain</td>
<td></td>
</tr>
<tr>
<td>13. HT in early postmenopausal women may slightly increase the risk of stroke although the absolute increase in risk, if present, is very small.</td>
<td>3 opposed</td>
<td></td>
</tr>
</tbody>
</table>

*Roundtable participants were asked to draw up consensus statements, based on the best evidence available, which includes both observational and clinical trial data. Unanimous agreement was reached on several topic areas, however, where necessary, the dissenting opinions are presented as well. Most of the consensus statements are based on studies of estrogen (conjugated equine estrogen) alone or with medroxyprogesterone acetate as continuous combined therapy. Each of the consensus statements is based on available data concerning the relationship between HT and a particular chronic condition. More research is necessary in each area. When considering the use of the following, a benefit-risk evaluation should be performed to include the entirety of a woman’s health history.

1. All present agreed that HT does not pose a risk on total mortality. However, 10 members wanted the stronger wording that HT “reduces” total mortality, while 5 members wanted to state that HT “may reduce” total mortality.
2. The opposing vote supported a stronger statement and did not want the inclusion of “insufficient” in this statement.

3. The three opposing votes wanted a stronger statement that the risk, if present, is “rare” as opposed to “very small.” 

9.4c Sexuality in the Later Years

There are numerous changes in the sexuality of women and men as they age (Vickers, 2010). Frequency of intercourse drops from about once a week for those 40 to 59 to once every 6 weeks for those 70 and older. Changes in men include a decrease in the size of the penis from an average of 5 to about 4 ½ inches. Elderly men also become more easily aroused by touch rather than visual stimulation, which was arousing when they were younger. Erections take longer to achieve, are less rigid, and it takes longer for the man to recover so that he can have another erection. "It now takes me all night to do what I used to do all night" is the motto of the aging male.

Levitra, Cialis, and Viagra (prescription drugs that help a man obtain and maintain an erection) are helpful for about 50% of men in their late 60s. Others with erectile dysfunction may benefit from a pump that inflates two small banana-shaped tubes that have been surgically implanted into the penis. Still others benefit from devices placed over the penis to trap blood so as to create an erection.

Women also experience changes including menopause, which is associated with a surge of sexual libido, an interest in initiating sex with her partner, and greater orgasmic capacity. Not only are they free from worry about getting pregnant, estrogen levels drop and testosterone levels increase. Her vaginal walls become thinner and less lubricating. (Lubricants like KY Jelly can resolve the latter issue.)

Chao and colleagues (2011) studied the sexuality of 283 individuals ages 45 to over 75. While sexual intercourse decreased as the respondent aged (to once a month), the respondents rated themselves more interested in sex than others their age. The National Institute on Aging surveyed 3,005 men and women ages 57 to 85 and found that sexual activity decreases with age (Lindau, et al., 2007). Almost three-fourths (73%) of those 57 to 64 reported being sexually active in the last 12 months. This percentage declined to about half (53%) for those 65 to 74 and to about a fourth (26%) for those ages 75 to 80. An easy way to remember these percentages is three-fourths of those around 60, half of those about 70, and a fourth of those around 80 report being sexually active.

As noted above, the most sexually active individuals are in good health. Diabetes and hypertension are major causes of sexual dysfunction. Incontinence (leaking of urine) is particularly an issue for older women and can be a source of embarrassment. The most frequent sexual problem for men is erectile dysfunction; for women, the most frequent sexual problem is the lack of a partner.

Some spouses are sexually inactive. Karraker and DeLamater (2013) analyzed data on 1,502 men and women ages 57 to 85 and found that 29% reported no sexual activity for the past 12 months or more. The longer the couple had been married, the older the spouse, and the more compromised the health of the spouse, the more likely the individual was to report no sexual activity. Syme and colleagues (2013) studied a sample of older adults ages 63–67 to identify conditions under which respondents were not satisfied with their sexual relationship. Having a spouse in poor health, a history of diabetes, and feeling fatigued were the primary culprits. In contrast, those who were satisfied with their sexual relationship were male, reported positive marital support, and had a spouse in good health.
Chapter Summary

Sexuality in Infancy and Childhood
Sexuality begins early. In the uterus, boys often have penile erections and girls have clitoral erections and vaginal lubrication. Masturbation has been observed in both boys and girls as infants. Parents might be mindful of not reacting negatively to their infant’s self-pleasuring. The sexual behaviors of children can be categorized into various areas including exhibitionism, self-stimulation, and voyeuristic behavior.

Parents are reluctant to talk with their children about sex. Not only do they feel inadequate in terms of their own knowledge (their parents taught them nothing), they fear that sexual discussions will spark experimentation and destroy their child’s innocence/nonsexual state. Regarding family nudity, children who grow up in this context tend to feel very positive about their bodies/sexuality.

Sexuality in Adolescence
Adolescence is defined as the developmental period between puberty and adulthood. It is a time when the individual transforms his or her image as a child into a young adult with a future adult life. Adolescence involves identity exploration, interacting with romantic partners, and school performance with a career objective in mind. The most noticeable changes in adolescence are the physical and anatomical changes. Psychological changes include moving from a state of childish dependence to a state of relative independence, resolving sexual identity issues, and feeling secure that one is normal.

Over half of adolescent males and a quarter of adolescent females have had their first intercourse by age 14. Early sexual debut is typically associated with high-risk sexual behavior including alcohol/drug use, no condom use, getting pregnant (or causing pregnancy) and violence. The first sexual experience is usually one of anxiety. About 15% of teens would be “okay” with getting pregnant.

Sexuality in Adulthood
While most individuals eventually marry, singlehood is a time of sexual freedom. About 60% of U.S. adults will live together. In general, cohabitants have permissive sexual attitudes and behavior. They are not as emotionally or sexually happy as spouses.

About 25% of husbands and 20% of wives report having had sexual intercourse outside the marriage. Reasons include the desire for variety, sexual unhappiness in the marriage, and drifting into a sexual relationship with a coworker. While an affair may strengthen a relationship, divorce or separation is the more frequent outcome.

Sexuality in the Middle and Later Years
Physiological and psychological changes occur among women and men in the middle/later years. Women experience the end of their periods; men experience the loss of testosterone. Hormone replacement therapy and testosterone therapy are indicated. However, the decision to use hormone/testosterone therapy is complex and should be undertaken with the advice of a specialist in elder sexuality.
Web Links

Talk about Sex

Un/Hushed (Talking with Adolescents about Sex)
http://www.unhushed.net/

Sex and the Elderly

Key Terms

Adolescence 234
Childhood 230
Climacteric 252
Cohabitation 244
Coolidge effect 249
Down low 250
Extradyadic sexual involvement 248
Extramarital affair 246

Infancy 230
Menopause 252
Middle age 252
Plan B 239
Puberty 234
Satiation 245
Semenarche 235
Sexting 235
Sexual debut 233

Additional study resources are available at www.BVTLab.com