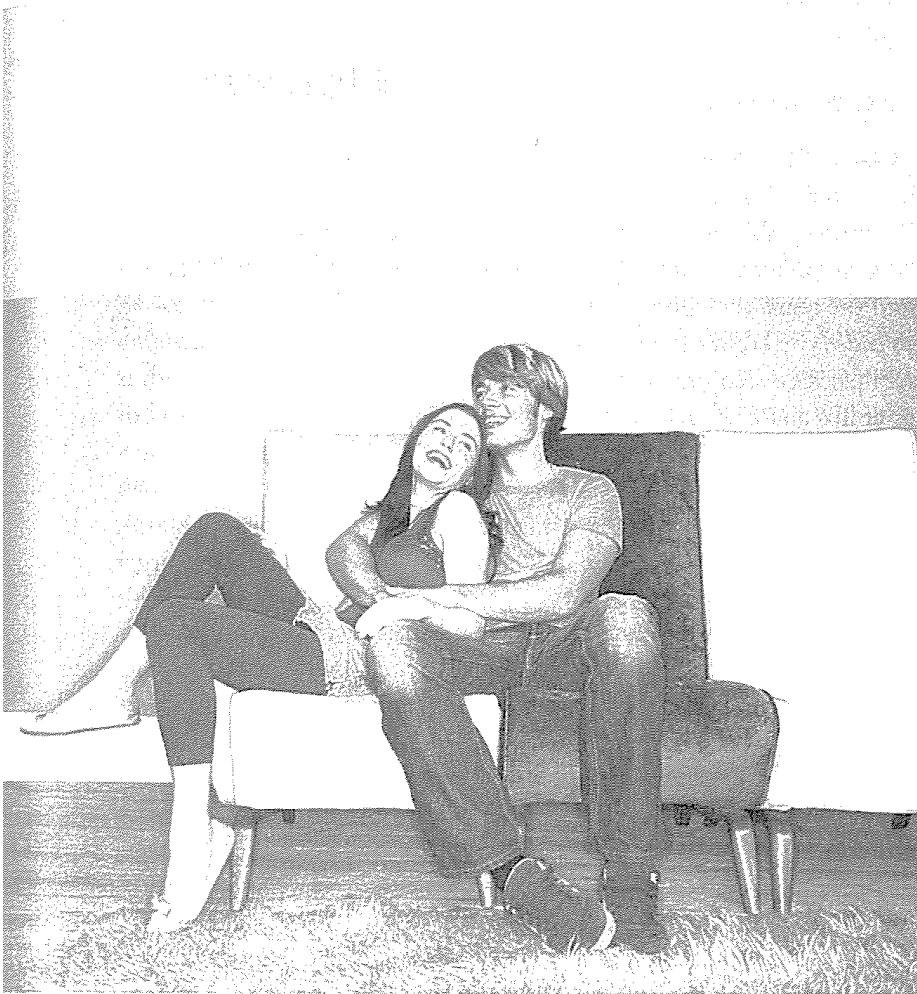


CHAPTER 6



I don't want to be forced to take care of a child that I'm not ready for or get an STD . . . As for sex, it'll happen someday, but just not today. (a 17-year-old female high school senior; in Villarosa, 2003, p. D6)

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. (a 65-year-old woman; in Doress-Worters & Siegal, 1994, p. 85)

Did these opening vignettes surprise you? Both of them run counter to the popular stereotypes of the hormonally driven, sexually active teenager on the one hand and the sexually disinterested older woman on the other. In this chapter, we explore the fascinating diversity of women's sexuality throughout the lifespan, including sexual attitudes, behaviors, problems, and orientations.

Sexuality

- Sexual Anatomy and Sexual Response
- Sexual Attitudes
- Sexual Behaviors
- Sexual Problems

Lesbians, Gay Men, Bisexuals, and Transgender Individuals

- Bisexuals
- Attitudes Toward Sexual Minorities
- Explanations of Sexual Orientation

Sexual Activity During Adolescence

- Frequency of Sexual Activity
- Factors Associated with Sexual Activity
- The Double Standard
- Sexual Desire

Sexual Activity in Midlife

- Physical Changes
- Patterns of Sexual Activity

Sexual Activity in Later Life

- Benefits of Sexual Activity in Later Life
- Sexual Behavior of Older People
- Factors Affecting Sexual Behavior
- Enhancing Sexuality in Later Life

SEXUALITY

We start with a discussion of women's sexual anatomy and sexual response. Then we look at sexual attitudes, behaviors, and problems.

Sexual Anatomy and Sexual Response

EXTERNAL FEMALE SEXUAL ANATOMY. The *external female sexual organs*, collectively called the **vulva**, are shown in Figure 6.1. Women can get a clear view of their own vulva by squatting and looking into a hand mirror. The **mons pubis** (also *mons veneris*, mountain of Venus) is a *pad of fatty tissue covering the pubic bone*. During puberty, it becomes covered with coarse hair. The hair continues between the legs and around the anus, the opening of the large intestine. The *fatty hair-covered area between the legs forms flaps called the labia majora* (outer lips). They surround *soft hairless flaps of skin, the labia minora* (inner lips). Between the inner lips and the anus lies the perineum (Rathus et al., 2010). Spreading the inner lips apart reveals that they join at the upper end to form a fold of skin, or *hood over the clitoris*. *This highly sensitive organ, whose only known function is sexual pleasure, consists of erectile tissue that swells during sexual stimulation* (somewhat like the penis). Although smaller than the penis, the clitoris has more than twice as many nerve fibers (Schulman, 2003). Right below the clitoris is the urethral opening, through which urine passes. Below that is the larger vaginal opening. The **vagina** is *the canal leading to the uterus*. The menstrual blood passes through it and it is the birth canal during childbirth (Rathus et al., 2010).

THE SEXUAL RESPONSE CYCLE. Women and men respond similarly during the four phases of the **sexual response cycle**, *the physiological responses of individuals to sexual stimulation from any source* (sexual intercourse, masturbation, etc.) (Donatelle, 2012). Here we discuss women's responses.

In the *excitement phase*, a major response is **vasocongestion**, *the swelling of genital tissues with blood*. Vasocongestion produces vaginal lubrication shortly after stimulation. The clitoris and labia swell with blood. The inner two-thirds of the vagina expand, the uterus elevates, the breasts enlarge, the nipples become erect, and the skin becomes flushed. Heart rate, breathing rate, and muscle tension increase.

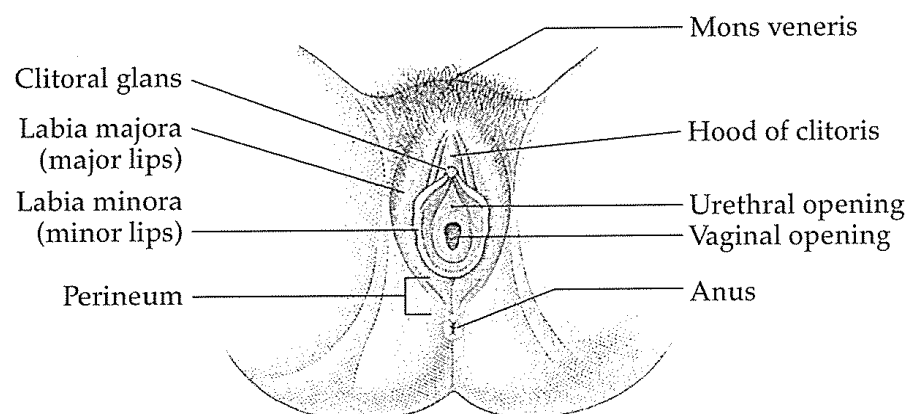


FIGURE 6.1 Female External Sex Organs

Source: Rathus, Spencer A., Nevid, Jeffrey S., and Fichner-Rathus, Lois, *Human Sexuality in a World of Diversity*, 8th edition, © 2010. Reprinted by permission of Pearson Education, Inc., Upper Saddle River, NJ.

During the *plateau phase*, the clitoris, now extremely sensitive, shortens and withdraws under the clitoral hood. *The low third of the vagina becomes engorged with blood, forming the orgasmic platform.* Heart rate, blood pressure, and breathing rate continue to rise.

In the *orgasmic phase*, the orgasmic platform, uterus, and anal sphincters contract strongly several times, at intervals of less than a second. These contractions constitute the orgasm.

During the *resolution phase*, the *body returns to its pre-arousal state* within 15 to 30 minutes. Blood is released from engorged areas; the clitoris, vagina, uterus, and labia return to normal size; and muscle tension dissipates. Heart rate and breathing rate return to pre-arousal levels.

MULTIPLE ORGASMS. Alfred Kinsey and his colleagues (Kinsey et al., 1953) reported that 14 percent of the women they interviewed experienced multiple orgasms. Although a few studies have reported higher percentages, most report figures of about 5 percent, more in line with Kinsey's research ("Women Can Have," 2007). Unlike women, few men are physiologically capable of multiple orgasms. This is one of the major gender differences in sexual response, the other being that men but not women ejaculate during orgasm. Although having multiple orgasms can be a good thing, some women now feel that they are sexually inadequate if they don't. One orgasm can be quite satisfying, as can sex that does not culminate in orgasm.

ONE OR TWO KINDS OF ORGASM? Freud (1938) proposed that there were two types of female orgasm: clitoral and vaginal. Clitoral orgasms were achieved through clitoral stimulation during masturbation. This form of orgasm, practiced by young girls, was considered immature and sexually inadequate in adult women. Women were expected to shift to vaginal orgasms, brought on by sexual intercourse. Research, however, has demonstrated that there is only one kind of orgasm, physiologically, whether it is brought on by clitoral or vaginal stimulation. Furthermore, the clitoris is indirectly stimulated even in vaginal intercourse. Although orgasms resulting from clitoral and vaginal stimulation are physiologically the same, there may be psychological or subjective differences (Rathus et al., 2010). For example, the context of sexual intercourse includes a partner to whom one may be emotionally attached, whereas masturbation is often (but not always) done without the presence of a partner. Sexual pleasure is also possible without orgasm. Expressing sexual feelings for another person involves a number of pleasurable activities, of which intercourse and orgasm may be only a part (Donatelle, 2012).

Sexual Attitudes

THE SEXUAL DOUBLE STANDARD. Historically, women's sexuality was discouraged and denied, especially outside of marriage. The social construction of norms about female and male sexuality is nowhere seen more clearly than in this **sexual double standard**, *which allowed and even encouraged premarital sex for men, but not for women.* As premarital sex became more acceptable, the double standard has evolved into a belief that casual sexual activity is acceptable for men, but that women's sexual experiences should occur only in the context of a serious relationship (Diamond & Savin-Williams, 2009). As examples of the double standard, young women are judged more negatively than young men when they provide a condom for protection (Fassinger & Arseneau, 2008) or when they have a sexually transmitted infection (Smith et al., 2008).

GENDER DIFFERENCES IN ATTITUDES. Women generally have less permissive attitudes toward sexual behavior than men (Fisher, 2010; Petersen & Hyde, 2010). In a recent meta-analysis of research in several countries on sexual attitudes and behavior, Jennifer Petersen and Janet Hyde (2010) found

that women reported more negative attitudes than men about casual sex. Women were somewhat more likely to feel anxious or guilty about sex and to emphasize relationships as a context for sex, and were less likely to endorse the double standard. No gender differences were found in attitudes toward masturbation, extramarital sex, and premarital sex when couples are committed or engaged. In general, gender differences in attitudes toward sexual behavior overall narrowed as people got older. These differences also diminished from the 1970s into the twenty-first century (Petersen & Hyde, 2010). A recent survey of Americans aged 45 and older found that although women continued to hold less permissive attitudes toward sex than men, attitudes of both groups have become more permissive. For example, women were still more likely than men to say that nonmarital sex is wrong (28 vs. 17 percent), but this opposition was down by half compared to 10 years ago (Fisher, 2010). Other studies show that men from countries around the world are more likely than women to rate sex as important and to report greater physical and emotional pleasure from it (Angier, 2007; Fisher, 2010).

ATTITUDES TOWARD WOMEN WITH DISABILITIES. Girls and young women with disabilities may face particular challenges in developing a healthy sexuality (Donatelle, 2012; Maxwell et al., 2007). A common assumption is that women with disabilities are asexual beings who have no sex life and who are unsuitable as romantic partners (Banks, 2010; Chrisler & Garnett, 2010; Groh & Serowsky, 2009; Nosek, 2010). Many women with disabilities have spoken out about the unavailability of adequate counseling on sexuality, birth control, pregnancy, and childbirth. Women with disabilities engage in less sexual activity and are less satisfied with their sex lives than able-bodied women (Groh & Serowsky, 2009; Nosek, 2010). Whereas able-bodied women often resent being treated as sex objects, some women with disabilities resent being treated as asexual objects (Nosek, 2010). The view of women with disabilities as asexual is based on misconceptions about their sexual desires and abilities. Most individuals with disabilities have the same sexual desires as able-bodied persons. Their ability to perform sexually depends on their adjustment to the physical limitations of their disability and the availability of a helpful partner (Nosek, 2010; Rathus et al., 2010).

Sexual Behaviors

The recent National Survey of Sexual Health and Behavior (NSSHB), the most comprehensive study of sexuality in the United States, surveyed a representative sample of nearly 5,900 individuals from ages 14 to 94. The researchers found that both women and men engaged in diverse solo and partnered sexual activities. Masturbation, oral sex, and vaginal intercourse were prevalent in both sexes. The proportion of women and men engaging in these behaviors peaked in the 20s and decreased with age. Being in good health and having a partner were related to higher levels of sexual activity for both sexes (Herbenick et al., 2010a,b; Reece et al., 2010).

GENDER DIFFERENCES. A number of gender differences in sexual activity were reported both in the NSSHB and in the recent meta-analysis by Petersen and Hyde (2010). Men, compared to women, had a higher incidence of intercourse and oral sex, more frequent intercourse, a greater number of partners, first intercourse at a younger age, and more extramarital sex. Women appear to be narrowing the adultery gap in recent years, however, with younger women being unfaithful to their spouses nearly as often as men (Parker-Pope, 2010).

Letitia Anne Peplau (2002) sums up these differences as indicating that men are more interested in sex than are women. She also contends that assertiveness and dominance are more closely linked to male sexuality than to female sexuality. For example, she notes that men tend to initiate

sex in heterosexual relationships and that men are more likely than women to use intimidation or physical force to get an unwilling partner to engage in sex (see Chapter 14). Another gender difference proposed by Peplau (2002) and by Lisa Diamond (2007) is that women have greater sexual plasticity, that is, their sexual beliefs and behaviors are more capable of being shaped and changed by cultural, social, and situational factors. For example, women are more likely than men to engage in sexual behavior that runs counter to their established pattern of sexual desire, that is, heterosexual women having sex with women and lesbians engaging in sex with men (Diamond, 2003b). Women's sexual attitudes and behaviors also seem to be affected more by their education level and by the views of their culture than are men's attitudes and behaviors (Fassinger & Arseneau, 2008; Peplau, 2002).

Although gender differences in sexuality are well documented, one must also keep in mind that there are tremendous variations in sexual expression among women of different ages, marital statuses, educational levels, religions, and races/ethnicities. Women who are younger, White, and well educated, and who have no religious affiliation have more varied sexual practices than other women. For example, they are more likely to have experienced oral and anal sex and to find these acts appealing (Laumann & Mahay, 2002).

Two limitations of research on sexual attitudes and behaviors must be kept in mind. One is the problem of volunteer bias. Many people refuse to participate in surveys of their sexual views and practices. Thus, samples are biased because they include the responses only of those individuals who are willing to discuss their intimate behavior. Such individuals tend to be more sexually permissive and to have more liberal attitudes toward sexuality than nonvolunteers. Therefore, survey results based on volunteer samples may not be representative of the population at large (Rathus et al., 2010).

A second problem is that all the results are based on self-reports, not on direct observations of behavior. It is possible that there are gender differences in reporting behaviors, but few, if any, differences in actual sexual behaviors or attitudes. Women may underreport their sexual experiences and men may exaggerate theirs (Jonason & Fisher, 2009). As a result of these two problems, one must take findings regarding gender differences in sexuality with a grain of salt.

Sexual Problems

What constitutes a sexual problem or dysfunction for women? How frequently do such problems occur? These issues are currently topics of vigorous debate among researchers. Some scholars have defined anything interfering with orgasm as a sexual problem. Others, however, argue that emphasizing orgasm reflects the male perspective that sex ends with ejaculation, whereas for many women, orgasm is not the goal or the most important part of sexual activity (Fassinger & Arseneau, 2008; Tolman et al., 2003). In this section, we examine changing views of women's sexual problems.

Researchers who study sexual problems have typically employed the widely used system for classifying sexual dysfunction from the *Diagnostic and Statistical Manual of Mental Disorders IV* (DSM-IV) of the American Psychiatric Association (1994). Four categories are recognized: sexual desire disorders, sexual arousal disorders, orgasmic disorders, and sexual pain disorders. Feminist scholars have criticized this categorization, as we shall see shortly, because it is overly genital and neglects issues of relationships and social context (Tiefer, 2008).

Large-scale studies have used the DSM-IV categories to examine sexual problems in U.S. adults ages 18–85 (Laumann et al., 1999, 2008). These studies have found that the most frequently reported sexual problem among women is *a lack of desire for sexual activity*, or **inhibited sexual desire**. About 25 percent of younger women and up to 40 percent of older women report having this

problem. (Persons who have little interest in sex, but are not concerned by it, are not considered to have the disorder.) About one in seven younger women and over one in three older women report **sexual arousal disorder**, which involves *insufficient lubrication or a failure to be aroused*. Nearly one in four younger women and one in three older women report **female orgasmic disorder**, defined as *experiencing the excitement phase of the sexual response cycle but not achieving orgasm*. (If a woman is satisfied with this situation, she is not considered to have an orgasmic disorder.) About 7 percent of younger women and 18 percent of older women report **dyspareunia**, or *painful intercourse*. Often a physical condition, such as a sexually transmitted infection (STI), lack of lubrication, or a structural problem, is involved. Psychological factors such as anxiety about sex or prior sexual trauma may also be responsible (Rathus et al., 2010). Another sexual pain disorder documented by Laumann and his colleagues is **vaginismus**, the *involuntary contraction of vaginal muscles*, making intercourse painful or impossible. Vaginismus is often caused by factors such as childhood sexual abuse, rape, a family upbringing that included negative attitudes toward sex, and a history of painful intercourse (Rathus et al., 2010).

Laumann and his colleagues (2008) also found that factors such as age, marital status, ethnicity, education, and economic status were related to the incidence of sexual dysfunction. For women, the prevalence of sexual problems declined until about age 60 and then leveled off, except for those who reported trouble lubricating. Men, on the other hand, had more problems with age, particularly erectile dysfunction and inability to achieve orgasm. Single, divorced, separated, and widowed individuals showed an elevated risk of sexual problems. Ethnicity also was associated with sexual problems. For example, among younger women, White women were more likely to report sexual pain, whereas Black women more often experienced low levels of desire and pleasure. Latinas, on the other hand, reported lower rates of sexual problems than other women.

Women and men with less education and lower income reported more sexual problems than more highly educated and affluent individuals. What might account for this social class difference in sexual problems? Poorer physical and mental health in individuals of lower social status may be a factor because diminished health is related to problems with sex (Laumann et al., 2008). Underlying physical conditions that can cause sexual dysfunction include diabetes, heart disease, neurological disorders, side effects of medications, alcoholism, drug abuse, and heavy smoking. Psychological causes of sexual problems include stress or anxiety from work, concern about poor sexual performance, marital discord, or depression. Some of these problems are all too common in the lives of poor women and men (Heiman, 2008). Unfortunately, the sociocultural predictors of sexual problems studied by Laumann and his associates have often been given little attention in the popular and professional media. Instead, media focus on the high incidence of physiological problems, and the need for drug companies to develop medical treatments, such as female Viagra, to treat women's sexual "illnesses" (IsHak et al., 2010; Moynihan & Mintzes, 2010; Singer, 2010).

A NEW VIEW OF WOMEN'S SEXUAL PROBLEMS. Recently, however, a group of therapists and sex researchers has developed a new view of women's sexual problems that focuses on the socio-cultural, political, psychological, social, and relational bases of women's sexual problems (Groh & Serowsky, 2009; Tiefer, 2008). These researchers define sexual problems as discontent or dissatisfaction with any emotional, physical, or relational aspect of sexual experiences that may arise in one or more of four interrelated aspects of women's sexual lives (see Table 6.1). This view focuses on the *prevention* of women's sexual problems through tackling the economic, political, and socio-cultural root causes of the problems, and not on medical treatment alone (Castañeda & Ulibarri, 2010; Tiefer, 2008).

TABLE 6.1 Women's Sexual Problems: A New Classification

Sexual problems, defined as discontent or dissatisfaction with any emotional, physical, or relational aspect of sexual experience, may arise in one or more of the following four interrelated aspects of women's sexual lives.

I. Sexual Problems Due to Sociocultural, Political, or Economic Factors

- A. Ignorance or anxiety due to inadequate sex education, lack of access to health services, or other social constraints:
 - 1. Lack of vocabulary to describe physical or subjective experience.
 - 2. Lack of information about sexual biology and life-stage changes.
 - 3. Lack of information about how gender roles influence men's and women's sexual expectations, beliefs, and behaviors.
 - 4. Inadequate access to information about and services that could provide contraception and abortion, STI prevention and treatment, and counseling for sexual trauma and domestic violence.
- B. Sexual avoidance or distress due to perceived inability to meet cultural norms regarding correct or ideal sexuality, including:
 - 1. Anxiety or shame about one's body, sexual attractiveness, or sexual responses.
 - 2. Confusion or shame about one's sexual orientation or identity, or about sexual fantasies and desires.
- C. Inhibitions due to conflict between the sexual norms of one's subculture or culture of origin and those of the dominant culture.
- D. Lack of interest, fatigue, or lack of time due to family and work obligations.

II. Sexual Problems Relating to Partner and Relationship

- A. Inhibition, avoidance, or distress arising from betrayal, dislike, or fear of partner; partner's abuse or couple's unequal power; or partner's negative patterns of communication.
- B. Discrepancies in desire for sexual activity or in preferences for various sexual activities.
- C. Ignorance or inhibition about communicating preferences or initiating, pacing, or shaping sexual activities.
- D. Loss of sexual interest and reciprocity as a result of conflicts over commonplace issues such as money, schedules, or relatives, or resulting from traumatic experiences, such as infertility or the death of a child.
- E. Inhibitions in arousal or spontaneity due to partner's health status or sexual problems.

III. Sexual Problems Due to Psychological Factors

- A. Sexual aversion, mistrust, or inhibition of sexual pleasure due to:
 - 1. Past experiences of physical, sexual, or emotional abuse.
 - 2. General personality problems with attachment, rejection, cooperation, or entitlement.
 - 3. Depression or anxiety.
- B. Sexual inhibition due to fear of sexual acts or of their possible consequences, such as pain during intercourse, pregnancy, STI, loss of partner, or loss of reputation.

IV. Sexual Problems Due to Medical Factors

- A. Pain or lack of physical response during sexual activity despite a supportive and safe interpersonal situation, adequate sexual knowledge, and positive sexual attitudes. Such problems can arise from:
 - 1. Numerous local or systemic medical conditions affecting neurological, neurovascular, circulatory, endocrine, or other systems of the body.
 - 2. Pregnancy, STIs, or other sex-related conditions.
 - 3. Side effects of many drugs, medications, or medical treatments.
 - 4. A medical treatment or diagnostic procedure, such as a hysterectomy or other necessary procedure.

Source: From the Manifesto of the New View Campaign. Copyright © 2000 Leonore Tiefer. Reprinted by permission of the author. www.newviewcampaign.org/manifesto5.asp.

LESBIANS, GAY MEN, BISEXUALS, AND TRANSGENDER INDIVIDUALS

Before reading this section, try the exercise in Get Involved 6.1. Compare your findings with the information that follows.

Sexual orientation consists of three components: sexual/romantic attraction, sexual behavior, and sexual identity (Jordan-Young, 2010). In the past, women's sexual orientation was divided into two categories: lesbian and heterosexual. Later, the bisexual category was added. Recently, a "mostly straight" identity has been proposed to describe women who fall between homosexuality and heterosexuality (Thompson & Morgan, 2008). A **lesbian** is a woman who is *emotionally and sexually attracted to other women*, a **gay man** is *attracted to other men*, and a **bisexual** person is *attracted to both men and women* (Meem et al., 2010). A **transgender** person is an individual whose gender identity differs from the gender she or he was assigned at birth (Schilt & Westbrook, 2009). It is difficult to estimate the number of women who are lesbian, bisexual, or transgender because negative attitudes toward sexual minorities discourage some individuals from reporting this behavior. In addition, sexual identities of women may change over time. Whereas many gay men recall their same-sex attraction as beginning before puberty, many lesbians report not feeling same-sex attractions until adulthood (Diamond, 2007). In the NSSHB mentioned earlier, 7 percent of American women *identified* themselves as having a lesbian or bisexual sexual orientation; but twice that number reported *engaging in sexual behavior* with women during their lifetime (Herbenick et al., 2010b,c). However, a 10-year longitudinal study of lesbian and bisexual women found that two-thirds of the participants had changed sexual minority identities at least once in their lives and over one-third had done so more than once (Diamond, 2008). In addition, the comprehensive National Longitudinal Study

GET INVOLVED 6.1

Attitudes Toward Lesbians

Ask two female and two male friends to complete the following exercise:

Our society views some groups of unmarried women as having higher social status or acceptability than other groups of unmarried women. Give

each group below a social status score based on how you think these groups are viewed in society. Assign each group a score ranging from 1 to 100, with *high* scores indicating *high* status and *low* scores indicating *low* status.

Social Status Score

divorced heterosexual women

never-married lesbians

widowed heterosexual women

never-married heterosexual women

WHAT DOES IT MEAN?

1. In what ways are your female and male respondents' answers alike? In what ways are they different? Explain the differences and similarities.
2. How does the social status of lesbians compare to that of the three groups of heterosexual women?
3. How would you account for the differences in social status of these four groups of women?

Source: Etaugh and Fulton (1995).

of Adolescent Health found a great deal of fluidity in romantic attractions and relationships over an 18-month period. For example, of the 4 percent of girls who reported bisexual attraction at the beginning of the study, only one-fourth did so 18 months later; the majority of them later reported attraction to and relationships with males (Russell & Seif, 2002). Findings like these suggest that, as noted earlier in the chapter, female sexual orientation is more “fluid” than that of males, meaning that it is more sensitive to situational and contextual factors (Diamond & Savin-Williams, 2009).

Bisexuals

Because most people view sexual orientation as consisting of two categories—heterosexual and homosexual—many bisexual individuals feel misunderstood or invisible (Burn, 2011; Hequembourg & Brallier, 2009). Bisexual women and men are often viewed as going through a transitional stage between heterosexuality and homosexuality, denying their true sexuality, or avoiding commitment to a particular lifestyle or partner (Bowles, 2011; Hequembourg & Brallier, 2009; Rust, 2009). Furthermore, bisexuality is often criticized by both heterosexuals and homosexuals as indicating promiscuity, indecisiveness, or immaturity (Meem et al., 2010; Rust, 2009). The dilemma faced by a bisexual woman was expressed this way:

Invisibility is a problem. Few people know we exist because we don't “fit” into either the heterosexual or the lesbian world. When we are open, both worlds judge us.

(Boston Women's Health Book Collective, 1992, p. 214)

One of Claire's bisexual students described the following experience in her journal:

If I hear “The lesbian's dating a boy?!” one more time . . . So I met a boy and we've started dating, not a big deal to me but obviously to others. My main issue here is pigeon-holing. “I thought you were supposed to be gay,” as if I have become a caricature of a human.

(Angelique, age 22)

Research shows that some individuals feel attracted to both sexes simultaneously and may carry on relationships with both men and women at the same time (Rust, 2009). This is more likely to occur in women than in men (Chandra et al., 2011; Diamond & Savin-Williams, 2009). Large-scale surveys have found that among women, bisexual attractions are much more common than exclusive attractions to women (Chandra et al., 2011), and many bisexuals are more attracted to one gender than the other (Rust, 2001). Currently, more women are experimenting with bisexuality or at least feel more comfortable reporting same-sex encounters than was the case in the 1990s: 12 percent in 2005 versus 4 percent in 1998 (Mosher et al., 2005).

Same-sex sexuality thus is a matter of degree for many women, who do not clearly fit into any one category. In the words of Susan:

I'm in a physical/sexual sense 60 percent heterosexual and 40 percent gay . . . My sexual fantasies are often with a man but my romantic ones are with a woman . . . In the emotional realm I'm 30 percent heterosexual and 70 percent gay. I can't imagine spending my life with a guy! Sex wouldn't be enough. I want to take long trips with girls. I want to exchange lipstick colors and compare Hillary [Clinton] stories . . . I'm attracted to certain types of males, both the really femme girly boys and the really masculine studs . . . and the really feminine girls with powdered faces. The butch ones can be a Friday night fantasy. Don't think about writing down that I'm a lesbian, or even bisexual. I hate both words!

(Savin-Williams, 2006, p. 316)

Attitudes Toward Sexual Minorities

Heterosexism is *the view that heterosexuality is the norm and that homosexuality is abnormal*. Sexual minority individuals may themselves internalize heterosexist attitudes (Szymanski & Owens, 2008). This view often leads to **homophobia**, *negative reactions to homosexuality and irrational fear of homosexuals*. Such reactions are pervasive not only in American society (Herek, 2009a; Kantor, 2009; Pew Research Center, 2007c) but also in many other parts of the world (see Explore Other Cultures 6.1). In a 2010 survey of American adults, for example, 75 percent of individuals aged 65 and over felt that sex between adults of the same sex is always wrong, although on a positive note, only 43 percent of young adults felt this way (Pew Research Center, 2010a). Although heterosexual men are more negative than women toward gay men, there are small or no gender differences in attitudes toward lesbians (Gallagher, 2008; Moskowitz et al., 2010; Petersen & Hyde, 2010). This finding is consistent with the research we discussed in Chapters 3 and 4 showing that men who violate gender roles are judged more harshly than women who do so. Although about one-half of older Americans oppose gay marriage, civil unions, and same-sex couples rearing children, only about one-third of young adults feel that way (Pew Research Center, 2007c; 2010a; “The Nation,” 2010). Homophobic views are especially strong among males, political conservatives, people with a high degree of religious commitment, those with less education, and individuals who hold traditional gender-role attitudes and authoritarian right-wing views. These individuals are less likely to have family members or friends who are openly gay or lesbian, and they are more

EXPLORE OTHER CULTURES 6.1

Sexual Minorities Around the World

Sexual minorities are discriminated against in varying degrees by laws and social policies around the world (Bakirci, 2011; Fumia, 2011; Hooghe et al., 2010; Štulhofer & Rimac, 2009). Same-gender sexual behavior is still illegal in dozens of countries, including many African and predominantly Muslim nations. In these countries, homosexuality may be punishable with prison sentences (for example, in Nicaragua), beatings (Malaysia), and death (Afghanistan, Iran, Sudan, and Yemen [Burn, 2011]). Even where homosexuality is not illegal, lesbians and gay men often do not “come out” for fear of losing their children, jobs, and social status, or becoming the target of physical or verbal attack (Burn, 2011).

Although Americans have become more accepting of homosexuality in the past few decades, they are less tolerant than citizens of most other advanced democracies in western Europe and North America. In France, Britain, Italy, Germany, Czech Republic, and Canada, 75 percent or more believe society should accept homosexuality. Americans,

by comparison, are evenly divided on this issue, similar to the views in Latin American countries.

Lesbianism was acceptable in a number of Native American cultures before Western colonization. For instance, women from the Mohave, Maricopa, Cocopa, Klamath, and Kaska tribes could marry other women and make love with other women without stigma (Burn, 2011). However, contemporary attitudes of Native Americans, which have been influenced by the dominant American culture, may be less accepting (Amaro et al., 2002). Similarly, in the African country of Lesotho, it is not unusual for women to have romantic relationships with each other before and even during heterosexual marriage (Burn, 2011). However, these relationships occur less often in Lesotho women exposed to Western ideas.

The experiences of sexual minorities vary not only among countries but also within them. San Francisco, for example, has an active sexual minority community, but in many places in the United States, sexual minorities are more likely to remain closeted.

likely to believe that a homosexual orientation is freely chosen (Herek, 2009b; Hooghe et al., 2010; Lipka, 2010; Morrison et al., 2009; Nagoshi et al., 2008; Petersen & Hyde, 2010; Saad, 2010; Schwartz, 2010; Smith et al., 2009; Whitley, 2007). On the other hand, about 75 percent of Americans feel that sexual minorities should have equal rights in housing, and 60 percent support equal rights in employment and health benefits for lesbian and gay partners (Lax & Phillips, 2009).

WOMEN OF COLOR. Black individuals hold somewhat more negative attitudes toward sexual minorities than do Whites (Pew Research Center, 2009; Vincent et al., 2009; Whitley et al., 2011). Thus, Black lesbian and bisexual women are confronted with the intersecting societal barriers of sexism, racism, and homophobia, placing them in “triple jeopardy” (Bowleg, 2008; Fassinger & Israel, 2010). In some ethnic minority cultures, women who do not adhere to traditional gender roles or who are not subordinate to men are often ostracized or mistreated. For example, “two spirit” Native American women experience disproportionate levels of sexual and physical violence (Lehavot, 2009). Sexual minority women in these communities may be more reluctant to “come out,” choosing to remain invisible rather than be rejected (Castañeda, 2008; Cole & Guy-Sheftall, 2003; Parks et al., 2004).

DISCRIMINATION. Discrimination against sexual minorities can take many forms. The most virulent form of homophobia is expressed in violent “hate crimes” often committed against gay men by groups of adolescent or young adult males (Federal Bureau of Investigation, 2009; Herek, 2009a). One national study found that 38 percent of gay men had experienced crimes against their person or property, compared with about 13 percent of lesbians and bisexual women and 11 percent of bisexual men. Gay men were also more likely than other sexual minorities to be verbally harassed (Herek, 2009a). Sadly, homophobia and prejudice are daily experiences for many sexual minority students during the school day (Biegel, 2010; Russell et al., 2010). In one nationwide survey of more than 6,200 lesbian, gay, bisexual, and transgender middle and high school students, nearly nine out of ten were called names or threatened because of their sexual orientation. Almost half had been physically harassed and nearly one-quarter had been assaulted. More than half felt unsafe in school and one-third missed at least a day of school because of feeling unsafe (Kosciw et al., 2008). Transgender students are even more likely than their lesbian, gay, and bisexual peers to experience harassment and assault (Greytak et al., 2009). Another recent study found that sexual minority college students and employees were twice as likely as heterosexuals to report experiencing harassment. The incidence was even higher among sexual minority students of color (Rankin et al., 2010). Sexual minority youth are also more likely to be harshly punished by schools and courts than their straight peers, even though they are less likely to engage in serious misdeeds (Himmelstein & Bruckner, 2011).

Home may not be a safe haven either. Sexual minority teens and adults who “come out”—that is, declare their sexual orientation to others—may be rejected by their families. In some cases, they are compelled to leave home and seek survival in the streets (Goldman, 2008; Grossman, 2006, Herek & Garnets, 2007). Such experiences, not surprisingly, can lead to a reluctance to reveal one’s sexual orientation (Fassinger & Arseneau, 2008; Rosenfeld, 2009) and to increased levels of emotional stress and psychological problems among harassed individuals (Hatzenbuehler et al., 2010; Plöderl & Fartacek, 2009; Wylie et al., 2010). We shall explore some of these problems more fully in Chapter 13. Despite the stress faced by many lesbian, gay, bisexual, and transgender youth, the good news is that most display strength and resiliency and are often involved in antihomophobia advocacy efforts (Russell et al., 2010).

Although some states have laws that ban discrimination on the basis of sexual orientation in employment, credit, housing, and public accommodation, more than half do not (Meyer, 2011). Same-sex marriage is specifically banned in most states; as of this writing, it is legal in only Connecticut, the District of Columbia, Iowa, Massachusetts, New Hampshire, New York, and Vermont, although California, Colorado, Delaware, Hawaii, Illinois, Maine, Maryland, Nevada, New Jersey, Oregon, Rhode Island, Washington, and Wisconsin give same-sex couples spousal rights (Patterson, 2009). Argentina, Belgium, Canada, Iceland, Mexico City, the Netherlands, Norway, Portugal, South Africa, Spain, and Sweden allow same-sex marriages, and several other countries permit same-sex couples to register as partners (Barrionuevo, 2010; Cole, 2010; Human Rights Campaign, 2011). Courts in slightly more than half the states in the United States allow lesbian or gay individuals to adopt their partner's child (Patterson, 2009), a right endorsed by the American Academy of Pediatrics.

See What You Can Do 6.1 for ways in which you can help support the rights of sexual minorities.

Explanations of Sexual Orientation

The origins of homosexuality are complex and controversial (Hines, 2010; Werhun, 2011). A number of psychological and biological theories have been proposed. According to Sigmund Freud (1925/1989), all individuals are initially bisexual. The mother is the original love object for both girls and boys. In heterosexual development, the father becomes the girl's love object, and she substitutes other males for him as she gets older. When the mother remains the love object, lesbian development occurs. Little evidence exists in support of this theory, however (Werhun, 2011). From a learning theory point of view, early positive sexual activity with members of one's own gender or negative sexual experiences with members of the other gender could lead to homosexuality. However, many lesbians and gay men are aware of their sexual orientation before they have engaged in any sexual activity (Carver et al., 2004).

Biological theories focus on genetic or hormonal factors. In one study, 48 percent of identical twin sisters of lesbians were also lesbians, compared with just 16 percent of fraternal twin sisters, and 6 percent of adopted sisters (Bailey et al., 1993). So, sexual orientation appears to be at least partly genetic. But if genetics were the whole story, 100 percent of the identical twin sisters would be lesbian.

Is sexual orientation influenced by sex hormones? In adulthood, there is no link between levels of female and male sex hormones and sexual orientation (Veniegas & Conley, 2000). *Prenatal* sex hormones may be a factor, however. Studies of intersexuality discussed in Chapter 3

WHAT YOU CAN DO 6.1

Supporting Rights of Sexual Minorities

1. If your school has a gay-straight alliance, get involved. If not, start one. Ideas can be found at www.glsen.org.
2. Volunteer for Parents and Friends of Lesbians and Gays (PFLAG). For information, contact www.pflag.org.
3. Volunteer for the Trevor Project, www.thetrevorproject.org, a suicide prevention hotline that supports sexual minority youth.

Source: Burn (2011).

pointed to the prenatal influence of androgen on the development of females' sexual orientation (Berenbaum et al., 2009; Hines, 2010). For example, the finger-length patterns in lesbians resemble those of men more than those of heterosexual women (Breedlove, 2010; Meem et al., 2010; Werhun, 2011). This finding and others suggest that high levels of androgens (male sex hormones) during the prenatal period may partially masculinize certain physiological and anatomical characteristics of lesbians, including the brain structures responsible for sexual orientation (Hines, 2010; Honekopp & Watson, 2010).

Most likely, complex interactions among biological, psychological, and environmental factors determine sexual orientation, and different causal mechanisms may operate for different individuals (Donatelle, 2012; Jordan-Young, 2010).

SEXUAL ACTIVITY DURING ADOLESCENCE

Why does it seem that all boys want is sex? (Brenda, age 14)

What happens when I have a boyfriend who wants to have sex and I don't? (Ruth, age 13)

Why is it that when a guy has sex with a girl, he is called a "stud," but the girl is considered a "slut"? (Veronica, age 13; all in Zager & Rubenstein, 2002)

Although most teenagers have their first sexual intercourse in their mid-to-late teens (Guttmacher Institute, 2011a), the experience is quite different for females and males. Women, compared to men, describe their first experience as less positive and more negative, and they are less likely to report physical pleasure and orgasm. Women are also more likely to indicate an emotional connection with their partners and partner pressure as reasons for their sexual initiation (Walsh et al., 2011). In fact, nearly one out of four girls who first have sex at age 14 or younger report that the act was nonvoluntary (Hoffman, 2008). Let's take a closer look at sexual activity during adolescence. We'll discuss teenage pregnancy in Chapter 7.

Frequency of Sexual Activity

Males become sexually active at younger ages than females. Among females, Black girls show the earliest onset of sexual activity and Asian Americans the latest ("Facts on American Teens," 2010; Zimmer-Gembeck & Helfand, 2008). In addition, adolescent boys, compared to adolescent girls, have more sex (including same-sex behavior) and more sex partners (Chandra et al., 2011). Rates of teenage sexuality reached near-record highs in the late 1980s, but have declined since the early 1990s. For example, the percentage of high school students who had intercourse decreased from 54 percent in 1991 to 46 percent in 2009 (Eaton et al., 2010). The decline has been most noticeable among Black females and among males of all ethnicities. Efforts to educate young people about safe sex and about the risks of pregnancy and STIs such as AIDS have played a key role in reducing these numbers. Still, by the time they graduate from high school, about two-thirds of girls will have engaged in sex ("Facts on American Teens," 2010; Kirby & Laris, 2009).

Two forms of sexual activity that are growing in popularity among college students and young adults are the "hook-up" and "friends with benefits." For a more detailed look at these sexual encounters, see Learn About the Research 6.1.

Another trend in teenage sexuality involves using the Internet to interact with others (Denizet-Lewis, 2004). The term **cybersex** has several meanings but is often defined as a *social interaction between at least two persons who exchange computer messages for purposes of sexual arousal and satisfaction* (Döring, 2000). There are two feminist views of cybersex, quite different from each other.

LEARN ABOUT THE RESEARCH 6.1

Hook-Ups and Friends With Benefits

Among both female and male college students and young adults, one increasingly common form of sexual activity is the **hook-up**, a *one-time casual unplanned sexual encounter that can range anywhere from kissing to intercourse* (Bogle, 2008; Regnerus & Uecker, 2011; Stepp, 2007). Another form of sexual intimacy is known as **friends with benefits**. In this arrangement, the *partners start out as friends and decide to periodically engage in sexual behavior but not become a couple* (Diamond, 2010). Paula England and her colleagues (England et al., 2007) found that over 70 percent of the students they surveyed had

hooked up, usually after consuming alcohol. One in five of these students had hooked up with ten or more different partners during their college years. Men are more likely than women to prefer hooking up to dating while the reverse is true for women (Bradshaw et al., 2010; Rhoads et al., 2010). Why is this? Women view hooking up as less likely to lead to a relationship and as more likely to produce feelings of distress, shame, or regret (Eshbaugh & Gute, 2008; Fielder & Carey, 2010; Hamilton & Armstrong, 2009; Owen et al., 2010; Regnerus & Uecker, 2011; Smith et al., 2008).

WHAT DOES IT MEAN?

1. Discuss concerns that young people who have hook-ups or friends with benefits don't learn to build emotional intimacy before they get physically intimate and may fail to know how to connect with future partners on an intimate level. Are these concerns valid? Why or why not?
2. When, if at all, do you consider it to be acceptable to have a hook-up or a "friend with benefits"? What level of physical intimacy do you think is appropriate between people who don't have an emotional relationship?

The victimization perspective focuses on how women and girls as individuals and as a group are harmed by online harassment and virtual rape. In contrast, the liberation perspective argues that cybersex benefits girls and women by allowing them to explore their sexuality freely and more safely (Döring, 2000). Which view do you agree with, and why?

Factors Associated with Sexual Activity

Many factors affect the onset of sexual activity, the number of sexual partners, and the risk of becoming pregnant or causing a pregnancy. These include the effects of puberty, family, and peers, as well as individual characteristics. As we noted in Chapter 4, early-maturing girls tend to initiate sexual activity sooner than other girls (Lansford et al., 2010; Zimmer-Gembeck & Helfand, 2008). One likely reason for this is that the development of breasts, curves, and other secondary sex characteristics may attract sexual attention from males (Zabin & Cardona, 2002).

You may be surprised to learn that parents are the biggest influence on teenagers' decisions about whether to have sex and that friends are next (National Campaign to Prevent Teen Pregnancy, 2003). Parents, however, underestimate their own influence and believe that teenagers' friends play a more important role. Unfortunately, fewer than half of older teen women and just over one-fourth of men this age say that they have talked with a parent about birth control and how to say "no to sex" (Centers for Disease Control and Prevention, 2011). And although many teens look up sexual health information online, these Websites often contain inaccurate information (Guttmacher Institute, 2011b).

Teenagers who delay the onset of sexual activity, who have fewer partners, and who are at lower risk of pregnancy are close to their parents, see them as supportive, and communicate well with them (Kan et al., 2010; Parera & Surís, 2004; Parkes et al., 2011; Roche et al., 2005). Their parents are more likely to be married, are better educated, have a higher income level, use firm, consistent discipline, and are aware of their teen's friends and activities (Dupéré et al., 2008; East et al., 2006; Manlove et al., 2009; Roche & Leventhal, 2009; Zimmer-Gembeck & Helfand, 2008). Teenagers who begin sexual activity at a later age are also more apt to be religious; have better grades in school, higher educational aspirations, greater social maturity, and lower levels of alcohol, cigarette, and drug use; and, in the case of girls, are more apt to participate in sports (Collins & Steinberg, 2006; Gold et al., 2010).

An early onset of sexual activity, a greater number of partners, and increased risk of pregnancy are linked to having sexually active or pregnant siblings and peers, having had a single teenage mother, having parents who are permissive about sex but do less monitoring of their teen's behavior, and being in a committed dating relationship (Bersamin et al., 2008; East, 2009; Hawes et al., 2010; Hofferth & Goldscheider, 2010; Lansford et al., 2010; Manlove et al., 2009; McHale et al., 2009; Siebenbruner et al., 2007; Uecker, 2008). Girls who have sexual intercourse at an early age, as well as those who fail to use contraceptives, tend to be depressed and have low self-esteem, negative body image, and little sense of control over their lives (APA Task Force, 2007; Meier, 2007; Rubin et al., 2009; Spencer et al., 2002). Sexual and physical abuse in childhood, which may contribute to these negative feelings about oneself, also increase the likelihood of both early sexual activity and early pregnancy (Hendrick & Reddy, 2007; Logsdon-Conradsen, 2011; Tyler & Johnson, 2006).

The Double Standard

Despite the relaxing of sexual prohibitions over the past few decades, the double standard of sexuality in society—acceptable for boys, but not girls—remains alive and well (Schalet, 2010). Parents may be willing to condone sexual experimentation in their sons (“Boys will be boys”) but rarely sanction it in their daughters. Girls, more than boys, are encouraged to express their sexuality only within the context of a committed, socially approved relationship. Consequently, it is not surprising to find that adolescent girls are more likely than adolescent boys to focus on the emotional aspect of sex (Tiegs et al., 2007) and to consider affection a prerequisite for sexual intimacy (Walsh et al., 2011). As one example, a survey of nearly 300,000 first-year college students found that 60 percent of males but only 35 percent of females agreed with the statement, “If two people really like each other, it's all right for them to have sex even if they've known each other for only a very short time” (“This Year's Freshmen,” 2005).

Sexual Desire

Girls and young women receive powerful societal messages that it is *their* responsibility to suppress desire and serve as sexual gatekeepers (Diamond & Savin-Williams, 2009). Perhaps for this reason, the sexual desire of teenage girls is rarely studied (Bay-Cheng et al., 2009). When Deborah Tolman (2002) interviewed adolescent, low-income girls of color and middle-income White girls, all reported feelings of powerful sexual desire. At the same time, the girls feared the potential of negative consequences of expressing these desires: pregnancy, STIs, losing respect and reputation, and limiting educational opportunities. The ethnic minority girls were more afraid of physical violation, and encountered stereotypes that they are oversexualized. White girls felt physically safer but faced a different troublesome stereotype, that of the “good girl” who is supposed to show no evidence of

sexuality. Individual girls resolved these “dilemmas of desire” in different ways. Some suppressed their sexual desires, others avoided situations that could arouse sexual feelings, and still others arranged conditions in which they could safely express desire.

SEXUAL ACTIVITY IN MIDLIFE

Sexual activity and satisfaction vary among midlife 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. In this section, we examine the sexuality of women in midlife.

Physical Changes

Most women experience a number of physical changes as they enter menopause, some of which may affect sexual activity (Seiden & Bilett, 2007; Wroolie & Holcomb, 2010). Decline in the production of estrogen is responsible for many of these changes. The vaginal walls become less elastic, thinner, and more easily irritated, causing pain and bleeding during intercourse. Decreases in vaginal lubrication can also lead to painful intercourse (Herbenick et al., 2010a).

Various lubricants and moisturizers can ease vaginal dryness. Paradoxically, one of the best remedies is to have more sex! Sexual activity increases blood flow to the vagina, which makes the tissues fuller, and also triggers lubrication (Brody, 2009a). Signs of sexual arousal—clitoral, labial, and breast engorgement and nipple erection—become less intense in midlife, and sexual arousal is slower. 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).

Patterns of Sexual Activity

Whereas some midlife women report a decline in sexual desire and the capacity for orgasm during these years, others report the opposite pattern (Birnbaum et al., 2007; Brody, 2009a; Tracy & Junginger, 2007; Woods et al., 2010). Some women report an increased desire for nongenital sexual expression such as cuddling, hugging, and kissing (Block, 2008; Groh & Serowsky, 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 et al., 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, 2007) 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 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. A second reason is the increase in marital satisfaction that often develops during the postparental (“empty nest”) years (Etaugh, 2008).

Sexual activity 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). Physical causes 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 & Holomb, 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 (American Cancer Society, 2011).

Sexual activity and contentment during middle age are more likely to diminish for individuals who have lost their partners (Fisher, 2010; Lindau & Gavrilova, 2010). For example, in a recent nationally representative study of sexuality in Americans aged 45 and over, only one in ten who had no partner, but six in ten of those with sexual partners, were satisfied with their sex lives (Fisher, 2010). Although about three-fourths of men of all ages have a sexual partner, only two-thirds of young and middle-aged women do. Among women aged 75 and over, only four in ten have a partner (Lindau & Gavrilova, 2010).

SEXUAL ACTIVITY IN LATER LIFE

Before reading this section, try Get Involved 6.2. See how your attitudes and those of your friends compare to the information in the chapter.

Sexual activity can be as gratifying in the later years as in the younger years (Alexander et al., 2010). Unfortunately, as Get Involved 6.2 demonstrates, there are a number of myths and stereotypes about sexuality in later life. 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 mentioned earlier in the chapter exists for adults of all ages. Older women also are subjected to the double standard of aging discussed in Chapter 2. Thus, compared to older men, women in their later years are perceived as sexually inactive and sexually unattractive (Antonucci et al., 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). A few years ago, in a special issue of the *Journal of Social Issues* devoted entirely to sexuality, there was not a single word about the sexuality of older women (Goodchilds, 2000). Many older women themselves are self-conscious about their aging bodies (Henig, 2004a). Let us examine older women's sexuality—the benefits of sexual activity in later life, 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 physical, psychological, and emotional benefits for older adults (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,

GET INVOLVED 6.2**Attitudes Toward Sexuality in Later Life**

On a scale from 1 (strongly disagree) to 7 (strongly agree), indicate the extent to which you disagree or agree with each of the following statements. Also, ask three female and three male acquaintances who vary in age to respond to these statements.

1. Older people lose their interest in sex and no longer engage in sexual activity.
2. Changes in hormone levels that occur during and after menopause cause women to find sex unsatisfying and unpleasant.
3. Women who are beyond the childbearing years lose their sexual desire and their sexual desirability.
4. In order to have a full and satisfying sex life, a woman must have a male partner.
5. Older women who still enjoy sex were probably nymphomaniacs when they were younger.
6. Older people with chronic illness or physical disabilities should cease sexual activity completely.

WHAT DOES IT MEAN?

Add up the ratings you gave to these six statements. Do the same for each of your respondents. Note that each statement reflects a myth based on folklore and misconceptions. Therefore, the higher the score, the more the respondent holds unfounded beliefs about sexuality in later life.

1. Are there differences between the views of your female and male respondents? Explain your answer.
2. Are there differences between the views of respondents who vary in age? Explain your answer.
3. In what way might society's attitudes toward aging and older people be related to the persistence of these myths about sexuality in later life? Explain your answer.

Sources: Doress-Worters and Siegal (1994); Gibson (1996).

Leitner & Leitner, 2004). Sexual activity among older people 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 Older People

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 & Gavrilo, 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 & Gavrilo, 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 over age 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 second vignette at the beginning of the chapter.)

In the earlier mentioned survey (Lindau & Gavrilova, 2010), over 80 percent of men aged 57–64, two-thirds of those aged 64–75, and 40 percent between age 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 were 60 percent, 40 percent, and 17 percent, respectively. Women at all ages were less likely than men to be sexually active, in part because more of them lacked 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 older people (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 (see Chapter 7) become more pronounced in the later years, as estrogen levels continue to decline. Physical changes, illness, chronic disabilities, and medication can affect sexuality in later life (Lindau & Gavrilova, 2010). However, even the most serious conditions should 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 is low. Most people can resume sexual activity in 12 to 16 weeks. Stroke rarely damages sexual function and it is unlikely that sexual exertion will cause another stroke. Arthritis, the most common chronic disability, causes joint pain that can limit sexual activity (Read, 2004). Surgery and drugs can relieve the pain, but in some cases, 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 can also reduce a woman's sexual desire. However, a physician can often prescribe a different medication without this side effect.

PSYCHOSOCIAL FACTORS. A person's attitudes 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 older adults, especially older women, is abnormal (Block, 2008). As a result, older adults who want to fulfill their sexual desires may feel apprehensive and guilty. In addition, many older women feel unattractive and thus may avoid sexual activity with a partner or decide not to seek a new partner if they become widowed or divorced (Burgess, 2004).

Another constraint for residents of nursing homes is that the attitudes of nursing home staff are often not supportive of sexual behavior. Although more nurses 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).