

**State of
Sexual
Freedom
in the
United States**

**2011
REPORT**



**WOODHULL
SEXUAL FREEDOM
ALLIANCE**

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2011 Report



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A Woodhull Sexual Freedom Alliance Report Affirming Sexual Freedom as a Fundamental Human Right

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Foreword

Our Fundamental Human Right to Sexual Freedom And the State of Sexual Freedom in the United States, 2011 Report

By Ricci Levy

"The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of man's spiritual nature, of his feelings and of his intellect. They knew that only a part of the pain, pleasure and satisfactions of life are to be found in material things. They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized men. To protect, that right, every unjustifiable intrusion by the government upon the privacy of the individual, whatever the means employed, must be deemed a violation of the Fourth Amendment."—

Supreme Court Justice Louis Brandeis,
Olmstead v. U.S., 277 U.S. 438 (1928)

This report is a glimpse into the many issues that comprise the sexual freedom movement. Each author has outlined where we are and where we need to be in order to realize the promise of sexual freedom as a fundamental human right. Each person has a different perspective and a different focus, some see the cup as half full, some as half empty, but one thing is certain as you read each chapter and that is that we must stand together. If we don't, there will be no victory for any one of us. And the greatest opportunity for intersectional work exists in the one framework that unites all issues: human rights.

One of the goals of this report is to help change the nature of the discussions about sexual freedom. Our view is that sexual identity politics, that is, advocacy centered on an identity or a single activity, while fine as far as they go, will be largely ineffective unless they are integrated into a human rights framework. In this way, the advocacy of sexual freedom issues will be put into the framework of fundamental ideals

central to humanity -- individual freedom to shape one's own life, non-discrimination, freedom of sexual speech and expression, tolerance for differences, compassion for the oppressed and, as a result, freedom from government intrusion into our privacy, our personal autonomy.

Woodhull has a strong record of bringing like-minded voices together to demonstrate and show how to integrate sexual freedom into their work and also in promoting contact with each other, thus bringing strength to the movement. We take on a very important role of facilitator of that work, a role for which Woodhull is uniquely suited.

This report, for example, brings together allies with a variety of individual issues and provides excellent opportunities for alliances that will help forward the sexual movement.

As the conservative forces in this country and abroad have become more emboldened, we find state legislatures and Congress much more in the grip of a sex panic that has led to the rolling back of many of the gains that have been made in sexual health and personal autonomy over the last several decades.

Public attacks on sexual freedom are bold and shameless. Our opponents no longer seek to wrap their sex-negative agendas in lofty ideals. Instead they simply propose the legislation, fan the hysteria, and pass the laws that restrict our personal autonomy, eating away at freedom of sexual speech and expression. One excellent example is the restriction of funds to Planned Parenthood. Facts were irrelevant to the rhetoric, and, in a moment of hysteria, millions of women were left without the most basic sexual health care.

According to Lawrence Walter in his chapter, "[Killing the Messenger: An Analysis of the Legal Issues Associated with Imposing Criminal Liability on Internet](#)

Service Providers for Acts of Their Customers"

"Each day, thousands of erotic forums, hosts, adult dating sites, erotic-themed "tube" sites, online escort classified sites, and adult content review sites are essentially forced to operate in fear that a swat team might at any moment descend on their corporate headquarters, or that the Department of Justice might seize their domain name(s), based on the uncertain legal issues pertaining to criminal liability for content originating from third parties. Despite the existence of this uncertainty lingering for almost two decades, Congress has failed to act, while the problem grows larger by the day."

At the same time, the courts, while heavily stacked with ultra-conservative judges, are not always finding against sexual freedom, according to Dr. Marty Klein in the Introduction to this report, *"The State of Sexual Freedom, From Bush to Obama: Forwards? Backwards? Sideways?"*

"While the judicial system is far from uniformly supportive of sexual rights, neither are they a rubber stamp for every restriction on nudity, sexual photography, or sex toys that sex-phobic minds continue to conjure. District and federal courts continue to surprise and inspire with their decisions supporting privacy and commerce, "even" when the content is sexual."

At the same time, unnecessary, excessively restrictive and onerous legislation like § 2257, Record Keeping Requirements for the adult entertainment industry are upheld and, indeed, even amended to be more restrictive. As Mark Kerns points out in *"Mark Kerns, in "Law & Disorder: The Courts' Schizophrenic View of Sexual Speech":*

"Perhaps the single fact that best exemplifies the uselessness of the regulations is that while producers of sexually explicit material are required to examine and retain a copy of a performer's government-issued photo identification document, there is no requirement that the producer authenticate that document!"²¹ In other words, if a performer

presents an authentic-looking forged ID, the producer will not have violated the 2257 law if he maintains a copy of the document in his/her records. However, in such a case, the producer would be guilty of violating the existing child pornography laws—the very laws that make 2257 unnecessary."

But how do we look at issues in a way that allows that opportunity to build alliances and share common goals? We can examine each issue with a deliberate focus on the opportunities for alliances. For example, In a world where approximately 50,000 Americans are diagnosed with HIV each year and over one million are currently living with HIV (Appendix 2), it is a perfect example of the framing I discuss above that debate on sexuality focuses more on the fear that if young people know HOW to have sex, they will have sex.

A study published in the British Medical Journal finds that the over-45 population engaging in non-monogamous sexual expression is at high risk for chlamydia and gonorrhea. In fact, the infection rates among older study subjects were nearly as high as other high-risk populations, including men who have sex with men and young people. They posit that this may be because older people are not as well educated about sexually transmitted diseases as their younger partners and so they don't regularly practice safe sex or get regular screenings. (CNN: By Caitlin Hagan CNN Medical Associate Producer <http://thechart.blogs.cnn.com/2010/06/24/study-older-folks-swinging-their-way-to-stds/>)

By looking at just this one opportunity, we can illustrate the intersections between all the sexual rights communities – reproductive justice, lesbian, gay, bisexual, and transgender, non-monogamous communities, and the senior population and those who advocate for sexuality education, and thus, the opportunities for alliances.

We are sexual beings from cradle to grave and yet what little sexuality education exists focuses on a relatively small portion of the population – virtually ignoring both ends of the age spectrum. And yet the rate of new sexually transmitted diseases continues

to rise – particularly among the only portion of the population receiving formal sexuality education.

In the chapter “[Sexual Health Education and Policy in Medical Schools: The Importance of Incorporating Basic Human Rights into Medical Education and Training](#),” Megan Andelloux declares:

“Providing sexual health care and acknowledging people’s sexual selves should be a staple of medical care, not an afterthought. Sexual medicine should not be underfunded, silenced, or dismissed as irrelevant. Instead, it should be recognized and valued just as other areas of medicine are, such as oncology or cardiology.”

If we listen to the cacophony of shrill voices declaring the end of marriage, the moral decline of our nation, the need for more religion and more government restrictions on personal freedoms we can hear echoes of other times in the history of the world when those few in control sought to suppress the general population through control of their physical and emotional autonomy.

This time they can not succeed. This time we are the majority and we are not silent. The only time the minority can control the majority is when the majority are silent. In terms of fundamentalist attacks here or abroad it is vitally important that human rights activists and organizations step up and speak out in support of our fundamental human right to sexual freedom.

We must affirm that sexual rights are human rights related to sexuality. “Sexual rights are constituted by a set of entitlements related to sexuality that emanate from the rights to freedom, equality, privacy, autonomy, integrity and dignity of all people.” (Appendix 1)

We have moved forward on personal freedoms – not as far forward as we need to move, but we have made progress. As author Kate Kendell says in her chapter, “[Relationships and Family Freedoms and Protections](#),”

“The bottom line is that everyone has a fundamental right to form a family, and we are steadily making progress towards laws and policies that recognize and respect our choices about how we exercise that right.”

The opportunities for alliances around the critical issue of family, of the rights that accrue to those in civilly sanctioned relationships, are opportunities for several communities to come together in a shared advocacy. Marriage as a religious function should have nothing to do with the civil rights granted by the state. This country was founded with a clear goal of separation between Church and State. Those who share that belief could come together with the senior population who often chose to live together without the “benefit” of marriage and are denied many of those civil benefits. And those two groups could come together with the lesbian, gay, bisexual and transgender communities, as well as those who live a non-monogamous lifestyle to advocate for that separation and to ensure that all “families” have the same benefits and rights.

Freedom is both the freedom “to do” something and the freedom “not to do.” As Diana Adams notes in her chapter, “[The Freedom Not to Marry: Separating Sexual Relationships from Economic Dependence](#)”

“Our notion of a traditional American family is crumbling. As a society, we have a choice; we can continue to try to rehabilitate marriage with nostalgic family values campaigns, or we can work within a changed society to create stable families for children with new models. If we separate marriage from its legal incentive, and support alternative legal partnerships to marriage, we may bolster the institution of marriage from its decline and high divorce rate, while supporting the rights of Americans to choose to form family in other ways.”

There are many organizations and movements that endorse the idea of sexual freedom and, in many cases, don’t just support it but are actively engaged in insuring it. While that belief informs their work, their

missions and advocacy are directed by goals that are inclusive of a sex-positive commitment but are directed toward achieving other specific policy or educational outcomes; they're doing other things.

It is vital to have an organization with the central guiding ethic and solitary focus on sexual freedom and that organization is the Woodhull Sexual Freedom Alliance.

This report summarizes some of the discussions around sexuality and freedom. Justice Brandeis recognized the danger and, indeed, unconstitutional violation of intrusion by the government in matters of privacy. When he reminds us that the Constitution is designed to “secure conditions favorable to the pursuit of happiness” it is a clarion call for vigilance against invasion into the intimate lives of all of us. Now, more than ever, sexual freedom as a fundamental human right must be affirmed as a bedrock principle of American freedom and liberty.

Introduction

The State of Sexual Freedom, From Bush to Obama:

Forwards? Backwards? Sideways?

Marty Klein, Ph.D.

Sexual freedom expands or contracts within political, social, economic, cultural, and psychological contexts—some of them contradictory, some of them mutually reinforcing.

This introductory piece briefly examines some of these contexts, providing a broad background with which to understand this report's analyses of specific areas of American life.

Narratives of Sexuality

In everyday life—in culture, in politics, in personal relationships—facts do NOT speak for themselves. People and institutions (such as the media, organized religion, and government) make meaning from the infinite array of facts we face each day.

A “narrative” is a coherent storyline, a set of assumptions and a history that enables people to make meaning out of raw facts. To take a simple example, consider the mass murder at the Utoya Island Norwegian summer camp in July 2011. Since a Christian fanatic did it, in the dominant narrative he is portrayed as deranged, the incident an isolated one. If a Muslim fanatic did it, the dominant narrative would presumably portray the killer as a dangerous warrior, the incident connected with others across Europe. Dramatically different narratives would give the two incidents completely different meanings. Similarly, some people consider the annual incidence of 1,000,000 American abortions as evidence of moral weakness and sexual promiscuity, while others think it reflects poor contraception use and a culture that discourages sexual planning.

As you read the chapters in this report, often describing contemporary restrictions of sexual rights, you will see certain recurring narratives at work. Narratives that support the restriction of sexual rights, of course, are the ultimate target of the work of the Woodhull Sexual Freedom Alliance.

These common narratives restricting sexual freedom today are:

Sex is dangerous.

When sex is discussed in American society, it is typically through topics such as unwanted pregnancy, sexual violence, HIV and STDs, child molestation, infidelity, sexual crime, sexual perversion, child pornography, and sexual dysfunction. America's discussions tend to focus on the risks of sexual activity rather than on its benefits, advantages, or pleasures.

Government should protect us from sexual danger.

While the idea of shrinking government is again highly popular, many people want government at all levels to protect Americans from sexual danger, sexual violence, perceived sexual abnormality, and the evidence (visual or cultural) of others' sexuality. There are continued demands for government to criminalize various sexual behaviors, restrict sexual commerce, and control sexual expression in the mass media.

Certain people aren't sexually normal, and certain kinds of sex aren't normal; society needs to be protected from both.

While “diversity” and “acceptance” are currently American watchwords in a range of matters including race, gender, employment, health, ethnicity, language, and physical ability, sexuality is still typically understood as either “normal” (acceptable) or “abnormal” (unacceptable), with no consideration for culture, history, or personal predilection.

“Morality” can be measured by sexual criteria—the less sex, the less evident the sex, and the less adventurous the sex, the more “moral” the person.

This is different than measuring a person's morality by looking at their decision-making criteria, willing-

ness to take responsibility for their actions, honesty in dealing with others, or willingness to sacrifice for the common good.

Sexual expression is appropriate only for some people, only under certain conditions. Anything else is unauthorized, and bad for society.

A broad swath of Americans are still uncomfortable with the idea of teens, the elderly, the non-heterosexual, the physically or mentally handicapped, the incarcerated, or even the unmarried being sexual. Some forms of sexual expression, such as BDSM, are often considered unauthorized for anyone.

When it comes to civil rights, sexuality is different.

Most of the exceptions to our rights of free expression, assembly, commerce, privacy, and the judicial system are related to sexuality. This is generally taken completely for granted.

Baseline: Bush

For the most part, the eight-year presidency of George W. Bush was a continual series of new restrictions on sexual rights. During this period the United States struggled through:

- The Congressional pursuit of internet censorship
- The creation of the Department of Justice's Obscenity Prosecution Task Force
- Massive funding of dangerous, inaccurate abstinence-only sex education, totaling over \$1 billion
- Dramatic reduction of reproductive rights
- Multiple lawsuits, punitive actions, and regulations launched by the FCC against "indecent" on TV and radio
- Fierce maintenance of laws excluding gay people from military service.
- Enhanced government cooperation with, and financial support of, "decency" groups such as Morality in Media, Enough Is Enough, Family Research Council, Concerned Women for America, and Focus on the Family.
- Increased state and municipal government

interference with the rights of sexual privacy, assembly, and commerce. Successful targets included sexually explicit magazines and videos, strip clubs, adult bookstores, revealing swimsuits, swing clubs, bathhouses, and even adult sex education centers.

Enter Obama

The election of Barack Obama in 2008 was supposed to change many things, including government intrusion into private life. In the area of sexual rights, unfortunately, the positive effects were quite limited. More than halfway through Obama's presidency, we can see several clear trends in federal, state, and local governments and society. These include:

- Abdication of federal leadership in maintaining or developing sexual rights;
- Continued legislative ignorance about how the First Amendment and other protections of free expression relate to sexuality;
- Continued legitimacy of scare tactics, inaccurate beliefs, ideological agendas, and false assertions to justify virtually any legislative restriction on sexual rights;
- Continued expansion of government tools to undermine sexual rights, including zoning, eminent domain, police power, redevelopment, public health, exclusion zones, Sexually Oriented Business laws, secondary effects doctrines, and medical regulations
- Use of the Patriot Act and "National Security" considerations to undermine sexual rights.

Ultimately, individual states have led the way in increasing restrictions on sexual rights and sexual expression. Examples include restrictions on access to abortion; expansion of sex offender registries with increasingly onerous conditions; restrictions on available adult entertainment; protections for those who wish to decline their professional responsibilities (often medical personnel); and heightened entrapment programs (often motivated by federal grants) to pursue adults in adult internet chatrooms engaged in fantasy age-play.)

These trends have led to the restrictions of sexual rights that are detailed in various chapters of this report.

In addition, it should be noted that during the last two years several sex-negative narratives have begun or have become more popular in American culture. These include:

- Sex trafficking is an enormous problem, and is getting worse.
- Adult use of legal, adult pornography is a public health menace.
- The internet is increasingly full of predators preying on young people.
- Both minors and adults should be allowed to opt-out of virtually any contact with sexuality they find distasteful, whether in school (sex education), at work (“conscience clauses” for pharmacists and others), in professional training (most medical students are no longer required to learn a full range of gynecological procedures), or in public (public art is increasingly sanitized of sexual content, including classic Greek sculpture).
- Sex research is a waste of time and money.

Such narratives continue to complicate progressive efforts to base public policy on fact and science rather than on emotion and opinion. As the media and conservative politicians continue to trivialize science as one perspective out of many—i.e., just an opinion—it is increasingly difficult to find legitimate venues with which to counter anti-sex arguments with fact.

Religion

One of the most troubling aspects of the Obama presidency, and the culture of state and local politics, is the continued exceptionalism regarding religious belief in political life. Religious sensitivities are given a special seat at virtually all public policy tables, from reproductive rights to employment policies.

Obama has actually expanded the Office of Faith-Based Funding begun by George W. Bush. Billions of dollars in federal money are poured into social ser-

vice programs that, because they are “faith-based,” are exempt from normal federal employment requirements such as non-discrimination in hiring and firing, and non-proselytizing. The suspension of modern American workers’ rights in any other context would be considered shocking, and rightfully resisted. The federal Department of Health and Human Services has reaffirmed that health workers who are licensed to provide medical care are not required to perform their duties if their “conscience” (religious belief) instructs them not to. This is in clear contrast to anyone who declines to do their job if they believe Napoleon or Cleopatra instructs them not to. Favoring religious “instructions” to decline to do one’s job over non-religious “instructions” is a clear violation of America’s critical separation of Church and state.

Virtually all instances of these religious fits of “conscience” involve sexuality—generally reproductive services such as filling prescriptions for contraception, providing D&Cs, performing abortions, etc.. The door is wide open for taxi drivers, janitors, textile workers, and virtually anyone to claim a religious exemption from doing work that supports sexual expression with which a worker disagrees.

America’s tax codes are quite clear in requiring that, in exchange for massive tax exemptions, religious institutions are barred from directly participating in election campaigns. Unfortunately, there are dramatic, ongoing violations of this regulation under the Obama administration. Thus, churches are now firmly part of the infrastructure that helps elect candidates who oppose reproductive choice, contraceptive access, and other sexual rights.

Summary

So what’s the problem? Why have sexual rights continued to be so tenuous for the last two years?

Part of the reason is the lack of a coherent vision of sexual rights coming from the President. He has waffled on gay rights, and still has not fully implemented the end of the military’s disastrous discrimination policy. He refuses to challenge the disastrous and mean-spirited policies virtually criminalizing abortion in state after state. He solemnly affirms his concern over sex crime, trafficking, child molesta-

tion, and internet predators even as the rate of these crimes decreases or stays low—according to his own FBI’s statistics.

Worst still, the Obama presidency shows very little interest in developing a real vision of sexual health. Fierce battles were fought—and lost—over inclusion of contraception and abortion in any reform of our health care system. Both sexual information and contraception are still routinely withheld from students in public, private, and home-schools. The continued astronomical rate of unprotected sex and unplanned pregnancy among American youth is treated as a moral rather than practical problem. As the Catholic Church has become the nation’s largest operator of hospitals, sexual health services—even routine testing for STDs—has dwindled substantially in city after city across America.

The Religious Right has become stronger, smarter, and more aggressive in the last two years with regard to sexuality. Having almost completed its planned criminalization of abortion, it is going after contraception. They have successfully marginalized the wonder drug Gardasil, which could have protected an entire generation from HPV—on the grounds that the drug’s very effectiveness “might” lead to “promiscuity.” They have created coalitions on zoning boards, city councils, and state legislatures that have reduced or even eliminated adult entertainment in large parts of the country. They have persuaded many major hotel chains, such as the Omni, to stop offering adult movies in guest rooms.

Postscript: Four Bright Spots

Four bright spots in this otherwise daunting overview should be noted.

The Judicial System

While the judicial system is far from uniformly supportive of sexual rights, neither are they a rubber stamp for every restriction on nudity, sexual photography, or sex toys that sex-phobic minds continue to conjure. District and federal courts continue to surprise and inspire with their decisions supporting privacy and commerce, “even” when the content is sexual. Recent examples include a judgment against Daytona Beach Shores, FL for strip-searching

exotic dancers in a raid (yes, even strippers have rights), and a Third Circuit decision affirming that school districts cannot punish students for satirical myspace.com pages of school officials created off campus (reinforcing students’ right of self-expression).

(Almost) The End of Abstinence-Only

One of the most mean-spirited and destructive policies of the Bush Administration involved the cruel destruction of American school sex education and replacing it with training in abstinence. This mandated that schools teach that “sexual activity outside of marriage is likely to have harmful psychological and physical effects;” if contraception is mentioned, only “failure rates” may be taught, not “effectiveness rates.”

Over one billion dollars of U.S. tax dollars was poured into programs across the country that denied young people the information they need to make good decisions—and instead “trained” them with religious propaganda, medical misinformation, and outright lies.

Although scientific evaluations of these programs were resisted by their Congressional supporters and curriculum designers, evaluations were eventually done. With funding from the federal Centers for Disease Control, Dr. Douglas Kirby of ETR Associates supervised a national evaluation program that affirmed in 2007, that “no abstinence program...has been found to positively impact teen sexual behavior...there is no evidence to support continued investments of public funds in rigid abstinence-only-until-marriage programs.”

In 2010, Congress eliminated two federal abstinence-only programs totaling \$112 million per year, and initiated two new evidenced-based sex education programs: the Personal Responsibility Education Program (PREP), and the Teen Pregnancy Prevention (TPP) initiative, totaling \$155 million annually. At the insistence of Senator Orrin Hatch, during 2011 a total of \$33 million was awarded to abstinence-only programs.

Lesbians, Gay Men, and Bisexuals Edge Closer to Full Citizenship

Only four few decades ago, American psychiatry described homosexuality as a mental disorder; “sodomy” (non-intercourse sex) was still illegal in much of the country less than a decade ago. It’s hard to overstate just how far the United States has come in the area of civil rights for gay men and women.

With New York State a recent entry, six states and Washington, DC have now legalized same-gender marriage, dramatically increasing the number of people who now have a right to marry. Gay people have also acquired significant rights to their partners’ pensions, insurance benefits, participation in medical decisions, and adoption privileges.

Corporations, looking for competitive advantages in hiring highly-skilled workers, are announcing their non-discrimination policies more and more loudly. The Home Depot can claim particular effectiveness in this arena; as a result of sponsoring a float in gay pride events, they are now being boycotted by the American Family Association.

With the blinding speed of a comatose snail, American’s military is inching toward complete inclusion of gay and lesbian servicemembers. Professional sports figures are coming out as gay, as are entertainers. Major psychological associations, such as the California Association of Marriage & Family Therapists (25,000 members), now requires all continuing education activity to be explicitly sensitive to issues of sexual orientation. Over 150,000 students participate in school-based gay-straight alliances. And where students lead, adults eventually follow: LGBT history will be mandated in California schools starting January 1, 2012.

Young People: A Reason for (Cautious) Optimism

While almost half of Americans still support legal discrimination against gay men and lesbians, and more than half of Americans believe bizarre ideas about the impact of pornography (even though sex crimes continue to decrease as pornography use increases), and more than half of Americans support dramatic restrictions on abortion, Americans under 25 are different from their older neighbors: They are less likely

to describe sexuality with a fear-and-danger narrative. Young Americans are more tolerant of alternative sexual arrangements, and more likely to participate in sexual expression that is currently under legal scrutiny. They are more honest about viewing pornography. With a very high average age of first marriage (around 26-27), they are highly unlikely to stigmatize premarital sex, even if they decline it for themselves. They are highly accepting of sex toys, cross-racial sexual relationships, nudity, and non-intercourse sex. They expect access to contraception and sexual health information.

Perhaps by the time their views shape our country’s policies, this report will look very different.

The Human Right to Sexual Expression

Killing the Messenger:

An Analysis of the Legal Issues Associated with Imposing Criminal Liability on Internet Service Providers for Acts of Their Customers

Lawrence G. Walters, Esq.

Introduction

Since the inception of the Internet, Congress has been trying to keep pace with the technological developments in Cyberspace, and the unique legal issues they spawn. U.S. law is infamous for its knack of lagging behind technology at a seemingly embarrassing pace. Over the last decade or so, Internet-related cases have been watched closely because they confronted novel, and at times previously nonexistent, areas of law. But gone are the days where the Internet was infamously described as a “series of tubes¹” or where lack of understanding of online communications *almost* qualified as an excuse for trial and error legislation. Concerns with online content liability have become more and more prevalent, and yet Congress, along with the judiciary, has chosen to remain silent on many of the most pressing issues confronting online communication. One such example is the legal, criminal (as opposed to civil) exposure facing various types of online service providers, based on content generated by third parties.

The legal protections carved out by lawmakers for “service providers” thus far have focused on protection from monetary, civil liability. They have traditionally been designed to benefit web hosts, ISP’s, and search engines; but in recent years, especially given the influx of social networking sites, a new category of service provider has emerged; the user-generated content (“UGC”) website. UGC sites provide an online forum, or web space, for third parties to communicate, thus allowing them to fall into this “service provider” category. Liability concerns, particularly criminal issues, constantly plague all UGC sites regardless of their subject matter or focus – getting hit with a large judgment and filing for bankruptcy is one thing, but going to jail is quite another. Accordingly, UGC sites have collectively tried to get a handle on where the legal line might be drawn when it comes to being held criminally responsible for a user’s conduct or content. However, it is the UGC sites that concen-

trate on more controversial subject matter, like erotic media, drugs or gambling, that face the most legal uncertainty.

Every day, thousands of erotic forums, hosts, adult dating sites, erotic-themed “tube” sites, online escort classified sites, and adult content review sites are essentially forced to operate in fear that a swat team might at any moment descend on their corporate headquarters, or that the Department of Justice might seize their domain name(s), based on the uncertain legal issues pertaining to criminal liability for content originating from third parties. Despite the existence of this uncertainty lingering for almost two decades, Congress has failed to act, while the problem grows larger by the day.

This article focuses on the concerns facing service providers that operate in the adult entertainment space – or “sex business” – for want of a better term. Every day, thousands of erotic forums, hosts, adult dating sites, erotic-themed “tube” sites, online escort classified sites, and adult content review sites are essentially forced to operate in fear that a swat team might at any moment descend on their corporate headquarters, or that the Department of Justice might seize their domain name(s), based on the uncertain legal issues pertaining to criminal liability for content originating from third parties. Despite the existence of this uncertainty lingering for almost two decades, Congress has failed to act, while the problem grows larger by the day.

The Development and Current Status of Service Provider Criminal Liability in the U.S.

Historical Approach

Service providers initially adopted the “ignorance is bliss” mentality when dealing with issues of criminal liability for UGC, but such a flippant state of mind is rarely seen anymore. A service provider’s liabil-

ity for the activities or content originating from its subscribers was traditionally based solely on actual knowledge of the subscribers' actions. If the service provider was unaware of the behavior of its customer, historically, most courts seemed reluctant to hold the provider criminally liable for that behavior and/or content. But if an ISP knew that a customer had posted illegal material and refused to take action, criminal liability could be imposed.² A portion of the analysis appeared to be based on politics as well: The mega-corporations with active lobbyists seemed to be given a pass, while other less powerful interests – engaged in the same or similar online activity – would garner the attention of law enforcement. However, as it stands, the line between legal protection and serious criminal liability in this area remains quite blurred and service providers remain wholly uncertain of their exposure and obligations.

Civil vs. Criminal Exposure

It is important to distinguish immediately between the state of the law relating to service provider liability for civil, as opposed to criminal, statutes and penalties. Congress has taken an active role in ensuring that service providers are protected from civil liability for a wide variety of user-oriented activities. For example, in 1996 it passed Section 230 to the Communications Decency Act³, 47 U.S.C. 230 ("Section 230"), which provides interactive computer service providers with broad immunity from virtually all civil claims arising from the communications posted by third parties on the Internet.⁴ Section 230 immunity excludes, however, intellectual property claims.⁵ Thus, for a time, online service providers remained exposed to intellectual property claims, such as copyright infringement suits.

However, Congress acted to fix this problem in 2000, by passing the Digital Millennium Copyright Act ("DMCA")⁶, which allows service providers (who comply with specified statutory prerequisites) to take advantage of certain "safe harbor" protections from monetary liability for copyright claims, based on material posted by third party users on service provider networks.⁷ Section 230, in tandem with the DMCA safe harbor protections, affords service providers with comfortable legal protection from just about any

civil claim arising from user generated content, such as copyright infringement, publicity rights violations, and defamation.⁸ Some loopholes remain, however, such as liability for third party trademark or patent infringement. But for the most part, service providers can go about their business without fretting about being sued by an ex-girlfriend who happened to find her risqué photo shoot – intended for her ex-boyfriend's eyes only – on some adult oriented amateur photography site. But what about the bigger criminal concerns like obscenity, child pornography, prostitution, solicitation or exploitation of minors? One would think that these would be the primary concerns on the minds of service providers who allow third party users to post messages, images and video without prior review and approval by the online service provider. To date, the unsettled status of criminal liability issues has produced interesting, albeit inconsistent, results.

The Campaign against Online Escort Sites

One of the first online service providers targeted for imposition of criminal liability based on third party material, in modern times, was Craigslist.org. The underlying basis for its alleged criminal exposure emanated from its escort classified ads. In 2009, law enforcement agencies at both the state and federal levels focused their attention on Craigslist's "adult personals" classified advertising category, which contained ads for adult companionship and "escorts." Believing that this category was nothing more than a thinly-veiled attempt to openly advertise prostitution services, the team of state Attorneys General sprang into action, with demands of censorship under the penalty of criminal prosecution.⁹ After some skirmishes in court, where Craigslist.org seemed to be winning, the site ultimately abandoned its U.S. based erotic services category in response to the intense public pressure and threats of baseless criminal prosecution.¹⁰

After adding a few more states to their gang, the band of bullying Attorneys General then turned their sights on the next most popular escort ad destination: Backpage.com. Not surprisingly, the law enforcement action against Craigslist.org did not result in the demise of the escort industry – instead the

escorts just found another site on which to advertise: Backpage.com. Twenty-one (21) Attorneys General across the country teamed up and wrote a letter to Backpage.com, demanding that the site immediately censor its online advertising of “adult services” or face potential criminal charges and other law enforcement action – a dangerous threat, especially during election season.¹¹ Connecticut’s Attorney General, Richard Blumenthal, called the demands for censorship, “common-sense steps toward protecting women and children.”¹² The fact that the site was sued by a 15-year-old female victim of sex trafficking, for turning a blind eye to illegal activity, did not help.¹³ Backpage.com initially fought back with the unveiling of its opposition blog, blog.backpage.com, but eventually compromised to a degree in announcing new “security measures” associated with its adult personal ads. At the same time, it sought to diffuse the intense public attention on its website by calling on its “industry brethren” such as eros.com, cityvibe.com, escorts.com and myredbook.com, to form a “National Task Force” to study ways to prevent misuse of online escort advertising venues for illicit purposes.¹⁴

Backpage.com’s purported gesture of goodwill ultimately resulted in investigation of, and prosecutorial threats pertaining to, the business practices of several of the sites outed by Backpage’s call for action, by a variety of state and local authorities. For example, law enforcement officials from Montgomery County, Maryland went so far as to label one of the websites identified by Backpage.com as the “primary internet advertiser of human trafficking,” and launched an investigation into the site.¹⁵ Within weeks of Backpage.com’s announcement, state and federal investigations into escort sites across the country were launched. During this time frame, over 100 federal law enforcement agents raided the corporate offices of Escorts.com, a successful online escort advertising site, seizing substantial business and personal assets.¹⁶ Speculating for months, adult industry insiders debated whether or not this would be the end of online escort advertising.¹⁷ As the FBI conducted its investigation into Escorts.com, the raid that had briefly turned the online adult industry on its head eventually dropped from the headlines. Then, after more than six months of virtual silence on the

issue, on June 21, 2011, Escorts.com quietly shut down its website, without explanation.¹⁸

As recently as July 25, 2011, the campaign against Backpage.com took on new life, as Seattle’s Mayor, Mike McGinn, ordered all city departments to halt any advertising business with the *Seattle Weekly*, a subsidiary of the company that owns Backpage.com, Village Voice Media.¹⁹ The action was taken in response to a letter sent by the National Organization for Women, a few days before, which demanded that McGinn support a boycott of Village Voice Media. This retaliatory use of municipal advertising dollars has been called “government regulation of speech” by one legal expert.²⁰ So the pressure remains on these online service providers, but no law imposes clear liability upon them for illegal acts of third parties of which they are unaware.

Although Craigslist.org stepped out of the limelight for a while, after it removed the U.S. escort ads, groups in other countries such as Canada started to demand that the site remove its ads in those locations as well.²¹ The Ontario government claimed that this request for removal of the ads was “just a matter of fairness,” given the removal of the ads in the United States.²² Shortly thereafter, the company capitulated and removed the Canadian ads.²³ Apparently deciding that enough was enough, [Craigslist](http://Craigslist.org) finally drew the proverbial line in the sand in December of 2010. After initially agreeing to dismiss its litigation against South Carolina Attorney General Henry McMaster seeking an injunction permanently barring criminal charges against [Craigslist](http://Craigslist.org) executives related to the site’s adult advertisements, the company filed a motion to reconsider the entire matter, with the South Carolina district court, effectively reopening the case.²⁴ A hearing on the effort to reinvigorate the case was set for March 10, 2011, but was later cancelled as [Craigslist](http://Craigslist.org), quietly and unexpectedly withdrew its request for reconsideration without explanation.²⁵ Thus ended [Craigslist](http://Craigslist.org)’s lengthy battle with state law enforcement officials, yet no progress was made on clarifying the legal liability imposed on service providers based on UGC.

The Current State of Affairs in 2011

The previous examples, of course, are just a recent

sampling of the government's effort to hold online service providers criminally responsible for acts of third parties. The scope of service provider liability has been a boiling legal issue for decades. As noted above, the boundaries of civil liability have become clearer, resulting in relatively well-settled law. Unfortunately, criminal liability premised on third party conduct has become ever more confused and ambiguous. Given the complexity of the relevant state and federal laws, coupled with the lack of specific interpretative case law, service providers could technically be prosecuted for crimes ranging from obscenity, to child exploitation, to prostitution, regardless of the fact that the providers have no involvement in the creation and/or selection of the content being circulated on the network. This unsettled state of affairs has resulted in a massive black hole in Internet law that should ultimately be clarified by federal legislation providing legal protection to service providers, with respect to criminal liability, in specified circumstances.

The Dangers of Self-Censorship

Criminal liability for service providers is a controversial issue, but one that must be addressed if the Internet is to continue to function, free of government-encouraged self-censorship. The lack of clarity in this realm often causes online service providers to take the "safe route" by censoring broad categories of content or activity – in the hopes of avoiding a very public criminal indictment. The old adage, "you can beat the rap but you can't beat the ride," is never more applicable than with large, often publicly-listed corporations threatened with criminal prosecution. One wrong move that aggravates a single investigator can result in a charge that then causes the company's stock to tumble. Then come the shareholder derivative suits and claims of breach of fiduciary duty against the board of directors. In the end, large respected internet service providers cannot risk being caught up in any "messy" business like allowing third parties to engage in controversial speech, absent clear statutory protection from criminal prosecution. The end result is massive self-censorship, designed to avoid any criminal problems. The Craigslist case is a prime example. Given the absence of statutory protection allowing the company to continue pro-

viding a venue for erotic-themed personal ads, the company simply could not afford to risk the admittedly frivolous threats of criminal prosecution being thrown about by the band of state Attorneys General. Censorship of an entire category of protected speech became the only realistic option.

Research – Case Law & Statutory Interpretation

The case law on criminal liability, specifically, leaves something to be desired in terms of volume, but underlying legal issues have been a long time coming. Over the last decade certain cases have, for example, touched on the potential scope of Section 230 protection, and its possible applicability to state level *criminal* prosecution. For example, in *Doe v. AOL*, a complaint was filed against AOL by a woman seeking to recover for emotional injuries suffered by her son resulting from sexual exploitation.²⁶ Doe claimed that her son was lured into engaging in sexual activity with an adult and images of such activity were subsequently marketed via AOL's chat rooms.²⁷ The court upheld AOL's immunity against the claims of negligence based on "chat room marketing" of the pornographic images of the minor.²⁸ Stating that AOL, as an intermediary, was immune from liability under criminal statutes prohibiting marketing and dissemination of child pornography, the Florida Supreme Court effectively extended Section 230 immunity to civil claims arising from criminal activities.²⁹

Later, in 2009, an Illinois court touched on the possibility of extending Section 230 immunity to criminal actions in *Dart v. Craigslist*.³⁰ The primary argument advanced in that case was that Craigslist facilitated prostitution through its adult services advertisements, and thus constituted a public nuisance.³¹ Sheriff Thomas Dart, claiming that Craigslist violated Illinois statute, because it arranges "meetings of persons for purposes of prostitution and directs them to a place for the purpose of prostitution," ultimately sought to enjoin the service provider from continuing to offer its adult personals section.³² In ruling on the request for the injunction, the court stated that even if Craigslist had violated Illinois law, the Section 230(e) exception for state law claims would control.³³ Sheriff Dart further alleged that Craigslist had violated the federal statute, 18 U.S.C. § 1952, which prohibits the facilita-

tion of prostitution.³⁴ The court deftly avoided confronting the federal law issue in a footnote where it stated that merely referencing a federal statute does not bring the public-nuisance suit within the federal criminal law exception to Section 230.³⁵

In coming to this decision, the court cited an unreported Texas district court case involving private litigants bringing civil claims against service providers predicated upon federal criminal statutes, for the purposes of circumventing Section 230 immunity.³⁶ In *Doe v. Bates*, Yahoo! hosted a website that was used to distribute child pornography.³⁷ In the attempt to avoid Section 230 immunity, the plaintiff argued that the defense did not apply to the situation because the suit sought enforcement of federal child pornography statutes.³⁸ Acknowledging the novelty of the argument, the court nonetheless rejected the assertion that a civil claim based on an alleged violation of a federal criminal law should be recognized as falling within the exception set forth in Section 230(e)(1).³⁹ The court also went a step further in recognizing that Congress's legislative intent was "not to allow private party litigants to bring civil claims based on their own beliefs that a service provider's actions violated the criminal laws."⁴⁰

Based on the evolving interpretation of Section 230 described above, it would appear consistent with legislative objectives and sound judicial policy to immunize an online service provider from criminal legal exposure, so long as the provider did not take an active role in the user's conduct and did not refuse to act after being put on notice of its services being used for criminal purposes. In this respect, three factors should be considered: lack of duty, lack of knowledge, and lack of intent. With regard to "duty," Congress's legislative intent is crystal clear on the issue, and courts have determined that online service providers do not have a duty to monitor third-party content published on their networks.⁴¹ Imposing such a duty would bring Internet traffic to a screeching halt, given the sheer manpower necessary to review the millions of files uploaded to some networks, on a regular basis. Without being *required* to scrutinize UGC prior to publication, there is a substantial likelihood that a service provider truly has no knowledge of specific illegal content displayed on or

distributed through its network. The lack of knowledge goes hand in hand with lack of criminal intent, or *scienter*. The intent to violate the law is essential to the imposition of criminal liability, in most instances.⁴²

Many prosecutors know that nothing strikes fear in the hearts of online service providers like the word *obscenity*. Whether looking for headlines or shock value, one of the more likely charges that could be brought against an online service provider that permits uploading of erotic material is a charge based on the distribution of obscene materials.⁴³ As seen above in the *Doe v. AOL* case, service providers have the capability of being misused for the circulation of offensive, and sometimes illegal material – including obscenity or child pornography. Unfortunately for the service provider, there is no litmus test for obscenity. An expressive work can only be declared obscene by a judge or a jury applying the three part test set forth in *Miller v. California*.⁴⁴ Therefore, the service provider would have no way to filter out potentially obscene material without eliminating all erotic material, in its entirety. Obscenity and prostitution violations are typically considered "predicate acts" for application of state and federal racketeering laws, which carry serious criminal penalties including decades of incarceration and seizure of all business assets.⁴⁵

Service providers face potential criminal exposure under two primary theories of liability: 1) Conspiracy;⁴⁶ and 2) "Aiding and Abetting."⁴⁷ Both are examples of accomplice liability theories which allow a defendant to be charged with committing a crime, even if that particular individual (or company) did not actually complete or carry out the offense charged. Thus, even if a service provider's activity is not sufficient to warrant direct criminal charges, its actions in providing a forum for such illegal activity, coupled with some level of knowledge of such activity, could arguably warrant the imposition of accomplice liability, under either conspiracy or "aiding and abetting" laws. For example, had Attorney General McMaster made good on his threats, Craigslist could have eventually been charged with aiding and abetting prostitution or solicitation. Under such a charge, the government would have to prove that Craigslist was aware that its advertising forum was being used to facilitate the prostitution-related activities, and

either agreed to assist in this endeavor, or did substantially assist in, or induce, the commission of the crime. Craigslist need not be involved with the acts of prostitution, themselves, be present when they are performed, or even be aware of the details of their execution, to be pursued under accomplice liability theories. However, a general suspicion that a user's advertisement may involve potential sex for money is simply not enough to trigger criminal liability. A key element of criminal liability is "intent," as the law requires a "willful" criminal action to be committed voluntarily and intentionally. Fortunately for online service providers, most criminal statutes require that the state prove this element of intent, or *scienter*, which is a bedrock principle for imposing criminal liability.

Although Congress has remained relatively silent on the issue of service provider criminal liability, in 2002 a bill was introduced that was designed specifically to immunize service providers from criminal liability in certain circumstances.⁴⁸ Although the Bill was relatively well-received in the House, it ultimately died in committee a few short months after its introduction. The Online Criminal Liability Standardization Act ("OCLSA"), introduced by Representative Bob Goodlatte, was the legislature's first notable recognition of the plight of service providers in the criminal realm. The OCLSA was intended to amend the federal criminal code to provide that no interactive computer service provider could be found liable for a crime arising from transmitting, storing, distributing, or making available material provided by another person, in other words, UGC.⁴⁹ However, this limitation on criminal liability would be waived if it was proven that the provider intended that the service be used in the commission of the crime in question.⁵⁰ Delving into the issue of intent, the OCLSA stated that the service provider would not be found to have the requisite intent to defeat the liability limitation unless: (1) the provider's employee or agent possessed intent to commit the crime; and (2) the conduct constituting the offense was authorized, requested, commanded, or performed by a managerial member of the corporate structure acting for the benefit of the provider.⁵¹

Thus, almost an entire decade ago service providers were able to generate sufficient awareness for this problematic issue, such that Capitol Hill took notice

and realized that criminal liability for service providers is a very real problem. Since the introduction and subsequent failure of the OCLSA, criminal liability issues for online service providers have only gotten worse, and the legal issues even more uncertain. A resurgent effort lobbying for new OCLSA-type legislation would be an immense benefit to the service provider community, and the health of the online economy, overall. Since this first attempt in 2002, UGC sites like social networks, along with online dating sites, forums and online classified sites have soared in popularity. The stakes for such e-commerce have therefore become much more significant. Section 230 immunity recognizes that fostering an environment of cooperation between the law and service providers is key. A major detriment to this symbiotic paradigm of teamwork is the valid concern by online providers that any efforts on their part will be ultimately used against them. One day they are helping law enforcement by providing information about a wanted criminal, and the next day they're the target of a criminal investigation. Accordingly, some clarity in statutory obligations (with associated immunity) is the only way to alleviate these growing concerns.

Moving Forward

Sadly, until a service provider calls the bluff of law enforcement, and meets a criminal charge head on in court, the cycle will simply continue. For many established service providers, a criminal test case is simply not a realistic option. Moving an entire operation overseas is often seen as more attractive. Thus, until Congress acts, with a rational piece of legislation that is long overdue or a court interprets existing law to provide protection for criminal liability, the stalemate remains. And another online business decides to open in Cyprus.

Given the uncertainty surrounding the potential exposure for criminal violations, the draconian penalties associated with the relevant criminal offenses, and the stakes relating to the free flow of information on the Internet, this issue cannot be ignored much longer. Failure of the U.S. to take the lead by developing clear protections for innocent service provid-

ers whose networks are exploited by criminals, will lead to a movement of the service provider industry offshore – which has already begun. The ambiguities associated with obscenity and other statutes directed at the adult entertainment industry,⁵² have fostered paranoia by service providers causing them to make premature, irrational business decisions. As seen first-hand with the scenarios involving Craigslist and Escorts.com, service providers are reaching a point of utter panic, where they are more willing to censor an entire category of erotic speech, or cease doing business entirely, rather than face the unknowns of criminal liability. The author agrees that “online” should not be a euphemism for anarchy, but current law should not result in the stifling of speech and innovation. The lack of any recognized statutory protection for service providers has resulted in the chilling of speech via a medium of communication that was created for the sole purpose of disseminating speech. The situations experienced by Craigslist, Backpage and Escorts.com amount to nothing more than glorified bullying by law enforcement. In the cases of Craigslist and Escorts.com, the censors won. Backpage is fighting off boycotts, threats and intimidation by everyone from local politicians to the National Organization for Women. Sadly, until a service provider calls the bluff of law enforcement, and meets a criminal charge head on in court, the cycle will simply continue. For many established service providers, a criminal test case is simply not a realistic option. Moving an entire operation overseas is often seen as more attractive. Thus, until Congress acts, with a rational piece of legislation that is long overdue or a court interprets existing law to provide protection for criminal liability, the stalemate remains. And another online business decides to open in Cyprus.

Notes

- 1 On June 28, 2006, Senator Ted Stevens used this wildly inappropriate metaphor to criticize a proposed amendment to a committee bill pertaining to "net neutrality."
- 2 J. Scheeres, *ISP Guilty in Child Porn Case*, *Wired.com* (Feb. 16, 2001), available at: <http://www.wired.com/culture/lifestyle/news/2001/02/41878>
- 3 47 U.S.C. § 230(c). Protection for "Good Samaritan" blocking and screening of offensive material. (1) Treatment of publisher or speaker: No provider or user of an interactive computer service shall be treated as the publisher or speaker of any information provided by another information content provider. (2) Civil liability: No provider or user of an interactive computer service shall be held liable on account of (A) any action voluntarily taken in good faith to restrict access to or availability of material that the provider or user considers to be obscene, lewd, lascivious, filthy, excessively violent, harassing, or otherwise objectionable, whether or not such material is constitutionally protected; or (B) any action taken to enable or make available to information content providers or others the technical means to restrict access to material described in paragraph (1).
- 4 *Zeran v. American Online, Inc.*, 129 F.3d 327 (4th Cir. 1997); *Doe v. MySpace, Inc.*, 528 F.3d 413 (5th Cir. 2008); *Dart v. Craigslist*, 665 F. Supp. 2d 961 (N.D. Ill. 2009); *Doe IX v. MySpace, Inc.*, 629 F. Supp. 2d 663 (E.D. Tex. 2009).
- 5 47 U.S.C. § 230(e)(2). Whether this means all "intellectual property" claims or only federal intellectual property claims is an issue that has not been completely settled. But see, *Perfect 10, Inc. v. CCBill LLC*, 488 F.3d 1102 (9th Cir. 2007)(holding that the immunity exemption only applies to intellectual property claims arising under federal law).
- 6 17 U.S.C. § 512.
- 7 17 U.S.C. § 512(c).
- 8 *Supra* note 3.
- 9 E. Bailey, Jr., *State AGs: Craigslist Should Drop Adult Services*, ABC News (August 25, 2010), available at: <http://abcnews.go.com/Technology/wireStory?id=11472712>.
- 10 G. Sandoval, *Craigslist to Remove 'Erotic Services' Section*, *CNET* (May 13, 2009), available at: http://news.cnet.com/8301-1023_3-10239610-93.html?part=rss&sub=1&tag=2547-1023_3-0-5.
- 11 G. Duncan, *Attorneys General Target Backpage Online Classifieds*, *DIGITAL TRENDS* (Sept. 23, 2010), available at: <http://www.digitaltrends.com/computing/attorneys-general-target-backpage-online-classifieds>. See also, Letter from state Attorneys General to Backpage.com, OFFICE OF MISSOURI ATTORNEY GENERAL (Sept. 21, 2010), available at: <http://ago.mo.gov/pdf/Backpage.pdf>.
- 12 Press Release, *Attorney General Leads 21 States In Calling On Backpage To Close Adult Services Section*, OFFICE OF CONNECTICUT ATTORNEY GENERAL (Sept. 21, 2010), available at: <http://www.ct.gov/ag/cwp/view.asp?Q=466074&A=3869>.
- 13 W. Davis, *Village Voice Sued for Aiding & Abetting Sex Trafficking*, *MEDIA POST NEWS* (Sept. 20, 2010), available at: http://www.mediapost.com/publications/?art_id=136047&fa=Articles.showArticle. See also, *M.A. v. Village Voice Media Holdings*, Civil Action No. 4:2010cv01740 (Sept. 16, 2010).
- 14 The Backpage.com Blog, *Backpage Steps Up Safety Efforts, Calls for National Task Force* (Oct. 18, 2010), available at: <http://blog.backpage.com>.
- 15 See Press Release, *Vice and Intelligence Detectives Develop Initiatives Against Human Trafficking*, MONTGOMERY COUNTY, MD SHERIFF'S OFFICE (Nov. 8, 2010), available at: http://www.montgomerycountymd.gov/Apps/Police/News/NA_details.asp?NaID=5695. ("The Vice Section is using a variety of investigative techniques to make web hosts accountable for their complicity in the advertising of human trafficking.") ("The Vice Section is also requesting that Backpage and EROS discontinue the future advertisement of these individuals or be prepared to be found complicit in the crime of human trafficking.")
- 16 R. Pardon, *FBI Agents Raid Hotmovies' Office*, *XBIZ* (Oct. 27, 2010), available at: <http://newswire.xbiz.com/view.php?id=126774>.
- 17 UPI, *Agents Raid Porno Giant in Philadelphia* (Oct., 28, 2010), available at: http://www.upi.com/Top_News/US/2010/10/28/Agents-raid-porno-giant-in-Philadelphia/UPI-56781288320801.
- 18 See www.escorts.com, as of July 26, 2011, the page resolves to a message stating: "The domain is not in use."
- 19 C. McNerthney, *Mayor Gets Support Targeting Village Voice Online Ads*, *SeattlePI.com* (July 22, 2011), available at: [http://www.seattlepi.com/local/article/Mayor-gets-](http://www.seattlepi.com/local/article/Mayor-gets-support-targeting-Village-Voice-1542869.php)
[support-targeting-Village-Voice-1542869.php](http://www.seattlepi.com/local/article/Mayor-gets-support-targeting-Village-Voice-1542869.php)
- 20 *Id.*
- 21 Craigslist, Ontario to Discuss Prostitution Listings, *The Canadian Press* (Oct. 19, 2010). D. Bramham, *Craigslist Pressured to Eliminate Sex Ads, But They Are Still Just a Couple Clicks Away*, *CANADA.COM* (Oct. 14, 2010), available at: <http://www.canada.com/news/Craigslist+pressured+eliminate+they+still+just+a+couple+clicks+away/3669201/story.html>.
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- 23 T. Cherry, *Craigslist Removes Erotic Services Ads*, *TORONTO SUN* (Dec. 18, 2010), available at: <http://www.torontosun.com/news/torontoandgta/2010/12/18/16603501.html>.
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- 25 W. Davis, *Craigslist Drops Suit Involving Execs, Adult Ads*, *MEDIA POST* (Mar. 7, 2011), available at: http://www.mediapost.com/publications/?fa=Articles.showArticle&art_id=146263.
- 26 *Doe v. America Online*, 783 So. 2d 1010 (Fla. 2001).
- 27 *Id.* at 1011. Doe did not allege that photographs or images of her son were transmitted via the AOL service.
- 28 *Id.* at 1012.
- 29 *Id.* at 1018.
- 30 *Dart v. Craigslist, Inc.*, 665 F. Supp. 2d 961 (N.D. Ill. 2009).
- 31 *Id.* at 961.
- 32 *Id.* at 963.
- 33 *Id.* at 965.
- 34 *Supra* note 29.
- 35 *Supra* note 30. See also 47 U.S.C. 230(e)(1). "Nothing in this section shall be construed to impair the enforcement of section 223 or 231 of this title, chapter 71 (relating to obscenity) or 110 (relating to sexual exploitation of children) of title 18, or any other Federal criminal statute."
- 36 *Doe v. Bates*, 2006 WL 3813758 (E.D. Tex. Dec. 27, 2006) (unpub.).
- 37 *Id.* at 1.
- 38 *Id.* at 2.
- 39 *Id.* at 3.
- 40 *Id.* at 5.
- 41 See "Personal Explanation." 141:129. *Congressional Record* (August 4, 1995) p.H8468; *Stoner v. eBay, Inc.*, 2000 WL 1705637 (Cal. Sup. Ct. 2000) (unpub.).
- 42 Over time, some exceptions have developed, and these are known as "strict liability offenses." Exploitation of a minor often falls into this category, since neither consent nor lack of knowledge of the minor's age are typically considered as valid defenses to such a charge.
- 43 18 U.S.C. § 1465. Whoever knowingly transports or travels in, or uses a facility or means of, interstate or foreign commerce or an interactive computer service (as defined in section 230(e)(2) (1) of the Communications Act of 1934) in or affecting such commerce for the purpose of sale or distribution of any obscene, lewd, lascivious, or filthy book, pamphlet, picture, film, paper, letter, writing, print, silhouette, drawing, figure, image, cast, phonograph recording, electrical transcription or other article capable of producing sound or any other matter of indecent or immoral character, shall be fined under this title or imprisoned not more than five years, or both.
- 44 413 U.S. 15 (1973). Obscenity means the status of a material which a) the average person, applying contemporary community standards, would find, taken as a whole, appeals to the prurient interest in sex, nudity or excretion; b) depicts or describes, in a patently offensive way, sexual conduct as specifically described by statute; and c) taken as a whole, lacks serious literary, artistic, political or scientific value.
- 45 E.g., § 895.02, Fla. Stat. (2010).

46 18 U.S.C. § 371, makes it illegal for someone to form an agreement to commit a crime, and take any overt act in furtherance of the commission of the offense.

47 18 U.S.C. § 2. To "aid and abet" means to substantially assist someone else in committing a crime.

48 See H.R. 3716: Online Criminal Liability Standardization Act of 2002. "No interactive computer service provider, or corporate officer of such provider, shall be liable for an offense against the United States arising from such provider's transmitting, storing, distributing, or otherwise making available, in the ordinary course of its business activities as an interactive computer service provider, material provided by another person. The liability limitation created by this section does not apply if the defendant intended that the service be used in the commission of the offense."

49 *Id.*

50 *Id.*

51 *Id.*

The Human Right to Relationships & Family

Relationship and Family Freedoms and Protections

Kate Kendell, Esq.
National Center for Lesbian Rights

“The bottom line is that everyone has a fundamental right to form a family, and we are steadily making progress towards laws and policies that recognize and respect our choices about how we exercise that right.”

Introduction

Sexual freedom includes the freedom to form and nurture our families with the people we choose. This chapter provides an overview of current legal and policy issues relating to our ability to exercise this freedom. These issues include relationship recognition – marriage, civil unions, domestic partnership – and parenting, including adoption and foster care.

The lesbian, gay, bisexual and transgender (LGBT) community has a lot at stake in this discussion, and many recent changes in law and policy on these issues have been driven by LGBT people and families. From marriage to second-parent adoptions, to a push to recognize multi-parent families and families of choice, LGBT people are at the forefront of a movement to win recognition and protection for families of all kinds.

But legal and policy questions about how we form our families and how they are recognized go beyond issues of sexual orientation and gender identity, and encompass issues of race, class, age, disability, and all of the other facets of our identities. The bottom line is that everyone has a fundamental right to form a family, and we are steadily making progress towards laws and policies that recognize and respect our choices about how we exercise that right.

The State of Relationship and Family Freedoms and Protections in the U.S. in 2011

The current state of sexual freedom regarding relationships and family

Relationship Recognition

The past few years have seen dramatic changes in how relationships are recognized across the United States. In the last year, marriage equality for same-sex couples came to New York, and Illinois, Hawaii and Delaware established civil unions. This means that as of July 2011, same-sex couples may marry in Massachusetts, Connecticut, Iowa, New Hampshire, New York, Vermont, and the District of Columbia.

Civil unions are recognized in Illinois, New Jersey, New York, Vermont; and will be recognized in Hawaii and Delaware beginning January 1, 2012. Comprehensive domestic partnerships are available in California, the District of Columbia, Nevada, Oregon, and Washington, and these states with comprehensive domestic partnerships should also recognize civil unions.

Five states — Colorado, Hawaii, Maine, Maryland, and Wisconsin — provide more limited rights to same-sex (and sometimes different-sex) couples through statuses variously called domestic partnership, reciprocal beneficiaries, or designated beneficiaries. And more than 80 cities and counties offer “domestic partnership” registration with some legal protections and benefits for unmarried cohabitants, including same-sex couples.

Cohabitation

Same-sex and different-sex couples who live together but do not have a legally-recognized relationship are increasingly likely to be protected by courts, and to have their mutual obligations honored. In many states, cohabitation agreements are recognized as contracts governing the distribution and rights to any income, real property, or other assets. These agree-

ments, whether created expressly or based on the actions and words of the parties, can offer unmarried couples some of the same protections marriage offers after a relationship dissolves or a partner dies.

Some challenges remain for unmarried, cohabiting couples. In a few states, unmarried cohabitants are barred from becoming adoptive or foster parents. This prohibition disproportionately harms same-sex couples, who cannot marry in any of these states, and are thus not able to adopt or foster children jointly.

In the past, courts making custody determinations have treated post-divorce cohabitation unfavorably. In some states, where one parent lives with another adult who is not his or her spouse, courts have used that cohabitation as a reason to limit visitation or custody. Fortunately, the modern trend is towards recognizing that courts should not base custody or visitation determinations on a parent's marital status.

Parenting

Adoption and foster care

Families may be formed in many different ways, including through adoption and foster care. The right to participate equally in these processes without discrimination based on sexual orientation, gender identity, or marital status is critical.

In the past, some states have restricted adoption and foster parenting based on the sexual orientation of the prospective parent. But in the last year, there have been two major victories for equal access to adoption and foster parenting. As of January 2011, when the Florida law banning adoption by gay men or lesbians was struck down as unconstitutional, no state bars individuals from adopting based solely on sexual orientation. And in April 2011, the Arkansas Supreme Court struck down a state law banning any person cohabiting with an unmarried partner from adopting or serving as a foster parent.

A growing number of states affirmatively prohibit discrimination on the bases of sexual orientation, gender identity, or marital status in adoption and foster care. These states include California, Connecticut, the District of Columbia, Massachusetts, New

Jersey, New York, Oregon, and Rhode Island. Texas recently passed a Foster Care Bill of Rights that provides that youth in the system are entitled to be free from discrimination on the basis of sexual orientation. Wisconsin requires that all contracting agencies include a provision obligating the contractor not to discriminate on the basis of sexual orientation. Wisconsin also has a regulation that prohibits foster parents from discriminating against foster children on the basis of sexual orientation.

In addition, these states and the District of Columbia prohibit discrimination on the basis of sexual orientation in public accommodations, which may apply to public or private agencies providing adoption and foster care services: California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Iowa, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Vermont, Washington, and Wisconsin. Thirteen of these states and the District of Columbia also prohibit discrimination on the basis of gender identity in public accommodations. And a number of cities, including Los Angeles, San Francisco, Trenton, and New York City, have taken affirmative steps to encourage more lesbian and gay people to become foster parents.

But, as noted above, some states still have statutes or regulations that prevent a member of a same-sex or unmarried couple from adopting a child and/or serving as foster parents. Utah continues to prohibit individuals who are “cohabiting in a relationship that is not a legally valid and binding marriage under the laws of this state” from adopting, and similarly restricts foster parents. Utah laws and regulations also provide that married couples will be given preference in adoptive and foster care placements. Mississippi prohibits “[a]doption by couples of the same gender.”

Even in states without discriminatory laws or policies, prospective adoptive parents who are lesbian, gay, bisexual, or transgender may encounter bias on the part of adoption or foster care placement agencies or officials. For example, a recent report issued by the Evan B. Donaldson Adoption Institute found that 25% of adoption agencies rejected applications from

gay and lesbian prospective adoptive parents. In addition, some agencies or jurisdictions may have policies or practices of preferring heterosexual and/or married applicants.

Second-parent and joint adoptions

The court not only held that North Carolina courts may no longer grant second-parent adoptions, but actually voided all of the second-parent adoptions that had previously been granted – wiping out the legal ties between thousands of children and their parents.

Even in states where one member of a same-sex or unmarried couple can adopt, it may not be possible for both members of a couple to become legal parents. This depends on whether second-parent adoptions or joint adoptions are available in that state.

In the past two decades, second-parent adoptions have been granted in a steadily growing number of state and county jurisdictions. California, Colorado, Connecticut, the District of Columbia, Illinois, Indiana, Iowa, Maine, Massachusetts, Nevada, New Hampshire, New Jersey, New York, Oregon, Pennsylvania, Vermont, and Washington allow the unmarried partner of a legal parent to adopt. When Hawaii and Delaware begin recognizing civil unions on January 1, 2012, civil union spouses will be able to adopt jointly or using stepparent adoption procedures. Second-parent adoptions have also been granted by trial court judges in certain counties in many states, although appeals courts in Nebraska, Ohio, and Wisconsin have held that second-parent adoptions are not permissible under their adoption statutes, and a Kentucky appellate court has noted that an unmarried couple cannot use the stepparent adoption procedures in Kentucky to establish legal parentage for both partners.

Unfortunately, within the last year, LGBT parents in North Carolina suffered a terrible loss on second-parent adoptions. North Carolina courts had been granting second-parent adoptions for years. But in December 2010, the North Carolina Supreme Court decided *Boseman v. Jerrell*, a custody dispute between a lesbian couple in which the non-biological

parent had adopted her child through a second-parent adoption. The court not only held that North Carolina courts may no longer grant second-parent adoptions, but actually voided all of the second-parent adoptions that had previously been granted – wiping out the legal ties between thousands of children and their parents.

De facto or psychological parenting

Same-sex parents have also made progress towards being able to maintain legal ties to their children after their spousal or partnership relationships end. Several courts have granted legal parent status to non-biological parents who participated in planning for children conceived through alternative reproduction, parents who played the role of a parent for a number of years (de facto parents), and parents who were held out by their ex-partner to be parents.

Sexual orientation and gender identity as a factor in custody disputes

In the past, family courts often considered a divorced parent's sexual orientation in deciding whether the parent retained custody of his or her child. Fortunately, nearly every state has said that courts cannot deny custody or visitation solely because of a parent's sexual orientation. But unfortunately, bias against parents based on sexual orientation, and even more commonly gender identity, continues to play a role in custody disputes in many states.

The road ahead – towards complete respect and protection for all families

Despite the victories we have achieved, many people in the United States are still not able to form and nurture their families with the freedom and security that every person deserves, and many face uncertainty about whether their family relationships will be respected when it counts. The landscape of parentage and relationship recognition laws and policies in the United States is varied and rapidly changing. For families, especially LGBT families, the laws can be confusing, inconsistent, and often unfair.

This overarching issue is reflected in numerous cur-

rent legal and policy problems on the federal and state levels. We make progress every year, but these are some examples of the issues we continue to face:

- In Massachusetts, a court held that even though a same-sex female couple had planned to have a child together and had used artificial insemination to get pregnant while still together, the non-biological mother was not responsible for paying child support because she was not a parent under Massachusetts law. In Ohio, the Ohio Supreme Court held that a biological mother had revoked her co-parenting agreement with her ex-partner, the child's non-biological mother, and that therefore the non-biological mother could not obtain a hearing on whether she should have joint custody of her daughter.
- For elders, legal documents protecting chosen family relationships are particularly important. But in a study of nearly 800 LGBT elders and services providers for the aging, one out of ten respondents indicated that they or someone they knew had had a document assigning power of attorney disrespected.¹
- Spouses of LGBT elders in long-term care facilities face impoverishment by Medicaid laws that refuse to acknowledge same-sex couples as economically co-dependent. A few states, including Massachusetts, have passed laws to counteract this and ensure equality for same-sex elder couples.
- For transgender people, it remains very challenging to establish legal security without the help of an attorney, which is often not available to low-income people. Whether transgender people can marry, receive recognition of their marriage, or have their legal gender recognized can depend upon the state where they were born, the state that issued their identity documents, the state where they married, and the state where other legal factors come into play, such as custody and visitation law or probate law.
- Because of the federal Defense of Marriage Act (DOMA), which defines marriage as between a man and a woman for federal government

purposes, a member of a same-sex married couple cannot sponsor his or her foreign-born same-sex spouse for immigration into the U.S. based on their marriage. Although the Department of Justice is not currently defending this law in court, it is still in effect and being defended in court in a number of cases by the U.S. House of Representatives. The Uniting American Families Act (UAFSA) would create a pathway to citizenship for same-sex partners similar to the path afforded to married different-sex partners, but it has not become law and is not anticipated to in the near future. In August 2011, the Obama Administration announced that Immigration and Customs Enforcement (ICE) officials evaluating deportation cases will weigh a person's ties and family relationships, including LGBT families and same-sex relationships, in determining whether to prioritize deporting that person. Ultimately, however, foreign-born partners in same-sex couples need a pathway to citizenship.

Recent wins and losses on relationship and family freedoms and protections

Wins

Arkansas adoption/foster parenting ban

In April 2011, the Arkansas Supreme Court struck down a state law passed by voters that had banned any person cohabiting with an unmarried partner from adopting or serving as a foster parent.

New York marriage

In late July of 2011, New York became the seventh and largest jurisdiction to allow same-sex couples to marry.

Illinois, Hawaii, and Delaware civil unions

In 2011, Illinois, Hawaii, and Delaware all passed laws granting same-sex couples the right to a civil union.

California marriage ban trial court victory

In August 2010, a federal trial court held that Califor-

nia's Proposition 8 is unconstitutional after a lengthy trial featuring unprecedented and overwhelming evidence that there is no reason to prevent same-sex couples from marrying, and that exclusion from marriage based on sexual orientation stigmatizes and harms LGBT people and their families. The case is currently on appeal.

Obama Administration refusal to defend DOMA

In February of 2011, the Obama Administration directed the Department of Justice to cease defending the constitutionality of DOMA. Attorney General Eric Holder issued a statement that "given a number of factors, including a documented history of discrimination, classifications based on sexual orientation should be subject to a more heightened standard of scrutiny."²

Obama Administration hospital visitation regulations

In January of 2011, Obama Administration regulations went into effect that permit patients to designate who may visit them and expressly forbid denying visitation privileges because of sexual orientation and gender identity. The regulations address tragic situations in which people are isolated from their loved ones by hospital staff because they do not have a legally-recognized relationship.

Obama Administration deportation policy change

In August 2011, the Obama Administration announced a policy change that could lower the risk of deportation for foreign-born spouses in same-sex couples. Administration officials will review the cases of those facing possible deportation to determine which cases are high priority and low priority for removal, and will weigh a person's ties and contributions to the community and family relationships. The Obama administration has said that family relationships include LGBT families and same-sex couples.

Losses

North Carolina second-parent adoption decision

In December 2010, the North Carolina Supreme Court issued a devastating ruling for LGBT families, invalidating a state senator's adoption of her former partner's child, ruling that second-parent adoptions

are not available in North Carolina, and invalidating all second-parent adoptions ever performed in the state, immediately severing the legal tie between countless children and loving parents.

Louisiana birth certificate decision

The Louisiana state registrar refused to issue a new birth certificate for a child who had been adopted out-of-state by two men. This happened even though it is common practice for a new birth certificate to be issued when a child is adopted, and under the Full Faith and Credit Clause of the U.S. Constitution, even states that do not permit adoption by same-sex couples must recognize adoption orders issued by other states. The Fifth Circuit Court of Appeals, a federal appellate court, upheld the lower court's decision, and the U.S. Supreme Court has been asked to review the case.

Important current policy issues affecting relationship and family freedoms

This section describes several ongoing federal legislation efforts to improve relationship and family freedoms. Efforts to pass these important changes in the law will continue beyond the current Congress.

At the federal level, advocates continue efforts to repeal the federal Defense of Marriage Act (DOMA). A number of bills have been introduced in support of comprehensive immigration reform, including the Uniting American Families Act (UAF), which would allow United States citizens and lawful permanent residents to sponsor their same-sex foreign national partners for immigration.

Additional immigration reform bills are on the table, including the Development, Relief, and Education for Alien Minors (DREAM) Act, and the Comprehensive Immigration Reform Act. All of these bills would affirm the human dignity of immigrants, refugees, and asylum-seekers regardless of sexual orientation.

The Affordable Care Act, and subsequent guidance from Health and Human Services (HHS), provides important nondiscrimination protections for families. For example, the law clarifies that same-sex couples on Medicaid may be provided with many of the same

benefits as opposite-sex couples

The federal Office of Personnel Management (OPM), which oversees government employees, now allows federal employees to designate freely their beneficiaries, rather than be restricted to a spouse or someone with whom they are in a romantic relationship. As part of this change, federal employees who are not legal parents, but are acting as parents, should now be able to extend health insurance and other benefits to children in their care. Federal employees would additionally benefit from the proposed Domestic Partnership Benefits and Obligations Act (DPBO), which would allow them to include their families in their benefits, without requiring a legal relationship between the employee and the employee's children or partner.

Support also continues to build for the Every Child Deserves a Family Act (ECDF), which would prohibit states from discriminating against LGBT prospective parents seeking to adopt.

In order to support and guide policy advocacy efforts on relationship and family freedoms and protections, more and better data related to sexual orientation and gender identity must be collected on a national level. Data collection itself is a policy issue. In 2010, for example, after pressure from advocates and the Obama Administration, the U.S. Census recorded and reported data about same-sex couples for the first time. Future Census questions should gather more complete data and include transgender people.

At the state level, advocates continue to push legislatures to pass marriage, civil union or domestic partnership, or other relationship recognition laws, and for parentage statutes that offer equal protection to non-biological parents as well as unmarried parents. Advocates are also facing challenges in many states, including Minnesota, where a constitutional amendment banning marriage for same-sex couples will be on the ballot in 2012. Adoption and foster parenting bans based on marital status or sexual orientation are expected to continue to be proposed in some states as well.

Research

Most current research on relationship and family freedoms and protections

Much of the current research bearing on relationship and family freedoms and protections concerns LGBT families. The Williams Institute at the University of California Los Angeles has done several groundbreaking demographic studies in this area. In 2009, the Williams Institute undertook the first analysis of the poor and low-income lesbian, gay, and bisexual (LGB) population, and found clear evidence that same-sex couple families are significantly more likely to be poor than are heterosexual married couple families. The study further found that lesbian couples and their families are much more likely to be poor than heterosexual couples and their families, and that African American people in same-sex couples and same-sex couples who live in rural areas are much more likely to be poor than white or urban same-sex couples.³ Similarly, the 2010 Census showed that twice as many black same-sex couples are raising children as white same-sex couples, and that black same-sex couples are also much more likely to be struggling economically.

Another Williams Institute study has shown that four percent of adopted children in the United States are being raised by non-heterosexual parents.⁴ Along similar lines, the Evan B. Donaldson Adoption Institute has published research showing that tens of thousands of children in foster care need adoptive homes, that LGBT people are important resources for waiting children and that children do just as well in families headed by LGBT people as they do in other families.⁵

The Family Acceptance Project has published a groundbreaking study establishing a clear link between rejecting behaviors of families towards lesbian, gay and bisexual adolescents and negative health problems in early adulthood. These findings reinforce the importance of accepting and affirming the lives and families of LGBT people more broadly.⁶

The Movement Advancement Project (MAP), in conjunction with Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders (SAGE),

authored a report underscoring the unique challenges facing LGBT older adults.⁷ These organizations found that LGBT elders are far less likely to have legally recognized families who can care for them, and more often rely on families of choice whose rights and relationships are not recognized.

In February 2011, the National Center for Transgender Equality (NCTE) and the National Gay and Lesbian Task Force (the Task Force) released the findings of their Transgender Discrimination Survey. 29% of respondents experience an ex-partner limiting their contact with their children, and courts stopped or limited relationships with children for 13% of respondents.

What research questions need to be addressed, moving forward?

Much additional research is needed to guide law and policy towards respecting and protecting all families. In particular, more research on rural families, families of color, and low-income families is needed, with a focus on unmarried couples and individuals, same-sex couples, and transgender people and their families. More research is also needed on the non-marital family and caregiving relationships of older adults.

Are there data points we can track to help us gauge progress in this report and in the sexual freedom movement?

Changes in public opinion polls about marriage or relationship recognition for same-sex couples, and parenting by LGBT people, unmarried people, or other families, can help us to see the progress we are making. Surveys that compare relationship recognition laws and parenting laws, including adoption and foster care laws, across the United States are also a good measure of how free people are to form families with the people they choose.

Are there metrics for comparing various locations around the country?

Because each state does address many family and relationship issues under state law, it is easy to compare states. Comparing rural areas with urban areas may be more challenging. It is also worth noting that the legal landscape does not tell us everything about

how families and individuals are treated in any given area. It is harder to measure social atmosphere, although opinion polls can provide some information. Census data on where different forms of families are more or less common could also provide a comparison, but because so many families are unable to move to friendlier areas or simply don't want to leave their communities, that data also does not tell the complete story.

Case Study

This past year, Martin Gill and his partner of more than ten years successfully fought back against the Florida ban on adoption by lesbian, gay, and bisexual people.

Martin Gill and his partner were foster parents to two brothers, who had been severely neglected and abused. When the boys joined Gill's family, one was a baby and his brother was four. Both boys had serious medical problems, and the four-year-old did not speak -- his main concern was changing, feeding and caring for his baby brother. But under the devoted care of Martin and his partner, the boys thrived, and they bonded with the 8-year-old son of Martin's partner, who welcomed them into the family as well.

Two years after they had joined Martin's family, the boys became available for adoption. Even knowing that he could not legally adopt in Florida because he was gay, Martin applied to adopt the boys in order to keep their family together. The agency responsible for investigating the family's home found that it was a safe, healthy, stable and nurturing home for the boys, where their physical, emotional, social and educational needs were met. But because Martin is gay, the state denied his application. The state admitted that if it hadn't been for the ban on adoptions by gay people, Martin would have been able to adopt the boys.

Represented by the American Civil Liberties Union (ACLU), Gill challenged the adoption ban and won in the Florida trial court and again in the intermediate court of appeals. The state decided to stop enforcing the ban and did not appeal, bringing to an end 33 years of discrimination against gay parents. Gill, his partner and their three boys, who were six, ten,

and fourteen years old by the time the younger boys' adoptions were finally secure, are now a forever family.⁹

Moving Forward

What are the most important strategies for expanding freedoms in this area?

Relationship and family freedoms and protections need to be expanded on all fronts: federal, state and local, using litigation, legislation and public education. Advocates must continue litigation and policy advocacy to make family law gender-neutral in all states and for purposes of federal law. We must also increase legal protections and freedoms for unmarried people and for non-biological parents. And we need to continue to fight bias in parenting and custody cases by continuing to educate the judiciary and to build capacity among legal services providers to effectively serve low-income LGBT and unmarried clients in family-related cases.

Opportunities for collaboration and intersectional work

Relationships and families are universal, and there are many opportunities for collaboration on expanding freedoms and protections in this area. As just a few examples, the immigrant rights movement has done and will continue to do important work on keeping families together, including the families of LGBT people. People with disabilities have faced challenges to their right to marry, to choose to have children, and to raise their own children, just as LGBT and other marginalized people have, and there are opportunities for intersectional work there as well.

Great intersectional work is being done by people of faith and LGBT people. For example, the Welcoming Church movement works to counter religious-based bigotry and to increase the number of congregations that welcome people of all sexual orientations and gender identities and their families.

But more can be done on all of these fronts. Although this work is happening already, there is room for more collaboration and intersectional work between LGBT advocates, poverty advocates, com-

munities of color and others to support the principle that each family is unique and all must be respected. Policies that allow same-sex couples to parent their children with access to all the benefits that opposite-sex couples receive also help aunts and uncles to raise their nieces and nephews, and grandparents to raise their grandchildren. These inclusive policies strengthen all families.

Resource list of organizations

Family Acceptance Project

<http://familyproject.sfsu.edu/>

Family Equality Council

www.familyequality.org

Immigration Equality

www.immigrationequality.org

Lambda Legal

www.lambdalegal.org

LGBT Movement Advancement Project

www.lgbtmap.org

National Center for Lesbian Rights

www.nclrights.org

National Center for Transgender Equality

www.transequality.org

National Gay and Lesbian Task Force

www.thetaskforce.org

National Senior Citizens Law Center

www.nsclc.org

Queers for Economic Justice

www.q4ej.org

Southern Poverty Law Center

www.splcenter.org

The American Civil Liberties Union

www.aclu.org

Notes

- 1 Stories From the Field: LGBT Older Adults in Long-Term Care Facilities. National Senior Citizens Law Center, et al., 2011, available at http://www.ncrights.org/site/DocServer/LGBT_Elder_Care_Report.pdf?docID=8401
- 2 Statement of the Attorney General on Litigation Involving the Defense of Marriage Act, Attorney General Eric Holder. Department of Justice (February 23, 2011), available at <http://www.justice.gov/opa/pr/2011/February/11-ag-222.html>.
- 3 Poverty in the Lesbian, Gay and Bisexual Community, Randy Alberda, M.V. Lee Badgett, Alyssa Schneebaum, Gary J. Gates. The Williams Institute (March 2009), available at <http://www3.law.ucla.edu/williamsinstitute/pdf/LGBPoverlyReport.pdf>
- 4 Adoption and Foster Care by Gay and Lesbian Parents in the United States, Gary J. Gates, M.V. Lee Badgett, Jennifer Ehrle Macomber, Kate Chambers. The Williams Institute and the Urban Institute. (March 2007), available at <http://www3.law.ucla.edu/williamsinstitute/publications/FinalAdoptionReport.pdf>
- 5 Expanding Resources for Children: Is Adoption by Gays and Lesbians Part of the Answer for Boys and Girls Who Need Homes? : The Evan B. Donaldson Adoption Institute (March 2006), available at http://www.adoptioninstitute.org/publications/2006_Expanding_Resources_for_Children%20_ExecSummary_March_.pdf.
- 6 Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults, Caitlyn Ryan et al. PEDIATRICS Vol. 123 No. 1 January 1, 2009 pp. 346 -352 (doi: 10.1542/peds.2007-3524) available at <http://pediatrics.aappublications.org/content/123/1/346.full?ikey=NrrcY0H897IAU&keytype=ref&siteid=aapjournals>.
- 7 Improving the Lives of Older LGBT Adults, Movement Advancement Project (March 2010), available at <http://www.lgbtmap.org/file/improving-the-lives-of-lgbt-older-adults.pdf>.
- 8 See *Florida Dept. of Children & Families v. Adoption of X.X.G.*, 45 So. 3d 79, 82 (Fla. Dist. Ct. App. 2010)

The Freedom Not to Marry:

Separating Sexual Relationships from Economic Dependency

Diana Adams, Esq.

Joining sexual relationships to financial dependency is a hindrance to sexual freedom. Many feminist and LGBT activists argue that the government should not be in the business of making legal contracts related to sex at all. In many instances, poor women are coerced into the sexual relationship of marriage through economic need.

Introduction

Sexual expression between consenting adults is a fundamental human right. That human right to sexual freedom includes the ability to form families of mutual support, financial dependency, and love with the people we choose, without interference from the government. True sexual freedom also includes freedom from entering into sexual relationships out of economic duress. This chapter provides an overview of the current American rights to form family outside the institution of marriage and the tradition of monogamy.

Historically, heterosexual monogamous marriage has been the principle vehicle for creating legal family in the USA. Pro-marriage family values campaigns champion marriage as a solution for myriad social ills and problems among children. On the opposite end of our political spectrum, the fight for same-sex marriage dominates the resources and activist efforts of the Lesbian, Gay, Bisexual, Transgender (LGBT) community. As same-sex marriage laws are passed in more states, celebration of marriages in the LGBT community receives tremendous public attention. As of August 2011, same-sex couples may marry in New York, Connecticut, Massachusetts, Iowa, New Hampshire, Vermont, and the District of Columbia.

The U.S. Government Accountability Office identifies 1,138 provisions of federal law that treat a relationship between people who are married differently from any other relationship¹, often preferentially. Federal and state public policy consistently encourages and privileges marriage among citizens as a way of priva-

tizing dependency outside of the social welfare state, maintaining social order, and organizing its citizens.

Despite this public celebration of marriage, and the preferential legal status of marriage, fewer than 50% of American adults are married in 2011. Half of all marriages end in divorce. Nearly 40% of Americans describe marriage as becoming obsolete, but value family highly in its other forms.²

The fight for same-sex marriage is not the only response to the inherent inequality of denying legal rights and privileges to the unmarried. There are other solutions to this inequality beyond fitting more categories of citizens into the institution of marriage. Perhaps marriage should not be the primary means of creating legal partnership in the eyes of the government. Sexual relationships are not the only way to create economic dependency relationships- and may not even be the best way. As we defend the right of all citizens to marry, we must also defend the right not to marry without disadvantage.

As others document the progress of the same-sex marriage fight, this report will leave aside that topic and address the state of relationship and family rights for unmarried Americans. This report will address trends in divorce and unmarried citizens; monogamy and its alternatives, polyamory and swinging; the option of creating platonic legal family relationships; and possible government recognition of other relationship and family structures beyond marriage.³

The State of Relationship and Family Freedoms and Protections for Non-Marital and Non-Traditional Families in the United States, 2011.

The government's placing of a privileged status on sexual relationships instead of parenting relationships or other forms of family both coerces women into sexual relationships to

meet their financial needs and disadvantages women by not providing benefits for the caretaking they provide within families.

The Current State of Marriage Alternatives in America

The American relationship to marriage in 2011 is highly ambivalent. While more than 50% of marriages end in divorce, and nearly 40% of Americans describe marriage as becoming obsolete, 70% of Americans have been married at least once and 46% of unmarried Americans claim to want to marry.⁴ At the same historical moment that the percentage of married adults has dipped below 50% for the first time, marriage is being valorized by same-sex marriage proponents as a fundamental human right for the first time. Despite the fact that many marriages are unsuccessful, as a culture we tend to celebrate weddings as an accomplishment, whether done in haste or with careful reflection, and whether the underlying relationship is a healthy one. Marriage is often still treated as an essential hallmark of adulthood; in the words of Andrew Cherlin, author of *The Marriage-Go-Round*, marriage is the ultimate merit badge.⁵

The majority of Americans are unmarried in 2011. However, these people are often emotionally and financially supported by other family structures, which are seldom discussed as valid family forms, and even less often supported by public policy. In this section, I will address the current legal and cultural state of divorce, monogamy and non-monogamy, platonic family relationships, and government recognition of relationship and family structures beyond marriage.

Divorce

Our notion of a traditional American family is crumbling. As a society, we have a choice; we can continue to try to rehabilitate marriage with nostalgic family values campaigns, or we can work within a changed society to create stable families for children with new models. If we separate marriage from its legal incentive, and support alternative legal partnerships to marriage, we may bolster the institution of marriage from its decline and high divorce rate, while supporting the rights of Americans to choose to form family in other ways.

While marriage can be entered into with relative ease, it is an arduous legal process to divorce, involving a mountain of paperwork even if completely mutual and uncontested with no property to divide and no children. This is intentional from a public policy perspective. In a married couple, each spouse agrees to take some of the burden of potential support of their spouse away from the social welfare state. With the benefits of marriage, come the obligations to share all debts of your spouse and share all income as well, creating an equalizing of finances of at least two.

Over the years, it has become easier (and more common) to get divorced in the United States, as evidenced by the shift from a primarily fault-based divorce regime, in which one spouse had to show that he or she was wronged by the other spouse in order to get a divorce, to a no-fault divorce regime, in which fault is no longer an issue with respect to allowing the dissolution of a marriage.

In 2010, New York State became the 50th state to allow no fault divorce. This “irretrievable breakdown” ground will allow one spouse, unilaterally, to conclude that he or she wants out of a marriage and to accomplish this objective whether or not the other spouse agrees to end the marriage and whether or not the other spouse has been guilty of any marital misconduct. All 49 other states have allowed no fault divorce since 1985. For 25 years, New York State has been the last remaining state to require grounds because of the powerful impact of lobbying in Albany for grounds to remain.

This shift to no fault divorce brings up the policy objectives behind the divorce grounds process that lingered for so long. In the grounds process, one spouse needed to petition the court with an argument of marital misconduct on the part of the other spouse, as a good reason why the court should allow the parties to divorce. In practical effect, requiring ‘grounds’, that one spouse allege some wrongdoing by the other to get a divorce, adds unnecessary hostility at the onset of an already painful divorce process. After alleging a horrible act on behalf of the other spouse in court, then the two spouses are expected to negotiate the separation of all their property and finances and negotiate child custody. Grounds make clear

that a divorce process is hostile and adversarial, and the divorce is happening because one spouse did something wrong. Worst of all, most divorcing parents will continue to have shared decision-making for the children, and will be thrown straight from a war-like divorce process back into parenting together. This is a recipe for acrimony between parents, and children suffer from this hostile divorce process. If both spouses allege grounds (such as one alleging adultery and the other alleging abuse) and can prove them, then the grounds cancel each other and the couple would stay married. Today, grounds of adultery, abandonment, cruel and inhuman treatment, or constructive abandonment (a spouse's refusal to have sex with their spouse) can still be argued in New York, but couples have the option of circumventing fault and making a case for why they should be able to divorce.

The archaic grounds process does not reflect the shifting conceptions of marriage. Many Americans no longer view marriage as an economic dependence unit that must last a lifetime for reason of religious morality or out of obligation to care for a helpless dependent woman. With women's greater economic independence and legal equality, many married couples now conceive of marriage as a romantic family relationship entered into by two equals who have the free will to leave if the relationship breaks down. Until the change to the law in 2010, many divorcing New Yorkers were indignant and surprised that legally, they could not leave a marriage based on a personal decision that the relationship was broken down without asking permission from a "Daddy State" government.

As our culture becomes more secular, divorce is losing its cultural taboo. Greater emphasis is placed on personal fulfillment and happiness for the individuals in marriage, counterbalancing the forces of church and state that historically colluded to make divorce culturally and legally challenging. Divorce may be experiencing a cultural shift away from being viewed as a terrible failure, and toward a view that it is an unfortunate, often painful, but ultimately healthy and good decision to end relationships that are broken and no longer serving the couple. The legal divorce process is finally catching up to this cultural change –

albeit several decades late.

Monogamy and its Alternatives: Polyamory and Swinging

As the nature of marriage has been challenged, so has the presumption of monogamy as an underpinning of committed relationship structure. Infidelity has been a widespread crisis that has always gone hand in hand with monogamy. Within the past several years, press about infidelity and the possibility of consensually non-monogamous relationships boomed. Each infidelity scandal, from high-profile politicians like Anthony Weiner and Arnold Schwarzenegger to celebrities like Tiger Woods, brings media attention to just what a wide spread problem infidelity is, with its corrosive effect on family. We demonize the unfaithful, but also gradually acknowledge as a culture that our ideal of monogamy may not be occurring in reality.

Simultaneously, public conversation about non-monogamous alternatives have received massive media attention. The 2010 national bestseller "Sex at Dawn" by Christopher Ryan, PhD and Cacilda Jetha, MD, addressed the anthropological underpinnings of human behavior, documenting that monogamy is not the natural state of human sexuality.⁶ Like vegetarianism, they argue, monogamy is a choice for humans that is against their nature, and may be much more difficult for some people than others. Nationally-syndicated sex and relationship columnist Dan Savage, who created the "It Gets Better" campaign to inspire queer teens, has championed the option of non-monogamy as a choice for couples if it involves full honesty, consent and negotiation. Savage also created the new word "monogamish" in 2011 to describe couples that negotiate some limited exceptions to monogamy of their own creation. Savage's ideas have been widely discussed in mainstream publications, including a New York Times Magazine cover story in 2011.⁷

In this cultural landscape, it's become increasingly difficult to maintain the argument that monogamy is the only responsible healthy relationship style. A next step in our cultural evolution toward sexual freedom and away from sexual shame is to acknowledge that each person should be able to honestly negotiate their sexual desires with their partner, and move away from a "one-size fits all" approach to sex and

committed relationships. If lovers and partners could voice their sexual desires to one another without their partner taking this as a betrayal or an inability to be in a healthy adult relationship, perhaps fewer relationships and families would be torn apart by the lies of infidelity.

Since the 1960s and 1970s, non-monogamous swinging and polyamory communities have been on the rise. With the 1990s internet explosion, local communities have organized nation-wide. In the past several years, membership in local “poly” organizations has skyrocketed, but there’s little hard data on how many Americans identify as members of a non-monogamous community.

Swinging and polyamory have different definitions, but often have some overlap in communities because of the myriad variation and self-definition of these relationships. Swinging is a relationship style in which an established primary couple has the option of sexual relationships (generally non-romantic) outside of the relationship. Polyamory, meaning many loves, is a community which takes this notion a step further and allows for the idea that one person can be in love with more than one person at once. Myriad forms of poly relationships are possible, with the central tenants of self-awareness of one’s own needs, honesty with one’s partners about one’s needs and sexual behaviors, and the concept that a person can get one’s needs met as an individual without relying on one partner to meet all needs for a lover/financial partner/co-parent/best friend/hobby partner. Parties in a poly relationship can negotiate the rules of their relationship instead of taking the established rules of love and marriage as a given. Some poly people form committed primary couples but still date other people, and may from an external view appear just like any other couple, possibly married and/or with children. Other poly structures don’t create hierarchy between relationships (such as primary and secondary) but allow for fluidity and change in this regard. Some poly relationships involve three people in a triad or four people in a quad relationship. Some of these relationships include polyfidelity (3, 4, or more people in a relationship not open to sexual behavior with others), which is sometimes called group marriage.⁸

Currently, no state in the United States legally recognizes plural marriages. Bigamy is illegal in all states. There is, however, no federal law that would prohibit a state from legally recognizing plural marriages. However, the Reynolds case from the late 19th century upheld the right of a state’s government to outlaw polygamy, and has never been overturned.

While the polyamory movement is swelling in 2011, there is no legal movement for plural marriages. Instead, primary couples are often creating their own rules of committed relationship, whether or not they get legally married, and many other poly people are opting out of the institution of marriage altogether. These Americans question why their choice not to enter into a monogamous marriage structure should have any bearing on their legal status and benefits, and encourage the unbundling of family privileges from the institution of marriage.

Platonic Family Relationships

Romantic couples are not the inherent building block of family. Family may be viewed more broadly as structures of caretaking and financial interdependence. Families may be senior citizens living together in support of one another, intentional communities or groups of single adults choosing to live together, blended families, or adult children living with and caring for their elderly parents.

In fact, relationships based on sexual or romantic attraction may not be the best way to create stable caretaking units. As we understand more about pheromones and desire, we understand that sexual attraction in the first months often clouds rationality. Put simply, if a single woman could choose to blend finances and co-parent a child with her best friend of twenty years or sister, or a sexy man she met last month, she would likely create a more lasting economic unit and co-parenting structure with her friend or sister. Yet the law has not encouraged these platonic family relationships or acknowledged their value historically.

While queer and feminist theorists have critiqued the traditional institution of marriage for decades, in the past decade many of the financial resources and energy of the LGBT activist community have been dedi-

cated to achieving same-sex marriage, and some of this critique of marriage has been lost. In 2006, the Beyond Marriage campaign brought together the voices of LGBT scholars, activists, and attorneys to voice support a vision of family policy that would include many more families than those based on romantic relationships.⁹ Nancy Polikoff's exceptional 2008 text *Beyond (Straight or Gay) Marriage* outlines the need to value all families and possible models to do so.

Surprisingly, some of the most interesting advances in the field of queer family policy have occurred in conservative states that explicitly ban same-sex marriage. The LGBT legal community in these states has been forced into creativity to find alternative means to achieve stable legally recognized families, without marriage. A prime example of this is Salt Lake City, Utah. Utah has a Defense of Marriage Act and a constitutional amendment banning gay marriage. The City Council in Salt Lake City, Utah adopted an ordinance that allowed employees to select their own 'adult designee' to receive spousal benefits. The designee could be a roommate, relative, or domestic partner who lives indefinitely with the employee and is financially connected to the employee.¹⁰ This could allow a single woman to put her best friend or sister, and that woman's children, on her health insurance plan, and create a connection of financial support unrelated to sexuality.

A number of cities and states allow non-romantic domestic partnerships and/or non-romantic civil unions, with varying definitions.¹¹ Some limit these programs to those who cannot legally marry, which does not acknowledge the validity of choosing a platonic legal partnership even when one could legally marry.

Existing Platonic Legal Partnership Programs, alphabetically by state and city:

- Eureka Springs, AR: "committed relationship of mutual support and caring which is intended to be of indefinite duration" [Municipal Code 7.60](#)
- California Domestic Partnership: "intimate and committed relationship of mutual caring" [Cal. Fam. Code § 297](#).
 - Berkeley, CA: "must reside together and share the common necessities of life . . . and must be sole domestic partner" [Required affidavit](#)
- Cathedral City, CA: No intimate relationship requirement. [Municipal Code 11.97.010](#).
- Davis, CA: No intimate relationship requirement. [Municipal Code 10.05.020](#).
- Laguna Beach, CA: "must reside together and share the common necessities of life . . . and must be sole domestic partner" [Municipal code 1.12.010](#).
- Los Angeles, CA: No intimate relationship required. [L.A. county code 2.210](#).
- Oakland, CA: No intimate relationship required. [Municipal website](#).
- Colorado: No intimate relationship required. Any two unmarried adults may enter into a Designated Beneficiary Agreement [C.R.S.A. §15-22-104](#).
 - Boulder, CO: "relationship of mutual support, caring, and commitment and intent to remain in such a relationship". Open to same sex and opposite sex couples. [City page](#).
 - Denver, CO: "close, committed relationship with the present intention to remain in that relationship". Open to same and opposite sex couples.
- District of Columbia: No intimacy requirement. Same and opposite sex couples. Even immediate family members can register as domestic partners [DC Domestic Partnership FAQ](#).
- Hawaii: No intimate relationship requirement. Registering gives same rights as married couples. [Hawaii Department of Health](#).
- Maryland: Available for couples in "a relationship of mutual interdependence". Domestic partners, as defined by statute, are entitled to 11 protections available to spouses, including the rights to visit one another in the hospital, share a room in a nursing home, and make funeral decisions. [SB 566](#).

- New Jersey: Must have “chosen to share each other’s lives in a committed relationship of mutual caring”. Domestic partnerships available for same-sex couples and couples over the age of 62. N.J. Stat. Ann. §26:8A.
- Vermont: Limited to for blood relatives who are unable to marry or join in civil union, e.g., siblings. 15 VSA 1301.
- Washington: (only for same-sex or couples over the age of 62). No intimacy requirement. [Washington FAQs for domestic partnerships](#).
- Wisconsin: The couple must consider themselves “members of each other’s immediate family”. Domestic partners treated the same as married couples. [Explanation of Chapter 40](#).

Addressing the Main Problem: Unbundling sexual relationships from financial dependency

Historically, marriage is based on a romantic/sexual relationship between a man and an economically dependent woman. Conservatives valorize the 1950s vision of traditional marriage as the most wholesome and healthy form of human family. In 1950, 78% of American adults were married, compared to 49% today.¹² However, the higher rate of marriage does not indicate happiness and satisfaction in marriage. In fact, women may not have had economic opportunity to exist unmarried, and many women were likely financially and culturally coerced into entering sexual relationships or staying in unhappy marriages.

Joining sexual relationships to financial dependency is a hindrance to sexual freedom. Many feminist and LGBT activists argue that the government should not be in the business of making legal contracts related to sex at all. In many instances, poor women are coerced into the sexual relationship of marriage through economic need.

In fact, the institution of marriage is used as part of our welfare state in America, creating a means of providing for the financial needs of health insurance and support of children and their caretakers through a family breadwinner. Whether marrying couples realize it or not, from the date of their marriage until the filing of divorce papers or death, all money earned, prop-

erty purchased or debt incurred is divided evenly between both married spouses, unless they contract around this by pre or post-nuptial agreement.

In reality, marriage is failing as a means of creating stable family support. The largest group of people in poverty receiving public assistance in the US is not addicts or the mentally ill; it is unmarried mothers and their children. Rather than find other means of support for these single mothers, the federal government funded marriage promotion, encouraging women to get off of public assistance by entering a sexual relationship with a man. The Healthy Marriage Initiative and the Responsible Fatherhood Program were created as five-year experiments by the so-called Deficit Reduction Act of 2005. Grants totaling nearly \$750 million were awarded to hundreds of programs under the umbrella of Temporary Assistance for Needy Families (TANF) in 2006 alone. Some of these funds went to billboards promoting marriage as an end to poverty.¹³ These women were encouraged through official government programs to enter the presumed sexual relationship of a marriage as a means of creating financial support for themselves and their children. Encouraging single mothers to enter sexual relationships is a failure of our social welfare state, and does nothing to create stable families for children. Furthermore, it encourages the blending of sexual relationships and financial dependency. This program is comparable to the government acting as a pimp. Fortunately, in a major win for sexual freedom advocates, on September 30, 2010, Congress ended welfare funding for marriage promotion.

Rather than defining family around romantic couples, family could be defined around care-taking relationships for children or elderly family members. Feminist legal theorist Martha Fineman argues that the family should be redefined away from the sexual dyad to the caretaking dyad, prototypically the mother and child. When caretaking relationships for children and elderly people are treated as a private rather than collective responsibility, these needs will be met by the family, disproportionately by women.¹⁴ The government’s placing of a privileged status on sexual relationships instead of parenting relationships or other forms of family both coerces women into sexual relationships to meet their financial needs and dis-

advantages women by not providing benefits for the caretaking they provide within families.

Then why does our government set aside a romantic coupling as the basis of family? Marriage law sanctions confined sexuality and reproduction, and leaves all other sexuality and reproduction deviant, both culturally stigmatized and legally disfavored. Marriage becomes “the zone of privacy outside of which sex is unprotected.”¹⁵ To achieve true separation of church and state in our secular society, and true sexual freedom, we must separate the legal economic dependency units from sexual relationships.

Recent wins

Removal of marriage incentives from federal welfare program

On September 30, 2010, Congress ended welfare funding for marriage promotion.

New York no fault divorce

In 2010, New York State became the 50th and final state to allow no fault divorce.

Policy issues to watch to advance the rights of the unmarried

Same-sex marriage advocates must also respect the unmarried

When advocating for same-sex marriage rights, LGBT legal activists should also keep in mind a longer-term vision of family variation beyond marriage. Proponents of same-sex marriage in the Proposition 8 case in California described marriage as a “fundamental human right” and the highest form of adult human expression; in other same-sex marriage cases, the LGBT advocates have described marriage as crucial to adult human flourishing and healthy parenting, and stated that every American should aspire to this greatest dignity. This rhetoric sounds alarmingly like that of their religious fundamentalist opponents. While equal marriage rights for LGBT citizens are obviously crucial, it is also critical to keep in mind that many LGBT citizens and others do not wish to marry. Legal precedent that prioritizes marriage as the healthiest form of family and parenting relationship may hurt the LGBT community in future.

Watch the Domestic Partner and Civil Union policies in each state

As same-sex marriage victories are won, we need to monitor Domestic Partner and Civil Union policies to see if these options are lost when same-sex marriage victories occur. If marriage is an option for a couple, these alternatives are sometimes lost. For example, the legal “Reciprocal Beneficiary Relationships” registration in Hawaii, which gives the same rights as those to married couples, and is open to parties who are not in an intimate relationship, but is only open to those prohibited from marrying. Two opposite sex friends could not benefit from this program. If same-sex marriage passes in Hawaii, same-sex couples will not have the option of this program either.

As the struggle for same-sex marriage continues, we must also remind legislators and the public that the freedom not to marry should be defended. For example, Domestic Partners in New York City can share health insurance through many employers, without needing to opt into the financial obligations of marriage, mandating that all assets or liabilities occurred after marriage are marital property subject to even division in a New York State divorce. Even with the option of same-sex marriage in New York State, heterosexual and homosexual couples may want to choose this option.

Child custody cases for polyamorous, non-biological, and non-traditional families

While the legislature is often several decades behind the cultural evolution of families, the court system must deal with these new family structures sooner. This happens frequently in child custody cases, and it behooves sexual freedom advocates to monitor these cases not only to defend the rights of the individuals involved but also to attempt to create positive rather than negative local precedent if cases are brought up on appeal.

Child custody cases are often affected dramatically by the cultural prejudices of the lone judge deciding based on the subjective standard “best interest of the child.” Polyamorous parents, as well as parents engaged in kink or bondage/domination/sadomasochistic sexuality, have lost custody of their children

in local courts based on the slippery slope presumption that sexuality outside of convention might lead to amorality toward child-rearing and parenting judgment. Defenders of sexual freedom should intercede with sexuality-aware legal support and consulting in these situations, both for the sake of the parties and for the possibility of creating positive rather than negative precedents if the cases go to appeal at higher courts. Legal referrals by area can be made from the Kink Aware Professionals program, a project of the National Coalition of Sexual Freedom, <https://ncsfreedom.org/key-programs/kink-aware-professionals/kap-program-page.html>, or the Sexual Freedom Legal Defense and Education Fund, <http://www.sfldef.org/>.

In addition, cases involving custody requests by people not biologically related to the child should be monitored. As our cultural standards evolve with the “best interest of the child” standard, some courts recognize that biology is not the only relevant factor in determining which adults have an important parental role for a child. These cases occur in contexts of lesbian motherhood, in which the non-biological mother did not do a legal second parent adoption but was held out as the child’s other parent; contexts of polyamorous triads and quads in which a third parental figure lives in the household and may want to continue a relationship with a child if the relationship dissolves; and contexts in which a non-romantic co-parenting, such as a lesbian couple and gay couple co-parenting a child after a sperm donor context. In these cases, it may be possible to establish that a non-biological parent could arguably have a parental role in the life of a child, and that it would be in the child’s best interest for that relationship to continue.

Polygamy

Polygamy and polyamory generally occur on very different ends of the social and political spectrum. Polygamy, meaning multiple spouses but historically multiple wives, is most often publically considered in the context of the Mormon Church, with concerns about child brides and the consent of women involved. In the August of 2011, the leader of the Fundamentalist Church of Jesus Christ of Latter-day Saints, Warren Jeffs, was sentenced to a maximum

sentence of life in prison on his conviction of sexually assaulting a 12-year-old and a 15-year-old who were his “spiritual wives.”

Advocates of sexual freedom should watch these cases carefully to prevent overbroad rulings and legislation targeting problematic polygamous sects but also infringing on the rights of multi partner families of consenting adults. The Canadian case against Section 293 of Canada’s Criminal Code is related to this, and worth watching for comparison to American cases that may occur.

In winter 2011, a major trial in Canada challenged Section 293 of Canada’s Criminal Code, which criminalizes polygamy but also any form of multiple person relationship. While the statute is considered a tool to target polygamists (with multiple spouses, and more specifically polygynists with multiple wives) it could also be used to send others to jail for nontraditional relationship styles, which could be a breach of Canadian Constitution’s Charter of Rights and Freedoms.

Section 293 reads as follows:

Polygamy: Everyone who

- a. practices or enters into or in any manner agrees or consents to practise or enter into
 - i. any form of polygamy, or
 - ii. any kind of conjugal union with more than one person at the same time,
 whether or not it is by law recognized as a binding form of marriage, or
- b. celebrates, assists or is a party to a rite, ceremony, contract or consent that purports to sanction a relationship mentioned in subparagraph (a)(i) or (ii)

is guilty of an indictable offence and liable to imprisonment for a term not exceeding five years.

When this statute was written in 1890 to limit polygamy, modern polyamorous relationships with full gender egalitarianism were surely beyond contemplation. Polyamory is fundamentally different than polygamy and does not present the concerns that polygamy

presents, in that it does not give special rights to men, there are not concerns about lack of consent in assigned spouses or underage spouses, or teach customs inside closed communities without members seeing a realm of options. Polyamorous people are also not attempting to enter into multiple legal marriages in Canada. However, Section 293 may inadvertently criminalize these consensual polyamorous people for being in a romantic conjugal relationship with more than one person, even without an attempt to legally marry. If three or four people choose to live together in a romantic relationship, should they face criminal penalties?

In the current Canadian case, a tiny Mormon-derived polygynous commune of 120 spouses called Bountiful represents the example of those who would be criminalized by the law. Many Canadians may be led to believe that these small patriarchal communities of Mormon and Muslim people with multiple wives are the only ones who are affected by this law. In fact, the Canadian Polyamory Advocacy Association (CPAA), who have become involved in the case, remind us although there are no definitive statistics on the number of polygamous versus polyamorous people in Canada that there are definitively many times more polyamorous Canadians affected by the law, who have not been accused of any wrongdoing and who deserve freedom to choose their relationship structure.

Oral arguments in Canada's case have been made, but a decision has not yet been rendered. If Section 293 is declared unconstitutional, it is likely that both polygamy and nonmarital cohabitation would be legalized in Canada. Although the United States does have a federal law like Section 293 encompassing nonlegal conjugal partnerships of more than two people, many states do criminalize bigamy and polygamy where a person already has a legal spouse. Moreover, many Americans might be disturbed to learn that 'unlawful cohabitation' statutes still exist in five states, making it illegal to live with a partner without getting married: Florida, Michigan, Mississippi, North Carolina and Virginia. Although criminal charges in these cases are rare, these unlawful cohabitation statutes are regularly used against non-married couples in child custody cases, employment,

housing, and parole to incriminate nonmarried people because they are technically breaking the law.

Americans deserve to be able to choose to live together unmarried, in couples or in polyamorous family structures. As the legal challenge to Canada's Section 293 unfolds, and may lead to Canada's Supreme Court, this is an exciting historical moment for the possibility of a Canadian recognition that laws restricting relationship structure violate civil rights. This may be a useful model for American challenges to non-marital cohabitation statutes or rulings against multiple person conjugal relationships.

Research

Current Research

In 2011, the Census Bureau reported that married couples dropped below 50% of all American households for the first time.¹⁶ In 1950, 78% of American adults were married. When marriage was at its all-time high in the 1950s, marriage defined gender roles, distribution of labor in and out of the home, and an individual's role in society. As women went to work and society became more secular, marriage has gradually declined since. Today only 1/5 of American households fit the model of a traditional family, a married couple with children, down from about 25% in 2000.¹⁷

With rising income inequality, a socioeconomic marriage gap has also widened. Women with college degrees are now more likely to get married than those with high school diplomas, a reverse of several decades ago. Today women with college degrees are more likely to get married at a later age and stay married. Women with only a high school diploma, who are generally lower-income, are increasingly choosing not to marry the fathers of their children, and when they do marry, are more likely to divorce.¹⁸ A Pew Research Center poll found that 64% of college graduates were married compared to 48% married with no higher education.¹⁹ A theory for this marriage divide is that fathers with no higher education have low economic potential in the current economic crisis, and given that the traditional family vision of a male breadwinner does not apply, mothers choose not to marry these fathers of their children.

A widely publicized study was released in August 2011 claiming that children of unmarried cohabitating parents are at risk for a range of serious problems, including academic trouble, physical abuse, psychological stress and poverty. Report co-author Bradford Wilcox claims that while divorce rates have dropped since their 1979-1980 peak, out of wedlock births have steadily risen; he reports that 41% of all births are now to unwed mothers, many of them living with but not married to the fathers of their children. The crisis for these children, the report argues, is a carousel of temporary partners and parental figures entering and leaving children's lives.²⁰

However, the National Marriage Project and the Institute for American values, conservative organizations with the explicit mission of defending the traditional institution of marriage, conducted this study. While there does seem to be evidence that the children of unmarried cohabitating parents have higher risk factors, this correlation does not indicate causation. This study does not account for the socioeconomic marriage gap in America, with lower-income Americans less likely to marry. Children of struggling lower-income families fare worse, but this is likely caused by a host of factors other than whether their parents possess a marriage certificate.

In August 2011, the Brookings Institute published *The Marginalization of Marriage in Middle America*, coauthored by Wilcox and a more progressive counterpoint, Andrew J. Cherlin, author of *The Marriage-Go-Round*. Cherlin points out that stable care arrangements, whether achieved through marriage or otherwise, are what matter most for children.²¹ Thus cohabitation in itself is not the likely culprit for harm to children, but rather instability of family arrangements. Cohabiting couples can be viewed in three categories: those pursuing a stepping stone to marriage, those in committed relationships who choose not to marry, and those not committed enough to marry. Only the latter is harmful for children involved. But we do not measure instability- we measure cohabitation vs. marriage.

If unstable partnerships are harmful to the children of these partnerships, other policy options may be better solutions than encouraging marriage, such as

investing in preschool education for low-income children, or comprehensive sex education to empower low-income Americans to make more intentional decisions about when and with whom to parent. Wilcox and Cherlin agree on some possible solutions other than incentivizing marriage, such as improved preschool education. Up until now, the government has often responded to concerns about healthy families by creating more incentives for marriage.²² However, if people choose to get married for health insurance, immigration, or tax purposes, it is possible that this would also not be a formula for the creation of healthy stable families in the long-term.

The Census Bureau

The constitutionally-mandated U.S. Census happens every ten years, and is presented to every American. It is an extremely short questionnaire, partly to increase the likelihood of response and partly because statistically, there is no need to question every American to understand out demographic trends.

Instead, the Census Bureau presents the American Community Survey annually. This is a much longer survey, presented to only a sample portion of the population. In 2011, its demographic questions on family include marital status of persons in the home, and the relationship of each person in the household to "Person 1", the survey responder. The options are: spouse, biological child, adopted, child, stepchild, sibling, parent, grandchild, parent-in-law, son/daughter-in-law, other relative, roomer or boarder, housemate or roommate, unmarried partner, foster child, nonrelative. It questions whether each person lived in the house a year ago, and how many bedrooms exist in the home. It also questions how often household members work and contribute to the household.²³

Research issues that must be addressed

While research highlights the percentage of unmarried adults, there is ample room for research on what other family configurations exist outside of marriage. Tracking the rate of marriage or un-marriage alone does not count the variety of other existing family structures. While the Census itself is brief, there is room for change in the American Community Survey. While it inquires about the relationships between

household members in a limited capacity, it could also ask about relationships of financial support and dependency in terms of how finances are shared. It could ask more questions about how long household members have lived together, beyond the sole question of whether they have lived in the house for more or less than a year. The questionnaire could also address caretaking relationships for children and elderly persons. These would get to the key issue of family instability for children, to move beyond the proxy of cohabitation.

It costs several million dollars in federal funds to add one question to the American Community Survey. It is possible to survey Americans cheaper independently. Furthermore, the American Community Survey can only address issues affecting millions of Americans, and the size of some family populations such as polyamorous families would be too small.

To protect the rights of polyamorous families, we need more information about the number of people engaged in these relationships. If there were more awareness and knowledge about the number of people engaged in polyamorous relationships or consensually non-monogamous relationships, these relationships might be destigmatized, which would help culturally as well as legally when these families face issues such as child custody cases and are labeled as fringe deviants. In these child custody cases, data showing how many Americans identify as polyamorous or consensually non-monogamous would replace stereotypes about these families. In the Canada case on Section 293 on plural conjugal relationships, there is some evidence that there are more polyamorous people who would be affected than polygamous people targeted by the law, but may not be enough solid data to present this in court.

Furthermore, if we had data on what kind of non-marital families do exist, including relationships of economic dependency that are non-marital such as households of committed friends and caregivers for the elderly, we would have a greater sense of the need for nonromantic legal partnerships. With both non-marital families and non-monogamous families, there's much anecdotal evidence and cultural examples that these family forms are widespread, but

statistics are needed.

As debates rage on about whether marriage is a solution to the instability of families, it would also be worth studying the circumstances of divorce. Why did divorcing couples marry, and what was the circumstance of the breakdown? Its possible that legal incentives to marry, such as health insurance, immigration, and tax benefits, may actually do a disservice to the movement for stable families by encouraging marriage for the wrong reasons.

The variety of healthy family forms should be valued under the law, and not penalized in terms of health insurance and tax benefits because they don't involve heterosexual monogamous marriage. We don't currently have data on the number of people in these other family formations. With this information, we could demonstrate how many Americans are disadvantaged by these marriage laws, and thus make a much stronger case for unbundling legal privileges from marriage. Rather than continue to coerce Americans into the institution of marriage with policy incentives, research could help us understand what forms family and economic dependency actually takes in America, and how policy could best assist the families that already exist.

Case Study: The Consequences of Devaluing Non-marital and Non-biological Family

As an attorney and mediator, I maintain a law practice in New York City, Diana Adams Law²⁴, serving clients throughout New York State who wish to create stable nontraditional family structures outside of the institution of marriage, contract their own terms of relationship within marriage using prenuptial agreements, and defending the rights of nontraditional parents in child custody cases. I consult on child custody cases nationwide in situations in which a parent's polyamorous relationship status, sexuality, or non-biological relationship to the child is used against them in an assessment of their ability to parent in the best interest of the child involved. The following is a true synopsis of a case on which I consulted, with names and some details changed to protect the family's confidentiality. I share it in the hope that it will demonstrate the need to value family connections beyond marriage and biological connection.

Sean and Cassandra have been cohabitating best friends for 10 years. Sean is homosexual, and they were never in a romantic or sexual relationship. Cassandra is a single mother of an 8-year-old boy, Luke. Although Sean is not biologically or legally related to Luke, he has been a consistent source of financial and emotional support to Cassandra and Luke from the time of Cassandra's pregnancy. When Cassandra took time off from work during her latter pregnancy and the first six months of Luke's life, Sean paid almost all the rent and utility payments for the apartment they share. In Luke's infancy and early childhood, Sean was a daily presence in Luke's life and acted as a co-parent with Cassandra. Sean and Cassandra noticed the signs of Luke's autism together, and Sean researched doctors and programs to help Luke and set up the appointments, at times paying the co-payments for Luke to see specialists out of his health insurance network.

For the three years of pre-kindergarten through second grade, Luke was enrolled in a special private school that helps with social and emotional development as well as academics. The tuition is \$20,000/year. Sean helped Cassandra research the school options and select this school, and both agree that it gives Luke opportunities to excel far beyond any other local school. Cassandra would not have been able to afford the school on her own, but Sean voluntarily paid approximately \$15,000/year and while Cassandra paid approximately \$5,000/year.

Sean continued to be the primary male figure in Luke's life, and act as a co-parent to Luke. Cassandra and Luke relied on him for financial support and childcare, and considered the three of themselves a happy family.

Sean received excellent private health insurance through his job. He hoped to cover Cassandra and Luke under his health insurance, but could not because they are not married, and their area does not have a domestic partnership program for non-romantic partners. Luke was covered by a state health insurance program for children, which did not cover the specialists and therapies in child autism that Sean's health insurance would. Cassandra had no health insurance.

In 2010, Cassandra delayed doctor's visits for flu symptoms for over a month to avoid paying for the visits without health insurance. She developed pneumonia and spent several weeks in the hospital going downhill until she lost consciousness. Sean was not allowed to visit her when she was admitted to the hospital because they are not married or biologically related, and was unable to provide the input on her wishes that a husband would have been invited to provide, although Sean was the person most aware of her medical wishes. Doctors refused to let him know Cassandra's medical status. Cassandra's parents stepped in and gave input instead. Cassandra's parents disapprove of homosexuality, and would not allow Sean to visit Cassandra, and refused to keep him informed about the state of her care. Moreover, Cassandra's parents took Luke to their home and refused to let Sean visit Luke or have any contact with him.

Cassandra died after a month at the hospital, and Sean was never allowed to visit her to say goodbye. After she passed away, Cassandra's parents brought Luke home with them a state away, with the intention that he would live with them permanently as his new guardians. Cassandra's parents continued to refuse to allow visitation access to Sean or any contact with Luke. Cassandra's parents also denied Luke's autism diagnosis, and Sean was very concerned that Luke wasn't getting adequate assistance with his autism in his new public school and home life.

After many unsuccessful attempts to communicate with Cassandra's parents to implore them to let him continue a relationship with Luke, directly and through third party mediators, Sean brought a child custody case to request shared legal custody (decision-making about health, education, etc) and physical custody of Luke with Luke's maternal grandparents, or at minimum, visitation access to Luke to continue their relationship. After spending nearly a year on court visits and over \$50,000 in legal fees, Sean was denied any visitation access to Luke because he was not a biological parent, a legal parent through second-parent adoption, or a biological relative. Sean was devastated to learn during the proceeding that Luke was suffering greatly with the transition to life without either of the parents he had

known, or contact with the school that nurtured him; Luke's teachers reported to his court-appointed attorney that Luke was nearly mute, avoided eye contact, and exhibited alarming symptoms of anxiety and distress such as banging his head against the wall. Despite this information, and the evidence presented about Sean's consistent relationship with Luke, the decision of custody in the best interest of the child was made by one judge, who did not value the family relationship between Sean and Luke. There is no legal precedent in their state to support the upholding of this non-legal non-biological relationship, and the prospect of a successful appeal for Sean is very limited. As of August 2011, Sean has not had any contact with Luke for over a year.

Moving Forward

By the numbers, marriage is on the decline. Incentives to marry, such as health insurance and tax benefits, may create marriages of economic convenience rather than the right reasons of deep commitment. Getting into marriage, or any other family commitment, with deliberate intentions toward financial responsibilities, monogamy, and other factors, would make better marriages and better commitments.

Our notion of a traditional American family is crumbling. As a society, we have a choice; we can continue to try to rehabilitate marriage with nostalgic family values campaigns, or we can work within a changed society to create stable families for children with new models. If we separate marriage from its legal incentive, and support alternative legal partnerships to marriage, we may bolster the institution of marriage from its decline and high divorce rate, while supporting the rights of Americans to choose to form family in other ways.

We must stay united as an LGBT movement, whether advocating for same-sex marriage or its opponents. By staying in respectful open dialogue, we have the opportunity to advocate both perspectives. We can advocate both for the freedom to marry and also for the freedom not to marry. We should stay united with the larger social justice community, because strengthening our social welfare state by valuing caretakers, offering universal health care, and ensuring quality preschool education for low-income

Americans would help bridge the socioeconomic gap in America in general, but also help ensure that unmarried families are not disadvantaged and that poor women are not coerced into sexual relationship.

Marriage is a wonderful cultural institution, but it should not be a legal one. To honestly separate church and state, marriages should not be government registration but rather continue in churches, synagogues, mosques and secular communities, with their own definitions of whether marriage is for heterosexuals or not. Legal families could then register as economic dependence units such as adult designees, whether they are lovers, sisters, friends. We must transcend a system in which the government scrutinizes our sexual relationships to determine if they pass muster to receive government benefits. Only then can we achieve true sexual freedom.

Notes

- 1 *Defense of Marriage Act Update to Prior Report*, U.S. Government Accountability Office, Washington, D.C., January 23, 2004.
- 2 *Marriage: What's It Good For?* Time Magazine report by Belinda Luscombe, November 29, 2010, based on data from a 2010 Time Magazine/Pew Research Center Poll, cited directly below.
- 3 Many thanks to the law student and law graduate interns who assisted with the research for this chapter: Matthew Baiotto, Meghan Fay, Amanda Izenzon, Jess Levy, Derek Loh, Michael Pontone, Maria Roumiantseva, Yekaterina Zarkh.
- 4 *Marriage: What's It Good For?* Cited above fully footnote ii.
- 5 *Marriage: What's It Good For?* Cited above fully footnote ii.
- 6 *Sex at Dawn: The Prehistoric Origins of Modern Sexuality*, by Christopher Ryan and Cacilda Jetha (Harper Collins, 2010).
- 7 *Married, With Infidelities*, by Mark Oppenheimer, New York Times Magazine, July 3, 2011.
- 8 For more information on polyamory and tools to negotiate polyamorous relationships, see *The Ethical Slut: A Practical Guide to Polyamory, Open Relationships & Other Adventures* by Dossie Easton and Janet Hardy, or *Opening Up: A Guide to Creating and Sustaining Open Relationships* by Tristan Taormino.
- 9 *Beyond Same-Sex Marriage: A Strategic Vision for all our Families & Relationships*, policy statement and signed petition, July 26, 2006, [beyondmarriage.org](http://www.beyondmarriage.org).
- 10 *Beyond (Straight and Gay) Marriage: Valuing All Families under the Law*, by Nancy Polikoff (Beacon Press, 2008).
- 11 Human Rights Campaign data, http://www.hrc.org/issues/marriage/domestic_partners/9133.htm.
- 12 *The Decline of Marriage and Rise of New Families*, by Pew Social Trends Staff at the Pew Research Center, released November 18, 2010. <http://pewsocialtrends.org/2010/11/18/the-decline-of-marriage-and-rise-of-new-families/>
- 13 *Let Them Eat Wedding Rings*, publication of the Alternatives to Marriage Project, www.unmarried.org, second edition, June 2007.
- 14 *The Neutered Mother, the Sexual Family, and Other Twentieth Century Tragedies* by Martha Fineman (New York: Routledge, 1995).
- 15 *Friends with Benefits?* By Laura Rosenbury, Michigan Law Review, November 2007, page 200, citing *Beyond Gay Marriage* by Michael Warner, in *Left Legalism/Left Critique*, page 267 (Wendy Brown & Janet Halley eds., 2002).
- 16 U.S. Census Bureau, The 2011 Statistical Abstract, Population: Marital Status and Living Arrangements, tables 56-58.
- 17 *Married Couples are No Longer a Majority, Census Finds*, by Sabrina Tavernise, The New York Times, published May 26, 2011, http://www.nytimes.com/2011/05/26/us/26marry.html?_r=1&emc=eta1.
- 18 *Red Families v. Blue Families: Legal Polarization and the Creation of Culture*, by Naomi Cahn and June Carbone, Oxford University Press, Feb 2010.
- 19 *The Decline of Marriage and Rise of New Families*, by Pew Social Trends Staff at the Pew Research Center, released November 18, 2010. <http://pewsocialtrends.org/2010/11/18/the-decline-of-marriage-and-rise-of-new-families/>
- 20 *Why Marriage Matters, Third Edition, Thirty Conclusions from the Social Sciences*, by a team of scholars chaired by W. Bradford Wilcox. <http://americanvalues.org/bookstore/pub.php?pub=81>
- 21 *The Marginalization of Marriage in America*, by W. Bradford Wilcox and Andrew J. Cherlin, Center on Children and Families at Brookings, August 2011 CCF Brief #46.
- 22 *Let Them Eat Wedding Rings*, cited above.
- 23 U.S. Department of Commerce, U.S. Census Bureau, the American Community Survey 2001 questionnaire booklet.
- 24 www.DianaAdamsLaw.net

Resource list of organizations working on the issue and useful resources

Alternatives to Marriage Project

www.unmarried.org

Beyond Marriage

www.beyondmarriage.org

Human Rights Campaign

www.hrc.org

National Coalition for Sexual Freedom

<https://www.ncsfreedom.org/>

Sexual Freedom Legal Defense and Education Fund

<http://www.sfldef.org/>

Diana Adams Law

www.DianaAdamsLaw.net

The Human Right to Freedom of Sexual Speech

Law & Disorder:

The Courts' Schizophrenic View of Sexual Speech

Mark Kernes

Sr. Editor and Chief Legal Analyst, AVN Media Network/AVN.com

Introduction

Yeah; speech by picketers whose “contribution to public discourse may be negligible” has to be protected even if it adds to a father’s pain on the death of his son, but busting the producers or sellers of sexual material because the stuff may “arouse[] contempt” of or is “upsetting” to some number of sexually-repressed churchgoers is just business as usual!

If the past few years have shown nothing else, they have made clear the importance of having a socially-progressive Democrat—or, though unlikely, a socially-progressive third party candidate—in the White House. Why? Because the President is the one person in the United States who submits nominees for the U.S. Supreme Court to the Senate for confirmation. And why is that important? Because presidents, senators and congresspeople come and go, but Supreme Court justices stay in power for as long as they wish, barring death or impeachment, and their opinions on matters of sexuality (in the broadest sense) affect American culture for decades, if not centuries. The same is true of all federal judges, though their overall effect is usually somewhat less. And nowhere is that concept more important to Woodhull Sexual Freedom Alliance supporters than in the area of adult entertainment (that is, sexual) content (though their rulings on sexual *conduct* are surely a close second).

Consider, for instance, that in overturning the ban on corporate expenditures for political candidate advocacy in *Citizens United v. Federal Election Commission*,¹ the high court had to overturn its own 1990 decision, *Austin v. Michigan Chamber of Commerce*,² in which the then-justices had recognized “the corrosive and distorting effects of immense aggregations of wealth that are accumulated with the help of the

corporate form and that have little or no correlation to the public’s support for the corporation’s political ideas.” The practical effect of *Austin’s* rejection, which could easily be seen in the 2010 elections, was to allow super-rich religious fundamentalist and conservative corporate donors to buy unlimited ads for, and in many other ways exorbitantly support, the campaigns of religiously conservative candidates in federal (and state) elections—whose *very first order of business* when elected to the new Congress was to attempt to restrict abortion rights and women’s access to contraception—a topic undoubtedly covered more fully in other sections of this report. However, the point to be made here is, the most pertinent parts of the *Citizens United* decision turned on a direct “party line” vote: The court’s five conservative justices—Kennedy (who’s sometimes not so conservative but who delivered this opinion), Alito, Scalia, Thomas and Chief Justice Roberts—voted for lifting the ban; the more liberal justices—Stevens, Ginsburg, Breyer and Sotomayor—voted against its more onerous provisions.

The State of Adult Sexual Content in the US

The state of adult sexual content in the U.S. in 2011 is a confused one. I will cover three Supreme Court decisions which, had the majority applied its own logic to the issue of explicit sexual content, would have turned federal obscenity law on its head—and still might, given the modern high court’s propensity for overturning its own precedents when it suits them to do so. Hence, it is important to analyze those decisions as they *should* apply to hardcore pornography that allegedly “crosses the line” into obscenity.

As readers are no doubt familiar, federal (and most states’) obscenity laws are governed by the Supreme Court’s 1973 decision in *Miller v. California*.³ Distilled to its basics, and having gone through a minor tweak or two, *Miller* describes—but *does not define!*—the

(incredibly vague) criteria to be used in attempting to prosecute a particular work for obscenity: The work, taken as a whole, must appeal to the “prurient interest” (usually described as a “morbid or unhealthy interest in sex or excretion”) of the “average person” applying “contemporary community standards”; must depict or describe explicit sexual conduct (as defined by applicable state or federal law) in a “patently offensive way”; and, taken as a whole, must be without “literary, artistic, political or scientific value.” A Ninth Circuit ruling in *U.S. v. Kilbride & Schaffer*⁴ defined the “community standard” for internet content to be a *national* standard, but absent Supreme Court review, such ruling only applies to the nine western states covered by the Ninth Circuit.

The idea that obscenity laws are unconstitutional under the First and Ninth Amendments has been previously discussed (See “Prosecuting Porn: A Journalist’s Perspective,” *State of Sexual Freedom in the United States 2010 Report*, pg. 56), but beyond the fact that only one state—Massachusetts—had anything approaching an obscenity law for the first 33 years of this country’s existence, there is ample evidence that the First Amendment’s unequivocal free speech right was more influenced in its creation by the “natural rights” philosophies of founder John Locke than by the more traditionalist Sir William Blackstone. Locke’s essentially secularist libertarian views, which emphasized education in critical-thinking skills and the need to treat people, particularly the young, as “Rational Creatures,” were “popularized, and fused with the republican political tradition” by early political commentators John Trenchard and Thomas Gordon, who together published the weekly periodical *The Independent Whig*, and who pseudonymously wrote *Cato’s Letters*, a series of 144 political tracts published in the 13 colonies in the early 18th century.⁵

The Locke/“Cato” philosophy of free speech, at least as that concept was embodied in Oregon’s Constitution, was explored by Oregon Appeals Court Judge W. Michael Gillette in a 2005 case, *State v. Ciancanelli*,⁶ where the court expanded on the anti-Blackstonian concept that at least as far as speech was concerned, the state’s primary duty was to enforce the fundamental, “natural” rights of individuals rather

than to “protect society as a whole from undesirable ‘tendencies’ or to promote the majority’s idea of a greater good.”

Obviously, the Framers’ thoughts on the U.S. Constitution’s free speech and press clauses could stand quite a bit more scholarship, but what’s become clear in several of the U.S. Supreme Court’s speech-related decisions over the past two years is that aside from what Chief Justice John Roberts characterized as “historic and traditional categories” of acceptable limitations on speech, which he described as “well-defined and narrowly limited,” the conservative wing of the high court has shown itself willing to perform the most amazing legal and semantic contortions to continue to exempt “obscene” sexual speech from constitutional protection.

Research and Case Studies

Case Study #1—*U.S. v. Stevens: Videotaping criminal activity is legal. Videotaping legal activity is criminal.*

The first recent example of this occurred in *U.S. v. Stevens* (#08-769, decided April 20, 2010), where the high court, in an 8-1 decision, ruled that petitioner Robert J. Stevens had a First Amendment right to sell videos of dogs fighting, often to the death.⁷⁸

Early on in the decision, Roberts notes that although the Solicitor General had correctly argued to the court in October, 2009 that American law has a long history of prohibiting cruelty to animals, “we are unaware of any similar tradition excluding depictions of animal cruelty from ‘the freedom of speech’ codified in the First Amendment, and the Government points us to none.”

In other words, laws against staging dogfights for public or private viewing are perfectly okay because such acts are cruel to animals, but laws against recording those fights for eventual sale are not, even though to create such recordings, dogs would have to fight each other. Contrast that with the fact that there is nothing illegal about humans having consensual sex with each other, consensually binding and disciplining each other or even pissing or shitting on each other, but in some cases, *recording* such acts on videotape or DVD is illegal under Supreme Court

doctrine.

The majority in the Stevens case dug itself in even deeper as it attempted to distinguish its ban on child pornography in *New York v. Ferber*⁹ from the dogfight videos at issue here. After hair-splitting that minors engaged in sexual activity are “intrinsically related” to child porn videos, but dogfights are somehow not so related to dogfight videos, the majority looked with favor on Stevens’ preemptive challenge (since he hadn’t yet been busted under it) to the anti-animal-cruelty-video law, 18 U.S.C. §48. Roberts, writing for the majority, asserts:

In the First Amendment context, however, this Court recognizes ‘a second type of facial challenge,’ whereby a law may be invalidated as overbroad if ‘a substantial number of its applications are unconstitutional, judged in relation to the statute’s plainly legitimate sweep’. Stevens argues that §48 applies to common depictions of ordinary and lawful activities, and that these depictions constitute the vast majority of materials subject to the statute. The Government makes no effort to defend such a broad ban as constitutional. Instead, the Government’s entire defense of §48 rests on interpreting the statute as narrowly limited to specific types of ‘extreme’ material... We read §48 to create a criminal prohibition of alarming breadth.

It does indeed—but it merely copied the “criminal prohibition of alarming breadth” that the high court has officially accepted for nearly 40 years: The government’s power to charge *any* sexually explicit content with “obscenity,” even though the vast majority of federal obscenity prosecutions, “judged in relation to the statute’s [for the sake of argument] plainly legitimate sweep,” have ended in “not guilty” verdicts! Shouldn’t that invalidate the federal obscenity statutes?

What’s even funnier are the exceptions built into §48’s sweeping ban, which Roberts terms, “The only thing standing between defendants who sell such depictions and five years in federal prison.”

But after admitting that “Most of what we say to one

another lacks ‘religious, political, scientific, educational, journalistic, historical, or artistic value’ (let alone serious value), but it is still sheltered from government regulation,” Roberts nonetheless inadvertently recognizes that the very quality—vagueness—that invalidates the anti-animal-cruelty-video law should also invalidate federal obscenity laws. It’s therefore incredible that he can write, “But the First Amendment protects against the Government; it does not leave us at the mercy of *noblesse oblige*. We would not uphold an unconstitutional statute merely because the Government promised to use it responsibly.” Try to tell that to the thousands of adult retailers who’ve been busted for selling obscenity, only to have their charges thrown out by socially aware juries! The opinion continues:

This prosecution is itself evidence of the danger in putting faith in government representations of prosecutorial restraint. When this legislation was enacted [1999], the Executive Branch announced that it would interpret §48 as covering only depictions ‘of wanton cruelty to animals designed to appeal to a prurient interest in sex.’ No one suggests that the videos in this case fit that description. The Government’s assurance that it will apply §48 far more restrictively than its language provides is pertinent only as an implicit acknowledgment of the potential constitutional problems with a more natural reading.

Amazing! But when it comes to sexually explicit videos, the overwhelming majority of which do not remotely appeal to even the government’s ill-defined idea of “prurient interest,” anti-obscenity laws are still okay. And yet, earlier in the decision, where the majority recognizes that, “The demand for hunting depictions exceeds the estimated demand for crush videos or animal fighting depictions by several orders of magnitude... Those seeking to comply with the law thus face a bewildering maze of regulations from at least 56 separate jurisdictions,” a simple substitution of “hardcore videos” for “hunting depictions” and “obscene videos” for “crush videos or animal fighting depictions” should signal that the *Stevens* decision means that federal obscenity laws should fall under a facial challenge if “a substantial number of its appli-

cations are unconstitutional, judged in relation to the statute's plainly legitimate sweep."

Of course, it didn't, and it won't, as long as the makeup of the high court remains unchanged.

Case Study #2—*Snyder v. Phelps: Speech that upsets grieving parents is not obscene. Speech that upsets conservative churchgoers is obscene.*

The next speech decision with implications for sexual freedom jurisprudence was *Snyder v. Phelps*, where Fred Phelps, the founder of the Westboro Baptist Church of Topeka, Kansas, and two of his daughters were sued for defamation, intentional infliction of emotional distress and several similar torts for picketing the funeral of Marine Lance Corporal Matthew Snyder, carrying signs reading, "God Hates the USA/ Thank God for 9/11," "America is Doomed," "Thank God for Dead Soldiers," "Priests Rape Boys," "God Hates Fags," "You're Going to Hell," and other similar slogans. Lower courts had found in favor of Snyder's father, the plaintiff, and awarded him roughly \$5 million in punitive and compensatory damages. The high court, of course, reversed, to the consternation of many.¹⁰ Writing for the court's majority near the beginning of the opinion, Roberts writes:

Whether the First Amendment prohibits holding Westboro liable for its speech in this case turns largely on whether that speech is of public or private concern, as determined by all the circumstances of the case. "[S]peech on 'matters of public concern' ... is 'at the heart of the First Amendment's protection'." The First Amendment reflects "a profound national commitment to the principle that debate on public issues should be uninhibited, robust, and wide-open." That is because "speech concerning public affairs is more than self-expression; it is the essence of self-government."

Now, one might question whether some ignorant yahoos parading around private property down the block from Snyder's funeral represented speech of public or private concern, so Roberts quickly delves into the issue, and undertakes some significant verbal gymnastics to avoid legitimizing freedom for

sexual speech.

First, he quotes from *Connick v. Myers*¹¹ to better define the "not well-defined ... boundaries of the public concern test" by noting, "Speech deals with matters of public concern when it can 'be fairly considered as relating to any matter of political, social, or other concern to the community'," but since this is not an obscenity case, Roberts obviously sees no need to comment on whether sexually explicit material as a category is a "matter of political, social, or other concern to the community," since if it were, it would be "public speech" and protected under the *Snyder* decision:

While these messages ["God Hates Fags," etc.] may fall short of refined social or political commentary, the issues they highlight—the political and moral conduct of the United States and its citizens, the fate of our Nation, homosexuality in the military, and scandals involving the Catholic clergy—are matters of public import.

A "matter of public import" like, say, the question of whether people carrying incendiary protest signs are more or less likely to cause public unrest (or at least discussion) than images of two people fucking on a public sidewalk? Would it make a difference if the two fucking people were dressed as clergy?

Even more outrageously, Roberts quotes the case of *Texas v. Johnson*¹², noting that

If there is a bedrock principle underlying the First Amendment, it is that the government may not prohibit the expression of an idea simply because society finds the idea itself offensive or disagreeable.

"Offensive"? That's porn to a lot of people. So based on that logic, how could a display of people fucking not be protected "simply because society finds the idea itself offensive or disagreeable"—bearing in mind that the plain language of the First Amendment permits no such discretion?

And to add insult to injury, when Roberts states that:

In most circumstances, 'the Constitution does not permit the government to decide which types of otherwise protected speech are sufficiently offensive to require protection for the unwilling listener or viewer. Rather, ... the burden normally falls upon the viewer to avoid further bombardment of [his] sensibilities simply by averting [his] eyes'

he's actually quoting from the seminal sexual speech decision *Erznoznik v. City of Jacksonville*¹³, a mid-'70s case where the Supremes struck down a Jacksonville, Florida ordinance that made it a "public nuisance" to show a film containing nudity at a drive-in theater where the screen is visible from a public street or other public place. That era's Supreme Court majority viewed the ordinance as a content-based restriction, and found that that outweighed the various justifications put forth by the city: Protection of children and prevention of distraction to passing motorists.

And the Roberts court's conclusion?

"Westboro's funeral picketing is certainly hurtful and its contribution to public discourse may be negligible," Roberts tellingly admits. "But," he continues:

Westboro addressed matters of public import on public property, in a peaceful manner, in full compliance with the guidance of local officials... Speech is powerful. It can stir people to action, move them to tears of both joy and sorrow, and—as it did here— inflict great pain. On the facts before us, we cannot react to that pain by punishing the speaker. As a Nation we have chosen a different course—to protect even hurtful speech on public issues to ensure that we do not stifle public debate. That choice requires that we shield Westboro from tort liability for its picketing in this case.

Yeah; speech by picketers whose "contribution to public discourse may be negligible" has to be protected even if it adds to a father's pain on the death of his son, but busting the producers or sellers of

sexual material because the stuff may "arouse[] contempt" of or is "upsetting" to some number of sexually-repressed churchgoers is just business as usual!

Case Study #3—*Brown v. Entertainment Merchants Association: Sexual assault in a video game is not obscene. Consensual sexual activity is.*

Finally, there's the June, 2011 decision in *Brown v. Entertainment Merchants Association*, which struck down a California law prohibiting the sale of violent video games to minors, even with a parent's permission—but this time, it's Justice Antonin "We are fools for Christ's sake" Scalia¹⁴ who gets to parse whose (violent) speech gets constitutional protection and whose (sexual) speech doesn't.¹⁵¹⁶

At issue in the case is California Assembly Bill 1179, whose authors clearly tried to make its language sound as much like an anti-obscenity bill as they could: Describing games that include, in the

range of options available to the player... killing, maiming, dismembering, or sexually assaulting an image of a human being, if those acts are depicted' in a manner that '[a] reasonable person, considering the game as a whole, would find appeals to a deviant or morbid interest of minors,' that is 'patently offensive to prevailing standards in the community as to what is suitable for minors,' and that 'causes the game, as a whole, to lack serious literary, artistic, political, or scientific value for minors,'

is basically the *Miller* test rewritten for kids and games.

Indeed, Scalia realizes that:

As in Stevens, California has tried to make violent-speech regulation look like obscenity regulation by appending a saving clause required for the latter. That does not suffice. Our cases have been clear that the obscenity exception to the First Amendment does not cover whatever a legislature finds shocking, but only depictions of 'sexual conduct'.

Why? Tradition! (Cue Topol from *Fiddler on the Roof*...)

But when Scalia, one of the Court's strongest opponents of sexual speech rights, writes, "The Free Speech Clause exists principally to protect discourse on public matters, but we have long recognized that it is difficult to distinguish politics from entertainment, and dangerous to try," it's as if he lives in a universe where sexual content doesn't exist, since in every case involving sex that's come before him, Scalia has gone out of his way to make exactly those distinctions, and has never given the slightest hint that he considers the distinction process "dangerous." Compare this statement with his dissent in *Lawrence v. Texas*¹⁷, where he hyperbolically claimed that allowing consensual sodomy would doom (or at least "call into question") all "[s]tate laws against bigamy, same-sex marriage, adult incest, prostitution, masturbation, adultery, fornication, bestiality, and obscenity." Okay, Nino; we get it: All sex bad; all other "entertainment," including violent video games, good—even for kids. Scalia writes:

Because speech about violence is not obscene, it is of no consequence that California's statute mimics the New York statute regulating obscenity-for-minors that we upheld in Ginsberg v. New York¹⁸. That case approved a prohibition on the sale to minors of sexual material that would be obscene from the perspective of a child. We held that the legislature could 'adju[s]t the definition of obscenity "to social realities by permitting the appeal of this type of material to be assessed in terms of the sexual interests..." of ... minors'.

But, of course, not to include violent speech.

Indeed; Scalia's all in favor of watching violence. Attendant to the Stevens decision, it was reported that Scalia loves bullfight videos, so his authorship of *Brown* is hardly a surprise—nor is his dissection of Justice Samuel Alito's lukewarm concurrence:

JUSTICE ALITO has done considerable independent research to identify video games in which 'the violence is astounding'. Victims

are dismembered, decapitated, disemboweled, set on fire, and chopped into little pieces.... Blood gushes, splatters, and pools.' JUSTICE ALITO recounts [in his concurrence] all these disgusting video games in order to disgust us—but disgust is not a valid basis for restricting expression.

Hmm... That's certainly not the message anyone would get from, for instance, Scalia's *Lawrence* dissent! He continues:

And the same is true of JUSTICE ALITO's description of those video games he has discovered that have a racial or ethnic motive for their violence—"ethnic cleansing" [of] ... African Americans, Latinos, or Jews'. To what end does he relate this? Does it somehow increase the 'aggressiveness' that California wishes to suppress? Who knows? But it does arouse the reader's ire, and the reader's desire to put an end to this horrible message. Thus, ironically, JUSTICE ALITO's argument highlights the precise danger posed by the California Act: that the ideas expressed by speech—whether it be violence, or gore, or racism—and not its objective effects, may be the real reason for governmental proscription.

Talk about "irony": How fascinating is it that Scalia castigates Alito for the exact reasoning that Scalia himself applies to sexual speech!

But wait, there's more!

The State's evidence is not compelling. California relies primarily on the research of Dr. Craig Anderson and a few other research psychologists whose studies purport to show a connection between exposure to violent video games and harmful effects on children. These studies have been rejected by every court to consider them, and with good reason: They do not prove that violent video games cause minors to act aggressively (which would at least be a beginning). Instead, "[n]early all of the research is based on correlation, not evidence of causation, and most of the studies suffer from significant, admitted flaws

in methodology.” They show at best some correlation between exposure to violent entertainment and miniscule real-world effects, such as children’s feeling more aggressive or making louder noises in the few minutes after playing a violent game than after playing a nonviolent game.

Of course, Scalia refuses to give the same benefit to sexual speech, even though the only “research” that’s found a connection between exposure to porn and harmful effects on anyone is anecdotal, and in most cases from thoroughly biased “researchers.”

Of course, there’s plenty more to show the congruence between the alleged but bogus effects of exposure to violent video games and exposure to sexually explicit material, but considering that the focus of the *Brown* decision is children, it will come in handier *after* the high court has solved its problems with alleged “obscenity.”

Case Study #4—Free Speech Coalition et al v. Holder, A.G.: Adult videos don’t use children, so it’s important to know how old every adult is.

The final topic that’s worth covering briefly is the adult entertainment industry’s ongoing battle against the federal record-keeping and labeling laws, 18 U.S.C. §§2257 and 2257A, which require all adult content that features real or simulated sexually explicit conduct between consenting adults be labeled as compliant with the law, and that records attesting to the ages of the participants be kept in a certain form in a specified location by the producers and some re-packagers of such material.

Free Speech Coalition (FSC), the industry’s trade organization, along with more than a dozen other plaintiffs, sued the government over these requirements in September of 2009, but Third Circuit District Court Judge Michael Baylson, a Bush appointee, dismissed the suit in mid-2010. After Baylson refused to reconsider his decision, the FSC plaintiffs appealed the dismissal to the Third Circuit U.S. Court of Appeals, restating in plainer language several of the inarguable points against the onerous law¹⁹:

1. The 2257 law and regulations fail the mid-level speech-regulation test of intermediate scrutiny, in that the statutes “do not directly and materially advance the government’s interest in combating child pornography,” the brief states. The statute is not narrowly tailored to achieve the government’s stated purpose in enacting the law, but rather is:

narrowly tailored to achieve an illegitimate governmental interest in requiring all producers of expression to establish that their expression is not child pornography, thus reversing the constitutional presumption conferred on all expression required by the First Amendment. Moreover, the statutes are overinclusive and burden substantially more speech than is necessary to advance its avowed interest in battling child pornography.

2. The statute also doesn’t survive the strict scrutiny test, in that it is clearly content-based. The law affects only actual sexually explicit speech while specifically exempting simulated sexual speech from the same regulations if the creator of such simulated speech merely files a letter with the Attorney General of the United States stating that the producer keeps certain identity and tax records as a regular course of doing business—something which producers of actual sexually explicit speech also do, but cannot avail themselves of the same exemption.
3. The statute violates producers’ Fourth Amendment rights against unreasonable searches and seizures, since it gives government agents free rein to enter producers’ premises without a warrant and to search through the producer’s records, as well as giving them the power to seize any “evidence” of what the agents may perceive as felonies being committed by the producer, again without a warrant. Worse, refusal to admit the “inspectors” to a producer’s premises in itself constitutes a felony under the challenged law.
4. The statute is overbroad, in that it applies to “a vast quantity of private, non-commercial expression between adults,” as well as to an even wider array of commercial speech—i.e., the vast majority of commercially-released adult DVDs—which

unquestionably contains no minors or even performers who look like minors; yet all must keep 2257 records and label their products as if it were possible that some minor therein gave a sexually explicit performance.

The 2257 battle has been ongoing for more than 20 years, since the first version of the law was enacted shortly after the Meese Commission report was released, but until actual regulations regarding the 2257 requirements were first published in mid-2005 by then-Attorney General Alberto Gonzales, there had been zero enforcement of the law.²⁰ In fact, to date, although the FBI “inspectors” have examined the records of more than 25 adult companies, the Justice Department has yet to bring charges against any adult company solely for its alleged lack of compliance with the 2257 requirements.

But once the regulations were published, FSC quickly sued to have the law overturned and its regulations stricken, filing a lawsuit in district court in Colorado that, after much briefing and several hearings, was largely dismissed by agreement of the parties—even though, in the interim, the 2257 law and regulations were again revised, this time adding 2257A to cover simulated sexual depictions.

Perhaps the single fact that best exemplifies the uselessness of the regulations is that while producers of sexually explicit material are required to examine and retain a copy of a performer’s government-issued photo identification document, there is no requirement that the producer *authenticate* that document!²¹ In other words, if a performer presents an authentic-looking forged ID, the producer will not have violated the 2257 law if he maintains a copy of the document in his/her records. However, in such a case, the producer would be guilty of violating the existing child pornography laws—the very laws that make 2257 unnecessary.

Moving Forward

As noted above, in order for there to be good rulings on sexual speech and conduct from the U.S. Supreme Court, it will take the election of liberal/progressive (or at least *putatively* liberal/progressive) presidents and senators, since those are the ones

who will, in the first instance, nominate, and in the second instance, approve sexually rational Supreme Court justices. It’s a process that Woodhull Sexual Freedom Alliance members can assist by working to get such candidates elected, and supporting sexually sane nominees for the high court.

Sadly, that doesn’t help the near-term situation, but that could easily change. As the Supreme Court now stands, there are four dedicated conservatives—Chief Justice John Roberts and Associate Justices Samuel Alito, Antonin Scalia and Clarence Thomas—and four nearly dedicated liberals—Ruth Bader Ginsburg, Sonia Sotomayor and Elena Kagan, though it’s unclear just where Justice Stephen Breyer stands on some issues—and one justice who’s considered a “swing vote,” Anthony Kennedy.

However, information has recently surfaced that casts great doubt on Scalia’s and Thomas’ ethics. For one thing, both justices have been guests at, and participated in political strategy sessions at, retreats for conservative corporate owners sponsored by Koch Industries, whose owners are multi-million-dollar contributors to a variety of conservative causes.²² Yet neither justice has recused himself from several Supreme Court decisions that would affect the Koch brothers, their companies and companies and issues the Koch’s support.

Thomas in particular has come under fire for failing to report, on his financial disclosure forms, five years’ worth of his wife’s income from the conservative Heritage Foundation, from whom she received \$686,589 between 2003 and 2007.²³ Until recently, Virginia Thomas was also head of the Liberty Central, a PAC which, like Heritage Foundation, has supported a variety of conservative causes with interests in cases (like *Citizens United*) in which Thomas has been called upon to rule from the bench, and she now heads a lobbying firm, Liberty Consulting—yet another good reason for recusal.^{24,25} The group Citizens for Responsibility and Ethics in Washington has called for a congressional investigation into Thomas’ ties to, and receipt of gifts and money from, conservative individuals and political groups, and the group Common Cause has petitioned the Justice Department to investigate whether the *Citizens United* deci-

sion should be set aside because Scalia and Thomas took active roles in the Koch retreats.²⁶

Scalia too has ethical problems, stemming at least from his concurrence in the ruling that then-Vice President Dick Cheney did not have to reveal the attendees at his energy summit in early 2001, after Scalia spent several days duck hunting with the VP. Scalia also, at the invitation of Rep. Michele Bachmann (R-Minn.), spoke to a closed-door session of the House Tea Party Caucus in January—a partisan act that calls into question Scalia’s impartiality in deciding cases in which Tea Partiers have an interest.

As part of its stance, then, in support of recognition of humans’ fundamental right to sexual freedom, Woodhull Sexual Freedom Alliance members might be well-served to support, and urge others to support, the enactment of a “code of ethics” for Supreme Court justices²⁷—something they don’t currently have and which, at least from the evidence noted above, they sorely need.

What’s undeniable is that, sexually speaking, the modern world is changing rapidly, and for every adult bookstore some uptight city council zones out of existence, ten more adult “e-tailers” open up on the internet—but no matter where citizens buy their porn, the official Morality Police, crosses in hand, are waiting to intercept DVDs in the commerce stream and attempt to prosecute the vendors, and occasionally even the customers. Moreover, some venues like strip clubs and swingers’ clubs have no online equivalents, just “brick and mortar” addresses, and while First Amendment protections are supposed to exist for all of this sexual speech, it will take a modern, sexually-sane Supreme Court to uphold those rights, and precedent-setting decisions like those discussed above to pave the way out of this country’s anti-sex-law morass. If only future Justices can be made to see the hypocritical undercurrent of their predecessors’ speech analyses.

Notes

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The Human Right to Sexuality Education

Comprehensive Sexuality Education for Youth:

Where Are We Now?

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Introduction

Comprehensive sexuality education provides a framework from which all students can make decisions that will make them happier. Access to this education is indeed a human right, and in many ways we have been denying this right to our youth for decades.

Every person has human rights which go beyond the laws enumerated by the laws of the country in which one resides, and include our inalienable rights, such as those outlined in the second paragraph of the United States Declaration of Independence: our rights to “life, liberty and the pursuit of happiness”. While many people are familiar with that expression, there’s more to it. If a person starts reading that phrase three words earlier, he or she will see the words “among these are”. Our human rights are not limited to just the three rights with which people are most familiar. They extend beyond those and include the means required to attain them. One of these rights is access to information so that people can make the best decisions for themselves and lead happier lives. As sexuality is a part of everyone’s life, access to sexuality information is part of our rights.

In order to understand the impact that sexuality has on people, one needs to expand the definition of sexuality to go beyond sexual intercourse. In the broadest terms sexuality encompasses everything from engaging in sexual acts, to how people see themselves in terms of body image and gender roles, to how people relate to others in emotional and physical relationships (Advocates for Youth, 2007). Looking at sexuality from this more holistic perspective, one can see the impact that sexuality information can have in helping people lead sexually healthy and happy lives.

Providing a person with information is not enough. People also need to understand how this information impacts them, and how best to utilize this information. This is what comprehensive sexuality education strives to do. Comprehensive sexuality education includes information on many facets of human sexuality, including sexual anatomy and physiology, abstinence, contraception, relationships and the role of sexuality in society. This type of sexuality education enables students to examine their own values and attitudes so that they can decide how the information they are learning fits with their beliefs. In addition, comprehensive sexuality education provides students with the tools that they will need to help implement behaviors in a way that is consistent with their values and goals. These tools include negotiation skills, communication skills and decision-making skills (SIECUS, 2004).

The Sexuality Information and Education Council of the United States (SIECUS, 2004) has developed guidelines for the implementation of school-based comprehensive sexuality education. These guidelines offer a framework from which schools can create a K- 12 program that would provide students with medically accurate, age-appropriate sexuality information. This is not a redundant program where the same information is taught and re-taught year after year. Rather it is designed to increase both the depth and breadth of information as the learner matures. For example, in first grade students learn about disease transmission though basic concepts such as the importance of washing hands, and an explanation of how to do so effectively. As students mature and move into middle school and high school, the information regarding disease transmission includes the names of sexually transmitted infections (STIs), methods of preventing transmission through the use of a barrier method or by choosing not to have sex, and information about STI testing.

Comprehensive sexuality education also addresses personal skills. This includes helping learners identify their attitudes, beliefs and values, learning how to make decisions, and how to communicate those decisions effectively. For a topic such as STIs, students can identify how they feel about being sexually active at their age, what the risks and benefits might be of engaging in sexual behavior, and what they can do to protect themselves from STIs if they choose to be sexually active. They can then use the communication and negotiating skills they have learned to talk to their partners about implementing those protective behaviors in their lives. This information is vital for teens as 46% of high school students report having had sexual intercourse (Centers for Disease Control and Prevention [CDC], 2010a). This number does not include those teenagers who may be engaging in sexual behaviors other than vaginal intercourse. According to one study, more than half of adolescents had engaged in oral sex, and 10% had engaged in anal sex (Lindberg, Jones & Santelli, 2008). For those students who choose not to engage in any sexual activity while in high school, comprehensive sexuality education is important in that it gives them the opportunity to explore their values and beliefs, and receive information on relationships, body image, and gender roles.

Comprehensive sexuality education provides a framework from which all students can make decisions that will make them happier. Access to this education is indeed a human right, and in many ways we have been denying this right to our youth for decades.

The State of Sexuality Education in the US

A History of Abstinence and Sexuality Education

School and community based sexuality education in the United States is currently in a state of change. For almost thirty years, federal funding was spent on abstinence-only-until-marriage (AOUM) programs. These programs were based on the government's 8-point definition of abstinence education. This definition, which includes teaching that a mutually monogamous marriage is the "standard of human sexual

activity" (Social Security Online, 2011, para. 1), is not supported in any way by research or science. However, in the last three years there have been major changes in the types of programs that are being funded and the amount of money that is available for these programs.

In order to understand how these recent changes are impacting the current state of comprehensive sexuality education, it is important to review the history of funding for abstinence-only programs in the United States. In 1982, the Adolescent Family Life Act allocated \$4 million to be given to AOUM programs. More than a decade later, the amount of funding available for abstinence-only programs had grown exponentially. In 1996, with the enactment of welfare reform, Congress established funding through Title V, Section 510 of the Social Security Act. This act provided for funding to be made available to programs that were abstinence-based, and it required individual states to provide \$3 in state funds for every \$4 of federal funds. Through the Adolescent Family Life Act, Title V funding and funding through the Community-Based Abstinence Education program that was established in 2000, AOUM funding from the federal government reached \$176 million by 2006 (Howell, 2007).

During the last decade, many individuals and organizations have questioned the effectiveness of these federally funded abstinence-only programs. After the first five years of Section 510 funding, a review of abstinence-only programs run in ten states found that these programs could only demonstrate limited short-term benefits and no long-term positive changes among those who completed the programs (Hauser, n.d.).

In 2002 Douglas Kirby, a professional with decades of experience studying adolescent behavior and evaluating programs that are designed to change these behaviors, conducted a research analysis of 10 programs that had previously been identified as those that prove that abstinence-only programs work. Dr. Kirby's analysis, which was published by the National Campaign to Prevent Teen Pregnancy, found that nine out of ten of those programs failed to show any indication that they resulted in participants delay-

ing initiation of sex, or if participants were sexually active, reducing how often they had sex.

In 2004, a report was issued by Representative Henry Waxman's office that evaluated abstinence-only programs receiving federal funding. At that time Waxman, of the 30th Congressional District in California, was a member of the House Committee on Oversight and Government Reform. This report, commonly known as the Waxman Report, evaluated AOUM programs that were used by the majority of community organizations that received federal funding through Special Programs of Regional and National Significance Community-Based Abstinence Education. The report found that more than 80% of the curricula being used contained information that was not medically and/or scientifically accurate.

In the same year that the Waxman Report was released, a number of states began to refuse to accept federal funding for abstinence-only programs. By 2008, a total of 16 states refused to accept federal funds for abstinence-only programs. As the states rejected abstinence-only funding there were no options for funding for other types of programs. The first attempt to fill this void was the Responsible Education About Life (REAL) Act.

Introduced in Congress in 2007 and again in 2009 by California Representative Barbara Lee and New Jersey Senator Frank Lautenberg, the REAL Act was designed to provide federal funding for programs that would provide youth with accurate sexuality information that included abstinence, as well as information about disease prevention and contraception. Each time the bill was introduced, it was referred to committee, and each time the committee did not act. While the bill never made it out of committee, the fact that it was introduced, combined with the refusal of many states to accept federal funding, marked a huge shift away from the nearly thirty years of support for AOUM education.

What Needs to be Addressed Now?

Despite increasing recognition of the importance of comprehensive sexuality education, it is still not available to all youth in the United States.

Despite all of the scientific and technological advances that have been made in the United States, the country is falling short in the area of sexuality education. The lack of availability of comprehensive sexuality education for all youth needs to be addressed so that they can obtain the information and skills they need to be sexually healthy teens today, and sexually healthy adults in the future.

Sexual activity among teenagers is not a phenomena unique to the United States, so why is it that American teens have high STI rates and, according to the American Congress of Obstetricians and Gynecologists (2010), the highest teen pregnancy rate among industrialized nations? Two important reasons are that other developed countries have easier access to contraception and health care services, and there is more comprehensive sexuality education (Alford & Hauser, 2011).

Despite increasing recognition of the importance of comprehensive sexuality education, it is still not available to all youth in the United States. This means that students are growing up and making sexuality choices without the information and skills they need to make healthy decisions. The end result is that many teenagers must deal with the consequences of these decisions, some of which may affect them for the rest of their lives. One of the consequences most often discussed in schools, the research and the media is STIs .

The rates for STIs among teens in the United States are staggering. Teenagers account for almost half of all new STIs in this country even though they represent only one quarter of the population that is sexually active, and girls aged 15 – 19 have the highest rates of chlamydia and gonorrhea in the US (CDC, 2010b). Youths aged 13 – 24 account for almost 20% of new HIV cases. As staggering as these numbers are they do not give tell the whole story, as the differences that exist when the data is analyzed by race

shows a disparity similar to what is seen for many other health conditions in the US. In 2008, the HIV rate among black teens was nine times higher than it was for whites (Hall, Hughes, Dean, Mermin, & Fenton, 2011). This is all occurring in a country where 18 states don't require any type of HIV/AIDS education (CDC, 2011).

While STIs, including HIV/AIDS, are serious and should be discussed with teens, there are other sexuality issues that cannot be ignored. Some teens are drinking alcohol and/or using other drugs prior to having sex, which may interfere with their decision-making abilities and their use of contraception. Our youth are also dealing with dating violence and rape. Results from the Centers for Disease Control and Prevention Youth Risk Behavior Surveillance indicate that almost 10% had reported some experience with dating violence, and 7% of the students who responded reported that they had been forced to have sexual intercourse (CDC, 2010a).

Research has given us an understanding of the sexuality issues that our youth are facing. Despite this knowledge, more than half the states in this country do not require sexuality education. With the recent changes in available funding, there is a possibility that more states will utilize comprehensive sexuality education to help address these issues.

Recent "Wins" and "Losses"

The health care reform of 2010 resulted in both a "win" and a "loss" for comprehensive sexuality education. The "win" was the creation of PREP, the Personal Responsibility Education Program. Individual programs that apply for PREP funding must not only address both abstinence and contraception; they must also provide education on three "adulthood preparation subjects" (Department of Health and Human Services, 2010, p. 8). These subjects include financial literacy, parent-child communication, healthy relationships, healthy life skills, adolescent development and educational and career success. The PREP program requires the federal government to make available \$75 million a year for five years, and the states do not have to provide any matching funds.

The "loss" was the re-establishment of funding for Ti-

tle V abstinence-only programs. Title V's funding had ended in 2009, but the health care reform of 2010 re-established its funding for five years. This was a disappointment to many given that the research has consistently demonstrated that these programs are ineffective, and often inaccurate and misleading. As before, this funding will require states to match \$3 for every \$4 of federal money that programs in their state receive.

Despite the reinstatement of funds for abstinence-only programs, in 2010 only four states applied for this as their sole funding (Minnesota, North Dakota, Texas and Virginia). Many states chose to apply for funding through both Title V and PREP, and 18 states and the District of Columbia chose to apply for PREP funding only¹.

Policy Issues: Federal

Many Americans were unaware of the multitude of changes that were taking place as a result of health care reform in 2010. They may or may not have known that the funding for abstinence-only-until-marriage programs ended in 2009, and that while research has shown that these programs are generally ineffective, funding was re-established in 2010 for the next five years. As citizens, we need to be cognizant of what is happening with regard to Title V funding and the PREP program. We also need to be aware when there is legislation introduced to Congress that would create additional funding opportunities for either abstinence-only or comprehensive sexuality education programs.

In addition, people need to be aware of continuing efforts to defund sexuality programs. Though health care reform in 2010 created funding of \$75 million a year for the PREP program, attempts were made to defund this in 2011. A bill has been introduced to Congress that would make the funding that had been earmarked for PREP into discretionary funds. This bill is currently in committee. If this bill becomes law, then the United States will be left with no federal funding dedicated to addressing the issues of teen development, teen pregnancy, or STIs. All that will remain at the federal level is funding for abstinence-

only-until-marriage programs.

Policy Issues: State and Local

Education is not a function of the federal government. The government can make suggestions as to what should be taught, but it cannot mandate what is in a state's curriculum. For this reason, it is the decision of each individual state what subjects will be taught and how they will be addressed. While the availability of federal funding may have an impact on the types of programs that may be offered, in the end the decisions of each state and community will dictate what type of education is available to its students. At this time, 20 states and the District of Columbia require sexuality education, but that number may be changing.²

In May 2011, the Illinois Senate passed a bill that would require comprehensive sexuality education statewide, but the bill has not yet passed the Illinois House of Representatives. A month earlier, the North Dakota Legislature added language to legislation that would require sexuality education to address the benefits of remaining sexually abstinent and the risks associated with being sexually active as an adolescent.

Research

Current Research

Current research on comprehensive sexuality education clearly indicates that it works. These programs are effective at changing behavior, and these behavioral changes are both short term and long term. In 2007, Douglas Kirby reviewed comprehensive sexuality programs and found that teens who participated in them reported an increase in how often they were using condoms or other methods of contraception. These results were found not only at the conclusion of the programs, but also two years after the teens had completed the programs.

Research done in 2003 and 2008 also showed that participation in comprehensive sexuality education programs resulted in an increase in condom use and use of other contraceptive methods (Advocates for Youth, 2008). This research also found that participation in these programs caused an increase in re-

ported monogamy within relationships, which meant fewer overall sex partners.

One of the arguments often used by opponents of sexuality education is that participation in these programs will cause teens to become sexually active. However Douglas Kirby's research (2007) found that comprehensive sexuality education might do the exact opposite. These programs may delay the age when a teen chooses to first become sexually active. Research has also shown that teenagers who already were sexually active may reduce the number of partners they have, or choose to return to being sexually abstinent after participating in these programs (Advocates for Youth, 2008; Kirby, 2007).

Questions That Need to Be Addressed

The first question that needs to be addressed is that of availability. It is important to ascertain how many sexuality education programs are being offered, to whom they are being offered and how comprehensive they are. The second research question that needs to be addressed regarding sexuality education is: are the available programs effective?

In 2007, Douglas Kirby identified 17 characteristics of sexuality education programs that are effective. These characteristics targeted three specific aspects including curriculum development, content and implementation. Each of these aspects allow for tailoring a program to the meet the needs of specific groups. It is vital that the programs being designed and implemented incorporate these characteristics, but that is only a first step. There needs to be continuous evaluation of programs to monitor what is effective, especially as the target audience changes.

Today's youth are different from the youth of ten years ago, and technology has had a big impact on changing what teens know, what they are aware of and from where they get their information. In 2001, texting was rare, but today the average teenager sends and receives more than 3,300 texts a month (Nielson, 2010). Ten years ago, YouTube and Facebook didn't exist. Today a teen can get on the Internet from virtually anywhere and have access to everything they want in a matter of seconds. Teaching teens who are in constant contact with the world around them requires

different pedagogies than those used 10 years ago. Ongoing program evaluation is essential so that curriculum developers are able to create sexuality education programs that continue to be effective.

The Teen Pregnancy Prevention Initiative introduced in 2010 helps to address both the issues of availability and effectiveness by providing funds to implement programs that have been evaluated and have proven to work. Funds are also available for the creation and evaluation of new programs. This ongoing program creation and evaluation will increase the options schools and communities have when choosing a program that best fits the needs of their youth.

Gauging the Availability of Comprehensive Sexuality Education

Having funding available is an important first step, but in order for comprehensive sexuality education to work it must be implemented, so it is important to monitor the number and type of programs that exist, and the types of populations that receive these programs. One way this can be done is by observing how many states apply for federal funding through PREP, Title V and the Teen Pregnancy Prevention Initiative, and examining how this changes from year to year. Another way is to track the changes in the number of individual states that require sexuality education and HIV education.

One might assume that the best way to monitor comprehensive sexuality education is to track the data in regards to teen sexual behavior. This would include how many teens report engaging in sex by a specific age, the rates of teen pregnancies, STI rates, and HIV/AIDS rates. While this data is important for understanding the sexual health of American teenagers, in and of itself it is not an indication of the availability, or effectiveness, of sexuality education.

If the number of teen pregnancies started to decrease in 2011, some might assume it could be linked to the fact that sexuality education programs were now more available because of new federal funding, but that kind of conclusion would be unwarranted. Teen sexual behavior is influenced by a number of factors, and while sexuality education is one

of them it is not the only one. The impact of peers, parents, religion and the use of alcohol and other drugs can all play a role in a teenager's decision to be sexually active.

Case Study

Brittany (name changed) grew up in a state where neither sex education or HIV education were mandated. While her health class touched briefly on sexual anatomy and diseases, there was no in-depth conversation about sexuality and the information was rolled into a section on alcohol, tobacco and healthy decisions. Despite the lack of information in class, she never really felt as though she missed anything as she had talked about sexuality with her parents and her youth group.

Brittany was dating Mike throughout much of her junior year of high school. Although they did their fair share of breaking up and getting back together, Brittany was madly in love with him. Brittany had been raised to believe in being abstinent until marriage. They had talked about Brittany's beliefs, and Mike understood them. One night, she and Mike were drinking and fooling around and he began to put a lot of pressure on her to have sex. He said it was okay because they loved each other and they would be together forever. She said no twice, but then after he kept asking, she said yes.

The next day she regretted her decision. She tried to contact Mike to talk about what happened, but he wouldn't return any of her calls or texts. When her period didn't come the next month, she became concerned. Because she had never thought she would have sex before marriage, she was not on any hormonal method of contraception, and she had had no condom with her at the time, so the sex had been unprotected. Brittany went to a local clinic to find out if she was pregnant. The pregnancy test revealed that she was not pregnant, but the STI test confirmed that she had chlamydia.

It is unreasonable to assume that a comprehensive sexuality education program alone would have saved Brittany from an STI. Sexuality education is not a perfect method of prevention, but because of the information that it provides, and the life skills that it

addresses, it is an important method of prevention that can make a difference in students' lives. Had the class Brittany attended been more comprehensive, had it been more than just a review of anatomy and a mention of diseases, Brittany may have felt more comfortable saying no to Mike. She may have had the opportunity to learn negotiation and refusal skills in class that she could have used when Mike was pressuring her. She may have been better equipped to stand up for her initial decision to be abstinent, and when she changed her mind she might have had the necessary skills to discuss the timing of sex, and the need for a condom to help decrease their chances of getting an infection or getting pregnant. Brittany would not have been the only one who could have benefited from having comprehensive sexuality education. Had Mike had access to this type of education, he could have learned more about negotiation and communication skills. He also could have learned about respecting other people and their boundaries.

Moving Forward

Expanding the Availability of Comprehensive Sexuality Education

Young people have a fundamental human right to comprehensive sexuality education. As a nation, we have taken the first step in increasing the availability of comprehensive sexuality education by funding federal programs that do not focus solely on abstinence, but also include accurate information about contraception in addition to teaching life skills. This is a good first step, but we need to do more. We need to advocate for more funding. The PREP program allocates for \$75 million a year for five years for pregnancy prevention programs. This is not nearly enough money.

Increasing the amount of funding that is available will help to provide much wider access to comprehensive sexuality education. Students in every community, in every state need to have access to comprehensive sexuality education. Once we have increased the availability of educational programs, we should move towards making these programs more com-

prehensive. We need to support the creation and implementation of multi-year programs, so that youth can receive more information from K-12, not just for one semester in school, or through outreach that runs for a few weeks in a community program.

We can accomplish this in two ways. The first is at the federal level where we can urge our Senators and Representatives to pass legislation that expands funding for comprehensive sexuality education. The second is by participating actively in what is happening at the state and local level. Since education is a function of the individual states, we need to focus on what is happening in our communities. We need to be aware of the state and local policies regarding sexuality education and be vocal about the need for this education. On the community level, we can work with state and local elected officials, and also with local Boards of Education and Parent Teacher Associations.

Opportunities for Collaboration

For school-based comprehensive sexuality education we need to work with our elected officials and our local school boards. It can be helpful to be aware of the national organizations that have publicly supported the need for this type of education, including the American Medical Association, the American Public Health Association, and the American Academy of Pediatrics. Organizations that are implementing comprehensive sexuality education programs, and those that advocating for expansion of these programs, can be resources in our efforts to increase program availability. A list of such organizations can be found at the end of this article.

While comprehensive sexually education is important, it alone cannot be expected to help prevent STIs and teen pregnancy, nor can it single-handedly change how youth think about sexuality and how they make sexuality decisions. Learning about the importance of HIV testing in school is an important first step, but if a student has no where to go to have that testing done then the education will not result in behavior change. In addition to education, teens also need to have access to reproductive health care, and that health care must be affordable and youth friendly. This means that reproductive health centers and doctors' offices

must offer appointment hours after school, and possibly have the option of drop-in times (Cornerstone Consulting Group, Inc, 2003).

Teen sexual behavior is influenced by multiple factors. In addition to providing education and access to reproductive health care, efforts must also be made to address the environmental issues that impact how youth view sexuality. This can be done through youth development programs which can help youth learn job skills, address issues of peer support and help teens focus on their options for the future (Cornerstone Consulting Group, Inc, 2003).

If we think beyond the schools the potential for collaboration becomes limitless. We can reach out to religious groups to create sexuality education programs that provide information, and work within their religion's belief structure. We can work with any number of organizations including youth groups, community programs, clinics and continuing education programs. This is essential given that school-based education cannot be effective for those students who drop out of school. Groups that have higher dropout rates, including males, students from low income families and racial minorities (Chapman, Laird, KewalRamani, 2010) may not be receiving any school-based sexuality education even if it is mandated in the state in which they live.

The opportunities for collaborative work in this field are endless, and it is imperative that we start exploring them. A lack of accurate, comprehensive sexuality information does not stop people from being sexually active. We need to provide individuals with the information and the tools they need to utilize that information in their lives, otherwise we will continue to have a population that is sexually active yet sexually "illiterate." If we care about the health and welfare of our citizens, if we want them to have better lives, then we need to make sure that they have access to the sexuality education that is their basic human right.

List of Organizations That Are Working On This Issue

Advocates for Youth

advocatesforyouth.org

The Center for Family Life Education

plannedparenthood.org/greater-northern-nj/local-education-27433.htm

Healthy Teen Network

healthyteennetwork.org

National Campaign to Prevent Teen and Unplanned Pregnancy

thenationalcampaign.org

Planned Parenthood

plannedparenthood.org

Sexuality Information and Education Council of the United States (SIECUS)

siecus.org

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Notes

- 1 These states applied for both Title V and PREP funding: Alabama, Arizona, Arkansas, Colorado, Florida, Georgia, Kansas, Kentucky, Louisiana, Maryland, Michigan, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Utah, West Virginia.
- 2 These states applied only for PREP funding: Alaska, California, Connecticut, Delaware, District of Columbia, Idaho, Illinois, Iowa, Maine, Massachusetts, Montana, New Mexico, Ohio, Oklahoma, Rhode Island, Vermont, Washington, Wisconsin, Wyoming
- 2 For information on sexuality education in your state, please see http://www.guttmacher.org/statecenter/spibs/spib_SE.pdf

Sexual Health Education and Policy in Medical Schools:

The Importance of Incorporating Basic Human Rights

into Medical Education and Training

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Introduction

Why is Sexual Health Education for Medical Providers a Sexual Freedom Issue?

In terms of sexuality (information), we're not producing capable physicians.

- S. Michael Plaut, associate professor of psychiatry at the University of Maryland School of Medicine, quoted by Fulbright (2007, p. 28).

Medical providers hold a high status in our society. They are recognized as experts in the field of health and sought out by patients seeking accurate information about their bodies, but they have little information or training on sexual health or on talking to their patients about sexuality issues. A study released in 2003 found that more than half of all the medical schools in the US provided student physicians with only 3-10 hours of training in sexual health education during all of medical school training. The most common lectures provided were on sexually transmitted infections, the pill, erectile dysfunction medications and sexual side effects of medications (Solursh, 2003).

The lack of information and training on sexual health leaves the general population at a severe disadvantage. Patients want to turn to their doctors, but they don't trust that they have the answers. More importantly, they want the doctors to start the conversation (Wittenberg and Gerber, 2009). When patients do engage their medical providers in sexual health conversations, they are often met with silence, or worse yet, incomprehension. In turn, patients seek out other sources, often the Internet (Marwick, 1999; Brandenburg & Blitzer, 2009; Ferrara, et al., 2003).

What Is Sexual Health?

Sexual health is more than just the ability to achieve erections or obtain birth control. It involves the ability

to experience sexual pleasure and to protect oneself from disease and infection. Sexual health requires that people have the right to obtain medically accurate information so they can make informed and educated decisions about their health. Sexual health is not the promotion of certain behaviors, but rather the acknowledgment of their existence and the creating of guidelines for safety and health covering the range of practices in which individuals engage. Sexual health is not a moral issue, yet it is treated as such by many.

A Basic Human Right

The World Health Organization (WHO) states, "Since health is a fundamental human right, so must sexual (and reproductive) health be a basic human right." (WAS, 2008, p. 155).

In 1997, the World Association for Sexual Health (WAS) created a Bill of Sexual Rights, titled Sexual Rights are Fundamental and Universal Human Rights. The Bill reads as follows:

- The right to sexual autonomy, sexual integrity, and safety of the sexual body. This right involves the ability to make autonomous decisions about one's sexual life within a context of one's own personal and social ethics. It also encompasses control and enjoyment of our own bodies free from torture, mutilation, and violence of any sort.
- The right to sexual pleasure. Sexual pleasure, including auto-eroticism, is a source of physical, psychological, intellectual, and spiritual well being.
- The right to make free and responsible reproductive choices. This encompasses the right to decide whether or not to have children, the number and spacing of children, and the right to full access to the means of fertility regulation.
- The right to sexual information based upon scientific inquiry. This right implies that sexual informa-

tion should be generated through the process of unencumbered and yet scientifically ethical inquiry, and disseminated in appropriate ways at all societal levels.

- The right to comprehensive sexuality education. This is a lifelong process from birth throughout the life cycle and should involve all social institutions.
- The right to sexual health care. Sexual health care should be available for prevention and treatment of all sexual concerns, problems and disorders (WAS, 2008, p. 155).

We are still working towards obtaining these rights in 2011.

The State of Sexual Health Education for Medical Providers in the US in 2011

Defining the problem

Medical students want to learn about sexual health, and the public thinks providers have knowledge of sexual health, yet sexual health programs taught in medical schools or through Continuing Medical Education programs are under-researched, under-supported, and do not have any standard guidelines mandated by medical organizations at this time.. A 2008 study of sexual health curricula found that 44% of schools lacked a formal sexual health curriculum (Malhotra, 2008). While obviously highlighting a problem, this actually represents a significantly worse situation from just five years earlier when Solrush found that out of 125 medical schools (she?) studied, only 7 claimed a lack of sexual health curricula (2003). Of course, as I mentioned in the introduction, over half of the schools Solrush studied offered only 3-10 hours of sexual health training over the course of their entire programs (2003). All of this points to a greater problem: the lack of systematic standards for sexual health within the American Medical Association (Malhotra, et al., 2008).

Few organizations (other than World Association for Sexual Health or The World Health Organization) want to explicitly state what sexual and reproductive health involves. Fear of opposition shuts the conversation down in the early stages, and with so many

medical schools receiving large portions of their funding through grants, these organizations often refrain from addressing socially controversial issues for fear of losing money. Yet, without a definition of sexual health from governing bodies and medical organizations, individuals are denied access to comprehensive care.

Given the lack of licensing examinations and formal curriculum, each teaching hospital is left to its own agenda as it defines sexual health and the practice of sexual health care. Since the United States includes communities with very different norms, values, and belief systems, the training medical providers receive as it relates to sexuality can vary widely varies around the country.

For example, in the South and Midwest portions of America, lesbian, gay and bisexual orientations are less widely accepted as natural forms of sexual expression than they are in the Northeast or on the West Coast. Solursh's study of medical school curricula in the early 2000s found that eight school systems (out of 126) reported that they did not provide any education on gay and lesbian issues at all (Solursh, 2003). East coast schools provide more options for reproductive health training than anywhere else in the nation. West coast schools offer more comprehensive programs for medical providers on compassionate and efficient methods to practice genital exams. When it comes to learning about cardiovascular health, kidney function or orthopedics, standards are enforced across the board, yet when it comes to sexual health education standards differ from place to place. Forty three percent of medical students do not feel comfortable discussing sexual health with their patients (Frank, Coughlin, Elon, 2008). Over half of the medical students also state that they do not feel as though they were properly trained to offer relief to their patients from concerns or ailments their patients did discuss with them (Shindel, Ando, Nelson, Breyer, Lue, & Smith, 2010).

With no nationwide standardization models or curricula, we have perpetuated the existence of a sexually unhealthy nation in which medical students feel unprepared, uncomfortable, and unsure in regards to bringing up the topic of sexual health with their pa-

tients (Shindel et al., 2010; Frank, et al., 2008). Nevertheless, patients are waiting for their physicians to ask them about their sexual health. Organizations like the World Association for Sexual Health, the Center for Excellence in Sexual Health, and the World Health Organization consistently make recommendations regarding these subjects, and dozens of scientific journals explain the need for the standardization and support of sexual and reproductive health instruction. The United States governing medical institutions have not followed through with meeting these demands.

Accreditation Standards and Training in Sexual Health Today

The Liaison Committee on Medical Education (www.lcme.org) determines accreditation standards for medical schools. The committee oversees all medical educational programs, providing a basic structure of proper medical school standards and practices.

The LCME curricular requirements related to sexual health are general and include learning about behavioral subjects, communication skills, diversity in culture and belief systems, and gender biases. Following medical school, all medical providers choose a specialty. The Accreditation Council for Graduate Medical Education (ACGME) determines the specific requirements for knowledge and training in those specialty areas.

The ACGME has created a helpful (but difficult for the general public to navigate) resource named “The Data Resource Book,” which contains the topics that medical education is required to provide so that students are prepared for the final accreditation process of becoming a physician. While the ACGME states that this book (or its PDF equivalent) is intended to be “a concise reference for policymakers, residency program directors, institutional officials, and others to identify and clarify issues affecting the accreditation of residency programs”, there is no list of sexual health topics covered for each and every program.

The Accreditation Council for Graduate Medical Education does have some requirements regarding sexual health, though, and they are very loosely and not very thoughtfully or inclusively defined. Listed below are the graduate level sexual health require-

ments for all medical disciplines that address those issues in which medical providers should be competent and knowledgeable in relation to their patients’ sexual health (ACGME, 2009).

Internal Medicine: Residents should receive “instruction and clinical experience in the prevention, counseling, detection, diagnosis, and treatment of gender-specific diseases of men and women” (ACGME, 2009a).

Family Medicine: “All residents must be trained to competency in normal gynecological examinations, gynecological cancer screening, preventive health care in women, common STDs and infections, reproductive and hormonal physiology including fertility, family planning, contraception, options counseling for unintended pregnancy, pelvic floor dysfunction, and disorders of menstruation, peri-menopause, and post-menopause, including osteoporosis.

In addition, the program should provide adequate instruction and clinical experience in issues of sexual health, management of breast disorders, and management of cervical disease. Residents should become competent in the performance of appropriate procedures” (ACGME, 2007a).

Pediatric Medicine: Residents are required to learn about sexual abuse and male and female reproductive health, including sexuality, pregnancy, contraception, and STDs (ACGME, 2007b).

Urology: Residents should receive training in sexual and reproductive dysfunction and infertility (ACGME, 2009b).

Pediatric Urology: Residents should understand sexual development in utero and how to navigate management of intersex individuals. (ACGME, 2009c).

Adolescent Medicine: The program must provide adequate instruction and clinical experience for all of the adolescent medicine fellows in the following: sexuality, including sexual identity, development, and sexual health problems; sexually transmitted infections (diagnosis, treatment and prevention); reproductive health issues of males and females (e.g. menstrual disorders, gynecomastia, contraception, pregnancy, and fertility); physical and sexual abuse,

risk-taking behaviors, injuries, sexual assault, and violence (ACGME, 2007c).

Colo-Rectal Surgery: Residents must be knowledgeable of colorectal infectious diseases and sexually transmitted infections (STIs) (ACGME, 2011).

Obstetric-Gynecology: Residents are required to be familiar with topics more directly relevant to sexual health (including contraception, infertility, menopause, high-risk behavior) as well as specific sexual medicine skills, such as sexual history-taking and psycho-sexual counseling (ACGME, 2008a).

Psychiatry: The guidelines for sexual health in the field of psychiatry are quite vague, with a focus on cultural differences that address issues of gender, race, ethnicity, socioeconomic status, religion/spirituality, and sexual orientation (knowledge and attitudes) (ACGME, 2008b).

Unfortunately, the ACGME does not state how these standards are measured nor does it evaluate the success or failure of a program in educating its residents in each specialty. The public is only made aware of whether a program is accredited or not, since there does not appear to be a public grading score available.

Most requirements were determined in 2007, although a few listed above were created in 2010. The ACGME does not require residents in all specialties to have sexual health training or clinical skills experience. It is of special note that there are no sexual health requirements in Preventative Medicine, nor is there a Sexual Medicine specialty.

If a medical provider is interested in learning about sexual health, the following organizations provide Continuing Medical Education opportunities.

- The American College of Physicians (represents general internists and the sub-specialists)
- The American Psychiatric Association
- The North American Menopause Society
- The American Urological Association
- Society for General Internal Medicine

- International Society for the Study of Women's Sexual Health

Wins and losses

Few programs have created innovations in sexual health education, the Robert Wood Johnson Medical School (RWJMS) has been an internationally recognized model for comprehensive sexual health education for medical students since 1973.

A course titled "Sex Week," started in 1973, sought to provide a culturally diverse and patient-centered approach, focusing on three components:

- Integration of cognitive and attitudinal learning
- Role of a multidisciplinary team in managing sexual problems
- Clinical skills including general communication skills and sexual history taking

Using a combination of lectures, small-group discussions, media, role-plays, and more, students receive information, practice its application, and are provided with answers to their sexual health questions. At the end of each day, there is a debriefing session that allows students to process the considerable amount of information taken in during such a short period of time. Sexuality/gender educators, sexologists, activists, and sexual medicine specialists from all over the country donate their time to assist in teaching the RWJMS students topics that will be relevant to their future profession. Training for house staff incorporated the three elements described above into an analogous half-day program (Rosen, Kountz, Post-Zwicker, Leiblum, & Wiegler, 2006).

Sadly, while the sexual health education program at RWJMS still exists, the amount of time devoted to it has been significantly reduced. When it began, the program was a 40-hour training and educational opportunity, but at the time of this writing it only provides 21 hours of education and skill-building.

In recent years, "Sex Weeks" have begun to pop up around the country on college campuses. These educational experiences are designed to discuss sexual health, values, experiences, and rights in a campus-wide effort at improving the dialogue around

sexuality and health. Somewhat different from sexual health fairs and “Sexual Responsibility Days,” these weeks usually include information about pleasure, a wider variety of sexual identities and practices, and the ways in which socio-cultural factors affect sexual health and overall fulfillment.

Though these event-weeks are coordinated primarily by undergraduate student groups, some medical schools are also stepping up and holding similar events. A variety of medical schools at institutions of higher learning (e.g. Brown, Stanford, Michigan State, Vanderbilt, etc.) also have LGBTQ student organizations that specifically plan programs and event-series to raise awareness of issues directly impacting the LGBTQ communities, oftentimes ignored in broad sexual health discussions.

Another school of note is the University of Minnesota Medical School, which provides first-year medical students with a full-semester course through the Program of Human Sexuality. This mandatory human sexuality course prepares students to offer effective primary care for patients’ sexual concerns. If other medical schools examined these leading examples of successful sexual health education, we could move forward in effectively teaching our future medical providers.

University of Minnesota should be also recognized for going above and beyond the minimum requirements of the ACGME, offering graduate-level courses in the field of sexual health in addition to their mandatory human sexuality course. These courses are further enriched by the availability of a one and a half day elective seminar for residents on sexual counseling through Residency Education, which covers common sexual problems medical providers may encounter during their clinical practice. Family Medicine residents also have the option of rotating through the Program in Human Sexuality as a clinical elective, but only one to two residents are eligible for this course at any given time.

Policy Issues on the Federal and State Level

Sexual health needs to be formally defined in our culture, and the definition needs to be one that is inclusive of physical, mental, and social aspects of sexual health. For us as a society to recognize the im-

portance of sexually healthy individuals, our medical leaders need to definitively state that sexual health involves the body, spirit, mind, and support of the community (WHO, 2002).

As sexual and reproductive health (SRH) are fundamental human rights, explicit, specific, and well-enforced national policies are desperately needed. The World Health Organization recognizes this when it states that sexual and reproductive health requires “the formulation of sound national policies that support and enable the existence of local health-care environments...and also competent health providers, who have the knowledge, skills and tools to carry out specific SRH tasks, working within a multidisciplinary primary health-care team approach” (WHO, 2011).

The basic considerations for such policies are simple. First, the policy must address the sexual and reproductive health needs of the country. Second, all governing bodies that oversee medical schools’ education standards, certifications, and school/program accreditations must reach an agreement regarding the educational requirements expected of the professionals providing the services. Third, the policy must enable the training and education of professionals to meet those requirements and, where necessary, provide funding towards that end. Finally, the policy must encourage clinical environments where staff can act upon their training and knowledge with regards to sexual and reproductive health (WHO, 2011).

These policies must not advocate any particular sexual practice or identity, but rather should enable an improvement of education for providers so they are able to support their patients regardless of their sexual practices or identities. It is partly through more widespread policies that medical professionals across the board will be able to sufficiently provide sexual health care to their patients. Standardization of curricula is the most efficient way to ensure proper training and education. Additionally, these policies will help address the discrepancies between care available in different regions of the country.

These main policy changes in the United States would be instituted at the medical school accreditation level. These changes would alter the graduation requirements for medical students and the board

certification, helping ensure the proper training for specialties (including primary care) to which sexual and reproductive health are applicable. The goal is to have medical providers who are “adequately prepared, regularly supervised and supported in their work, regardless of if they are non-specialist physicians, or health personnel, who are not physicians” (WHO, 2011). Moreover, as the WHO indicates, the providers need to be aware of the competence of each higher referral level so as to best guide their patients in the right direction.

Because it is neglected so frequently in these discussions, it is worth emphasizing that sexual pleasure must be included as a key component of sexual health. “Although often ignored or stigmatized, sexual pleasure cannot be an afterthought in sexual health promotion” (WAS, 2008). Not only has research demonstrated that Americans consider pleasure an important part of sexual health, but it would also be irresponsible to ignore one of the major reasons people engage sexually with themselves and/or others.

Sadly, the U.S. has been spinning its wheels in regards to providing uniform sexual health care for over sixty years. Until there is adequate support from the governing medical bodies and certification organizations, there is little medical schools can do individually other than attempt to enact some of the national recommendations and/or continue offering hospital-by-hospital training.

Legal Issues

Providing sexual health care and acknowledging people's sexual selves should be a staple of medical care, not an afterthought. Sexual medicine should not be underfunded, silenced, or dismissed as irrelevant. Instead, it should be recognized and valued just as other areas of medicine are, such as oncology or cardiology.

The main legal issue around sexual health care in the U.S. is the conflict between the providing of comprehensive sexuality education and the respecting of certain religious ideologies. As is, medical schools and other institutions with religious affiliations oppose many of the specific consensual sexual health issues we argue should be key components of curriculum.

The conflict arises in that we advocate for education regarding a one fundamental human right, the right to engage in the consensual sexual expression of our choice, but this is sometimes understood to be incompatible with another human right: the freedom of religious practice. The policy in the United States has focused on protecting the rights of religious individuals and organizations instead of protecting the rights of patients and those in need of medical care. An interesting way to instigate reform in this arena and balance the scales could be to look at the policies around Christian Science and model sexual health care policies after them. Under similar policies, patients (or their legal guardians) would have full access to sexual health information and services, but would have the choice of whether or not to use them. There, the control is in the hands of the patients or their proxies, not the medical institution.

This does not, however, address the larger and more difficult legal issue of religious medical institutions' and schools' refusal to train comprehensively in regards to sexual health and to provide certain services due to religious beliefs.

Providing sexual health care and acknowledging people's sexual selves should be a staple of medical care, not an afterthought. Sexual medicine should not be underfunded, silenced, or dismissed as irrelevant. Instead, it should be recognized and valued just as other areas of medicine are, such as oncology or cardiology. Despite how individual providers personally feel about its nuances, sexual health remains a fundamental human right.

Research

Pfizer Inc., famous for their production of Viagra, attempted to stimulate sexual health education in medical school systems. They distributed \$100,000 grants to seven medical schools in order to enhance and provide evaluation of sexual medicine programs. Three grant recipients--the University of Virginia School of Medicine, Case Western Reserve University School of Medicine, and the University of Massachusetts Medical School--have published data.

Interesting points pulled from these schools' reports include:

- Students felt most comfortable discussing sexual side effects of medication and least comfortable discussing sexually-related health problems. This suggests students' overall discomfort with discussing sensitive psychosocial issues (McGarvey, Peterson, Pinkerton, Keller, & Clayton, 2003).
- "Third year students were significantly less likely to rate 'discussing sex in a routine office visit' as important, a response that may reflect supervising attending physicians' negative attitudes toward, or discomfort with, taking a sexual history in the inpatient setting" (Parish & Clayton, 2007).

Students desired additional didactic sessions within:

- Case-based learning
- Standardized patient interviews
- Testing using multiple choice questions and Objective Structured Clinical Examinations (OSCEs), including both sexual health content in existing stations and stand-alone stations devoted to the topic
- Assessment of students' attitudes using the Sex Knowledge and Attitudes Test

Students desired that sexual health curricula included:

- Self-awareness of one's own beliefs, values, attitudes
- Reflection/desensitization
- Variations of normal sexual behavior
- Ethical issues
- Biology of sexual development on a molecular level
- Anatomy and physiology of human sexual response
- Psychological influences on sexual development
- Causes of sexual dysfunction (biological, psychological, and social)
- Impact of medical illness, treatment, medications

- Sexual health in adolescence
- Impact of menopause and/or aging on sexuality
- Sociological issues (ethnicity, race, culture, religion, sexual orientation and economic status)
- Sexuality in special populations (e.g. disabled)
- Reproductive biology (contraception, pregnancy, and infertility)
- Sexually transmitted diseases
- Sexual abuse/violence
- Gay/lesbian/transgender health care
- Treatments for sexual dysfunction (pharmacological and behavioral)
- Sexual history-taking
- Comfort with sexual language
- General communication skills
- Gynecological/genitourinary exams
- Integrated diagnosis of sexual dysfunction
- Management of sexual disorders (pharmacological, counseling, and devices)
- Management of sexual side effects of medications
- Behavioral Therapy

Current strategies to incorporate sexual health content include:

- Faculty development to enhance sexual communication skills
- Dissection of the female pelvis (UMMS)
- Elective course and/or training on the Medical Risks facing the Gay, Lesbian, Bisexual and Transgendered Community

Students reported that challenging topics included:

- Extramarital affairs
- Multiple partners

- Sexual violence
- Gathering sexual information from older patients
- Patients who engage in higher risk sexual behaviors

Ongoing research needs

Ongoing research is necessary to track the number of medical schools that offer sexual health education for their students. But we also need systematic program evaluation of those sexual health curricula that are offered.

We must also begin to evaluate the impact of educational directors in medical schools. Under the administration of those who conflate morality and sexual health rights, some subjects are still considered “too taboo to teach,” even when they directly impact sexual health. The public expects medical providers to be knowledgeable about a wide spectrum of sexual health issues and to be up to date with the latest research. When faculty problems and individuals’ inhibitions combine with a lack of institutional support and resources, vital information is kept from the public and from future medical providers. Since many schools are now headed by board members who hold conservative values, one must wonder if these individuals are largely responsible for lack of comprehensive attention to sexual health. If so, they are partly responsible for blocking avenues for people to pursue health and safety. Until the situation changes, our nation will remain ignorant and sexually unhealthy.

Case Study

In the middle of writing this report, I received a phone call from a woman who was extremely distraught after an attempted pelvic exam earlier in the day. After speaking to her, I asked her to write up a report regarding her experience. This recap reflects why it is imperative for medical students and providers to have training regarding sexual health and exam enhancement skills.

I scheduled a physical/pap - after putting the exam off for nearly two years - with a doctor I had established a relationship with over the past three months. I felt as if I could trust this provider for an exam that is particu-

larly sensitive for me. When I went in for the appointment, the technician immediately had me change out of my clothes and into the tissue paper exam robe before I saw the doctor. My vital signs were taken, the list of current medications I take was updated, and I was told the doctor would be in to see me shortly. After a brief wait, the doctor did indeed enter the exam room and began typing away on the computer in front of her as she asked questions from the screen illuminating her face.

The doctor asked me a laundry list of the general questions like ‘do you smoke, do you drink, how much do you exercise, when was your last period, what is your average cycle length, have you ever been pregnant, are you currently pregnant,’ etc. When she asked ‘are you sexually active’ and I responded yes, she asked if I ‘liked men or women.’ I was offended by this question for a few reasons – people could be sexually active with men, women, or both genders (or some combination at various points) and the use of ‘like’ was plain inappropriate to me. Liking men/ women in the context of the ‘are you sexually active’ question felt like asking me if I like mint chocolate chip ice cream or not. Providers who have successfully asked that question of me in the past have done so in the following fashion: ‘Are you sexually active? Do you partner with men, women, or both?’

Another question, somewhat out of order during this ping-pong style dialog was ‘do you have any problems in the bedroom?’ Being the slightly humorous person I am sometimes, I said, ‘what, like my partner’s laundry on the floor?’ I clearly knew this was not the type of answer she was looking for but also wanted to point out that if she was seeking a particular type of information, the question needed to be asked such that I could disclose that information. She responded with something along the lines of performance, desire, enjoyment, etc... and I said, well, sometimes, yes, in fact I do...and she asked if it was my partner...to which I responded there’s nothing wrong with my partner, she’s wonderful, beautiful, and I love her. The doctor then said, ‘Well I think you should see a psychiatrist. I’m referring you to such and such. He’s good. He sees many young patients.’ To which I said, ‘Hold on a minute, I do not want a referral at this time, and even if I did, I would really like a female psychiatrist.’ The

response... 'Those are really hard to find. You'll like this doctor. He has an entire clinic.' Apparently a shiny building will make me like this doctor.

After the breast exam it was time for the part I had been dreading for years. The entire time I was in the room in the tissue paper robe I was sweating. My stomach was in knots, I felt like I was going to have diarrhea at any moment, and literally wanted nothing to do with the whole situation. When the doc asked me to come to the end of the table, I told her about small cuts I sometimes get around my anus and vagina. Her response to this concern was, 'Well your vagina is too moist. What kind of underwear are you wearing?' Um, excuse me, lady. I have zero control over how 'moist' my vagina is. How about the next time someone tells you something like that you say something a little more humane/empathic like, 'I'm really sorry to hear that. It sounds really painful. I have had other patients bring that concern up to me before. If you don't mind, I would like to examine the external area of your vagina to see if I can locate the areas you are describing to get a better understanding of how best to help you.'

After the 'what kind of underwear are you wearing' comment the doctor went into autopilot and seemingly forgot there was a human on her exam table and not a body. There was no longer any sort of communication coming from her and as I saw her remove the speculum from the vacuum-sealed plastic wrapper, a wave of terror shot through my body because it was massively large. I did not see her apply any lubrication to the speculum, although to be fair, she may have while she was silently working away behind the sheet between my feet. The room was silent except for the sound of my heart beating in my ears and the next thing I know, without warning; she's trying to insert the speculum. I know the vagina is illusive to many people in the world, but when I say she missed, she legit missed. She like drove the speculum somewhere into the region of my posterior fornix/perineal body. I don't know how she did that, but she did. I felt no human hands/fingers to pull my outer labia apart to more gently insert the speculum. There was no asking for permission to begin the procedure...just...utter violation and force. At this point I locked up and started to bring my knees together; she tried to push them apart.

I started trembling and sobbing, pressing the palms of my hands over my eyes and said 'I can't do this now.'

The doctor, I think, felt rather awkward and embarrassed. She was trying to coerce me back into the stirrups and said, 'It's fine! What? It's fine! Let's go. I didn't even do anything. Are you really that sensitive?' I continued to cry and couldn't really talk. She offered me water (I think she wanted an excuse to leave the room; I didn't want any water so she had to stay there.) She realized after a few minutes that there was no pap happening in that office and switched her approach to 'you need one soon because you missed one in 2010. We don't have to do this today. We can do this when you're ready.'

What I wish happened: I wish I didn't have to wear that itchy uncomfortable paper robe while she asked me questions ad nauseum. I wish when she came into the room she shook my hand and asked me how things were going in my life, if I had anything new, fun, or exciting going on. Perhaps if there was anything I was looking forward to. I believe those non-structured general questions can reveal a great deal about a patients' mental health and wellness that can inform other areas of the visit and could possibly raise flags depending on how a patient responds. I wish she asked for permission to touch my body, even if it was just to feel for lymph nodes in my neck or underarms. I wish she again asked for permission to perform a breast exam and a third time when she wanted to start the pap. I wish she showed me the instruments she wanted to insert into my body. I wish she asked if I had any questions or concerns. I wish she explained what she wanted to do and then during every step of the process spoke out loud what she was doing e.g. 'If it is okay with you, I'd like to perform a pap smear today. I'm going to use this speculum (show me the speculum) during the exam today and if at any point you'd like me to stop, you just need to say. Does this sound okay?' Theoretically after I had given her my permission to continue, I wish she would have said I'm going to use my fingers to gently guide the speculum into your vagina, etc...like literally gone through every moment of the process out loud with me. Because in my mind I'm being triggered this way and that way and if she's talking to me and telling me exactly what she's doing and asking me how I'm do-

ing and saying things like almost done blah blah I'm not going to those dark places in my mind. Lastly, I wish she had asked if I had ever experienced sexual assault/violence/trauma/abuse/incest/rape/etc.

I think doctors can do so much in reducing the stigma associated with sexual assault/trauma by normalizing the conversation with their patients. Perhaps every patient won't be honest with them about their sexual assault/trauma history, but if a physician asks every person that walks into their office during a physical exam that question, regardless of orientation, relationship status, religion, race, age, sexual practices, job, etc., etc., then everyone is offered the same opportunity to have an honest dialog with their physician. I have many male friends ('straight' in appearance who partner with men, women or some combination thereof) who are dying on the inside for their doctors to ask them this question. People are suffering around this issue and a series of short questions could resolve a lot of anxiety and improve overall patient health and wellness. In my case, I don't think I'll be able to go back to the doctor for any sort of GYN exam for quite some time.

There are numerous gross problems that occurred during this sexual health screening. This woman is now searching for a new provider with whom she potentially could work. While the International Society for the Study of Women's Sexual Health has an up to date online resource list of providers who are skilled and comfortable dealing with pelvic pain issues, there are currently no published resources, other than word of mouth, of medical providers who are trained or comfortable in taking sexual health histories, discussing concerns with individuals who have been sexually assaulted, or providing basic genital and rectal exams.

Moving Forward

If we, as a society, are going to recognize the fundamental human right to sexual freedom, we need to create change in many of our basic social institutions. Below I have listed the basic changes required in medical education so that providers can directly support their patients' sexual freedom.

Sexual health needs to be redefined.

Sexual health is a function of health, happiness, and satisfaction in both the mind and body. If we approach sexual health only through the lens of preventing disease and death, we ignore the full spectrum of its sexuality and thus reduce our nation's ability to produce sexually mature, intelligent, and fulfilled individuals. A broader and more positive definition of sexual health includes access to medically accurate information, freedom to experience sexual pleasure, and freedom to express one's sexuality (Tepper, 2000).

We must examine biology more, and morals less.

All too often, sexual health is approached as a moral issue and not a medical issue. Debates regarding homosexuality, BDSM (bondage, dominance/submission, sadism/masochism), abortion, sex work, sexual assault, and gender expression greatly influence how topics are approached and taught within medical schools. While the moral issues should be explored within specific medical school courses that focus on the ethics of treatment (for the purpose of value clarification), it is imperative that medicine be practiced to provide health for all individuals and not to impose a medical provider's value-system onto a patient. This is a major point that has not been researched.

Medical school education needs to be enhanced with innovative curricula.

Programs on sexual health deal with challenging issues; merely learning facts and figures leaves medical providers with gaps in their knowledge and preparation. It is of utmost importance that medical schools also critically examine issues of race, ethnicity, cultural values, life experiences, etc in the realm of sexual health. By approaching the more nuanced and complex world of values and ideologies, along with the biological facts, students will feel more prepared and at ease discussing sexual health issues with their patients (Gill & Hough, 2007).

Medical students and respected health/medical leaders have reported the following topics should be included in sexual health education:

- Sexuality language & communication
- Models of sexuality

- Values, attitudes & beliefs
- Sexuality across the lifespan
- Sexual anatomy, physiology & response cycles
- Sexual function & dysfunction
- Disabilities & chronic conditions
- Relationships & love
- Fertility, pregnancy & contraception
- Infertility
- Body image, self esteem, & sexual self esteem
- Media & the Internet
- Sexual orientation, identity & behavior
- Gender & gender variation
- Culture & religion
- Behaviors, practices, & expressions
- STDs, HIV & AIDS
- Sexual abuse, violence, & harassment (Morehouse School of Medicine, 2011)

In addition, students have also stated that they wish to have the following topics discussed in medical school:

- Ethical Issues
- Biology of sexual development on the molecular level
- Psychological influences on sexual development
- Impact of medical illness, treatment, medications
- Sexual health in adolescence
- Impact of menopause, aging on sexuality
- Treatments for sexual dysfunction (pharmacological and behavioral)
- Sexual history-taking
- Gynecological/genitourinary exams
- Integrated diagnosis of sexual dysfunction

- Management of sexual disorders
- Management of sexual side effects of medications (Kingsberg, et al., 2003; Wittenberg & Gerber, 2009)

We need to incorporate different learning models.

Teaching students and professionals about sexual health issues in a variety of formats allows them to build on their knowledge and better grasp complex topics. Different learning models also target different learning styles, resulting in more effective, inclusive instruction that can make students more comfortable with sexuality (Wittenberg & Gerber, 2009).

Examples of different learning methods include:

- Concrete lectures and panels
- Small-group discussions
- Sexual Attitude Reassessments (SARs)
- Pelvis dissections
- Case-based learning
- Practice with taking sexual health histories, risk reduction strategies, and genital/reproductive exams with standardized patients

While most medical schools reported providing sexual history taking lectures, the students themselves said that they rarely were evaluated on how well they did practicing sexual health history with patients. This highlights the need for multiple methods of teaching, learning, and evaluation of learning. (Galletly, et al., 2010).

Medical school faculty need support and empowerment while incorporating sexual health into medical school education.

Faculty may feel ill equipped to provide sexual health training to medical students. If the leaders are ill prepared, they cannot be expected to educate others. In addition, lack of time in the curriculum is a serious issue that has to be addressed. Incorporating sexual health into all dimensions of courses (psychology, epidemiology, cardiology, gynecology/urology, etc.) would ease the burden off of only one group of professors, allow for time management, and

help implement different perspectives on how sexual health permeates every area of medicine. Thus, faculty development and multiple course institutions are critical to the success of sexual health education initiatives (Wittenberg & Gerber, 2009).

Sexual health curricula need strong evaluation and assessment.

Should the governing agencies that monitor what is being taught in medical schools evaluate the current sexual health medical programs, we can start to build data that shows what teaching methods work, what methods do not, and what methods need to be more critically reviewed.

If administrators and regulating bodies are to support sexual health education for medical students, evaluation tools must be researched and expanded upon, otherwise, this instruction will not gain acceptance within the medical health field.

Sexual health education must be mandatory for all medical school programs.

Other developed nations, like the U.K., have systematic standards for sexual health within the field of medicine; it is time for the U.S. to catch up. While the majority of U.S. schools reported that human sexuality was a lecture requirement, less than half of the programs provided formalized education on sexual health concerns or treatment options. Additionally, one third of medical schools did not offer supervision within the focused programs that were provided (Solursh, et al., 2003).

Without standardization, merely offering sexual health courses is insufficient. As of yet, the Association of American Medical Colleges (AAMC), the American College of Physicians (ACP), the Association of Academic Psychiatry (AAP), and the Medical School Objective Project have all failed to provide assistance with structuralized sexual health curricula or competency standards. (Galletly, et al., 2010).

These medical school governing bodies and standards organizations have numerous structures and guidelines in other areas of medicine, but little to none in sexual medicine. When put in place, such structures set the standards for health care and

ensure that the same information is taught nationwide. Since the field of sexual medicine education lacks those structures, it creates wild disparities in providers' preparation and less effective sexual health care. Including standards for a comprehensive understanding of sexual health, one that incorporates sexual pleasure and freedom of expression, would stress the importance of teaching and training medical students within each program regardless of location or background.

One medical school organization that has done some work on standardizing sexual health education within its discipline is the Association of Directors of Medical Student Education in Psychiatry (ADMSEP). They have published their expectations of what medical students should master in sexual health under the title "Psychopathology and Psychiatric Disorders" (ADMSEP, 2007). The clinical learning objectives stipulate that all physicians should have knowledge of sexual biology and physiology, as well as common concerns and dysfunctions. It also calls for certain skills, like effective communication, the taking of sexual histories, and the providing of referrals (ADMSEP, 2007). While it doesn't directly address all the concepts of healthy sexuality or comprehensive sexual health, their expectations stress that dissatisfaction regarding one's sexuality can have devastating results on total health, a connection that many individuals and organizations have failed to recognize.

The American Academy of Family Physicians (AAFP) has also outlined its basic expectations for family physicians regarding sexual health, but its approach is narrowly focused on disease-prevention, ignoring the numerous other components of comprehensive sexual health. Furthermore, AAFP has clearly stated that family physicians should not have to perform procedures or provide information that is not aligned with their values (AAFP, 2011). Such a stipulation does not exist for any other medical specialty, and its enforcement often results in patients being denied critical medical care.

It is the responsibility of a medical provider to help patients achieve their desired health outcomes and counsel them about their options, not deny them care due to personal ideology. While AAFP suggests

that, in those cases where their morals conflict with patient care, providers refer the patient to a practitioner willing to give them the attention they require, this ignores the considerations of time and money that make it less likely that medical care will be provided in time.

Residency training must include sexual health.

“Postgraduate education in sexual health is understudied and under-addressed, lagging behind the rudimentary efforts made in medical schools. Much work is needed to create adequate curriculum and skills training in sexual health assessment and treatment and in residency programs and beyond” (Goldstein, Meston, Davis, & Traish, 2005).

Post-graduate education in sexual health is currently not systematized in the United States. Less than half of the medical schools offered courses in healthy sexual function, dysfunction, or related topics. (Solursh, et al., 2003).

Moreover, graduate students in medicine are often not supported by their attending supervisors when it comes to covering sexual health during patient visits. Recent graduates from several Northeastern schools have been advised by their supervisors that sexual health histories are not necessary because they make patients embarrassed and/or uncomfortable, and because health insurance companies set strict time allotments allowed each patient.

While Continuing Medical Education (CME) opportunities exist, they are exceedingly scarce.

For those who can attend outside events, organizations like the American Association of Sex Educators, Counselors, and Therapists (AASECT), the International Society for the Study of Women's Sexual Health (ISSWSH), and the Society for Scientific Study of Sexuality (SSSS) offer yearly conferences where individuals can learn about various topics in the field of sexual science. The Journal of Sexual Medicine highlights upcoming events on a monthly, in print and online, so individuals can stay informed about developments in the field and opportunities to further their education. Finally, The Association for Reproductive Health Professionals (ARHP) provides a wide variety of online resources, including teaching tools

and news updates for SRH. Further information on these organizations can be found at the end of this document.

National certification standards must be developed.

International Society for the Study of Women's Sexual Health (ISSWSH) is currently developing a fellowship program that involves sufficient training in female sexual medicine within a clinical or research track. It would be beneficial for other professional organizations, such as AASECT or the Society for Sex Therapy and Research (SSTAR), to follow ISSWSH's example in the creation of a national medical sexual health certification. Such certification would allow the public to seek out individuals who can demonstrate training and expertise in sexual health and medicine. Right now, such groups focus only on women's sexual health.

Conclusion

Currently, sexual health (both as a concept and as a field of education) is not standardized in medical schools or in postgraduate degrees/programs in the United States. With no standard models, curricula, or certification processes, there is no way to ensure that medical schools are on the same page regarding sexuality education, or that providers nationwide are at the same level of competency when dealing with patients' sexual issues.

Based on research evidence and the recommendations from well-respected international health organizations, such as WHO, sexual and reproductive health must be considered a basic human right. Education surrounding it should reflect that significance and value. Unfortunately, medical providers have little information, support, or training regarding what sexual health is, how to talk to their patients about it, and what knowledge they need to have in order to best treat and advocate for the people they see. As it stands, vital information and care are not reaching the public due to institutional and structural barriers, as well as conservative influence on multiple levels.

We must move toward a model of education that acknowledges and navigates around micro- and macro-level biases that silence discussion on certain sexuality topics and deny providers education

about them in medical settings. Additionally, we must provide support in all relevant arenas so that comprehensive sexual health education can be standardized, implemented, and sustained in the medical field for the benefit of all citizens.

The public expects and deserves medical providers who are knowledgeable about a wide spectrum of sexual health issues and who remain up to date with the latest research. Every minute that passes without this situation changing is one more minute our nation remains ignorant and sexually unhealthy.

Resource list of organizations that are working on these issues

Established professionals and organizations working for sexual health should consider partnering with future medical leaders to ensure that sexual health has more support, resources, and influence in medicine. What follows is a comprehensive list of organizations that are working towards educating and supporting medical providers in sexual health.

1. The American Medical Association of Student Associates (AMSA)

<http://www.amsa.org>

AMSA is a student-governed, national organization committed to representing the concerns of physicians-in-training. AMSA members are medical students, premedical students, interns, residents, and practicing physicians. AMSA firmly believes in comprehensive sexual education for people throughout the life cycle. As such, they believe it is crucial that medical students be taught about sexual health and dysfunction in order to effectively treat and teach their patients.

AMSA has two committees that are focused on creating change for sexual and reproductive freedoms within the medical communities.

- AMSA's Committee on Gender and Sexuality

<http://www.amsa.org/AMSA/Homepage/About/Committees/GenderandSexuality.aspx>

- AMSA Sexual Health Scholars Program

<http://www.amsa.org/AMSA/Homepage/EducationCa->

[reerDevelopment/AMSAAcademy/SHSP.aspx](http://www.amsa.org/AMSA/Homepage/EducationCareerDevelopment/AMSAAcademy/SHSP.aspx)

2. Medical Students for Choice® (MSFC)

<http://www.ms4c.org/>

MSFC stands in the face of violent opposition, working to destigmatize abortion provision among medical students and residents and to persuade medical schools and residency programs to include abortion as a part of the reproductive health services curriculum.

3. Project Prepare

<http://www.projectprepare.org/>

Project Prepare trains medical students to provide outstanding patient care in the area of sexual health. Professional Gynecological and Male Urological Teaching Associates (GTAs/MUTAs) teach students to perform comfortable and effective genital exams. Project Prepare's diverse staff of educators gives medical students the unique opportunity to receive individual feedback from an educator who also assumes the role of patient. The topics covered include an overview of the technical and psychosocial elements of performing the physical exam and hands-on experience with guidance and feedback from the Patient Educator.

Project Prepare teaches students to perform thorough and relevant sexual history interviews (SHIs), so that they may address patient concerns in the areas of fertility, sexually transmitted infections (STIs), and sexual function and well-being.

4. The Association for Reproductive Health Professionals

<http://www.arhp.org/>

ARHP is a medical association that defines reproductive health in broad terms, and its mission zeroes in on providing education. ARHP translates science into practice by producing accredited, evidence-based programs for health-care professionals across a broad range of topics. Founded by Alan Guttmacher in 1963 as the education arm of Planned Parenthood® Federation of America (PPFA), ARHP became an independent organization in 1972.

5. The American Association of Sexuality Educators, Counselors and Therapists (AASECT)

<http://aasect.org/>

AASECT is a not-for-profit, interdisciplinary professional organization. In addition to sexuality educators, sexuality counselors, and sex therapists, AASECT members include physicians, nurses, social workers, psychologists, allied health professionals, clergy members, lawyers, sociologists, marriage and family counselors and therapists, family planning specialists and researchers, as well as students in relevant professional disciplines. These individuals share an interest in promoting understanding of human sexuality and healthy sexual behavior.

Recently, a sexual medicine special interest group has formed for members. They are creating dialogue through a listserv on current issues in sexual medicine.

6. The Society for the Scientific Study of Sexuality (SSSS)

<http://www.sexscience.org/>

SSSS is an international organization dedicated to the advancement of knowledge about sexuality. It is the oldest organization of professionals interested in the study of sexuality in the United States. SSSS brings together an interdisciplinary group of professionals who believe in the importance of both the production of quality research and the clinical, educational, and social applications of research related to all aspects of sexuality.

7. The International Society for the Study of Women's Sexual Health (ISSWSH)

<http://www.isswsh.org/>

Currently, ISSWSH is the foremost professional medical organization devoted to professional development in the field of sexual health. ISSWSH is a multidisciplinary academic and scientific organization whose purpose is to provide opportunities for communication among scholars, researchers, and practitioners about women's sexual function and sexual experi-

ence. It also reaches beyond the professional scope, providing the public with accurate information about women's sexuality and sexual health.

8. The World Health Organization (WHO)

www.who.int/reproductivehealth

WHO is a leader in the sexual health movement, issuing statements that have created waves within medical education. WHO believes that sexual and reproductive health must be part of the existing health care system as it reflects human rights. For a more detailed look at the guidelines and suggestions created by WHO regarding SRH core competencies in primary medical care, visit http://whqlibdoc.who.int/publications/2011/9789241501002_eng.pdf.

9. The World Association for Sexual Health (WAS)

<http://www.worldsexology.org/>

WAS is a national sexology association that advocates for sexual health education in the field of medicine. It promotes sexual health throughout the individual lifespan and around the world by developing, promoting, and supporting sexology and sexual rights for all. WAS accomplishes this through advocacy actions, networking, facilitating the exchange of information, ideas, and experiences, and advancing scientifically based sexuality research, sexuality education, and clinical sexology, with a trans-disciplinary approach.

10. The Center of Excellence for Sexual Health (CESH)

http://www.msm.edu/research/research_centersandinstitutes/SHLI/aboutUs/CESH/aboutUs.aspx

CESH's mission is to raise the level of national dialogue on human sexuality, sexual health, and sexual well-being in a sustained, informed, honest, mature, and respectful way, linking it to actions that reflect scientific evidence and deeply held beliefs.

The CESH, which is part of The Morehouse School of Medicine, has created an impressive sexual health

curriculum for health care providers they are happy to share. They have the former surgeon general as their leader, and they are extremely responsive to questions people ask. A gold star goes to them!

11. Pfizer

While many people bristle at the notion of partnering with pharmaceutical companies, Pfizer issued \$700,000 for development and research towards creating and implementing sexual health curricula in medical schools. For more information about the curriculum, please visit this link: <http://www.smsna.org/meetings/2003/January/Friday%2001-10-03/Pfizer%20Sexual%20Health%20Medical%20School/index.html>

12. National Advisory Council on Sexual Health (NAC)

NAC provides continuous, comprehensive advisory discussion forums among a diverse group of eminent experts and community leaders regarding sexual health issues for the purpose of developing a national dialogue on human sexuality, sexual health, and responsible sexual behavior, as well as effective initiatives in specific areas within the field of sexual health.

13. The Curricula Organizer for Reproductive Health Education (CORE)

<http://www.arhp.org/publications-and-resources/core>

CORE is an open access tool for building scientific presentations on the full spectrum of reproductive health topics from a collection of peer-reviewed, evidence-based materials. CORE can be used to access up-to-date materials on reproductive health topics, build personal curricula and other educational presentations, download activities, case studies, and handouts for learners, or to enhance knowledge about current issues in sexual and reproductive health care.

Medical schools in the United States that offer courses in Human Sexuality

California

University of California at Los Angeles (UCLA) Medical School

Human Sexuality Program
300 UCLA Medical Plaza, Suite 2200
Los Angeles, CA 94143
Contact person: Joshua Golden, M.D.

University of California at San Francisco (UCSF) School of Medicine

Human Sexuality Program
350 Parnassus Ave.,
Suite 300
San Francisco, CA 94143

Illinois

Loyola University

Sexual Dysfunction Training Elective
Department of Psychiatry, Medical School
Medical Center
2610 South First Avenue
Maywood, IL 60153
Tel: (708) 216-3752
Contact person: Dr. Domeena C. Renshaw
Email: drensha@wpo.it.luc.edu

Minnesota

University of Minnesota Medical School

Department of Family Practice and Community Health
1300 South Second St., Suite 180
Minneapolis, MN 55454
Tel: 621-625-1500
Fax: 612-626-8311
Contact person: Eli Coleman, Ph.D.
Email: colem001@maroon.tc.umn.edu

University of Minnesota School of Public Health

Graduate Program in Human Sexuality
1360 Mayo Memorial Building
420 Delaware St., S.E.
Minneapolis, MN 55414

New Jersey

Rutgers University

Post-Graduate Training Program in Sex Therapy
Medical School, Department of Psychiatry,
P.O. Box 101
Piscataway, NJ 08854
Tel: (732) 235-4273
Contact person: Sandra Leiblums
Email: leiblum@umdnj.edu

University of Medicine and Dentistry of New Jersey

Three day human sexuality course (21 hours)
Robert Wood Johnson Medical School, Department
of Psychiatry
675 Hoes Lane
Piscataway, NJ 08854
Tel: (908) 235-4273
Fax: (908) 235-5158
Contact person: Sandra R. Leiblums, Ph.D.
Email: leiblum@umdnj.edu

New York

SUNY Downstate College of Medicine

Center for Human Sexuality
450 Clarkson Avenue,
Brooklyn, NY 11203

Washington

University of Washington

Postdoctoral Fellowship in Reproductive and Sexual
Medicine
Reproductive and Sexual Medicine Clinic
4225 Roosevelt Way NE, Suite 306
Seattle, WA 98105
Tel: (206) 543-3555
Contact person: Dr. Julia R. Heiman
Email: jheiman@u.washington.edu

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The Human Right to Sexual Health

The Science of Adolescent Sexual Health

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Introduction

Phrases such as “sexual freedom,” “sexual rights,” “choice,” and “consent” (often used in definitions of sexual health) raise critical issues about the concept of sexual health as applied to adolescents. Adolescents’ sexual behavior is substantially limited by legal proscriptions, as well as social and cultural controls.

The purpose of this review is to outline a scientific perspective on adolescent sexual health. The review purposefully reconfigures traditionally oriented research perspectives to focus on three key aspects of sexual behavior: abstinence, masturbation, and partnered sexual activities. The review is not intended – indeed cannot be – comprehensive because of the vast research literature related to adolescent sexual behavior. Rather, the three areas will be used to enhance understanding of the current empirical justification for a sexual health perspective on adolescent sex.

An intellectually compelling perspective on adolescents’ sexual health includes clinical and research paradigms that acknowledge positive aspects of adolescents’ sexuality and sexual behaviors, as well as the social risks of stigma, and the health risks of unplanned pregnancy and sexually transmitted infections. This perspective is based in the recognition of sexual rights, choice and consent as the foundation of sexual health. This means that a scientific approach to adolescents’ sexual health should address the development of sexuality across a range of behaviors that includes abstinence, solo masturbation, and partnered sexual activities.

The State of Adolescent Sexual Health in the U.S. in 2011

Phrases such as “sexual freedom,” “sexual rights,” “choice,” and “consent” (often used in definitions of

sexual health) raise critical issues about the concept of sexual health as applied to adolescents. Adolescents’ sexual behavior is substantially limited by legal proscriptions, as well as social and cultural controls. Most states have specific age thresholds to distinguish illegal and legal partnered sexual activity (English, 2002; Findholt & Robrecht, 2002). Partnered sexual activity before a specified age is often defined as child abuse, without consideration of consent by the participants. This means that the precept of individual sexual autonomy explicit in definitions of sexual health is legally restricted for adolescents in most jurisdictions. This point is not made to argue pro or con the appropriateness of such restrictions. Rather, it is simply noted that adolescents do not have sexual rights equal to those of adults, and our understanding of adolescent sexual health is shaped, to some degree, by those restrictions.

A second issue related to sexual rights has to do with adolescents’ access to correct sexual health information. This type of access is often restricted by local governmental or school board policy, as well as by state and federal statutes. For example, the content of sex education curricula is often skewed toward abstinence, pregnancy, and STI, with little or no mention of masturbation, sexual pleasure or orgasm (Koyama, Corliss, & Santelli, 2009; Santelli, 2008). It is doubtful that many people within public health would endorse purposeful under-education as a national health strategy, but that is the approach taken in much of the United States.

A final issue that affects full sexual rights of adolescents has to do with access to research participation. Autonomy and informed consent – essential principles of contemporary research ethics – are typically restricted for adolescents under age 18 years. Adolescents’ lack of autonomy is explicit only in reference to provision of consent for research participation; de facto autonomy allows adolescents refusal

rights for research participation, even if permission was provided by parents. Again, this point is made to highlight the idea that research on adolescent sexual health often requires active engagement of an additional person, i.e., the adolescent's parent/guardian.

Research

Keeping in mind these limits on research, many data nonetheless exist describing adolescents' sexual attitudes and behaviors. However, few of these data reflect a true sexual health perspective. Instead, research motivated by concern about adverse outcomes of sexual activity typically focuses on five themes: the timing and context of first heterosexual penile-vaginal intercourse; association of sexual activity with substance use and other health-harming behaviors; contraceptive use; sexually transmitted infections (STI), including those due to human immunodeficiency viruses (HIV); and, pregnancy. Less predominant but still frequently addressed themes include sexual coercion, non-coital sexual behaviors, exposure to and use of sexually-explicit media, and same-sex sexual experiences. Data from research related to these large themes are often used to justify policy, public health, and clinical interventions intended (typically) to restrain adolescent sexual behaviors. The predominance of such themes has overshadowed a detailed understanding of the place of sexual health within adolescent development, and has failed to link adolescent sexual health to subsequent adult sexual health.

The perspective taken for the current review is that all of the conditions of sexual health applicable to adults are applicable to adolescents, without regard to age. Thus, all of the tenets of sexual health identified in sexual health manifestos (such as the Millennium Declaration of the World Association for Sexual Health) describe conditions for sexual health that are equally appropriate for 15 year olds as for 50 year olds.

However, it is inappropriate to approach adolescent sexual health as if it were a perfect mirror for adult sexual health. It is likely that at no other period of the lifespan is sexuality at such a period of developmental change. While elements of sexuality and sexual interest are observable in children, the reorganization

of the hormonal, anatomic, and neuropsychological substrates of sex during early adolescence is profound. Likewise, adolescence brings into play detailed and complex rules governing sexual display, sexual interaction, mating, and reproduction. The emergence of a variety of sexual behaviors is important to recognize, but it is also highly relevant to note that many adolescents don't have sex at all. A scientifically informed perspective on adolescent sexual health must include this observation as well.

Abstinence

Abstinence is a term widely used in discussions about sex education, in debates about the role of public health in adolescent sexuality, and in research about sexually transmitted infections and unplanned pregnancy. Abstinence is often defined as refraining from oral, vaginal, and anal partnered sexual behaviors. However, no single definition exists for what is and is not abstinence and a range of sexual interactions such as kissing and mutual genital touching are included in many young people's definitions of abstinence.

This section proposes that adolescents' sexual abstinence is distinct from the sexual abstinence of younger children (De Graaf & Rademakers, 2011; Rademakers, Rademakers, & Straver, 2003). This distinction is based on evidence for emergence of conscious sexual identities, motivations and desires during early and middle adolescence (Reynolds & Herbenick, 2003). These emerging identities, motivations and desires can be enacted through choice of a variety of sexual behaviors, including abstinence. Framing abstinence as a behavior chosen within the context of sexual motivations and desires creates a developmentally appropriate framework for adolescent sexual health that is separated from social, cultural and religious issues of chastity, virginity and non-virginity.

A sexual health perspective on sexual abstinence in adolescence requires consideration of the degree to which abstinence is concordant with adolescents' capacity to choose abstinence (however defined by a given adolescent) as a sexual behavior (as opposed to choosing solitary masturbation or partnered sexual behaviors). This perspective is based in identifi-

cation of sexual desires and motivations, and the capacity for meeting the criterion of “consensuality” that anchors most definitions of sexual health. The term “sexually abstinent behavior” has been used to define a negative response to an item “Have you ever had sexual intercourse?” (Buhi, Goodson, Neilands, & Blunt, 2011).

The Sexual Desires and Motivations of Abstinent Adolescents

Abstinence is often discussed as if an adolescent either “is” or “is not” abstinent. This perspective of abstinence as an absolute characteristic allows little insight into the ways adolescents incorporate experience of their sexuality into sociocultural expectations for abstinence.

As a starting point, the idea is explicitly rejected that abstinence is synonymous with asexuality. Thus, abstinent adolescents have sexual desires, interests, attractions, and fantasies, although these are poorly understood. A sexual health perspective on abstinence requires understanding of how adolescents perceive abstinence as an expression of their sexuality. For example, satisfaction with abstinence (identified by items such as “being sexually abstinent makes me feel good”) is correlated with abstinence intentions, beliefs and norms (Buhi, et al., 2011). This is consistent with definitions of sexual health built around the idea that sexual health is in large part congruence of one’s sexual behaviors with one’s sexual desires, ideals, and values.

This discussion of abstinence depends on the developmental emergence of cognitive orientations that include sexual interests, sexual attractions, and sexual arousals. Emergence of sexual cognitions differentiates adolescents from children. This differentiation is critical because sexual cognitions identify an autonomous sexual person. Emergence of sexual cognitions is likely hormonally mediated in association with adrenarche and pubarche (Ellis & Essex, 2007; Graber, Nichols, & Brooks-Gunn, 2010; Herdt & McClintock, 2000; Oberfield & White, 2009). In a study of 4th and 5th grade boys and girls (ages 9 – 11 years), self-relevant sexual thoughts were reported by 16% (30/190) (Butler, Miller, Holtgrave, Forehand,

& Long, 2006). Of those reporting sexual thoughts, all remained abstinent of sexual intercourse but about 10% reported initiation of partnered sexual touching. Prospective studies suggest that sexual cognitions become evident over a short period of time, perhaps as little as 3 months (Mary A. Ott & Pfeiffer, 2009). It is important to remember, then, that adolescence is not a developmentally homogenous period.

Once sex becomes developmentally relevant to adolescents, understanding of adolescents’ perspectives on abstinence are important. Cognitions about abstinence (for example, attitudes and intentions) are not independent from cognitions about sexual behavior (Mary A. Ott & Pfeiffer, 2009). Younger adolescents form attitudes and intentions about abstinence and other sexual behaviors (Masters, Beadnell, Morrison, Hoppe, & Gillmore, 2008). Other studies show that adolescents’ definitions of abstinence often include masturbation as well as partnered sexual interactions (Byers, Henderson, & Hobson, 2009; Planes et al., 2009).

Abstinence is often discussed as if an adolescent either “is” or “is not” abstinent. This perspective of abstinence as an absolute characteristic allows little insight into the ways adolescents incorporate experience of their sexuality into sociocultural expectations for abstinence. Young adolescents describe abstinence as a normal aspect of a continuum that uses “developmental readiness” as a standard for motivated decisions about shifting from sexually abstinent activity to sexual activity (M. A. Ott, Pfeiffer, & Fortenberry, 2006). Stronger attitudes about abstinence and intentions to be abstinent are associated with increased likelihood of choosing abstinence six months later (Masters, et al., 2008). Interactions of abstinence and sex cognitions were important in that adolescents with high levels of abstinence intentions and high levels of sex intentions were less likely to be abstinent six months later (Masters, et al., 2008).

Masturbation

This section addresses masturbation as the most prevalent of adolescent sexual behaviors (J. Dennis Fortenberry et al., 2010). Masturbation was historically subject to substantial religious condemnation and aggressive anti-masturbation medical treatments.

Contemporary views hold masturbation to be developmentally normal, and health-neutral if not health-enhancing. As an aside, it seems contradictory that a purportedly “normal” (and even “healthy”) behavior is so little addressed in sexuality education curricula, in discussions between adolescents and parents, and between adolescents and physicians (Robbins et al., 2011).

No data prospectively date the ages and contexts of onset of masturbation. Retrospective studies suggest average ages of 13 and 15 years for men and women, respectively (Pinkerton, Bogart, Cecil, & Abramson, 2002). The prevalence of masturbation in the past three months increases with age among adolescent men: about 43% of 14 year olds report masturbation in the past 90 days compared to 67% of 17 year olds (Robbins, et al., 2011). In contrast, the percentages of 14 and 17 year old women reporting masturbation in the past 90 days are quite similar at about 36% for both ages (Robbins, et al., 2011). Lifetime prevalence of masturbation, however, continues to increase into young adulthood, with prevalence highest among those aged 25–34 (Gerressu, Mercer, Graham, Wellings, & Johnson, 2008). The magnitude of underreporting of masturbation is not established but may be substantial (C. J. T. Halpern, Udry, Suchindran, & Campbell, 2000).

Masturbation and the Development of Sexual Health

The perspective that masturbation is developmentally “normal” in adolescence raises an additional question of whether masturbation is a developmental phase of sexuality subsequently supplanted by various forms of partnered sex. If masturbation serves only as a means of sexual learning and self-exploration, then rates should decrease markedly as rates of partnered sex increase during middle and late adolescence (Hogarth & Ingham, 2009). Likewise, if masturbation serves only as a sexual outlet without risk of sexually transmitted infection or pregnancy, then masturbation among adolescents and young adults should diminish as partnered sex becomes socially normative.

Neither of these perspectives is consistent with data showing that rates of masturbation remain high over the lifespan, especially among men (Herbenick et

al., 2010; Kontula & Haavio-Mannila, 2002). This suggests an alternative perspective that masturbation serves important functions to sexual health, and that these functions are not dependent on partnered sexual behavior in adolescence or at any point in the lifespan (Das, 2007; Das, Parish, & Laumann, 2009; Gerressu, et al., 2008; Kontula & Haavio-Mannila, 2002; Robinson, Bockting, & Harrell, 2002).

Understanding of the association between masturbation and other aspects of adolescents’ sexual health is rudimentary. Earlier studies found no long-term association (either positive or negative) with sexual function (Leitenberg, Detzer, & Srebnik, 1993). Among American 14-17 year olds, those reporting masturbation in the past year reported higher levels of several forms of partnered sex, including given/received oral sex, penile-vaginal intercourse, and penile-anal intercourse (Robbins, et al., 2011). Gender differences are evident in that women’s masturbation prevalence increased from 34% among those reporting penile-vaginal sex less than four times in the last four weeks to 72% among those women reporting at least 16 occasions. In contrast, the prevalence of masturbation was most frequent among men reporting less than four occasions of sex in the last four weeks (Gerressu, et al., 2008).

Other data suggest that masturbation is associated with several key aspects of sexual health. For example, young men reporting masturbation in the past year are substantially more likely to report condom use with penile-vaginal intercourse than young men who do not report masturbating. (Robbins, et al., 2011). This suggests that masturbation provides a familiarity and comfort with one’s genitals in a way that supports successful condom use. Interestingly, this same study found no differences in condom use among young women based on self-reported masturbation. However, masturbation has a role in young women’s sexual health development as well. Young women with a history of masturbation and non-coital orgasmic responsiveness had higher levels of sexual self-awareness and felt more entitled to sexual pleasure through masturbation, more efficacious in achieving pleasure, and reflected more on the sexual aspects of their lives than those who had never experienced a non-coital orgasm. Further, these women

were more expressive in their intimate relationships and more resistant to gendered double standards (Sharon Horne & Melanie J. Zimmer-Gembeck, 2005).

Masturbation and Adolescent Brain Development

Associations of masturbation and adolescent brain development have received very little research attention, with most studies directed toward explanations for increases in partnered sexual risk-taking thought to be generally characteristic of adolescence (Johnson, Blum, & Giedd, 2009). A more contemporary perspective on the changes in the adolescent brain is that reward-seeking peaks in mid-adolescence and impulsivity declines during adolescence into young adulthood (Steinberg et al., 2008). These changes are associated with active refinement of prefrontal and subcortical regions related to goal-directed behavior (Giedd et al., 2010). Imaging studies show that differences in cortical sub-systems associated with visio-spatial perception (typically more advanced in male adolescents) are associated with functional polymorphisms in the androgen-receptor gene (Raznahan et al., 2010). Thus, aspects of brain development could explain the substantial gender differences in masturbation rates that emerge during adolescence and remain a characteristic gender difference throughout the sexual lifespan (Oliver & Hyde, 1993; Petersen & Hyde, 2010).

Partnered Sex

This section addresses aspects of partnered sexual behaviors that become prominent during mid- and late adolescence. These behaviors include sexual kissing, breast and genital touching, partnered masturbation, fellatio, cunnilingus, penile-vaginal intercourse, and penile-anal intercourse. Other partnered behaviors such as sexual exchange via electronic media (e.g., phone sex, “sexting”), and shared viewing of sexually explicit media also emerge during this time. The essential element of this aspect of adolescent sexuality is the sexual dyad. The nature and content of the dyadic relationship defines a substantial perspective on social attitudes, motivations, and outcomes (e.g., STI, pregnancy) of adolescents’ sexual relations.

Forms of Partnered Sexual Relationships

Sex plays a complex role in the formation and maintenance of several types of dyadic relationships, and serves different functions in relationships with different partners. Even within partnerships, the relational, recreational and reproductive functions of sex vary in relevance and salience at different times. Sexual factors predominate in some relationships: exchange of sex for money, drugs or rent, or single encounters with poorly known partners are examples. A common term for such encounters – one-night stand – is still widely used, but terms such as “casual partners,” “hook-ups” or “friends with benefits” are also commonly used. Up to half of adolescents in some studies report having sex outside of a dating context, but many choose partners who are friends or ex-girlfriends and/or boyfriends (Manning, Giordano, & Longmore, 2006). Studies of college students show that the sexual behavior content of these short-term relationships is highly varied, with a substantial proportion not involving penile-vaginal or penile-anal intercourse (Epstein, Calzo, Smiler, & Ward, 2009).

For many adolescents, sexual activity occurs within the context of an established relationship characterized by terms indicating relative commitment and exclusivity (e.g., friend, boyfriend/girlfriend or fiancée) (Manning, Flanigan, Giordano, & Longmore, 2009). In the past, many sexual relationships occurred in dating relationships with a subsequent marriage partner, and dating relationships remain important contexts for adolescents’ sexual activity (Giordano, Manning, & Longmore, 2010; Manning, Giordano, Longmore, & Hocevar, 2011). Serial romantic and sexual relationships - serial monogamy - represent a temporal sequence of sexual relationships characterized by commitment and sexual exclusivity, not necessarily leading to marriage or cohabitation. A substantial proportion of young adults – but relatively few adolescents – establish cohabiting relations with a partner, often prior to marriage (Cohen & Manning, 2010).

Partnered Sexual Behaviors

Vaginal sex is often viewed in both popular and professional dialogue as the sine qua non of sexual development. Many societies develop separate language and social status for adolescents before and after an initial vaginal sexual experience. However, the range and meanings of sexual behaviors available to adolescents suggest the need for a more nuanced perspective.

Partnered, non-coital sexual behaviors such as kissing, non-genital touching, and genital touching are also common adolescent sexual behaviors that often precede first sexual intercourse (O'Sullivan, Cheng, Harris, & Brooks-Gunn, 2007). The prevalence of oral sex has also become more common in recent years, perhaps in response to a greater emphasis on the value of virginity and media popularized "risks" associated with sexual intercourse. Oral sex, in particular, also allows for sexual learning that emphasizes exchange, physical intimacy and pleasure, as well as "safer" sexual behaviors (Halpern-Felsher, Cornell, Kropp, & Tschann, 2005). To the extent that non-coital sexual behaviors provide opportunity to experience partnered arousal, sexual agency and sexual control, oral sex is likely an important part of the development of healthy sexuality during adolescence and young adulthood (Galinsky & Sonenstein, 2011; S. Horne & M. J. Zimmer-Gembeck, 2005).

Vaginal sex is often viewed in both popular and professional dialogue as the sine qua non of sexual development. Many societies develop separate language and social status for adolescents before and after an initial vaginal sexual experience. However, the range and meanings of sexual behaviors available to adolescents suggest the need for a more nuanced perspective. For example, a recent daily diary study showed no difference in daily mood on days before and after first coitus (Tanner, Hensel, & Fortenberry, 2010).

Data from the National Survey of Sexual Health and Behavior (NSSHB) provided age-specific rates of a range of sexual behaviors of adolescents aged 14-19 years (J. Dennis Fortenberry, et al., 2010; Herbenick, et al., 2010). Vaginal intercourse was a rare event for

the majority of 14-15 year olds with 90% of males and 88% of females never having engaged in such sex. Among 16-17 year olds, vaginal sex occurred more frequently. However, only approximately one-third of males and females in this age group reported ever having vaginal sex. Among 18-19 year-olds, 63% of males and 64% of females reported experiencing vaginal sex at least once during their lifetime.

Anal sex, and especially receptive anal sex, was a low occurring behavior among most adolescents. For instance, among 18-19 year-old males, lifetime prevalence rates of receptive and insertive anal sex were 4% and 10%, respectively. Among adolescent women, anal sex was also a very low occurring event and was endorsed at a rate of 4% among 14-15 year-olds and 7% among 16-17 year-olds. Higher rates of anal sex were reported among 18-19 year-old adolescent females, with over 20% having experienced anal sex at least once during their lifetimes (Herbenick, et al., 2010).

Family Sexual Culture and Adolescent Partnered Sex

Family sexual culture refers to the values, attitudes, and behaviors directly or indirectly influenced by parents and siblings. Family sexual culture includes, but is not limited to, parental communication about sexuality and sex, and supervision of sexual exposure opportunities (e.g., access to sexually explicit media; dating). In short, family sexual culture represents a specific means of sexual socialization, by which specific social and religious sexual values and attitudes are reinforced (Fingerson, 2005). It is also important to note that sexual socialization occurs through interaction of parents with adolescents, rather than through a unidirectional transmission from parents (de Graaf, Vanwesenbeeck, Woertman, & Meeus, 2011).

A substantial body of research demonstrates that aspects of family sexual culture influence adolescent sexual behaviors. Most of this research focuses on ways in which parenting behaviors are associated with older age at first penile-vaginal intercourse, fewer intercourse partners, and greater use of condoms and contraceptives (de Graaf, et al., 2011).

Research emphasis families' influence on the timing

and expression of specific sexual and contraceptive behaviors has obscured the potential importance of family sexual culture and aspects of sexual health: sexual assertiveness, control, esteem, and satisfaction. For example, among Dutch adolescents, greater parental support was associated with greater sexual assertiveness and satisfaction, controlling for effects of parental knowledge. Parental knowledge, however, was associated with assertiveness, control, esteem, and satisfaction, even while controlling for mediation effects of parental support (de Graaf et al., 2010). We still have a great deal to learn about how parents influence the experiences of sex by their adolescents.

Subjective Sexual Experiences: Desire, Pleasure, Arousal, Orgasm, and Sexual Difficulties

Subjective aspects of sex acts are clearly important elements of adults' sex (Meston & Buss, 2007) but are virtually unaddressed in the research literature about adolescent sexuality, sexual behavior, and sexual consequences.

Sexual arousal summarizes the complex psychological and physiologic activation associated with sexual stimuli (Levin, 2002). Many models of adult sexual response assume that sexual desire precedes and generates sexual arousal but these models have been especially criticized as less accurate for women (Graham, Sanders, Milhausen, & McBride, 2004). Our cultural mythology (exemplified in the phrase "raging hormones") suggests that adolescence is a time of innate, hormonally-mediated sexual arousal. This view has been supplemented by contemporary neuropsychological data suggesting a developmental imbalance in dual brain systems associated with sensation-seeking and behavioral control (Steinberg, et al., 2008). A review of six published diary-based studies of a single cohort of adolescent women showed that greater sexual interest on a given day was associated with sexual activity on that day, whether the behavior was first lifetime coitus, coitus, fellatio, cunnilingus, anal intercourse, or coitus during menses (J. Dennis Fortenberry & Hensel, 2011).

Adolescents do identify pleasure as an important motivation for sex, although young women place less emphasis on pleasure than young men (Latka, Kapadia, & Fortin, 2008; Suvivuo, Tossavainen, &

Kontula, 2010). Research on sexual pleasure among adolescents largely addresses perceptions of the effects of condom (or contraceptive) use on pleasure (Higgins, Hoffman, Graham, & Sanders, 2008). Even young adolescent men without coital experience mention interference with pleasure as a negative aspect of condom use (Rosenberger, Bell, McBride, Fortenberry, & Ott, 2010). Sexual pleasure has also emerged – because of the potential lubricating qualities of vaginal microbicides – as an important element of microbicide acceptability, even for young women (Tanner et al., 2009).

No data obtained from adolescents less than age 18 years of age address physiologic or psychological correlates of orgasm. The average age of retrospectively-reported first orgasm is 13 years and 17 years of age for men and women, respectively (Reynolds & Herbenick, 2003). These data refer in part to orgasm from masturbation but demonstrate that the capacity for orgasm is present in adolescence. About 10% of adolescent women report orgasm with first heterosexual coitus (Raboch & Bartak, 1983). Among 18-24 year old Swedish women, 26% reported that first orgasm occurred in association with penile-vaginal intercourse, and an additional 25% from cunnilingus or partner masturbation (Fugl-Meyer, Oberg, Lundberg, Lewin, & Fugl-Meyer, 2006). In a national Australian survey, 84% of 16-19 year old men, and 52% of women reported an orgasm at their most recent sexual encounter (Richters, Visser, Rissel, & Smith, 2006).

We know that adolescence is a time of changes and new experiences but we know little about how sexual health changes during this time. Adolescents' sense of worth as a sexual person – summarized by the term 'sexual self-esteem' – is associated with higher sexual self-efficacy (i.e., the capacity to enact one's sexual interests and desires. Adolescents with higher sexual self-esteem have more sexual self-efficacy in potentially risky sexual situations (for example, in negotiating condom use with a new sexual partner) (Rostosky, Dekhtyar, Cupp, & Anderman, 2008). As young women move through adolescence, both sexual self-esteem and sexual self-efficacy increase with time. A third aspect of sexual self-concept – sexual anxiety – decreases with time (Hensel, O'Sullivan, &

Fortenberry, 2011). Sexual self-concept is important because it is associated with positive motivations toward sex, and with greater sexual satisfaction (Impett & Tolman, 2006). Even more general individual characteristics – autonomy, general self-esteem, and empathy – are related to sexual health outcomes like frequency of orgasm, and liking to give/receive oral-genital sex (Galinsky & Sonenstein, 2011). Taken together, these recent research findings suggest that maturation, sexual learning and experience are associated with generally positive changes in sexual health through adolescence into young adulthood.

Most of the limited data on adolescents' subjective sexual experiences is based on retrospective reports, often some years after their adolescent experiences. Clinically, this means that an empiric basis is largely incomplete for addressing sexual function and dysfunctions associated, for example, with hormonal contraceptives or selective serotonin release inhibitors (M. A. Ott, Shew, Ofner, Tu, & Fortenberry, 2008; Scharko, 2004) or for anticipatory guidance related to sexuality and sexual behavior (Blythe & Rosenthal, 2000). From a public health perspective, adolescent sexual health is often viewed according to narrow proscriptions of sexual activity, and, in particular, of condom-unprotected sexual activity (J. D. Fortenberry, 2009). An emerging perspective emphasizes the importance of a broader and more detailed understanding of adolescent sexuality as the proper context for infection and pregnancy prevention efforts. (C. T. Halpern, 2010)

Sexually Explicit Media and Adolescent Sex

Discussion of sexually explicit materials is included in this section rather than in relation to masturbation because all of the research addresses associations of sexually explicit material with partnered sexual behaviors, even though much of the use of sexually explicit material is for solo masturbation (Hald, 2006). Contemporary adolescents have access to a variety of sexually explicit media (e.g., television, internet, chat lines, books, magazines) with exposures often beginning at age 14 or earlier (Štulhofer, Buško, & Landripet, 2010; Ybarra & Mitchell, 2005). Timing of pubertal development is associated with increase in use of sexually explicit media among boys (Lofgren-

Mårtensson & Månsson, 2010; Skoog, Stattin, & Kerr, 2009). Exposure to sexually explicit media may be unintentional but is often intentionally chosen for sexual content (Bleakley, Hennessy, & Fishbein, 2011). A substantial body of research associates use of sexually explicit media with outcomes such as age of first intercourse and number of sexual partners but few data exist in terms of associations with adolescents' sexual satisfaction or function (Braun-Courville & Rojas, 2009).

One form of contemporary sexually explicit media – “sexting” – has received substantial popular attention but relatively little research (Weiss & Samenow, 2010). Sexting involves the transmission of sexual text, nude or sexual photographs (or both) via cellular smart phones. Up to 20% of adolescents report sending or receiving sexual visual images [cited in (O’Keeffe, Clarke-Pearson, Council on, & Media, 2011)]. No data describe the integration of such texts/images into adolescents' sexual lives. However, some jurisdictions interpret sexting in the context of child pornography laws, prosecution of which certainly has important long-term consequences (Ostrager, 2010).

Case Study – Bringing Public Health Relevance to Adolescent Sexual Health

Adolescents have been at the center for years of marked debate and controversy over sex education as an approach to the prevention of unintended pregnancy and sexually transmitted infections. Even teaching about sexuality seems to provoke marked anxiety, with the expectation that sexual knowledge will incite sexual behavior. During the first decade of this century, debate moved to the point of public health policy advocating intentional misrepresentation of facts about contraception and condoms as a means of emphasizing the importance of abstinence. More recently, exclusive emphasis on abstinence has been shifted to a more balanced emphasis on accurate facts, and recognition that abstinence is not chosen by all adolescents.

An emerging emphasis on sexual health at the Centers for Disease Control & Prevention offers an

unusual case study demonstrating the importance of continued emphasis on the science of adolescent sexual health. Some details of the emerging emphasis on sexual health can be reviewed in publicly available documents: Centers for Disease Control and Prevention. A Public Health Approach for Advancing Sexual Health in the United States: Rationale and Options for Implementation, Meeting Report of an External Consultation. Atlanta, Georgia: Centers for Disease Control and Prevention; December, 2010. <http://www.cdc.gov/sexualhealth/docs/Sexual-HealthReport-2011-508.pdf>

The document cited above is a remarkable development, and promises to revise public health practice in the United States markedly. However, from a perspective of adolescent sexual health, three points should be made. These points demonstrate the substantial difficulty faced in bringing a sexual health perspective into the discussion of adolescent sexuality and sexual behavior.

First, very little of the text developed so far directly addresses issues related to adolescents. Rather, a life-course perspective is taken, suggesting that sexual health may vary depending on the age and situation of a person. So, we can assume that adolescence is a life phase of relevance, but the specific aspects of adolescent sexual health that may differ from those of adults are not addressed.

Second, the issue of adolescents' sexual rights is not addressed at all. Even organizations such as the World Health Organization have not closely grappled with this issue in a positive way. It is easy to think about adolescents' sexual rights from perspectives of freedom from coercion, or unwanted genital modification. It is also easy to see that an adolescent's choice of abstinence as a sexual behavior is an acceptable exercise of sexual rights. But, many might find asserting an adolescent's right to sexual activity a much more untouchable topic.

Finally, sexual pleasure – so integral to most definitions of sexual health – is almost unaddressed in this new public health perspective on sexual health. Pleasure remains the great unmentionable subject within the broad literature on adolescent sexuality and sexual behavior. As remarkable as the emerging

emphasis on sexual health seems, pleasure remains a taboo word. It is an odd conundrum that we seem as a society willing to study in extraordinary detail the consequences of adolescents' sexual behaviors, but we seem quite unwilling to address adolescents' pleasure and other aspects of sexual functioning.

This case study points out that an empirical basis for thinking about adolescent sexual health is still needed, even as we move into the second decade of the 21st century.

Moving Forward

A scientific basis for understanding adolescent sexual health remains limited but there are indicators of an emerging focus on thinking of adolescent sex outside of its potential for adverse consequences. The tools of contemporary research will allow substantial new insights into the development of sexuality and sexual behavior within adolescence, and the linkages of this development to subsequent sexual health through the lifespan. Some aspects of adolescent sexuality are likely to be outside of ethically acceptable standards for research with minors and will remain unknown. For example, laboratory-based studies of sexual responsiveness are unlikely to be conducted in the foreseeable future. However, thoughtful use of existing and new research should provide a strong empirical basis from which public policy, public health practice and clinical services can be developed that will enhance adolescent health and well-being while preventing disease and adverse consequences.

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Viral Apartheid: Sexuality and Discrimination Involving HIV

Todd A. Heywood

Introduction

In addition to the criminalization of specific behaviors, those living with HIV sometimes are required to sign restrictive documents acknowledging the laws and, in many instances, agreeing to forego specific behaviors. One such form in Mississippi forces women to agree not to have children after diagnosis with HIV.

A 1987 federal government theory of criminalization,¹ which in turn drove 34 U.S. states and two territories to create a bevy of HIV-specific criminal laws, has been as slow acting as the virus itself. This virus of discrimination has slowly undermined the body politic, hanging over the heads of persons living with HIV like a proverbial Sword of Damocles. The string on the sword has broken, and in recent years, the legal revenge has burst forth on the body politic like an unsightly series of pustulant boils on the face of American jurisprudence's Lady Justice.

Ironically, with more people living longer with the virus and science documenting that the very medications that are extending lives are also making people less infectious, American society has shifted into overdrive, criminalizing consensual behavior for those with the virus. Other diseases with similarly lifelong and jeopardizing impacts are not subject to lengthy jail terms and/or additional sanctions.

America is seeing an unprecedented confluence of events that feed and support criminalization. At 30 years into the epidemic, while medicine has been able to control the virus successfully, the rise of anti-science based sex education programs in the U.S. in 1998, combined with the success of anti-retroviral treatments, and topped with a shifting of prevention priority, have moved prevention in America from a personal responsibility of all people to an individual responsibility just of those infected.

The State of HIV Criminalization in the U.S. in 2011

Criminalization is found in two distinct categories. First is the HIV-specific criminal law. These are laws which have been created around the requirement of persons with HIV to disclose their condition prior to engaging in certain behaviors. Some of these laws criminalize needle sharing, but all of them criminalize sexual activity. In some instances, sexual behavior which has little or no ability of transmitting the virus is criminalized.² Most fail to delineate an act done to mitigate transmission risks. Some states have gone a step further, criminalizing consensual adult commercial sexuality while being infected with HIV.

This first set of laws was pushed by the 1987 Reagan Commission on the HIV Epidemic. In that report, the Commission recommended that those with HIV have an affirmative responsibility to disclose their infection to sexual and needle sharing partners prior to engaging in behavior which might infect another with the virus. This affirmative duty was also a key responsibility laid out in the seminal 1983 Denver Principles, which was written by those living with HIV. While these were merely recommendations, in 1990, with the passage of the first Ryan White Care Act, states were ordered to certify that there were legal ways to enforce this affirmative duty. This certification requirement drove states to pass HIV-specific laws in order to qualify for the Ryan White funds. Some states, however, refused to pass HIV-specific laws, instead relying on traditional criminal laws.

The second criminalization category involves the use of traditional criminal laws in charging HIV-positive persons. But the laws that are used over-charge the accused. In this category we see HIV-positive persons – or those thought to be HIV positive – charged with attempted murder, bioterrorism and other extreme criminal acts. The prosecutions are based solely on the HIV-positive status of the defendant.

Criminalization has continued to escalate in the United States and Canada, with these two countries having the vast majority of known cases. However, these known cases are thought to be merely the tip of the iceberg, based upon self-reported situations and media reports. No state in the U.S. has a system in place to track and report all such cases. In Michigan, for example, one would need to review manually thousands of police reports involving the “Sex Crime: Other” category. This disparate category can include window peeking, public urination, and HIV disclosure cases.

In addition to the criminalization of specific behaviors, those living with HIV sometimes are required to sign restrictive documents acknowledging the laws and, in many instances, agreeing to forego specific behaviors. One such form in Mississippi forces women to agree not to have children after diagnosis with HIV. In Missouri, refusal to sign a document acknowledging the HIV disclosure laws in that state results in loss of access to the AIDS Drug Assistance Program (ADAP) or medical case management. These programs are federally funded. In Indiana, HIV-positive persons are expected to sign documents that can be interpreted to direct HIV-infected persons to cease unprotected sexual activity and the conception of children.

Unfortunately, the prosecution of those living with HIV, as well as the restriction of their consensual, non-commercial private behaviors have increased dramatically in the U.S. in the past three years. Each prosecution often carries with it tabloid headlines in which the media fails to address all aspects of the case. Many outlets decline to identify the “victims” of disclosure, even though the exposure was consensual. Some outlets ignore the actual threat of transmission, hyping biting as a risk – which has no risk of transmission – as though it has the same transmission risk as sexual intercourse. This is particularly troubling given that the Kaiser Family Foundation reported in June, 2011 that 75 percent of Americans get their information from the media. As a result, the report notes, 25 percent of Americans still believe one can get infected with HIV by sharing a glass with someone who is infected with the virus. The CDC noted in 2010 that the American public had the same level of knowledge about HIV then as it had in 1987

– the year that the Reagan Commission on the HIV Epidemic first recommended criminalization.

Remedying the Problem of HIV Criminalization

Several things would need to happen to remedy the criminalization of those living with HIV. First, educational and media programs would be needed to address the widespread public ignorance about HIV in the U.S. This would need to be followed by a recommitment of federal and state monies to prevention for all Americans, and away from the failed and stigmatizing Prevention for Positives programming currently the focus of federal prevention efforts. And finally, the laws and policies related to HIV criminalization would have to be overturned at the federal and state levels.

While there is a nascent movement to address the HIV criminalization crisis in the United States, there have been more losses than wins in the battle to overturn the laws. Even while activists are working with lawmakers and policymakers to remedy the situation, some states are proceeding with the development and implementation of additional wrong-headed laws. For example, in Nebraska, lawmakers in the spring of 2011 passed legislation called “the Assault with Body Fluids” law. Under this overly broad legislation, if a person with HIV sneezes in the direction of a law enforcement agent, he or she can be charged with a five year felony.

A key area of success, however, has been a concerted effort to address so-called client acknowledgment forms. These documents have been challenged in Michigan, Mississippi, Missouri and Indiana. In all but the last state, policymakers have worked to address onerous provisions and lessen the government-driven stigma of HIV infections. Michigan’s Department of Community Health in April 2011 issued a letter noting that these documents contributed to stigma and that they were “neither encouraged nor endorsed” by the state agency. In Missouri, policymakers stopped the use of the documents altogether after they became a public issue. And in Mississippi, a Department of Justice investigation led to an end of that state’s documents, which prohibited HIV-positive women from having children.

The nascent movement to address criminalization is

meeting the most success in federal policy drives. In 2010, President Barack Obama released the country's first ever National HIV/AIDS Strategy (NHAS). This document encouraged an end to HIV-specific criminal laws: "In many instances, the continued existence and enforcement of these types of laws run counter to scientific evidence about routes of HIV transmission and may undermine the public health goals of promoting HIV screening and treatment," the report says, after acknowledging the rationale behind passage of such laws. "CDC data and other studies, however, tell us that intentional HIV transmission is atypical and uncommon. A recent research study also found that HIV-specific laws do not influence the behavior of people living with HIV in those states where these laws exist."

In 2011, The President's Advisory Council on HIV/AIDS (PACHA) voted unanimously to make ending HIV criminalization a top NHAS implementation priority. In addition, California Congresswoman Barbara Lee has begun floating federal legislation that would call on states to repeal the HIV-specific criminal laws that are on the books or risk a loss of federal funds.

On a state level, there have been two court rulings of interest in the last 18 months. First is the June 2010 ruling by Macomb County Circuit Court Judge Peter Maceroni. In that ruling, Maceroni dismissed bio-terrorism charges against a gay man who claimed he had bit a neighbor during a brutal anti-gay beating. But Maceroni's ruling holds significant problems, in that he ruled the defendant in the case could not be charged because there was no evidence on the record that the defendant had blood in his mouth at the time of the bite. As a result, his ruling leaves open the opportunity for future prosecutors to charge HIV-positive persons with possession or use of a harmful biological device – the state bio-terror law.

In a second case, in Florida, an appellate court ruled that the state's disclosure law applied solely to HIV-positive persons engaged in heterosexual sex. The court made this decision based on the state's incest law, which is the only place Florida law defines sexual intercourse. As a result, the conviction of a woman who was HIV positive and charged under the Florida law for failing to disclose to her female sex part-

ner was overturned, and the prosecutor in Pinellas County dismissed a case against a gay man.

As the movement against criminalization moves forward, it will be particularly important to follow this progress in relation to the Lee bill in Congress. This legislation, if passed, could do a great deal in turning around the criminalization trend and in restoring the privacy and sexual rights of HIV-positive persons. Additionally, the PACHA resolution will likely have direct and immediate impact on Department of Justice activities and is likely to result in DOJ directives related to HIV criminalization.

In the 34 states and two territories with HIV-specific laws, it is unlikely that we will see significant movement to eradicate these laws until such removals are tied to federal funding. Without a federal drive, which gave birth to these laws in the first place, it is highly unlikely that we will see the states move to eliminate such laws on their own.

While state legislatures may be reluctant to address these laws, policymakers in state and local health departments can address criminalization and the attendant stigma by eliminating client acknowledgment forms. But it is not enough just to eliminate such forms, because states and localities continue to maintain files on each HIV diagnosis. These files could easily be accessed through court orders in order to bring criminal actions against persons living with HIV.

Documenting the Failure of HIV-Specific Laws

A study by Mykhalovskiy published earlier this year found the following in relation to criminalizing HIV non-disclosure: "It emphasizes three key findings: (1) the concept of significant risk poses serious problems to risk communication in HIV counseling and contributes to contradictory advice about disclosure obligations; (2) criminalization discourages PHAs' [People Living with HIV/AIDS] openness about HIV non-disclosure in counseling relationships; and (3) the recontextualization of public health interpretations of significant risk in criminal proceedings can intensify criminalization."³

This study is not the only scientific evidence critical of HIV disclosure laws. Professor Carol Galletly and

Professor Steven Pinkerton from the Center for AIDS Intervention Research, at the Medical College of Wisconsin concluded: “HIV disclosure laws, which by-and-large omit any reference to condom use, turn the public health response to HIV upside down by implying that reliance on disclosure is an effective strategy for reducing HIV risk and by weakening efforts to reinforce presumptive condom use as a social norm.”⁴

In addition, Burris et al., in a 2007 study published by the Arizona State Law School, reported this conclusion after investigating 490 men who have sex with men and intravenous drug users:

People who lived in a state with a criminal law explicitly regulating sexual behavior of the HIV-infected were little different in their self-reported sexual behavior from people in a state without such a law. People who believed the law required the infected to practice safer sex or disclose their status reported being just as risky in their sexual behavior as those who did not. Our data do not support the proposition that passing a law prohibiting unsafe sex or requiring disclosure of infection influences people's normative beliefs about risky sex. Most people in our study believed that it was wrong to expose others to the virus and right to disclose infection to their sexual partners. These convictions were not influenced by the respondents' beliefs about the law or whether they lived in a state with such a law or not. Because law was not significantly influencing sexual behavior, our results also undermine the claim that such laws drive people with and or at risk of HIV away from health services and interventions.

*We failed to refute the null hypothesis that criminal law has no influence on sexual risk behavior. Criminal law is not a clearly useful intervention for promoting disclosure by HIV+ people to their sex partners. Given concerns about possible negative effects of criminal law, such as stigmatization or reluctance to cooperate with health authorities, our findings suggest caution in deploying criminal law as a behavior change intervention for seropositives.*⁵

It is also important to note that the Centers for Disease Control and Prevention in Atlanta has determined that, while 25 percent of the people infected with HIV are unaware of their infections, they are responsible for 70 percent or more of the new infections in the United States. Criminal laws have been identified as a barrier to testing in some studies, as those at risk do not wish to be placed in a felon status category. This in turn feeds unchecked HIV infection, causing higher viral loads and more infectivity in the group of at-risk, untested persons.

Recent studies have found that heterosexual partners on HIV medications have a 96 percent reduction in transmission risk for uninfected partners. Studies have also shown that use of barriers – condoms, dental dams and such – is also significant in reduction of transmission. However, studies on both chemical prevention and barrier prevention in relation to criminal laws do not exist. In fact, in many states where criminalization laws are in effect, such mitigating factors are not considered and often are not allowed as a defense in disclosure cases.

While these studies and others shed light on the issue of criminalization of HIV and non-disclosure, future studies are needed to determine the numbers of prosecutions, the demographics of those charged, the demographics of those convicted, and to review the legal procedures involved in the prosecution of such laws. It would also be beneficial for states to begin tracking HIV-related prosecutions as part of data reported annually to the Department of Justice. Such a move would create a far more transparent system, wherein the depth and scope of the issue could be better identified and addressed.

With the lack of such tracking currently, the only way to follow HIV criminalization is through media reports – which are often poorly written and provide little or no information about the specific behaviors involved with the charges – and self-reporting of situations in which the stigma of being HIV positive is compounded by the stigma and shame of being criminally charged under HIV-specific laws. Such prosecutions inevitably lead to the identification of persons living with HIV, fueling stigma and harassment.

Case Studies

The Case of Michael Holder, Bay City, MI

Holder went on trial, accused of violating the state's HIV disclosure law in November 2001. Because the case was against a black man accused of failing to disclose his HIV status to a white woman with whom he was having a relationship, the court authorized the use of questionnaires to evaluate prospective jurors. During jury selection, five potential jurors were identified through their juror surveys as having questionable beliefs about inter-racial relationships. As a result, they were put under oath and asked questions by the trial judge.

One juror informed the court in her questionnaire that "black men deal with hate or revenge with violence more so than other races." She also told the judge that non-Caucasians committed more crime. That juror told the judge that these opinions would not impact her view of the case. Another juror informed the court that she "did not care for inter-racial relationships," and that "a person should stay within their own race."

The following survey question was given: "the defendant in this case is a black man who is accused of having sex with a white woman without telling her that he had the HIV virus. Based upon this information, have you already formed an opinion about him and, if so, what is your opinion?" Two of the jurors said that they thought the accused was guilty, with one writing: "Yes. This is a deadly disease. He took her life into his hands by putting her at risk. He's a horny coward." A third juror wrote in her response that if a person was accused of a certain act, her response would be "I would say he is guilty."

"Well, I feel that children would be a mixed breed," another juror told the court in explaining her discomfort with inter-racial relationships. "It's just some — I think they might suffer down the road. Their children would be — don't know if they're — what breed they really are!"

Despite the inter-racial relationship that was at the heart of the case and the statements of pre-judgment, all five jurors were seated in the case of *Michigan v. Michael Steven Holder*.

Holder's defense attorney and the prosecutor stipulated to the first element of the crime, that Holder knew he was HIV positive. The stipulation was made because investigators had obtained a document signed by Holder in Jackson State Prison in 1993 which not only acknowledged he was HIV positive, but that he was aware of the disclosure law.

Holder's ex-girlfriend had testified in a preliminary hearing in August 2000 and once again during trial that Holder did not inform her of his HIV-positive status. In fact, she claimed, he had denied rumors that he had AIDS.

But then something happened. The night she testified in court, Holder and the ex-girlfriend had a phone conversation that was recorded by the Bay County Jail. During that conversation, Holder told the woman "I hope you know what you did. I just hope you know what you did, you know. That's all I hope. I hope you know, you know, next year or the year after or the year after, you can't take it back and say 'well, I didn't mean to say that', you know. It's — it's done."

The woman went to the prosecutor the next morning and informed her she had lied on the stand. The prosecutor put the woman back on the stand, where she proceeded to tell the jury that in fact, prior to any sexual activity, Holder had informed her he was HIV-positive. Her story directly supported the testimony Holder had given. The prosecutor asked her if she knew that HIV could lead to AIDS, and the woman testified that she did. She acknowledged lying to police investigators and on the stand. The prosecutor argued that the ex-girlfriend's recantation had been coaxed by Holder's phone call from jail.

On Dec. 3, 2001, the jury of 11 white women and one white man — including the five jurors who noted their opposition to inter-racial relationships on their questionnaires — voted to convict Holder of violating the disclosure law. He was sentenced to 10-15 years in prison, three times the recommended sentence. That sentence was reduced in 2003 to 7 1/2 to 15 years because of an appeal to which the state Attorney General's office failed to respond. But Holder's pleas for justice in regard to incompetent counsel were denied by the Michigan Court of Appeals and the Michigan Supreme Court. A writ of Habeas Corpus

filed in federal court was denied.

The Bio-Terrorism Case of Daniel Allen

Another example related to HIV criminalization comes from Michigan as well. In this instance, already mentioned earlier, a gay man was charged with bio-terrorism for biting a neighbor during a fight. Daniel Allen alleges that he bit Winfred Fernandis, Jr. during a gay-bashing incident that was the culmination of years of anti-gay harassment. The fight happened Oct. 18, 2009. Allen was charged at first with assault with intent to maim. But on Nov. 2, during a preliminary hearing in district court, Eric Smith, the Macomb County Prosecutor, added a charge of possession or use of a harmful biological device and a count of assault causing great bodily harm less than murder.

Smith's attorneys argued that an appeals court ruling in *Michigan v. Odom* supported their claim of the biological device charge. That charge was the result of Allen's admission that he is HIV positive, and the law is part of the state's terrorism laws. The *Odom* ruling dealt with a prisoner in the Michigan Department of Corrections who was co-infected with both HIV and Hepatitis B. He was involved in a fight in the prison, and as guards removed him, he spit blood and saliva at the guards. The circuit court, when sentencing *Odom*, found that he had used a weapon in the case and that added to *Odom*'s sentence. *Odom* appealed. But the Appeals Court ruled that HIV-infected blood is in fact a weapon. Curiously, the court was silent about Hepatitis B, even though the Circuit Court had ruled that it too was part of the weapon.

In the prosecutor's view, because Allen was HIV positive and he bit Fernandis, Allen was a harmful biological device. In a June 2010 ruling by Macomb County Circuit Court Judge Peter Maceroni, Smith's claim was shot down. However, the ruling was made because Maceroni noted that there was no evidence that Allen was bleeding at the time of the assault, not because being HIV positive was not, in and of itself, automatically placing a person with HIV in the category of being in possession of a harmful biological device. This ruling has the potential to force HIV-positive persons to face terror charges in the future if they are bleeding.

Ultimately, Allen pled guilty to one count of assault with intent to maim and received probation.

The Iowa Case Against Nick Clayton Rhoades

A third instance that shows the negative impact of HIV criminalization comes from Iowa. In 2009, Nick Clayton Rhoades was charged under Iowa's HIV Criminal Transmission law – which, despite its title, criminalizes the failure to disclose one's HIV-positive status – for a one-time sex hook-up with another man in 2008. Rhoades was convicted and sentenced to 25 years in prison with lifetime probation. In addition, Rhoades was ordered to register as a sex offender. While Rhoades' time in prison was quickly reduced, he remains on probation and continues to have to register as a sex offender. As a result of his sex offender status, Rhoades is required to submit to quarterly polygraph examinations, where he is subjected to questions about sex with children – something he was not accused of or charged with. In addition, Rhoades has to agree to allow law enforcement to examine his computer and the computers of his parents, with whom he lives, anytime the law enforcement officials desire to do so. Rhoades' case made national headlines and drew attention to the issue of criminalization in a way that the laws have not been scrutinized in the past.

The Florida Man Charged with Criminal Transmission of HIV, Although He Was Not Infected

And finally, one need not actually be infected with HIV to be charged under HIV criminal laws. Take for instance the case in June of 2011 where Broward County Florida Sheriff officials charged a man with shoplifting and criminal transmission of HIV. The man allegedly attempted to bite law enforcement officials when he was being arrested for a shoplifting charge. He allegedly said that he is HIV positive or has AIDS.

But an HIV test performed on the man once he was in jail determined that the man was not infected with HIV. The charge was dropped, but Broward County law enforcement had already released his name and identified him as being HIV positive. The man is now subject to the harassment and stigma of being HIV positive even though he is not infected.

This Florida case points to an ethical concern in relation to HIV criminalization cases that has yet to be discussed at length for those in journalism: is it appropriate to identify by name persons charged with HIV-related crimes? In some instances, such as the case of a woman in Mt. Pleasant Michigan, news outlets reported the name of the woman accused of failing to disclose her HIV-positive status to a sex partner. This partner had been with the woman on and off for a year, according to court records. The sex was consensual. But when he found out she is HIV positive, he filed criminal charges against the woman. The prosecution and the media did not identify the victim, saying he was “embarrassed” about the situation.

An ethicist for the Poynter Institute, a media consulting agency in Florida, said that identifying one party in an HIV criminalization case but not the other was a violation of the basic rules of ethics. The ethicist said that either both or neither should be identified in the media and noted that in refusing to identify the victim, the media create a perception that feeds HIV stigma – that being HIV positive is something of which one should be ashamed. That stigma often leads those infected with HIV to fail to disclose their status to sexual partners.

Each of these cases highlights the stigma of living with HIV and the challenges one can face in the criminal justice system. Biases can affect the juries, judges, prosecutors and defense attorneys. As indicated above, these biases can result from ignorance about HIV infection.

Moving Forward

Moving the process forward in addressing these laws will require more than HIV-specific organizations stepping up to the plate. Various organizations, such as the National Association for the Advancement of Colored People (NAACP), the Human Rights Campaign, the National Gay and Lesbian Task Force and more, need to come together and address the crisis as not only a health crisis, particularly as it applies to men of color who have sex with men, but also as a crisis in criminalizing people of color.

The path forward for addressing HIV criminalization is a three-prong process. It will require a re-evaluation of the way in which health care professionals, public health agents and agencies, prevention experts and the media use language to talk about HIV and the risks of transmission. Despite a decade of health experts calling HIV a manageable disease and attempts to normalize HIV testing, these efforts have failed to reach the broader public. As the Kaiser Family Foundation report clearly shows, ignorance and stigma still reign in the United States in relation to HIV. Until education succeeds and ignorance is defeated, addressing HIV criminalization will continue to be an uphill battle.

Second, HIV-related prosecutions need to be challenged in court. The accuracy of genetic testing in identifying directional infection remains in serious question, and the failure of the courts and law enforcement to understand the issues associated with criminalization will continue to stigmatize HIV. This will also continue to allow those who assume that they are HIV negative to decline to take the HIV test and allow them to place responsibility for their sexual health on other persons. The courts, by allowing HIV criminalization, in effect remove this personal responsibility.

Finally, in order to address HIV criminalization issues, our prevention programs need to be re-evaluated. The majority of HIV prevention programming focuses on “Prevention for Positives.” While P4P in theory includes identifying HIV infections, in reality it addresses only those living with HIV. During a briefing on the 30 years of the epidemic by the CDC in June 2011, an official told members of the press that P4P was a funding priority and would remain so for the foreseeable future, because it is easier to reach 1.1 million people in the U.S. believed to be infected with HIV than it is to reach every American. This policy is shortsighted and results in primary prevention being sero-sorting – based in all likelihood on faulty knowledge.

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Colored People (NAACP), the Human Rights Campaign, the National Gay and Lesbian Task Force and more, need to come together and address the crisis as not only a health crisis, particularly as it applies to men of color who have sex with men, but also as a crisis in criminalizing people of color. Of the cases identified above, two of the defendants were men of color, and, anecdotally, people of color and women – particularly commercial sex workers – are more likely to be charged with HIV crimes.

The Small but Growing Anti-Criminalization Movement

The criminalization of HIV is facing a small but growing movement of criticism. This is lead, in part, by the Center for HIV Law and Policy's Positive Justice Project. This project involves a coalition of people with HIV, activist organizations, government agencies and more. It has released a comprehensive evaluation of legal issues in all 50 states, and it is a regular voice when HIV criminalization cases arise in the U.S.

The ACLU has started getting involved in litigation, such as the HIV-as-Terrorism case involving Daniel Allen in Macomb, Michigan. And there is, of course, Lambda Legal's HIV program, which has also filed amicus briefs in a variety of cases.

But even with these groups involved, the movement is small and underfunded. It is also facing a withering opposition by those who believe that legislating morality is an appropriate action. This opposition plays on the uninformed opinions of many, making HIV-specific criminalization sound like a key tool in the prevention toolbox. They ignore the scientific facts related to HIV transmission, treatment and social stigma and play on the fears of an American public informed about HIV not through education and fact, but through hyped up media reports that fail to address even the most basic realities of HIV transmission probabilities.

The issue of criminalization grows from an American fear of HIV, of sexuality, of drug use and of death. Sadly, this fear continues to grip the nation, making realistic change very difficult, leaving those infected with HIV in the unenviable position of being discrimi-

nated against, facing tremendous stigma and isolation over intimacy, or choosing intimacy over fear. It is a Sophie's Choice no American should face.

Notes

- 1 The first official government sanction of criminalization can be found in the 1987 President Reagan's Commission on the HIV Epidemic. In that document, commissioners opine that those infected with HIV had an affirmative duty to disclose their status to sexual and needle sharing partners before engaging in those behaviors which could result in transmission of the virus. It was codified in the Ryan White CARE Act of 1990, with a requirement that all 50 states, and the territories, certify that they had the legal ability to force criminal charges for those persons who violated the "affirmative duty," created by the Reagan Commission. All of the states and territories had certified this by 2000.
- 2 For instance, Missouri makes it a crime to bite another while HIV-positive. In Michigan, use of sex toys and any sexual penetration "however slight," is criminalized.
- 3 "The problem of "significant risk": Exploring the public health impact of criminalizing HIV non-disclosure," Eric Mykhalovskiy. Social Science and Medicine, 2011.
- 4 <http://www.aidsmap.com/US-criminal-HIV-disclosure-laws-may-do-more-harm-than-good/page/1424402/>
- 5 http://papers.ssrn.com/sol3/papers.cfm?abstract_id=977274

Sexual Freedom Timeline

Sexual Freedom Timeline

LEGISLATION 2011

Many state legislatures pass laws that restrict access to abortion

Laws include requirements for "counseling," mandatory waiting periods, sonograms and increased restrictions for family planning facilities that also provide abortion

COURT CASE FEBRUARY

Justice Dept. announces that they will no longer defend the Defense of Marriage Act

Indication that the Defense of Marriage Act is no longer popular

POLICY MARCH

Cook County Jail changes policy and houses transgender prisoners by gender identification rather than birth

LEGISLATION MARCH

.XXX Top-Level Domain approved by ICANN

May lead to ghettoization of adult content on the internet

POLICY APRIL

Department of Labor bars discrimination on the basis of gender identity

Federal agencies continue to implement positive laws related LGBT rights

JANUARY

FEBRUARY

MARCH

APRIL

SEXUAL FREEDOM TIMELINE 2011

JANUARY

FEBRUARY

MARCH

APRIL

COURT CASE JANUARY

2nd Circuit Overturns FCC fine levied against ABC Corp. for brief nudity on 'NYPD Blue'

Though slated for Supreme Court review, reduces FCC power to levy fines for "fleeting indecency"

COURT CASE FEBRUARY

Free Speech Coalition files appeal of dismissal of lawsuit to overturn Federal 2257 recordkeeping law

Adult industry continues fight to overturn useless, expensive recordkeeping and labeling mandate

COURT CASE MARCH

Snyder v. Phelps decided by US Supreme Court

Upholds the right to protest even if protest slogans offend the target of the protest

COURT CASE APRIL

Additional obscenity charges filed against adult movie producer Ira Isaacs

Though a holdover case from Bush II, evidence that DOJ still wants to prosecute obscenity

OUTCOME POSITIVE NEGATIVE



OUTCOME POSITIVE NEGATIVE

Appendices

Sexual rights are human rights related to sexuality

IPPF affirms that sexual rights are human rights. Sexual rights are constituted by a set of entitlements related to sexuality that emanate from the rights to freedom, equality, privacy, autonomy, integrity and dignity of all people.

Many international instruments, norms and standards recognize important principles related to sexuality. Sexual rights are specific norms that emerge when existing human rights are applied to sexuality. Sexual rights protect particular identities, but reach beyond this and protect all people's right to be allowed to fulfil and express their sexuality, with due regard for the rights of others and within a framework of non-discrimination.

The following sexual rights apply basic, well-established human rights principles to the field of human sexuality. Their application is of particular importance to the poor, marginalized, the socially excluded and under-served, whether such characteristics are historical or recent.

Given that IPPF affirms the universality, interrelatedness, interdependence and indivisibility of all human rights, the order in which the following sexual rights are incorporated in this Declaration do not imply a particular hierarchy. Implementation of the following articles should be informed by the general principles that precede them.

Article 1

Right to equality, equal protection of the law and freedom from all forms of discrimination based on sex, sexuality or gender

- All human beings are born free and equal in dignity and rights³⁴ and must enjoy the equal protection of the law³⁵ against discrimination based on their sexuality, sex or gender.³⁶
- All persons must be ensured an environment where everyone enjoys and has equal access to full rights afforded by the State. States and civil society must take steps to promote the modification of social and cultural practices based on stereotyped roles of women or men or on the idea of superiority or inferiority of sexes, genders or gender expressions.
- All persons have the right to work, education, health, social security and other economic, social and cultural rights, as well as the facilities, goods, services and conditions necessary to realise them, without discrimination on any grounds.
- All persons shall be accorded legal capacity and the same opportunities to exercise that capacity, equal rights to enter into contracts and to administer property, and shall be treated equally in all stages of procedure in courts and tribunals, with due regard for the evolving capacity of the child.
- All persons shall have the same rights regarding the law relating to the movement of persons and the freedom to choose their residence and domicile, without discrimination.

Article 2

The right to participation for all persons, regardless of sex, sexuality or gender

- All persons are entitled to an environment that enables active, free and meaningful participation in and contribution to the civil, economic, social, cultural and political aspects of human life at local, national, regional and international levels, through the development of which human rights and fundamental freedoms can be realized.³⁷
- All persons are entitled to participate in the development and implementation of policies that determine their welfare,³⁸ including their sexual and reproductive health, without formal or informal barriers such as marriage qualifications, conditions related to HIV status³⁹, or discriminatory gender norms, stereotypes and prejudices that exclude or restrict the participation of persons based on ideas of gender and sexual propriety.
- Young people, who are frequently excluded, shall have the right to be participants and protagonists in processes of change in their societies. They shall have meaningful ways to contribute to and shall share the responsibilities for the development of policies and programmes to protect, promote and fulfil sexual and reproductive health and rights.⁴⁰
- All persons shall be able to participate in public and political life, including holding public office and performing all public functions, without discrimination on any grounds.
- As a basis for participation, all persons shall enjoy the right to mobility and to leave and return to their own country as well as equal access to documents that enable such mobility and travel without discrimination.⁴¹

Article 3

The rights to life, liberty, security of the person and bodily integrity

- All persons have the right to life, liberty⁴² and to be free of torture and cruel, inhuman and degrading treatment⁴³ in all cases and particularly on account of any prohibited grounds of discrimination, and shall have the right to exercise their sexuality free of violence or coercion.
- All persons have the right to life and bodily integrity,⁴⁴ these rights shall not be threatened or be put at risk to 'avenge the honour' of a family.⁴⁵
- No person shall be subjected to judicial or extra-judicial killings, judicial or extra-judicial corporal punishment for their sexual history or behaviour, gender identity or expression.⁴⁶
- No woman's life or health shall be put at risk as a consequence of medical treatment being denied to her for any physical or mental condition, or based on others placing a competing value on the foetus she may be carrying.
- No woman shall be condemned to forced maternity as a result of having exercised her sexuality.
- All persons have the right to be free from harmful traditional practices, including female genital mutilation and forced or early marriage.⁴⁷
- All persons have the right to be free from violence, including all forms of physical, verbal, psychological or economic abuse, sexual harassment or sexual violence, rape and any other forms of coerced sex within or outside marriage, in armed conflict or in detention.
- All persons, including sex workers of all genders⁴⁸ or in the instance of real or alleged sexual activity outside marriage, have the right to be free from the risk of violence created by stigma and discrimination based on their sex, sexuality or gender.
- No one shall be subjected to arbitrary detention, nor subjected to the imposition of arbitrary or discriminatory sanctions for violations of imprecise or ill-defined criminal provisions regarding consensual sex.⁴⁹
- No person's sexual choices, practices or expressions, including real or imputed practices of sex work, can justify, excuse or mitigate punishment for violence, abuse or harassment.⁵⁰
- All migrants and migrant workers, particularly young, female and transgender migrants, must have access, in

the countries where they work and live, to the means of protection from bodily harm and from violence and abuse based on their sexual and gender expressions, as well as to the means to protect and fulfil their sexual health and rights.

- All persons have the right to seek and enjoy asylum from persecution, including persecution arising from either a State's action or failure to take sufficient steps to protect a person from serious abuse,⁵¹ on the basis of sex, gender, gender identity, sexual history or behaviour or sexual orientation or HIV status.⁵²
- All persons shall be free from the removal, extradition or expulsion or threats thereof to any State where they may face a well-founded fear of persecution based on sex, gender, gender identity, sexual history or behaviour or sexual orientation or HIV status.⁵³

Article 4

Right to privacy

- All persons have the right not to be subjected to arbitrary interference with their privacy, family, home, papers or correspondence⁵⁴ and the right to privacy which is essential to the exercise of sexual autonomy.
- All persons are entitled to sexual autonomy and shall be able to make decisions about their sexuality, sexual behaviour and intimacy without arbitrary interference.
- All persons have the right to confidentiality regarding sexual health services and care, medical records, and in general to protect information concerning their HIV status and to be protected from arbitrary disclosures or threats of arbitrary disclosures, within the framework of permissible limitations and without discrimination.⁵⁵
- All persons have the right to control the disclosure of information regarding their sexual choices, sexual history, sexual partners and behaviours and other matters related to sexuality.

Article 5

Right to personal autonomy and recognition before the law

- All persons have the right to be recognized before the law and to sexual freedom, which encompasses the

opportunity for individuals to have control and decide freely on matters related to sexuality, to choose their sexual partners, to seek to experience their full sexual potential and pleasure, within a framework of non-discrimination and with due regard to the rights of others and to the evolving capacity of children.

- All persons have the right to recognition everywhere as a person before the law, without discrimination on any grounds.
- All persons are free to exercise autonomous and relational sexual practices and conduct, within an environment of social, political and economic conditions in which all rights and freedoms can be realized equally by all, free of discrimination, violence and coercion or abuse.
- No person shall be subjected to laws that arbitrarily criminalize consensual sexual relations or practices nor be subjected to arrest or detention on the basis of sex, sexuality or gender, or consensual sexual practices or conduct.
- All persons in custody have a right not to face abuse or risk of harm on the basis of any prohibited grounds of discrimination. All persons in custody have the right to protection from marginalization⁵⁶ and to have regular conjugal visits.⁵⁷
- All persons shall enjoy freedom from the harms associated with the crime of trafficking.⁵⁸
- No person shall be subjected to involuntary medical research or procedures, forced to undergo medical testing or arbitrary medical confinement on the grounds of protected sexual expression; sexual orientation; sexual history or behaviour, real or imputed or gender identity or expression.
- No person shall be forced to undergo medical procedures, including sex reassignment surgery, sterilization or hormonal therapy, as a requirement for legal recognition of their gender identity or be subjected to pressure to conceal, suppress or deny his/her sex, age, gender, gender identity or sexual orientation.
- No person shall be denied identity papers which indicate his/her gender or sex as reflecting the person's self-defined gender identity, including but not limited to birth certificates, passports and electoral records.

Article 6

Right to freedom of thought, opinion and expression; right to association

- All persons have the right to exercise freedom of thought, opinion and expression regarding ideas on sexuality, sexual orientation, gender identity and sexual rights, without arbitrary intrusions or limitations based on dominant cultural beliefs or political ideology, or discriminatory notions of public order, public morality, public health or public security.⁵⁹
- All persons have the right to freedom of thought, conscience and religion,⁶⁰ including the right to hold opinions without interference, within a framework of non-discrimination and respect for the evolving capacity of children.
- All persons have the right to explore their sexuality, to have dreams and fantasies free from fear, shame, guilt, false beliefs and other impediments to the free expression of their desires, with full regard for the rights of others.
- All persons, particularly women, have the right to expressions of identity or personhood through speech, deportment, dress, bodily characteristics, choice of name and other means without restriction.⁶¹
- All persons have the freedom to seek, receive and impart information and ideas with regards to human rights, sexual rights, sexual orientation, gender identity and sexuality through any legal medium and regardless of frontiers, within a framework of non-discrimination and taking into consideration the rights of others and the evolving capacity of children.
- All persons have the right to freedom of peaceful assembly and association⁶² in diverse formations. This includes the right to establish, join and create groups and organizations and to develop, exchange, campaign and impart information and ideas on issues related to human rights, sexual rights, sexuality, sexual orientation and gender identity through any medium, within the framework of a social order in which the rights and freedoms of all can be fully realized.

Article 7

Right to health and to the benefits of scientific progress

- All persons have a right to the enjoyment of the highest attainable standard of physical and mental health,⁶³ which includes the underlying determinants of health⁶⁴ and access to sexual health care for prevention, diagnosis and treatment of all sexual concerns, problems and disorders.
- All persons have the right to insist on safer sex for the prevention of unwanted pregnancy and sexually transmitted infections, including HIV and AIDS.
- All persons have the right to participate in the establishment of laws, policies, programmes and services pertaining to public health in their communities.
- All health interventions must be sensitive to the special needs of marginalized individuals and communities.
- All persons shall have access to health care and services independently of the conscientious objection of health service providers.⁶⁵
- All persons have the right to access information about sexual rights, sexual orientation, sexuality and gender identity in relation to health, and to access the best possible health services based upon evidence and scientifically valid research.
- All persons, including sex workers, have the right to safe working conditions, access to health services, and the support and protection necessary to be able to insist on safer sex practices with all partners and clients.
- All persons in armed conflict or forced displacement shall have access to comprehensive sexual and reproductive health services.
- All persons have the right to enjoy the benefits of scientific progress and its applications⁶⁶ to sexual rights and sexual health.
- All persons shall have the right and means to access or refuse reproductive health technologies, services or medical interventions on an equal basis with others, without discrimination. Age-based restrictions to this entitlement must meet the requirements of non-discrimination and the principle of the evolving capacity of the child.
- All persons shall have the right and means to access or to refuse participation in scientific research on an equal basis with others, and without discrimination.

Article 8

Right to education and information

- All persons, without discrimination, have the right to education and information generally and to comprehensive sexuality education and information necessary and useful to exercise full citizenship and equality in the private, public and political domains.
- All persons have the right to education aimed at eradicating stigma and discrimination, promoting the development of young people as informed actors taking responsibility for their lives and empowering them to participate in determining policy regarding sexual health and sexuality education.⁶⁷
- All persons and young people in particular have the right to give input on comprehensive sexuality education programmes and sexuality-related policies.
- All persons have the right to the means to develop skills to negotiate stronger and more equitable relationships.
- All persons shall, without regard to national borders, have access to non-traditional and traditional information in all mediums that enhances sexuality, sexual rights and sexual health; young people in particular shall have access to information on sexually and gender non-conforming lives and sexual relations.
- All persons shall have access to community-, school-, and health service provider-based information regarding sexuality in understandable language, including information on the means to ensure sexual and reproductive health and decision-making on when, how, and with whom to have sex and when sexual behaviour will become reproductive.⁶⁸
- All persons have the right to sufficient education and information to ensure that any decisions they make related to their sexual and reproductive life are made with full, free and informed consent.⁶⁹

Article 9

Right to choose whether or not to marry and to found and plan a family, and to decide whether or not, how and when, to have children

- All persons have the right to choose whether or not to marry, whether or not to found and plan a family, when to have children and to decide the number and spacing of their children freely and responsibly, within an environment in which laws and policies recognize the diversity of family forms as including those not defined by descent or marriage.⁷⁰
- All persons have the right to enter freely and with full consent into marriage or other partnership arrangements which shall be available to all within the framework of non-discrimination and with due regard to the evolving capacity of children.
- All persons have the right to family-related social welfare and other public benefits such as those regarding employment and immigration, independently of the family form they have chosen to found, including those not defined by descent or marriage.
- All persons have the right to have access to the information, education and to the means they need to be able to decide whether or not and when to have children to decide freely and responsibly the number and spacing of their children.⁷¹
- All persons have the right to make free and responsible choices regarding reproduction and family formation; including the right to decide whether or not to have biological or adopted children, as well as to all safe, effective, acceptable and affordable methods of fertility regulation, reproductive technologies, and treatments.
- All persons have the right to counselling and other services related to reproduction, infertility and pregnancy termination, irrespective of marital status, and within a framework of non-discrimination and taking into account the evolving capacity of children.
- All women have the right to information, education and services necessary for the protection of reproductive health, safe motherhood and safe abortion, which are

accessible, affordable, acceptable and convenient to all users.

- All persons shall have the same rights and responsibilities with regard to guardianship, trusteeship and adoption of children, or similar institutions where these concepts exist in national legislation, within a framework of non-discrimination; in all cases the best interests of the children shall be paramount.

IPPF is committed to do all within its capabilities, including providing technical assistance, capacity building and financial assistance, to encourage all its Member Associations to advocate for sexual rights, provide client oriented non-discriminatory sexual health services, information and comprehensive sexuality education; and treat their staff and participants in their programmes and projects in accordance with the Principles and Sexual Rights incorporated in this Declaration.

Article 10

Right to accountability and redress

- All persons have the right to effective, adequate, accessible and appropriate educative, legislative, judicial and other measures to ensure and demand that those who are duty-bound to uphold sexual rights are fully accountable to them. This includes the ability to monitor the implementation of sexual rights and to access remedies for violations of sexual rights, including access to full redress through restitution, compensation, rehabilitation, satisfaction, guarantee of non-repetition and any other means.⁷²
- States shall establish mechanisms of accountability for ensuring that their obligations related to the guarantee of sexual rights are fully upheld.
- All persons shall have the right to access effective mechanisms for accountability and redress during armed conflict, especially in relation to sexual and gender-based violence.
- All persons shall have access to the information and assistance necessary to be able to seek remedies and secure redress for violations of their sexual rights.
- All persons have the right to hold to account non-state actors whose actions or omissions impact upon their enjoyment of sexual rights. This includes the ability to seek remedies and redress for any violations of sexual rights.
- States shall take steps to prevent third parties from violating the sexual rights of others.

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Sexual Behavior, Sexual Attraction, and Sexual Identity in the United States: Data From the 2006–2008 National Survey of Family Growth

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Abstract

Objective—This report presents national estimates of several measures of sexual behavior, sexual attraction, and sexual identity among males and females aged 15–44 years in the United States, based on the 2006–2008 National Survey of Family Growth (NSFG). These data are relevant to demographic and public health concerns, including fertility and sexually transmitted infections among teenagers and adults. Data from the 2006–2008 NSFG are compared with data from the 2002 NSFG and other national surveys.

Methods—Data for 2006–2008 were collected through in-person interviews with a national sample of 13,495 males and females in the household population of the United States. The measures presented in this report were collected using audio computer-assisted self interviewing (ACASI), in which the respondent enters his or her own answers into the computer without telling them to an interviewer. The overall response rate for the 2006–2008 NSFG was 75%.

Results—Sexual behaviors among males and females aged 15–44 based on the 2006–2008 NSFG were generally similar to those reported based on the 2002 NSFG. Among adults aged 25–44, about 98% of women and 97% of men ever had vaginal intercourse, 89% of women and 90% of men ever had oral sex with an opposite-sex partner, and 36% of women and 44% of men ever had anal sex with an opposite-sex partner. Twice as many women aged 25–44 (12%) reported any same-sex contact in their lifetimes compared with men (5.8%). Among teenagers aged 15–19, 7% of females and 9% of males have had oral sex with an opposite-sex partner, but no vaginal intercourse. Sexual attraction and identity correlates closely but not completely with reports of sexual behavior. Sexual behaviors, attraction, and identity vary by age, marital or cohabiting status, education, and race and Hispanic origin.

Keywords: oral sex • anal sex • sexual orientation

Introduction

This report presents national estimates for several types of sexual behavior among men and women aged 15–44 years in the United States in 2006–2008, as well as measures of sexual attraction and identity for adults aged 18–44. These behaviors and characteristics are relevant to birth and pregnancy rates, as well as to the incidence of sexually transmitted infections (STIs), including human immunodeficiency virus (HIV)—the virus that causes acquired immune deficiency syndrome (AIDS) (1–3). The Centers for Disease Control and Prevention (CDC) estimates that about 19 million new cases of STIs occur each year (2). About one-half of all STIs occur among persons aged 15–24, and the direct medical cost of these diseases for that age group alone was estimated at \$6.5 billion in the year 2000 (4). In 2008, CDC estimated that rates of chlamydia increased, and the largest numbers of reported cases of chlamydia and gonorrhea were among teenagers aged 15–19 (5). These recent data also suggest that there were significant racial disparities in the rates of reportable STIs in the United States in 2008, particularly



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among teens and young adults. Among women, black teenagers aged 15–19 had the highest rates of chlamydia and gonorrhea, followed by black women aged 20–24 (5).

With regard to HIV/AIDS, approximately 50,000 Americans are diagnosed with HIV each year (6), and over 1 million Americans are currently living with HIV (1). Although current HIV medications have substantially increased life expectancy (7), the medical costs are substantial, averaging approximately \$20,000 per year for each person in care (8). These infections not only affect HIV-positive individuals but may also be transmitted to spouses and partners, and among pregnant women, to their babies. Data for HIV/AIDS cases (in 37 states with confidential name-based reporting) in 2008 suggest that 54% of HIV cases diagnosed in 2008 were transmitted by same-sex sexual contact among males, and another 32% by heterosexual sexual contact. Therefore, approximately 86% of HIV cases were acquired through sexual behavior (1).

A previous report on sexual behavior and selected health measures used data from the 2002 National Survey of Family Growth (NSFG) to present national estimates of some basic statistics on certain types of sexual behavior, sexual identity, and sexual attraction in the United States that have public health significance (9). The present report contains more recent data from the 2006–2008 NSFG on the following topics:

- Numbers of opposite-sex sexual partners in the past year and in lifetime for persons aged 15–44 (Tables 1–4).
- Types of sexual behavior (including opposite-sex and same-sex partners) among persons aged 15–44 (Tables 5 and 6, and Figure 1).
- Types of sexual behavior (including opposite-sex and same-sex partners) among persons aged 15–24 (Tables 7 and 8, and Figure 2).
- Numbers of sexual partners (opposite-sex and same-sex) in the past year among persons aged 15–44 (Table 9).

- Same-sex sexual activity among persons aged 15–44 (Table 10).
- Sexual attraction and sexual identity among persons aged 18–44 (Tables 11–13).
- Association of sexual behavior, sexual attraction, and sexual identity (Tables 14 and 15).

Improvements were made in some of the questions in NSFG, and some new items have been collected on these topics to improve the utility of the data. Comparisons with Cycle 6 (2002) of NSFG and other national surveys (Table 16) are made to the extent possible to shed light on the reliability of the results and to suggest whether any marked trends have occurred.

Selected Previous Studies

In addition to NSFG, several nationally representative studies of sexual behavior have been conducted in the United States in the last two decades. These surveys were based on in-person interviews and used national probability samples. The surveys include:

- The National Survey of Men (10,11), conducted in 1991 with 3,321 men aged 20–39.
- The National Health and Social Life Survey (NHSLs), conducted in 1992 with 3,432 men and women aged 18–59 (12,13).
- The General Social Survey (GSS), which has included some questions on sexual behavior in its national samples of adults aged 18 and over since 1988 (14–17).

In addition, some surveys limited to teenagers have collected data on some aspects of sexual behavior, including CDC's Youth Risk Behavior Survey—a biennial school-based survey of high school students that included data on condom use, sexual intercourse, and numbers of sexual partners (18). The Urban Institute's National Surveys of Adolescent Males collected data on the sexual activity and contraceptive use of national samples of males aged 15–19 in 1988 and 1995 (19). In 2009, researchers at Indiana University

conducted the National Survey of Sexual Health and Behavior (NSSHB)—an Internet-based study of sexual behaviors among adolescents and adults called. NSSHB asked about behaviors in a sample of 5,865 men and women aged 14–94 (20). Other national studies that examined sexual behaviors in the general population are referenced in our previous report on sexual behavior (9).

Methods

Data source

NSFG has been conducted seven times by CDC's National Center for Health Statistics (NCHS): in 1973 and 1976 with samples of married and formerly married women; in 1982, 1988, and 1995 with samples of women of all marital status categories; and in 2002 and 2006–2010 with national samples of both women and men aged 15–44. Each time, the interviews have been conducted in person by trained female interviewers in the selected persons' homes. The current report is based on the first data release from the 2006–2010 NSFG, specifically those interviews conducted from June 2006 through December 2008 and referred to as the 2006–2008 NSFG. The 2006–2008 NSFG is a nationally representative, multistage probability sample drawn from 85 areas across the United States. The sample is designed to produce national, not state, estimates. Large areas (counties and cities) were chosen first; within each large area or “primary sampling unit,” groups of adjacent blocks, called segments, were chosen at random. In each segment, addresses were listed and some addresses were sampled at random. The sampled addresses were visited in person, and a short “screener” interview was conducted to see whether anyone aged 15–44 lived there. If so, one person was chosen at random for the interview and was offered a chance to participate. To protect the respondent's privacy, only one person was interviewed in each selected household. In 2006–2008, as well as in 2002, teenagers and black and Hispanic adults were sampled at higher rates than others. The final sample for 2006–2008

consisted of 13,495 respondents aged 15–44—7,356 females and 6,139 males.

All respondents were given written and oral information about the survey and were informed that participation was voluntary. Adult respondents aged 18–44 were asked to sign a consent form but were not required to do so. For minors aged 15–17, signed consent was required first from a parent or guardian, and then signed assent was required from the minor; if either the parent or the minor declined to give written consent, the minor did not participate in the survey. Respondents were assured that the confidentiality of their information would be protected. The response rate for the 2006–2008 NSFG was 75% overall—76% for women and 73% for men.

Over the course of fieldwork in 2006–2010, about 100 female interviewers were hired and trained by the survey contractor, the University of Michigan's Institute for Social Research, under the supervision of NCHS. At any point in the data collection period, 40–45 interviewers were in the field conducting NSFG interviews. Respondents in the 2006–2010 survey were offered \$40 as a “token of appreciation” for their participation. NSFG questionnaires and materials were reviewed and approved by both the CDC/NCHS Research Ethics Review Board and the University of Michigan Institutional Review Board. The female questionnaire lasted an average of about 80 minutes, and the male questionnaire lasted about 60 minutes.

More detailed information about the methods and procedures of NSFG and its sample design, weighting, imputation, and variance estimation has been published (21,22). Results of the 2006–2008 NSFG on vaginal intercourse, contraceptive use, and childbearing experience of teenagers (23), and the contraceptive use of women aged 15–44 (24), have also been published. Forthcoming reports will show national estimates of HIV risk and testing for men and women aged 15–44, similar to what was published from the 2002 NSFG (25,26).

Use of audio computer-assisted self interviewing (ACASI)

Much of the data in the survey were collected by computer-assisted personal interviewing, or CAPI, in which the questionnaire was stored on a laptop computer and administered by an interviewer. Many of the variables described in this report were collected using ACASI. The ACASI portion of the NSFG interview was significantly expanded for the 2002 and 2006–2010 surveys in response to the need for reliable, general population-based national data on sexual and drug behavior related to HIV/AIDS and other STIs, as well as data on sexual identity measures (25,27–29). NSFG staff worked with CDC's Division of HIV/AIDS Prevention, other collaborating agencies, and experts who had conducted surveys on closely related topics (10–14), to develop appropriate questions for this purpose. In ACASI the respondent listens to the questions through headphones, reads them on the screen, or both, and enters the response directly into the computer. This method avoids asking the respondent to give his or her answers to the interviewer, and it has been found to yield more complete reporting of sensitive behaviors (30). ACASI may also make it possible for persons with lower literacy to complete the self interview by listening to the questions instead of reading them. All data on sexual behavior shown in this report were collected using ACASI.

Demographic variables used in this report

The data on sexual behavior, attraction, and identity presented in this report are shown with respect to several key background or demographic characteristics—including age, marital or cohabiting status, educational attainment, and Hispanic origin and race. Age of respondent and educational attainment reflect status at time of interview. Educational attainment is shown based only on respondents aged 22–44 because large percentages of

those aged 15–21 are still attending school. Using the full 15–44 age range would potentially underestimate the percentage of persons with a college degree. The definition of marital or cohabiting status used in this report also reflects status at time of interview and includes only those relationships with opposite-sex spouses or partners, in keeping with the recoded variables that have been defined across all NSFG surveys to date. Although it is theoretically possible to construct a measure of same-sex cohabitation using the NSFG household roster information, the sample sizes reporting these relationships do not permit analyses for this population subgroup.

The definitions of Hispanic origin and race used in this report take into account the reporting of more than one race, in accordance with 1997 guidelines from the Office of Management and Budget. However, the 2006–2008 NSFG's sample does not include sufficient numbers of respondents of multiple-race or single-race groups other than black and white to be able to show more detail in the tables. For convenience in writing, the term “black” or “non-Hispanic black” will be used instead of the full phrase, “non-Hispanic black or African American, single race.” Similarly, the term “white” or “non-Hispanic white” will be used instead of the full phrase, “non-Hispanic white, single race.” The full forms of these category labels are shown in the tables. Further technical details and definitions of terms associated with the demographic variables used in this report can be found in earlier NSFG reports (23,24 and 31,32).

In this report, the term “intercourse” refers to heterosexual vaginal intercourse. The terms “sex” or “sexual contact” refer to all types of sexual activity, including vaginal intercourse, oral sex, and anal sex, either with opposite-sex or same-sex partners. All measures related to sexual behavior, attraction, and identity as used in this report are described in more detail in the following text.

Measurement of sexual behavior in NSFG ACASI

This section defines the sexual behaviors and related variables presented in this report, in part by showing the wording of the questions asking about them. NSFG is historically and primarily a study used to measure factors related to pregnancy and birth rates (24,32,33). For this purpose, much of the main part of the interview, administered by the interviewer, is focused on behaviors most closely related to birth and pregnancy rates—namely, heterosexual vaginal intercourse, contraceptive use, infertility, breastfeeding, and heterosexual marriage and cohabitation. The self-administered, or ACASI part of the interview, includes questions on a wider range of sexual activities—including oral and anal sex with opposite-sex partners and sexual contact with same-sex partners—to address more factors related to risk of HIV and other STIs.

The wording of the NSFG questions on sexual behaviors was based on wording used in previous studies, along with consultations with the directors of many of those studies and other experts. As described earlier, answering questions in ACASI means that respondents saw the question text on the computer screen, or heard the question through headphones, or both. They entered their responses directly into the laptop computer and were routed by the interview program to the next applicable question. Between Cycle 6 (2002) and the 2006–2008 NSFG, there were a few small changes made to the ACASI portion of the interview for males and females, such as improvements in routing, changes in question wording, and changes to response categories to improve clarity. The NSFG *User's Guide* Appendix 5, “Summary of NSFG Questionnaire Changes” provides a detailed list of these changes (33). The *User's Guide* supplement for the 2006–2008 ACASI data files also provides detail on the changes made from Cycle 6 (2002) (34).

Below is the question wording related to types of sexual behavior in the NSFG ACASI section for 2006–

2008. All of these questions were not asked in the actual sequence shown below. To see the questions in their full context, with intervening questions, please see the full questionnaires on the NSFG webpage (<http://www.cdc.gov/nchs/nsfg.htm>).

Types of sexual behavior for female respondents

The question on vaginal intercourse with a male partner was only asked in ACASI for those female respondents who did not provide clear evidence of intercourse in the interviewer-administered portion of the interview. Specifically, if the respondent had ever been married or cohabited with a male partner or if she had ever been pregnant, she was not asked again in ACASI about vaginal intercourse. The question wording for all other respondents was as follows:

Has a male ever put his penis in your vagina (also known as vaginal intercourse)?

All female respondents answered two questions on oral sex with male partners and one question on anal sex with male partners. The two questions on oral sex with a male partner are shown below, following a preface:

The next few questions are about oral sex. By oral sex, we mean stimulating the genitals with the mouth.

- *Has a male ever performed oral sex on you?*
- *Have you ever performed oral sex on a male? That is, have you ever stimulated his penis with your mouth?*

Below is the question female respondents were asked about anal sex with a male:

- *Has a male ever put his penis in your rectum or butt (also known as anal sex)?*

With regard to *same-sex* sexual partners, female respondents were asked up to three questions on sexual contact with female partners, following a preface:

The next questions ask about sexual experiences you may had with another female.

- *Have you ever performed oral sex on another female?*
- *Has another female ever performed oral sex on you?*

If the respondent answered “no” to both of the above questions on oral sex with a female partner, then she was asked the more general question that mirrors the single question that females were asked on same-sex experience in the 2002 NSFG.

- *Have you ever had any sexual experience of any kind with another female?*

A “yes” answer to any of these three questions was classified as “same-sex sexual behavior” for females. The more specific behavioral questions on oral sex with a female partner were added for the 2006–2008 NSFG due to concerns that the single question asked in 2002 was too vague to be interpretable and could not be compared with the male data on same-sex sexual experience.

Types of sexual behavior for male respondents

As for female respondents, the question on vaginal intercourse was only asked in ACASI for those male respondents who did not provide clear evidence of intercourse in the interviewer-administered portion of the interview. Specifically, if the respondent had ever been married or cohabited with a female partner or if he had ever fathered a pregnancy, he was not asked again in ACASI about vaginal intercourse. The question wording for all other respondents was as follows:

Have you ever put your penis in a female's vagina (also known as vaginal intercourse)?

All male respondents answered two questions on oral sex with female partners and one question on anal sex with female partners. The two questions on oral sex with a female partner are shown below, following a preface:

The next few questions are about oral sex. By oral sex, we mean stimulating the genitals with the mouth.

- *Has a female ever performed oral sex on you, that is, stimulated your penis with her mouth?*
- *Have you ever performed oral sex on a female?*

Below is the question male respondents were asked about anal sex with a female:

- *Have you ever put your penis in a female's rectum or butt (also known as anal sex)?*

With regard to same-sex sexual partners, male respondents were asked four questions on same-sex sexual contact with male partners, following a preface:

The next questions ask about sexual experiences you may have had with another male. Have you ever done any of the following with another male?

- *Have you ever performed oral sex on another male, that is, stimulated his penis with your mouth?*
- *Has another male ever performed oral sex on you, that is, stimulated your penis with his mouth?*
- *Has another male ever put his penis in your rectum or butt (anal sex)?*
- *Have you ever put your penis in his rectum or butt (anal sex)?*

A “yes” answer to any of these four questions was classified as “same-sex sexual behavior.” A “yes” to either of the oral sex questions was classified as “any oral sex with a male,” and a “yes” answer to either of the anal sex questions was classified as “any anal sex with a male.” Unlike the question series for female respondents in the NSFG’s ACASI, male respondents who answered “no” to all four of the specific behavioral questions were not asked a more general question about “any sexual experience of any kind with a male partner.”

Numbers of opposite-sex sexual partners

In the 2006–2008 NSFG ACASI, all respondents who reported ever having vaginal, oral, or anal sex with an opposite-sex partner were asked their total numbers of opposite-sex partners in

their lifetime (to time of interview) and in the last 12 months. These questions are shown in the following text as worded for females, and analogous questions were asked for males. The phrasing of the prefatory sentence is due to the placement of this question right after a series of questions about nonvoluntary vaginal intercourse.

Number of male (opposite-sex) partners in lifetime:

This next question is also about your male sex partners. This time, think about any male with whom you have had vaginal intercourse, oral sex, or anal sex—any of these.

Thinking about your entire life, how many male sex partners have you had? Please count every partner, even those you had sex with only once.

Number of male (opposite-sex) partners in last 12 months:

Thinking about the last 12 months, how many male sex partners have you had in the 12 months since [appropriate month/year filled in]? Please count every partner, even those you had sex with only once in those 12 months.

Numbers of same-sex sexual partners

All respondents who reported ever having any same-sex sexual experience were asked their total number of same-sex partners in their lifetimes and in the last 12 months. Again, these questions are shown below as worded for females, and analogous questions were asked for males.

Number of female (same-sex) partners in lifetime:

Thinking about your entire life, how many female sex partners have you had?

Number of female (same-sex) partners in last 12 months:

Thinking about the last 12 months, how many female sex partners have you had in the 12 months since [appropriate month/year filled in]? Please count every partner, even those you had sex with only once in those 12 months.

Please count every partner, even those you had sex with only once in those 12 months.

For one table in the report (Table 9), the total number of partners in the last 12 months was defined based on opposite-sex and same-sex partners. Because the numbers of respondents reporting more than one same-sex partner in the last year was too small to show separately, the table groups all those who reported any same-sex partners in the last year. Those who had no same-sex partners in the last year are broken down by their number of opposite-sex partners in the last year (one compared with two or more).

Measurement of sexual attraction and identity

In ACASI, all respondents were also asked questions on sexual attraction and sexual identity. Based on prior analyses with the 2002 NSFG (9) and NCHS cognitive lab testing results based on the National Health and Nutrition Examination Survey (NHANES) (35), the sexual identity response categories were modified for 2006–2008 to include additional words that respondents may recognize more readily. The “heterosexual” category was reworded to say “heterosexual or straight.” The “homosexual” category was changed to say “homosexual or gay” for men and “homosexual, gay, or lesbian” for women.

For females, the questions were as follows:

People are different in their sexual attraction to other people. Which best describes your feelings? Are you. . .

- *Only attracted to males*
- *Mostly attracted to males*
- *Equally attracted to males and females*
- *Mostly attracted to females*
- *Only attracted to females*
- *Not sure*

Do you think of yourself as. . .

- *Heterosexual or straight*
- *Homosexual, gay, or lesbian*
- *Bisexual*
- *Something else*

For males, these questions were as follows:

People are different in their sexual attraction to other people. Which best describes your feelings? Are you. . .

- Only attracted to females
- Mostly attracted to females
- Equally attracted to females and males
- Mostly attracted to males
- Only attracted to males
- Not sure

Do you think of yourself as. . .

- Heterosexual or straight
- Homosexual or gay
- Bisexual
- Something else

Given the higher-than-expected percentages reporting “something else” in the 2002 NSFG (3.8%–3.9%), ACASI respondents who answered “something else” in the 2006–2008 NSFG were asked a follow-up question to clarify what they meant:

When you say “something else,” what do you mean? Please type in your answer.

Based on their verbatim, typed responses, a number of respondents who had answered “something else” could be unambiguously classified (or “back-coded”) into the provided response categories. Due to significantly lower levels of “something else” seen in the original, pre-back-coded data from 2006–2008, as well as the expense of administering and coding this follow-up question, the “something else” response option, along with the verbatim follow-up, was dropped beginning in July 2008. NSFG respondents interviewed after this point either chose one of the three response categories provided or chose “don’t know” or “refused,” as is allowed on any question in the survey. In this report, all respondents who chose “don’t know” or “refused” are grouped as “did not report.” For further information on NSFG’s measurement of sexual identity, see the Technical Notes section.

Strengths and limitations of the data

The data presented in this report are primarily from the 2006–2008 NSFG, which has a number of strengths for studying sexual behavior in the U.S. population:

- NSFG has a rigorous probability sampling design, so the estimates can be generalized to the national population.
- The response rate for NSFG was 75%, which is considered high in household survey research, and suggests that the data for most statistics can be generalized to the population with confidence.
- Questions asked on NSFG have undergone testing and review in an effort to make them understandable to persons participating in the survey. For example, a pretest was conducted before the Cycle 6 (2002) NSFG that included a number of randomized experiments to test ideas from the survey methodology literature to improve data collection (36). In addition, most of the ACASI questions used in this report were also asked in the 2002 NSFG, and some were refined as a result of that experience (34).
- Sensitive questions associated with sexual behavior, reproductive health, or drug abuse were collected using ACASI methods, which have been found to yield more complete reporting of sensitive behaviors, and they also avoid the large amounts of missing data often found due to routing mistakes through self-administered paper-and-pencil questionnaires (9,30).
- The questionnaire was administered in both English and Spanish; those who preferred to answer the interview in Spanish were interviewed by bilingual interviewers. The translation of the questionnaire into Spanish was done with particular attention to making it understandable and culturally appropriate for major Hispanic groups, including Mexican and Puerto Rican, and to recent

immigrants and those with limited education (37).

The data included in this report also have some limitations:

- As a household-based sample survey, NSFG excludes from the sampling frame those who are currently homeless, incarcerated or otherwise institutionalized, and those living on military bases in the United States. (The NSFG sample does include respondents with past experience with military service or incarceration who currently live in the household population, including respondents on active duty with the military, but not living on military bases.) To the extent that groups excluded from the NSFG sample may have different patterns of sexual behavior, the survey results cannot be generalized to those populations.
- As in any survey, nonsampling error could affect the results. NSFG makes use of extensive quality control procedures to try to minimize the effects of such errors (21,22).
- The results could be affected by underreporting of sensitive behaviors, although using ACASI has been found to yield more complete reporting of these items than other types of questionnaires (30).
- NSFG provides national estimates, but is not designed to provide state or local estimates of the behaviors described in this report.
- The age range of NSFG is 15–44 years. Therefore, it is not possible to measure the sexual behavior of those outside that age range.
- Given the sample size of the 2006–2008 NSFG, the numbers of men and women in the sample who have had sexual contact with same-sex partners, while larger than in most other studies, are still relatively small, so the sampling errors of percentages for these groups are larger than they are for larger groups. It also means that the amount of subgroup analysis (for example, by age, race or ethnicity, and other characteristics) that can be done for these populations is limited.

- The scope of this report is limited to a few measures of sexual behavior, attraction, and identity that could be studied within the sample sizes of the 2006–2008 NSFG. With the release of the larger 2006–2010 NSFG data, more detailed and statistically powerful subgroup analyses will be possible.

Statistical analysis

All estimates in this report are based on sampling weights that are designed to produce unbiased estimates for the approximately 124 million men and women aged 15–44 in the United States. The statistical package SAS, Version 9.2, was used to produce all estimates of percentages and numbers in this report (<http://www.sas.com>). SUDAAN software was used to estimate the sampling errors of the statistics; this software takes into account the use of weighted data and the complex design of the sample in calculating estimates of standard errors and significance tests (<http://www.rti.org/sudaan/>). Each table in this report includes standard errors as a measure of the precision of each point estimate, including all percentages and medians.

Significance of differences among subgroups was determined by standard two-tailed *t* tests using point estimates and their standard errors. For selected comparisons, chi-square tests of overall association were also performed within SUDAAN's Proc Crosstab. No adjustments were made for multiple comparisons. Terms such as “greater than” and “less than” indicate that a statistically significant difference was found. Terms such as “similar” or “no difference” indicate that the statistics being compared were not significantly different. Lack of comment regarding the difference does not mean that significance was tested and ruled out.

In the description of the results in the following text, when the percentage being cited is below 10%, the text will cite the exact percentage to one decimal point. To make reading easier and to remind the reader that the results are based on samples and subject to sampling error, percentages above 10%

will generally be shown rounded to the nearest whole percent. Readers should pay close attention to the sampling errors for small groups, such as subgroups of teenagers or persons who report same-sex sexual behavior. In this report, percentages are not shown if the denominator is less than 100 cases, or the numerator is less than five cases. When a percentage or other statistic is not shown for this reason, the table contains an asterisk signifying that the “statistic does not meet standards of reliability or precision.” For most statistics presented in this report, the numerators and denominators are much larger.

Results

Numbers of opposite-sex sexual partners in the last 12 months and in lifetime among persons aged 15–44 (Tables 1–4)

Tables 1–4 give numbers of opposite-sex sexual partners involving vaginal, oral, or anal sex, as reported by selected groups of men and women aged 15–44. The first two tables describe numbers of partners in the past 12 months, and the latter two tables summarize numbers of partners in lifetime (defined as “to this point in their lives” or “by time of interview”). Each table also compares the percent distribution in 2006–2008 with what was seen in Cycle 6 (2002). While it is recognized that social network and structural factors are also important in explaining disparities across population subgroups, studies have documented the correlation of higher numbers of sexual partners with increased risk and prevalence of STIs (1,2,9,12,28,38).

Among women aged 15–44 in the 2006–2008 NSFG, 11% had never had any form of sexual activity with a male partner in their lives, 6.1% had sex in their lifetime but had no opposite-sex sexual activity in the past 12 months, and 69% had one male partner in the past 12 months. Nearly 8% had two partners in the past year, and about 5% had three or more partners in the past

year. These percentages were all similar to the distribution of numbers of partners seen in 2002. Given that sexual experience is associated with age, Table 1 also shows the distribution by numbers of partners for women aged 25–44. Among women aged 25–44, 1.6% never had any form of sexual activity with a male partner, 6.6% have had sex with a male but not in the past year, and 82% had one partner in the past year. Having one partner in the past 12 months was more common at older ages, presumably because more of these women are married. Having one partner in the past year was significantly more common among married (97%) or cohabiting (86%) women than those in other groups. No significant difference was seen by educational attainment in the percentages reporting one partner in the past year. However, women aged 22–44 with less than a high school diploma were nearly twice as likely (13%) to have had two or more partners in the past 12 months as women with a bachelor's degree or higher (7%). No difference was seen by race and Hispanic origin in the percentages reporting four or more partners in the past year; however, non-Hispanic black women were significantly less likely to report one partner in the past year (60%) relative to Hispanic women (71%) and non-Hispanic white women (70%). This difference in distribution appears related to higher percentages of black women reporting two partners in the past year (12%) compared with Hispanic (5.9%) and white women (7.3%).

Among men aged 15–44 shown in Table 2, the percentage distribution by numbers of partners in the past year was similar to the distribution for women in 2006–2008, and also for men in the 2002 survey. About 11% had no sexual contact of any kind with a female partner, 6.6% had no opposite-sex contact in the past year, 63% had one partner, 8.6% had two partners, and roughly 10% had three or more partners. Among men aged 25–44, similar percentages as seen for women 25–44 had never had sexual contact with a female (2.3%) or had sex in their lifetime but not in the past year (6.3%).

A lower percentage of men aged 25–44 (75%) than women aged 25–44 (82%) reported having one partner in the past year, likely due to the higher percentages of men reporting higher numbers of partners overall for the past year. In general, the associations with age, marital or cohabiting status, education, and race and Hispanic origin were also similar to what was seen for women in 2006–2008. Of note, somewhat lower percentages of men in all race and Hispanic origin groups had one partner in the past year—65% of non-Hispanic white men, 61% of Hispanic men, and 53% of non-Hispanic black men, compared with 70%, 71%, and 60% of their female counterparts.

Tables 3 and 4 show the total numbers of opposite-sex sexual partners of any type reported by men and women to this point in their lives (called “lifetime” number here). These data from 2006–2008 show little change since the 2002 NSFG. Among women aged 15–44, the median number of male partners is 3.2 and in 2002 it was essentially the same at 3.3. For men aged 15–44, the median number of female partners was 5.6 in 2002 and remained similar at 5.1 in 2006–2008. As in 2002 when 23% of men and 9% of women reported 15 or more partners in their lifetimes, men were more likely than women to report 15 or more partners in 2006–2008 (21% of men and 8% of women). This is likely to explain, in part, the higher median number of partners for males. These results are consistent with prior findings from surveys in the United States and other countries, which all show that men on average report higher numbers of opposite-sex sexual partners than do women of the same age range (9,12,14,31,32). Several explanations for this ubiquitous finding have been suggested and all play some role in the NSFG results presented here:

- The possibility that survey respondents are reporting sexual partners outside the sample frame of NSFG, such as:
 - Partners outside the age range of 15–44, which would be quite plausible given typical age gaps

between sexual partners or spouses.

- Partners outside the general U.S. household population (for example, prison, military, homeless, commercial sex workers, partners in other countries).
- The occurrence of extreme values in the reporting of numbers of sexual partners—for example, a small proportion of men or women may be reporting extremely high numbers, and these values will skew the means and possibly the median values if the proportions of men reporting higher numbers of partners are sufficiently large compared with women—as seen in the 2002 and 2006–2008 NSFG.
- Variations in what different groups of respondents may include in their counts of sexual partners, perhaps defined by the type of sexual activity involved, the duration or type of relationship, and concurrency with other partners (38–43).
- Overreporting by men and underreporting by women may accentuate the gender disparity despite all efforts to improve the accuracy of this self-reported, sensitive information.

Despite variation in the self-reported numbers of sexual partners reported among men and women, number of partners in lifetime has been shown to be consistently reported in NSFG and other nationally representative household surveys (44), and, in the general household population, remains correlated with HIV (45) and other STIs (1,2,9,12,38,46–50).

As expected, current age is the strongest correlate shown in Tables 3 and 4 for numbers of partners in lifetime. With regard to marital or cohabiting status, formerly married, noncohabiting men and women, followed by current cohabitators, were more likely to report 15 or more opposite-sex partners and to have higher median numbers than those in the other groups. For women more so than for men, higher educational attainment was associated with lower percentages with

15 or more partners in lifetime. While 11%–12% of women with lower levels of education reported 15 or more partners, 6.8% with bachelor’s degrees or higher reported 15 or more partners. For men (Table 4), the disparity by college education was smaller but still apparent.

Although men were more likely than women to report higher numbers of opposite-sex sexual partners in their lifetimes, men and women showed a similar pattern of association between numbers of opposite-sex partners and race and Hispanic origin. Among women, Hispanic women were less likely to have had 15 or more partners (4.4%) than were non-Hispanic white (8.9%) and non-Hispanic black (11.3%) women. Among men, the comparable figures with 15 or more partners were 19% for Hispanic, 21% for white, and 30% for black men. These differences by race and origin may relate to differences in marital or cohabiting status, age at marriage, education, and age distributions. Future NSFG data sets with larger numbers of interviews will allow more detailed subgroup analyses.

Types of sexual behavior with opposite-sex and same-sex partners among persons aged 15–44 (Tables 5 and 6)

Tables 5 and 6 show percentages of men and women who ever had the specified types of sexual contact with opposite-sex and same-sex partners. Several studies have documented that oral and anal sex can transmit HIV and certain STIs, such as gonorrhea, chlamydia, genital herpes, chancroid, and syphilis (51–54). Indeed, an increasing proportion of cases of genital herpes in the United States are being attributed to oral sex (50). Although risk of HIV transmission is lower for oral sex than for vaginal intercourse or anal sex, HIV transmission through oral sex is known to occur (54). Some groups may also be at elevated risk of HIV transmission through oral sex, including men who have sex with men and certain drug users (52). For opposite-sex partners, the percentages that ever had

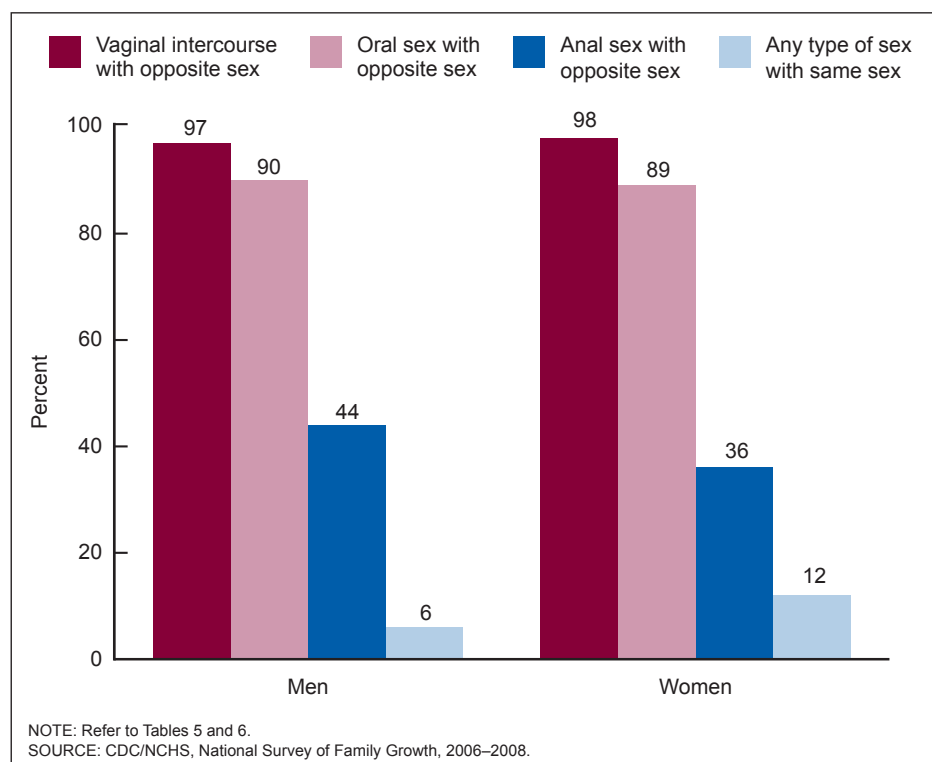


Figure 1. Sexual behavior in lifetime among men and women aged 25–44 years: United States, 2006–2008

vaginal, oral, and anal sex are presented separately. (More detail for younger people is shown in [Tables 7 and 8](#), and more detail for same-sex partners is shown in [Table 10](#).) Comparable percentages of men and women have had *any* opposite-sex sexual contact, vaginal intercourse, and oral sex with opposite-sex partners. Somewhat higher percentages of men (36%) than women (31%) report ever having had anal sex. Given that percentages reporting specific types of sexual experience may increase with age and level off in adulthood, [Figure 1](#) shows the percentages of men and women aged 25–44 who reported different types of sexual behavior. As in the 2002 NSFG, nearly all men and women aged 25–44 (97% of men and 98% of women) have had vaginal intercourse; 90% of men and 89% of women have had oral sex with opposite-sex partners. Anal sex with opposite-sex partners was reported by 36% of women and 44% of men aged 25–44. Some form of same-sex sexual behavior was reported by twice as many women aged 25–44 (12%) as men aged 25–44 (5.8%).

With regard to opposite-sex partners, no clearcut patterns by educational attainment were seen in the reporting of anal sex among men or women aged 22–44. Among both men and women aged 22–44, oral sex was reported more often by those with bachelor's degrees or higher (91% of women and 90% of men) than those with no high school diploma or GED (75% of women and 83% of men). Oral sex with an opposite-sex partner was reported more often by non-Hispanic white men and women (85%) than by those in other Hispanic origin and race groups shown. More Hispanic men (77%) reported opposite-sex oral sex experience than did Hispanic women (70%).

Looking at same-sex sexual experience, men showed no significant differences by educational attainment, but women with bachelor's degrees or higher were less likely to report same-sex sexual behavior than women in the other education categories. Hispanic women (6.3%) were less likely than either non-Hispanic white (15%) or

non-Hispanic black (11%) women to report same-sex sexual behavior. Among men, non-Hispanic white men were more likely than either Hispanic men or non-Hispanic black men to report such behavior.

Types of sexual behavior with opposite-sex and same-sex partners among persons aged 15–24 (Tables 7 and 8)

[Table 7](#) presents similar information on sexual behavior as shown in [Tables 5 and 6](#), but focused on teens and young adults, and includes an additional column for those who have never had any sexual contact with another person, male or female. This focused look at oral and anal sex among teens and young adults is prompted by concerns that some young people may engage in other types of sexual contact before they have vaginal intercourse, to avoid the risk of pregnancy; in addition to placing themselves at risk of STIs, some studies have documented that engaging in these other types of sexual contact may hasten young people's initiation of vaginal intercourse (9,55–60). [Table 7](#) shows that 27% of boys aged 15 and 23% of girls aged 15 have ever had oral sex with an opposite-sex partner. At ages 18–19, those percentages are 70% for boys and 63% for girls. Among those aged 15–17, 6.2% of boys and 7.0% of girls have had anal sex with an opposite-sex partner. Any same-sex sexual behavior was reported by nearly 2% of boys and 10% of girls aged 15–17. Compared with data from the 2002 NSFG, a higher percentage of males and females aged 15–24 in 2006–2008 have had no sexual contact with another person. In 2002, 22% of young men and women aged 15–24 had never had any sexual contact with another person, and in 2006–2008, those figures were 27% for males and 29% for females.

Given the public health concern about young people potentially placing themselves at risk for STIs even though they may abstain from vaginal intercourse (55–61), [Table 8](#) classifies young people aged 15–24 by the type of

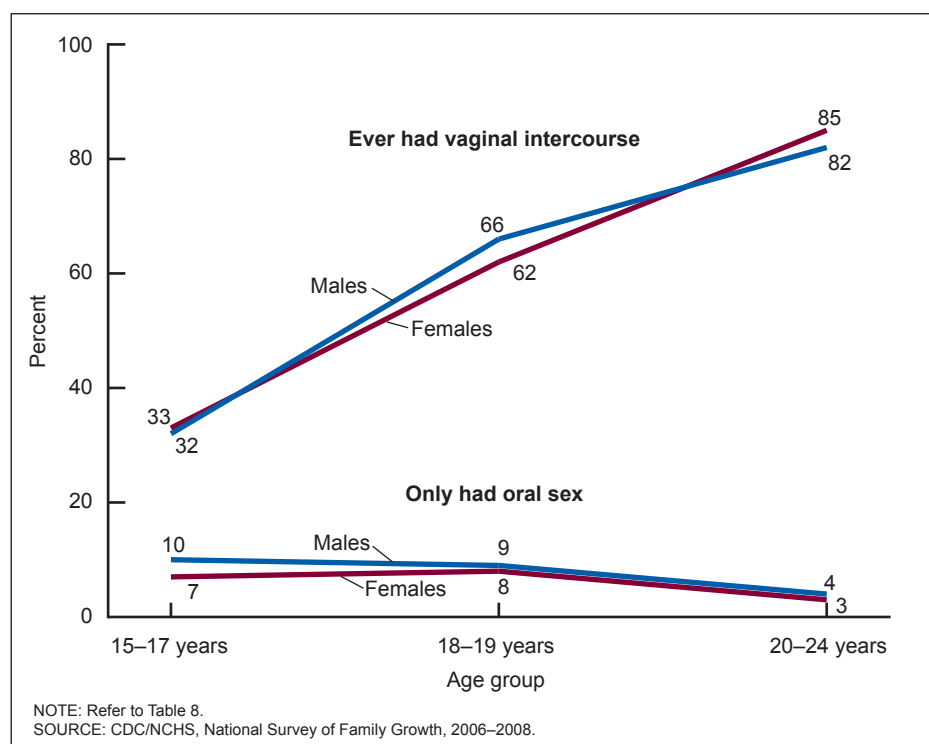


Figure 2. Vaginal and oral sex experience with an opposite-sex partner among males and females aged 15–24 years: United States, 2006–2008

sexual behavior they have engaged in with an opposite-sex partner. Those who have had vaginal intercourse at all are shown in the first column of percentages, followed by those who have never had vaginal intercourse but have had oral sex. The 2006–2008 NSFG data indicate that 6.8% of males

aged 15–24 and 4.9% of females aged 15–24 have had oral sex but no vaginal intercourse. As depicted in Figure 2, the percentages of young people who have only had oral sex but not vaginal intercourse are very low and decline with age as they begin to have vaginal intercourse, but these percentages reflect

just part of the subgroup of young people who may potentially be placing themselves at risk of STIs or HIV before they are ever at risk of pregnancy. Some proportion of young people in the upper lines of Figure 2, those who have had vaginal intercourse, may also have had oral sex before their first intercourse.

To address this gap in the data, in 2007 (year 2 of the 2006–2008 NSFG), a new question was added to the female and male questionnaires to determine the relative timing of oral sex and vaginal intercourse for all those aged 15–24 who reported both types of sexual contact. For females, this “TIMING” question read,

Thinking back to when you had oral sex with a male for the first time, was it before, after, or on the same occasion as your first vaginal intercourse with a male?

An analogous question was asked of males about sex with females. The respondent could choose one of the following responses:

- Before first vaginal intercourse.
- After first vaginal intercourse.
- Same occasion.

The Table below gives the percentages of males and females aged 15–24 who had oral sex before they ever had

Table. Percentage who had first oral sex before first vaginal intercourse among males and females aged 15–24 years who ever had oral sex, by selected characteristics: United States, 2007–2008

Characteristic	Number in thousands	Percent who had first oral sex before first vaginal intercourse ¹	(Standard error)
All persons aged 15–24 who ever had oral sex ²	27,266	50.9	(2.05)
Sex			
Male	13,384	49.8	(2.29)
Female	13,883	51.9	(3.32)
Age at first vaginal intercourse			
17 years or under	18,423	41.4	(2.35)
18–19 years	4,396	56.0	(4.25)
20–24 years	1,577	70.1	(5.70)
Hispanic origin and race			
Hispanic or Latino	4,679	39.0	(4.91)
Not Hispanic or Latino:			
White, single race	17,319	56.6	(2.17)
Black or African American, single race	3,772	39.4	(4.24)

¹The question on the timing of oral sex relative to vaginal intercourse was asked starting in 2007. Those who never had vaginal intercourse but had oral sex are classified as having had oral sex before vaginal intercourse.

²Includes those of other or multiple race and origin groups not shown separately.

SOURCE: CDC/NCHS, National Survey of Family Growth, 2006–2008.

vaginal intercourse. These percentages include those who either responded “before first vaginal intercourse” on the TIMING question in ACASI or who had not yet had vaginal intercourse but have had oral sex. About one-half of males and females aged 15–24 in 2006–2008 who ever had oral sex reported they had oral sex before their first vaginal intercourse. Among those who have had vaginal intercourse, older age at first intercourse was associated with higher percentages having had oral sex first: 41% of young people aged 15–24 who had first vaginal intercourse at age 17 or under had oral sex before first vaginal intercourse, compared with 70% of those who had first intercourse at age 20 or over. Non-Hispanic black and Hispanic males and females aged 15–24 were about two-thirds as likely as non-Hispanic white youth to have had oral sex before first vaginal intercourse or to have only had oral sex (39% compared with 57%).

Distribution of number of sexual partners in the past year (including opposite-sex and same-sex partners)

Table 9 gives the percent distribution of all males and females aged 15–44 by the sex and number of their partners in the last 12 months, including sexual behavior with opposite-sex and same-sex partners. Unlike Tables 1 and 2 that looked solely at numbers of opposite-sex partners in the past year, Table 9 combines opposite-sex and same-sex partners to describe overall sexual experience in the past year for persons aged 15–44. Due to small sample sizes in the 2006–2008 data, it was not possible to subdivide those with any same-sex experience by their numbers of partners, nor was it possible to show the percentages that had both male and female partners in the past year. Roughly three in five men or women had one opposite-sex partner in the last 12 months, and 16% reported no partners at all. The distributions for men and women differed for two categories: twice as many men as women (18% compared with 9.4%)

reported two or more opposite-sex partners in the last 12 months, and nearly three times as many women as men reported any same-sex partners in the past 12 months (12% compared with 4.3%).

For women aged 22–44, no clear pattern was seen by educational attainment in the sex and number of sexual partners in the past year, but those with a bachelor’s degree or higher were less likely to report any recent same-sex partners than those in the other education groups (9.4% compared with 13%–15%). Among men aged 22–44, a somewhat opposite association with education was seen, with higher reports of recent same-sex partners for men in higher education groups. For both men and women, the data indicate higher reports of “no partners in the last 12 months” for persons with some college but no bachelor’s degree, relative to the other education groups.

With regard to Hispanic origin and race, higher percentages of non-Hispanic black men and women reported “two or more opposite-sex partners” in the past year, compared with the other Hispanic origin and race groups shown. Non-Hispanic black men (31%) were twice as likely as non-Hispanic black women (16%) to report two or more opposite-sex partners in the past year.

Black men (2%) were less likely to report recent same-sex partners than white men (4.8%), but no difference was seen between black and Hispanic men (3.5%). Hispanic women were less likely than either non-Hispanic white or non-Hispanic black women to report recent same-sex partners.

Same-sex sexual activity among persons aged 15–44 (Table 10)

Further detail on same-sex sexual activity “in lifetime” (or to this point in their lives) is shown in Table 10 for males and females aged 15–44. As noted in Tables 5 and 6, twice as many women as men report having had any same-sex sexual contact in their lifetimes (13% of women and 5.2% of men). When the 2002 NSFG data on this topic were

published (9), there had been speculation that the questions on same-sex sexual activity were not sufficiently comparable or specific for females, and that this may draw into question any male-female difference seen. As a result, more behaviorally specific questions were added to the 2006–2008 NSFG ACASI (see the Methods section of the present report) to ask female respondents about oral sex with a female partner, and only those who did not report oral sex with a female partner were asked the more general question about *any* sexual contact with a female. The 2006–2008 data show that 12.5% of women aged 15–44 reported any same-sex sexual experience with a female partner, and 9.3% reported they ever had oral sex with a female partner. This indicates that most of the reporting (about 75%) of same-sex experience among females is accounted for by oral sex, rather than the more general question about “any sexual experience.” This figure of 9.3% of women reporting oral sex with a female partner is still higher than the 5.2% of men reporting any oral or anal sex with a male partner, and it may be the more comparable figure because it is based on specific behaviors. Looking at the different characteristics shown in Table 10, similar patterns of association were seen with both “any same-sex experience” and “any oral sex” with a female partner. As noted in Methods, men who answered “no” to the specific same-sex behavioral questions were not asked, as were women, the more general question about “any sexual experience with a male partner.” It is therefore unknown whether asking such a question would have increased reports of same-sex experience among men to the levels seen among women or possibly narrowed the gender gap.

Marital or cohabiting status showed a somewhat different association with same-sex experience for men and women. Married (3.5%) or cohabiting men (3.2%) reported lower levels of same-sex experience than never-married (7.2%) or formerly married men (6.4%), while for women lower percentages of same-sex experience were seen for

currently married (8.3%) or never-married (13%) women compared with formerly married women (20%) or cohabiting women (21%). Similar patterns by marital or cohabiting status were seen among women reporting oral sex with female partners as among women reporting *any* same-sex experience. (As was noted in Methods, NSFG classifies as “cohabiting” only those who are cohabiting with an opposite-sex partner so this difference does not reflect misreporting or misclassification of same sex cohabitations.) Education also showed a different association with same-sex experience by sex. Women aged 22–44 with a bachelor’s degree or higher were less likely to report same-sex experience than those in the other education groups (9.9% compared with 14%–15%). Similar patterns were seen among women specifically reporting oral sex with female partners. For men, the pattern was less clearcut, but higher educational attainment was associated with *higher* reports of same-sex experience.

Table 10 also shows same-sex experience according to numbers of *opposite-sex* partners in lifetime. For men the prevalence of same-sex experience does not correlate closely with numbers of opposite-sex partners, but for women, those who reported four or more opposite-sex partners in their lifetimes were more likely to report any same-sex experience (20%) or same-sex oral sex (16%) than those with fewer or none. With regard to Hispanic origin and race, the associations with same-sex experience are again somewhat different between men and women. Non-Hispanic white men (6%) were more likely to report any oral or anal sex with a male partner than were non-Hispanic black men (2.4%), and this appears to be driven by differences in both oral and anal sex. No difference in reporting was seen between Hispanic men and non-Hispanic white men. Among women, Hispanic women were less likely than either non-Hispanic white or black women to report same-sex experience, including same-sex oral sex.

Sexual attraction and sexual identity among persons aged 18–44 (Tables 11–13)

The measures of sexual attraction and identity are shown in this report only for adults aged 18–44 to facilitate comparisons with other surveys, and also because these characteristics may not yet be known or accurately reported among teenagers 15–17 (62). Sexual attraction and identity as stated at the time of interview are presented here as important risk *markers* for HIV and STIs. They are not intended to substitute for actual behavioral risk *factors* such as same-sex sexual behaviors presented earlier in this report, but are correlated with reports of same-sex behavior to show the extent to which their use as risk markers may be warranted.

Table 11 shows the full distribution of men and women aged 18–44 by their sexual attraction. Women in 2006–2008 were less likely than men to report they are attracted “only to the opposite sex”—83% of women compared with 94% of men—and this pattern is similar to patterns seen in 2002. However, when the “only to opposite sex” and “mostly to opposite sex” categories are summed, no difference is seen between men and women. To address concerns that socioeconomic factors or language barriers may play a role in the reporting (or misreporting) of sexual attraction and identity, Tables 11–13 show these variables tabulated by education, Hispanic origin and race, and the language in which ACASI was conducted. Among men, no clear-cut patterns in sexual attraction were seen by education, Hispanic origin and race, or ACASI language, but among women some differences were seen in Table 11. Non-Hispanic white women (81%) were less likely than Hispanic women (89%) and black women (86%) to say they are attracted “only to the opposite sex.” Women who completed ACASI in Spanish (95%) were more likely than other women (82%) to say they are attracted “only to the opposite sex.”

In both Tables 12 and 13, the distribution by sexual identity reported by women and men aged 18–44 in 2006–2008 was similar to that seen in

2002. The primary change from 2002 in the distribution by sexual identity relates to the significantly lower percentages reporting “something else.” As described in Methods and in Technical Notes, the decrease in reporting of “something else” is mainly attributable to the addition of clearer terms in the response categories for the 2006–2008 NSFG’s question on sexual identity. Those fewer cases in the 2006–2008 NSFG who reported their sexual identity as “something else” were asked a follow-up question, as described in Methods. Based on what the respondents typed into the computer, 37 of 87 women and 20 of 39 men who reported “something else” were unambiguously classified into one of the preexisting categories of heterosexual, homosexual, and “don’t know.” As shown in Technical Notes, this reclassification or “back-coding” did not significantly alter the overall distribution by sexual identity for adults aged 18–44 in the 2006–2008 NSFG. In addition, the percentages did not change from 2002 to 2006–2008 for those who responded “don’t know” or “refused,” which are labeled in Tables 12 and 13 as “did not report.” The question wording change, along with the small amount of back-coding, also appear to have resulted in an increase in the percentages reporting “heterosexual or straight”—94% of women in 2006–2008 compared with 90% in 2002 and 96% of men in 2006–2008 compared with 90% in 2002.

Age appeared more closely associated with sexual identity for women than for men. Women at the upper end of the 18–44 age range were more likely to report themselves as heterosexual and less likely to report themselves as bisexual. Among men aged 18–44, no such pattern was seen. Looking at marital or cohabiting status, which is itself correlated strongly with age, 2.1% of currently married women and 0.4% of currently married men report themselves as bisexual. Among current cohabitators, 6.2% of women and 0.5% of men report themselves as bisexual. Among those men and women aged 18–44 who have never married and are not cohabiting, 2.8% of women and

4.4% of men report themselves as homosexual; 4.6% of never-married women and 2.1% of never-married men report themselves as bisexual.

As in Table 11 on sexual attraction, Tables 12 and 13 show sexual identity tabulated by education, Hispanic origin and race, and the language in which ACASI was conducted. For women and men aged 22–44, those with less than a high school diploma were more likely (3.2% of women and 3.9% of men) to say “don’t know” or “refused” (that is, “did not report”) on sexual identity than those with at least a high school education. With respect to race and Hispanic origin, Hispanic women (4.1%) and men (3.9%) were more likely not to report sexual identity than those in other race and origin groups shown. Some evidence of a language barrier was suggested by the fact that 7.9% of women and 8.5% of men who completed ACASI in Spanish did not report sexual identity compared with less than 1% of men and women who completed it in English.

Association of sexual behavior, sexual attraction, and sexual identity (Tables 14 and 15)

Table 14 presents percentages of women and men aged 18–44 who reported different types of sexual activity with opposite-sex and same-sex partners, according to their sexual attraction and sexual identity. These figures show the extent to which sexual attraction and identity correlate with reports of sexual behavior, with both opposite-sex and same-sex partners. Women who said they are “mostly attracted to the opposite sex” (55%) rather than “only attracted to the opposite sex” (30%) were more likely to have had anal sex with an opposite-sex partner. Women “mostly attracted to the opposite sex” (47%) were also more likely than women “only attracted to the opposite sex” (5%) to have had any same-sex sexual experience with a female partner. Among men, no such difference was seen by sexual attraction for anal sex with opposite-sex partners, but those who were “mostly attracted to

the opposite sex” were more likely to have ever had same-sex sexual contact with a male partner (21%) compared with men who were “only attracted to the opposite sex” (3%). Among those men and women who self-identify as heterosexual, 9% of women and 3.2% of men have ever had same-sex sexual experience. Conversely, among those who report themselves as homosexual or bisexual, 15% of women (100% minus 85%) and 12% of men have never had same-sex sexual experience. A higher percentage (92%) of homosexual or bisexual women have ever had an opposite-sex sexual partner compared with 70% of homosexual or bisexual men who have had such experience.

Looking at specific types of sexual experience with opposite-sex partners, some interesting differentials were seen. Close to one-third of heterosexual women have ever had anal sex with an opposite-sex partner compared with 48% of homosexual or bisexual women. In contrast, anal sex with an opposite-sex partner was more likely to be reported by heterosexual men (40%) compared with homosexual or bisexual men (24%). For oral sex with an opposite-sex partner, no difference was seen by sexual identity for women, but for men, those who reported themselves as homosexual or bisexual (65%) were less likely than heterosexual men (88%) to have ever had oral sex with an opposite-sex partner.

Table 15 shows the association of sexual attraction and sexual identity among adults aged 18–44. Nearly all (99%) women and men who reported being attracted only to the opposite sex gave their sexual identity as heterosexual or straight. Among those attracted mostly to the opposite sex, 87% of women and 90% of men were heterosexual or straight. Due to small sample sizes, all other categories of sexual attraction were collapsed, including those who were equally attracted to both sexes, mostly attracted to the same sex, and only attracted to the same sex. This group labeled “all other” showed a different distribution by sexual identity for women and men. Women in the “all other” group were twice as likely as men to report

themselves as bisexual (42% compared with 21%) or heterosexual (27% compared with 13%). Men in the “all other” group for sexual attraction were twice (16%) as likely as women (7.5%) not to report their sexual identity. These results suggest that these measures of sexual attraction and identity are closely associated but not identical and that different patterns of association may exist for women and men.

Comparisons with other data

Table 16 compares 2006–2008 NSFG data on number of opposite-sex partners, same-sex sexual experience in lifetime, and sexual identity from the 2006–2008 NSFG with data from the 2002 NSFG; NHANES 1999–2002, 2007–2008, and 2001–2006; the 2009 NSSHB; and the 2004 and 2008 GSS. Age ranges for the statistics presented are shown in the table. For NHANES, data on sexual behavior and identity are from three sources. Published data on opposite-sex partners were available for 1999–2002 (63), and two recent articles show the prevalence of same-sex behavior for males and females using 2001–2006 data (64,65). Weighted frequencies of sexual identity based on the NHANES 2007–2008 public-use data were also included in the table (66). Similarly, information on sexual identity was first collected in the 2008 GSS (67), and other data on sex and number of partners are from a published report using the 2004 GSS (68). The comparisons between NSFG and these other surveys are not always direct because the surveys were conducted in different years and their age ranges, question wording, and response rates differ. Therefore, differences among these surveys do not always reflect trends or differences in behavior; they may reflect, at least in part, sampling error and differences in survey questions or procedures.

Despite those potential limitations, the survey results are fairly similar across several of these indicators of sexual behavior. The median number of opposite-sex partners in lifetime for males ranges between five and seven, with three to four opposite-sex partners

in lifetime among females. About 17%–19% of males had two or more female partners in the last 12 months, compared with 8%–15% of females who had two or more male partners. About 4%–6% of males ever had same-sex contact. For females, the percentage who have ever had same-sex contact ranges from about 4% in the GSS, to 11%–12% in the 2002 and 2006–2008 NSFG. The percentage reporting their sexual identity as homosexual ranged from 2% to 4% of males, and about 1% to 2% of females. The percentage reporting their sexual identity as bisexual is between 1% and 3% of males, and 2% to 5% of females. As was described previously, the proportion reporting “something else” was significantly lower in the 2006–2008 NSFG than in the 2002 NSFG due in part to question wording changes that were made in the 2006–2008 NSFG (also see Technical Notes).

Conclusions

This report was intended to provide updated national estimates of some basic statistics related to certain types of sexual behavior, attraction, and identity for men and women aged 15–44 in the household population of the United States, in order to (a) measure the populations at risk of STIs and (b) to provide insights about factors related to birth and pregnancy rates. The results presented here are based on a large national sample ($n = 13,495$), interviewed in person with the most reliable self-administered technique, and a good response rate (75%). The results reported here are generally similar to those in our report based on the 2002 NSFG (9). But the current report also presented improved NSFG measures for sexual identity, female-female sexual activity, and the relative timing of first vaginal and oral sex among those aged 15–24. Further, more detailed subgroup analyses will be possible when the next report is released, in about a year, with a national sample of over 22,000 men and women. The current report does, however, have limitations: the results are national, not state, estimates, and they are limited to the household

population of the United States aged 15–44. They do not cover persons who are currently homeless, incarcerated, living on military bases, or persons under age 15 or over age 44. Nevertheless, the data should prove useful for planning programs to prevent the spread of STIs and to prevent unintended pregnancy among men and women aged 15–44 in the United States.

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Table 1. Number of opposite-sex sexual partners in the 12 months prior to interview among females aged 15–44 years, by selected characteristics: United States, 2002 and 2006–2008

Characteristic	Number in thousands	Total	Never had sexual contact with opposite sex	Had sex with opposite sex but not in last 12 months	Number of opposite-sex (male) sexual partners in last 12 months ¹					Did not report
					1	2	3	4 or more		
Percent distribution (standard error)										
2002										
All females aged 15–44 years ²	61,561	100.0	8.3 (0.4)	6.9 (0.4)	68.2 (0.9)	7.6 (0.4)	3.0 (0.2)	4.1 (0.3)	1.9 (0.2)	
2006–2008										
All females aged 15–44 years ²	61,865	100.0	11.0 (1.3)	6.1 (0.4)	69.0 (1.2)	7.6 (0.5)	2.5 (0.3)	2.9 (0.3)	0.8 (0.2)	
Age:										
15–19 years	10,431	100.0	46.8 (2.7)	5.9 (0.9)	27.7 (2.3)	9.8 (1.1)	3.4 (0.5)	5.3 (0.9)	1.2 (0.6)	
15–17 years	5,833	100.0	60.3 (2.7)	5.1 (1.0)	19.1 (2.0)	7.8 (1.3)	3.0 (0.7)	3.8 (1.0)	1.1 (0.7)	
18–19 years	4,598	100.0	29.7 (4.8)	6.9 (1.4)	38.6 (4.4)	12.3 (1.9)	4.0 (0.7)	7.3 (1.5)	1.3 (1.0)	
20–24 years	10,140	100.0	12.3 (3.4)	4.7 (0.9)	57.8 (2.5)	14.1 (2.2)	5.1 (1.0)	4.6 (0.9)	1.3 (0.6)	
25–44 years	41,294	100.0	1.6 (0.4)	6.6 (0.5)	82.3 (0.9)	5.4 (0.4)	1.7 (0.3)	1.9 (0.3)	0.6 (0.2)	
25–29 years	10,250	100.0	3.4 (1.1)	5.6 (0.8)	75.8 (1.7)	8.2 (1.1)	3.6 (0.7)	2.7 (0.5)	0.7 (0.3)	
30–34 years	9,587	100.0	1.9 (0.6)	4.6 (0.8)	82.8 (1.7)	5.5 (0.7)	1.7 (0.4)	2.9 (1.2)	0.7 (0.4)	
35–39 years	10,475	100.0	0.9 (0.4)	6.7 (1.0)	86.2 (1.5)	4.3 (0.8)	0.9 (0.3)	0.7 (0.3)	0.4 (0.2)	
40–44 years	10,982	100.0	0.3 (0.1)	9.1 (1.3)	84.2 (1.6)	3.9 (0.8)	0.6 (0.2)	1.2 (0.6)	0.6 (0.3)	
Marital or cohabiting status:										
Currently married	27,006	100.0	–	0.7 (0.3)	96.5 (0.6)	1.4 (0.3)	0.2 (0.1)	0.6 (0.4)	0.5 (0.2)	
Currently cohabiting	6,821	100.0	–	0.8 (0.3)	85.9 (1.7)	8.3 (1.4)	3.0 (0.9)	1.3 (0.4)	0.7 (0.4)	
Never married, not cohabiting	22,847	100.0	29.8 (3.1)	11.2 (0.9)	35.4 (2.0)	12.2 (1.0)	4.8 (0.6)	5.6 (0.6)	1.1 (0.4)	
Formerly married, not cohabiting	5,190	100.0	–	19.2 (2.1)	51.6 (3.2)	19.1 (2.3)	3.8 (0.9)	5.0 (1.1)	1.3 (0.8)	
Number of opposite-sex (male) partners in lifetime:										
Never had sex with a male	6,752	100.0	100.0	–	–	–	–	–	–	
1	13,395	100.0	...	9.0 (1.1)	90.7 (1.1)	–	–	–	*	
2	6,485	100.0	...	8.3 (1.1)	80.1 (1.7)	11.6 (1.6)	–	–	*	
3	6,054	100.0	...	7.8 (1.5)	77.1 (2.5)	10.5 (1.9)	4.5 (1.1)	–	*	
4 or more	27,744	100.0	...	4.7 (0.5)	72.5 (1.4)	11.7 (0.8)	4.6 (0.5)	6.4 (0.7)	*	
Education ³ :										
No high school diploma or GED	6,210	100.0	0.8 (0.3)	6.4 (1.2)	78.5 (2.3)	8.7 (1.5)	2.5 (0.5)	1.4 (0.4)	1.8 (0.8)	
High school diploma or GED	11,793	100.0	1.2 (0.5)	6.2 (0.7)	80.2 (1.6)	6.7 (0.9)	2.0 (0.5)	3.1 (0.8)	0.7 (0.3)	
Some college, no bachelor's degree	13,537	100.0	4.5 (2.0)	7.3 (1.0)	75.1 (2.2)	7.6 (1.0)	2.3 (0.5)	2.9 (0.8)	0.3 (0.1)	
Bachelor's degree or higher	15,543	100.0	4.0 (1.2)	6.0 (0.8)	82.8 (1.7)	4.3 (0.8)	1.2 (0.3)	1.3 (0.3)	0.5 (0.2)	
Hispanic origin and race:										
Hispanic or Latina	10,377	100.0	10.5 (1.0)	5.5 (0.7)	71.4 (1.5)	5.9 (0.8)	2.4 (0.6)	2.6 (0.5)	1.8 (0.6)	
Not Hispanic or Latina:										
White, single race	37,660	100.0	11.6 (1.8)	5.5 (0.5)	70.3 (1.7)	7.3 (0.7)	2.1 (0.3)	2.9 (0.4)	0.4 (0.1)	
Black or African American, single race	8,452	100.0	9.7 (1.4)	9.5 (1.2)	59.5 (2.1)	12.0 (1.4)	4.6 (0.9)	3.2 (0.4)	1.6 (0.7)	

— Quantity zero.

... Category not applicable.

¹ Figure does not meet standards of reliability or precision.² Includes male partners with whom she had any type of sexual contact (vaginal, oral, or anal sex) as reported in the audio computer-assisted self interview (ACASI).³ Includes females of other or multiple race and origin groups and females with missing data on number of lifetime partners, not shown separately.⁴ Limited to females aged 22–44 years at time of interview. GED is General Educational Development high school equivalency diploma.

NOTES: Percentages may not add to 100 due to rounding. "Did not report" includes "don't know" and "refused" responses, as well as responses that were not ascertained due to interview breakoffs before these ACASI questions.

SOURCE: CDC/NCHS, National Survey of Family Growth, 2002 and 2006–2008.

Table 2. Number of opposite-sex sexual partners in the 12 months prior to interview among males aged 15–44 years, by selected characteristics: United States, 2002 and 2006–2008

Characteristic	Number in thousands	Total	Never had sexual contact with opposite sex	Had sex with opposite sex but not in last 12 months	Number of opposite-sex (female) sexual partners in last 12 months ¹					Did not report
					1	2	3	4 or more		
					Percent distribution (standard error)					
2002										
All males aged 15–44 years ²										
	61,147	100.0	10.0 (0.6)	6.4 (0.4)	62.7 (1.1)	8.0 (0.5)	4.1 (0.4)	6.8 (0.4)	2.0 (0.4)	
2006–2008										
All males aged 15–44 years ²										
	62,199	100.0	11.2 (1.0)	6.6 (0.5)	62.5 (1.2)	8.6 (0.7)	3.9 (0.3)	6.0 (0.5)	1.3 (0.2)	
Age:										
15–19 years	10,777	100.0	41.6 (2.3)	8.2 (1.0)	25.6 (2.0)	11.1 (1.5)	5.0 (0.7)	5.6 (0.8)	3.0 (0.8)	
15–17 years	6,643	100.0	52.4 (2.9)	7.7 (1.3)	20.4 (2.7)	8.5 (1.3)	3.6 (0.8)	3.7 (0.8)	3.7 (1.2)	
18–19 years	4,134	100.0	24.1 (2.9)	9.0 (1.7)	33.9 (3.3)	15.1 (2.8)	7.4 (1.4)	8.7 (1.7)	1.7 (0.6)	
20–24 years	10,404	100.0	14.3 (3.1)	5.9 (0.9)	49.8 (2.2)	12.2 (1.7)	6.8 (1.1)	9.5 (1.5)	1.5 (0.9)	
25–44 years	41,019	100.0	2.3 (0.3)	6.3 (0.7)	75.4 (1.3)	7.0 (0.7)	2.9 (0.4)	5.2 (0.6)	0.9 (0.2)	
25–29 years	10,431	100.0	3.8 (0.8)	5.6 (1.2)	68.6 (2.1)	9.7 (1.2)	4.0 (0.9)	7.5 (1.2)	0.8 (0.3)	
30–34 years	9,575	100.0	3.1 (0.8)	4.8 (0.8)	77.4 (2.4)	6.2 (1.0)	2.4 (0.6)	5.1 (1.2)	0.9 (0.3)	
35–39 years	10,318	100.0	1.3 (0.5)	5.7 (0.9)	77.2 (2.0)	7.3 (1.4)	3.4 (0.8)	4.4 (1.3)	0.7 (0.3)	
40–44 years	10,695	100.0	1.2 (0.3)	9.1 (1.8)	78.6 (2.5)	4.7 (1.7)	1.7 (0.4)	3.6 (0.8)	1.0 (0.6)	
Marital or cohabiting status:										
Currently married	24,763	100.0	–	1.5 (0.5)	93.8 (0.9)	2.0 (0.5)	0.6 (0.3)	1.3 (0.3)	0.8 (0.3)	
Currently cohabiting	7,301	100.0	–	0.7 (0.3)	83.6 (2.1)	6.6 (1.4)	2.5 (0.9)	6.0 (1.8)	0.6 (0.3)	
Never married, not cohabiting	27,012	100.0	25.7 (2.0)	11.7 (1.0)	30.6 (1.5)	14.1 (1.2)	6.7 (0.6)	9.1 (0.8)	2.2 (0.5)	
Formerly married, not cohabiting	3,123	100.0	–	16.2 (2.8)	39.9 (3.3)	17.7 (3.0)	9.6 (1.8)	16.4 (3.1)	*	
Number of opposite-sex (female) partners in lifetime:										
Never had sex with a female	6,906	100.0	100.0	...	–	–	–	–	–	
1	9,072	100.0	...	13.4 (1.8)	86.1 (1.8)	–	–	–	0.6 (0.2)	
2	4,570	100.0	...	15.4 (2.3)	70.8 (2.6)	13.7 (2.1)	–	–	*	
3	4,231	100.0	...	9.9 (1.7)	68.9 (2.9)	14.0 (2.4)	7.2 (1.4)	–	–	
4 or more	35,700	100.0	...	4.2 (0.6)	67.9 (1.3)	11.4 (1.0)	5.9 (0.5)	10.3 (0.8)	0.4 (0.3)	
Education ³ :										
No high school diploma or GED	8,530	100.0	1.2 (0.5)	6.4 (1.4)	73.3 (3.0)	7.2 (1.6)	3.4 (0.8)	5.9 (1.5)	2.5 (1.2)	
High school diploma or GED	12,278	100.0	3.0 (0.8)	6.5 (1.3)	71.8 (2.2)	7.5 (1.1)	3.7 (0.7)	6.7 (0.9)	0.8 (0.2)	
Some college, no bachelor's degree	13,521	100.0	6.8 (2.6)	6.9 (1.3)	69.4 (2.6)	7.2 (1.1)	3.8 (0.8)	5.5 (1.2)	0.5 (0.2)	
Bachelor's degree or higher	13,112	100.0	5.0 (1.0)	5.7 (1.0)	74.7 (2.3)	7.9 (1.8)	2.4 (0.5)	3.4 (0.8)	0.8 (0.3)	
Hispanic origin and race:										
Hispanic or Latino	11,724	100.0	7.6 (0.7)	7.9 (1.2)	60.5 (2.0)	9.8 (1.2)	4.3 (0.5)	7.4 (1.2)	2.5 (0.7)	
Not Hispanic or Latino:										
White, single race	37,374	100.0	11.5 (1.6)	6.5 (0.6)	65.2 (1.6)	7.9 (0.9)	3.1 (0.4)	5.1 (0.6)	0.8 (0.2)	
Black or African American, single race	7,186	100.0	9.2 (1.7)	4.7 (0.8)	52.7 (2.8)	13.9 (1.7)	7.5 (1.3)	10.8 (1.2)	1.2 (0.4)	

— Quantity zero.

^{*} Figure does not meet standards of reliability or precision.

... Category not applicable.

¹ Includes female partners with whom he had any type of sexual contact (vaginal, oral, or anal sex) as reported in the audio computer-assisted self interview (ACASI).² Includes males of other or multiple race and origin groups and males with missing data on number of lifetime partners, not shown separately.³ Limited to males aged 22–44 years at time of interview. GED is General Educational Development high school equivalency diploma.

NOTES: Percentages may not add to 100 due to rounding. "Did not report" includes "don't know" and "refused" responses, as well as responses that were not ascertained due to interview breakoffs before these ACASI questions.

SOURCE: CDC/NCHS, National Survey of Family Growth, 2002 and 2006–2008.

Table 3. Number of opposite-sex sexual partners in lifetime among females aged 15–44 years, by selected characteristics: United States, 2002 and 2006–2008

Characteristic	Number in thousands	Number of opposite-sex (male) partners in lifetime ¹							15 or more	Median number ²	
		Total	0	1	2	3–6	7–14				
		Percent distribution (standard error)									
2002											
All females aged 15–44 years ³	61,561	100.0	8.6 (0.4)	22.5 (0.8)	10.8 (0.4)	32.6 (0.8)	16.3 (0.7)	9.2 (0.4)	3.3 (0.1)		
2006–2008											
All females aged 15–44 years ³	61,865	100.0	11.3 (1.3)	22.2 (1.2)	10.7 (0.7)	31.6 (1.2)	16.0 (0.9)	8.3 (0.6)	3.2 (0.2)		
Age:											
15–19 years	10,431	100.0	48.1 (2.8)	22.7 (1.8)	8.2 (1.0)	15.7 (1.4)	4.1 (0.9)	1.1 (0.4)	1.4 (0.2)		
20–24 years	10,140	100.0	12.6 (3.4)	24.5 (1.7)	12.5 (1.6)	31.6 (2.8)	11.7 (1.2)	7.2 (1.2)	2.6 (0.2)		
25–44 years	41,294	100.0	1.6 (0.4)	21.4 (1.6)	10.9 (0.9)	35.6 (1.3)	20.1 (1.2)	10.4 (0.8)	3.6 (0.2)		
25–29 years	10,250	100.0	3.4 (1.1)	20.0 (1.9)	12.4 (1.5)	31.0 (2.3)	20.4 (2.0)	12.8 (1.7)	3.6 (0.3)		
30–34 years	9,587	100.0	1.9 (0.6)	20.9 (2.5)	10.6 (1.6)	31.9 (2.1)	21.3 (2.4)	13.4 (1.9)	4.2 (0.4)		
35–39 years	10,475	100.0	0.9 (0.4)	22.2 (2.1)	9.9 (1.3)	38.3 (2.8)	20.8 (2.4)	7.9 (1.2)	3.5 (0.3)		
40–44 years	10,982	100.0	0.4 (0.1)	22.4 (2.6)	10.8 (1.9)	40.5 (3.0)	18.0 (1.9)	8.0 (1.1)	3.4 (0.3)		
Marital or cohabiting status:											
Currently married	27,006	100.0	–	32.2 (2.3)	12.3 (1.1)	34.4 (1.7)	15.0 (1.4)	6.1 (0.8)	2.5 (0.2)		
Currently cohabiting	6,821	100.0	–	12.8 (2.1)	11.6 (1.8)	37.0 (2.8)	24.9 (3.0)	13.7 (1.8)	4.6 (0.4)		
Never married, not cohabiting	22,847	100.0	30.5 (3.1)	16.4 (1.1)	9.1 (0.9)	25.2 (1.6)	11.9 (1.0)	6.9 (0.7)	3.2 (0.2)		
Formerly married, not cohabiting	5,190	100.0	–	6.8 (1.6)	8.7 (1.9)	37.7 (3.0)	28.0 (2.8)	18.8 (2.1)	5.3 (0.5)		
Education ⁴ :											
No high school diploma or GED	6,210	100.0	0.8 (0.4)	22.2 (2.9)	12.5 (2.0)	36.4 (3.0)	16.4 (2.3)	11.7 (1.9)	3.2 (0.4)		
High school diploma or GED	11,793	100.0	1.2 (0.5)	16.6 (2.0)	10.1 (1.1)	38.3 (2.4)	22.2 (1.9)	11.6 (1.4)	4.1 (0.3)		
Some college, no bachelor's degree	13,537	100.0	4.5 (2.0)	17.8 (1.7)	11.8 (1.4)	33.3 (2.2)	20.5 (1.9)	12.2 (1.5)	4.1 (0.3)		
Bachelor's degree or higher	15,543	100.0	4.0 (1.2)	27.7 (2.5)	10.9 (1.6)	32.9 (2.5)	17.7 (1.6)	6.8 (0.9)	2.9 (0.3)		
Hispanic origin and race:											
Hispanic or Latina	10,377	100.0	10.7 (1.0)	35.0 (1.8)	16.7 (1.4)	26.6 (2.0)	6.6 (0.8)	4.4 (0.7)	1.6 (0.1)		
Not Hispanic or Latina:											
White, single race	37,660	100.0	11.7 (1.9)	19.2 (1.4)	9.7 (0.8)	31.4 (1.7)	18.9 (1.3)	8.9 (0.8)	3.7 (0.2)		
Black or African American, single race	8,452	100.0	10.5 (1.5)	12.3 (1.5)	8.3 (1.1)	40.9 (2.2)	16.7 (1.4)	11.3 (1.4)	4.4 (0.2)		

– Quantity zero.

¹Includes male partners with whom she had any type of sexual contact (vaginal, oral, or anal sex). "In lifetime" refers to time of interview.²Excludes those who have never had vaginal, oral, or anal sex with a male partner.³Includes females of other or multiple race and origin groups, not shown separately.⁴Limited to females aged 22–44 years at time of interview. GED is General Educational Development high school equivalency diploma.

NOTE: Percentages may not add to 100 due to rounding.

SOURCES: Reference 9 and CDC/NCHS, National Survey of Family Growth, 2006–2008.

Table 4. Number of opposite-sex sexual partners in lifetime among males aged 15–44 years, by selected characteristics: United States, 2002 and 2006–2008

Characteristic	Number in thousands	Number of opposite-sex (female) partners in lifetime ¹							15 or more	Median number ²	
		Total	0	1	2	Percent distribution (standard error)					
						3–6	7–14				
2002											
All males aged 15–44 years ³	61,147	100.0	9.6 (0.6)	12.5 (0.8)	8.0 (0.6)	27.2 (1.0)	19.5 (0.9)	23.2 (1.0)	5.6 (0.2)		
2006–2008											
All males aged 15–44 years ³	62,199	100.0	11.4 (1.0)	15.0 (1.0)	7.6 (0.6)	26.5 (1.2)	18.1 (0.8)	21.4 (1.1)	5.1 (0.2)		
Age:											
15–19 years	10,777	100.0	43.3 (2.4)	21.2 (1.9)	9.4 (1.1)	17.6 (1.5)	5.4 (1.0)	3.1 (0.6)	1.8 (0.2)		
20–24 years	10,404	100.0	14.4 (3.1)	19.1 (2.8)	8.0 (1.3)	26.1 (2.9)	18.1 (2.6)	14.2 (2.3)	4.1 (0.6)		
25–44 years	41,019	100.0	2.4 (0.4)	12.3 (1.0)	7.0 (0.7)	28.9 (1.3)	21.5 (1.3)	27.9 (1.6)	6.1 (0.3)		
25–29 years	10,431	100.0	3.8 (0.8)	11.8 (1.5)	8.9 (1.4)	29.5 (2.3)	22.9 (2.1)	23.1 (1.6)	5.7 (0.3)		
30–34 years	9,575	100.0	3.1 (0.8)	14.2 (1.8)	6.1 (1.0)	26.6 (3.0)	21.7 (2.4)	28.3 (3.1)	6.4 (1.0)		
35–39 years	10,318	100.0	1.4 (0.5)	13.3 (2.4)	5.6 (0.9)	29.7 (2.4)	19.6 (2.2)	30.6 (3.0)	6.2 (0.9)		
40–44 years	10,695	100.0	1.3 (0.3)	10.3 (1.7)	7.2 (1.2)	29.7 (2.5)	21.6 (2.8)	30.0 (2.8)	6.4 (0.8)		
Marital or cohabiting status:											
Currently married	24,763	100.0	–	19.1 (1.9)	7.5 (0.9)	30.7 (2.0)	20.7 (1.6)	22.1 (2.0)	4.9 (0.3)		
Currently cohabiting	7,301	100.0	–	10.3 (3.0)	7.6 (1.6)	24.4 (3.0)	25.9 (2.5)	31.8 (2.9)	7.3 (0.8)		
Never married, not cohabiting	27,012	100.0	26.3 (2.0)	14.1 (0.9)	8.2 (0.8)	23.6 (1.6)	12.9 (1.0)	14.9 (1.2)	4.1 (0.2)		
Formerly married, not cohabiting	3,123	100.0	–	1.4 (0.8)	2.2 (1.0)	23.9 (2.7)	25.1 (3.3)	47.4 (3.5)	11.9 (1.3)		
Education ⁴ :											
No high school diploma or GED	8,530	100.0	1.2 (0.5)	9.9 (1.9)	9.8 (2.3)	31.2 (4.5)	21.5 (2.2)	26.4 (3.2)	5.8 (0.5)		
High school diploma or GED	12,278	100.0	3.1 (0.9)	12.2 (2.3)	5.2 (0.8)	27.5 (2.2)	23.3 (2.1)	28.8 (2.3)	6.7 (0.8)		
Some college, no bachelor's degree	13,521	100.0	6.9 (2.7)	10.3 (2.5)	5.2 (0.8)	29.6 (3.0)	19.3 (2.1)	28.8 (2.7)	6.4 (0.8)		
Bachelor's degree or higher	13,112	100.0	5.1 (1.0)	18.9 (1.7)	8.4 (1.3)	26.4 (1.9)	20.0 (2.1)	21.2 (2.2)	4.8 (0.4)		
Hispanic origin and race:											
Hispanic or Latino	11,724	100.0	7.9 (0.7)	12.5 (1.1)	10.2 (1.5)	32.6 (2.5)	17.8 (1.6)	19.1 (1.7)	4.6 (0.3)		
Not Hispanic or Latino:											
White, single race	37,374	100.0	11.6 (1.7)	16.1 (1.5)	7.3 (0.7)	25.7 (1.6)	18.4 (1.2)	20.9 (1.6)	5.1 (0.3)		
Black or African American, single race	7,186	100.0	9.6 (1.8)	8.3 (1.3)	5.0 (1.0)	25.6 (2.0)	21.6 (2.3)	30.0 (2.1)	6.9 (0.8)		

– Quantity zero.

¹Includes female partners with whom he had any type of sexual contact (vaginal, oral, or anal sex). "In lifetime" refers to time of interview.²Excludes those who have never had vaginal, oral, or anal sex with a female partner.³Includes males of other or multiple race and origin groups, not shown separately.⁴Limited to males 22–44 years of age at time of interview. GED is General Educational Development high school equivalency diploma.

NOTE: Percentages may not add to 100 due to rounding.

SOURCES: Reference 9 and CDC/NCHS, National Survey of Family Growth, 2006–2008.

Table 5. Sexual behavior with opposite-sex and same-sex partners among females aged 15–44 years, by selected characteristics: United States, 2002 and 2006–2008

Characteristic	Number in thousands	Opposite-sex sexual behavior				Any same-sex sexual behavior ²
		Any ¹	Vaginal intercourse	Oral sex	Anal sex	
2002		Percent (standard error)				
All females aged 15–44 years ³	61,561	91.7 (0.4)	89.2 (0.5)	82.0 (0.6)	30.0 (0.7)	11.2 (0.5)
2006–2008						
All females aged 15–44 years ³	61,865	89.0 (1.3)	86.8 (1.3)	80.1 (1.4)	30.7 (1.3)	12.5 (0.8)
Age:						
15–19 years	10,431	53.0 (2.7)	45.6 (2.5)	44.6 (2.5)	10.5 (1.2)	11.0 (1.0)
15–17 years	5,833	39.7 (2.7)	33.0 (2.2)	30.2 (2.3)	7.0 (1.2)	10.3 (1.3)
18–19 years	4,598	70.0 (4.8)	61.7 (4.7)	62.9 (4.7)	14.9 (2.1)	11.9 (1.8)
20–24 years	10,140	87.7 (3.4)	85.0 (3.6)	81.1 (3.3)	30.2 (2.4)	15.8 (1.8)
25–44 years	41,294	98.4 (0.4)	97.6 (0.4)	88.8 (0.8)	36.0 (1.6)	12.0 (0.9)
25–29 years	10,250	96.6 (1.1)	95.2 (1.0)	88.5 (1.6)	38.5 (2.4)	15.0 (1.5)
30–34 years	9,587	98.1 (0.6)	97.6 (0.7)	88.6 (1.5)	34.8 (2.4)	14.2 (1.7)
35–39 years	10,475	99.1 (0.4)	98.5 (0.8)	89.7 (1.2)	38.3 (3.1)	11.5 (2.5)
40–44 years	10,982	99.7 (0.1)	99.2 (0.4)	88.6 (1.4)	32.4 (2.7)	7.9 (1.4)
Marital or cohabiting status:						
Currently married	27,006	100.0	100.0	91.0 (0.8)	33.7 (2.1)	8.3 (1.1)
Currently cohabiting	6,821	100.0	100.0	90.2 (1.7)	44.6 (3.0)	20.5 (2.0)
Never married, not cohabiting	22,847	70.1 (3.1)	64.1 (3.0)	61.7 (2.8)	20.1 (1.3)	13.4 (1.0)
Formerly married, not cohabiting	5,190	100.0	100.0	91.1 (1.9)	43.3 (3.3)	19.6 (2.6)
Education ⁴ :						
No high school diploma or GED	6,210	99.2 (0.3)	99.2 (0.3)	75.1 (3.0)	32.2 (2.6)	15.2 (2.1)
High school diploma or GED	11,793	98.8 (0.5)	98.6 (0.5)	87.4 (1.7)	38.9 (2.5)	14.2 (1.8)
Some college, no bachelor's degree	13,537	95.5 (2.0)	94.4 (2.0)	89.9 (1.9)	37.3 (2.4)	13.8 (1.4)
Bachelor's degree or higher	15,543	96.0 (1.2)	94.4 (1.2)	91.2 (1.6)	34.0 (2.8)	9.9 (1.3)
Hispanic origin and race:						
Hispanic or Latina	10,377	89.5 (1.0)	88.9 (0.9)	69.8 (1.4)	24.7 (1.7)	6.3 (0.9)
Not Hispanic or Latina:						
White, single race	37,660	88.4 (1.8)	85.7 (1.8)	84.8 (2.0)	34.3 (2.0)	14.6 (1.1)
Black or African American, single race	8,452	90.2 (1.4)	88.6 (1.5)	74.2 (2.3)	24.6 (1.4)	11.3 (1.4)

¹Includes vaginal, oral, or anal sex. See Methods section for description of all questions on sexual behavior used in this report.²Includes oral sex or any sexual experience. See Methods section for description of all questions on sexual behavior used in this report.³Includes females of other or multiple race and origin groups, not shown separately.⁴Limited to females 22–44 years of age at time of interview. GED is General Educational Development high school equivalency diploma.

NOTE: Respondents could report whatever types of sexual contact they have had, with either opposite-sex or same-sex partners.

SOURCES: Reference 9 and CDC/NCHS, National Survey of Family Growth, 2006–2008.

Table 6. Sexual behavior with opposite-sex and same-sex partners among males aged 15–44 years, by selected characteristics: United States, 2002 and 2006–2008

Characteristic	Number in thousands	Opposite-sex sexual behavior				Any same-sex sexual behavior ²
		Any ¹	Vaginal intercourse	Oral sex	Anal sex	
2002		Percent (standard error)				
All males aged 15–44 years ³	61,147	90.8 (0.6)	87.6 (0.7)	83.0 (0.8)	34.0 (1.1)	6.0 (0.5)
2006–2008						
All males aged 15–44 years ³	62,199	88.8 (1.0)	85.6 (1.1)	81.3 (1.1)	35.8 (1.4)	5.2 (0.5)
Age:						
15–19 years	10,777	58.0 (2.3)	44.8 (2.5)	48.4 (2.1)	10.2 (1.2)	2.5 (0.7)
15–17 years	6,643	46.8 (2.9)	31.8 (3.1)	35.0 (2.3)	6.2 (1.1)	1.7 (0.7)
18–19 years	4,134	75.8 (2.9)	65.6 (3.5)	69.8 (2.9)	16.6 (2.8)	3.8 (1.2)
20–24 years	10,404	85.7 (3.1)	81.5 (3.6)	80.1 (3.3)	31.9 (3.3)	5.6 (1.1)
25–44 years	41,019	97.7 (0.3)	97.3 (0.4)	90.4 (0.8)	43.5 (1.7)	5.8 (0.6)
25–29 years	10,431	96.2 (0.8)	95.6 (0.9)	90.5 (1.5)	42.5 (2.4)	5.2 (1.1)
30–34 years	9,575	96.9 (0.8)	96.7 (0.8)	89.4 (1.6)	45.2 (2.7)	4.0 (0.9)
35–39 years	10,318	98.7 (0.5)	98.4 (0.5)	90.6 (2.1)	45.0 (3.5)	5.7 (0.9)
40–44 years	10,695	98.8 (0.3)	98.5 (0.4)	90.8 (1.6)	41.7 (3.4)	8.1 (1.6)
Marital or cohabiting status:						
Currently married	24,763	100.0	100.0	92.5 (0.9)	42.5 (2.2)	3.5 (0.6)
Currently cohabiting	7,301	100.0	100.0	89.8 (2.7)	47.7 (3.1)	3.2 (0.9)
Never married, not cohabiting	27,012	74.2 (2.0)	66.8 (2.2)	67.2 (2.0)	23.5 (1.4)	7.2 (0.9)
Formerly married, not cohabiting	3,123	100.0	100.0	97.0 (1.0)	62.1 (4.1)	6.4 (1.3)
Education ⁴ :						
No high school diploma or GED	8,530	98.8 (0.5)	98.7 (0.5)	82.8 (2.2)	40.7 (2.7)	3.6 (1.0)
High school diploma or GED	12,278	97.0 (0.8)	96.6 (0.9)	89.9 (1.5)	44.1 (2.2)	5.1 (0.9)
Some college, no bachelor's degree	13,521	93.2 (2.6)	91.8 (3.0)	89.3 (2.9)	46.7 (3.5)	8.0 (1.5)
Bachelor's degree or higher	13,112	95.0 (1.0)	94.1 (1.1)	90.4 (1.4)	36.7 (2.6)	6.7 (0.9)
Hispanic origin and race:						
Hispanic or Latino	11,724	92.4 (0.7)	89.7 (0.8)	76.9 (1.5)	38.6 (1.7)	3.8 (0.6)
Not Hispanic or Latino:						
White, single race	37,374	88.5 (1.6)	84.8 (1.8)	84.7 (1.9)	38.0 (2.0)	6.0 (0.7)
Black or African American, single race	7,186	90.7 (1.7)	87.9 (1.7)	78.4 (2.6)	26.9 (2.3)	2.4 (0.5)

¹Includes vaginal, oral, or anal sex. See Methods section for description of all questions on sexual behavior used in this report.²Includes oral or anal sex. See Methods section for description of all questions on sexual behavior used in this report.³Includes males of other or multiple race and origin groups, not shown separately.⁴Limited to males 22–44 years of age at time of interview. GED is General Educational Development high school equivalency diploma.

NOTE: Respondents could report whatever types of sexual contact they have had, with either opposite-sex or same-sex partners.

SOURCES: Reference 9 and CDC/NCHS, National Survey of Family Growth, 2006–2008.

Table 7. Sexual behavior with opposite-sex and same-sex partners among females and males aged 15–24 years, by selected characteristics: United States, 2002 and 2006–2008

Opposite-sex sexual behavior										
Characteristic	Number in thousands	Any opposite-sex sexual contact ¹	Oral					Anal sex	Any same-sex behavior ²	No sexual contact with another person
			Vaginal intercourse	Any oral sex	Gave oral sex	Received oral sex				
							Percent (standard error)			
2002										
All females aged 15–24 years ³	19,674	77.3 (1.1)	70.2 (1.3)	68.6 (1.3)	59.8 (1.2)	64.9 (1.3)	20.3 (1.0)	12.4 (0.9)	21.9 (1.1)	
All males aged 15–24 years ³	20,091	77.4 (1.3)	68.1 (1.7)	68.5 (1.5)	55.4 (1.6)	65.6 (1.6)	21.7 (1.3)	5.0 (0.5)	21.9 (1.3)	
2006–2008										
All females aged 15–24 years ³	20,570	70.1 (2.8)	65.1 (2.7)	62.6 (2.6)	55.8 (2.6)	59.2 (2.6)	20.2 (1.5)	13.4 (1.1)	28.6 (2.8)	
Age:										
15–19 years	10,431	53.0 (2.7)	45.6 (2.5)	44.6 (2.5)	37.5 (2.5)	40.6 (2.4)	10.5 (1.2)	11.0 (1.0)	45.0 (2.8)	
15–17 years	5,833	39.7 (2.7)	33.0 (2.2)	30.2 (2.3)	25.1 (2.0)	26.8 (2.2)	7.0 (1.2)	10.3 (1.3)	58.2 (2.7)	
15 years	2,147	32.3 (5.1)	23.2 (4.0)	22.7 (4.2)	16.0 (3.2)	20.3 (4.1)	4.6 (1.6)	11.0 (3.0)	64.1 (5.2)	
16 years	1,830	39.4 (3.7)	33.6 (3.9)	32.4 (3.5)	29.2 (3.4)	29.2 (3.6)	5.4 (1.6)	7.3 (1.5)	60.4 (3.8)	
17 years	1,856	48.5 (4.1)	43.6 (3.9)	36.7 (4.0)	31.4 (3.6)	32.0 (3.7)	11.2 (2.5)	12.5 (2.6)	49.2 (3.9)	
18–19 years	4,598	70.0 (4.8)	61.7 (4.7)	62.9 (4.7)	53.2 (5.1)	58.2 (4.5)	14.9 (2.1)	11.9 (1.8)	28.0 (4.9)	
20–24 years	10,140	87.7 (3.4)	85.0 (3.6)	81.1 (3.3)	74.6 (3.4)	78.4 (3.3)	30.2 (2.4)	15.8 (1.8)	11.9 (3.3)	
Hispanic origin and race:										
Hispanic or Latina	3,517	70.3 (3.1)	69.0 (2.9)	58.0 (3.0)	50.4 (3.8)	51.7 (2.8)	19.5 (2.6)	8.8 (1.6)	28.1 (3.1)	
15–19 years	1,812	50.3 (3.7)	48.2 (3.4)	41.1 (3.1)	32.9 (4.4)	37.5 (3.1)	10.7 (2.1)	8.3 (1.7)	46.7 (3.7)	
20–24 years	1,705	91.9 (2.1)	91.2 (2.2)	76.4 (4.4)	69.4 (4.6)	67.8 (4.2)	29.0 (4.6)	9.4 (2.5)	8.1 (2.1)	
Not Hispanic or Latina:										
White, single race	12,309	67.8 (3.7)	61.2 (3.5)	64.7 (3.5)	59.8 (3.8)	61.6 (3.4)	19.8 (1.7)	14.7 (1.7)	31.0 (3.7)	
15–19 years	6,186	51.8 (3.6)	42.0 (3.1)	47.7 (3.5)	42.6 (3.6)	43.0 (3.2)	10.1 (1.3)	12.1 (1.4)	46.3 (3.6)	
20–24 years	6,122	84.0 (4.7)	80.6 (5.0)	81.8 (4.7)	77.0 (5.2)	80.3 (4.7)	29.6 (3.6)	17.3 (3.0)	15.7 (4.7)	
Black or African American, single race	3,047	75.8 (3.1)	72.1 (3.2)	59.1 (3.2)	43.1 (3.7)	57.3 (3.2)	19.5 (2.4)	13.2 (2.3)	22.6 (3.1)	
15–19 years	1,606	59.1 (5.6)	53.1 (5.1)	38.2 (4.9)	22.5 (3.7)	35.4 (4.7)	8.8 (2.0)	10.0 (2.8)	39.2 (5.4)	
20–24 years	1,440	94.0 (2.0)	93.4 (2.0)	81.7 (3.9)	66.0 (5.3)	81.0 (3.9)	31.4 (4.3)	16.7 (3.8)	4.4 (1.6)	
All males aged 15–24 years ³	21,181	71.7 (2.0)	62.9 (2.1)	64.0 (2.1)	52.2 (2.1)	61.9 (2.2)	20.9 (1.6)	4.0 (0.7)	27.2 (2.1)	
Age:										
15–19 years	10,777	58.0 (2.3)	44.8 (2.5)	48.4 (2.1)	34.9 (1.9)	46.7 (2.1)	10.2 (1.2)	2.5 (0.7)	41.1 (2.3)	
15–17 years	6,643	46.8 (2.9)	31.8 (3.1)	35.0 (2.3)	22.5 (1.9)	33.4 (2.3)	6.2 (1.1)	1.7 (0.7)	52.6 (2.8)	
15 years	2,250	34.0 (3.3)	20.6 (3.1)	26.5 (3.4)	16.6 (2.8)	24.7 (3.4)	2.8 (1.0)	*	65.6 (3.4)	
16 years	2,328	46.3 (4.8)	31.5 (4.9)	31.6 (4.0)	16.8 (2.8)	30.0 (3.9)	5.0 (1.6)	2.2 (1.5)	53.4 (4.8)	
17 years	2,065	61.4 (4.6)	44.4 (4.7)	48.0 (4.7)	35.2 (4.2)	46.8 (4.8)	11.4 (2.9)	*	37.4 (4.5)	
18–19 years	4,134	75.8 (2.9)	65.6 (3.5)	69.8 (2.9)	54.8 (3.3)	67.9 (2.9)	16.6 (2.8)	3.9 (1.2)	22.9 (2.9)	
20–24 years	10,404	85.7 (3.1)	81.5 (3.6)	80.1 (3.3)	70.0 (3.5)	77.6 (3.6)	31.9 (3.3)	5.6 (1.1)	13.0 (3.4)	
Hispanic origin and race:										
Hispanic or Latino	3,796	79.4 (1.9)	71.4 (2.2)	69.0 (1.9)	52.4 (4.5)	66.6 (2.2)	30.8 (2.8)	2.3 (0.6)	20.4 (1.8)	
15–19 years	1,891	63.0 (3.2)	47.9 (3.6)	52.5 (3.7)	34.4 (3.9)	49.1 (3.8)	12.4 (2.4)	2.6 (0.8)	36.7 (3.2)	
20–24 years	1,905	95.5 (1.7)	94.6 (1.8)	85.6 (3.4)	70.6 (5.5)	84.2 (3.5)	49.2 (4.0)	2.0 (1.0)	4.3 (1.6)	
Not Hispanic or Latino:										
White, single race	12,878	70.8 (3.2)	60.9 (3.1)	65.3 (3.4)	57.9 (3.5)	63.1 (3.6)	20.1 (2.4)	4.1 (0.8)	28.2 (3.2)	
15–19 years	6,208	56.3 (3.4)	42.0 (3.5)	49.4 (3.0)	40.7 (2.8)	48.0 (3.0)	10.3 (1.7)	2.2 (0.7)	42.8 (3.3)	
20–24 years	6,671	84.2 (5.0)	78.5 (5.2)	80.0 (5.3)	73.9 (5.9)	77.1 (5.7)	29.1 (4.6)	5.9 (1.5)	14.7 (5.1)	

See footnotes at end of table.

Table 7. Sexual behavior with opposite-sex and same-sex partners among females and males aged 15–24 years, by selected characteristics: United States, 2002 and 2006–2008—Con.

Characteristic	Number in thousands	Opposite-sex sexual behavior							Any same-sex behavior ²	No sexual contact with another person
		Any opposite-sex sexual contact ¹	Vaginal intercourse	Oral				Anal sex		
				Any oral sex	Gave oral sex	Received oral sex				
Black or African American, single race	2,799	79.0 (3.7)	72.2 (3.5)	62.8 (4.5)	38.4 (3.2)	61.4 (4.4)	17.2 (3.1)	2.5 (0.9)	20.7 (3.7)	
15–19 years	1,558	71.5 (5.6)	60.1 (5.2)	48.2 (5.4)	21.4 (3.7)	47.6 (5.4)	9.6 (2.8)	*	28.1 (5.7)	
20–24 years	1,241	88.3 (3.7)	87.1 (3.6)	81.0 (5.9)	59.8 (5.7)	78.6 (5.9)	26.6 (5.4)	4.5 (1.8)	11.7 (3.7)	

* Figure does not meet standards of reliability or precision.

¹Includes vaginal, oral, or anal sex. See Methods section for description of all questions on sexual behavior used in this report.²For females, includes oral sex or any sexual experience. For males, includes oral or anal sex with male partners. See Methods section for description of all questions on sexual behavior used in this report.³Includes those of other or multiple race and origin groups, not shown separately.

NOTES: Respondents reported all types of sexual contact they may have had. As a result, percentages reporting specified types of sex with opposite-sex partners may add to more than the percentage reporting any opposite-sex sexual contact. Similarly, the percentages reporting no sexual contact with another person may be larger than the difference from 100% of the sum of the percentages reporting opposite-sex and same-sex partners because respondents could report contact with both opposite-sex and same-sex partners.

SOURCES: Reference 9 and CDC/NCHS, National Survey of Family Growth, 2006–2008.

Table 8. Type of sexual behavior with an opposite-sex partner among females and males aged 15–24 years, by selected characteristics: United States, 2002 and 2006–2008

Characteristic	Number in thousands	Type of sexual behavior with opposite-sex partners				
		Total	Vaginal intercourse	Oral sex, but no vaginal intercourse	No vaginal intercourse or oral sex, but other sexual contact	Never had opposite-sex sexual contact
2002		Percent distribution (standard error)				
All females aged 15–24 years ¹	19,674	100.0	70.1 (1.3)	7.2 (0.7)	–	22.7 (1.1)
All males aged 15–24 years ¹	20,091	100.0	67.9 (1.6)	8.0 (0.8)	1.6 (0.3)	22.6 (1.3)
2006–2008						
All females aged 15–24 years ¹	20,570	100.0	65.2 (2.7)	4.9 (0.7)	–	29.9 (2.8)
Age:						
15–19 years	10,431	100.0	45.9 (2.5)	7.1 (1.2)	–	47.0 (2.7)
15–17 years.	5,833	100.0	33.0 (2.2)	6.7 (1.6)	–	60.3 (2.7)
18–19 years.	4,598	100.0	62.3 (4.7)	7.6 (1.8)	–	30.0 (4.8)
20–24 years	10,140	100.0	85.1 (3.6)	2.6 (0.7)	–	12.3 (3.4)
Hispanic origin and race:						
Hispanic or Latina	3,517	100.0	69.0 (2.9)	1.4 (0.6)	–	29.7 (3.1)
15–19 years.	1,812	100.0	48.2 (3.4)	2.0 (0.9)	–	49.8 (3.7)
20–24 years.	1,705	100.0	91.2 (2.2)	*	–	8.1 (2.1)
Not Hispanic or Latina:						
White, single race	12,309	100.0	61.2 (3.5)	6.6 (0.9)	–	32.2 (3.7)
15–19 years	6,186	100.0	42.1 (3.1)	9.8 (1.6)	–	48.2 (3.6)
20–24 years	6,122	100.0	80.6 (5.0)	3.4 (1.0)	–	16.0 (4.7)
Black or African American, single race	3,047	100.0	73.2 (3.0)	2.5 (1.3)	–	24.3 (3.1)
15–19 years.	1,606	100.0	54.6 (5.0)	4.5 (2.3)	–	40.9 (5.6)
20–24 years.	1,440	100.0	93.6 (2.0)	*	–	6.0 (2.0)
All males aged 15–24 years ¹	21,181	100.0	62.9 (2.1)	6.8 (0.8)	1.9 (0.5)	28.3 (2.0)
Age:						
15–19 years	10,777	100.0	44.9 (2.5)	9.4 (1.1)	3.8 (0.9)	42.0 (2.3)
15–17 years.	6,643	100.0	31.9 (3.1)	9.8 (1.5)	5.2 (1.4)	53.2 (2.9)
18–19 years.	4,134	100.0	65.6 (3.5)	8.7 (1.5)	1.6 (0.5)	24.2 (2.9)
20–24 years	10,404	100.0	81.5 (3.6)	4.2 (1.0)	–	14.3 (3.1)
Hispanic origin and race:						
Hispanic or Latino	3,796	100.0	71.4 (2.2)	6.2 (1.3)	1.7 (0.6)	20.7 (1.9)
15–19 years.	1,891	100.0	47.9 (3.6)	11.6 (2.6)	3.5 (1.1)	37.0 (3.2)
20–24 years.	1,905	100.0	94.6 (1.8)	0.9 (0.4)	–	4.5 (1.7)
Not Hispanic or Latino:						
White, single race	12,878	100.0	61.0 (3.1)	7.8 (1.1)	2.1 (0.7)	29.2 (3.2)
15–19 years	6,208	100.0	42.1 (3.5)	10.0 (1.5)	4.3 (1.3)	43.7 (3.4)
20–24 years	6,671	100.0	78.5 (5.2)	5.7 (1.4)	–	15.8 (5.0)
Black or African American, single race	2,799	100.0	72.2 (3.5)	4.9 (1.3)	2.0 (0.8)	21.0 (3.7)
15–19 years	1,558	100.0	60.1 (5.2)	7.8 (2.2)	3.6 (1.4)	28.5 (5.6)
20–24 years	1,241	100.0	87.1 (3.6)	1.3 (1.0)	–	11.7 (3.7)

– Quantity zero.

* Figure does not meet standards of reliability or precision.

¹Includes those of other or multiple race and origin groups, not shown separately.

NOTE: Percentages may not add to 100 due to rounding.

SOURCES: Reference 9 and CDC/NCHS, National Survey of Family Growth, 2006–2008.

Table 9. Number of sexual partners in the past 12 months, including same-sex and opposite-sex partners, among females and males aged 15–44 years, by selected characteristics: United States, 2002 and 2006–2008

Characteristic	Number in thousands	Total	Sexual partners in last 12 months ¹				
			No partner in last 12 months	Any same-sex partners	One opposite-sex partner, but no same-sex partners	Two or more opposite-sex partners, but no same-sex partners	Did not report
Percent distribution (standard error)							
All females aged 15–44 years ²	61,865	100.0	15.9 (1.3)	11.7 (0.7)	61.3 (1.2)	9.4 (0.6)	1.7 (0.4)
Age:							
15–19 years	10,431	100.0	51.3 (2.6)	9.5 (0.8)	24.2 (2.0)	13.5 (1.1)	1.6 (0.6)
20–24 years	10,140	100.0	15.8 (3.3)	15.2 (1.8)	49.5 (2.1)	17.7 (2.5)	1.8 (0.8)
25–44 years	41,294	100.0	7.0 (0.6)	11.4 (0.8)	73.6 (1.1)	6.3 (0.5)	1.8 (0.5)
25–29 years.	10,250	100.0	7.6 (1.3)	14.3 (1.5)	65.1 (2.1)	10.6 (1.4)	2.4 (1.4)
30–34 years.	9,587	100.0	5.2 (0.9)	13.6 (1.7)	73.8 (2.0)	6.0 (0.7)	1.5 (0.5)
35–39 years.	10,475	100.0	6.8 (1.1)	10.8 (2.4)	76.2 (2.8)	4.2 (0.8)	2.0 (1.0)
40–44 years.	10,982	100.0	8.3 (1.2)	7.1 (1.4)	79.0 (2.2)	4.5 (0.8)	1.1 (0.4)
Education ³ :							
No high school diploma or GED	6,210	100.0	6.7 (1.2)	14.5 (2.1)	68.1 (2.3)	7.5 (1.1)	3.2 (1.0)
High school diploma or GED	11,793	100.0	6.1 (0.8)	13.4 (1.8)	70.6 (2.1)	7.7 (0.9)	2.2 (1.0)
Some college, no bachelor's degree	13,537	100.0	10.6 (2.3)	13.0 (1.3)	66.3 (2.1)	9.3 (1.2)	0.8 (0.4)
Bachelor's degree or higher	15,543	100.0	8.4 (1.4)	9.4 (1.3)	75.5 (1.9)	5.2 (0.8)	1.5 (0.7)
Hispanic origin and race:							
Hispanic or Latina	10,377	100.0	14.9 (0.9)	5.6 (0.9)	67.7 (1.7)	8.4 (0.8)	3.5 (1.0)
Not Hispanic or Latina:							
White, single race	37,660	100.0	16.0 (1.8)	13.9 (1.1)	60.8 (1.6)	8.4 (0.8)	0.9 (0.4)
Black or African American, single race	8,452	100.0	17.6 (1.8)	10.6 (1.3)	53.9 (2.2)	15.9 (1.5)	2.1 (0.7)
All males aged 15–44 years ¹	62,199	100.0	16.0 (1.2)	4.3 (0.4)	60.2 (1.3)	17.6 (0.8)	2.0 (0.3)
Age:							
15–19 years	10,777	100.0	48.9 (2.6)	1.5 (0.4)	25.1 (1.9)	21.2 (1.7)	3.3 (0.9)
20–24 years	10,404	100.0	18.3 (3.8)	4.6 (1.0)	48.0 (2.3)	27.2 (2.8)	1.9 (0.9)
25–44 years	41,019	100.0	6.8 (0.7)	4.9 (0.5)	72.4 (1.4)	14.2 (0.9)	1.7 (0.3)
25–29 years.	10,431	100.0	7.6 (1.5)	4.8 (1.0)	65.7 (2.2)	20.3 (1.6)	1.6 (0.5)
30–34 years.	9,575	100.0	6.6 (1.2)	3.6 (0.8)	75.3 (2.6)	13.0 (1.6)	1.4 (0.4)
35–39 years.	10,318	100.0	5.1 (0.9)	5.0 (0.9)	73.7 (2.0)	14.2 (1.9)	2.0 (0.8)
40–44 years.	10,695	100.0	7.7 (1.7)	6.2 (1.0)	75.2 (2.4)	9.3 (1.8)	1.6 (0.6)
Education ² :							
No high school diploma or GED	8,530	100.0	6.9 (1.4)	2.6 (0.7)	71.3 (3.2)	15.4 (2.4)	3.8 (1.2)
High school diploma or GED	12,278	100.0	7.4 (1.4)	4.4 (0.9)	69.2 (2.5)	17.3 (1.5)	1.7 (0.4)
Some college, no bachelor's degree	13,521	100.0	12.1 (3.0)	6.2 (1.1)	65.5 (3.0)	15.2 (1.7)	1.0 (0.5)
Bachelor's degree or higher	13,112	100.0	7.5 (1.1)	6.4 (0.9)	71.7 (2.5)	13.0 (1.9)	1.4 (0.4)
Hispanic origin and race:							
Hispanic or Latino	11,724	100.0	14.3 (1.1)	3.5 (0.6)	58.7 (2.0)	20.1 (1.5)	3.4 (0.9)
Not Hispanic or Latino:							
White, single race	37,374	100.0	16.2 (1.7)	4.8 (0.6)	62.4 (1.8)	15.5 (1.2)	1.2 (0.3)
Black or African American, single race	7,186	100.0	13.0 (2.0)	2.0 (0.5)	52.0 (2.7)	31.0 (2.3)	2.0 (0.5)

¹Includes vaginal, oral, or anal sex. See Methods section for description of all questions on sexual behavior used in this report.²Includes those of other or multiple race and origin groups, not shown separately.³Limited to persons aged 22–44 years at time of interview. GED is General Educational Development high school equivalency diploma.

NOTE: Percentages may not add to 100 due to rounding.

SOURCE: CDC/NCHS, National Survey of Family Growth, 2002 and 2006–2008.

Table 10. Sexual activity with same-sex partners in lifetime among females and males aged 15–44 years, by selected characteristics: United States, 2002 and 2006–2008

Characteristic	Females			Males		
	Number in thousands	Any sexual experience	Any oral sex	Number in thousands	Any oral or anal sex	Any anal sex
		Percent (standard error)			Percent (standard error)	
2002						
All persons aged 15–44 years ¹	61,561	11.2 (0.5)	---	61,147	6.0 (0.5)	3.7 (0.4)
2006–2008						
All persons aged 15–44 years ¹	61,865	12.5 (0.8)	9.3 (0.6)	62,199	5.2 (0.5)	2.9 (0.3)
Age:						
15–19 years	10,431	11.0 (1.0)	7.1 (0.8)	10,777	2.5 (0.7)	1.2 (0.4)
15–17 years	5,833	10.3 (1.3)	5.4 (1.0)	6,643	1.7 (0.7)	1.1 (0.6)
18–19 years	4,598	11.9 (1.8)	9.3 (1.6)	4,134	3.9 (1.2)	1.5 (0.5)
20–24 years	10,140	15.8 (1.8)	11.2 (1.3)	10,404	5.6 (1.1)	2.5 (0.7)
25–44 years	41,294	12.0 (0.9)	9.3 (0.8)	41,019	5.8 (0.6)	3.4 (0.5)
25–29 years	10,250	15.0 (1.5)	11.3 (1.2)	10,431	5.2 (1.1)	2.6 (0.6)
30–44 years	31,044	11.1 (1.0)	8.7 (0.9)	30,588	6.0 (0.8)	3.7 (0.6)
Marital or cohabiting status:						
Currently married	27,006	8.3 (1.1)	5.8 (0.9)	24,763	3.5 (0.6)	1.1 (0.2)
Currently cohabiting	6,821	20.5 (2.0)	16.7 (2.0)	7,301	3.2 (0.9)	0.6 (0.3)
Never married, not cohabiting	22,847	13.4 (1.0)	9.5 (0.8)	27,012	7.2 (0.9)	5.0 (0.7)
Formerly married, not cohabiting	5,190	19.6 (2.6)	16.8 (2.5)	3,123	6.4 (1.3)	3.3 (1.1)
Education ² :						
No high school diploma or GED	6,210	15.2 (2.1)	12.9 (1.9)	8,530	3.6 (1.0)	1.1 (0.3)
High school diploma or GED	11,793	14.2 (1.8)	12.3 (1.7)	12,278	5.1 (0.9)	2.8 (0.7)
Some college, no bachelor's degree	13,537	13.8 (1.4)	11.4 (1.3)	13,521	8.0 (1.5)	4.2 (1.1)
Bachelor's degree or higher	15,543	9.9 (1.3)	5.5 (0.8)	13,112	6.7 (0.9)	4.4 (0.8)
Number of opposite-sex partners in lifetime:						
None	6,752	4.9 (1.1)	2.9 (0.8)	6,906	7.5 (1.5)	5.1 (0.9)
1	13,395	3.5 (0.6)	2.2 (0.4)	9,072	4.4 (1.0)	1.6 (0.4)
2	6,485	9.0 (1.7)	6.9 (1.5)	4,570	6.8 (1.6)	6.2 (1.6)
3	6,054	8.5 (2.5)	5.5 (2.0)	4,231	2.6 (0.8)	1.9 (0.7)
4 or more	27,744	20.3 (1.1)	15.6 (1.0)	35,700	5.1 (0.7)	2.4 (0.5)
Hispanic origin and race:						
Hispanic or Latino	10,377	6.3 (0.9)	4.9 (0.9)	11,724	3.8 (0.6)	2.4 (0.4)
Not Hispanic or Latino:						
White, single race	37,660	14.6 (1.1)	10.6 (0.9)	37,374	6.0 (0.7)	3.2 (0.5)
Black or African American, single race	8,452	11.3 (1.4)	9.6 (1.3)	7,186	2.4 (0.5)	1.5 (0.5)

--- Data not available from 2002 NSFG.

¹Includes persons of other or multiple race and origin groups and persons with missing information on types of same-sex activity, not shown separately.²Limited to those aged 22–44 years at the time of interview. GED is General Educational Development high school equivalency diploma.

NOTE: See Methods section for description of all questions on sexual behavior used in this report.

SOURCES: Reference 9 and CDC/NCHS, National Survey of Family Growth, 2006–2008.

Table 11. Sexual attraction among women and men aged 18–44 years, by selected characteristics: United States, 2002 and 2006–2008

Characteristic	Number in thousands	Sexual attraction						
		Total	Only opposite sex	Mostly opposite sex	Equally to both	Mostly same sex	Only same sex	Not sure
2002		Percent distribution (standard error)						
All women aged 18–44 years ¹	55,742	100.0	85.7 (0.6)	10.2 (0.5)	1.9 (0.2)	0.8 (0.1)	0.7 (0.1)	0.8 (0.1)
All men aged 18–44 years ¹	55,399	100.0	92.2 (0.6)	3.9 (0.4)	1.0 (0.1)	0.7 (0.1)	1.5 (0.2)	0.7 (0.2)
2006–2008								
All women aged 18–44 years ¹	56,032	100.0	83.3 (1.1)	11.9 (0.9)	2.8 (0.2)	0.6 (0.1)	0.8 (0.2)	0.7 (0.1)
Age:								
18–19 years	4,598	100.0	82.4 (2.3)	9.4 (1.8)	4.8 (1.1)	0.9 (0.5)	1.3 (0.8)	1.2 (0.8)
20–24 years	10,140	100.0	77.6 (2.3)	16.7 (1.9)	3.7 (0.9)	0.8 (0.3)	0.8 (0.3)	0.4 (0.2)
25–29 years	10,250	100.0	81.4 (1.8)	12.9 (1.4)	3.8 (0.9)	0.5 (0.2)	1.1 (0.4)	0.4 (0.2)
30–34 years	9,587	100.0	81.4 (2.3)	13.0 (2.1)	2.8 (0.6)	0.7 (0.3)	0.9 (0.4)	1.2 (0.5)
35–44 years	21,457	100.0	87.9 (1.4)	9.1 (1.4)	1.4 (0.3)	0.4 (0.2)	0.5 (0.1)	0.6 (0.2)
Education ² :								
No high school diploma or GED	6,210	100.0	84.1 (1.8)	8.7 (1.4)	5.2 (1.3)	*	0.5 (0.2)	1.4 (0.6)
High school diploma or GED	11,793	100.0	85.4 (1.6)	9.6 (1.5)	2.8 (0.7)	0.4 (0.2)	1.2 (0.4)	0.6 (0.2)
Some college, no bachelor's degree	13,537	100.0	82.4 (1.6)	13.1 (1.5)	1.9 (0.4)	1.0 (0.4)	0.7 (0.2)	1.0 (0.4)
Bachelor's degree or higher	15,543	100.0	83.7 (1.8)	13.1 (1.5)	1.8 (0.5)	0.4 (0.2)	0.8 (0.3)	*
Hispanic origin and race:								
Hispanic or Latina	9,272	100.0	89.1 (1.1)	6.4 (0.9)	2.1 (0.6)	0.5 (0.2)	0.8 (0.3)	1.2 (0.4)
Not Hispanic or Latina:								
White, single race	34,410	100.0	81.1 (1.4)	14.3 (1.2)	3.0 (0.4)	0.6 (0.2)	0.7 (0.2)	0.3 (0.1)
Black or African American, single race	7,520	100.0	86.4 (1.7)	7.6 (1.2)	2.5 (0.7)	0.8 (0.5)	1.1 (0.4)	1.5 (0.6)
ACASI language ³ :								
English	51,754	100.0	82.4 (1.2)	12.5 (1.0)	2.9 (0.3)	0.6 (0.1)	0.9 (0.2)	0.7 (0.2)
Spanish	4,118	100.0	94.8 (1.1)	3.3 (0.8)	1.4 (0.9)	*	*	*
All men aged 18–44 years ¹	55,556	100.0	93.5 (0.5)	3.7 (0.3)	0.5 (0.2)	0.7 (0.2)	1.2 (0.2)	0.4 (0.1)
Age:								
18–19 years	4,134	100.0	91.7 (1.8)	5.7 (1.6)	*	0.7 (0.4)	1.1 (0.5)	0.6 (0.3)
20–24 years	10,404	100.0	91.3 (1.7)	5.8 (1.2)	1.1 (0.6)	0.5 (0.3)	0.7 (0.3)	0.7 (0.5)
25–29 years	10,431	100.0	94.3 (0.9)	3.1 (0.7)	0.3 (0.1)	0.7 (0.4)	1.3 (0.5)	0.4 (0.2)
30–34 years	9,575	100.0	95.3 (0.9)	2.7 (0.6)	*	0.5 (0.3)	0.8 (0.2)	0.4 (0.3)
35–44 years	21,013	100.0	93.6 (0.8)	3.1 (0.6)	0.4 (0.2)	0.9 (0.3)	1.7 (0.4)	0.2 (0.1)
Education ² :								
No high school diploma or GED	8,530	100.0	94.9 (1.0)	3.6 (0.8)	*	*	0.6 (0.3)	0.6 (0.3)
High school diploma or GED	12,278	100.0	93.5 (1.3)	2.9 (0.7)	1.1 (0.6)	0.7 (0.4)	0.9 (0.3)	0.9 (0.5)
Some college, no bachelor's degree	13,521	100.0	95.0 (0.7)	3.0 (0.6)	0.5 (0.2)	0.4 (0.2)	1.0 (0.3)	0.2 (0.1)
Bachelor's degree or higher	13,112	100.0	91.8 (1.2)	4.0 (0.8)	0.4 (0.2)	1.4 (0.5)	2.4 (0.6)	0.1 (0.1)
Hispanic origin and race:								
Hispanic or Latino	10,618	100.0	93.0 (0.8)	5.0 (0.7)	0.3 (0.1)	0.7 (0.3)	0.7 (0.2)	0.4 (0.2)
Not Hispanic or Latino:								
White, single race	33,573	100.0	93.8 (0.6)	3.3 (0.4)	0.6 (0.2)	0.6 (0.2)	1.4 (0.3)	0.2 (0.1)
Black or African American, single race	6,208	100.0	95.9 (1.0)	2.6 (0.8)	*	*	0.8 (0.3)	0.4 (0.2)
ACASI language ³ :								
English	51,263	100.0	93.5 (0.5)	3.5 (0.4)	0.5 (0.2)	0.7 (0.2)	1.3 (0.2)	0.4 (0.1)
Spanish	4,277	100.0	93.3 (1.7)	6.3 (1.6)	*	*	*	*

* Figure does not meet standards of reliability or precision.

¹Includes those of other or multiple race and origin groups and missing information on sexual attraction, not shown separately.²Limited to those aged 22–44 years of age at time of interview. GED is General Educational Development high school equivalency diploma.³ACASI is audio computer-assisted self interviewing.

NOTES: Percentages may not add to 100 due to rounding. See Methods section for description of all questions used in this report.

SOURCES: Reference 9 and CDC/NCHS, National Survey of Family Growth, 2006–2008.

Table 12. Sexual identity among women aged 18–44 years, by selected characteristics: United States, 2002 and 2006–2008

Characteristic	Number in thousands	Sexual identity					
		Total	Heterosexual or straight	Homosexual, gay, or lesbian	Bisexual	Something else ¹	Did not report
2002		Percent distribution (standard error)					
All women aged 18–44 years ²	55,742	100.0	90.3 (0.4)	1.3 (0.2)	2.8 (0.2)	3.8 (0.3)	1.8 (0.2)
2006–2008							
All women aged 18–44 years ²	56,032	100.0	93.7 (0.5)	1.1 (0.2)	3.5 (0.3)	0.6 (0.1)	1.1 (0.2)
Age:							
18–19 years	4,598	100.0	90.1 (1.5)	1.9 (0.9)	5.8 (1.2)	*	*
20–24 years	10,140	100.0	90.4 (1.6)	1.3 (0.4)	6.3 (1.1)	0.9 (0.3)	1.2 (0.8)
25–29 years	10,250	100.0	91.9 (1.2)	1.2 (0.4)	5.4 (1.0)	0.6 (0.2)	0.9 (0.3)
30–34 years	9,587	100.0	94.4 (0.9)	1.1 (0.5)	2.9 (0.6)	0.8 (0.3)	1.0 (0.4)
35–44 years	21,457	100.0	96.6 (0.5)	0.7 (0.2)	1.1 (0.2)	0.2 (0.1)	1.3 (0.3)
Marital or cohabiting status:							
Currently married	26,983	100.0	96.1 (0.6)	*	2.1 (0.4)	0.3 (0.1)	1.4 (0.4)
Currently cohabiting.	6,789	100.0	90.4 (1.4)	*	6.2 (1.0)	1.7 (0.8)	1.3 (0.6)
Never married, not cohabiting.	5,190	100.0	91.2 (1.1)	2.8 (0.6)	4.6 (0.7)	0.6 (0.2)	0.7 (0.2)
Formerly married, not cohabiting.	17,070	100.0	94.2 (1.0)	1.0 (0.4)	3.8 (0.8)	0.6 (0.3)	0.4 (0.2)
Education ³ :							
No high school diploma or GED	6,210	100.0	90.0 (1.3)	0.4 (0.2)	5.3 (0.9)	1.0 (0.4)	3.2 (0.9)
High school diploma or GED	11,793	100.0	94.4 (0.8)	1.4 (0.4)	3.1 (0.6)	0.4 (0.2)	0.7 (0.2)
Some college, no bachelor's degree	13,537	100.0	94.2 (0.8)	1.1 (0.3)	3.6 (0.6)	0.3 (0.2)	0.8 (0.3)
Bachelor's degree or higher.	15,543	100.0	96.5 (0.6)	1.0 (0.3)	1.5 (0.3)	0.4 (0.2)	0.6 (0.2)
Hispanic origin and race:							
Hispanic or Latina.	9,272	100.0	92.1 (1.2)	0.9 (0.3)	2.2 (0.5)	0.7 (0.3)	4.1 (1.2)
Not Hispanic or Latina:							
White, single race	34,410	100.0	94.2 (0.7)	0.9 (0.2)	4.1 (0.5)	0.5 (0.2)	0.4 (0.1)
Black or African American, single race	7,520	100.0	93.3 (1.0)	1.6 (0.5)	3.0 (0.8)	1.5 (0.4)	0.7 (0.2)
ACASI language ⁴ :							
English.	51,754	100.0	94.1 (0.5)	1.1 (0.2)	3.7 (0.4)	0.6 (0.1)	0.6 (0.1)
Spanish	4,118	100.0	88.9 (2.6)	*	1.1 (0.4)	1.3 (0.5)	7.9 (2.6)

* Figure does not meet standards of reliability or precision.

¹This category was only offered in years 1 and 2 of the 2006–2008 data collection. See Methods section and Technical Notes for further details.²Includes women of other or multiple race and origin groups and those missing on ACASI language, not shown separately.³Limited to those aged 22–44 years at time of interview. GED is General Educational Development high school equivalency diploma.⁴ACASI is audio computer-assisted self interviewing.

NOTES: Percentages may not add to 100 due to rounding. "Did not report" includes "don't know" and "refused" responses, as well as responses that were not ascertained due to interview breakoffs before these ACASI questions.

SOURCES: Reference 9 and CDC/NCHS, National Survey of Family Growth, 2006–2008.

Table 13. Sexual identity among men aged 18–44 years, by selected characteristics: United States, 2002 and 2006–2008

Characteristic	Number in thousands	Sexual identity					
		Total	Heterosexual or straight	Homosexual or gay	Bisexual	Something else ¹	Did not report
2002		Percent distribution (standard error)					
All men aged 18–44 years ²	55,399	100.0	90.2 (0.7)	2.3 (0.4)	1.8 (0.3)	3.9 (0.5)	1.8 (0.3)
2006–2008							
All men aged 18–44 years ²	55,556	100.0	95.7 (0.5)	1.7 (0.2)	1.1 (0.2)	0.2 (0.1)	1.3 (0.3)
Age:							
18–19 years	4,134	100.0	96.6 (0.8)	1.6 (0.6)	1.1 (0.5)	*	0.6 (0.2)
20–24 years	10,404	100.0	95.1 (1.4)	1.2 (0.4)	2.0 (0.9)	0.4 (0.2)	1.3 (0.9)
25–29 years	10,431	100.0	96.3 (0.8)	1.7 (0.6)	0.8 (0.3)	0.5 (0.2)	0.8 (0.4)
30–34 years	9,575	100.0	96.2 (0.9)	1.5 (0.5)	0.6 (0.3)	*	1.8 (0.7)
35–44 years	21,013	100.0	95.2 (0.7)	2.1 (0.4)	1.0 (0.3)	0.2 (0.1)	1.5 (0.4)
Marital or cohabiting status:							
Currently married	24,763	100.0	97.7 (0.5)	*	0.4 (0.2)	*	1.8 (0.5)
Currently cohabiting	7,292	100.0	98.1 (0.6)	*	0.5 (0.2)	*	1.0 (0.5)
Never married, not cohabiting	3,123	100.0	92.2 (0.9)	4.4 (0.5)	2.1 (0.5)	0.4 (0.1)	1.0 (0.5)
Formerly married, not cohabiting	20,379	100.0	96.9 (1.2)	1.3 (0.8)	1.5 (0.7)	*	0.0 (0.0)
Education ³ :							
No high school diploma or GED	8,530	100.0	93.7 (1.4)	1.3 (0.4)	0.8 (0.3)	*	3.9 (1.4)
High school diploma or GED	12,278	100.0	95.2 (1.0)	1.2 (0.3)	1.8 (0.8)	0.4 (0.2)	1.5 (0.5)
Some college, no bachelor's degree	13,521	100.0	96.8 (0.6)	1.3 (0.3)	1.1 (0.3)	0.2 (0.1)	0.6 (0.3)
Bachelor's degree or higher	13,112	100.0	95.2 (0.9)	3.1 (0.6)	0.9 (0.4)	*	0.7 (0.4)
Hispanic origin and race:							
Hispanic or Latino	10,618	100.0	93.4 (0.8)	1.2 (0.3)	0.9 (0.3)	0.6 (0.3)	3.9 (0.9)
Not Hispanic or Latino:							
White, single race	33,573	100.0	96.6 (0.5)	1.8 (0.3)	1.1 (0.3)	0.1 (0.1)	0.4 (0.1)
Black or African American, single race	6,208	100.0	97.8 (0.5)	1.2 (0.4)	*	*	0.4 (0.2)
ACASI language ⁴ :							
English	51,263	100.0	96.2 (0.4)	1.8 (0.2)	1.1 (0.2)	0.2 (0.1)	0.7 (0.2)
Spanish	4,277	100.0	89.3 (2.0)	0.7 (0.3)	1.1 (0.7)	*	8.5 (2.3)

* Figure does not meet standards of reliability or precision.

0.0 Quantity greater than zero but less than 0.05.

¹This category was only offered in years 1 and 2 of the 2006–2008 data collection. See Methods section and Technical Notes for further details.²Includes men of other or multiple race and origin groups and those missing on ACASI language, not shown separately.³Limited to those aged 22–44 years at time of interview. GED is General Educational Development high school equivalency diploma.⁴ACASI is audio computer-assisted self interviewing.

NOTES: Percentages may not add to 100 due to rounding. "Did not report" includes "don't know" and "refused" responses, as well as responses that were not ascertained due to interview breakoffs before these ACASI questions.

SOURCES: Reference 9 and CDC/NCHS, National Survey of Family Growth, 2006–2008.

Table 14. Sexual attraction, sexual identity, and selected sexual behavior indicators among women and men aged 18–44 years: United States, 2006–2008

Characteristic	Number in thousands	Any opposite-sex sexual contact ¹	Any vaginal intercourse with opposite-sex partner	Any oral sex with opposite-sex partner	Any anal sex with opposite-sex partner	Any same-sex sexual contact ¹
Percent (standard error)						
All women aged 18–44 years ²	56,032	94.1 (1.3)	92.4 (1.3)	85.3 (1.4)	33.2 (1.5)	12.7 (0.8)
Sexual attraction:						
Only to opposite sex	46,144	94.0 (1.5)	92.2 (1.5)	84.7 (1.6)	29.6 (1.6)	4.6 (0.6)
Mostly to opposite sex	6,567	97.6 (0.5)	96.0 (0.8)	94.1 (1.3)	54.8 (2.7)	47.4 (2.9)
All other ³	2,857	89.2 (2.6)	87.6 (2.8)	75.3 (3.4)	40.9 (3.3)	65.8 (3.6)
Sexual identity:						
Heterosexual	52,070	94.3 (1.4)	92.6 (1.4)	85.7 (1.4)	32.7 (1.5)	9.0 (0.7)
Homosexual or bisexual	2,536	91.6 (2.2)	89.2 (2.5)	86.0 (2.6)	47.5 (3.5)	84.5 (2.8)
All men aged 18–44 years ²	55,556	93.8 (0.9)	92.0 (1.0)	86.9 (1.0)	39.3 (1.5)	5.6 (0.5)
Sexual attraction:						
Only to opposite sex	51,362	94.9 (0.9)	93.3 (1.0)	88.3 (1.0)	40.0 (1.6)	2.8 (0.5)
Mostly to opposite sex	2,056	88.0 (3.2)	84.1 (3.6)	77.6 (4.4)	41.5 (5.4)	20.6 (3.0)
All other ³	1,863	69.4 (4.1)	64.6 (4.4)	55.8 (1.1)	15.5 (4.3)	73.5 (3.3)
Sexual identity:						
Heterosexual	52,886	94.5 (0.9)	92.8 (1.1)	87.9 (1.1)	40.0 (1.6)	3.2 (0.5)
Homosexual or bisexual	1,543	69.8 (4.6)	64.7 (4.7)	64.8 (4.7)	24.0 (4.9)	88.4 (2.9)

¹Any sexual contact with opposite-sex partners includes vaginal, oral, or anal sex. Any sexual contact with same-sex (female) partners includes oral sex or any sexual experience. For males, it includes oral or anal sex with male partners. See Methods section for description of all questions on sexual behavior used in this report.

²Includes those with missing information on sexual attraction, sexual identity, or sexual contact with opposite-sex or same-sex partners.

³Includes those responding “equally attracted to both sexes,” “mostly to same sex,” and “only to same sex.”

SOURCE: CDC/NCHS, National Survey of Family Growth, 2006–2008.

Table 15. Sexual identity and sexual attraction among women and men aged 18–44 years: United States, 2006–2008

Characteristic	Number in thousands	Sexual identity					
		Total	Heterosexual or straight	Homosexual or gay	Bisexual	Something else ¹	Did not report
2002		Percent distribution (standard error)					
All women aged 18–44 years	56,032	100.0	93.7 (0.5)	1.1 (0.2)	3.5 (0.3)	0.6 (0.1)	1.1 (0.2)
Sexual attraction:							
Only to opposite sex	46,144	100.0	98.8 (0.3)	*	0.11 (0.4)	0.2 (0.6)	0.79 (0.2)
Mostly to opposite sex.	6,567	100.0	86.8 (1.8)	0.0	10.5 (1.4)	2.1 (0.8)	0.5 (0.3)
All other ²	2,857	100.0	27.2 (3.8)	19.7 (2.6)	42.1 (3.5)	3.4 (1.4)	7.5 (2.0)
All men aged 18–44 years	55,556	100.0	95.7 (0.5)	1.7 (0.2)	1.1 (0.2)	0.2 (0.1)	1.3 (0.3)
Sexual attraction:							
Only to opposite sex	51,362	100.0	98.9 (0.3)	0.1 (0.1)	0.1 (0.1)	0.1 (0.1)	0.8 (0.2)
Mostly to opposite sex.	2,056	100.0	90.0 (2.1)	*	6.9 (1.8)	*	*
All other ²	1,863	100.0	13.2 (3.2)	47.5 (4.5)	20.8 (4.6)	2.7 (1.3)	15.9 (3.7)

* Figure does not meet standards of reliability or precision.

0.0 Quantity more than zero but less than 0.05.

¹This category was only offered in years 1 and 2 of the 2006–2008 data collection. See Methods section and Technical Notes for further details.

²Includes those responding “equally attracted to both sexes,” “mostly to same sex,” and “only to same sex.”

SOURCE: CDC/NCHS, National Survey of Family Growth, 2006–2008.

Table 16. Comparison of selected National Survey of Family Growth measures of sexual behavior and sexual identity with selected other nationally representative surveys

Characteristic	NSFG, 2006–2008	NSFG, 2002	NHANES, 1999–2002, 2001–2006, and 2007–2008	NSSHB, 2009	GSS, 2004 and 2008
	Age range of respondents for reported statistics				
	18–44 years	18–44 years	1999–2002: 20–59 years 2001–2006: 18–59 years 2007–2008: 20–44 years	14–94 years	18 years and over
Females					
Sex with opposite-sex partners:					
Median number of male partners in lifetime	3.2	3.3	3.7
Percent with two or more male partners in last 12 months ¹ . . .	13.0	14.7	10.0	...	8.0
Sex with same-sex partners:					
Ever had same-sex sexual contact ²	12.5	11.2	7.1	...	4.3
Sexual identity ³ :					
Homosexual	1.1	1.3	1.5	0.9	1.8
Bisexual	3.5	2.8	4.9	3.6	1.5
Something else	0.6	3.8	0.8	2.3	...
Males					
Sex with opposite-sex partners:					
Median number of female partners in lifetime	5.1	5.6	6.8
Percent with two or more female partners in last 12 months ¹ . . .	18.5	18.9	16.7	...	16.7
Sex with same-sex partners:					
Ever had same-sex sexual contact ²	5.2	6.0	5.2	...	5.1
Sexual identity ³ :					
Homosexual	1.7	2.3	2.0	4.2	1.5
Bisexual	1.1	1.8	1.3	2.6	0.7
Something else	0.2	3.9	0.3	1.0	...

... Data not available.

¹GSS contains questions that allow the respondent to specify whether sex partners in the last 12 months were exclusively male or female, or both. However, the sex of the partners in the last 12 months was not specified in the report used for this comparative table.

²GSS asks about any same-sex partners since age 18.

³Sexual identity estimates from NHANES were run using public-use data from 2007–2008.

NOTE: NSFG is National Survey of Family Growth; NHANES is National Health and Nutrition Examination Surveys; NSSHB is National Survey of Sexual Health and Behavior; GSS is General Social Survey. See Methods section for description of all NSFG questions on sexual behavior used in this report.

SOURCES: CDC/NCHS, NSFG 2006–2008; CDC/NCHS, NSFG 2002; NHANES references 63–66; NSSHB reference 20; and GSS references 67 and 68.

Technical Notes: The National Survey of Family Growth's Measurement of Sexual Identity

Basic information on NSFG's measurement of sexual identity was provided in the Methods section. Below, further detail is provided on the changes made to the sexual identity question since the 2002 NSFG and the effects these changes have had on the results. In 2002 and 2006–2008 of NSFG, the question on sexual identity directly followed the sexual attraction question in ACASI, and both of these items followed all ACASI questions on sexual behavior with opposite-sex and same-sex partners. In 2002, the sexual identity question was worded as follows, for both males and females:

Do you think of yourself as...

- *Heterosexual*
- *Homosexual*

- *Bisexual*
- *Something else*

As shown in Tables 12 and 13 of the report based on 2002 NSFG data (8), 3.8% of females aged 18–44 and 3.9% of males aged 18–44 reported “something else.” For some population groups, such as Hispanic and non-Hispanic black persons, the percentages reporting “something else” were higher than the percentages reporting “homosexual” or “bisexual.” To understand and potentially reduce the percentages reporting “something else,” two changes were made to the sexual identity question at the start of interviewing for the 2006–2008 NSFG:

1. More commonly known terms for sexual identity were added to the response categories. Instead of “heterosexual,” the response was changed to “heterosexual or straight” for both men and women. Instead of “homosexual,” men were offered “homosexual or gay,” and

women were offered “homosexual, gay, or lesbian.”

2. Those who reported “something else” were asked a follow-up question:

When you say “something else,” what do you mean? Please type in your answer.

The verbatim text they typed in was reviewed by NSFG staff and coded, where possible and unambiguous, into the preexisting categories.

Based on analyses with the 2006–2008 NSFG data, the first change had by far the larger impact on reporting of “something else.” Table I shows that even before the verbatim responses were examined for “something else” responses, the unweighted numbers and the weighted percentages reporting “something else” were significantly smaller than those found with the 2002 NSFG. In 2002, there were 294 women aged 18–44 and 175 men aged 18–44 who responded “something else,” and as was noted

Table I. Sexual identity reported as “something else” among women and men aged 18–44 years: United States, 2002 and 2006–2008

NSFG sexual identity variable	Women			Men		
	Unweighted number	Change from original reporting	Weighted percentage	Unweighted number	Change from original reporting	Weighted percentage
2002 NSFG sexual identity variable						
Original reports of “something else” ¹	294	...	3.8	175	...	3.9
2006–2008 NSFG sexual identity variable						
Original reports of “something else”	87	...	1.0	39	...	0.7
Remaining “something else” after coding of verbatim responses ²	50	...	0.6	19	...	0.2
Original sexual identity variable (before back-coding):						
Heterosexual or straight	6,023	...	92.8	4,997	...	95.0
Homosexual, gay (or lesbian)	93	...	1.0	132	...	1.6
Bisexual	274	...	3.5	69	...	1.1
Something else	87	...	1.0	39	...	0.6
Not ascertained	28	...	0.8	27	...	0.5
Refused	44	...	0.6	47	...	1.0
Don't know	20	...	0.4	12	...	0.3
Sexual identity variable after back-coding:						
Heterosexual or straight	6,043	20	92.9	5,007	+10	95.2
Homosexual, gay (or lesbian)	97	4	1.1	138	+6	1.7
Bisexual	274	0	3.5	69	0	1.1
Something else	50	-37	0.6	19	-20	0.2
Not ascertained	28	0	0.8	27	0	0.5
Refused	44	0	0.6	47	0	1.0
Don't know	33	13	0.5	16	+4	0.3

... Category not applicable.

¹No follow-up question was included for “something else” responses in the 2002 NSFG.

²The difference between the original reports and those remaining “something else” consisted of 37 women aged 18–44 and 20 men aged 18–44 who gave information in their verbatim responses that could be used to classify them in one of the preexisting response categories (i.e., back-coding).

NOTE: NSFG is National Survey of Family Growth.

SOURCE: CDC/NCHS, National Survey of Family Growth, 2002 and 2006–2008.

earlier, these unweighted numbers represented nearly 4% (weighted) of men and women aged 18–44 in 2002. Meanwhile, in the 2006–2008 NSFG, many fewer men and women aged 18–44 originally reported “something else”—87 women and 39 men, yielding weighted percentages of 1.0% of women and 0.7% of men aged 18–44. After the verbatim responses were examined from the follow-up question, 37 of 87 women and 20 of 39 men provided information that could readily classify them into one of the provided categories (that is, the responses were able to be back-coded). This back-coding was done conservatively, only editing responses that used words expressly contained in the provided response categories such as “straight” or “gay,” or responses that

directly stated the respondent’s sexual preference such as men saying “I only like women” and women saying “I only like men.” Among the 50 women and 19 men whose verbatim responses yielded no codable information, a few had entered only blank spaces, presumably to get past the question, and the remainder gave ambiguous or unrelated comments that could not be used to code sexual identity. [Table I](#) also shows the full distribution of sexual identity before and after the back-coding of 37 women and 20 men; no significant change was seen in any of the categories shown.

To describe the net effects of both of these question changes on the reporting of sexual identity, [Table II](#) shows the percentages reporting

“something else” in the 2002 and 2006–2008 NSFG. Also shown are percentages that “did not report” sexual identity, a category which consists of those who responded “don’t know” or “refused” and those who terminated their ACASI interviews before the sexual identity question. Given the differentials seen in the percentages reporting “something else” by Hispanic origin and race in 2002 and 2006–2008, the percentages are also shown by educational attainment and ACASI language. While no significant difference was seen in the “did not report” percentages between 2002 and 2006–2008, [Table II](#) documents that the overall reduction in “something else” reporting for all men and women aged 18–44 was mirrored in every subgroup

Table II. Percentage of women and men aged 18–44 years who reported “something else” as their sexual identity or did not report sexual identity, by selected characteristics: United States, 2002 and 2006–2008

Characteristic	Sexual identity reporting					
	2002			2006–2008		
	Number in thousands	Something else	Did not report	Number in thousands	Something else	Did not report
		Percent			Percent	
All women aged 18–44 years ¹	55,742	3.8	1.8	56,032	0.6	1.1
Hispanic origin and race:						
Hispanic or Latina	8,194	6.1	4.1	9,272	0.7	4.1
Not Hispanic or Latina:						
White, single race	35,936	2.3	1.2	34,410	0.5	0.4
Black or African American, single race	7,399	6.5	2.0	7,520	1.5	0.7
Education ² :						
No high school diploma or GED	5,617	10.2	4.9	6,210	1.0	3.2
High school diploma or GED	14,247	5.4	3.0	11,793	0.4	0.7
Some college, no bachelor’s degree	14,279	1.9	0.6	13,537	0.3	0.8
Bachelor’s degree or higher	13,526	0.6	0.9	15,543	0.4	0.6
ACASI language ³ :						
English	52,216	3.6	1.5	51,754	0.6	0.6
Spanish	3,468	5.9	6.7	4,118	1.3	7.9
All men aged 18–44 years ¹	55,399	3.9	1.8	55,556	0.2	1.3
Hispanic origin and race:						
Hispanic or Latino	9,336	7.3	3.5	10,618	0.6	3.9
Not Hispanic or Latino:						
White, single race	35,154	2.3	0.7	33,573	0.1	0.4
Black or African American, single race	6,127	7.5	3.2	6,208	*	0.4
Education ² :						
No high school diploma or GED	6,355	9.5	3.2	8,530	*	3.9
High school diploma or GED	15,659	6.3	2.4	12,278	*	1.5
Some college, no bachelor’s degree	13,104	1.3	0.4	13,521	0.2	0.6
Bachelor’s degree or higher	11,901	1.3	*	13,112	*	0.7
ACASI language ³ :						
English	51,301	3.6	1.8	51,263	0.2	0.7
Spanish	4,098	8.1	3.9	4,277	*	8.5

* Figure does not meet standards of reliability or precision.

¹Total includes those for whom ACASI language was not ascertained.

²Limited to those aged 22–44 at the time of interview. GED is General Educational Development high school equivalency diploma.

³ACASI is audio computer-assisted self interviewing.

NOTES: The “something else” category was only offered in years 1 and 2 of the 2006–2008 data collection (June 2006–June 2008). See Methods and Technical Notes sections for further details. “Did not report” includes “don’t know” and “refused” responses, as well as responses that were not ascertained due to interview breakoffs before these ACASI questions.

SOURCE: CDC/NCHS, National Survey of Family Growth, 2002 and 2006–2008.

shown. For Hispanic origin and race, the 2002 data had shown significantly higher levels of “something else” for Hispanic and non-Hispanic black men and women, relative to non-Hispanic white women and men. Those differentials were no longer seen in 2006–2008 for reports of “something else,” but instead Hispanic women (4.1%) and men (3.9%) were more likely not to report sexual identity than the other race and origin groups.

To address concerns that language barriers or educational attainment may impact reporting of “something else” on sexual identity or increase the chances of nonresponse, [Table II](#) shows these percentages by educational attainment and the language in which ACASI was conducted. In most education groups shown, the levels of both “something else” and “did not report” fell in 2006–2008 for both women and men aged 22–44. Women (3.2%) and men (3.9%) with less than a high school education continued to show higher percentages not reporting sexual identity than those in other education groups. In both 2002 and 2006–2008, those completing ACASI in Spanish were significantly more likely not to report sexual identity. For example, nearly 8% of women aged 18–44 in 2006–2008 who completed ACASI in Spanish did not report sexual identity compared with 0.6% of women who completed it in English. For percentages reporting “something else” on sexual identity, the differentials by ACASI language were more striking in 2002 (for example, 8.1% of men completing it in Spanish compared with 3.6% of men completing it in English) than in 2006–2008, but given the significant reduction overall in the numbers and percentages responding “something else” in 2006–2008, the ACASI language variable no longer shows a significant association.

In summary, the changes made to the sexual identity question between the 2002 NSFG and the 2006–2008 NSFG appear to have had a significant impact on the percentages reporting “something else” as well as on the percentages who “did not report” sexual identity. The majority of reduction in “something else” reporting since the 2002 NSFG is

attributable to the addition of several commonly known terms to the heterosexual and homosexual response categories for the 2006–2008 NSFG. While some back-coding was done based on the “something else” follow-up question’s verbatim responses, this affected a fairly small fraction of cases in the overall 2006–2008 NSFG sample because less than 1% of men and women aged 18–44 originally reported “something else,” and did not significantly alter the overall distribution by sexual identity. As a result of the significantly reduced levels of “something else” reporting in 2006–2008 and the survey costs associated with the follow-up question, the “something else” response option and follow-up question were deleted beginning in July 2008, year 3 of the 2006–2010 NSFG.

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- Division of Reproductive Health (CDC)
- Children's Bureau of the Administration for Children and Families
- Office of the Assistant Secretary for Planning and Evaluation

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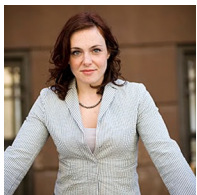
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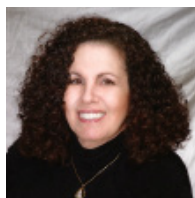
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In 2002, Ricci Levy helped found Woodhull Sexual Freedom Alliance, (then Woodhull Freedom Foundation), an organization whose mission is to affirm sexual freedom as a fundamental human right. As the Executive Director and President of both the Foundation and the Federation, she has been instrumental in Woodhull's growing leadership in the sexual freedom movement. Ricci has testified before Congress and has shared the mission of Woodhull in the media, at conferences and in dialogs with legislators and decision makers all over the country. Ms. Levy serves as Co-Chair of the US Human Rights Network Sexual Rights and Gender Justice working group, as well as on the Steering Committee of the Free Expression Network (FEN, the Advocacy Advisory Committee of the American Association of Sexuality Educators, Counselors and Therapists (AASECT), and the Education Committee of the US Human Rights Network.

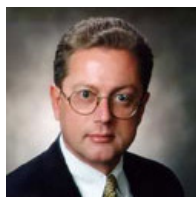


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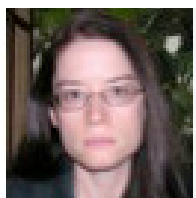


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