

International Handbooks of Population 5

Amanda K. Baumle *Editor*

International Handbook on the Demography of Sexuality

 Springer

International Handbook on the Demography of Sexuality

International Handbooks of Population

Volume 5

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Editor

International Handbook on the Demography of Sexuality

 Springer

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ISSN 1877-9204

ISBN 978-94-007-5511-6

ISBN 978-94-007-5512-3 (eBook)

DOI 10.1007/978-94-007-5512-3

Springer Dordrecht Heidelberg New York London

Library of Congress Control Number: 2013935591

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Printed on acid-free paper

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Part I

**Introduction to the Demography
of Sexuality**

Introduction: The Demography of Sexuality

1

Amanda K. Baumle

Introduction

The field of demography has historically been slow to embrace research that addresses the heterogeneity of populations.¹ Indeed, research on the manner in which race and sex affect demographic outcomes has only become commonplace in the last 20–30 years (Saenz and Morales 2005; Riley 2005; Hauser and Duncan 1959). It is perhaps unsurprising then that demographic research has paid little attention to sexuality as a whole, or to sexual orientation in particular.

The majority of demographic articles that do mention some aspect of sexuality are those that focus on sexual behavior as it relates to sexually transmitted infections (e.g. Schiltz 1998; Ericksen and Trocki 1994; Smith 1991). And, at demography conferences, sessions devoted solely to the examination of the demography of sexuality have occurred only in the past decade, and quite infrequently. Sexuality, therefore, has been introduced into the field of demography primarily through its connections to sexual behavior (rather than identity or

desire) and, in turn, reproduction. It is to be expected that sexual orientation and other aspects of sexuality would have found their first entrance into the discipline through their interconnections with fertility, one of the core demographic processes. Indeed, it is noteworthy that so little demographic work has been done in the broad area of sexuality, given its undeniable tie to fertility outcomes.²

More recent research, however, shows that sexuality affects demographic outcomes well beyond specific studies estimating the odds of contracting sexually transmitted infections (see e.g. Baumle and Poston 2011; Baumle et al. 2009; Gates and Ost 2004; Walther and Poston 2004; Black et al. 2000). Sexuality results in differential outcomes on a number of issues that are fundamental to population study, including migration, fertility, morbidity, and other areas (see e.g. Baumle et al. 2009; Gates and Ost 2004).

It is important, therefore, for demographers to consider the effects of sexuality on demographic factors, in addition to how sexuality intersects with other demographic characteristics—such as sex and gender—to shape outcomes. This handbook takes a step toward encouraging the incorporation of sexuality variables into demographic analyses, as well as demographic theory and models. In this introductory chapter, I provide

¹ Portions of this chapter are revised or reprinted by permission from *Same-Sex Partners: The Social Demography of Sexual Orientation* by Amanda K. Baumle, D’Lane R. Compton, and Dudley L. Poston Jr., the State University of New York Press ©2009, State University of New York.

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² Riley (1999) makes a similar observation regarding the surprising exclusion of feminist perspectives from demographic study, given the strong focus on reproductive behaviors in the field of demography.

a brief overview of the history of research on population sexuality, as well as explore what it would mean to formalize the development of the demography of sexuality. I conclude by highlighting the sections of this handbook and the topics covered herein.

A Brief History of Sex Research

Alfred Kinsey

In the early 1900s, sex research in the United States was very limited, focusing primarily on that of “deviant” sexual activities. Prohibitions on material of a sexual nature were to such a degree that it was unlawful to mail research surveys, or any other sexual material (Jones 1997). As a result, when the Rockefeller Foundation began to fund research in the area of sexuality in the 1930s, much of the initial research focused on areas such as prostitution, homosexuality, or endocrinology (Jones 1997). It was Alfred Kinsey who gained notoriety by encouraging the development of a methodical analysis of “typical” sexual behavior. Departing from a focus on the so-called deviant sexual experience, Kinsey explored the sexual behavior of married men and women in the United States, publishing two important works: *Sexual Behavior in the Human Male* (1948) and *Sexual Behavior in the Human Female* (1953).

Trained as an entomologist, Kinsey advocated detailed data collection and analysis when it came to human sexual behavior. To this end, his data were collected from thousands of individual “sexual histories,” in which Kinsey and his trained interviewers detailed sexual desires, behaviors, and identities from pre-pubescence onward (Jones 1997; Bullough 1994). Although his samples were those of convenience, and thus flawed in terms of their representativeness, Kinsey’s work nonetheless emphasized the notion of an objective and scientific approach to studying sexuality (Ericksen and Steffen 1999; Jones 1997). This perspective was embraced by his successors, who were able to build upon the public dialogue about sexuality generated by Kinsey in order to further data collection efforts.

Beyond data collection, one of Kinsey’s most invaluable contributions to sexuality research concerns his seven point continuum regarding heterosexuality and homosexuality. In his analysis of sexual behaviors and desires, Kinsey emphasized individual variation. He did not ask individuals to simply identify as homosexual or heterosexual. Instead he questioned them on a broad range of behaviors and desires and then classified individuals along a continuum, with “essentially heterosexual” and “essentially homosexual” as the extreme ends of the scale (Kinsey 1948). Similarly, when Kinsey presented data on his findings concerning homosexuality, he presented a range of percentages expressing differing degrees of behavior rather than classifying individuals into a binary scheme (Kinsey 1948). This approach was novel in many respects as it acknowledged the socially constructed nature of sexual categories: there is not an “essential” characteristic that renders one heterosexual or homosexual, which consequently makes categorization of sexual identities challenging. As discussed in Chapter 3 on measurement of sexual identity, researchers today still grapple with the best way to capture this variation in sexuality on surveys and in interviews.

Two of Kinsey’s findings have particularly persevered over the years. The most notable, perhaps, is his estimate that approximately 10% of men are gay (Kinsey 1948). This number is oft-cited as evidence that the gay population is not insignificant in size, particularly by those pursuing policy change. Notably, this is actually an overestimate even according to Kinsey’s nonrepresentative sample. Although Kinsey noted that approximately 10% of men reported some same-sex sexual desire, only about 4% classified themselves as “exclusively homosexual” on his scale (Kinsey 1948).³ Nonetheless, these data contributed toward a reduction in the stigma associated with homosexuality by “normalizing” the behavior to a broader segment of the population.

³ It is noteworthy, given that he oversampled from prisons and university populations, that his estimate of 4% is so closely mirrored in today’s representative surveys (see Chapter 11 for discussion of prevalence of gay and lesbian identity).

In terms of female sexuality, Kinsey's (1953) work challenged the notion of whether and how females experience orgasm. The assumption was that females achieve orgasm primarily through intercourse, but Kinsey's data provided one of the first indications of the importance of clitoral stimulation for orgasm and that orgasm was commonly achieved during masturbation and "heavy petting". Although this and related findings are perhaps more commonly attributed to Shere Hite (2004), Kinsey's work was some of the first to describe female sexuality in a manner beyond that of a passive participant in intercourse.

Kinsey's research laid the groundwork for later demographic analyses of sexual behavior and desire. His contributions to both data collection and analysis for sexuality research lend merit to the assertions by Bullough (2004) and others that after Kinsey, "sex will never be the same."

Sex Research After Kinsey

Since Kinsey's groundbreaking work, there have been huge strides made in sex research. Data collection on sexuality has increased with scientific inquiry being shaped both by methodological developments as well as social changes or "crises" which prompt additional collection. As Michaels and Giami (1999) note, the content of data collected has often been spurred by crises. For example, while Kinsey's data collection focused primarily on sexuality within marriage, surveys from the 1970s focused on heterosexual activity within nonmarital relationships, sexual positions, contraception, and abortion; the focus on such questions was spurred by the women's movement and the notion of sexual freedom. The HIV/AIDS scare in the 1980s and 1990s resulted in increased data collection on the number of sexual partners, condom use, anal sex, and homosexuality. And, as identity politics have increasingly dominated the landscape, we have seen data collection turn toward sexual identities. In this section, I provide an overview of three of the most well-known sexuality studies as illustrative of the evolution in data collection. Issues surrounding

sexuality data collection and measurement are considered in more detail in Chapters 2 and 3.

In the mid-1970s, Shere Hite conducted some of the most prominent studies of female sexuality. Published during the height of the women's movement, her "Hite Reports" were reflective of the period's focus on women's equality and sexual freedom. Advertising through women's magazines, Hite distributed essay questionnaires to women in order to gather data about the manner in which women themselves describe their sexuality (Weisstein 2006; Hite 2004; Ericksen and Steffen 1999). Hite argued that previous (primarily male) researchers had dictated to respondents what was or was not important to describe in terms of one's sexuality. With the essay approach, women had more freedom to describe rather than to simply select a pre-ordained response. Consequently, Hite collected data about sexual behaviors, as well as love and relationships.⁴

One of Hite's (2004) most important substantive findings was that 70% of women do not orgasm from intercourse alone, but do orgasm from more direct clitoral stimulation like through masturbation, genital touching, or oral sex. Hite was not the first one to realize the importance of the clitoris in female orgasm. Masters and Johnson (1966) noted that clitoral stimulation was important, but they asserted that females should receive enough clitoral stimulation during intercourse for orgasm. Similarly, Kinsey (1953) noted that women had the highest rate of orgasm during masturbation, but his analysis of the data did not then lead him to question whether this meant that orgasm during intercourse was limited due to insufficient stimulation. Hite contended that these researchers viewed female sexuality through "cultural blinders", wherein a patriarchal ideology detailed the appropriate sexual submissiveness and pleasures for women (Weisstein 2006: 458). Because of her distinct viewpoint and approach to gathering and analyzing data from women, she came to a different, maybe seemingly obvious, con-

⁴ Hite was not alone in this focus. Simon and colleagues (1972), who gathered sexuality data in France during the late 1960s, were highly critical of Kinsey's focus on counting orgasms and the acts that led to orgasm. Rather, Simon emphasized the importance of gathering data on love, relationships, and control of procreation.

clusion: that it was *normal* for women not to orgasm during vaginal intercourse. If most women said that was the case, then it was not due to low sex drive or another physical or psychological dysfunction. Hite's findings led her to question how we define sex, in that if our definition is one of penetrative intercourse, but women typically do not orgasm through intercourse, then is our definition of sex "sexist" (Hite 2004)? Her data collection, findings, and analysis are typified by the time period in which she was conducting her research, and raised questions regarding the manner in which sex researchers were (and should be) gathering data about sex.

In order to address health concerns that are linked to sexual behavior, such as HIV/AIDS, Edward Laumann and colleagues (1994) conducted the first nationally representative sex survey in 1992. The National Health and Social Life Survey captured data on topics such as the prevalence and type of sexual behaviors, the number of sexual partners, sexual networks, epidemiological issues, homosexuality, early sexual experiences, sex within marriage and cohabiting relationships, and fertility (Laumann et al. 1994). Laumann and colleagues, like Kinsey, attempted to assess the number, frequency, and types of sexual behaviors. Their data collection and analysis, however, went further in order to understand the manner in which sexual partners negotiate, navigate, and ultimately understand their interaction. In this manner, their efforts incorporated the social aspect of sexual experience rather than simply the biological. Furthermore, their focus on capturing data on sexual desire, behavior, and identity render this survey important, as it incorporates a holistic approach to understanding sexuality that is usually absent from survey data collection efforts. This approach has at times been mirrored in later sex surveys (see Chapters 2 and 3 for further discussion).

Today, some of the most prominent sex-related surveys focus on gathering data about sexual identity and corresponding attitudes, behaviors, or characteristics. For example, data from the General Social Survey and the U.S. Census capture sexual identity that can then be used to examine questions regarding political/social attitudes, demographic characteristics, economic outcomes, and family composition. Given the pressing social and legal

issues surrounding sexual minorities, data which are able to shed light on existing inequalities or provide greater understanding of the lives of LGB persons have garnered the greatest attention by academics and policymakers. Publications based on such data have been used, for example, to explore whether antidiscrimination laws are needed due to inequalities in income based on sexual orientation (see e.g. Baumle and Poston 2011; Badgett 2001).

The study of population sexuality is accordingly a constantly evolving field, with the quantity and content of data collected spurred on by broader changes in the public dialogue about sex. For demographers seeking to study sexuality at this point in time, the availability of data on sexual identity in nationally representative surveys permits new analyses of the extent to which sexual orientation affects traditional demographic outcomes. In the following section, I discuss some of the ways in which demographers might advance the discipline through consideration of sexuality.

The Demography of Sexuality

Although Kinsey's work might have spurred the collection of data on population sexuality, it is nonetheless the case that studies of sexuality have rarely been the foray of self-identified demographers. Instead, epidemiologists, psychologists, geographers, economists, and others have generated much of our current knowledge base regarding sexual behaviors and identities. While sexuality studies are increasingly published in demographic outlets, such articles remain limited in both number and scope.

In 2006, my colleagues and I conducted a search of the population journals in JSTOR⁵ focusing particularly on articles containing terms

⁵ The population studies journals included in this search are: *Demography*, *Family Planning Perspectives*, *International Family Planning Perspectives*, *International Migration Review*, *Population: English Edition*, *Population: French Edition*, *Perspectives on Sexual and Reproductive Health*, *Population and Development Review*, *Population Index*, *Population Studies*, and *Studies in Family Planning*.

related to sexual orientation (Baumle et al. 2009). We found that in the prior three decades, only 69 articles contained the phrase “sexual orientation”, 48 contained the word “lesbian”, 221 contained the word “gay”, and 181 included the word “homosexual.” As previously noted, the majority of these studies focused on sexual orientation as a variable in epidemiological studies, particularly those concerning HIV/AIDS (e.g. Schlitz 1998; Eriksen and Trocki 1994; Smith 1991).

Given the increased availability of data on gay and lesbian persons, most notably the data on same-sex partners from the U.S. Census (see discussion in Chapters 2 and 3 on these data), we might expect to see a large increase in publications within demographic journals on sexuality. From 2006 to the present, an additional 53 articles were published in these same journals containing the phrase “sexual orientation”, 21 containing the term “lesbian”, 44 containing the word “gay”, and 35 containing the word “homosexual”. Although this is a notable leap, particularly in those articles containing “lesbian”, a review of the content of these articles suggests primarily a continued focus on reproductive and health outcomes (e.g. Hollander 2007; London 2006; Rice et al. 2006). Some notable exceptions include articles such as Festy (2006) analysis of the legal recognition of unions of same-sex couples in Europe, Carpenter and Gates’ (2008) study of gay and lesbian partnerships in California, and Manalansan’s (2006) analysis of sexuality within migration studies. Significantly, it is not that new research is absent on population sexuality in general, or sexual orientation in particular. Rather, it is that the research is being conducted by individuals other than “demographers” and/or published in other outlets.

Demographers, then, must consider the importance of embracing sexuality as both a disciplinary focus in and of itself, as well as its implications for more traditional demographic inquiry. To this end, the advancement of demographic research of sexuality should be twofold. Sexuality (behavior, desire, and identity) should be incorporated as a variable into traditional demographic research, but demographers must also consider the degree to which demographic

models and theories are able to capture and explain the experiences of non-heterosexual individuals.⁶

As highlighted throughout this volume, there has been limited research assessing the manner in which sexual behavior or identity can serve as important shapers of demographic processes. Consequently, the first step toward opening the demographic discipline to studies of sexuality should involve incorporating such variables into current demographic models. Demographers must “bring sexuality in”⁷ to their studies of migration, fertility, mortality, labor force, family, and the other subfields of demography. When possible, sexual orientation should be included as an important individual characteristic in demographic research, much as gender, race, and ethnicity have become.

Several studies have already demonstrated the manner in which demographic outcomes are affected by sexual identity in particular. For example, research has established that sexual orientation affects both migration and the geographic distribution of individuals (e.g. Baumle et al. 2009; Gates and Ost 2004). Several studies (e.g. Baumle and Poston 2011; Klawitter and Flatt 1998; Badgett 1995) have highlighted the role that sexual behavior and identity play in labor outcomes, such as earnings from employment. In addition, research emphasizes that sexual orientation plays an important role in family structure, including partnership rates (Carpenter and Gates 2008), marital unions (Andersson et al. 2006), and the presence of children in the household (Baumle and Compton 2011; Baumle et al. 2009). Given these findings, and others discussed within the following chapters, it would seem that continued analysis of the manner in which sexual orientation and other sexuality variables affect demographic outcomes is warranted.

In addition to incorporating sexuality variables into demographic analyses, demographers should

⁶ See Riley (1999) for a similar discussion regarding incorporating gender into demographic research.

⁷ See Poston et al. (2005) or Riley (1999) for similar arguments regarding “bringing men in” or “bringing women in” to demographic studies.

question whether our current models or theories are capable of explaining the experiences of non-heterosexual individuals. In particular, the interaction of sexual orientation and gender creates unique dynamics demanding new assumptions, models, and theories. Studies in the areas of fertility, migration, family demography, labor demography, and other subfields, have been dominated by a heteronormative perspective. Research in all of these areas, for example, has examined the manner in which sex and gender affect demographic outcomes as a consequence of power differentials (e.g. women will be less likely to make migration decisions than men because, on average, they earn less money and have less relationship power than do men). When one considers same-sex couples, however, using sex as a proxy for power differentials becomes problematic and forces a reevaluation of current understandings of these models. As noted by Manalansan (2006: 224), incorporating sexuality into migration studies “not only expands the meaning of migration but also alters our understanding of gender and challenges migration studies’ reliance on heteronormative meanings, institutions, and practices.” This is the case for many demographic outcomes, wherein our current models and theories should be reevaluated for their applicability to non-heterosexual and—perhaps—to heterosexual individuals in response to new empirical findings on population sexuality.

In this handbook, data and analyses are presented in order to provide a foundation for the development of research in the demography of sexuality. In the following chapters, both researchers with traditional demographic backgrounds, as well as those with training in other disciplines, provide an overview of the state of current research on population sexuality. I have deliberately chosen not to include chapters focused on sexually transmitted infections or pregnancies, i.e. the “consequences” of sexual activity. Instead, the content of this handbook explores population sexuality in order to describe the prevalence of sexual behaviors, desires, and identities, as well as their connections with other demographic outcomes. The focus, then, is on analyzing sexuality as a demographic topic in its own right, rather than solely as

a variable in studies of sexually transmitted infection or other health-related topics.

To this end, I have divided the handbook into six primary sections. First, an overview of data and methods pertaining to demographic studies of sexuality and sexual orientation is provided. The next section reviews population sexuality through an international lens, analyzing data from the United States, China, Africa, and Latin America. In the third section, a more life course perspective is adopted focusing on sexuality within the context of relationships, in adolescence, and in older age. Next, specific sexual identities are examined, with attention paid to the role of gay or lesbian identity/behavior in affecting several demographic outcomes (prevalence, geographic distribution, labor market, and the family). In addition, data relating to both asexual and transgender identities and behaviors are presented. The last section is more applied, incorporating data on population sexuality into policy analyses on the topics of marriage, military service, adoption, and census data collection. In the final chapter, I offer suggestions regarding further development of this burgeoning field of demographic work.

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Sexual Behavior and Practices: Data and Measurement

2

Stuart Michaels

Introduction

Sexuality is a broad and complex topic which has been studied from a variety of perspectives and disciplines, including its own discipline of “sexology.” Even when interest is confined to sexual behavior, research approaches can range from the biological sciences to the social sciences and the humanities and from the laboratory to the cultural and historical. Sexuality is also a particularly sensitive and emotionally charged topic that evokes a wide range of strong reactions including political, moral, ethical, and religious responses. Even in the area of empirical scientific research, it is difficult to escape the “specialness” of sexuality. This is what Rubin (1984) referred to as the “fallacy of misplaced scale,” referencing Sontag who pointed out that “everything pertaining to sex has been a ‘special case’ in our culture” (Sontag 1969: 46). It is often difficult to maintain a level of objectivity and scale when thinking of sex. This has made it particularly difficult to conduct research directly about sexuality.

This chapter concerns research on sexual behavior and practices as part of the larger study of population, the domain of research and knowledge known as demography. My focus is on the

problems and issues related to studying sexuality in representative surveys of the population. The chapter begins by addressing the conceptualization of sexuality and sexual behavior. I argue that in order to overcome the resistance to the study of sexuality, it has always had to be justified and legitimated as being a necessary response to some larger pressing social need. This has affected the definition and conceptualization of sexuality which, in turn, has affected how it is measured. My hope is that a heightened awareness of the framing of research on sexuality can improve theory and research in this area.

Similar factors affect the measurement of sexuality in research, especially surveys. One of the greatest concerns is whether we can actually get accurate data on sexual behavior across the population via survey research. Here, the “special case” of sexuality is a double-edged sword. On the one hand, we need to pay special attention to the particularities of sexuality as an especially “sensitive topic” in survey research. On the other hand, we are often better served by thinking of sexual behavior as not that special at all. It needs to be treated as a legitimate research topic prone to exactly the same problems as surveys on other forms of behavior; not necessarily posing any impassable barrier, but still subject to the same methodological challenges encountered in any survey. The study of sexual behavior in surveys can benefit from the large body of research on questionnaire design and response error in survey research, which can be used to inform and improve our data collection efforts in this area.

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Surveying Sexual Behavior: Alfred Kinsey

My perspective grows out of my years of experience and reflection that began in 1988 when, as part of a team at the University of Chicago, we received a contract from the National Institutes of Health to design a national sexual behavior survey to produce data on sexual behavior and its correlates in the general population (Laumann et al. 1994a). The survey was motivated by the need for population-level information on sexual practices to respond to the HIV/AIDS epidemic in the United States. At the time, there were practically no data from representative samples of the U.S. population on sexual behavior and risk. Policy and planning was still drawing on data from the pioneering Kinsey studies that were collected starting a half a century earlier in 1938, and published in 1948 and 1953 (Kinsey et al. 1948, 1953), which (in spite of their size and breadth) were not based on a representative sample. The representative population data which had been collected in the interim was far from comprehensive both in terms of the populations studied (almost exclusively women or adolescents) and in the specific behaviors and practices (primarily if not exclusively heterosexual vaginal intercourse) (see Turner et al. 1989).

At the time, and even today, a watershed in the study of sexual behavior was the appearance of the massive volumes in 1948 and 1953 which have come to be known as the “Kinsey Reports.” Their titles, *Sexual Behavior in the Human Male* and *Sexual Behavior in the Human Female*, highlight the centrality of “sexual behavior”, as the main topic of the research creating the paradigm for subsequent work in population sexuality (Michaels and Giami 1999).

There are several characteristics of the Kinsey studies that shaped subsequent research on sexuality. First and foremost is the concept of sexual behavior. Sexual acts in and of themselves become the main object of study in Kinsey’s work. It is easy to overlook how innovative this was. Isolating sexual behavior and quantifying it over the lifetime for all types of people in a

society had not been attempted before. Kinsey does this primarily by taking orgasm as the defining characteristic of sexual acts and sets about counting all occurrences of acts that result in orgasm across the lifecourse, something he refers to as the “total outlet” (Kinsey et al. 1948, 1953). At first it was probably not obvious that this operationalization of the sexual has a masculine bias: orgasm is a more common and identifiable component of sexual acts for men than women (Robinson 1989). Kinsey devotes two full chapters to the physiology of the orgasm in the volume on women that had no parallel in the male volume, and the quantification of sexual acts in the women’s volume was no longer solely dependent on the presence of an orgasm (Kinsey et al. 1953). Quantification and measurement in the realm of sexuality involves choices and decisions that have significant consequences on the resulting science.

We will return to this crucial aspect of sex research, as it is central to the questions of data and measurement. For the moment, let me just point out that one of the effects of this momentous decision in Kinsey’s work is that it allows him to treat a number of phenomena as related in ways that had not been done previously in population research on sexuality. Surveys focused on sexuality that preceded Kinsey were primarily focused on “marital relations” (e.g., Dickinson and Beam 1932, 1934), but in Kinsey’s work intercourse between a man and a woman is only one form that sexual behavior may take. Masturbation, homosexuality, and sex with animals become topics to be studied and quantified along with heterosexual acts. Marriage nonetheless remains a central concern as is evidenced by the fact that heterosexual intercourse is quantified in Kinsey in terms of its context as before, during, or outside marriage, i.e., as pre-marital, marital, and extra-marital.

In addition to the decision to focus on sexual behavior, Kinsey’s work set as one of its primary goals to study variation of this object across the population. Kinsey was a trained zoologist and had made his name as the foremost student of the gall wasp (Pomeroy 1982; Robinson 1989). While Kinsey’s work was conceived as a study of

the “human male” and “human female,” in practice Kinsey’s project was to interview as diverse a population of all U.S. residents as possible and it is this goal which also makes it the model for subsequent research. While the methods were different than those we would use today, the goal was to interview a representative sample of the population in order to estimate the variation in the primary variable of interest, sexual behavior, across the whole population and to describe its distribution within the crucial socio-demographic groups of that population: sex, age, race, marital status, education, parents’ occupation, religious background, and urban/rural residence. Interestingly, even in terms of the decision not to use probability sampling (for which this work has received much criticism) the goal of representativeness was still present (Cochran et al. 1953). Although Kinsey believed that it would be impossible to approach subjects at random and instead embarked on creating what is in effect a huge convenience sample, his goal was to apply methods that he had used in his original field of ethnology to divide the social world into taxa and to gather as many specimens as possible within each square of a huge grid (Kinsey et al. 1948). In effect, he embarked on a sampling approach that approximates quota sampling, an approach to population sampling that has long since been replaced by probability sampling. Thus, while Kinsey’s work is in many ways outmoded and subject to methodological criticisms, in other ways it remains the exemplary model for subsequent population studies of sexuality.

Before turning to the issue of sexual behavior and practices in population studies, it is worth noting that social science research in general, but even more strongly research on charged topics such as sexuality, is shaped and driven by social concerns and problems. The history of sex research has been framed by social concerns, pressing social problems that need solution. The origins of modern sex research were at the nexus of criminal justice and emerging psychiatric disciplines. Most of the early subjects of sex research in both senses of the term—the topics of research and the people studied—were criminals who had been apprehended by the penal and judicial

systems. Deviant sexualities, that were beginning to be conceived as sexual psychopathologies, form the grist for the mill of much of this work, the most famous example being Krafft-Ebbing’s master work, *Psychopathia Sexualis* (1906/1929). In parallel, the beginnings of demography and, relatedly, the beginnings of statistics on populations and economies collected by the state concerned themselves with the outcomes of fertility and, often more implicitly than explicitly, sexual activity.

Issues related to marriage, the family, and reproduction (including contraception and abortion) were topics of social concern in such studies and are part of the modern history of population-based research on sexuality. Other topics such as prostitution, venereal disease, and delinquency (adolescent sexuality) have also driven research on topics that we would now think of as the corpus of sex research. Kinsey’s research can be seen as being part of the tradition of studies of marriage. If one looks at the studies he cites as precedents and part of the scientific literature that informed his work, studies of married persons loom large (Dickinson and Beam 1932, 1934).

A Short History of Sexual Behavior in Surveys Post-Kinsey

Sex research, perhaps even more than scientific endeavors in general, is responsive to social influences and pressures. Pressing social issues and problems are an important motivation for the topics that researchers study. In the period after Kinsey’s pioneering work, especially beginning in the 1970s, a central focus of demography and population studies was on fertility, contraception, abortion, and reproductive decision-making. One of the most important and continuing surveys in this area is the National Survey of Family Growth (NSFG) carried out by the National Center for Health Statistics which surveyed women ages 15–44 from 1973 to 1995, and since 2002 has included both men and women in this age range (http://www.cdc.gov/nchs/nsfg/about_nsfg.htm). There was also population research on adolescent sexuality during this period (e.g., Zelnick and Kantner 1980).

A thorough review of the state of data and knowledge on sexual behavior at the beginning of the AIDS period was presented by Turner et al. (1989). When the AIDS crisis emerged in the 1980s, interest turned to sexual behavior and practices, numbers of sexual partners, gender of sexual partners, and the use of condoms. In particular, in spite of political controversy resulting in the withdrawal of federal funding, the first large-scale representative population study of sexual partners and practices in the U.S. adult population was fielded in 1992. The National Health and Social Life Survey (NHSL) yielded a sample of 3,432 adults, ages 18–59 (Laumann et al. 1994a, b). In addition, a major longitudinal study of adolescent health began in 1994 which has come to be known as Add Health (<http://www.cpc.unc.edu/projects/addhealth/>). New sources of population-based data on sexual behavior continue to be produced, mostly in the area of health [e.g., CDC-funded, state-level studies of young people (Youth Risk Behavior Survey), adults (Health Risk Behavior Survey), and older adults (National Social Life, Health, and Aging Project)]. Sexual orientation, measured both in terms of partners and identity, has begun to be included in many of these studies and is a focus of research on health disparities (Michaels and Lhomond 2006; IOM 2011).

Before turning to methodological and measurement issues, it is important to discuss the substance of sexual behavior and practices commonly included in population research. This is important for two reasons. Methodological and practical decisions are made on theoretical and substantive research grounds. The selection of what behaviors and practices to inquire about is made based on the research questions and goals of the project. As previously alluded to, prior sex research has been driven by differing substantive concerns, e.g., reproduction, sexually transmitted infections, morality, psychological health. Whether to ask about condom use, oral contraception, masturbation, oral sex, or anal sex will in large part depend on the research questions, population studied, and the theoretical framework of a given project. These considerations also influence the construction of the questions about these behaviors and the language used to ask them.

There are two other issues that are fundamental to thinking about sexual behavior and practices: sexual partners and time frame. While as a sociologist, I would argue that all sex is social, even activities such as fantasizing, masturbation, and looking at pornography which are often solitary (see e.g., Gagnon and Simon 1973), most of the sexual activities asked about in surveys (vaginal intercourse, oral sex, anal sex, condom use, etc.) involve at least two people. Often the main question of interest is existence and/or enumeration of one or more sexual partners. This entails a clear definition of what constitutes a sexual partner, which hinges in part on a definition of what behavior and practices count as sexual. In practice, this varies widely in surveys and ultimately has to be determined based on the specific goals of the research.

Kinsey solved this problem by focusing on the orgasm, but this worked better for men than for women (see discussion in Kinsey et al. 1953). Great care and attention was paid to this issue in national surveys carried out in the early 1990s in the U.S. and Britain (Laumann et al. 1994b; Johnson et al. 1994). In the U.S. survey, it was decided to use a relatively broad definition when eliciting an enumeration of partners in the past year. Sex was defined as mutually voluntary activity involving arousal and physical contact with the genitals but not necessarily penetration or orgasm (Laumann et al. 1994b). Coerced sex was asked about separately in a later part of the interview both to minimize emotional distress and because it was not considered in the basis for defining sexual partners. The goal was to avoid a normative definition of sex as heterosexual, vaginal intercourse, and to provide a clear definition that would be equally applicable to women and men. In addition, in the context of a survey motivated by concerns about HIV/AIDS, every effort was made to have a definition that would elicit reporting of both male and female partners for both men and women. A broad definition of sex and sexual partners allowed researchers the greatest leeway in analyzing the data. Respondents were then asked about specific activities that had been engaged in with that partner. Depending on the research question, partners

where specific acts had not taken place could be excluded. The vast majority of sexual events included intercourse: 95–96% of the last sexual event with a sex partner involved intercourse (Laumann et al. 1994b: 100). It is impossible to distinguish whether respondents understood and attempted to apply the broader definition and that such partners are exceedingly rare, or whether respondents simply applied their own conventional definitions of sex and sexual partners that included penetration.

The distinction between partners and behavior/practices is important as well since relationship context has a powerful effect on sexual practices. For example, in the area of HIV risk or fertility and contraceptive use, patterns differ in risk and safe sex as a function of partnership type (casual versus long-term committed relationships). One of the difficulties in constructing surveys on sexual behavior is to determine how to collect data on both partners and behavior and how to integrate the two. The ideal would be to have all data on practices nested within partners, but this is usually too time-consuming to do systematically. The national surveys from the 1990s attempted to balance this trade-off by collecting information on specific partnerships and the practices engaged in within them, coupled with more global summary data on lifetime partners and practices (Laumann et al. 1994b; Johnson et al. 1994; Spira et al. 1993).

The power of population-based research resides in the ability to generalize from a sample and to analyze relations between explanatory and outcome variables. The ability to do this well depends on being able to assume that each respondent has the same understanding of the questions asked. If we want to compare differences in the number of sexual partners, we need each respondent to use the same definition of sex and partner. Too often, researchers assume that the meaning of their questions is clear and universal or they rely on the respondents to decide what questions mean. In the case of sexual behavior, this can certainly be problematic given that “sex” can mean different things to different people.

Methodological and Measurement Issues in the Study of Sexual Behavior

Research on sexual behavior in populations is dependent on self-reporting. The subject matter of such research has evoked a fair degree of skepticism on the part of the public as well as scientists, perhaps especially strongly when the findings do not correspond to a priori beliefs. This was a common response to Kinsey’s work in a period when sexual behavior was rarely discussed in public discourse and media and when his findings emphasized high rates of behaviors such as masturbation, pre-marital and extra-marital sex, and homosexuality which were pathologized, stigmatized, and criminalized at the time.

The public and scientists remained skeptical even in the 1990s, when major national population surveys of sexual behavior were carried out in response to a recognized public health crisis surrounding HIV/AIDS. Ironically, even in this period following the “sexual revolution” of the 1960s and 1970s, surveys of the general population generally found surprisingly low numbers of sexual partners, high rates of monogamy, and relatively low reporting of homosexuality. This produced the opposite kind of skepticism than did the Kinsey reports, as some individuals viewed the results as reflecting too little “sexual freedom”.

Concerns about the quality of data from sex surveys are valid and have helped to motivate important methodological research to understand and improve the data on sexual behavior and practices. But it should also be pointed out that there is no evidence that the problems and issues regarding the reliability and validity of responses in sex research are qualitatively different from other forms of survey research. Sources of measurement error in surveys, including surveys of sexual behavior, can be divided into error due to sampling and respondent or measurement error (Biemer et al. 1991). Both are crucial, though the former is easier to quantify. I deal with each in turn. While my primary focus will be on measurement and response error, sampling issues should not be ignored.

Sampling Error: Population Definition and Inclusion, Participation, and Selection

One of the greatest strengths of survey research is probability sampling. It is the basis on which results from sample surveys can be generalized to a larger population from which the sample was selected. Great scientific and practical advances have been made since the origins of modern survey research in drawing rigorous representative samples of populations. On the other hand, gaining cooperation and achieving high response rates have become more and more difficult and expensive (Groves 2006). There are two main forms of population sampling that have been used in sex surveys: household sampling used in face-to-face interviewing and random-digit dialing (RDD) used in telephone surveys. In addition, institutional-based sampling has been employed in surveys administered in schools, such as the Add Health study (<http://www.cpc.unc.edu/projects/addhealth>) and the state-based YRBS (Youth Risk Behavioral Surveys) (<http://www.cdc.gov/HealthyYouth/yrbs/index.htm>).

While for the purposes of demography and the study of sexuality in populations, probability methods are highly desirable and the focus of this chapter, it should be mentioned that non-probability methods are widespread in sex research. In large part, this is due to the need to study rare and/or hard to reach populations such as lesbians, gay men, bisexuals, and transgender persons. While these groups are present in representative population samples in the proportion of their distribution in the population, unless samples are very large, their relatively small numbers limit the researchers' ability to analyze their internal variation. For this reason much research on these populations has relied on convenience samples which make generalization beyond the sample studied impossible. The usefulness of this type of research is limited for the purposes of demographic research. Its greatest value is likely to be to suggest variables, hypotheses, and possible relationships that may be useful and testable in population studies (IOM 2011).

Drawing a sample—while perhaps the most statistically technically complicated problem of survey design—can usually be solved with the help of highly trained and proficient professionals. There are two main sources of sampling error: coverage and response rate. Coverage refers to the disjunction between the theoretical population of interest and the actual population from which potential respondents are drawn. For example, in household-based samples, persons who are not attached to households such as the homeless and persons in institutions are not included in the sample. Depending on the research question, this may be a more or less serious problem. At the very least, researchers have the responsibility to be transparent and explicit about the composition of the actual population studied. Careful consideration needs to be given to the threats to validity that research design decisions in this area pose. For example, what is the impact of not including persons not currently living in a household such as college students living in dormitories, persons serving in the military, or those incarcerated? Even though they may represent relatively small proportions of the populations, their inclusion may be crucial depending on the research question. If age is an important variable, the absence of a particular segment of the younger age groups, those away at college, may pose a serious problem. Given ample time and budget it might be possible to include them in the household roster even though they are not currently in the household, include them in the selection of respondents from the roster, and then make arrangements to interview them either in person or by telephone. If there is a concern that incarcerated populations are important, e.g., in a study of HIV/AIDS risk in minority populations, then a different research design may be necessary.

The other source of error which is a major concern in all surveys, and is especially important for surveys on sexual behavior, is gaining cooperation and participation of individuals selected via probability sampling methods (Groves 2006). No survey gains 100% cooperation and participation. Where this poses the greatest concern is if non-participation is related to variables of interest. For example, if it is

harder to get the cooperation of respondents who are more sexually active or more prone to certain types of sexual risk, the relationships found in the data may be distorted. The most serious problem is when respondents refuse to participate because of the substantive nature of the research and they differ systematically from the respondents most like themselves who do participate. This is often difficult to measure. Young men are the most difficult cases to contact and enroll in household and telephone surveys and are the population group with the lowest response rate. Increased effort to contact such respondents can improve their participation (e.g., through more household visits or phone attempts), but these efforts add cost. The problem of participation has been increasing over time and response rates in surveys have declined in general (Tourangeau et al. 2010; Pew 2012). There are a number of techniques for achieving the higher response rates including offering financial incentives. These can be effective but increase the cost of surveys.

Measurement Error

One of the greatest concerns in surveys of sexual behavior and practices is response or respondent error. Asking about sex in surveys is a classic example of a “sensitive question” that is likely to produce sources of error in reporting. Sensitive questions are those that produce the largest item non-response rates and are most subject to social desirability effects (responses skewed in the direction of social norms). Sexual behavior is a classic example, along with drug use, abortion, voting, and income. Income questions generally have the highest item non-response of any survey questions. Social desirability effects on illegal and/or highly disapproved behaviors produce under-reporting. Behaviors that are desirable such as voting or having a library card are over-reported. There is a fairly extensive survey research methodology literature on these questions (see Tourangeau and Yan 2007 for a recent thoughtful and thorough review of this literature).

While there is no way to eliminate these problems, there are techniques to reduce their impact. It has long been known that self-administered questionnaires where answers are not shown or known to the interviewer produce higher rates of reporting of sensitive questions (Fenton et al. 2001). One technique used in face-to-face interviews before the widespread use of computers by interviewers was to have respondents answer especially sensitive questions on a self-administered form and put these forms in a sealed envelope. This depended on the respondents having adequate reading and writing skills. With the expansion of the use of computer-aided interviewing, Audio-Computer Aided Self-Interviewing (ACASI) was developed. Used in face-to-face interviews, the respondent is given the computer which has questions and responses on the screen and an audio track that reads the question aloud. Respondents still need a minimal level of literacy to be able to select response categories (e.g., recognizing numbers or letters) and a degree of familiarity and comfort with computers. This technique tends to produce the highest reporting of socially undesirable behaviors, including sexual behaviors, and to reduce social desirability biases such as the tendency for men to report higher numbers of sexual partners than women (Turner et al. 1998). Another advantage of ACASI over the older form of self-administered paper and pencil forms is that computerized forms can incorporate and guide respondents through more complex skip patterns. A similar technique to ACASI has been developed for telephone surveys, T-ACASI or interactive voice response (IVR) (Cooley et al. 2000). The sensitive questions are administered by a recording rather than a live interviewer and the respondents provide their responses via the telephone keypad or by saying aloud the number corresponding to their answer.

ACASI represents an important advance to reducing response error due to social desirability, however it does not eliminate the need for careful attention to another set of issues and problems in survey questionnaire design. The

design of questionnaires and the application of established principles of question construction and survey design remain essential. In this area as well, there is an extensive literature and accumulated experience (Schaeffer 2000; Schwarz 1999; Sudman and Bradburn 1982; Sudman et al. 1996). The details and precepts of this literature are beyond the scope of this chapter. A couple of points can be made. First, it should be born in mind that answering questions about sex involves the same problems and processes as answering any questions about behavior: comprehension of the question, recall, and formulating a response. The clarity of the question and the minimization of cognitive burden in searching for and processing the necessary information to formulate an answer are as important to questions about sexual behavior as they are any other activity. Once engaged in an interview, respondents follow similar conventions of usual conversational exchange and these include trying to provide honest and useful information. Many of the well-known context effects in survey design, e.g., question order effects, effects of rating scales, etc. can be traced to respondents' attempts to use (often inadvertent) signals provided in questionnaires that lead them to infer the implicit expectations built into the questionnaire. For example, if the response categories for a question about numbers of partners in a given period of time imply low or high numbers, answers will tend to skew in the direction implied.

One issue that I believe is extremely important to the quality of data in any survey of sexual behavior is what I refer to as "framing." In a survey that contains questions about sexual behavior, we have to convince respondents that there is a good reason for them to share what might seem to be very personal and potentially embarrassing information about themselves. Respondents' willingness and motivation to do so depend to a great degree on their sense that there is a legitimate purpose for the survey. Establishing the scientifically and socially useful purpose of the research is crucial. Health has been the most common justification for asking questions about sexual behavior. Research on a pressing health

problem, such as reproductive health or sexually transmitted infections or HIV/AIDS, is likely to make questions about sexual behavior seem a legitimate topic, help gain higher participation, and may reduce under-reporting. Of course, this may appeal to some respondents more than others. Reassurance that it is important that all types of people selected participate, including persons who are not sexually active, is likely to be an important part of the explanation of the research purpose.

Belief in the confidentiality of responses in any survey is important and this is especially important in surveys on sexuality. The context of a survey can lend itself to this belief. There is a very reasonable expectation that the respondent will never see or hear from the interviewer again. The belief that the interviewer is in fact a sort of professional stranger can aid in respondents revealing information about themselves that they would not share with a person that they know and expect to see again.

Conclusion: The Future of Research on Sexual Behavior

Research on sexual behavior in representative population surveys has become much more common, especially since efforts mounted in the 1990s in response to the AIDS epidemic. What had been a relatively taboo subject exploded onto the international scene with the publication of the Kinsey reports in the post-World War II period, and then saw its funding by the Rockefeller Foundation withdrawn after congressional attacks in the 1950s. Sexuality research, accordingly, disappeared from the scientific scene for over 40 years (Kinsey et al. 1948, 1953; Gathorne-Hardy 2000). In 1993 and 1994, three national surveys of sexual behavior appeared almost simultaneously, in France, England, and the United States (Spira et al. 1993; Johnson et al. 1994; Laumann et al. 1994b; Hubert et al. 1998). In Britain and France the same teams have fielded follow-up versions of their original surveys approximately a decade later (Bajos et al. 2008).

While there has been no follow-up to the NHLS, there are a number of more recent surveys which include questions about sexual behavior. The 2005 National Social Life, Health, and Aging Project (NSHAP) grew out of the NHLS and is a longitudinal survey of older adults aged 57–85. A second wave was collected in 2010–11, including data on cohabiting spouses and romantic partners. Another important and useful survey is the National Survey of Family Growth (NSFG) which is quite large, and contains a substantial number of questions on sexual practices (oral and anal sex, same sex practices and partners, etc.) even though the main focus is on fertility and births. Since 2002, it includes both men and women aged 15–44 and, since 2006, it has changed to a continuous design which collects data on about 5,000 respondents per year. The National Longitudinal Study of Adolescent Health (Add Health) is a study of young people in grades 7–12 in the U.S. that began during the 1994–1995 school year; a fourth wave of data was collected in 2008. A recent study, the National Survey of Sexual Health and Behavior (NSSHB) of adolescents and adults aged 14–94 was carried out on an internet panel (Herbenick et al. 2010).

Representative population surveys that include questions about sexual behavior have finally become a standard practice and part of the social science data collection landscape around the world. The focus of these surveys is on relationships, health, and fertility and, compared to the Kinsey studies, cover a relatively restricted range of behaviors. At their core are usually questions about numbers of sexual partners, vaginal intercourse, oral and anal sex, as well as condom use and contraceptive practices. Same-sex as well as other sex partners and practices are now commonly included in all the surveys mentioned, but more exotic practices such as BDSM (bondage, discipline, sado-masochism), role-playing, sex toys, pornography, and fantasy are not included in population studies.

The data from these studies represent a powerful resource for demographic research. The data from all of the studies mentioned are publicly available to qualified researchers for secondary

analysis. The potential is beginning to exist for tracking changes in sexual behavior over time. The methodological and measurement problems discussed above remain, however, and further methodological research to better understand sources of error and bias is needed. Still, the studies mentioned are generally of very high quality and the ability to triangulate findings across studies and to look at changes in rates of reporting of sexual behavior and practices can contribute to a better understanding of sexual behavior within diverse segments of the population and over time.

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Best Practices: Collecting and Analyzing Data on Sexual Minorities

3

Laura E. Durso and Gary J. Gates

Introduction

High profile public policy debates about the rights of sexual minorities to enact legally sanctioned relationships, parent children, serve in the military, and live and work in environments free of harassment and discrimination have heightened the need for high quality scientific data on sexual minorities. The United States Federal Government's Healthy People 2020 objectives include a goal to, "improve the health, safety, and well-being of lesbian, gay, bisexual, and transgender (LGBT) individuals" (U.S. Department of Health and Human Services 2010). The document suggests that sexual minorities face health disparities linked to stigma, discrimination, and denial of their civil and human rights and notes the general lack of quality data that identifies sexual minorities and transgender individuals.

This chapter is largely an edited version of the report, "Best Practices for Asking Questions about Sexual Orientation on Surveys" (Williams Institute 2009), which presents findings from a multi-year effort of an expert panel of scholars from several disciplines in the health and social sciences. The document from which this chapter was adapted can be found at <http://williamsinstitute.law.ucla.edu/wp-content/uploads/SMART-FINAL-Nov-2009.pdf>.

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Fortunately, several private and some publicly funded surveys in the United States have begun to ask questions that allow identification of dimensions of sexual orientation and gender identity. These new data allow researchers to identify how sexual orientation and gender identity can predict health, social, and economic outcomes. Asking questions on sexual orientation and gender identity is necessary for scientific, practical, and policy purposes, and the research outlined in this chapter demonstrates that it is possible to include such questions without sacrificing data integrity or respondent retention. This chapter addresses many of the questions that arise regarding the inclusion of sexual orientation and gender identity questions on surveys, including what to ask, where to ask it, and how to analyze the data.

Why Ask Questions Designed to Identify Sexual Minorities

In ongoing public discussions about LGBT policy issues, the practical importance of good data that accurately describe the lives of sexual minorities and their families has become increasingly obvious. Discussions of civil rights, program evaluation, public health, and the delivery of human services must rely on sound facts and analyses that come at least in part from high-quality survey research. Facts about sexual minorities are often not available because specific questions

pertaining to sexual orientation and gender identity are not routinely included on surveys, leaving scholars, policymakers, and the general public to risk falling back on stereotypes and myths about the experiences and social situations of LGBT people.

Survey data gathered from probability samples is the source of a substantial amount of our knowledge about the family, health, economic, educational, and social status of individuals. Probability-based survey data are particularly important for assessing the need for and impact of public policies that address racial, ethnic, gender, or group disparities in important health and social outcomes. Unfortunately, data derived from probabilistic sampling techniques that allow researchers to assess whether and how life experiences differ by sexual orientation or gender identity are relatively rare (Institute of Medicine 2011). This has created a large scientific gap between what we know and what we need to know about sexual minorities.

Several private and some publicly funded surveys do ask questions that allow us to identify some dimensions of sexual orientation. Sexual orientation dimensions include sexual identity (thinking of oneself as lesbian, gay, bisexual, or heterosexual), sexual behavior (the sex of one's sex partners), sexual attraction (the psychological feeling of attraction or desire), or romantic partnership (having a same-sex spouse or unmarried partner) (Gagnon and Simon 1973). Questions about gender identity and gender nonconformity are less common, but such questions have been fielded in public surveys. For example, the Boston, Massachusetts, and Vermont Behavioral Risk Factor Surveillance Surveys (BRFSS) have included a question about gender identity (Massachusetts Department of Public Health 2007), as has the Boston Youth Survey (Almeida et al. 2009).

Studies clearly indicate that sexual minority status is often an important predictor of health and social outcomes. Therefore, the failure to identify individuals who consider themselves gay, lesbian, or bisexual and control for this status may lead to inaccurate conclusions about targeting health interventions or identifying risk

factors within this population. The evidence for this need encompasses a wide range of public policy domains. Family structure and forms have been changing in the United States and LGBT families are a part of the change. U.S. Census data have been particularly useful in showing that same-sex couples form families that often include children. Analyses of the 2009 American Community Survey (ACS) suggest that 19 percent of same-sex couple households include a child under the age of 18.¹ Gates and Ost (2004) demonstrate that same-sex couples live throughout the country and evidence a high degree of geographic diversity. Data from the 2010 U.S. Census indicate that same-sex couples are most likely to be raising children in states like Mississippi, Wyoming, Alaska, Idaho, and Montana.²

The extensive evidence of health disparities within the LGBT community is one reason that the Healthy People 2020 objectives include a focus on LGBT health. Research clearly demonstrates differences between heterosexual people and LGB people on a variety of measures of mental and physical health (e.g. Cochran 2001; Cochran et al. 2003; Dean et al. 2000; Diamant et al. 2000; Grant et al. 2011; Institute of Medicine 2011; Mays and Cochran 2001), and Ash and Badgett (2006) show that individuals in same-sex couples are less likely to have health insurance than those in different-sex married couples. Research also indicates that as a group, the health and well-being of transgender people may be among the poorest in the United States (Clements-Nolle et al. 2001; Fallis et al. 2000; Garofalo et al. 2006; Grossman and D'Augelli 2006; HIV Epidemiology Program 2000; Kenagy 2005; Kosciw and Diaz 2006; Lombardi et al. 2001; McGowan 1999; Xavier 2000), highlighting the need for surveys to assess both sexual orientation and gender identity or expression.

¹ Author analyses of 2009 American Community Survey Public Use Microdata Sample.

² Author analyses of 2010 U.S. Decennial Census data.

The need for better information about the LGBT population can also be documented within the corporate sphere. Many employers now view domestic partner benefits as an important component in maintaining competitive compensation packages. As a result, companies are interested in understanding possible take-up rates for such coverage in order to estimate costs both to the company and to employees (see Ash and Badgett 2006). Badgett (2001) also notes that corporate interest in defining and locating the LGBT consumer market has often relied on convenience samples that have likely inflated both the size and affluence of the LGBT market. For example, evidence suggests that gay men earn less than heterosexual men, while lesbians earn more than heterosexual women (Baumle and Poston 2011; Allegretto and Arthur 2001; Badgett 1995; Black et al. 2003; Blandford 2003; Klawitter and Flatt 1998). Recently, Conron et al. (2010) have reported that unemployment is more common among gay men than among heterosexual men, and among bisexuals compared to heterosexuals.

Finally, including questions to identify sexual minorities in population-based surveys is important to identify sub-groups within the LGBT community, such as LGBT youth. There is evidence that these youth often face pressure and prejudice in their school environment and from peers, and rates of certain risk behaviors, such as suicide attempts, are more common among LGBT youth (Remafedi 1990; Garofalo, 1998). Understanding the unique challenges that LGBT youth face is crucial to improving education environments and raising healthy young people.

The increased need for data on sexual orientation has highlighted the limitations of existing American data and the difficulty of generalizing published findings to the larger population. Despite the use of more sophisticated sampling techniques (e.g. stratified sampling, the use of social networks to recruit participants), there is no substitute for full probability sampling to draw conclusions about the population at-large. Thus the inclusion of questions relating to sexual orientation in such studies becomes imperative.

Measuring Sexual Orientation on Surveys: What to Ask

Conceptually, sexual orientation has three major dimensions—*sexual attraction*, *sexual behavior*, and *self-identification*. *Sexual attraction* is the sex or gender of individuals to whom someone feels attracted. It has been argued that attraction is the very essence of sexual orientation and that its inclusion is important in psychological, developmental, and other types of studies of public health (Cochran and Mays 2000; Russell and Joyner 2001). This may be particularly true of surveys of young people and those who are not sexually active (Saewyc et al. 2004). *Sexual behavior* defines the sex of an individual's sex partners, as not all of those with same-sex attraction engage in sexual activity with partners of the same sex or do so only with partners of the same sex (Laumann et al. 1994; Saewyc et al. 2004, 2009). *Self-identification* refers to how one identifies one's sexual orientation. Typically these responses include "gay," "lesbian," "bisexual," and "straight" or "heterosexual," though there is a small number of people who prefer other labels (e.g. "same-gender loving" or "queer").

It is important to note that self-identification can vary over time for some individuals and is heavily influenced by socio-cultural factors. Additionally, self-identification is also not always in concordance with the other dimensions of sexual orientation—sexual behavior and/or sexual attraction (Laumann et al. 1994; Saewyc et al. 2004). This discrepancy may be due to a number of factors, including stigma, laws and legal risks in some countries, cultural values, developmental changes, partner selection opportunities, and even economic considerations. Methodological factors which might impact the associations between sexual attraction, sexual behavior and self-identification include measurement error and variation based on the time periods asked about or implied in surveys. For example, a question which asks about an individual's sexual partners over the last 5 years may fail to accurately capture the self-identification and/or sexual attractions of a bisexual-identified woman who has been in a committed and monogamous relationship

for more than 5 years. The responses might suggest she is lesbian if she has a same-sex partner or heterosexual if she has a different-sex partner, however her attractions may be to both sexes.

The independent measurement of each of these three dimensions is likely to identify a somewhat different group of individuals and being aware of these variations when designing studies can improve the outcome. The best course of action to broadly explore sexual orientation in a given population is to measure all three dimensions outlined above. However, the use of multiple questions assessing different dimensions of sexual orientation may increase the burden on survey respondents, making their inclusion in large surveys at times unrealistic. In other cases, researchers may be most interested in measuring a specific dimension of sexual orientation. For example, a study of sexual health behaviors may assess only behavioral aspects of sexual orientation. Clearly defined study aims should dictate what questions to ask in a given survey.

Recommended Survey Items and Their Rationale³

Self-Identification

The following question was developed by researchers at the National Center for Health Statistics (NCHS)⁴ and provides clear response options that are generally comprehensible by adults. The question focuses only on identity self-labels rather than including another dimension such as attraction or behavior. Further, the

question uses the word “consider” to match the format of common questions assessing race and ethnicity, which do not use the words “race” or “ethnicity” in the question but rather allow the person to determine what the question is assessing through the offered response categories (e.g. Do you consider yourself to be: (1) Hispanic or Latino, or (2) Not Hispanic or Latino?). It is recommended to not include “sexual orientation” or “identity” in the stem of the question because the term “sexual orientation” is confusing to many respondents, just as the terms “race” and “ethnicity” can pose similar problems.

Recommended Item:

Do you consider yourself to be:

- (a) Heterosexual or straight;
- (b) Gay or lesbian; or
- (c) Bisexual?

In this question format, gay/lesbian and bisexual are assessed separately, allowing for analyses based on the combined or disaggregated categories. Including definitions for the terms used in the question, except in instances when a respondent does not understand the question, is not recommended. The use of “other” as a response category in population research is not recommended, as the subpopulation who would select this response is small and these data are often discarded, reducing sample size and lowering the power in a study. Rather than including a “don’t know” or “not sure” response category, it is recommended that researchers use a combination of items which would more clearly state why the respondent is not sure, such as including both “I am not sure yet,” and “I am not sure what this question means.” (Saewyc et al. 2004). The inclusion of a “prefer not to answer” response category is warranted as long as the choice is included on most other questions in the survey and sexual orientation is not inappropriately singled out.

A limitation of the use of this question format is that though the terms specifically reference the dimension of self-identification, a respondent’s own definition of the terms will potentially make reference to either attraction or behavior or both. In addition, Saewyc et al. (2004) have demonstrated that there is a risk of both false positive

³ These items are recommended for use in assessing the dimensions of sexual orientation for surveys of adults. For a discussion of the assessment of these dimensions among youth, please see the section of this chapter entitled, “Developmental and Cultural Considerations in Collecting Data on Sexual Orientation.”

⁴ Dr. Randall Sell and Dr. Kerith Conron worked with a team at NCHS to test the suggested question. Dr. Kristen Miller, Director of the Questionnaire Design Research Laboratory, designed and oversaw the testing. A manuscript discussing the findings is under review for publication.

responses (identifying as gay, lesbian, or bisexual when the term heterosexual would have been more appropriate) and false negative responses (identifying as heterosexual when gay, lesbian, or bisexual would have been more appropriate). This may be due to the misunderstanding of terms or the stigma of identifying as gay, lesbian, or bisexual. There is also evidence that heterosexual respondents have sometimes not thought about having or believe they do not have a sexual orientation (Katz 1995).

Sexual Behavior

The question below is worded to assess the behavioral component of sexual orientation by asking respondents to identify those with whom they have had sex in a given time period.

Recommended Item:

In the past (time period e.g. year) who have you had sex with?

- (a) Men only
 - (b) Women only
 - (c) Both men and women
 - (d) I have not had sex
-

It is recommended that surveys use the terms “sex” or “sexual experience” rather than “sexual intercourse,” as these first two are inclusive terms that imply a broad range of behaviors in which many people engage. Allowing respondents to use their own definition of what is meant by “sex” may result in wide variation within the sample (Miller 2002), but providing a definition is more likely to confuse than help a respondent. Sometimes a more precisely-defined term is appropriate for a given study, in which case it would be better to include a series of questions about specific behaviors rather than a single item using the more general term “sex.” The study aims should again guide the researcher in the choice of an appropriate time interval, keeping in mind that different intervals will capture slightly different subsamples within the population. When possible, it is better to vary the response option order by the sex of the respondent, placing the different sex option first, and varying the order of the other items in the surveys. As respondents tend to see the first answer as the default, always

listing men first may elicit some false positives among male respondents. Likewise, always including women first might generate false positives among women.

Other Acceptable Items:

Have you ever (or in the past X time interval) had sex with a female?

Yes

No

Have you ever (or in the past X time interval) had sex with a male?

Yes

No

These items break down the above single question into two items that may be easier for some individuals to answer and may also serve to reduce response bias associated with the presentation order of the response choices. The use of “ever” in the question stem may be less useful than clearly specified time periods, and researchers should take into account the study purpose and population before final selection of items.

Other Acceptable Items:

During the past (INSERT TIME INTERVAL), with how many different male partners have you had sex?

None

One

Two

Three

Four

Five

6 or more

During the past (INSERT TIME INTERVAL), with how many different female partners have you had sex?

None

One

Two

Three

Four

Five

6 or more

The main advantage of this approach is that it yields semi-continuous data, which is particularly useful when the number of sexual partners is an important consideration in studying behavior (e.g. assessing risk for sexually transmitted infections). It is limited to the extent that

it does not provide a measure of frequency of sexual behavior, so someone who has had sex with one partner once in the year and someone who has had sex with the same partner 365 days of the year will score the same on these measures (Sell 1996).

Sexual Attraction

The recommended item below is taken from the National Survey of Family Growth (NSFG). It is important to include each of these response categories since many people are attracted in varying degrees to people of both genders. As with the sexual behavior question, it is advisable to reverse the response categories when giving the item to men and women. For men “only attracted to females” should be the first response and for women the first response category should be “only attracted to males.”

Recommended Item:

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?

An alternative approach, presented below, allows the researcher to assess the absence of sexual attraction, as respondents can say no to both items.

Other Acceptable Item:

Are you sexually attracted to men?

Yes

No

Are you sexually attracted to women?

Yes

No

This set of questions may simplify the task for respondents and also avoids the problems inherent with the response ordering discussed with the previous question. This approach may also be particularly useful for surveys of adolescents, since some teens feel no sexual attraction until mid- or late-adolescence (Saewyc et al. 2004).

Transgender Status and Gender Nonconformity

As an umbrella term, “transgender” refers to people whose gender expression defies social expectations (Fineberg 1996). This definition is so broad that it likely encompasses gender non-conforming individuals who do not think of themselves as transgender. More narrowly, the term transgender describes a smaller group of people who experience incongruence between birth sex and gender identity (Gay and Lesbian Medical Association 2001; American Public Health Association 1999; Center for Substance Abuse Treatment 2001).

There are multiple approaches to identifying transgender individuals, including the use of questions designed to measure a respondent’s sex, gender, transgender status or gender expression. As the population of interest is small, avoidance of false positives and non-response is particularly important, and measures that include a definition of the term transgender may address this issue. The presence of multiple transgender response options in a measure of gender (such as transgender male-to-female, transgender female-to-male, and transgender) may provide enough information to reduce incorrect endorsement and confusion by non-transgender respondents. In addition, providing multiple response options will also enable subgroup analyses in larger samples. This may be useful because male-to-female and female-to-male individuals appear to have different health profiles (Clements-Nolle et al. 2001; Kenagy 2005). Given the lack of research evidence in this area, no one approach can be specifically recommended, however, there are measurement issues that should be considered.

A two-step approach to identifying transgender individuals would be to ask respondents to report both their sex (e.g. male, female, intersex) and their gender (e.g. man, woman, transgender etc.), though this has been shown to be confusing to non-transgender respondents (Conron et al. 2008a, b). A measure combining sex and gender has been tested by Conron et al. (2008a, b) in a small, racially/ethnically diverse group of adolescents. Respondents

were asked to select their “sex/gender” from several options: female; male; transgender male-to-female; transgender female-to-male; transgender (not exclusively male or female); not sure. Participants were accurately classified as male, female, or transgender, however, some transgender youth found the conflation of sex and gender confusing. A modified measure (Gender: male, female, transgender male-to-female, transgender female-to-male, transgender do not identify as exclusively male or female) was recommended for further testing.

An alternative approach involves directly asking participants if they are transgender, as was done in the 2006 Boston Youth Survey. In this self-administered survey, participants ($n=1,032$) responded to the question, “Are you transgender?” with 1.6% of respondents having answered yes, 86.3% answering no, 6.3% said that they didn’t know and 5.7% skipped the item (Almeida et al. 2009). Interviewer-administered telephone surveys of adults, such as the Boston, Massachusetts and Vermont BRFSS surveys, have included a definition of transgender in their assessments, which could reduce non-response rates among those not familiar with the term transgender. For example, the Massachusetts survey asks, “Some people describe themselves as transgender when they experience a different gender identity from their sex at birth. For example, a person born into a male body, but who feels female or lives as a woman. Do you consider yourself to be transgender? (yes, no)” (Massachusetts Department of Public Health 2007). The complexity of this measure may present comprehension problems for individuals with low literacy skill. A simplified version is under-going testing in Massachusetts: “When a person’s sex and gender do not match, they might think of themselves as transgender. Sex is what a person is born. Gender is how a person feels. Do you think of yourself as transgender? (Conron 2009).”

A third approach to assessing gender and gender nonconformity is the use of items designed to measure conformity between birth sex and gender expression (e.g. appearance or mannerisms). Clark et al. (2005) asked 40-75 year old heterosexual women and lesbians ($n=40$) to rate themselves on a

five-point bipolar gender expression scale: “How would you describe yourself? Would you say, very masculine ... very feminine?” This broadly worded question was shown to have several drawbacks. Women in the survey expressed confusion about whether they were being asked to report on how they see themselves versus how they believe others perceive them (2005). Additionally, participants were uncertain about whether they should answer the item in terms of their appearance or in terms of their mannerisms and personality traits. As a result, the authors recommended assessing different dimensions of gender expression separately.

Using a variation of this type of question, Ortiz-Hernandez and Granados-Cosme (2006) asked over 500 LGB adults in Mexico City to rate themselves as masculine and feminine relative to others of the same age and sex. Other items designed to assess gender expression rather than gender identity include those presented by D’Augelli et al. (2006), which asked participants if prior to the age of 12 they had been called effeminate (“sissy” or other taunts) if male or overly masculine (“tomboy” or other taunts) if female, and if prior to the age of 13 they had been considered too feminine or too masculine by parents.

In addition to research exploring ways to accurately identify transgender and gender nonconforming individuals, research is also needed on best practices to collect sexual orientation data from transgender respondents. In a small cognitive testing study (Austin et al. 2007), transgender adolescents expressed difficulty answering sexual orientation items because such questions are grounded in a binary gender system (degree of same-sex/same-gender versus different-sex/different-gender orientation). Garofalo et al. report that 47 percent of Chicago male-to-female transgender youth who reported sex with men ($n=50$) reported a homosexual sexual identity while 26 percent reported a heterosexual identity (2006), illustrating that some youth answered in terms of their birth sex while others answered in terms of their gender identity. A measure developed by Scout assesses sexual orientation and transgender status simultaneously. An interviewer asks: “Do you consider yourself to be one or more of the

following... straight, gay or lesbian, bisexual, transgender?" If a participant hesitates to select a response, the interviewer says, "You can name a different category if that fits you better." (Scout 2008).⁵

Recommended Survey Items to Accompany Questions About Sexual Orientation

Alongside items assessing the different dimensions of sexual orientation, it is important to gather information regarding respondents' marital status, partnership status, and cohabitation status. Doing so allows researchers to identify same-sex couples and explore correlates of relationship status and sexual orientation. Questions about marital status capture legal relationships, partnership questions allow respondents to identify romantic relationships, and cohabitation questions ask about living arrangements of adults, though as yet there is no consensus about the best approach to measure these differing types of relationships. There are therefore a number of issues to consider when designing questions on marital/partnership status and cohabitation.

When surveys have not directly asked about sexual orientation, data relating to respondents' marital, partnership and cohabitation status can be used as a proxy for sexual orientation, though doing so has limitations. Several large-scale surveys which have not asked direct questions about sexual orientation, including the U.S. Decennial Census and Current Population Surveys, the Canadian Census, and the BRFSS, have changed their marital status questions and response choices to include "living with partner" or a related category. In doing so, these surveys have provided a wealth of information for research on sexual orientation because researchers can use information on household sex composition to create samples of individuals in same-sex cohabiting relationships who are very

likely to be gay and lesbian couples (e.g. Black et al. 2000; Carpenter 2004, 2005; Ash and Badgett 2006; Carpenter 2008). However, this approach is unable to identify single sexual minorities or bisexual individuals not living with a same-sex partner, and may be more likely to miss sexual minorities who are widowed, divorced, or separated. Importantly, sexual minority couples who consider themselves to be married, or who are in some U.S. states legally married, are likely to be wrongly coded as heterosexuals if their sexual orientation is based solely on responses to marital status (sometimes explicitly so, as in Census 1990; see Gates et al. 2008 for a detailed description of this issue). Further, even minor measurement error at the population level in either or both of the items needed to extrapolate sexual orientation can result in much larger error variance in the derived sexual minority sample. Informal reports from other countries suggest that adding a separate option for new legal statuses (e.g. civil unions) might create a large false positive problem for unmarried heterosexual couples in particular, since the number of couples reporting such statuses far exceeds actual registrations.

There are additional issues in analyzing marital status questions among sexual minority populations. Traditional marital status questions will not allow researchers to identify same-sex domestic partnerships since many individuals in these partnerships either cannot get legally married (in most states in the U.S., for example) or choose not to marry for a variety of reasons. To try and overcome this issue and maximize the utility of this type of information, Carpenter and Gates (2008) recommend that demographers and survey researchers should: 1) measure marital status separately from both partnership and cohabitation; 2) separately measure current and former legal marital status; 3) add a civil union/registered domestic partner response to marital status questions; 4) collect a roster of the sex of all adults and children in the household as a check on data quality; 5) ask specific questions about the characteristics of the respondent's partner (e.g. sex, age, current/former legal marital status); 6) collect a detailed partnership and cohabitation

⁵ Information about the performance of this measure can be found at <http://www.lgbttobacco.org/resources.php?ID=19>.

history for each respondent; and importantly, 7) collect samples large enough to meaningfully describe gay and lesbian partnership experiences. By expanding the assessment of marital status beyond a single item, researchers will be able to more accurately identify the individual whom a respondent considers his or her partner, describe the characteristics of both persons in the relationship, and explore more fully the relationship histories of men and women who form same-sex partnerships.

Other Recommendations for Measuring Sexual Orientation

Overall, it is recommended that researchers always pilot-test questions when they are being used in new populations or are being asked in new settings, as questions may perform differently in different situations. It is also important that each wave of data collection in longitudinal surveys includes these same questions to better capture changes in sexual orientation or relationships over time. Finally, future modifications to measurement approaches are often necessary, as over time the construct of sexual orientation, like the construct of race, is likely to evolve.

Measuring Sexual Orientation on Surveys: How and Where to Ask

Careful consideration of the within-survey placement of items assessing sexual orientation, the chosen mode of how the survey will be conducted, the sampling methodology, as well as awareness of the possible influence of interviewer biases, may improve the quality of sexual orientation data collected by a given survey. Importantly, despite concerns about participant non-response and drop-off, substantial evidence suggests that questions designed to measure sexual minorities do not threaten respondents' willingness to participate in a survey. Respondents are not more likely to break-off their participation on surveys that include a sexual orientation

question (Case et al. 2006)⁶ and response rates for sexual orientation questions have been shown to be higher than rates for much more commonly included questions, such as income (e.g. Conron et al. 2008a).

Item Placement

Decisions about within-survey placement of questions assessing sexual orientation should be driven by survey goals and content, while being sensitive to the potential expectations of respondents. Placed in a relevant context, such as alongside questions about relationships, sexuality, AIDS prevention, reproductive health, love, social support or discrimination, the relevance of questions about sexual orientation may become more understandable to respondents. Care should be taken to ensure that questions about sexual orientation or same-sex sexual behavior do not directly follow questions about sexual violence or abuse, as studies using self-administered surveys among adolescents found higher non-response rates when the questions came after an abuse question (Saewyc et al. 2004). It is not recommended to use a lead-in statement or introduction to questions about sexual orientation, as this might send the message that this type of question is sensitive or may cause discomfort.

Placement of questions may be directly related to survey mode, such as the inclusion of questions about sexual orientation in a stand-alone module in surveys using audio computer-assisted self-administered interviews (ACASI) for sensitive topics. Careful consideration of question placement and survey administration should be given when a particular survey mode may threaten respondent anonymity or confidentiality. For example, many paper and pencil surveys of young people place their demographics questions at the beginning of the survey, meaning

⁶ In addition, researchers affiliated with the NSFG and the National Epidemiologic Survey on Alcohol and Related Conditions indicated the same finding about the break-offs to the expert panel convened to facilitate the development of the report upon which this chapter is based (<http://williamsinstitute.law.ucla.edu/wp-content/uploads/SMART-FINAL-Nov-2009.pdf>).

that most students are still on the same page when the sexual orientation question is viewed. As a result, when administering large-scale surveys in school-based environments, it is imperative that classrooms have enough space for students to complete the survey in relative privacy or that strategies are used to prevent others from looking at answers (e.g. using cover sheets or screens).

For most surveys, however, placement of questions should vary according to survey content. For example, it would be straightforward to add questions about recent (e.g. within the past year or within the past five years) and lifetime same-sex sexual behavior to modules which ask questions about HIV-related sexual behaviors, such as condom use and number of sexual partners. This approach has been successfully used by the Los Angeles County Health Surveys, state BRFS efforts (e.g. Connecticut), and both U.S. and Canadian school-based surveys. Questions about sexual orientation identity may be placed in a module of standard demographic characteristics such as race or citizenship, as has been done successfully in the 2001 California Health Interview Survey (CHIS), the Canadian Community Health Surveys, and the U.K.'s Integrated Household Survey trials. Assessment of same-sex sexual attraction, which research shows is more prevalent than either same-sex sexual behavior or a minority sexual identity (Laumann et al. 1994), may be done through the inclusion of a "sexual orientation" module, that includes distinct questions about attraction, behavior, and self-identity. The National Epidemiologic Survey on Alcohol and Related Conditions II and the NSFG both take this type of approach using modules placed at the end of each survey.

There is no published recommendation regarding the optimal order in which to ask about multiple aspects of sexual orientation, though most surveys that ask about more than one aspect of sexual orientation in the same section generally ask about self-reported identity last. Survey administrators should also consider the order of skip patterns within a survey, making sure that these patterns do not unintentionally skip people out of a series of sexual orientation identity questions. For instance, if a survey asks first about

sexual behavior and then about sexual identity, it is important that sexual abstainers are not skipped out of the entire section, since people who do not exhibit sexual behavior are still likely to report a valid sexual orientation identity response.

Survey Mode

Surveys typically choose among a wide variety of modes, including paper and pencil or web-based self-administered questionnaires (SAQ), paper and pencil personal interviews (PAPI), computer-assisted personal interviews (CAPI), audio self-administered questionnaires from tape recorders (audio-SAQ), computer assisted self-administered interviews (CASI), audio computer-assisted self-administered interviews (ACASI), and telephone audio computer-assisted self-interviewing (T-ACASI) (Tourangeau and Smith 1996). Given that LGBT individuals are socially stigmatized and disclosure of a sexual minority orientation can have meaningful, negative consequences in a variety of social spheres, ensuring the privacy of respondents should be the guiding principle in making determinations about item placement and survey mode.

Several studies suggest that self-administered questionnaires enhance respondents' sense of privacy and their willingness to report sensitive information (Gribble et al. 2000; Tourangeau and Smith 1996; Villarroel et al. 2006). However, these modes may involve other trade-offs that researchers will want to consider (see Gribble et al. 1999). For example, paper and pencil SAQs do not allow for complex skip patterns or for consistency checks, and they require a degree of literacy and comprehension that might be problematic for some respondents. Their use may also result in higher levels of non-response on sexual orientation questions (Taylor 2008). However, paper and pencil SAQs are generally less expensive than other more advanced methods of data collection, whose costs may be prohibitive.

If a survey is conducted by telephone only, there may be ways to increase response rates

and improve data quality regarding sexual orientation. Respondents may be given the option to press numbers on the telephone or state response options such as “A”, “B”, or “C” instead of having to say aloud the sexual orientation labels. Similar approaches can be used for in-person interviews, such as using response cards. These and other alternative methods have been used to ask sensitive questions regarding sexual behavior, illicit drug use, abusive situations, and abortion (see Barbara and Doctor 2007).⁷ Ideally, information on the setting and circumstances of an in-person or telephone interview, such as whether another person was present in the room when the respondent answered, should be noted.

Where possible, surveys using individual telephone and in-person interviews should provide training to interviewers who will ask questions about same-sex sexual attraction, same-sex sexual behavior, or sexual orientation identity. Though limited published evidence exists about the difficulty interviewers may have in reading questions related to sexual orientation, there exists the possibility for large interviewer effects. The Office for National Statistics in the United Kingdom conducted a series of trials of sexual orientation questions to study which questions and procedures would work best in household surveys in that country (Taylor 2008). Their findings showed that despite receiving specific instructions on when it was permissible to omit the sexual orientation module, interviewers skipped the question in 15 percent of interviews, often for reasons beyond privacy or logistical concerns. Interviewers often cited their personal belief that it was inappropriate to ask these questions of older people or that they had received a negative or confused reaction from respondents. Interviewers also reported that in some circumstances, respondents asked for further explanation of questions, suggesting

the need for training of the appropriate responses to such requests.

Training of interviewers should help contextualize the reasons for asking questions about sexual orientation so that it does not seem arbitrary or capricious to an interviewer (see, for example, Haseldon and Joloza 2009). The training should help interviewers understand that the survey team has decided that it is important to collect this information and it is the interviewers’ professional responsibility to collect it. Whatever interviewers may feel about asking these questions, they need to be able to ask in a way that implies no bias, shame, discomfort, or prejudice to the interviewee that could affect answers to the questions. Some of the ways to do this are to emphasize interviewers’ professionalism, talk about question placement, or conduct role playing or practice examples. Interviewers should be prepared, if asked, to reiterate the privacy protections afforded a respondent and whether the survey data are confidential or anonymous. An interviewer may also want to know how to reply to a respondent who asks, “Why do you need to know that?” and training should help the interviewer be able to give a brief answer to that question. Training should also aim to normalize the process of answering the questions and allow for some form of practice to ensure interviewer comfort. Role playing in particular is a useful method for normalizing the asking of a difficult question. The process of having an interviewer say the question to another person can help them overcome any hesitancy, difficulty with the words, vocal expressions that may communicate bias, or anything else that might convey stigma or reluctance to the interviewee. This method would also allow interviewers to be more specific about any concerns or difficulties they have with the question.

Providing high quality training on these questions depends upon finding qualified trainers. If experienced trainers are not available, a substitute would be providing training materials with background on the growing number of places where this question is asked, what refusal rate may be expected, and educating interviewers

⁷ See, for example, the Research Triangle Institute web site at <http://www.rti.org/page.cfm?objectid=B4634C77-0F07-45CC-96B00E2C2CF7D766>

about the lack of survey break-off among respondents being asked these questions.

Sampling Issues

When developing sampling strategies for identifying sexual minority populations, researchers should take care in designing and choosing screening questions and should look to use items that capture a broad range of individuals with same-sex sexual behavior and LGBT identities. Further, when the population from which a sample is taken is small, such as the adult population of transgender individuals (estimated to be 0.5-1.2% of the adult population⁸), simple random sampling approaches will fail to identify enough people for analysis unless the sample size is quite large and/or repeated over time. In these cases, stratified sampling and innovative methods (e.g., respondent driven sampling) to sample minority populations may be needed.

Consideration of sampling strategies is particularly important when researchers are interested in studying racially and ethnically diverse samples. In studies aimed at recruiting LGBT individuals, there may be stark racial/ethnic differences in the likelihood of being recruited into studies or willingness to participate. These concerns might be pronounced for racial/ethnic minority LGBT people who are more attached to their racial/ethnic communities, those who are less likely to reside in or socialize in mainstream LGBT areas or contexts, as well as those who do not identify as LGBT. Moreover, distrust that is rooted in histories of human subjects abuses—often expressed by communities of color toward researchers—complicate assumptions inherent in random sampling methods within large population-based surveys.

The use of sampling strategies that take advantage of gay enclaves (Gates and Ost 2004; Carpenter and Gates 2008) can lead to under-

representation of some racial-ethnic groups within sexual minority samples. Research has begun to develop sampling methods that are more attentive to the various ways LGBT people of color and lower income LGBT people organize their social and sexual lives, for example, modified chain referral, venue-based and time-space sampling techniques (Díaz et al. 2004; Ramirez-Valles et al. 2005, 2008). Follow-backs, oversampling, and better quality purposeful or convenience sampling are some recommended strategies for addressing these challenges. Determining an appropriate sampling strategy for survey work involving LGBT persons from different racial/ethnic groups may require ethnographic mapping and other qualitative formative research.

Developmental and Cultural Considerations in Collecting Data on Sexual Orientation

Designing and utilizing questionnaires that are developmentally and culturally appropriate present unique considerations for researchers gathering population data on sexual orientation. This next section highlights several issues in asking questions about sexual orientation among young people, older adults and non-White racial/ethnic and cultural groups.

Adolescents

Sexual orientation questions have been included on surveys of adolescents for more than twenty years and much is known about how and when to ask questions of this group. The earliest inclusion of sexual orientation questions in surveys was for assessments of school-based youth in the U.S. In 1986, the Minnesota Adolescent Health Survey included sexual orientation questions (Remafedi et al. 1992), followed by the Massachusetts and Seattle Youth Risk Behavior Surveys in 1995 (Reis and Saewyc 1999), and ADD Health Wave 1 in 1995 (Russell and Joyner 2001). In Canada, the first questions were asked in 1992 in the

⁸ Based on personal communications, R. McCormick, Dir. Vermont BRFS, March 5, 2007; M. Ostrem, Research Dir., Boston Public Health Commission, Boston BRFS, March 21, 2007.

Adolescent Health Survey of British Columbia (Peters et al. 1993). Other countries have followed suit, including a recent effort in the United Kingdom (Haseldon and Joloza 2009).

What to Ask

If survey constraints allow, the best course of action for studies of adolescents may be to measure attraction plus one of the other dimensions of sexual orientation, either self-identification or behavior. That being said, the purpose of the study should always guide final decision-making regarding item selection. In studies of adolescents, self-identification is often not the best choice for a single measure of sexual orientation, particularly given evidence that young people may be less familiar with the term heterosexual than with gay or lesbian (Austin et al. 2007). If only one dimension can be measured, attraction may be a better choice because many adolescents are yet to be sexually active (Saewyc et al. 2004).

Use of Terms

For adolescent surveys, asking questions about sexual behavior using a more precisely defined term than the term “sex” may be problematic. Specifically asking about penile, vaginal, oral, or anal sex in adolescent surveys may cause some school districts or parent groups to become uncomfortable with researchers using these terms with young people. On the other hand, not defining the term “sex” may be problematic for the adolescent respondents, as some youth do not know if “oral sex” means kissing, or what anal sex is. Including such precise terms can result in school districts or youth services delivery sites refusing to participate, and researchers should test the acceptability and face validity of the question content first. As with samples of adults, the use of items assessing the behaviors of interest is preferable for studies focused on types of sexual behaviors (e.g. sexual risk behaviors). For questions related to sexual behavior, the use of the term “ever” is appropriate to denote the time period of interest, as the majority of adolescent respondents are not sexually experienced.

Researchers should keep in mind that the experiences of adolescents and young adults may impact the ways in which they respond to and understand questions. For example, adolescence is the time when sexual orientation-based harassment is the most prevalent. The stigma associated with specific identity labels may reduce response rates or increase false responses, unless care is taken to ensure privacy and anonymity during survey administration.

Older Adults

Compared to studies of adolescents and middle-aged adults, few data relating to sexual orientation are available for older adults. For example, the 2002 NSFG only presented questions about sexual orientation to adults ages 18-44. The CHIS only administers questions about sexual orientation to adults ages 70 and younger. As a result, there is little understanding of how older adults comprehend and respond to questions about sexual orientation. At least one study has found that older respondents do not understand the term heterosexual (Haseldon and Joloza 2009). It may be that terms like heterosexual, homosexual, straight, and gay are not part of everyday language for older respondents. As a result, older respondents may select “Other” or not respond to questions assessing sexual orientation. Thus, researchers should be cautious when analyzing older age cohorts in surveys designed for middle-aged results.

Race/Ethnicity and Culture

The context of racial/ethnic diversity leads to additional methodological considerations related to the generalizability of sexual orientation measures and highlights the need to collect better data to study interactions among race/ethnicity, culture, and sexual orientation. Evidence for important variation in the relationship between sexual orientation identity and racial/ethnic or cultural identities can be seen in variance regarding terms used to describe sexual minority status. In many African-American

communities, the term “same-gender loving” is used to describe a same-sex sexual orientation (Boykin 1996, 2005; DeBlaere et al. 2010). Native Americans have a tradition of “two-spirit” that is associated with both same-sex sexual orientation and gender non-conformity (Adams and Phillips 2009). Measuring sexual orientation in Spanish can be challenging given a lack of non-pejorative terms to describe same-sex sexual orientation.

Measurement

Independent of the operationalized definition of sexual orientation or the accuracy of translating survey items into new languages, differences in relationships and sexual practices around the world call into question the cross-cultural equivalence of sexual orientation as a social construct. This may result in cultural differences in response patterns, and any observed differences among cultural groups may simply be artifacts of questionnaire design, differences in item interpretation, and/or interviewer effects. In addition, research demonstrates that categories of sexual orientation identities that have been historically developed in gay White contexts may be less culturally relevant among non-White groups (Carballo-Diéguez 1989; Centers for Disease Control 2000; Chauncey 1994; Ford et al. 2004; McKirnan et al. 1996; Wolitski et al. 2006; Zea et al. 2003). For example, there are no culturally equivalent words for “gay” in Spanish or in most Asian languages (Carballo-Diéguez 1989; Zea et al. 2003).

What to Ask

Foremost, sexual orientation survey items should be culturally appropriate, relevant, acceptable, and compatible with the respondent’s understanding of the construct that the question is intended to measure. In particular, using only measures related to identity and excluding other dimensions of sexuality, such as desire and behavior, may potentially lead to under-representing sexual minorities among non-White or non-U.S.-born populations. Research suggests that individuals might report same-sex sexual behavior or attraction without having a LGB identity (e.g. Centers for

Disease Control 2000; Laumann et al. 1994; McKirnan et al. 1996). Previous studies have also found that Black and Latino men who have sex with men (MSM) were less likely to identify as gay compared to White MSM (McKirnan et al. 1996; Centers for Disease Control 2000). A more recent study found that of participants who reported engaging in same-sex behaviors, Whites were more likely to identify as LGB compared to other racial/ethnic groups. Similarly, foreign-born participants were less likely to identify as LGB compared to U.S.-born participants (Chae et al. 2009).

The implications of different racial/ethnic group mappings of behavior or attraction onto sexual identities are important for several reasons. First, as suggested here, research findings of health disparities or economic differences between LGB-identified individuals and heterosexual-identified individuals might not be applicable to all racial/ethnic sub-groups. Second, the disparities or differences based on sexual orientation might be even larger if assessed using a different measure of sexual orientation that captured a more racially/ethnically diverse group. Third, larger studies of samples of sexual minorities, broadly defined, will need to be carefully constructed to avoid excluding some racial/ethnic groups.

Factors Influencing Identity Formation

It is incumbent upon researchers to understand factors that mediate the choice of identity categories among racial/ethnic minority LGBT individuals, particularly discrimination and acculturation. Measures of those constructs could include community participation, affinity, and adoption of values shared by the mainstream LGBT (mostly White and middle-class) community (Zea et al. 2003). Chae and Ayala (2009) have reported several socio-demographic correlates of LGB identification, including ethnic ancestry or national origin, gender, and socioeconomic factors. Measuring and accounting for these additional factors provides a frame through which study findings about sexual orientation and the variability of constructed sexual identities can be better understood.

Best Practices For Analyses of Sexual Orientation Data

Researchers undertaking responsible analysis of sexual orientation must be cognizant of several important factors that have been shown to potentially distort or misrepresent important nuances in these data. A growing body of research analyzing associations between sexual orientation and a wide variety of social and health outcomes suggests that the best research requires several important practices, discussed below.

Consideration of Differences among Non-Heterosexual Responses

It is important to keep in mind that data from several research studies and prominent surveys suggest the existence of distinct subgroups within the non-heterosexual population. For example, in the 2002 NSFG (Mosher et al. 2005), 2.3 percent of men aged 18-44 identified as “homosexual”, 1.8 percent as “bisexual”, and 3.9 percent as “something else.” Of those men who identified as homosexual, nearly three-quarters said they were mostly or exclusively sexually attracted to other men and, conversely, about a quarter reported a primary attraction (mostly or exclusively) to women. Among bisexual men, more than half said they were primarily attracted to women, about a third said they were equally attracted to men and women, and only 11 percent reported a primary attraction to men. Among those classified as “something else,” more than 87 percent reported a primary attraction to women.⁹ In the same survey, 1.3 percent of women in the same age group identified as “homosexual”, 2.8 percent as “bisexual”, and 3.8 percent as “something else.” Note the very different distribution across these identities as compared to men. The women were much more likely to identify as bisexual than the men. Like men, women identifying as lesbian are much more likely to be primarily

attracted to women than are bisexual women, and 85 percent of the “something else” group is primarily attracted to men. In the 2005 CHIS, findings suggested more than a third of those identifying as “not sexual/celibate/none/other” say they are currently married, compared to less than 3 percent of those identifying as lesbian or gay. More than half have not completed high school. They are also twice as likely as heterosexuals to be senior citizens and to not speak English well. Clearly, these are potentially very different groups who likely have distinctly different sexual behaviors and demographic characteristics. These differences will impact subsequent analyses and the interpretation of data.

As a result, researchers should never assume that respondents who choose “I don’t know” or “something else” as an option in a sexual orientation question are gay, lesbian, or bisexual. Indeed, as discussed above, most surveys demonstrate that these individuals appear to be primarily heterosexual in terms of attraction and behavior. They may be selecting the “something else” type of option because they do not understand the question, an outcome that is likely a product of other demographic characteristics including age, language ability, and education level.

In addition to finding differences between individuals identifying as LGB and those identifying as “something else,” research has demonstrated that demographic and economic characteristics and outcomes can vary between gay/lesbian and bisexual identified groups. For example, Albelda et al. (2009) studied poverty using the 2003/2005 CHIS data and showed that bisexual women are more than twice as likely as lesbians to be in poverty. Bisexual men are more than 50 percent more likely than gay men to be in poverty. In addition, Carpenter (2005) used the 2001 CHIS to show that, while there was not a statistically significant difference in earnings between gay men and lesbian women and their heterosexual counterparts, there was evidence suggesting that bisexuals earn less than heterosexuals.

Differences in outcomes have also been noted depending on how the category of “lesbian” is defined. Badgett (1995) analyzed General Social

⁹ Based on author calculation of the 2002 NSFG public-use data file.

Survey (GSS) data from 1989-1991 and found that behaviorally lesbian women (those who report some same-sex sexual partners) earn less than other women. Black (2003) also analyzed the GSS data (adding data from 1993, 1994, and 1996 to the sample used by Badgett) and used a much more restrictive definition of a lesbian sexual orientation - women who have only had same-sex sexual partners in the last year. They found that defining lesbian in this fashion yields a 20 percent wage premium for lesbians relative to other women. These examples highlight the importance of a careful consideration of how sexual orientation is defined and assessed in a given survey. They also suggest that whenever the size of subgroups allows, bisexuals should be analyzed separately from lesbian and gay respondents and differences between men and women should be explored.

Survey Methodology and Measurement Reliability and Validity

When reporting and analyzing results, researchers should consider how the survey was administered and any effect the mode and other survey features might have on responses. For example, based on Villarroel et al. (2006) findings that telephone computer-assisted survey methods dramatically increased the reporting of same-sex attraction and behavior, we would expect that an in-home, in-person survey would find a lower incidence of same-sex sexual behavior, attraction and sexual orientation than a survey conducted without a human interface. This could distort differences observed among groups identified based on sexual orientation. Researchers should also consider the effects that question placement could have on how individuals respond. Context can matter and individuals are likely to respond quite differently when surrounding questions do not somehow signal stigmatization of the sexual orientation or behavior questions.

Small sample sizes and missing data present additional problems for researchers, who may be tempted to consider methods of imputation to increase the study power. Respondents who do

not answer one type of question often do not answer a host of other sensitive questions, meaning that these data are likely not missing at random. Any manipulation of missing responses should consider patterns of missing data rather than simply considering a single item. Similar to “don’t know” responses to sexual orientation questions, researchers cannot safely categorize those not answering these questions as being within or outside of sexual minority groups.

Demographic Subgroup Analyses

Substantial differences in characteristics of sexual minorities exist across a variety of demographic sub-groupings. Researchers should be aware that attributes ascribed to the LGBT community are primarily associated with White LGBT individuals, since they represent the largest racial/ethnic grouping within the population. Clear differences in family structure and demographic, economic and geographic characteristics exist across racial and ethnic groups and these should be considered in the data analytic plan whenever sample sizes permit.

For example, Gates (2008) shows that African-American, Latino/Latina, and Native American individuals in same-sex couples are substantially more likely to be raising children than their White counterparts—in some cases, two to three times more likely. Gates and Ost (2004) show substantially different geographic distributions for African-Americans and Latinos in same-sex couples compared to the broader distribution of all same-sex couples. While states like Vermont, California, Washington, Massachusetts, and Oregon had the highest concentration of all same-sex couples in 2000, the rankings were quite different for couples that included an African-American or Latino/a partner. The top five states for concentration of couples with an African-American partner were Mississippi, Louisiana, South Carolina, Georgia, and Maryland. For those with a Latino/a partner, the highest ranked states were New Mexico, California, Texas, Arizona, and Nevada.

Several studies also show that non-White people in same-sex couples experience many of

the same economic disadvantages as do their counterparts in different-sex couples. Gates and Ramos (2008a, 2008b) show that African-American and Latino/Latina individuals in same-sex couples have lower education, income, and home ownership rates than the broader LGB community in California. Badgett et al. (2006) show evidence of a “double disadvantage” for African-American gay men, as their wages are lower than both Black heterosexual men and White gay men.

Socio-political and Policy Issues

The many high-profile public policy debates about the rights and lives of sexual minorities places a special responsibility on researchers to be conscious of how findings might be used in the public domain. While researchers cannot completely avoid others drawing inappropriate conclusions from reported findings, providing context is one important way that such circumstances can be minimized. For example, providing rates of reported behaviors among other demographic groups can be a way to contextualize whether the incidence of a particular behavior is notably high or low among sexual minorities. This is particularly important when findings involve illegal or stigmatized behaviors among sexual minorities, a group often already stigmatized by their sexual and gender identities and behaviors.

Another example of providing context involves research using data on same-sex couples. Carpenter and Gates (2008) show evidence of different effects of sexual orientation for coupled and single LGB individuals. Researchers should remind readers that analyses of couples may give biased predictions if readers attempt to apply findings to non-coupled individuals.

While we do not advocate researchers censoring potentially unflattering or controversial characteristics of sexual minorities, researchers can make an effort to provide appropriate context that can limit inappropriate use of data analyses in public discussions about LGBT issues.

Temporal Issues

Because of small samples, researchers might be tempted to combine data over several points in time to increase sample sizes. While this may be entirely appropriate based on the stated research question, caution should be taken when combining small samples collected over relatively long periods of time. For example, Carpenter (2005) showed that when combining GSS data across several years, results were sensitive to the time periods used to determine the sample. One reason for this is that sexual identity, attraction, and behaviors can change in relation to changing social norms and can be different across age cohorts. In addition, the willingness of individuals to report same-sex experiences or LGBT identities might increase over time. Researchers should consider the sensitivity of results to different combinations of data gathered over extended time periods.

Additional issues arise when considering the time periods specified in survey items. Relying on responses to questions about past sexual behavior in order to identify sexual minorities has several limitations. Researchers should be cautious when using data in which respondents are asked about behaviors for longer reference periods (e.g. lifetime versus a five year window). Longer time frames may yield substantially more variation in sexual behavior than shorter time frames and might also result in decreased accuracy of responses when individuals are asked to recall behaviors over a longer span of time.

The overlap of sexual behavior and sexual identity may be subject to temporal issues as well. Research suggests that more recent sexual behavior is likely a stronger indicator than past behavior of how individuals currently perceive their sexual orientation identity. Black et al. (2000) find more concurrence between recent same-sex sexual behavior (in the last one year or five years) and a gay/lesbian identity than between lifetime sexual behavior and current identity. When possible, researchers should construct measures that are temporally appropriate and carefully map the timing of influence between sexual orientation and other outcomes.

Measurement Error

When conducting analyses of data from very small subgroups within a larger sample, the problem of false positives is a common and potentially significant problem. The false positive problem occurs when errors made by those in a large population potentially misclassify individuals into a very small population. As the ratio between a large and small population increases, small errors among the large population that introduce incorrect observations into the small population have the increasing potential to substantially contaminate the small population of interest with misclassified individuals.

One example of this type of measurement error comes from the U.S. Census tabulations of same-sex couples (as described in more detail by Gates and Ost 2004; Black et al. 2007). Census Bureau coding procedures recode any same-sex “husband” or “wife” from the household roster as an “unmarried partner.” As a result of this procedure, any different-sex married couples that inadvertently miscode the sex of one of the spouses are coded as same-sex “unmarried partner” couples.¹⁰ Given the 90-to-1 ratio between married and unmarried partners in the census, even rare sex miscodes could significantly contaminate the same-sex couple sample with different-sex married couples. O’Connell and Feliz (2011) suggest that 40 percent of same-sex couple in Census 2000 and 28 percent of those in Census 2010 were likely different-sex couples who miscoded the sex of one of the spouses or partners.

Given that sexual minorities often represent less than 5 percent of the population, the false positive problem should always be considered in working with such data. Researchers should be vigilant in considering the degree to which errors in the larger population could yield to misclassification into the smaller population.

¹⁰ Beginning with the 2008 ACS, the Census Bureau has changed both the survey and post-data collection editing techniques. These changes will likely reduce the rate of sex miscoding among different-sex spouses.

Other Issues and Future Directions

As identified in this chapter, there are many issues for researchers to consider when gathering and analyzing data related to sexual orientation identities, same-sex sexual behavior and same-sex attraction. More research is needed to better understand how attraction and behavior are mapped onto sexual orientation identities, as well as additional research exploring the influence of age, race/ethnicity, culture and other factors on sexual behavior and self-identification.

Sexual orientation measurement has been challenged by questions about the politics of inclusion, exclusion and representation. Only a few of the issues and questions raised include:

- Who gets to be defined as LGBT and who gets left out of a definition of a community?
- How should the multiplicity of identification and its relationship to social discrimination be handled in research on sexual minority populations across race, ethnicity, culture and class lines?
- How does sexual orientation identity map to gender identity and expression?
- How should we handle data when there is an apparent incompatibility between identity and behavior?
- How should we approach sexuality measurement of people of color and working class people given that these groups are grossly over-represented in the prison system and among people living in poverty, both in the U.S. and around the world?

Further research in this area may require extensive qualitative work in advance of future population-based survey research.

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Part II

Sexual Practices: The Global Picture

Sexual Behavior, Sexual Attraction, and Sexual Identity in the United States: Data from the 2006–2010 National Survey of Family Growth

4

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Introduction

This chapter presents national estimates of several types of sexual behavior among men and women 15–44 years of age in the United States in 2006–2010, as well as measures of sexual attraction and identity for adults 18–44. These behaviors and characteristics are relevant to birth and pregnancy rates, as well as the incidence of sexually transmitted infections (STIs), including human immunodeficiency virus (HIV), the virus that causes acquired immune deficiency syndrome (AIDS) (CDC 2010a; Weinstock et al. 2004; Ventura et al. 2009). The Centers for Disease Control and Prevention (CDC) estimates that about 19 million new cases of STIs occur in the U.S. each year (Weinstock et al. 2004). About half of all STIs occur among persons 15–24 years of age, and the direct medical cost of these diseases to 15–24 year olds alone was estimated at \$6.5 billion in the year 2000 (Chesson et al. 2004). In 2008, CDC estimated that rates of chlamydia increased, and the largest numbers of reported

cases of chlamydia and gonorrhea were among teenagers ages 15–19 (CDC 2009). These recent data also suggest there were significant racial disparities in the rates of reportable STIs in the United States in 2008, particularly among teens and young adults. Among women, black teens ages 15–19 had the highest rates of chlamydia and gonorrhea, followed by black females ages 20–24 (CDC 2009).

Approximately 50,000 Americans are diagnosed with HIV infection each year (Hall et al. 2008), and over one million Americans are currently living with HIV/AIDS (CDC 2010a). Although currently available medications have substantially increased the life expectancy for persons with HIV (Bhaskaran et al. 2008), the medical costs are substantial, averaging approximately \$20,000 per year for each person receiving treatment (Gebo et al. 2010). These infections not only affect the 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 (CDC 2010a).

Two previous reports on sexual behavior, sexual attraction, and sexual identity have been published from the 2002 and 2006–2008 NSFG (Chandra et al. 2011; Mosher et al. 2005). This

The findings and conclusions in this paper are those of the authors and do not necessarily represent the official position of the National Center for Health Statistics, Centers for Disease Control and Prevention.

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chapter presents the latest national data from the 2006–2010 NSFG on the following topics:

- Types of sexual behavior (including opposite-sex and same-sex partners) among persons 15–44 (Tables 4.1 and 4.2; Fig. 4.1)
- Numbers of opposite-sex sexual partners in lifetime for persons 15–44 (Tables 4.3 and 4.4)
- Same-sex sexual activity among persons 15–44 (Table 4.5)
- Sexual identity among persons 18–44 (Tables 4.6 and 4.7)
- Association of sexual behavior, sexual attraction, and sexual identity (Table 4.8)

Improvements were made in some of the questions in the NSFG and some new items have been collected on these topics to improve the utility of the data. Selected comparisons with Cycle 6 (2002) NSFG are made to suggest whether any marked trends have occurred.

Selected Previous Studies

In addition to the NSFG, several nationally representative studies of sexual behavior have been conducted in the United States in the last 2 decades. These surveys were based on in-person interviews, using national probability samples, and include:

- The National Survey of Men (Billy et al. 1993; Leigh et al. 1993), conducted in 1991 with 3,321 men 20–39 years of age;
- The National Health and Social Life Survey (NHSLs), conducted in 1992 with 3,432 men and women 18–59 years of age (Laumann et al. 1994; Michael et al. 1994);
- The General Social Survey, which has included some questions on sexual behavior in its national samples of adults 18 and older since 1988 (Anderson and Stall 2002; Rogers and Turner 1991; Smith 2006; Turner et al. 2005); and
- The National Longitudinal Study of Adolescent Health, which started in 1994, and collects data on a wide range of sexual behaviors and contraceptive use among adolescents and young adults (Harris et al. 2009).

In addition, some surveys using self-administered questionnaires and limited to teenagers or young people have collected data on some aspects of

sexual behavior. These include the CDC’s Youth Risk Behavior Survey, a biennial school-based survey of high school students, which included data on condom use, sexual intercourse, and numbers of sexual partners (CDC 2010b). The Urban Institute’s National Surveys of Adolescent Males collected data on the sexual activity and contraceptive use of national samples of males 15–19 years of age in 1988 and 1995 (Abma et al. 2001). In 2009, researchers at Indiana University conducted an internet-based study of sexual behaviors among adolescents and adults, called the National Survey of Sexual Health and Behavior (NSSHB). The NSSHB asked about behaviors in a sample of 5,865 men and women ages 14–94 (Indiana University 2010). Other national studies that examined sexual behaviors in the general population are referenced in our previous reports on sexual behavior (Chandra et al. 2011; Mosher et al. 2005).

Methods

Data Source

The National Survey of Family Growth (NSFG) has been conducted seven times by the 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 15–44 years of age. Each time, the interviews have been conducted in person by trained female interviewers in the selected persons’ homes. This chapter is based on the data from the 2006–2010 NSFG, conducted from June 2006 through June 2010. The 2006–2010 NSFG is a nationally representative multi-stage probability sample drawn from 110 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 if

Table 4.1 Sexual behavior with opposite-sex and same-sex partners among women aged 15–44 years, by selected characteristics: United States, 2002 and 2006–2010

Characteristic	Number in millions	Opposite-sex sexual behavior				Same-sex sexual behavior ^b
		Any ^a	Vaginal intercourse	Oral sex	Anal sex	
Percent (standard error)						
2002						
All women 15–44 years of age ^c	61.6	91.7 (0.4)	89.2 (0.5)	82.0 (0.6)	30.0 (0.7)	11.2 (0.5)
2006–2010						
All women 15–44 years of age ^c	61.8	89.4 (0.7)	87.2 (0.7)	80.4 (0.8)	31.6 (0.9)	13.7 (0.6)
<i>Age</i>						
15–19 years	10.5	53.7 (1.8)	46.5 (1.7)	46.3 (1.6)	11.8 (0.9)	11.6 (0.9)
15–17 years	5.8	39.8 (1.9)	32.2 (1.8)	31.9 (1.8)	7.5 (0.9)	9.5 (1.0)
18–19 years	4.6	71.2 (2.6)	64.3 (2.6)	64.3 (2.5)	17.1 (1.6)	14.2 (1.6)
20–24 years	10.4	89.7 (1.6)	87.0 (1.8)	83.1 (1.7)	30.8 (1.7)	19.1 (1.4)
25–44 years	40.9	98.4 (0.2)	97.8 (0.3)	88.6 (0.7)	37.0 (1.1)	12.9 (0.7)
25–29 years	10.5	97.2 (0.7)	96.2 (0.7)	88.7 (1.3)	40.1 (1.6)	16.3 (1.3)
30–34 years	9.2	98.3 (0.5)	97.5 (0.6)	88.7 (1.1)	37.0 (1.7)	14.6 (1.3)
35–39 years	10.5	98.9 (0.4)	98.6 (0.5)	87.8 (1.1)	36.3 (1.9)	10.9 (1.2)
40–44 years	10.7	99.3 (0.2)	98.9 (0.3)	89.0 (0.9)	34.8 (1.9)	9.9 (1.2)
<i>Marital or cohabiting status</i>						
Currently married	25.6	100.0 (0.0)	100.0 (0.0)	90.4 (0.7)	35.1 (1.3)	9.0 (0.8)
Currently cohabiting	6.9	100.0 (0.0)	100.0 (0.0)	90.3 (1.0)	43.1 (2.0)	20.9 (1.4)
Never married, not cohabiting	23.6	72.2 (1.7)	66.6 (1.7)	64.0 (1.6)	21.8 (1.0)	15.5 (0.8)
Formerly married, not cohabiting	5.7	100.0 (0.0)	100.0 (0.0)	92.0 (1.3)	43.4 (2.6)	18.8 (1.6)
<i>Education^d</i>						
No high school diploma or GED	6.8	99.3 (0.3)	99.3 (0.3)	74.8 (2.2)	32.9 (2.0)	15.5 (1.6)
High school diploma or GED	11.6	98.9 (0.4)	98.7 (0.4)	87.9 (1.0)	40.0 (1.8)	14.7 (1.3)
Some college, no bachelor's degree	13.7	97.1 (0.7)	96.0 (0.7)	92.0 (1.0)	39.4 (1.6)	15.8 (1.0)
Bachelor's degree or higher	15.1	95.9 (0.7)	94.5 (0.7)	90.8 (1.1)	33.5 (1.7)	10.9 (0.9)
<i>Hispanic origin and race</i>						
Hispanic or Latina:	10.5	89.2 (0.7)	87.7 (0.7)	68.4 (1.1)	25.1 (1.1)	7.1 (0.7)
US-born	5.4	85.0 (1.2)	82.9 (1.2)	72.8 (1.9)	29.5 (1.7)	11.6 (1.5)
Not US-born	5.1	93.6 (0.8)	92.8 (0.9)	63.6 (2.1)	20.4 (1.5)	2.3 (0.4)
Non-Hispanic or Latina:						
White, single race	37.4	89.5 (1.0)	87.1 (1.1)	86.1 (1.1)	35.9 (1.4)	16.1 (0.9)
Black, single race	8.5	90.2 (0.8)	89.0 (0.8)	74.3 (1.3)	24.2 (1.1)	12.6 (1.0)
Asian or Pacific Islander, single race	2.5	84.4 (2.6)	81.2 (3.0)	67.4 (3.4)	17.8 (3.0)	2.8 (0.7)

Note: Respondents could report whatever types of sexual contact they have had, with either opposite-sex or same-sex partners.

Standard errors for each percentage are shown to the right of the percentage.

Source: Mosher et al. 2005 and CDC/NCHS, National Survey of Family Growth, 2006–2010.

^a“Any” sexual behavior with opposite-sex partners includes vaginal, oral, or anal sex.

^b“Any” sexual behavior with same-sex (female) partners includes oral sex or “any sexual experience”.

^cIncludes women of other race or multiple-race and women with missing information on types of sexual experience, not shown separately.

^dLimited to women aged 22–44 years at time of interview. GED is General Educational Development diploma.

Table 4.2 Sexual behavior with opposite-sex and same-sex partners among men aged 15–44 years, by selected characteristics: United States, 2002 and 2006–2010

Characteristic	Number in millions	Opposite-sex sexual behavior				Same-sex sexual behavior ^b
		Any ^a	Vaginal intercourse	Oral sex	Anal sex	
Percent (standard error)						
2002						
All men 15–44 years of age ^c	61.1	90.8 (0.6)	87.6 (0.7)	83.0 (0.8)	34.0 (1.1)	6.0 (0.5)
2006–2010						
All men 15–44 years of age ^c	62.1	88.9 (0.6)	85.7 (0.7)	81.7 (0.7)	37.0 (1.0)	5.1 (0.3)
<i>Age</i>						
15–19 years	10.8	57.5 (1.5)	43.6 (1.6)	48.4 (1.5)	10.4 (0.8)	3.0 (0.5)
15–17 years	6.6	46.5 (2.0)	30.3 (1.9)	37.0 (1.8)	5.8 (0.8)	2.2 (0.5)
18–19 years	4.2	74.6 (2.0)	64.5 (2.3)	66.2 (2.2)	17.7 (1.8)	4.4 (0.8)
20–24 years	10.4	86.9 (1.9)	83.6 (2.3)	81.4 (2.2)	32.9 (2.5)	5.2 (0.8)
25–44 years	40.9	97.7 (0.3)	97.3 (0.3)	90.9 (0.5)	45.2 (1.1)	5.7 (0.4)
25–29 years	10.8	96.2 (0.7)	95.5 (0.8)	90.2 (1.2)	44.5 (1.7)	4.8 (0.7)
30–34 years	9.2	97.7 (0.5)	97.4 (0.5)	90.6 (1.2)	47.5 (2.0)	4.7 (0.7)
35–39 years	10.4	98.0 (0.6)	97.8 (0.6)	91.0 (1.3)	46.8 (2.2)	5.8 (0.7)
40–44 years	10.5	98.8 (0.2)	98.4 (0.4)	91.6 (1.1)	42.2 (2.3)	7.3 (1.2)
<i>Marital or cohabiting status</i>						
Currently married	23.4	100.0 (0.0)	100.0 (0.0)	93.0 (0.6)	44.6 (1.7)	3.4 (0.4)
Currently cohabiting	7.6	100.0 (0.0)	100.0 (0.0)	92.3 (1.5)	53.2 (2.3)	3.9 (0.8)
Never married, not cohabiting	28.0	75.3 (1.3)	68.1 (1.5)	68.1 (1.3)	24.3 (1.0)	6.9 (0.6)
Formerly married, not cohabiting	3.3	100.0 (0.0)	100.0 (0.0)	96.6 (1.4)	55.1 (3.1)	5.8 (1.2)
<i>Education^d</i>						
No high school diploma or GED	9.0	98.8 (0.4)	98.8 (0.4)	84.7 (1.6)	43.5 (2.0)	4.4 (1.0)
High school diploma or GED	12.1	97.2 (0.6)	96.8 (0.6)	89.9 (1.1)	46.1 (1.5)	5.2 (0.8)
Some college, no bachelor's degree	13.2	94.8 (1.5)	93.9 (1.8)	91.1 (1.7)	49.9 (2.4)	6.5 (0.9)
Bachelor's degree or higher	12.8	94.9 (0.8)	93.7 (0.9)	91.1 (1.1)	36.5 (1.9)	6.7 (0.9)
<i>Hispanic origin and race</i>						
Hispanic or Latino:	11.8	91.1 (0.8)	88.8 (0.7)	76.9 (1.1)	40.8 (1.5)	4.3 (0.5)
US-born	5.7	87.6 (1.4)	83.4 (1.3)	81.8 (1.4)	41.9 (1.8)	5.8 (0.8)
Not US-born	6.1	94.4 (0.9)	93.8 (1.0)	72.2 (1.9)	39.7 (2.3)	2.8 (0.6)
Non-Hispanic or Latino:						
White, single race	37.3	88.8 (1.0)	85.0 (1.1)	85.1 (1.2)	39.0 (1.4)	5.7 (0.5)
Black, single race	7.3	90.2 (1.0)	87.9 (1.0)	78.4 (1.5)	28.1 (1.4)	3.6 (0.4)
Asian or Pacific Islander, single race	2.4	76.9 (2.8)	75.2 (2.7)	64.8 (3.4)	11.5 (2.5)	3.8 (1.8)

Note: Respondents could report whatever types of sexual contact they have had, with either opposite-sex or same-sex partners.

Standard errors for each percentage are shown to the right of the percentage.

Source: Mosher et al. 2005 and CDC/NCHS, National Survey of Family Growth, 2006–2010.

^a“Any” sexual behavior with opposite-sex partners includes vaginal, oral, or anal sex.

^b“Any” sexual behavior with same-sex (male) partners includes oral or anal sex.

^cIncludes men of other race or multiple-race and men with missing information on types of sexual experience, not shown separately.

^dLimited to men aged 22–44 years at time of interview. GED is General Educational Development diploma.

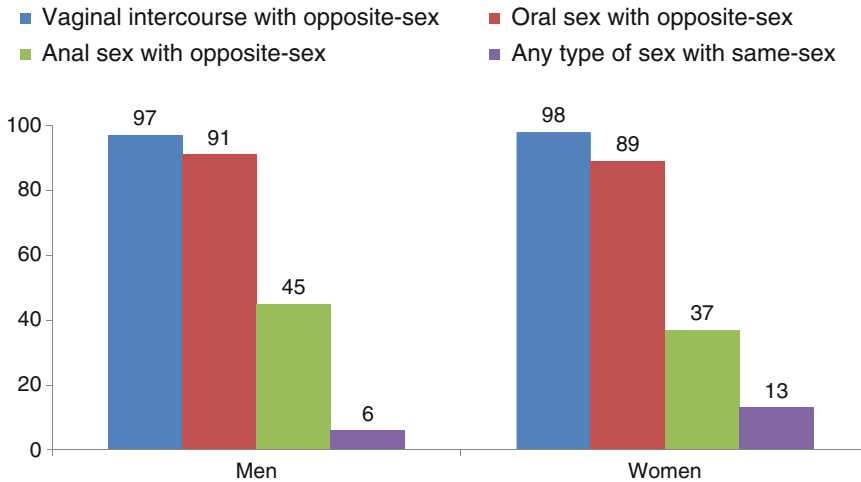


Fig. 4.1 Sexual behavior in lifetime among men and women 25–44 years of age: United States, 2006–2010 (Source: CDC/NCHS, National Survey of Family Growth, 2006–2010)

anyone 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 2006–2010, as well as in 2002, teenagers and black and Hispanic adults were sampled at higher rates than others. The final sample for 2006–2010 consisted of 22,682 respondents aged 15–44—12,279 women and 10,403 men.

All respondents were given written and oral information about the survey and were informed that participation was voluntary. Adult respondents 18–44 years of age were asked to sign a consent form but were not required to do so. For minors 15–17 years of age, 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 2006–2010 NSFG was 77% overall—78% for women and 75% for men.

Over the course of fieldwork in 2006–2010, about 110 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 given point in the data collection period, 40–45 interviewers

were conducting NSFG interviews across the country. Respondents in the 2006–2010 survey were offered \$40 as a “token of appreciation” for their participation. The 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 the NSFG and its sample design, weighting, imputation and variance estimation has been published (Groves et al. 2009; Lepkowski et al. 2010). Earlier reports based on the 2006–2008 and 2006–2010 NSFG data have also been published (Abma et al. 2010; Chandra et al. 2011, 2012; Martinez et al. 2011; Mosher et al. 2010).

Use of ACASI

Most of the data in the NSFG were collected by Computer-Assisted Personal Interviewing, or CAPI, in which the questionnaire was stored on a laptop computer, and administered by an interviewer, but many of the variables described in this chapter were collected using Audio Computer-Assisted Self Interviewing (ACASI). In ACASI

Table 4.3 Number of opposite-sex sexual partners in lifetime among women 15–44 years of age, by selected characteristics: United States, 2002 and 2006–2010

Characteristic	Number in millions	Number of opposite-sex (male) partners in lifetime ^a						
		Total	0	1	2	3–6	7–14	15 or more
2002								
All women 15–44 years of age ^b	61.6	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)
2006–2010								
All women 15–44 years of age ^b	61.8	100.0	10.8 (0.7)	20.5 (0.8)	10.7 (0.5)	32.3 (0.8)	16.7 (0.7)	9.0 (0.5)
<i>Age</i>								
15–19 years	10.5	100.0	47.1 (1.8)	20.7 (1.2)	8.9 (0.8)	17.2 (1.1)	4.1 (0.6)	2.0 (0.5)
20–24 years	10.4	100.0	10.4 (1.6)	22.4 (1.4)	11.6 (1.1)	33.2 (1.7)	14.9 (1.1)	7.5 (1.0)
25–44 years	40.9	100.0	1.6 (0.2)	19.9 (1.0)	11.0 (0.6)	35.9 (0.9)	20.4 (0.9)	11.2 (0.6)
25–29 years	10.5	100.0	2.8 (0.7)	20.7 (1.4)	10.7 (1.0)	33.0 (1.6)	20.2 (1.5)	12.6 (1.2)
30–34 years	9.2	100.0	1.8 (0.5)	19.0 (1.5)	11.4 (1.2)	34.1 (1.4)	21.9 (1.5)	11.8 (1.0)
35–39 years	10.5	100.0	1.1 (0.4)	20.6 (1.6)	10.6 (1.1)	36.9 (1.7)	21.1 (1.6)	9.7 (0.9)
40–44 years	10.7	100.0	0.7 (0.2)	19.3 (1.4)	11.3 (1.2)	39.5 (1.8)	18.6 (1.4)	10.6 (1.1)
<i>Marital or cohabiting status</i>								
Currently married	25.6	100.0	–	30.3 (1.5)	12.5 (0.8)	34.3 (1.3)	16.4 (1.1)	6.5 (0.6)
Currently cohabiting	6.9	100.0	–	12.4 (1.4)	11.4 (1.3)	40.0 (1.8)	22.0 (1.7)	14.1 (1.4)
Never married, not cohabiting	23.6	100.0	28.3 (1.7)	15.4 (0.8)	9.1 (0.6)	26.0 (1.0)	13.1 (0.7)	8.1 (0.6)
Formerly married, not cohabiting	5.7	100.0	–	6.5 (1.2)	8.6 (1.3)	40.1 (2.2)	26.6 (1.9)	18.1 (1.8)
<i>Education^c</i>								
No high school diploma or GED	6.8	100.0	0.7 (0.3)	19.4 (1.9)	12.7 (1.5)	37.7 (2.0)	16.2 (1.5)	13.2 (1.4)
High school diploma or GED	11.6	100.0	1.1 (0.4)	16.8 (1.3)	10.8 (1.0)	38.9 (1.8)	21.2 (1.3)	11.2 (1.1)
Some college, no bachelor's degree	13.7	100.0	2.9 (0.8)	16.7 (1.3)	10.4 (0.9)	36.7 (1.6)	20.4 (1.4)	12.9 (1.1)
Bachelor's degree or higher	15.1	100.0	4.1 (0.7)	25.6 (1.7)	11.3 (1.0)	31.4 (1.5)	19.8 (1.2)	7.8 (0.7)
<i>Hispanic origin and race</i>								
Hispanic or Latina:	10.5	100.0	11.0 (0.7)	31.6 (1.3)	15.9 (1.1)	29.5 (1.6)	7.9 (0.8)	4.2 (0.7)
US-born	5.4	100.0	15.1 (1.2)	21.8 (1.8)	13.3 (1.6)	32.0 (2.5)	10.9 (1.1)	6.9 (1.2)
Not US-born	5.1	100.0	6.5 (0.8)	42.1 (1.7)	18.7 (1.7)	26.8 (1.8)	4.7 (0.8)	1.2 (0.4)
Non-Hispanic or Latina:								
White, single race	37.4	100.0	10.6 (1.0)	18.5 (1.1)	10.1 (0.5)	31.8 (1.1)	19.0 (1.0)	10.0 (0.7)
Black, single race	8.5	100.0	10.0 (0.8)	10.0 (0.9)	8.9 (0.8)	40.3 (1.4)	19.7 (1.1)	11.2 (1.0)
Asian or Pacific Islander, single race	2.5	100.0	15.8 (2.6)	42.4 (3.5)	10.6 (1.9)	23.7 (3.1)	4.4 (1.1)	3.2 (1.4)

Standard errors for each percentage are shown to the right of the percentage.

Note: Percents may not add to 100 due to rounding.

Source: Mosher et al. 2005 and CDC/NCHS, National Survey of Family Growth, 2006–2010.

– Quantity zero.

^aNumber of male partners refers to those with whom she had any type of sexual contact—vaginal, oral or anal sex. “In lifetime” refers to time of interview.

^bIncludes women of other race or multiple-race and women with missing information on numbers of male partners in lifetime, not shown separately.

^cLimited to women aged 22–44 years at time of interview. GED is General Educational Development diploma.

Table 4.4 Number of opposite-sex sexual partners in lifetime among men aged 15–44 years, by selected characteristics: United States, 2002 and 2006–2010

Characteristic	Number in millions	Number of opposite-sex (female) partners in lifetime ^a							
		Total	0	1	2	3–6	7–14	15 or more	
		Percent distribution (standard error)							
2002									
All men 15–44 years of age ^b	61.1	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)	
2006–2010									
All men 15–44 years of age ^b	62.1	100.0	11.3 (0.7)	14.2 (0.7)	7.7 (0.4)	27.4 (0.7)	17.8 (0.6)	21.6 (0.8)	
<i>Age</i>									
15–19 years	10.8	100.0	43.7 (1.5)	19.6 (1.1)	9.3 (0.8)	18.4 (1.0)	5.5 (0.6)	3.5 (0.5)	
20–24 years	10.4	100.0	13.2 (2.0)	16.8 (2.3)	9.7 (1.1)	27.3 (1.9)	18.1 (1.8)	14.9 (1.6)	
25–44 years	40.9	100.0	2.4 (0.3)	12.2 (0.7)	6.7 (0.5)	29.7 (0.8)	20.9 (0.8)	28.1 (1.0)	
25–29 years	10.8	100.0	3.8 (0.7)	12.4 (1.2)	8.3 (1.0)	31.5 (1.7)	21.5 (1.6)	22.6 (1.5)	
30–34 years	9.2	100.0	2.4 (0.5)	12.2 (1.3)	6.8 (0.8)	26.2 (1.8)	22.6 (1.7)	29.8 (2.0)	
35–39 years	10.4	100.0	2.0 (0.6)	12.6 (1.4)	5.3 (0.7)	29.3 (1.7)	20.4 (1.6)	30.4 (1.8)	
40–44 years	10.5	100.0	1.2 (0.2)	11.4 (1.4)	6.5 (1.2)	31.5 (1.7)	19.4 (1.7)	30.0 (1.7)	
<i>Marital or cohabiting status</i>									
Currently married	23.4	100.0	–	–	19.3 (1.5)	7.3 (0.7)	32.2 (1.3)	19.6 (1.1)	21.5 (1.3)
Currently cohabiting	7.6	100.0	–	–	8.6 (1.5)	5.5 (1.0)	26.0 (2.0)	24.9 (1.8)	35.0 (2.0)
Never married, not cohabiting	28.0	100.0	25.2 (1.3)	12.9 (0.7)	9.0 (0.6)	24.2 (1.0)	13.7 (0.8)	15.1 (0.8)	
Formerly married, not cohabiting	3.3	100.0	–	–	1.6 (0.7)	4.2 (2.0)	22.8 (2.5)	23.4 (2.4)	48.0 (3.2)
<i>Education^c</i>									
No high school diploma or GED	9.0	100.0	1.2 (0.4)	10.6 (1.2)	7.2 (1.3)	32.0 (2.2)	20.8 (1.5)	28.1 (1.9)	
High school diploma or GED	12.1	100.0	2.9 (0.6)	9.2 (1.2)	6.5 (0.9)	28.0 (1.7)	22.6 (1.5)	30.7 (1.8)	
Some college, no bachelor's degree	13.2	100.0	5.3 (1.5)	10.9 (1.9)	5.5 (0.8)	29.6 (1.9)	21.0 (1.6)	27.8 (1.9)	
Bachelor's degree or higher	12.8	100.0	5.2 (0.8)	19.4 (1.4)	8.4 (1.0)	28.1 (1.5)	18.2 (1.5)	20.7 (1.5)	
<i>Hispanic origin and race</i>									
Hispanic or Latino:	11.8	100.0	9.2 (0.1)	13.2 (0.9)	9.4 (1.0)	31.3 (1.3)	16.9 (1.4)	20.0 (1.2)	
US-born	5.7	100.0	12.8 (1.4)	10.7 (1.2)	6.8 (1.0)	27.0 (2.2)	19.8 (2.2)	23.0 (2.0)	
Not US-born	6.1	100.0	5.8 (1.0)	15.6 (1.3)	11.8 (1.4)	35.4 (2.1)	14.3 (1.5)	17.2 (1.4)	
Non-Hispanic or Latino:									
White, single race	37.3	100.0	11.3 (1.0)	15.0 (1.1)	7.7 (0.5)	27.1 (1.0)	18.5 (0.9)	20.4 (1.1)	
Black, single race	7.3	100.0	10.1 (1.0)	8.5 (0.9)	4.3 (0.7)	25.1 (1.3)	19.8 (1.3)	32.2 (1.4)	
Asian or Pacific Islander, single race	2.4	100.0	24.0 (2.8)	32.7 (2.9)	10.7 (2.3)	18.4 (3.0)	8.6 (1.7)	5.6 (1.7)	

Standard errors for each percentage are shown to the right of the percentage.

Note: Percents may not add to 100 due to rounding.

Source: Mosher et al. 2005 and CDC/NCHS, National Survey of Family Growth, 2006–2010.

– Quantity zero.

^aNumber of female partners refers to those with whom he had any type of sexual contact—vaginal, oral or anal sex. “In lifetime” refers to time of interview.

^bIncludes men of other race or multiple-race and men with missing information on numbers of female partners in lifetime, not shown separately.

^cLimited to men aged 22–44 years at time of interview. GED is General Educational Development diploma.

Table 4.5 Sexual activity with same-sex partners in lifetime among women and men aged 15–44 years, by selected characteristics: United States, 2002 and 2006–2010

Characteristic	Women		Men	
	Number in millions	Percent reporting any sexual experience (SE)	Number in millions	Percent reporting any oral or anal sex (SE)
2002				
All persons 15–44 years of age ^a	61.6	11.2 (0.5)	61.1	6.0 (0.5)
		n/a		5.7 (0.5)
				3.7 (0.4)
2006–2010				
All persons 15–44 years of age ^a	61.8	13.7 (0.6)	62.1	5.1 (0.3)
		10.0 (0.5)		5.0 (0.3)
				2.9 (0.3)
<i>Age</i>				
15–19 years	10.5	11.6 (0.9)	10.8	3.0 (0.5)
		7.4 (0.7)		2.8 (0.4)
				1.7 (0.4)
15–17 years	5.8	9.5 (1.0)	6.6	2.2 (0.5)
		5.2 (0.8)		1.9 (0.4)
				1.2 (0.5)
18–19 years	4.6	14.2 (1.6)	4.2	4.4 (0.8)
		10.2 (1.4)		4.2 (0.8)
				2.4 (0.6)
20–24 years	10.4	19.1 (1.4)	10.4	5.2 (0.8)
		13.3 (1.2)		5.2 (0.8)
				2.9 (0.6)
25–44 years	40.9	12.9 (0.7)	40.9	5.7 (0.4)
		9.8 (0.5)		5.5 (0.4)
				3.2 (0.3)
25–29 years	10.5	16.3 (1.3)	10.8	4.8 (0.7)
		11.9 (1.0)		4.7 (0.7)
				2.3 (0.4)
30–34 years	9.2	14.6 (1.3)	9.2	4.7 (0.7)
		12.0 (1.0)		4.6 (0.7)
				2.3 (0.5)
35–39 years	10.5	10.9 (1.2)	10.4	5.8 (0.7)
		8.1 (1.0)		5.7 (0.7)
				3.5 (0.6)
40–44 years	10.7	9.9 (1.2)	10.5	7.3 (1.2)
		7.4 (1.1)		7.1 (1.2)
				4.4 (0.8)
<i>Marital or cohabiting status</i>				
Currently married	25.6	9.0 (0.8)	23.4	3.4 (0.4)
		6.1 (0.6)		3.2 (0.4)
				1.2 (0.2)
Currently cohabiting	6.9	20.9 (1.4)	7.6	3.9 (0.8)
		16.1 (1.3)		3.7 (0.8)
				0.9 (0.3)
Never married, not cohabiting	23.6	15.5 (0.8)	28.0	6.9 (0.6)
		10.7 (0.7)		6.7 (0.6)
				4.6 (0.5)
Formerly married, not cohabiting	5.7	18.8 (1.6)	3.3	5.8 (1.2)
		16.7 (1.6)		5.8 (1.2)
				3.8 (1.1)
<i>Education^b</i>				
No high school diploma or GED	6.8	15.5 (1.6)	9.0	4.4 (1.0)
		13.0 (1.5)		4.3 (1.0)
				1.5 (0.3)

High school diploma or GED	11.6	14.7 (1.3)	11.7 (1.1)	12.1	5.2 (0.8)	5.0 (0.8)	2.9 (0.6)
Some college, no bachelor's degree	13.7	15.8 (1.0)	12.1 (0.8)	13.2	6.5 (0.9)	6.4 (0.9)	3.6 (0.6)
Bachelor's degree or higher	15.1	10.9 (0.9)	6.6 (0.7)	12.8	6.7 (0.9)	6.7 (0.9)	4.4 (0.8)
<i>Number of opposite-sex partners in lifetime</i>							
None	6.5	5.4 (0.8)	3.3 (0.7)	6.9	8.3 (1.3)	8.3 (1.3)	6.8 (1.2)
1	12.4	4.0 (0.6)	2.8 (0.5)	8.6	4.3 (0.8)	4.2 (0.8)	2.0 (0.4)
2	6.5	8.0 (1.2)	5.7 (1.0)	4.6	7.1 (1.5)	6.9 (1.5)	5.5 (1.3)
3	5.9	7.3 (1.2)	4.4 (0.8)	4.5	2.1 (0.5)	2.1 (0.5)	1.4 (0.4)
4 or more	29.2	22.3 (0.8)	16.6 (0.7)	35.8	4.9 (0.4)	4.8 (0.4)	2.2 (0.3)
<i>Hispanic origin and race</i>							
Hispanic or Latina/o:	10.5	7.1 (0.7)	5.4 (0.7)	11.8	4.3 (0.5)	4.2 (0.5)	2.9 (0.4)
US-born	5.4	11.6 (1.5)	9.0 (1.2)	5.7	5.8 (0.8)	5.6 (0.8)	4.0 (0.7)
Not US-born	5.1	2.3 (0.4)	1.5 (0.4)	6.1	2.8 (0.6)	2.8 (0.6)	1.9 (0.5)
Non-Hispanic or Latina/o:							
White, single race	37.4	16.1 (0.9)	11.3 (0.6)	37.3	5.7 (0.5)	5.6 (0.5)	2.9 (0.3)
Black, single race	8.5	12.6 (1.0)	11.0 (1.0)	7.3	3.6 (0.4)	3.4 (0.5)	2.4 (0.4)
Asian or Pacific Islander, single race	2.5	2.8 (0.7)	1.7 (0.5)	2.4	3.8 (1.8)	3.8 (1.8)	2.9 (1.7)

SE is standard error of the percentage directly to the left.

Source: Mosher et al. 2005 and CDC/NCHS, National Survey of Family Growth, 2006–2010.

n/a - data not available from 2002 NSFG.

^aIncludes persons of other race or multiple-race, persons with missing information on numbers of opposite-sex partners, and persons with missing information on types of same-sex activity, not shown separately.

^bLimited to those aged 22–44 years at time of interview. GED is General Educational Development diploma.

Table 4.6 Sexual identity among women aged 18–44 years, by selected characteristics: United States, 2006–2010

	Number in millions	Sexual identity					
		Total	Heterosexual or straight	Homosexual or gay	Bisexual	Something else ^a	Did not report
All women 18–44 years of age^b	55.9	100.0	93.6 (0.4)	1.2 (0.2)	3.9 (0.3)	0.4 (0.1)	0.8 (0.1)
<i>Age</i>							
18–19 years	4.6	100.0	88.7 (1.5)	2.2 (0.7)	7.4 (1.4)	DSU	DSU
20–24 years	10.4	100.0	90.9 (1.1)	1.7 (0.5)	6.3 (0.9)	0.6 (0.3)	0.5 (0.2)
25–29 years	10.5	100.0	93.1 (0.8)	1.0 (0.2)	5.0 (0.8)	0.3 (0.1)	0.7 (0.2)
30–34 years	9.2	100.0	93.9 (0.8)	1.5 (0.4)	3.4 (0.6)	0.7 (0.3)	0.6 (0.3)
35–44 years	21.2	100.0	96.1 (0.4)	0.8 (0.2)	1.7 (0.3)	0.2 (0.1)	1.2 (0.3)
<i>Marital or cohabiting status</i>							
Currently married	25.6	100.0	95.8 (0.5)	0.1 (0.1)	2.6 (0.4)	0.3 (0.1)	1.1 (0.2)
Currently cohabiting	6.9	100.0	92.1 (1.0)	DSU	5.9 (0.8)	0.9 (0.4)	0.9 (0.3)
Never married, not cohabiting	17.8	100.0	90.8 (0.9)	3.3 (0.5)	4.9 (0.6)	0.4 (0.2)	0.6 (0.2)
Formerly married, not cohabiting	5.7	100.0	94.0 (0.9)	1.0 (0.3)	4.4 (0.8)	0.4 (0.2)	0.3 (0.1)
<i>Education^c</i>							
No high school diploma or GED	6.8	100.0	91.4 (0.9)	0.9 (0.3)	4.9 (0.7)	0.5 (0.2)	2.4 (0.6)
High school diploma or GED	11.6	100.0	93.2 (0.9)	1.4 (0.4)	4.4 (0.7)	0.3 (0.1)	0.7 (0.3)
Some college, no bachelor's degree	13.7	100.0	94.2 (0.6)	1.1 (0.2)	3.9 (0.5)	0.2 (0.1)	0.6 (0.2)
Bachelor's degree or higher	15.1	100.0	96.4 (0.5)	1.3 (0.3)	1.5 (0.2)	0.4 (0.2)	0.4 (0.2)
<i>Hispanic origin and race</i>							
Hispanic or Latina:	9.3	100.0	93.6 (0.7)	1.2 (0.3)	2.2 (0.3)	0.4 (0.2)	2.6 (0.5)
US-born	4.9	100.0	93.9 (1.0)	1.5 (0.6)	3.5 (0.7)	0.4 (0.2)	0.8 (0.4)
Not US-born	4.4	100.0	93.4 (1.1)	0.9 (0.4)	1.1 (0.3)	0.5 (0.2)	4.2 (0.9)
Non-Hispanic or Latina:							
White, single race	34.2	100.0	93.6 (0.5)	1.1 (0.2)	4.7 (0.4)	0.3 (0.1)	0.4 (0.1)
Black, single race	7.5	100.0	93.1 (0.8)	1.9 (0.4)	3.4 (0.6)	1.0 (0.3)	0.6 (0.2)
Asian or Pacific Islander, single race	2.3	100.0	96.0 (1.2)	DSU	1.2 (0.4)	DSU	2.0 (1.0)
<i>Sexual attraction</i>							
Only to opposite sex	45.9	100.0	99.0 (0.2)	0.1 (0.0)	0.2 (0.1)	0.2 (0.0)	0.6 (0.1)
Mostly to opposite sex	6.7	100.0	85.6 (1.6)	DSU	12.6 (1.4)	1.2 (0.4)	0.4 (0.2)
All other ^d	3.0	100.0	27.6 (2.9)	21.8 (2.4)	42.3 (2.8)	2.6 (1.1)	5.7 (1.3)
<i>ACASI language</i>							
English	52.1	100.0	93.7 (0.4)	1.3 (0.2)	4.1 (0.3)	0.4 (0.1)	0.5 (0.1)
Spanish	3.7	100.0	91.9 (1.4)	0.8 (0.5)	1.1 (0.4)	0.9 (0.4)	5.3 (1.2)

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 break offs before these ACASI questions.

Source: CDC/NCHS, National Survey of Family Growth, 2006–2010.

DSU Data statistically unreliable due to numerator fewer than five sample cases.

^aThe "something else" category was only offered in Years 1 and 2 of the 2006–2010 data collection.

^bIncludes those of other race or multiple-race, not shown separately. Also includes those with missing information on sexual attraction, not shown separately.

^cLimited to those aged 22–44 years at time of interview. GED is General Educational Development high school equivalency diploma.

^dIncludes those responding "equally attracted to both sexes," "mostly to same sex," and "only to same sex".

Table 4.7 Sexual identity among men aged 18–44 years, by selected characteristics: United States, 2006–2010

	Number in millions	Sexual identity					
		Total	Heterosexual or straight	Homosexual or gay	Bisexual	Something else ^a	Did not report
		Percent distribution (standard error)					
All men 18–44 years of age^b	55.5	100.0	95.6 (0.4)	1.8 (0.2)	1.2 (0.2)	0.2 (0.1)	1.2 (0.2)
<i>Age</i>							
18–19 years	4.2	100.0	95.0 (1.0)	2.1 (0.6)	1.9 (0.6)	DSU	1.0 (0.5)
20–24 years	10.4	100.0	95.6 (0.8)	1.6 (0.4)	1.7 (0.6)	0.3 (0.2)	0.8 (0.3)
25–29 years	10.8	100.0	96.4 (0.6)	1.2 (0.4)	1.0 (0.3)	0.6 (0.4)	0.9 (0.3)
30–34 years	9.2	100.0	96.7 (0.6)	1.4 (0.4)	0.8 (0.2)	DSU	1.1 (0.3)
35–44 years	20.9	100.0	94.9 (0.6)	2.3 (0.4)	1.0 (0.2)	0.1 (0.1)	1.6 (0.4)
<i>Marital or cohabiting status</i>							
Currently married	23.4	100.0	97.8 (0.4)	DSU	0.5 (0.2)	DSU	1.7 (0.4)
Currently cohabiting	7.5	100.0	97.6 (0.6)	DSU	0.8 (0.3)	DSU	1.4 (0.5)
Never married, not cohabiting	21.4	100.0	92.3 (0.7)	4.6 (0.5)	2.0 (0.4)	0.4 (0.2)	0.7 (0.2)
Formerly married, not cohabiting	3.2	100.0	97.3 (0.9)	0.9 (0.6)	1.6 (0.6)	DSU	DSU
<i>Education^c</i>							
No high school diploma or GED	9.0	100.0	95.4 (0.7)	1.0 (0.4)	0.8 (0.3)	DSU	2.6 (0.6)
High school diploma or GED	12.1	100.0	95.4 (0.8)	1.1 (0.3)	1.3 (0.4)	0.4 (0.3)	1.8 (0.6)
Some college, no bachelor's degree	13.2	100.0	96.2 (0.7)	1.7 (0.4)	1.3 (0.3)	0.2 (0.1)	0.6 (0.2)
Bachelor's degree or higher	12.8	100.0	95.1 (0.8)	3.2 (0.6)	1.2 (0.4)	DSU	0.6 (0.3)
<i>Hispanic origin and race</i>							
Hispanic or Latino:	10.7	100.0	94.2 (0.7)	1.5 (0.4)	1.1 (0.3)	0.5 (0.2)	2.7 (0.6)
US-born	5.9	100.0	95.4 (1.0)	2.2 (0.7)	0.9 (0.3)	DSU	0.9 (0.5)
Not US-born	4.8	100.0	93.3 (1.0)	0.9 (0.4)	1.3 (0.4)	DSU	4.2 (1.0)
Non-Hispanic or Latino:							
White, single race	33.5	100.0	96.2 (0.4)	1.9 (0.3)	1.2 (0.2)	0.2 (0.1)	0.6 (0.2)
Black, single race	6.4	100.0	96.7 (0.6)	1.6 (0.4)	1.1 (0.3)	DSU	0.5 (0.3)
Asian or Pacific Islander, single race	2.2	100.0	92.7 (1.9)	2.2 (1.2)	0.9 (0.5)	DSU	3.9 (1.6)
<i>Sexual attraction</i>							
Only to opposite sex	51.3	100.0	99.0 (0.2)	0.5 (0.0)	0.2 (0.1)	0.1 (0.3)	0.7 (0.2)
Mostly to opposite sex	1.9	100.0	89.9 (1.7)	DSU	7.3 (1.4)	1.7 (0.9)	DSU
All other ^d	2.0	100.0	13.8 (2.7)	47.7 (3.8)	21.3 (3.6)	2.9 (1.8)	14.3 (3.0)
<i>ACASI language</i>							
English	51.0	100.0	95.9 (0.4)	1.9 (0.2)	1.2 (0.2)	0.2 (0.1)	0.8 (0.2)
Spanish	4.5	100.0	92.0 (1.4)	1.0 (0.6)	1.1 (0.5)	0.4 (0.3)	5.6 (1.3)

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 break offs before these ACASI questions.

Source: CDC/NCHS, National Survey of Family Growth, 2006–2010.

DSU Data statistically unreliable due to numerator fewer than five sample cases.

^aThe “something else” category was only offered in Years 1 and 2 of the 2006–2010 data collection.

^bIncludes those of other race or multiple-race, not shown separately. Also includes those with missing information on sexual attraction, not shown separately.

^cLimited to those aged 22–44 years at time of interview. GED is General Educational Development high school equivalency diploma.

^dIncludes those responding “equally attracted to both sexes,” “mostly to same sex,” and “only to same sex”.

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 aloud to the interviewer, and it has been found to yield more complete reporting of sensitive behaviors (Turner et al. 1989, 1998). 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, sexual attraction, and sexual identity shown in this chapter were collected using ACASI.

Demographic Variables Used in This Chapter

The data on sexual behavior, attraction, and identity presented in this chapter 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 22–44 because large percentages of those aged 15–21 are still attending school. The definition of marital or cohabiting status used here also reflects status at time of interview and includes only those relationships with opposite-sex spouses or partners. The definition of Hispanic origin and race used here takes into account the reporting of more than one race, in accordance with 1997 guidelines from the Office of Management and Budget. Further technical details and definitions of terms associated with the demographic variables used in this chapter can be found in earlier NSFG reports (Chandra et al. 2011; Mosher et al. 2005).

Measurement of Sexual Behavior in NSFG ACASI

In this chapter, the term “intercourse” refers to vaginal intercourse between partners of the

opposite sex. 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 other measures related to sexual behavior, attraction, and identity are described in brief below, and further detail, including precise question wording, can be found in an earlier NSFG report (Chandra et al. 2011).

The NSFG is historically and primarily a study used to measure factors related to pregnancy and birth rates (Chandra et al. 2005; Martinez et al. 2006a; Mosher et al. 2010). 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, in order to address more factors related to risk of HIV and other STIs. Several studies have documented that oral and anal sex can transmit HIV and certain STIs, such as gonorrhea, chlamydia, genital herpes, chancroid, and syphilis (Baggaley et al. 2008; Chernes et al. 2005; Edwards et al. 1998; Rothenberg et al. 1998). Indeed, an increasing proportion of cases of genital herpes in the United States are being attributed to oral sex (Miller 2001). 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 (Baggaley et al. 2008). 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 (Rothenberg et al. 1998).

The wording of the NSFG questions on sexual behaviors in ACASI 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.

Types of Sexual Behavior for Female Respondents

For opposite-sex partners, the NSFG ACASI obtained information on vaginal intercourse, giving and receiving oral sex, and 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 have 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. When the 2002 NSFG data on this topic were published (Mosher et al. 2005), 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 2006–2010 NSFG ACASI 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.

Types of Sexual Behavior for Male Respondents

For opposite-sex partners, the NSFG ACASI obtained information on vaginal intercourse,

giving and receiving oral sex, and 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 2006–2010 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. The question wording reminds respondents to include all types of sex and partners with whom they may only have had sex once. Tables 4.3 and 4.4 show these data on numbers of partners in lifetime.

Measurement of Sexual Attraction and Sexual Identity in NSFG ACASI

In ACASI, all respondents were also asked questions on sexual attraction and sexual identity. Prior analyses with the 2002 and 2006–2008 NSFG (Chandra et al. 2011; Mosher et al. 2005) and NCHS cognitive lab testing results based on

the National Health and Nutrition Examination Survey (NHANES) (Miller 2001) showed higher levels of item nonresponse (“don’t know” and “refused” responses) among respondents of lower education levels and those who completed ACASI in Spanish. As a result of these earlier findings, the sexual identity response categories were modified for the 2006–2010 NSFG to include additional words that respondents may recognize and understand 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:

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*
- Or something else?*

For males, these questions were:

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*
- Or something else?*

In the 2006–2010 NSFG, the percentage who answered “something else” on sexual identity dropped markedly from 3.9% in 2002 to less than 1%, due largely to the rewording of the other response choices (Chandra et al. 2011). In addition, for the first 2 years of the 2006–2010 NSFG, ACASI respondents who answered “something

else” 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. Because of the lower levels of “something else” answers and the expense of administering and coding this follow-up question, the “something else” response option, along with the verbatim follow-up, were dropped beginning in July 2008. In this chapter, all respondents who answered “don’t know” or “refused” are grouped as “did not report.” For further information on the NSFG’s measurement of sexual identity, see Technical Notes in the earlier report (Chandra et al. 2011). In addition, work is ongoing in the NCHS cognitive lab and elsewhere to further improve measurement of sexual identity and understand relationships or identity with sexual behavior and sexual attraction.

Strengths and Limitations of the Data

The data presented in this chapter are primarily from the 2006–2010 NSFG, which has a number of strengths for studying sexual behavior in the U.S. population aged 15–44 years. The NSFG has a rigorous probability sampling design with a response rate of 77%, so the estimates can be generalized with confidence to the national population. 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 (Mosher et al. 2005; Turner et al. 1989, 1998). 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 Mexicans, Puerto Ricans, and to recent immigrants and those with limited education (Martinez et al. 2006b).

The data included in this chapter also have some limitations. As a household-based sample survey, the NSFG excludes from the sampling frame those who are currently homeless, incarcerated or otherwise institutionalized, and those living on military bases in the U.S. (The NSFG sample does include respondents with past experience with military service or incarceration who currently live in the household population, as well as 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. The NSFG makes use of extensive quality control procedures to try to minimize the effects of such errors (Groves et al. 2009; Lepkowski et al. 2010). The results could also 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 (Turner et al. 1989, 1998).

Statistical Analysis

All estimates in this chapter 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 chapter (www.sas.com). SAS SURVEYFREQ procedures were used to estimate the sampling errors of the statistics because these procedures take into account the use of weighted data and the complex design of the sample in calculating estimates of standard errors and significance tests. Each table in this chapter includes standard errors as a measure of

the precision of each point estimate (percentage) presented.

In keeping with NSFG reporting standards, percentages are not shown if the unweighted denominator is less than 100 sample cases, or the numerator is less than five sample cases. The denominator minimum was exceeded for all statistics presented in this chapter, and the few percentages based on fewer than five sample cases (all in Tables 4.6 and 4.7) are labeled “DSU” to indicate the data are statistically unreliable. Also, in the description of results in the following text, when the percentage being cited is below 10%, the text cites the exact percentage to one decimal point. Percentages above 10% are rounded the nearest whole percent.

Results

Types of Sexual Behavior with Opposite-Sex and Same-Sex Partners

Tables 4.1 and 4.2 show percentages of men and women who ever had the specified types of sexual contact with opposite-sex and same-sex partners. For opposite-sex partners, the percentages that ever had vaginal, oral, and anal sex are presented separately. Comparable percentages of men and women have had any opposite-sex sexual contact, vaginal intercourse, and oral sex with opposite-sex partners. Higher percentages of men (37%) than women (32%) report ever having had anal sex. Given that percentages reporting specific types of sexual experience may increase with age and level off in adulthood, Fig. 4.1 shows the percentages of men and women 25–44 who reported different types of sexual behavior. As in the 2002 NSFG, nearly all men and women 25–44 (97% of men and 98% of women) have had vaginal intercourse; 91% of men and 89% of women 25–44 have had oral sex with opposite-sex partners. Anal sex with opposite-sex partners was reported by 45% of men and 37% of women 25–44. Some form of same-sex sexual behavior was reported by twice as many women 25–44 (13%) as men 25–44 (5.7%).

With regard to anal sex with opposite-sex partners, no clear-cut patterns by educational attainment

were seen. Among both men and women 22–44, some type of oral sex was reported more often by those with bachelor’s degrees or higher (91% of women and 91% of men) than those with no high school diploma or GED (75% of women and 85% of men). Oral sex with an opposite-sex partner was reported more often by non-Hispanic white men and women (85–86%) than by those in other Hispanic origin and race groups shown. A higher percentage of Hispanic men (77%) than Hispanic women (68%) reported oral sex with opposite-sex partners.

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 (7.1%) and Asian women (2.8%) were less likely than either non-Hispanic white (16%) or black women (13%) to report same-sex sexual behavior. Among Hispanic women, those born in the United States were more likely to report same-sex sexual behavior than those born elsewhere. Among men, non-Hispanic white men (5.7%) were more likely than non-Hispanic black men (3.6%) to report such behavior.

Numbers of Opposite-Sex Sexual Partners in Lifetime

Tables 4.3 and 4.4 show the total numbers of opposite-sex sexual partners of any type (vaginal, oral, or anal sex) reported by men and women to this point in their lives (called “lifetime” number here). Each table also compares the percent distribution in 2006–2010 with what was seen in NSFG Cycle 6 (2002). There was little change since the 2002 NSFG. As in 2002 when 23% of men and 9.2% of women reported 15 or more partners in their lifetimes, men were more likely than women to report 15 or more partners in 2006–2010 (22% of men and 9.0% of women). These results are consistent with prior findings from surveys in the U.S. 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 (Chandra et al. 2005, 2011; Laumann et al. 1994; Martinez et al. 2006; Mosher et al. 2005; Smith 2006). 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 the 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 (e.g., 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 distributions, including 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 2006–2010 NSFG.
- There may be 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 (Adimora et al. 2007, 2011; Aral et al. 2005; Aral and Leichliter 2010; Ford et al. 2007; Leichliter et al. 2010).
- Over-reporting by men and under-reporting 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 the NSFG and other nationally-representative household surveys (Hamilton et al. 2010). Numbers of sexual partners in the general household population remains correlated with HIV (McQuillan et al. 2010) and other STIs (Aral et al. 2005; CDC

2010a; Chandra et al. 2011; Datta et al. 2007; Dunne et al. 2007; Markowitz et al. 2009; Mosher et al. 2005; Laumann et al. 1994; Sutton et al. 2007; Weinstock et al. 2004; Xu et al. 2006).

As expected, current age is the strongest correlate shown in Tables 4.3 and 4.4 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. For women more so than for men, higher educational attainment was associated with lower percentages with 15 or more partners in lifetime. While 11–13% of women with lower levels of education reported 15 or more partners, 7.8% with bachelor's degrees or higher reported 15 or more partners. For men (Table 4.4), the disparity by college education was smaller but still apparent.

Though women were less likely than men to report higher numbers of opposite-sex sexual partners in their lifetimes, women and men showed a similar pattern of association between numbers of opposite-sex partners and race and Hispanic origin. Among women, Hispanic women (4.2%) and Asian women (3.2%) were less likely to have had 15 or more partners than were non-Hispanic white (10%) and black women (11%). Among men, the comparable figures with 15 or more partners were 20% for Hispanic, 5.6% for Asian, 20% for non-Hispanic white, and 32% for non-Hispanic black men. These differences by race and origin may relate to differences in marital or cohabiting status, age at marriage, education, and age distributions.

Same-Sex Sexual Activity

Further detail on same-sex sexual activity “in lifetime” (or to this point in their lives) is shown in Table 4.5 for males and females 15–44. As noted in Tables 4.1 and 4.2, twice as many women as men report having had any same-sex sexual contact in their lifetimes (14% of women and 5.1% of men, corresponding to 8.5 million women 15–44 and 3.2 million men 15–44). The 2006–2010 data show that 14% of women 15–44

reported any same-sex sexual experience with a female partner, and 10% 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 10% of women reporting oral sex with a female partner is still higher than the 5.1% 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 4.5, similar patterns of association were seen with both “any same-sex experience” and “any oral sex” with a female partner. As noted in the [Methods](#) section, 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 and possibly narrowed the gender gap.

Marital or cohabiting status showed a somewhat different association with same-sex experience for men and women. Married (3.4%) or cohabiting men (3.9%) reported lower levels of same-sex experience than never married (6.9%) or formerly married men (5.8%), while for women lower percentages of same-sex experience were seen for currently married (9.0%) or never married women (16%) compared with formerly married women (19%) 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 the [Methods](#) section, the 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 gender. Women 22–44 with a bachelor's degree or higher were less likely to report same-sex experience than those in the other education groups (11% vs. 15–16%). Similar patterns were seen among

women specifically reporting oral sex with female partners. For men, the education differential was less wide, but higher educational attainment was associated with higher reports of same-sex experience.

Table 4.5 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 (22%) or same-sex oral sex (17%) than those with fewer or none; 4–8% of women with zero to three male partners in their lifetimes reported any same-sex experience. 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 (5.7%) were more likely to report any oral or anal sex with a male partner than were non-Hispanic black men (3.6%), and this appears to be driven by differences in reporting of oral sex—5.6% among white men and 3.4% among black men—as anal sex reporting was similar for the two groups. The percentages reporting same-sex experience were similar for Hispanic men and non-Hispanic white men. Among women, Hispanic women (7.1%) and Asian women (2.8%) were less likely than either non-Hispanic white (16%) or black women (13%) to report same-sex experience, including same-sex oral sex. Hispanic women born in the United States (12%) were more likely to report same-sex experience than Hispanic women born elsewhere (2.3%).

Sexual Identity and Sexual Attraction

The NSFG measures of sexual identity and sexual attraction are shown in this chapter only for adults aged 18–44 in order to facilitate comparisons with other surveys, and also because these characteristics may not yet be known or accurately reported among teens 15–17 (Pathela and Schillinger 2010). 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 chapter, but are correlated with reports of same-sex behavior to show the extent to which their use as risk markers may be warranted.

Tables 4.6 and 4.7 show the full distribution by sexual identity for women and men 18–44 in 2006–2010, and it is generally similar to that seen in 2002 (Mosher et al. 2005). Among women (Table 4.6), 94% reported they were “heterosexual or straight,” 1.2% “homosexual, gay, or lesbian” (corresponding to 0.7 million women 18–44), 3.9% “bisexual” (2.2 million women 18–44), 0.4% “something else,” and 0.8% did not report sexual identity. Among men (Table 4.7), 96% reported they were “heterosexual or straight,” 1.8% “homosexual or gay” (corresponding to 1.0 million men 18–44), 1.2% “bisexual” (0.7 million men 18–44), 0.2% “something else,” and 1.2% did not report sexual identity. Age appeared more closely associated with sexual identity reporting for women than for men. Women at the older 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 18–44 (Table 4.7), no such pattern was seen. Looking at marital or cohabiting status, which is itself correlated strongly with age, 2.6% of currently married women and 0.5% of currently married men report themselves as bisexual. Among current cohabitators, 5.9% of women and 0.8% of men report themselves as bisexual. Among those men and women aged 18–44 who have never married, and are not cohabiting, 3.3% of women and 4.6% of men report themselves as homosexual; 4.9% of never married women and 2.0% of never married men report themselves as bisexual.

Tables 4.6 and 4.7 also show sexual identity tabulated by education, Hispanic origin and race, sexual attraction, and ACASI language. For women and men 22–44, those with less than a high school diploma were more likely (2.4% of women and 2.6% of men) to say “don’t know” or “refused” (i.e., “did not report”) on sexual identity than those with at least a high school education.

With respect to race and Hispanic origin, Hispanic women (2.6%) and men (2.7%) were more likely not to report sexual identity than those in other race/origin groups shown. There is some evidence of a potential language barrier, based on the fact that 5.3% of women and 5.6% of men who completed ACASI in Spanish did not report sexual identity, compared with less than 1% of men and women who completed ACASI in English.

With regard to sexual attraction, 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, 86% of women and 90% of men reported they 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 (28% compared with 14%). Men in the “all other” group for sexual attraction were twice (14%) as likely as women (5.7%) 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.

Association of Sexual Behavior, Sexual Attraction, and Sexual Identity

Table 4.8 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” (56%) rather than “only attracted to the opposite-sex” (31%) were more likely to have had anal sex with an opposite-sex partner. Women “mostly attracted

to the opposite sex” (50%) were also more likely than women “only attracted to the opposite-sex” (5.5%) 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 (19%) compared with men who were “only attracted to the opposite sex” (2.7%). Among those men and women who self-identify as heterosexual, 10% of women and 3.0% of men have ever had same-sex sexual experience. Conversely, among those who report themselves as homosexual or bisexual, 14% of women (100 minus 86%) and 15% 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 63% of homosexual or bisexual men who have had such experience.

Looking at sexual identity and specific types of sexual experience with opposite-sex partners, some interesting differentials were seen. One-third of heterosexual women have ever had anal sex with an opposite-sex partner, compared with 52% of homosexual or bisexual women. In contrast, anal sex with an opposite-sex partner was more likely to be reported by heterosexual men (42%) compared with homosexual or bisexual men (21%). 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 (58%) were less likely than heterosexual men (89%) to have ever had oral sex with an opposite-sex partner.

Conclusion

This chapter provides recent national estimates of some basic statistics related to certain types of sexual behavior, sexual identity, and sexual attraction for men and women 15–44 years of age in the household population of the United States. These data are included in the NSFG in order to (a) measure the populations at risk of STI's and

Table 4.8 Sexual attraction, sexual identity, and selected sexual behavior indicators among women and men aged 18–44 years: United States, 2006–2010

Characteristic	Number in millions	Any opposite-sex sexual contact ^a	Any vaginal intercourse with	Any oral sex with opposite-	Any anal sex with opposite-	Any same-sex sexual contact ^a
			opposite-sex partner	sex partner	sex partner	
Percent (standard error)						
All women 18–44^b	55.9	94.6 (0.6)	93.0 (0.7)	85.5 (0.8)	34.2 (1.0)	14.2 (0.6)
<i>Sexual attraction</i>						
Only to opposite sex	45.9	94.4 (0.7)	92.9 (0.8)	84.9 (0.9)	30.6 (1.0)	5.5 (0.4)
Mostly to opposite sex	6.7	97.5 (0.5)	96.0 (0.7)	94.0 (0.9)	55.7 (2.0)	49.9 (2.1)
All other ^c	3.0	90.0 (1.8)	88.2 (2.0)	75.4 (2.6)	41.2 (3.1)	68.8 (2.8)
<i>Sexual identity</i>						
Heterosexual	52.0	94.8 (0.7)	93.2 (0.7)	85.8 (0.8)	33.3 (1.0)	10.0 (0.5)
Homosexual or bisexual	2.9	91.6 (1.5)	89.6 (1.8)	86.7 (1.9)	52.2 (2.9)	85.5 (2.3)
All men 18–44^b	55.5	93.9 (0.6)	92.2 (0.7)	87.2 (0.7)	40.8 (1.1)	5.5 (0.4)
<i>Sexual attraction</i>						
Only to opposite sex	51.3	95.3 (0.5)	93.8 (0.6)	88.8 (0.7)	41.6 (1.1)	2.7 (0.3)
Mostly to opposite sex	1.9	88.1 (2.7)	85.4 (2.9)	79.7 (3.1)	45.7 (4.6)	19.4 (2.6)
All other ^c	2.0	63.3 (3.9)	58.9 (4.1)	52.1 (4.1)	14.0 (3.3)	69.1 (4.0)
<i>Sexual identity</i>						
Heterosexual	52.8	95.0 (0.6)	93.4 (0.7)	88.5 (0.7)	41.7 (1.1)	3.0 (0.3)
Homosexual or bisexual	1.6	63.2 (4.3)	58.4 (4.4)	57.5 (4.3)	21.4 (3.9)	84.5 (3.2)

Source: CDC/NCHS, National Survey of Family Growth, 2006–2010.

^a“Any” 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.

^bIncludes those with missing information on sexual attraction, sexual identity, or sexual contact with opposite-sex or same-sex partners, not shown separately.

^cIncludes those responding “equally attracted to both sexes,” “mostly to same sex,” and “only to same sex”.

(b) provide insights about factors related to birth and pregnancy rates. The results presented here are based on the 2006–2010 NSFG, which consisted of a large nationally representative sample (n = 22,682), interviewed in person with the most reliable self-administered technique, and a good response rate (77%). The results reported here are generally similar to those from the 2002 NSFG (Mosher et al. 2005) and also comparable to other large national surveys (Chandra et al. 2011; Gates 2011). However, key changes since 2002 have been noted, including results from the NSFG’s improved measures of sexual identity and female-female sexual activity. The NSFG data have significant limitations: the results are limited to the household population of the United States, and do not cover persons who are currently homeless, incarcerated, living on military

bases, or persons outside the age range of 15–44. Nevertheless, the data should prove useful for planning programs to prevent the spread of sexually transmitted infections and to prevent unintended pregnancy among men and women aged 15–44 in the United States, and for further scientific research on factors associated with the sexual behavior of the U.S. population.

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Sexual Practices of Latin America and the Caribbean

5

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Introduction

Research on sexual behavior has increased in recent decades as a result not only of the outbreak of HIV/AIDS, but also of the difficulties raised by sexual and reproductive health policies. There is huge regional variation, both in the amount of knowledge about sexuality and the trends, mostly due to differences in the economic, social, and cultural determinants of sexual behavior (Wellings et al. 2006; Bozon 2003; Lloyd 2005). Designing interventions in the field of sexual health thus requires a good knowledge of region-specific trends. While many investigations focus on Africa or Europe and other high-income countries, and knowledge of Asia is rather scarce, Latin America falls in the middle, with a growing body of research on sexual behavior.

According to the classification made by the United Nations' Economic Commission for Latin America and the Caribbean (United Nations 2008), Latin America is made up of 20 countries and the Caribbean of 26 countries and dependent territories. This region is, therefore, made up of

countries with different histories and languages, as well as many similarities. Many of the countries share a common past of pre-Colombian civilizations (as in the case of the Mayan presence in Mexico and Central American countries, as well as the Quechua populations in Bolivia, Peru, Ecuador and the north of Argentina and Chile); many others share a past of colonization by Iberian countries (Spain and Portugal); and in more recent times, many of them have economic, cultural, and geopolitical ties.

The region's common trends were highlighted in a recent overview of the demographic trends of Latin America and the Caribbean since 1950: abrupt decline of fertility in most of the countries, little change in nuptiality and celibacy levels, and unprecedented progress in educational levels, together with the worsening of social inequality and high poverty levels (Guzman et al. 2006). High levels of violence against women (widely explored in demographic and health surveys), homophobia (Ortiz-Hernández and García 2005), and negative sexual health outcomes such as abortions (Sedgh et al. 2012; WHO 2007; Guillaume and Lerner 2007; Glasier et al. 2006; Singh 2006) are also part of the cultural context, shaped both by a chauvinist culture and the influence of the Roman Catholic Church. These common factors, however, do not prevent a high diversity of sexual patterns in the region, and a parallel diversity of sexual risk.

This chapter aims to explore the trends of sexual behavior in Latin America, viewed from a life course perspective, without leaving aside social

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differences. A central question to answer is whether there is a weakening of the traditionally tight link between sexuality and reproduction. Four main issues are considered: trends in the timing of early sexual and reproductive events, sexual activity during adulthood, contraception and abortion and measurement of homosexual/bisexual behaviors.

Data and Methodology

Different sources of information have been used to develop this chapter, such as the analysis of recent surveys and data obtained from previous publications, in addition to estimates generated specifically for this document. A preceding publication describing the trends in contemporary sexual behaviors in Latin America from a life course perspective (Bozon et al. 2009), focused on the analysis of DHS and CDC-RHS surveys between 2000 and 2005, and has been used as the starting point for this chapter. The 2003 National Reproductive Health Survey has been added for the case of Mexico, as well as other relevant indicators included in these surveys. Furthermore, the most recent DHS surveys and other available databases were processed using the CEPAL/CELADE's Redatam. New topics were included—such as contraception and abortion—based on previous literature and, for the case of Mexico, some aspects have been studied in more depth.

Among the advantages of working with DHS surveys is that variables are standardized for each of the countries participating in this program; this provides good conditions for comparative analysis. Among the shortcomings is the fact that there are many missing countries, especially those located in the southern area of South America, and that only a few surveys obtain information on men.

Among the indicators provided by the surveys, we selected data on the first events of sexual life and on sexual life as a whole, including use of contraception, unmet need for contraception, recurrence of induced abortions, separations, and experience of forced sexual relations. Following the analysis of Bozon et al. (2009), a comparison between two age-groups (cohorts aged 45–49

and 25–29) and three educational levels (less than secondary [incomplete primary, complete primary, and incomplete secondary], complete secondary, and superior) was conducted in order to consider both trends and social inequalities. The national educational systems vary among these countries, with a short primary level of 5 years in some cases (e.g. Colombia) and of 8 years in others (e.g. Bolivia or Dominican Republic), and with a long secondary level in some countries (e.g. Haiti) and a short one in others (e.g. Peru). Thus, the distribution and meaning of levels are not comparable from one country to another. However, it makes sense to differentiate educational levels within each country, as other research studies have shown that schooling is an important indicator of social class and has a great impact on events in the region (Castro and Juarez 1995).

Regarding homosexuality and bisexuality, because few data from surveys of the general population are available, this topic is included in an exploratory way (Caceres et al. 2006).

Trends in Early Sexual and Reproductive Events

In Latin and Latin American societies, the aim of teenage sexual socialization is clearly gender-specific. While men are traditionally urged to prove their manhood as soon as possible, social control is exerted over young women to delay their sexual initiation (Bozon and Hertrich 2004; Gayet 2011). This postponement is used until union formation in order to avoid the premarital loss of virginity, which remains a strong value (Amuchastegui 2000). First sexual intercourse, union formation, and birth of the first child are therefore strongly connected. A change in this traditional cultural pattern for women thus results in a shift in the timing of early events.

Among the countries of this sample, the trends in age at sexual initiation in the past two decades are very similar (Table 5.1). Only in Colombia did the age of women at sexual debut drop significantly (0.9 years). In all remaining countries, stability prevailed; the age remained unchanged, or had a small increasing or decreasing trend

Table 5.1 First sexual and reproductive events of women, by age groups and educational level, in selected Latin American countries

	Bolivia	Colombia	Haiti	Honduras	Nicaragua	Peru	Dominican Republic	Mexico 2003
Women	2003 DHS	2005 DHS	2005 DHS	2005 DHS	2001 DHS	2000 DHS	2002 DHS	ENSAR
Age group 25–29 (N)	2,673	5,652	1,761	3,294	1,943	4,245	3,624	3,140
Median age at first sexual intercourse 25–29	18.6	17.9	18.0	18.2	17.8	19.3	18.2	19.4
Educational level 1	17.6	15.9	16.9	16.9	16.2	17.1	16.3	17.2
Educational level 2	18.0	17.0	18.6	18.2	17.9	17.6	17.8	18.4
Educational level 3	20.6	18.8	20.1	21.4	20.9	21.5	20.9	20.7
Median age at first union 25–29	20.7	21.8	20.1	18.8	18.0	21.8	18.9	21.2
Educational level 1	19.0	18.4	18.4	17.3	16.2	18.3	16.6	18.0
Educational level 2	19.2	19.6	22.1	18.7	17.9	19.0	18.5	19.9
Educational level 3	24.3	24.6	25.7	22.5	21.5	25.0	22.6	23.2
Median age at first child 25–29	20.9	21.5	22.2	20.0	19.5	22.2	20.5	21.9
Educational level 1	19.4	18.5	19.7	18.5	18.0	19.1	18.3	18.7
Educational level 2	19.8	19.5	24.6	20.0	19.5	19.7	19.9	20.0
Educational level 3	24.8	24.9	–	23.9	23.2	25.4	23.9	23.7
Age group 45–49 (N)	1,477	4,379	939	1,585	1,066	2,529	2,201	1,774
Median age at first sexual intercourse 45–49	18.8	18.8	18.6	18.2	18.1	19.0	18.2	19.3
Educational level 1	18.3	17.2	18.4	17.2	16.9	17.5	17.0	18.1
Educational level 2	18.7	18.6	20.7	19.0	19.1	18.4	19.3	18.9
Educational level 3	21.2	21.5	20.5	22.4	22.1	22.0	22.7	21.6
Median age at first union 45–49	20.9	21.1	21.1	18.7	18.4	21.2	18.7	20.8
Educational level 1	20.3	19.5	20.7	17.7	17.1	19.4	17.3	18.9
Educational level 2	19.9	20.7	23.6	19.4	19.4	20.3	19.8	20.2
Educational level 3	23.6	24.1	25.3	22.7	22.2	24.6	23.5	22.8
Median age at first child 45–49	21.8	21.7	22.6	20.1	20.0	21.8	21.0	21.3
Educational level 1	21.4	20.2	22.3	19.0	18.8	20.2	19.4	20.0
Educational level 2	20.3	21.2	26.1	20.4	20.5	20.8	22.2	20.3
Educational level 3	24.5	25.0	26.2	23.7	24.2	25.2	25.7	23.6

Source: Bozon et al. (2009:S5)

(less than 0.5 year in two decades). As a result, the median age at sexual initiation is very much concentrated between 18 (17.8 in Nicaragua) and 19 years (19.4 in Mexico). In all countries, timing of sexual initiation was and remains strongly differentiated by educational level; the lower education groups start between 3 and 4 years earlier than the higher education groups. The overall stability of age at sexual debut for women is due to the persistence of the gender-specific class structure and the increase in education levels, which prevent sexual debut from decreasing too much given that women delay marriage (and thus sexual debut) in order to complete education.

In fact, social differences in timing of female initiation are tightly connected to differences in timing of first union. During the two decades under study, the link between initiation and first union has remained tight in Central America and the Dominican Republic, but has loosened in Andean countries and Colombia (and in other countries not included in this sample), where a growing disassociation between sexual initiation and union appears for women. Changes are not observed in Haiti or Mexico, where the existence of a premarital sexual period was already in place two decades ago. In all countries, groups with higher education experience a markedly longer period of premarital sexual activity in the younger cohorts, while groups with lower education still have very short premarital periods and an early first union (as also seen in Brazil) (Bozon 2005).

One paradox of Latin America, which has been noted by several authors, is that despite the rapid decrease in overall fertility—which could reach as low as replacement level before the end of the decade (Guzman et al. 2006)—there is no trend toward delaying childbearing in general, a phenomenon known as “the problem of teenage pregnancy” (Stern 2012). This persistent early entrance to fertility can be seen in the trends in age at first child, which remain stable among the cohorts or decrease slightly. Nevertheless, the proportions with a first child before 15 remain very low (between 1 and 3%, with the exception of Nicaragua at 5.2%) (Bozon et al. 2009). In Andean countries, Colombia and Mexico, first union and first child are very connected, while

Central American and Caribbean women tend to postpone the birth of their first child, despite early unions. On the other hand, the gap between groups with a higher level of education and those with a lower level in the timing of first child has tended to increase in the different cohorts and it now exceeds 5 years in all countries (Table 5.1). From the start, then, there are large social differences in sexual and reproductive trajectories. While early transitions to sexuality and reproduction are symbolically associated with women of lower class groups, a behavior of delaying sexual activity jointly with a period of childless sexual life has emerged as a new norm among the most educated groups.

In Mexico, an investigation conducted using event history analysis compares the sequence of first events (first sexual relation, first union, and first child) experienced by three cohorts of women until the age of 26 (born between 1951 and 1975) (Table 5.2; Solís et al. 2008). A significant group follows a traditional pattern, which means having their first intercourse in the context of a union and then the child (40.6% of women from the younger cohort). However, it can be seen that this traditional pattern loses its relative importance throughout the generations, in favor of those women who experience sexual intercourse before the union or those who have not experienced any of the three events at the age of 26 (Solís et al. 2008).

DHS surveys also collect contraceptive calendar information in countries with high levels of contraceptive use; however, this has been severely under-utilized for monitoring the sexual and reproductive lives of young people. A cross comparative study of eight countries uses these data (1990 and 2000) to examine the sexual and reproductive lives of young single women in Latin America, in terms of their exposure to sexual activity, contraceptive use, conceptions, and pregnancy resolutions. The methodology used is different from that directly obtained in surveys because of the detail of the calendar data. Estimates of the proportion of sexual exposure and protection by contraceptive methods, and the relative contribution of each contraceptive method, were calculated month by month. These calculations take into account whether the woman

Table 5.2 Mexico. Percentage distribution of Mexican women at age 26, according to a temporal sequence of events which marks the beginning of sexual and reproductive life, by birth cohort. ENNVIIH 2002

Events	Cohorts		
	1951–1960	1961–1970	1971–1975
No event	11.8	13.7	19.8
Initiating event first union	54.1	50.1	44.9
Union—first sexual relation	6.1	7.0	4.3
Union—first sexual relation—pregnancy	48.0	43.1	40.6
Initiating event first sexual relation	34.1	36.2	35.3
First sexual relation	4.2	4.1	2.8
First sexual relation—union	0.8	1.7	2.6
First sexual relation—pregnancy	7.2	5.6	5.0
First sexual relation—union-pregnancy	8.6	12.5	11.6
First sexual relation—pregnancy-union	13.3	12.4	13.3
Total	100	100	100

Source: Solís et al. (2008)

was sexually active and needed protection and considered the other aspects of exposure, such as postpartum amenorrhea and abstinence.

Table 5.3 presents the percentage of time spent as a virgin and percentages of sexually active woman-years that are unprotected, protected by contraception, or naturally protected. In all eight countries examined, virginity accounted for over half of all woman-years lived by young single women. The protective effect of virginity was most pronounced in Nicaragua, the Dominican Republic, and Guatemala, where it accounted for over 80% of woman-years. It was less protective in Bolivia, Peru, and Paraguay (70–75%) and least protective in Brazil (65%) and Colombia (58%). In the two countries where the protective effect of virginity was weakest, Brazil and Colombia, contraceptive protection was greatest, accounting for about 50% of sexually active exposure. In contrast, in Nicaragua, the Dominican Republic, and Guatemala where virginity was most prevalent, the minority of sexually active single women were least likely to protect themselves by using contraception, with prevalence ranging from 11 to 15% (Ali and Cleland 2005). The annual pre-marital conception rates among sexually active single women range from 14.1 per 100 woman-years in Nicaragua to 25.8 in Bolivia. Most reported pregnancies ended in live births. In the case of the Dominican Republic and

Guatemala, around half of pre-marital conceived births were “legitimized” by prompt marriage or cohabitation. Nevertheless, in the other six countries, the majority of live births remain to single mothers (no marital status change) (Ali and Cleland 2005).

In those countries for which we have information on men (Table 5.4), male age at sexual initiation is much lower than the age of women (by 2 years on average), and this gender gap did not decrease in the past two decades. Another aspect of the timing of male sexual initiation is that it does not vary much by educational level or by other socio-demographic or cultural factors. This indicates the universal continuity of masculinity requirements in these societies. A similar pattern is found in Brazil (Heilborn et al. 2006).

In Mexico, the Health National Survey 2000 obtained information on the age at sexual initiation for adult men. Based on this survey, a study calculated life tables for men and women and showed these same trends: earlier initiation for men and small variation based on their schooling level, a result that differs from what it is found among women (Figs. 5.1 and 5.2; Gayet and Solís 2007).

This early male sexual initiation implies a rather long premarital period for them, which favors experiences with sex workers and older women, given that younger girls are not available (Caraël 1995; Caraël et al. 2006). Men as a whole

Table 5.3 Percentages of woman-years lived in specific exposure states by single women aged 15–24 and percentage of sexually active exposure protected by contraception and conception rates

Countries (DHS data)	Woman years of exposure	Virgin	Sexually active:			Total	Sexually active protected by contraception ^b	Conception rates (per 100 women-years) [§]
			Unprotected	Protected by contraception	Naturally protected ^a			
Bolivia	9,003	75.4	16.5	3.9	100	19.0	25.8	
Brazil	12,235	65.2	14.8	16.1	100	52.1	18.7	
Colombia	13,029	58.2	18.9	17.9	100	48.6	16.7	
Dominican Republic	7,763	85.1	11.5	2.0	100	14.9	15.8	
Guatemala	6,528	83.7	11.7	1.4	100	10.4	31.4	
Nicaragua	10,713	89.7	8.1	1.0	100	11.4	14.1	
Paraguay	6,436	69.9	20.5	4.3	100	17.4	20.7	
Peru	31,921	71.7	16.7	7.5	100	30.9	20.2	

Source: Ali and Cleland (2005); Table 2, page 1178; and §Table 4, page 1180

^aNatural protection refers to protection by pregnancy or postpartum infecundability

^bNatural protection is excluded from denominator

Table 5.4 First sexual and reproductive events of men by age groups and educational level in Bolivia, Haiti, and the Dominican Republic

	Men age 25–29-years				Men age 45–49 years							
	Bolivia 2003 DHS		Haiti 2005 DHS		Dominican Republic 2002 DHS		Bolivia 2003 DHS		Haiti 2005 DHS		Dominican Republic 2002 DHS	
	N	Median age at first sexual intercourse	N	Median age at first sexual intercourse	N	Median age at first sexual intercourse	N	Median age at first sexual intercourse	N	Median age at first sexual intercourse	N	Median age at first sexual intercourse
	806	16.7	597	15.7	377	16.2	483	17.5	382	16.9	185	16.9
Educational level 1	16.5	16.5	16.3	16.3	16.2	16.2	17.9	17.9	16.9	16.9	17.1	17.1
Educational level 2	16.4	16.4	15.6	15.6	16.3	16.3	17.1	17.1	17.2	17.2	16.5	16.5
Educational level 3	17.1	17.1	15.3	15.3	15.8	15.8	17.2	17.2	–	–	17.1	17.1
Median age at first union	22.9	22.9	26.3	26.3	22.3	22.3	23.1	23.1	25.6	25.6	23.5	23.5
Educational level 1	21.0	21.0	24.5	24.5	21.8	21.8	22.5	22.5	25.1	25.1	21.8	21.8
Educational level 2	21.0	21.0	26.1	26.1	20.6	20.6	22.0	22.0	26.9	26.9	25.0	25.0
Educational level 3	25.6	25.6	–	–	24.8	24.8	25.1	25.1	–	–	26.1	26.1
Median age at first child	22.0	22.0	–	–	25.4	25.4	23.7	23.7	–	–	25.1	25.1
Educational level 1	21.4	21.4	–	–	24.2	24.2	23.1	23.1	–	–	24.3	24.3
Educational level 2	21.4	21.4	–	–	23.9	23.9	23.1	23.1	–	–	28.7	28.7
Educational level 3	23.6	23.6	–	–	–	–	25.6	25.6	–	–	27.7	27.7

Source: Bozon et al. (2009:S6)

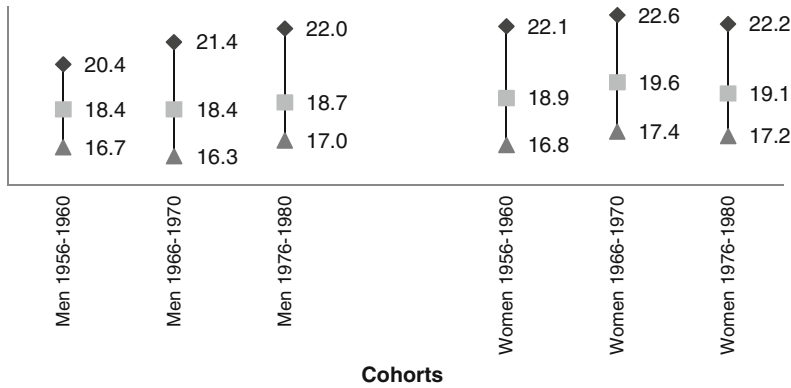


Fig. 5.1 Mexico Quartiles and median age at first sexual intercourse by cohort. Men and women (Source: Gayet and Solis 2007)

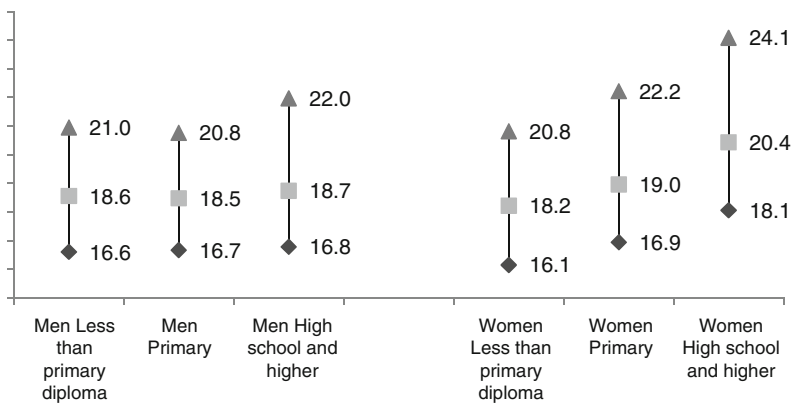


Fig. 5.2 Mexico. Quartiles and median age at first sexual intercourse by educational level. Cohort 1976–1980. Men and women (Source: Gayet and Solis 2007)

are induced to have early sexual initiation without the need to worry about union formation.

Context of Sexual Activity During Adulthood

Although the Latin American region seems to follow a somehow universal pattern of living in a partnership and having children (Quilodrán 2005), an analysis of union dissolutions, the length of reproductive period, use of contraceptive methods (especially permanent ones), and forced sexual intercourse helps highlight more

complex trajectories. These include the existence of several national or social models regarding the decoupling of sex life and reproductive life and the style of gender relations.

While the intensity of union (marriage or consensual union) is universal in almost all countries of the sample (more than 90% of women and 97% of men have had a stable union in their lives), the prevalence of marital dissolutions reveals heterogeneity among countries and social groups (García and Rojas 2002). In one group of countries, including Haiti, the Dominican Republic, and Nicaragua, the proportions of individuals with a dissolved union—either separated

at the time of the survey or with more than one union—are high (Table 5.5). In other countries, the levels are low (Peru, Bolivia, Mexico). Groups with lower education have the highest levels of union dissolution. Some DHS surveys that were administered to men provide some information on respondents with multiple partners: 3% of Bolivian men in unions versus 20% of Dominican men have had an extra partner in the preceding year, and the proportion grows with educational level (Table 5.6). These proportions are insignificant among women.

The couple's situation at last sexual intercourse suggests settings of sexual risk exposure that differ between men and women. Most of the couples at last sexual intercourse are cohabiting couples. However, there are clear differences between men and women: more men have had their last sexual intercourse with a non-stable partner (Tables 5.5 and 5.6). Proportions are higher in Peru, the Dominican Republic, and Colombia (7%) among the younger cohort of women, who reported that their last sexual intercourse was with friends, ex-partners, or occasional partners (e.g. "other") (Table 5.5). For those countries with available information, proportions of those having intercourse with a non-stable partner are much higher among the younger men (between 24% in the Dominican Republic and 11% in Bolivia) (Table 5.5).

Men also reported a higher condom use at last sexual intercourse than women. Among women of the younger cohort, the proportion of condom users range from 4 to 16% (higher in Colombia and Haiti, lower in Honduras and Nicaragua), and for young men from 14 to 29% (higher in Haiti, lower in Bolivia) (Tables 5.5 and 5.6).

In the region as a whole, fertility levels have seen a rapid reduction, but with great variation among countries. According to the Latin American and Caribbean Demographic Centre (CELADE), the region moved from an average total fertility rate of 5.9 children per women in 1950 to 2.27 between 2005 and 2010 (CELADE 2012). In 2010, some countries are under replacement level (Brazil, Cuba, Chile, and Costa Rica). While most countries in the region have relatively low fertility levels, four countries (Bolivia, Honduras,

Paraguay, and Haiti) have somewhat high fertility but are showing a rapid fall. Only Guatemala seems to witness a slow drop (Fig. 5.3).

The length of the reproductive period, which is related to the fertility level, varies according to country and social class, and can be interpreted as a descriptive indicator of the control of reproduction on sexual activity. In Bolivia and Haiti, the gap between the median age at first child and at last child exceeds 15 years, while it is only 10 years in Colombia and the Dominican Republic. In the entire region, the time dedicated to reproduction is longer among the least privileged groups (4–9 years difference between groups with lower and higher schooling levels), although reproductive intervals are more homogenous between educational groups in Colombia and the Dominican Republic (Bozon et al. 2009).

The availability of modern efficient contraceptive methods opened the possibility of separating sexual life from reproduction. Regarding the prevalence of modern contraceptives, Latin American countries present very different situations (Di Cesare 2007). The proportion in the older cohort who ever used a modern contraceptive method ranges from around 40% in Haiti and Bolivia to more than 75% in the Dominican Republic and 85% in Colombia (Bozon et al. 2009). If this information is combined with the data on reproductive life, two poles appear: a short reproductive period with high use of modern contraceptive methods in Colombia and the Dominican Republic, and a long reproductive period with low contraceptive use in Haiti and Bolivia. Although women of the younger cohort have had less time to get familiar with contraceptive methods, there is a marked increase in the use of modern contraception from one cohort to the other, and the gaps between countries remain unchanged. Among women in unions, the use of first contraceptive method occurs after the first birth. However, some countries show a tendency toward change. We can highlight the cases of the younger cohorts in Paraguay and Colombia, where almost half of women started using contraception without having had children (Table 5.7). The same process can be observed with the use of

Median age at last child 45–49	37.2	31.7	37.8	34.7	34.3	34.9	30.8	31.9
Educational level 1	38.7	31.7	38.1	36.3	35.3	37.5	30.3	33.7
Educational level 2	34.3	31.2	36.5	33.5	32.5	34.3	29.8	31.3
Educational level 3	34.4	32.6	35.0	33.2	31.4	33.7	32.9	31.3
Type of partner at last intercourse in the last 12 months (%)								
Husband/cohabiting partner	70.4	61.4	69.4	65.7	60.6	70.6	66.9	–
Fiancé	0.8	7.0	6.3	2.3	1.6	0.5	2.6	–
Other	1.0	5.8	0.1	0.8	1.2	2.5	5.0	–
No intercourse in the preceding year	27.8	25.8	24.2	31.2	36.6	26.3	25.5	–
Ever had forced intercourse from husband/cohabiting partner (%)	16.2	12.4	6.7 ^a	4.5	–	–	5.7 ^b	3.2

Source: Bozon et al. (2009:S7)

^aIn the case of Haiti, forced intercourse in the past 12 months

^bIn the Dominican Republic, no distinction is made between cohabiting partner or other partner

Table 5.6 Adult sexual and reproductive events of men by age groups and educational level, in Bolivia, Haiti, and the Dominican Republic

	Men age 25–29-years				Men age 45–49 years							
	Bolivia		Haiti		Dominican Republic		Bolivia		Haiti		Dominican Republic	
	2003 DHS	2005 DHS	2003 DHS	2005 DHS	2002 DHS	2003 DHS	2003 DHS	2005 DHS	2003 DHS	2005 DHS	2002 DHS	2003 DHS
N	806	597	377	483	382	185						
Ever separated (%)	8.9	7.2	22.0	23.2	32.4	52.0						
Educational level 1	13.2	10.2	23.1	19.3	36.5	54.6						
Educational level 2	6.8	5.7	30.8	33.0	21.4	71.3						
Educational level 3	7.1	5.7	12.3	23.0	–	18.3						
Had intercourse with cohabiting partner and other partner in the 12 months (%) ^a	2.3	4.4	14.1	2.9	10.4	19.9						
Type of partner at last intercourse in the last 12 months (%)												
Husband/cohabiting partner	68.7	40.0	54.6	80.0	80.4	82.5						
Fiancé	14.8	46.1	12.4	1.9	11.2	1.6						
Other	10.5	4.3	23.9	6.0	2.4	10.4						
No intercourse in the preceding year	6.0	9.6	9.1	12.2	6.0	5.4						
Use of condom at last intercourse (%)	14.4	28.8	20.4	3.4	4.9	5.7						
Educational level 1	6.3	10.3	21.7	1.4	3.5	6.5						
Educational level 2	12.1	30.8	15.4	1.3	7.3	4.1						
Educational level 3	20.9	57.5	23.2	8.3	25.2	4.8						
Never used condom (%)	43.9	–	21.6	67.8	–	44.9						
Educational level 1	71.1	–	26.9	85.8	–	57.4						
Educational level 2	52.0	–	22.4	63.6	–	32.3						
Educational level 3	22.1	–	13.7	39.4	–	19.1						
Ever had forced intercourse from other than partner (%) ^b	3.8	7.9	–	2.1	4.4	–						

Source: Bozon et al. (2009:S8)

^aIn the case of Haiti, the other partner is a second cohabiting partner^bIn the case of Haiti, no distinction is made between forced sex by cohabiting partner and by other partner

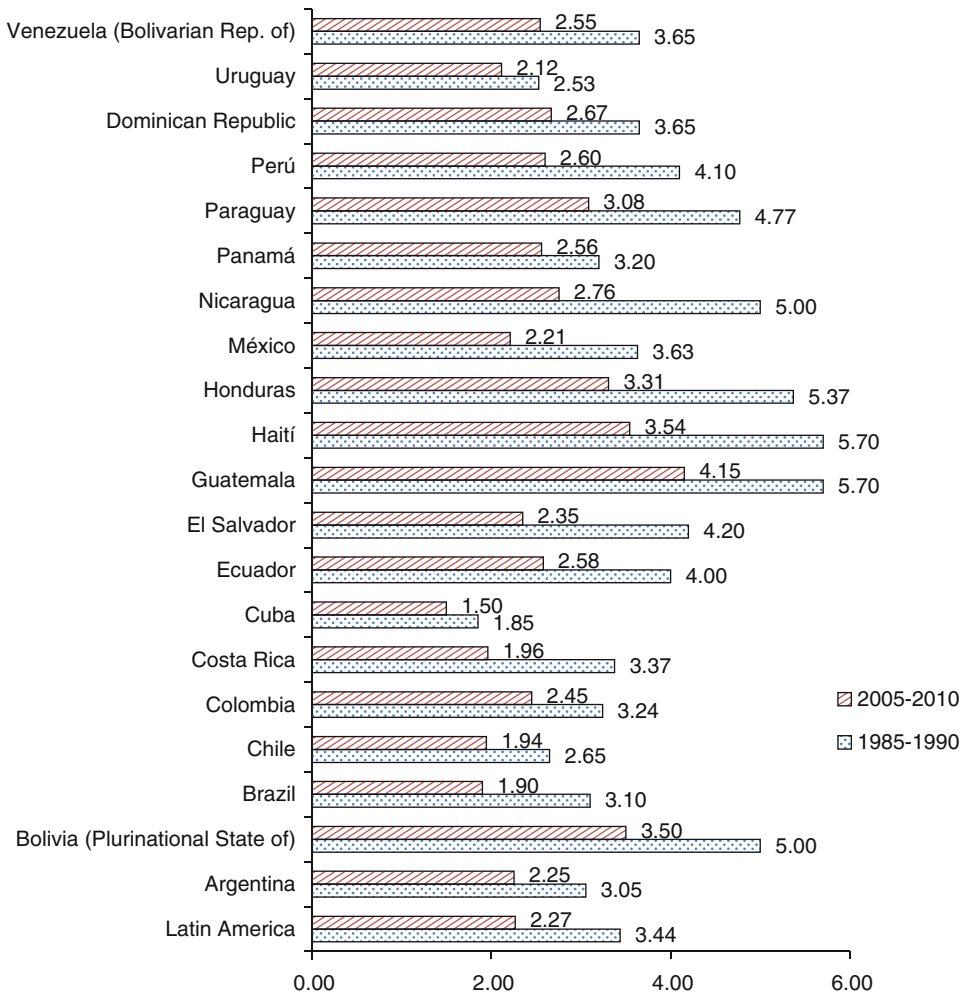


Fig. 5.3 Global fertility rate in Latin American countries. Periods 1985–1990 and 2005–2010 (Source: CEPAL/ CELADE, http://www.eclac.cl/celade/proyecciones/basedatos_BD.htm, accessed August 2, 2012)

condoms: men of the younger cohort have a higher prevalence of use. In both cohorts, use increases with education level (Table 5.6).

Even when an increase in the use of modern contraception among the younger cohort can be observed, some countries have large proportions of women with unmet need for contraception.¹ One-fourth of women aged 25–29 years have an

unmet need in Bolivia, and 37% in Haiti. This may result in unwanted pregnancies, which in turn can increase the number of wanted children or lead to induced abortions. Levels of unmet need are particularly high among young, unmarried, sexually active women. In most countries in the Latin American region, 30–50% of unmarried, sexually active women aged 15–24 were not

¹ Note: Unmet need for spacing includes pregnant women whose pregnancy was mistimed, amenorrheic women who are not using family planning and whose last birth was mistimed, and fecund women who are neither pregnant nor amenorrheic and who are not using any method of family planning and say they want to wait two or more

years for their next birth. Also included in unmet need for spacing are fecund women who are not using any method of family planning and say they are unsure whether they want another child or who want another child but are unsure when to have the birth unless they say it would not be a problem if they discovered they were pregnant in the

Table 5.7 Percent distribution of ever-married women by number of living children at time of first use of contraception, according to current age

	Number of children at first use (grouped)						Missing
	Never used	0	1	2	3	4+	
Bolivia 2008^a							
Age in 5 year categories							
25–29	13.3	25.0	32.0	17.0	7.7	4.5	0.0
45–49	29.9	6.5	17.0	12.0	9.3	25.0	0.0
Colombia 2010							
Age in 5 year categories							
25–29	2.1	55.0	34.0	6.4	1.9	1.3	0.0
45–49	4.4	32.0	39.0	12.0	6.5	6.0	0.0
Dominican Republic 2007							
Age in 5 year categories							
25–29	6.0	38.0	38.0	10.0	4.7	2.7	0.3
45–49	11.8	14.0	28.0	16.0	14.0	17.0	0.8
Ecuador 2004 RHS^b							
Age in 5 year categories							
25–29	9.6	30.0	40.0	12.0	5.1	3.2	0.2
45–49	16.1	16.0	25.0	14.0	11.0	18.0	0.7
El Salvador 2002 RHS^c							
Age in 5 year categories							
25–29	13.0	15.0	40.0	18.0	9.3	4.0	1.1
45–49	23.9	4.2	17.0	15.0	17.0	23.0	0.5
Guatemala 2002 RHS^d							
Age in 5 year categories							
25–29	41.8	7.4	25.0	11.0	8.0	7.1	0.0
45–49	46.0	4.3	14.0	12.0	9.7	15.0	0.0
Haiti 2005–06							
Age in 5 year categories							
25–29	28.7	17.0	29.0	14.0	7.5	4.0	0.0
45–49	45.4	1.8	7.8	7.4	9.5	27.0	0.7
Honduras 2005–06							
Age in 5 year categories							
25–29	10.2	17.0	44.0	17.0	6.8	4.6	0.1
45–49	23.1	5.6	20.0	14.0	9.7	28.0	0.3
Nicaragua 2001							
Age in 5 year categories							
25–29	10.9	21.0	43.0	14.0	5.3	5.5	0.4
45–49	22.2	7.5	28.0	12.0	8.8	22.0	0.1
Paraguay 2004 RHS^e							
Age in 5 year categories							
25–29	2.2	59.0	26.0	7.4	3.0	2.3	0.0
Peru 2000							
Age in 5 year categories							
25–29	8.3	26.0	38.0	16.0	6.5	4.7	0.0
45–49	19.6	8.8	21.0	15.0	11.0	25.0	0.2

Source: Macro International Inc 2011. Measure DHS STAT compiler. <http://www.measuredhs.com>, June 16, 2011

^aSection on adult mortality

^bCDC-RHS survey

^cCDC-RHS survey

^dCDC-RHS survey

^eCDC-RHS survey

using any type of contraceptive method in 2002–2007. Recent findings for Mexico indicate that abortion rates for 2006 and 2009 are highest among women aged 15–19 and 20–24, and respectively, this group of women has an extremely high unmet need for contraception. Among currently married women, unmet need reaches 36% among young women 15–19 years compared to 12% for women with 15–49 years (Juarez and Singh 2012; Juarez et al. 2008; Mendoza 2006).

There seems to be a lack of understanding of the risk of unintended pregnancy among women, in particular young women. When sexually active women who say they do not want to become pregnant are asked why they are not using a contraceptive method, the most common answer is that they have sex too infrequently. The next most common response is that they do not like the side effects or perceived health risks associated with modern contraceptives, suggesting a need for services that provide a broad range of contraceptive options (Singh 2009; Guttmacher Institute 2009) (Table 5.8).

One of the outcomes of concern for sexual and reproductive behavior is induced abortion. In parts of the world where abortion laws are restrictive, measurement of induced abortion is difficult. While pregnancy termination in many countries is seen as a basic component of comprehensive reproductive health services, and a key component of women's rights, in many less developed countries including Latin America it has been a sensitive issue—culturally, socially, and politically (Singh 2009). Few published country-level estimates are available; however, WHO, through an intensive review of the literature and approaches,

produced estimates of unsafe abortion by region² (Ahman and Shah 2010; WHO 2011). Thus, it is possible to describe the trend at this aggregated level.

A recent publication presented safe and unsafe abortion estimates for the period 1996–2008 (Sedgh et al. 2012). The number of women having abortions in the world has varied in time. A total of 45.6 million abortions were estimated for 1995, a number that dropped to 41.6 million for 2003 and then increased to 43.8 million for 2008. The worldwide abortion rate (the number of abortions per 1,000 women aged 15–44) substantially decline between 1995 and 2003, from 35 to 29. However, for the period between 2003 and 2008, the level stalled at a rate of 28. A similar pattern is observed for the overall abortion rate estimates of the developed and developing world. Studies have consistently shown that most unsafe abortions occur in poor countries, while practically all abortions in wealthier countries are safe. Estimates indicate that nearly half of all abortions worldwide are unsafe, and nearly all unsafe abortions occur in developing countries (Singh 2009; Sedgh et al. 2012).

Table 5.9 presents safe and unsafe abortion rates for the Latin American region. Latin America has the highest abortion rate when compared to Africa and Asia (43 compared to 29 and 28), and the majority of abortions are illegal and unsafe, at 95%. Within Latin America and the Caribbean, marked subregional abortion rates are observed. They range from 29 in Central America (this subregion includes Mexico) to 32 in South America and 39 in the Caribbean. The Caribbean (the subregion that includes Cuba, where abortions are generally safe) has the lowest proportion

next few weeks. Unmet need for limiting refers to pregnant women whose pregnancy was unwanted, amenorrheic women whose last child was unwanted, and fecund women who are neither pregnant nor amenorrheic and who are not using any method of family planning and who want no more children. Excluded from the unmet need category are pregnant and amenorrheic women who became pregnant while using a method (these women are in need of a better method of contraception).

² Throughout the chapter, unsafe abortion follows the WHO definition: a procedure for termination of an unintended pregnancy done either by people lacking the necessary skills or in an environment that does not conform to minimum medical standards, or both, refer to WHO. The prevention and management of unsafe abortion. Report of a technical working group. Geneva: World Health Organization, 1992 (WHO/MSM/92.5).

Table 5.8 Percentage of currently married women with unmet need for family planning and met need for family

	Unmet need—space	Unmet need—limit	Unmet need—total	% demand satisfied
Bolivia 2008 ^a				
Age in 5 year categories				
25–29	9.0	15.0	24.0	71.8
45–49	0.3	9.1	9.4	81.1
Colombia 2010				
Age in 5 year categories				
25–29	3.3	2.7	6.0	93.1
45–49	0.4	5.9	6.3	92.4
Dominican Republic 2007				
Age in 5 year categories				
25–29	10.7	4.9	15.6	81.2
45–49	0.6	3.8	4.5	94.6
Haiti 2005–06				
Age in 5 year categories				
25–29	20.5	16.4	36.8	48.6
45–49	0.6	20.8	21.4	51.9
Honduras 2005–06				
Age in 5 year categories				
25–29	10.7	7.9	18.6	77.7
45–49	0.1	9.1	9.2	86.5
Nicaragua 2001				
Age in 5 year categories				
25–29	7.2	9.0	16.1	81.2
45–49	0.1	10.8	10.9	84.4
Peru 2000				
Age in 5 year categories				
25–29	4.6	6.0	10.5	88.0
45–49	0.1	4.4	4.5	91.6

Source: Macro International Inc 2011. Measure DHS STAT compiler. <http://www.measuredhs.com>, June 16, 2011

^aSection on adult mortality

Table 5.9 Estimated safe and unsafe abortion rates^a for the Latin American region and year

Regions	1995				2003				2008			
	Total	Safe	Unsafe	% Unsafe	Total	Safe	Unsafe	% Unsafe	Total	Safe	Unsafe	% Unsafe
Latin America	37	2	35	95%	31	1	30	96%	32	2	31	95%
Caribbean	50	27	23	47%	35	19	16	45%	39	21	18	46%
Central America	30	<0.5	30	100%	25	<0.5	25	100%	29	<0.5	29	100%
South America	39	<0.5	39	100%	33	<0.5	33	100%	32	<0.5	32	100%

^aAbortions per 1,000 women aged 15–44 years

Source: Sedgh et al. (2012)

of unsafe abortions in the region (46%), compared with nearly 100% in Central and South America. These rates represent 4.4 million abortions in Latin America during the year 2008,

from which 0.4 million occurred in the Caribbean, 1.1 million in Central America, and three million in South America (Sedgh et al. 2012; Guttmacher Institute 2012).

Table 5.10 Estimates of the number of women admitted to hospital for induced abortion complications each year in the whole developing world and Latin American region, 2005

Regions	Estimates of annual rate of hospitalization because of induced abortion complications, per 1000 women	Annual number of women admitted for induced abortion complications
Total	5.7	5,047,540
Latin America	7.7	1,039,707
Caribbean	3.0	28,035
Central America	8.0	289,168
South America	8.0	722,504

Source: Singh (2006)

Unsafe abortion has substantial detrimental consequences for society, negatively affecting women and their families in different ways, imposing a cost on the public health systems, and ultimately, economic productivity. One of the health consequences of unsafe abortion is the large proportion of hospital admissions for gynecological services in developing countries and a significant number of women deaths. Table 5.10 presents estimates for 2005 of the number of women admitted to the hospital for induced abortion complications each year in the whole developing world and in the Latin American and the Caribbean region. Five million women were admitted to hospitals for treatment of complications related to induced abortions each year, while in developed countries complications from abortion procedures or hospitalization are rare. The number of women admitted to hospitals for induced abortion complications is 1.0 million in Latin America (Singh 2006), with a hospitalization rate due to induced abortion complications of 7.7. Evidence shows that rural and poor women, which are the ones with fewest resources to pay for a safe abortion procedure, are more likely to experience complications related to unsafe abortion. For example, in Guatemala and Mexico, informed experts estimated that 42–67% of poor women who had an induced abortion experienced severe health complications, compared with 28–38% of better-off women (Singh 2009; Sedgh et al. 2012).

As mentioned earlier, research on trends of the severity of complications is extremely scarce, but the few countries with reliable data on hospital abortion complications or that have collected

information of morbidity indirectly with sound methodologies,³ point out that the conditions of abortion provision have been changing and the proportion of abortions that resulted in severe complications is decreasing over time, though the pace of change varies across countries. For recent periods, there has been increased use of the drug misoprostol which, when administered clinically, is highly effective. This change began around 1990 in some Latin American and Caribbean countries, with Brazil standing out because of its early adoption and greater use of misoprostol, and since expanded to other countries in this region (Singh 2006, 2009).

Abortions occur as a result of unintended pregnancies and because a significant proportion of women with unintended pregnancies are determined to avoid an unplanned birth and will resort to clandestine abortions if safe abortion is not readily available. In 2008, the pregnancy rate in Latin America and the Caribbean was 123 per 1,000 while the unintended pregnancy was as high as 72 per 1,000. This level of unintended pregnancy is much higher than the world average of 55 per 1,000. The association between the high rate of unintended pregnancies and induced abortion is evident.

In Latin America, most of the research on abortion has focused on women, and the investigation of the role of men in reproductive health and the

³ National estimates of abortion-related hospital admissions in women aged 15–44 years have been compiled for six countries in Latin America and the Caribbean (Brazil, Chile, Colombia, Guatemala, Mexico, and Peru).

abortion decision process has been neglected (The Alan Guttmacher Institute 2003). Men have a central role as sexual partner in the use of contraception and in abortion decisions and consequences. And some of the difficulties experienced by women are partly related to the gender imbalance situation, where the social construct expressed by men considers sexuality as the masculine sphere (Guillaume and Lerner 2007).

Sexual Violence

Gender violence can be described as a set of harmful behaviors that include marital abuse, sexual assault, rape by partner, and rape by other known or unknown persons. Sexual coercion can take place at different moments in a woman's life, and even marital sex can sometimes be obtained by force. Sexual abuse can lead to unwanted pregnancies and sexually transmitted infections, including HIV. Different authors have noted that sexual violence in Latin America reflects the existence of gender inequalities, including a representation of masculinity based on aggression and a sign of power to prove one's virility. This concept of masculinity also includes the display of a hierarchy of power among men, either between adults or between adults and minors. In the context of the predominant gender culture, men have been victimized at various moments of their life.

Five DHS surveys from the region have included a specific module on suffered violence, with several questions on sexual violence. The main findings show that a high proportion of women between 45 and 49 years old in Bolivia (2003) and Colombia (2005) reported having been forced to have sexual intercourse at least one time by their partner (16 and 12%); this proportion is slightly lower (12 and 10%) for the 25–29 group (Table 5.5). In Haiti (2005), this question was asked about forced sexual contact within the last 12 months; 10% of Haitian women between 25 and 29 years old reported having been forced by their partner to have sex or to

engage in unwanted sexual practices (Table 5.5). Forced sexual intercourse by a person who was not the partner (father, step-father, brother, cousin, uncle, ex-partner, teacher, friend, employer, etc.) ranges from 2 to 10% in both age groups; the highest proportion was found in Honduras (2005) and the lowest in Bolivia (2003) (Bozon et al. 2009). Overall, between 15 and 19% of 45–49 year-old women reported forced sexual intercourse; the proportion for 25–29 year-old women is between 13 and 17%. The most educated groups reported a lower level of sexual violence for both age groups.

Limited data are available on men reporting forced or unwanted sexual contact. Among Bolivian men from the younger cohort, 1% reported having had sexual coercion from their partner and 4% from other people (possibly men). In Haiti (2005), 8% of 25–29 year-old men reported forced sexual intercourse in the last 12 months, without any information about the victimizer (Table 5.11).

Being a client of sex workers is a common experience among men, but there are not enough data on sex workers' clients among the general population, and especially on trends. A recent study estimated the number of sex workers' clients using data from different sex surveys (e.g. responses on the DHS surveys that reflect the percentages of 15–49 year old men who indicated that they had sexual intercourse with a sex worker in the past 12 months) or data from the national sex survey from Chile (Arredondo et al. 2000). The prevalence from the DHS surveys varied from 0.2% in Brazil and 1% in Chile to 4.8% in Haiti and 8% in the Dominican Republic. In the national sex survey from Chile, the prevalence in the past 5 years before the date of the survey was 5.4% among men 18–69 years. The number of men who have been sex workers' clients at least one time in their lives is much higher, showing how common this experience is among men: 54.5% of men between 45 and 49 years old in Honduras (National Survey of Male Health 2001 – Asociación Hondureña de Planificación de Familia de Honduras 2001) were clients at least one time, and 42.7% in the case of Chile.

Table 5.11 Declaration of homosexuality and bisexuality in Latin American countries (%) by sex

Country and year of survey	Same sex sexual partners in lifetime (Homosexual/Bisexual)		Sexual partners in past year (only Male/Male and Female)		Ever had any kind of homosexual experiences (Only homosexual/both homosexual/heterosexual)			
	Men	Women	Men	Women	Men adolescents	Women adolescents	Men young adults	Women young adults
GRAVAD (2002) ^a	2.8	2.8	-	-	-	-	-	-
Cáceres et al. 1997 ^b	-	-	-	-	5.2 / 10.4	2.6 / 0.3	0.3 / 13.0	0.7 / 3.7
Kornblit et al. 2004 ^c	3.0	-	-	-	-	-	-	-
Conasida 1992/1993 ^d	0.4 / 2.1	-	0.3 / 0.5	-	-	-	-	-
OPS/GTZ (2004) ^e	1.6	-	-	-	-	-	-	-
OPS/GTZ (2004)	2.1	-	-	-	-	-	-	-
OPS/GTZ (2004)	2.0	-	-	-	-	-	-	-
OPS/GTZ (2004)	1.3	-	-	-	-	-	-	-
OPS/GTZ (2004)	2.9	-	-	-	-	-	-	-
OPS/GTZ (2004)	2.2	-	-	-	-	-	-	-

Source: Bozon et al. (2009:S10)

^aGRAVAD survey was collected in Salvador de Bahia, Rio de Janeiro, and Porto Alegre, on the population from 18 to 24 years, N=4633

^bThe survey was collected in Lima, the capital city, on a 16 to 30-year-old population, N= 1218

^cThe Argentine study included 4000 individuals from 15 to 54 years throughout the country in cities with more than 50,000 inhabitants and province capitals. Men total: 1945

^dThis study was done in Mexico City on individuals sexually active in the last 5 years whose age ranged between 15 and 60 years, N= 8068. It included both men and women

^eThis survey was collected in Belice (Belice), San José (Costa Rica), San Salvador (El Salvador), Tegucigalpa (Honduras), Managua, Bluefields and Puerto Cabezas (Nicaragua), and Panamá. The target population was men from 15 to 44 years. Sample size varied between 291 in El Salvador to 600 in Nicaragua

Measuring Homosexual/Bisexual Behaviors in Latin American Countries

This last section focuses on the description and characterization of homosexuality/bisexuality prevalence in Latin America, based on data collected through questionnaires administered to the general population in some locations. In Latin America, research on homosexuality is growing. Many studies focus on male homosexuality and HIV prevalence among gay men. Sexual behavior surveys, administered to the general population, focus on the prevalence of homosexual/bisexual men and women and attitudes about homosexuality. These surveys are rather recent; they started to be collected after the AIDS outbreak in the nineties. Several studies from other countries have revealed that asking about homosexuality/bisexuality can be problematic (Caceres et al. 2006; Barbosa and Koyama 2006; Mora and Monteiro 2010; Instituto Mexicano de la Juventud-Centro de Investigación y Estudios sobre Juventud 2006). This may explain the delay of the region's research on these issues due to the sensitivity of the questions, particularly in environments where homosexuality is strongly stigmatized or penalized. Sexual relations among women have been less studied, although more research on the subject is currently reported in Latin America (Barbosa and Koyama 2006; Mora and Monteiro 2010; Instituto Mexicano de la Juventud-Centro de Investigación y Estudios sobre Juventud 2006).

It is hard to evaluate homosexuality/bisexuality frequency, and results are subordinated to the cultural context under study. Moreover, the reported frequency is associated with the definition of sex or sexual identity that is employed, such as the generally used phrase of “men who have sex with men” (MSM). The MSM category is used in HIV epidemiology studies, leaving out the prevalence of female homosexuality. Homosexuality refers to a series of constructs and ideas such as sexual desire, sexual behavior, and sexual identity, none of them binaries. Same-sex sexual behavior by far exceeds homosexual identity. In the world and in Latin America, a high percentage of men who have sex with men are married or have

sexual relations with women as well on a regular basis. Bisexual behavior seems to be common in Latin American societies. In spite of the huge number of relationships and connections between these concepts, homosexuality is still a source of stigma, prejudice, and discrimination in the region.

Results from the 2010 National Discrimination Survey from Mexico show that four in ten Mexicans would not be willing to allow a homosexual person to live in his/her house. Furthermore, three in ten people aged 40 years and older consider it to be “negative” or “very negative” that society is made up of people with different sexual orientations or preferences. The highest level of discrimination can be found in relation to the issue of adoption of minors by homosexual couples (Fig. 5.4). Between seven and eight in ten people, aged 40 years or older, reported they “disagree” or “strongly disagree” with the idea of male couples adopting girls and boys; the disagreement is higher among older people. The disagreement proportions related to adoption by a lesbian couple are slightly lower, but similar (between seven and eight in ten people “disagree” or “strongly disagree”, with variation depending on the age of the interviewee) (National Council to Prevent Discrimination 2011 – Consejo Nacional para Prevenir la Discriminación 2011).

According to recent meta-studies that include Latin America, a variety of studies related to same-sex sexual prevalence in Latin America have been conducted. Some focus on MSM prevalence, with results that fluctuate from 6 to 20%, but these studies lack information on the sample or are convenience samples. Other studies focus exclusively on MSM prevalence among the HIV-infected population. As these studies are often published as summaries, doubts remain as to whether the research is scientific and whether the definitions and questions are comparable, and findings show large differences within and between countries. Furthermore, most of these studies do not include women.

Only two countries of the region collected a sexual behavior survey for the general population in 1998 at a national level: Brazil and Chile (Table 5.11). In Brazil, 3.1% of men and 3% of women interviewed (from the 16–65 year-old

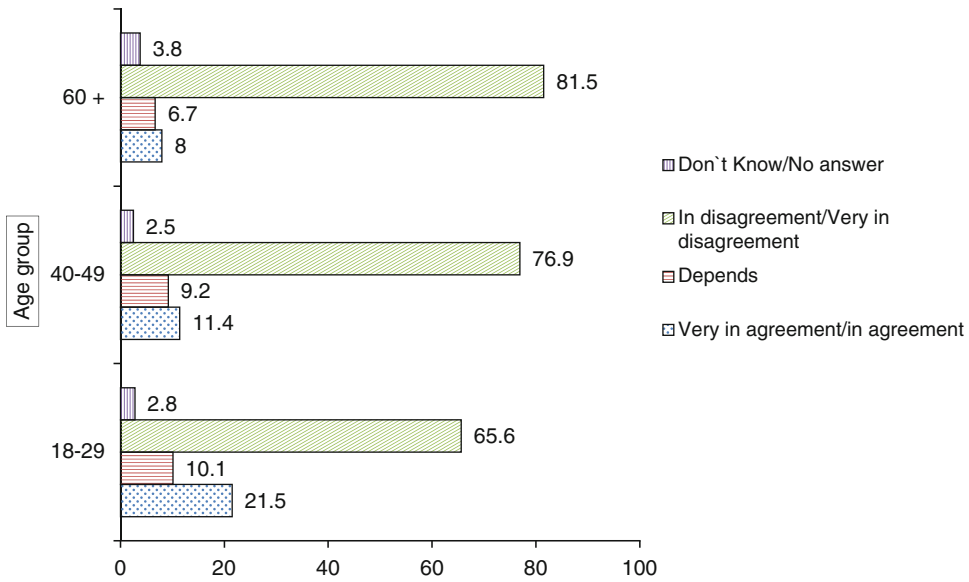


Fig. 5.4 Mexico. Discrimination by sexual preference. Percentage distribution in agreement that homosexual couples are allowed to adopt children by age group.

ENADIS 2010 (Source: Consejo Nacional para Prevenir la Discriminación 2011)

population) reported having had at least one same-sex sexual partner in their lifetime; these figures are 0.5 and 0.1%, respectively, for Chile. In Brazil, more than 90% of those who reported same-sex sexual behavior also reported opposite-sex sexual behavior. DHS surveys conducted in the region do not ask about homosexual and bisexual behaviors, while some countries such as Brazil, Mexico, and Chile have carried out studies focused on the young population. A question was included in the 2001 Honduran National Survey of Male Health. Other countries simply have not carried out this type of survey. Table 5.11 shows information collected for the general population in some Latin American capitals; the data are problematic, however, in that they are collected only for some age groups or have small-size samples (Bozon et al. 2009). These studies support the prevalence patterns revealed by the surveys on the general population in Brazil and Chile, even though large cities are generally considered to be more favorable environments for homosexual and bisexual behaviors.

Discussion

First, it is important to emphasize that this overview on trends of Latin American sexual behavior show mainly data from surveys not specifically focused on sexuality (namely DHS surveys, which are focused on women's reproductive health) and on surveys with convenience samples on epidemiological topics. In Latin America, contrary to Europe, very few surveys of the general population deal specifically with sexual behavior in itself.

Among what could be considered general trends of sexual behavior in the region is the early start of unions, still strongly connected to women's sexual initiation. A persistent gender gap in sexual initiation, with an earlier debut of men, seems to be a characteristic of Latin American sexuality, clearly related to the sexual double standard of Latin and Mediterranean sexual culture. A traditional feature of Latin American societies that is not decreasing is the huge level of socioeconomic inequality, which translates

directly into differences in sexual and conjugal histories, especially among women. Early debut, early fertility, higher rates of separations, earlier age at sterilization, and higher levels of sexual violence characterize the least economically privileged groups, while a later debut, a longer period of premarital sex, late fertility, and lower rates of sterilization, separation, and sexual violence are found among the more educated groups. In the past two decades, differences in the timing of sexual and reproductive trajectories by social condition tend to be widening. There is constant difficulty among women from the least privileged groups to disassociate sexual life from its reproductive aspects, which can lead them to early sterilization.

Another aspect of sexual culture in the region is the diversity of national patterns, which is far from the image of cultural homogeneity normally associated with Latin America. There is no unique principle of variation. Andean countries differ highly from Colombia; Colombia differs from the Caribbean and the Caribbean from Mesoamerica—without mentioning the countries from the Southern Cone which are not part of this sample. There are great differences in the levels of early sterilization (very high in the Dominican Republic), of separations (very low in Mexico), and of early unions (very early in Mesoamerica) and in the reported levels of sexual violence (very high in Haiti, but also in Bolivia and Colombia). These trends can reflect different stages of the demographic transition, the differential influence of reproductive and family planning policies, or the ethnic composition of the population, which result in different gender systems. From a gender perspective, there is an important lack of data and indicators, and it should be noted that this region has very few DHS surveys on men, if we compare this with Africa, for example.

In regard to homosexuality, little is known about the general population. Apart from the low prevalence and relative homogeneity of results, available data are comparable with international findings in the following aspects: (a) The general population reports itself as mainly engaging in heterosexual behavior, and (b) the identification of homosexual or bisexual behavior is in general low. However, data on prevalence must be analyzed

with caution because, in spite of the big changes regarding Latin America sexuality, the self-report of homosexuality can be strongly mediated by “social desirability” therefore resulting in under-reporting. Moreover, data can be biased as a result of the interest to quantify risky behaviors in the context of HIV more than homosexual behavior in itself. There are huge differences in the surveys’ measurement process, the way questions are written, and the cultural contexts. All these could affect the results, especially in countries characterized by a culture with male dominance, a rigid definition of masculinity, and a very negative evaluation of the trespassing of gender roles. Surveys on homosexual behavior should deal also with female homosexuality, mental and physical health, attraction, and homophobia.

Finally, this overview of Latin America reveals gaps in our knowledge that highlight the urgent need to conduct real sexual behavior surveys among the general population in the region. These surveys should work with more inclusive definitions of sexuality and sexual health, with an approach of sexual activity from a life course perspective. In addition, surveys must take into account the persistent gender imbalance in sexual interaction within the region, and the effects of social inequalities on the exercise of sexuality. Further, survey data are needed on the topic of discrimination, as sexual health depends on sexual rights.

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Yanyi K. Djamba

Introduction

The discourse on sexual practices in Africa is still very limited, despite the evidence that such practices are associated with health risks (Djamba 2005). This is partly because most research on African sexuality has focused on the behavioral aspects of sexual permissiveness. In addition, sexuality remains a taboo topic in many African societies. As a result, the definition of sexual practices itself remains largely elusive. For some researchers, sexual practices of interest primarily include age of sexual debut and number of sexual partners, probably because of their strong association with HIV/AIDS (Urassa et al. 2008). Others consider only those practices that can lead to sexual and reproductive complications (WHO 2008).

The study of the health risks of sexual practices became an important topic mostly in the biomedical literature in the 1990s when the HIV epidemic was initially associated with vaginal drying (Brown et al. 1992, 1993). However, at that time, any attempt to associate HIV/AIDS with sexuality in Africa was a daunting task. For example, when John Caldwell initiated the discussion of the behavioral aspects of HIV

infection in Africa 3 decades ago (Caldwell et al. 1989), the debate quickly turned to ethnocentric arguments from Africanist scholars (Ahlberg 1994; Le Blanc et al. 1991). Africanist scholars strongly rejected the thesis of an “African sexual regime” which they saw as a foreign attack on the African culture and knowledge. Certainly things have changed, as more evidence began to demonstrate that some forms of sexual behaviors and sexual practices found mostly in Africa increase the risk of sexually transmitted infections and HIV/AIDS (Caldwell 2000; Kun 1998).

Nonetheless, our knowledge of sexual practices in Africa remains very limited due to the sensitive nature of the topic and the enormous African cultural diversity, which makes any comparative approach a very difficult endeavor. As explained in this chapter, there are substantial cross-cultural differences in sexual practices within Africa. For example, female circumcision (also referred to by some scholars as genital cutting or female genital mutilation) is widely practiced in some countries, but it is an unknown practice in other parts of the continent. There are also enormous variations within countries. The study of sexual practices, however, is virtually absent from socio-demographic and other social science disciplines that address the African culture and African society.

This chapter is divided into four major sections. The first section presents sexual behavior in Africa from a comparative perspective. The second section describes vaginal practices and their association with prevailing cultural norms of love and

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intimacy. The third section examines male and female circumcisions within the cultural and health contexts. The last section gives an agenda for more research on sexual practices in Africa, followed by a discussion and conclusion.

Each practice is described to understand its utilization and its potential health consequences, including HIV risks. Some statistics are provided for a number of behaviors, practices, and surgical procedures for which appropriate data are available. It must be noted that the list of sexual practices and procedures discussed in this chapter is not exhaustive. There are certainly other practices unknown to the author and the scientific community. Therefore, this chapter gives an agenda for further research in order to obtain more information on current and other unknown sexual practices in Africa.

Sexual Behavior

Sexual behavior is often examined from a variety of indicators, ranging from first sexual experiences through the number and type of sexual interactions throughout the lifetime. Due to data limitations in Africa and most of the developing world, however, the present review of sexual behavior is limited to age of sexual debut, age at first marriage, prevalence of premarital sex, number of sexual partners, and condom use during high-risk sex. Data on same-sex relationships are not available to warrant cross-country comparison in Africa. For comparative purpose, only data collected in the last 6 years as part of the Demographic and Health Surveys are used here. These data sets are nationally representative samples of adult men and women (Measure DHS 2010). As such, the present review of sexual behavior is limited to areas covered by the recent waves of the Demographic and Health Surveys.

In many African countries, women marry at a younger age than men, but the conclusion of marriage itself may be a complex process of courtship and negotiations that can last for several years. In addition, several African countries are mosaics of ethnic groups, languages, and cultures. Consequently, as detailed in this section, the patterns of marriage, sexual behavior, and gender relations across African countries can be very different.

Age at First Sexual Intercourse

Age at first sexual intercourse is an important indicator of subsequent sexual health given that for many people, especially women, that event can be non-consensual (Ayeimba 2001; Dickson et al. 1998; Wight et al. 2000), without use of contraceptives, and/or associated with a larger lifetime number of sexual partners (Genuis and Genuis 2004; Harrison et al. 2005; Giesecke et al. 1992).

Data in Table 6.1 show that, in most African countries covered by the Demographic and Health Surveys, women had their first sexual intercourse in their late teenage years. There are, however, substantial variations across the continent. The median age at first sexual intercourse for African women in the countries shown in Table 6.1 ranges from 15.7 years in Niger to 18.9 years in Namibia. The corresponding figures observed elsewhere outside the African continent range from 17.2 years in Nepal to 20.0 years in Moldova.

Among African men, the lowest median age at first sexual intercourse was found in Congo-Brazzaville (16.8 years) and the highest came from Niger (21.9 years). Outside the African continent, Haiti had the lowest median age at first intercourse for men (16.2 years), whereas Indonesia had the highest value (23.5 years). Although these statistics are based on samples of men and women of different age groups (women ages 20–49 and men ages 25–54), the information in Table 6.1 indicates significant gender differences in the timing of first sexual intercourse in Africa and beyond. The age differences observed in Africa are, as explained below, affected in part by gender differences in age at first marriage.

Age at First Marriage

Marriage is virtually universal in Sub-Saharan Africa. Although this is true of other developing regions of the world, the age gap between spouses is wider in Africa than elsewhere (Wellings et al. 2006). For example, the highest median age difference between spouses was reported in Gambia,

Table 6.1 Median age at first sexual intercourse and median age at first marriage

	Median age at first sex		Median age at first marriage	
	Men	Women	Men	Women
	25–54 years	20–49 years	25–54 years	20–49 years
<i>African countries</i>				
Benin 2006	18.5	17.8	24.5	18.8
Cameroon 2004	18.6	16.5	24.8	17.8
Chad 2004	18.7	15.8	22.9	15.9
Congo-Brazzaville 2005	16.8	15.9	–	–
Congo, DRC 2007	18.0	16.9	24.3	18.7
Ethiopia 2005	21.2	16.5	23.7	16.5
Ghana 2008	20.0	18.4	–	–
Guinea 2005	19.9	16.0	–	16.3
Kenya 2008–09	17.7	18.2	–	–
Lesotho 2004	20.0	18.7	–	19.5
Liberia 2007	18.2	16.2	23.9	18.6
Madagascar 2008–09	18.1	17.3	22.8	18.7
Malawi 2004	18.6	17.3	22.9	18.0
Mali 2006	21.2	16.1	–	16.6
Namibia 2006–07	18.2	18.9	–	–
Niger 2006	21.9	15.7	23.0	15.6
Nigeria 2008	20.7	17.8	–	18.6
Rwanda 2005	20.8	–	24.7	–
Senegal 2005	20.8	18.7	–	18.5
Sierra Leone 2008	18.8	16.1	24.7	17.2
Swaziland 2006–07	19.5	18.1	–	–
Tanzania 2004–05	18.5	17.0	24.2	18.6
Uganda 2006	–	16.6	–	17.8
Zambia 2007	18.0	17.2	23.5	18.4
Zimbabwe 2005–06	–	18.7	–	19.4
<i>Non-African countries</i>				
Armenia 2005	19.8	–	–	–
Azerbaijan 2006	20.0	–	–	–
Moldova 2005	19.0	20.0	23.2	–
Ukraine 2007	18.7	19.6	23.0	–
Bangladesh 2007	–	–	24.5	15.3
India 2005–06	–	17.8	–	17.7
Indonesia 2007	23.5	–	24.0	–
Nepal 2006	19.6	17.2	20.2	17.2
Pakistan 2006–07	–	–	–	19.8
Philippines 2008	–	–	–	–
Colombia 2005	–	18.3	–	–
Dominican Republic 2007	16.6	18.0	24.2	18.9
Ecuador 2004	–	18.6	–	20.6
Haiti 2005–06	16.2	18.0	–	–
Honduras 2005–06	–	18.3	–	19.0
Paraguay 2004	–	18.2	–	21.3

Source: Compiled from the Demographic and Health Surveys

West Africa, with a record of 9.2 years, whereas the lowest figure came from France with -1.1 years (United Nations 2000), indicating a situation where a significant number of wives were older than their husbands.

These age gaps result in part from differences in age at first marriage (Table 6.1). Among African women, the median age at first marriage ranged from 15.6 years in Niger to 19.5 years in Lesotho. The corresponding values found elsewhere outside the African continent were 15.3 years in Bangladesh and 21.3 in Paraguay. Among African men, the median age at first marriage was in the early twenties, ranging from 22.8 years in Madagascar to 24.8 years in Cameroon. Outside the African continent, men's median age at first marriage ranged from 20.2 years in Nepal to 24.5 years in Bangladesh.

Further analysis of the data in Table 6.1 suggests the existence of a positive association between median age at first sex and median age at first marriage for women. The correlation coefficient between these two variables is 0.801 (significant at 0.01), for the 25 countries for which data are available. The corresponding value for African countries is 0.813 (significant at 0.01). This means that earlier sexual intercourse is associated with earlier marriage and vice-versa, especially in Africa. Therefore, it can be said that sexual intercourse is a precursor to marriage for many African women. No clear pattern is observed for men.

Premarital Sex

Sexual activity before marriage, especially at a younger age, can lead to health risks, including sexually transmitted infections and out-of-wedlock childbearing. Data in Table 6.2 show that, in general, the prevalence of premarital sex is higher in Africa than in other developing regions covered by recent Demographic and Health Surveys.

Among men, the highest prevalence of premarital sex was found in the African nation of Congo-Brazzaville (66.4%) and the lowest one came from Vietnam (2.7%), in South East Asia. Another African country, Liberia, was on the top of the list for

women's premarital sex (69.3%), whereas the lowest value was reported in Armenia and Azerbaijan (0%), Western Asia. In terms of gender, men were more likely to have had premarital sex than women, except in the African nation of Liberia.

Differences in premarital sex in Africa are primarily rooted in local cultures, especially the kinship system of gender socialization that determines men's and women's ranges of acceptable behaviors in society. Some scholars have argued the kinship system plays an important role in premarital sexual behavior of men and women. It is usually assumed that in matrilineal societies (such as those found in some parts of Zambia and Congo Brazzaville), where female autonomy is greater, women are more likely to engage in premarital and extramarital sexual relations than their counterparts living in more patrilineal areas (Djamba 1997). However, because current data are based on national samples without matrilineal and patrilineal variables, it is not possible to assess the impact of kinship system on premarital sex.

Multiple Sex Partners

The association between the number of sex partners and the risk of sexually transmitted infections has been documented in biomedical literature (Niccolai et al. 2004; Joffe et al. 1992). This is an even more serious public health concern in societies where sexual intercourse begins at a younger age and where condoms are not frequently used. Table 6.3 shows the percentages of sexually active men and women ages 15-49 who had multiple sexual partners in the last year, as well as those who used condoms during higher-risk sex (defined as having had sex with more than one person in the last 12 months).

The highest percentage of men who had sexual intercourse with more than one person during the last 12 months was found in Cameroon (40.4%), whereas the lowest figure was reported outside of the African continent, in Vietnam (0.7%). Among women, the highest prevalence of multiple sex partners came from Congo-Brazzaville (8.3%) and the lowest again outside of the African continent, in Azerbaijan and Vietnam (0.0%).

Table 6.2 Young people having premarital sex in the last year

	Percent of never-married men and women aged 15–24 years who had sexual intercourse in the last 12 months	
	Men	Women
<i>African countries</i>		
Benin 2006	40.5	37.5
Cameroon 2004	45.2	34.1
Chad 2004	34.1	6.4
Congo (Brazzaville) 2005	66.4	59.2
Ethiopia 2005	7.5	1.5
Guinea 2005	52.9	35.6
Liberia 2007	59.5	69.3
Malawi 2004	39.1	21.1
Mali 2006	15.9	8.1
Namibia 2006–07	48.5	46.3
Niger 2006	10.1	1.9
Rwanda 2005	8.7	4.7
Senegal 2005	20.9	2.1
Swaziland 2006–07	31.8	44.7
Tanzania 2004–05	43.2	29.0
Uganda 2006	27.6	24.2
Zambia 2007	37.6	28.7
Zimbabwe 2005–06	28.1	12.9
<i>Non-African countries</i>		
Armenia 2005	29.5	0.0
Azerbaijan 2006	31.1	0.0
Moldova 2005	54.1	17.4
Ukraine 2007	54.4	26.0
Cambodia 2005	8.3	0.1
India 2005–06	6.6	0.5
Nepal 2006	8.2	0.3
Vietnam 2005	2.7	0.2
Colombia 2005	–	39.1
Dominican Republic 2007	50.7	21.1
Honduras 2005–06	–	8.6
Bolivia 2008	42.4	19.1

Source: Compiled from the Demographic and Health Surveys

Despite these higher rates of multiple sexual partners, condom use is still relatively low in Africa. In fact, even when they had sexual intercourse with more than one person in the last 12 months, African men and women were in general less likely to have used a condom at their last sexual intercourse. The lowest values of condom use during the higher-risk sexual intercourse in the last 12 months were found in

Africa (6.6% for men in Niger and 6.8% for women in Chad).

These high-risk sexual behaviors contribute to the spread of sexually transmitted infections, including HIV, in Africa. There are, however, other practices that are more specific to African culture and that affect African men and women's sexual and reproductive health. Such practices are examined in the next section.

Table 6.3 Multiple sex partners in the last year among sexually active respondents and condom use during higher-risk sex

	Multiple sex partners in the last year among sexually active respondents aged 15–49, percentages		Condom use during higher-risk sex among respondents aged 15–49, percentages	
	Men	Women	Men	Women
<i>African countries</i>				
Benin 2006	27.4	0.9	17.5	20.6
Cameroon 2004	40.4	7.6	–	–
Chad 2004	23.4	1.1	20.2	6.8
Congo (Brazzaville) 2005	28.3	8.3	–	–
Ethiopia 2005	4.1	0.2	8.5	–
Guinea 2005	33.3	3.0	24.4	19.7
Liberia 2007	21.4	7.1	22.3	13.5
Malawi 2004	11.8	1.1	–	–
Mali 2006	22.2	1.4	12.2	8.1
Namibia 2006	16.1	2.5	74.4	65.7
Niger 2006	18.5	0.8	6.6	7.6
Rwanda 2005	5.1	0.6	25.0	19.1
Senegal 2005	22.9	1.8	40.4	23.4
Swaziland 2006–07	22.9	2.3	55.8	55.0
Tanzania 2004–05	30.1	4.3	–	–
Uganda 2006	28.7	2.4	20.4	23.9
Zambia 2007	19.7	1.6	28.0	33.1
Zimbabwe 2005–06	14.1	1.3	36.3	40.8
<i>Non-African countries</i>				
Armenia 2005	12.4	0.1	58.4	–
Azerbaijan 2006	7.9	0.0	26.0	–
Moldova 2005	14.3	1.8	71.5	27.4
Ukraine 2007	15.2	3.2	46.4	48.0
Cambodia 2005	9.5	0.3	41.1	–
India 2005–06	2.0	0.1	22.7	11.8
Nepal 2006	3.0	0.1	53.8	–
Vietnam 2005	0.7	0.0	–	–
Colombia 2005	–	4.6	–	36.2
Dominican Republic 2007	30.3	4.0	45.0	34.9
Honduras 2005–06	–	1.1	–	26.5
Bolivia 2008	15.4	–	35.2	–

Source: Compiled from the Demographic and Health Surveys

Vaginal Practices

Vaginal practices encompass all aspects of sexuality that attempt to modify or change the nature of the vaginal track. Some of these practices are performed on a daily basis, others are used as needed. I describe the most known practices used in Africa and explain their usage as well as

their health implications. According to biomedical literature on African sexual practices, the majority of vaginal sexual practices involve the insertion of liquids and/or other agents and objects into the vagina to produce a desired effect (Scorgie et al. 2009; Morar et al. 2003). Such practices include vaginal douching, and drying and tightening.

Vaginal Douching

Vaginal douching is a practice that involves the insertion of any liquid into the vagina. This practice has been reported in many parts of Africa from the Central Africa Republic (Gresenguet et al. 1997) and Kenya (Fonck et al. 2001), to South Africa (Morar et al. 2003). The majority of these reports are based on studies from small samples of women attending sexually transmitted infection clinics, or studies from samples of sex workers in specific locations. As such, it is not possible to estimate the magnitude of this practice in a country or even a city.

The in-depth interviews I conducted among African women from Botswana, Cameroon, Cote D'Ivoire, and Rwanda, while attending an international conference in Abidjan (Côte d'Ivoire), showed a variety of douching techniques (Djamba 2005). Some women reported using only cold water. Others, especially those in West Africa (e.g., Côte d'Ivoire), said that they used different substances and herbs in their douching practices. Some of these products are available in traditional healers' pharmacies in the city of Abidjan, Cote d'Ivoire and elsewhere. In another in-depth interview study conducted in Zimbabwe, Runganga and colleagues found that 87% of women reported using herbs and other agents regularly as a preparation for sexual intercourse (Runganga et al. 1992).

The motivations for vaginal douching are varied. A recent study from South Africa mentioned women's desire to enhance men's sexual pleasure as one key reason for douching (Scorgie et al. 2009). Elsewhere, such as in the Democratic Republic of the Congo, many women douche for hygienic reasons, especially during and after menses. This is also true for South African sex workers, where 65% of respondents cited hygienic purposes as the motivations for douching (Morar et al. 2003).

Vaginal douching has been associated with adverse gynecologic and reproductive health conditions, including sexually transmitted infections and HIV/AIDS. Data from the Demographic Republic of Congo, Malawi, Zambia, and Zimbabwe show a positive association between

vaginal douching and HIV infections (Kun 1998). Similar findings were echoed in other studies conducted in Kenya (Fonck et al. 2001; Rosenberg 2001), Zimbabwe (Janneke et al. 2001), and South Africa (Morar et al. 2003).

Because most of these studies were conducted on small samples of sex workers, sexual health clinic patients, and exploratory research with a limited number of women, we do not know the magnitude of vaginal douching in the general population in African countries.

Vaginal Drying and Tightening

In many parts of Africa, women use different methods to minimize vaginal secretions and to tighten the vaginal orifice. One of the pioneer articles on this subject was published in 1993 by Brown and colleagues under the title "Dry and Tight: Sexual Practices and Potential AIDS Risk in Zaire" (Brown et al. 1993). In this first clinical analysis of dry sex, Brown and colleagues found significant health risks among women who "dry" themselves.

Most dry sex practices involve the introduction of intra-vaginal douching, usually with astringent preparation, to dry and tighten the vagina. A variety of solutions and objects have been reported such as plants, leaves, small stones, powders, papers and cloth (Halperin 2000). Some men also participate directly in the drying process by inserting a piece of cloth in the woman's vagina to suck excessive secretions.

Dry sex practices have been reported in many African countries including Cameroon, Democratic Republic of Congo, Kenya, Malawi, South Africa, Zambia, (Djamba 2005; Baleta 1998) and Zimbabwe (Mbikusita-Lewanika et al. 2009). Such practices have also been found outside of the African continent. For example, a study in the Seattle area (in the United States) found that 16% of African American and 4% of white American women reported some dry sex-related practices (Halperin 2000).

Other reports of dry sex were mentioned in Haiti (Djamba 2005; Halperin 1999), the Dominican Republic (Halperin 1999), and Suriname (van

Andel et al. 2008). Dry sex, however, appears to be more prevalent in Africa than elsewhere. Research conducted on a random sample of South Africans age 16–35 years found that 60% of men and 46% of women practice dry sex (Beksinska et al. 1999). A recent study from the Western Cape Province in South Africa shows that 36.7% of women there prefer dry sex (Reddy et al. 2009). Another study of 812 Zambian women in the capital city of Lusaka reported that 76% of the women in the study practiced dry sex on a regular basis (Mbikusita-Lewanika et al. 2009). The prevalence of dry sex is even higher among sex workers. According to Baleta (1998), 80% of a group of 150 prostitutes in Kwazulu-Natal (South Africa) favor tight and dry sex.

Overall, dry sex is practiced as a way to enhance sexual pleasure, particularly for the male partner (Halperin 2000). One South African prostitute said: “Men do not like loose vaginas. If sex is wet then the man thinks that I have had sex with someone else and then he won’t pay me” (Baleta 1998). Evidently, the desire to please and keep men is the main motivation for vaginal drying and tightening. Nonetheless, some women prefer “dry sex” for their own sexual pleasure. A letter in the *Time Out New York*’s sex column read “I like dry sex with my husband, but it only happens a few times per month. I assume hormones are at work, but is there anything I can do to sustain this? Dehydration? I just feel so much more when everything is dry and not ruined by wetness” (Atterberry 2009).

Studies indicate that dry sex can be hazardous for women. For example, many leaves used by Congolese women produced visible lesions that decreased the integrity of the membranes lining the vagina and the uterine cervix (Brown et al. 1993). Similar clinical accounts were reported in Zambia (Hira et al. 1990). In contrast, a study in South Africa found that the consequences of dry sex were more serious for men than women. Dry sex was associated with increased prevalence of STDs in men, but not in women (Beksinska et al. 1999). Apparently, dry sex may cause small cuts on the penis that can easily transmit a variety of sexual infections, including HIV/AIDS.

Surgical Practices

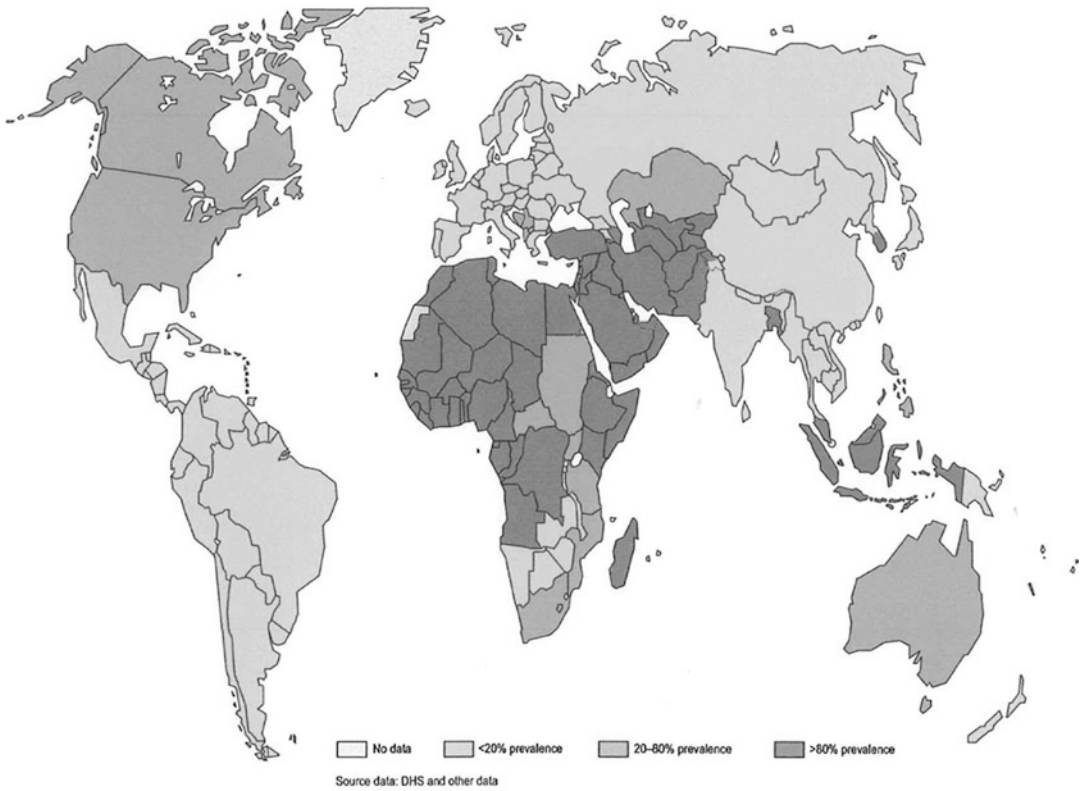
There are two main types of sex surgical practices found in some parts of Africa: male circumcision and female circumcision. The latter has also been called female genital mutilation (FGM) or female genital cutting (FGC). These practices are found only in some parts of Africa; there are places where neither of these two surgical operations is practiced. In some parts, only one of the two surgical practices is used, whereas in some places both methods are commonly used.

Male Circumcision

Male circumcision is one of the oldest surgical procedures in the history of mankind. Its origins date back to ancient Semitic peoples, including Egyptians and Jews around 2300 BC (Johnson 1993). It is also probably the sex surgical method most widely practiced in Africa. In fact, compared to other continents, Africa has the highest rate of male circumcision (WHO and UNAIDS 2007: 9) (see Map 6.1).

There are, however, major regional variations. For example, this practice is almost universal in North Africa and many parts of West Africa, but less common in the southern African region (Map 6.1). This is partly because male circumcision is strongly associated with Islamic and Jewish religious traditions. However, today many men undergo circumcision for non religious reasons. The data in Table 6.4 show that male circumcision is widely practiced among non-Muslims and non-Jews.

Age at circumcision varies, from infancy in countries like Ghana (neonatal circumcision) to childhood in Burkina Faso, Zambia, and Kenya (WHO and UNAIDS 2007). Today, as male circumcision is brought to East Africa and elsewhere as an HIV prevention method, many men undergo this surgical operation at older ages. A review of 13 studies assessing the acceptability of male circumcision in non-circumcising communities in sub-Saharan



Map 6.1 Prevalence of male circumcision at country level in 2006 (Source: WHO and UNAIDS 2007)

Table 6.4 Estimation of number of males aged 15 years or older circumcised for non-religious reasons, by country

	All males 15 years and older (millions)	Not Muslim or Jewish ^a			Number circumcised (millions)
		Percent	Number (millions)	Percent circumcised	
Angola	3.44	99.0%	3.4	90%	3.1
Congo, DRC	16.23	90.0%	14.6	90%	13.1
Ethiopia	20.92	55.0%	11.5	92%	10.6
Ghana	5.61	84.4%	4.7	85%	4.0
Kenya	9.99	93.0%	9.3	83%	7.7
Madagascar	4.24	90.0%	3.8	98%	3.7
Nigeria	35.23	50.0%	17.6	90%	15.9
South Africa	14.87	98.5%	14.6	35%	5.1
Uganda	6.94	85.0%	5.9	14%	0.8
Tanzania	9.84	65.0%	6.4	58%	3.7
United States of America	115.56	98.0%	113.2	75%	84.9

Source: Adapted from WHO and UNAIDS (2007)

^aThe last four columns represent males 15 years or older who were not Muslim or Jewish

Africa showed that the main factors associated with the current favorable attitude toward male circumcision are the desire to improve penile hygiene and to reduce the risk of sexually transmitted infections (WHO and UNAIDS 2007: 24).

In fact, many adult African men are now willing to become circumcised (65%, ranging from 29% in Uganda to 87% in Swaziland) (Westercamp and Bailey 2007). Moreover, the majority of women in Botswana, Kenya, South Africa, Swaziland, and Uganda said they want their partners to be circumcised. But so far there are unmet needs for male circumcision. Therefore, more resources are required in order to provide adequate male circumcision operations in safe and appropriate medical settings.

While the religious motivations remain the key determinant of male circumcision among Muslims and Jews, many men become circumcised today for other reasons, including social desirability and prevention of sexually transmitted infections. Social desirability is a strong motivation for male circumcision; for example, there are ethnic groups like the Akans of Ghana where only circumcised men could be elected as chiefs (WHO and UNAIDS 2007). In other groups, such as among the Telela of the Democratic Republic of Congo, male circumcision is so rooted in their culture that a woman would not have sexual intercourse with an uncircumcised man. Today, male circumcision has been included in programs of HIV prevention in several African countries (Bailey et al. 2007; Djamba and Davis 2007; Gray et al. 2007). Certainly, there are potential risks associated with male circumcision, especially if the operation is done in unsanitary conditions. Still, the sexual health benefits of male circumcision appear to outweigh the health risks.

Female Circumcision

For centuries, women in some parts of Africa have been subject to genital cutting and other female surgical procedures called female circumcision. This term has been mostly used by schol-

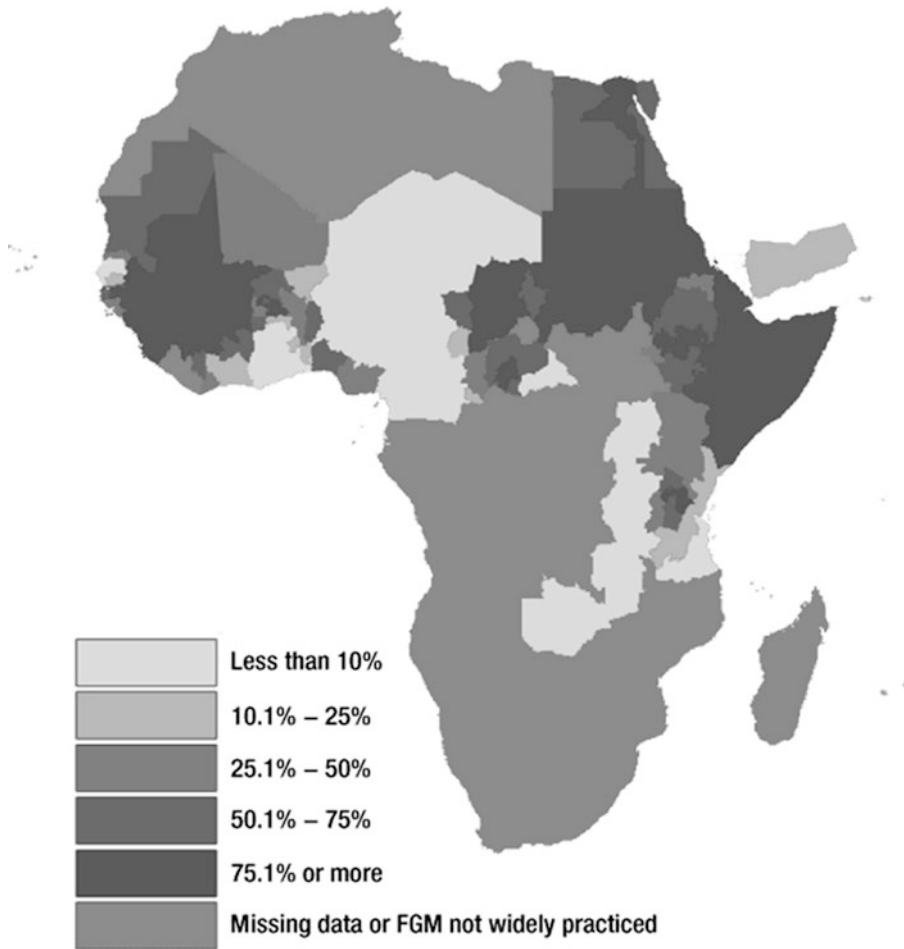
ars and those working directly with women (Obermeyer 2003; Althaus 1997), but more policy statements now include the term “female genital mutilation” (FGM), especially since the International Conference on Population and Development held in Cairo in 1994 (Althaus 1997). Others have used the term “female genital cutting” (FGC) to stress the horror associated with these kinds of operations, especially when they are performed in non-medical settings by non-medical professionals (Maslovskaya et al. 2009). I use the term female circumcision in this chapter because it is more neutral for descriptive purposes.

Unlike male circumcision, which is widely spread across Africa, female circumcision is found in a smaller number of countries (Map 6.2). This surgical procedure is usually practiced on girls aged 0–15 years, typically by women without any formal medical training. In some countries, female circumcision is also performed on adult women (UNICEF 2005). In 27 African countries where female circumcision has been documented among women 15–49 years, the highest prevalence was in Somalia (97.9%), whereas the lowest prevalence was in Uganda (0.6%) (see Table 6.5).

There are four types of female circumcision reported in Africa: clitoridectomy, excision, infibulations, and “nicking.”

1. Clitoridectomy involves the partial or total removal of the clitoris and/or the prepuce.
2. Excision is the partial or total removal of the clitoris and the labia minora, with or without cutting the labia majora.
3. Infibulation is a procedure used to narrow the vagina orifice and to create a covering seal by cutting and appositioning the labia minora and/or the labia majora with or without cutting the clitoris.
4. The last type, “nicking,” includes all other female genital procedures such as pricking, piercing, incising, scraping and cauterization (WHO 2008).

Clitoridectomy and excision are the most popular procedures. It is estimated that around 90% of female circumcision cases fall within these two categories (Yoder and Khan 2007).



Map 6.2 Prevalence of female circumcision among women aged 15–49 in Africa and Yemen (Source: WHO 2008)

Some of these female genital circumcisions have also been reported in other countries, including among certain ethnic groups in Central and South America. Furthermore, international migration has increased the number of girls and women living outside of their countries of origin who have undergone female genital circumcision (Yoder et al. 2004) or who may be at the risk of being subjected to this practice.

Research indicates that female genital cutting practices do not have any health or medical benefits. Rather, they have been associated with many immediate and long-term complications (WHO 2010a, b). Potential immediate complications include severe pain, trauma, excessive

bleeding, bacterial infections, and other injuries. Long-term consequences can include infertility, increased risk of childbirth complications and infant deaths, cysts, urinary tract infections, and a need for later surgeries (WHO 2010a, b).

Some people have argued that female circumcision is used to control or reduce female sexual promiscuity (WHO 2010a, b). One review of empirical research published between 1997 and 2005 concludes that available evidence does not support the view that female circumcision destroys sexual function or reduces sexual pleasure (Obermeyer 2005).

However, more recent investigations conducted in clinical settings show that circumcised

Table 6.5 Countries where female circumcision has been documented

Country	Year	Estimated prevalence of female circumcision in girls and women 15–49 (%)
Benin	2001	16.8
Burkina Faso	2005	72.5
Cameroon	2004	1.4
Central African Republic	2005	25.7
Chad	2004	44.9
Côte d' Ivoire	2005	41.7
Djibouti	2006	93.1
Egypt	2005	95.8
Eritrea	2002	88.7
Ethiopia	2005	74.3
Gambia	2005	78.3
Ghana	2005	3.8
Guinea	2005	95.6
Guinea–Bissau	2005	44.5
Kenya	2003	32.2
Mali	2001	91.6
Mauritania	2001	71.3
Niger	2006	2.2
Nigeria	2003	19.0
Senegal	2005	28.2
Sierra Leone	2005	94.0
Somalia	2005	97.9
Sudan, northern (approximately 80% of total population in survey)	2000	90.0
Togo	2005	5.8
Uganda	2006	0.6
United Republic of Tanzania	2004	14.6

Source: WHO (2008)

women had significant lower scores on sexual arousal, lubrication, orgasm, and overall sexual satisfaction than uncircumcised women (Alsibiani and Rouzi 2010). Such effects on female sexuality and other potential health complications associated with female circumcision are so serious that some activists, medical professionals, and other concerned world citizens have called for actions to end its practice. Today, several agencies of the United Nations have teamed to eliminate female circumcision, or what they call female genital cutting (WHO 2008).

What explains the differences in female circumcision between regions and countries? Unlike male circumcision, which is largely associated with religious beliefs (Johnson 1993), female

circumcision is primarily linked to local meanings of sexuality. For example, in places where it is widely practiced, female circumcision is mostly viewed as a rite of passage that has been followed for generations. Still, we do not know its true origins. Moreover, female circumcision remains a taboo and often an unknown practice in other parts of Africa.

Agenda for Future Research on Sexual Practices in Africa

This review of sexual practices in Africa shows the existence of a variety of methods and techniques used by men and women, either to enhance

sexual pleasure, attract and keep sex partners, or for hygiene or religious reasons. Many of these practices are rooted in cultural norms of gender roles and socialization specific to each African society. Yet, our knowledge of several of these practices is limited. In addition, there are indications that such sexual practices have significant health effects for both men and women.

Coupled with the practices previously mentioned, conversations with a few Togolese women suggest that wood insertion is a common sex practice among some ethnic groups (personal communication, July 8, 2010). This practice requires the inserting and keeping of a piece of wood in the vagina. A female American missionary who works with women in rural Togo indicated that there seems to be an association between vaginal wood insertion and sexual infection (personal communication, November 24, 2009). Such sexual practices have not been documented in the literature and social scientists and biomedical professionals need to investigate their magnitude and overall health effects.

As a consequence of the dearth of knowledge regarding most sexual practices in Africa, I encourage demographers and others to consider systematic studies to understand the prevalence and variety of sexual practices in Africa. I describe below suggestions regarding research design and potential problems for further research, as well as ways to increase response rates.

Research Design

Given that much knowledge of sexual practices in Africa is derived from convenience samples, new research must be based on national samples in order to obtain national estimates of various methods and techniques used by men and women. A cost effective approach is to incorporate the study of sexual practices into the next waves of the Demographic and Health Surveys (DHS).

There are currently two types of DHS Surveys: the Standard DHS Surveys and the Interim DHS Surveys. Both are based on nationally representative samples of households and provide data on a range of socio-demographic, health, and gender issues. However, the Standard DHS Surveys have

been conducted in more countries (45) than the Interim ones (2). In addition, the Standard DHS Surveys are based on larger samples (usually 5,000–30,000 households) than the Interim DHS Surveys (about 2,000–3,000 households). Typically, both men and women are interviewed in the Standard DHS Surveys, but not in Interim DHS Surveys. Moreover, Interim DHS Surveys have shorter questionnaires and they are conducted between rounds of Standard DHS Surveys (Measure DHS 2010).

Therefore, I suggest that future Standard DHS Surveys administered in Africa should include a section on sexual practices for both men and women. Such a section should include some of the reported, but less well-documented, practices described in this chapter, including surgical practices (female and male circumcisions), vaginal douching, dry sex, wood insertion and other practices. For each sexual practice, respondents should be asked about the knowledge, usage status (used/practiced/done versus never used/practiced/done), frequency, and (for those who have used/practiced/done it) the age at first event. Ideally, motivations and attitudes regarding various sexual practices would also be captured in order to shed light on cultural variations in sexual practices. For example, men should be asked about their knowledge and views on female circumcision and women should be asked the same thing about male circumcision.

On Sampling and Data Collection

Because the inclusion of the section on sexual practices will evidently increase the length of the Standard DHS questionnaires, I suggest that a subsample of men and women be selected to complete this module. Such samples should be similar to HIV testing samples used in some countries, and should be large enough and randomly selected to be representative of the national populations from which they are drawn.

Sexual practices are sensitive topics. Therefore, the data collection operations must be conducted by pre-trained adults. Ideally, men should be interviewed by men, and women by women. Organizers of the DHS Surveys have great

experience in survey methodology and should be able to adequately address any fieldwork problems that may be associated with the collection of data on sexual practices.

Discussion and Conclusion

Sexuality is universal, but there are substantial differences in sexual behaviors and sexual practices across the world. Most of these differences are rooted in the local cultures and norms that define socially acceptable sexual behaviors and practices. This chapter presents some aspects of the African sexuality through a review of sexual behaviors, sexual practices, and an agenda for further research. The overall conclusion is that most of the reported behaviors and practices discussed in this chapter are detrimental to the sexual and reproductive health of African men and women.

Regarding sexual behavior, the data presented in this chapter show that in several African countries, women have sexual intercourse at younger ages. For example, in Chad, Congo-Brazzaville, Niger, at least half of women aged 20–49 years had their first sexual experience before reaching age 16. In addition, spouses' age differences are greater in Africa than in many other parts of the world. These two factors, early initiation of sexual activity and large age differences between sexual partners, are known to be associated with higher risk of sexually transmitted infections (Kelly et al. 2003; Kaestle et al. 2005).

Africans were also more likely to have sexual intercourse with multiple partners than people in other parts of the world. Yet, condom use is still relatively low in many African countries, even in higher-risk sexual relations. Moreover, premarital sex is common in many African countries. For example, recent data from the Demographic and Health Surveys show that more than half of never-married men and women age 15–24 in the African nations of Congo-Brazzaville and Liberia reported having had sexual intercourse in the year before the survey.

Africa is also home to a variety of sexual practices. From female circumcision to newly reported

vaginal wood insertion, the majority of the more unique sexual practices that are reported in Africa are associated with hazardous sexual and reproductive health consequences. Many of the female sexual practices unique to Africa result in the destruction of vaginal membranes and, thus, increase the risk of sexually transmitted infection.

Vaginal douching, which is widely practiced in Africa, has been associated with a host of gynecologic and reproductive health problems (Kun 1998; Morar et al. 2003). Other practices such as vaginal drying and tightening found mostly in Africa have been associated with serious sexual health complications (Hira et al. 1990; Brown et al. 1993). More recently, we heard reports of women who insert wood in the vagina in Togo, West Africa.

What are the motivations underlying these practices? Some respondents said they use these sexual practices to enhance sexual pleasure, keep sexual partners, or for hygienic reasons. Still little is known about the origins and other cultural meaning of these sexual practices. Given the magnitude of the HIV/AIDS epidemic and the spread of other sexually transmitted diseases in Africa, more research is needed to understand the roots of these practices in order to improve sexual and reproductive health.

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Introduction

Some of the oldest erotic literature in the world is found in China (Ruan 1991). But there is a cultural paradox that has resulted in some disagreement among scholars about the sexual mores of the Chinese, both currently and historically. Some characterize Chinese society as sexually liberal and innovative (La Barre 1964; Russell 1928; van Gulik 1961; Bullough 1976; Jeffreys 2006), while others label it as cold, oppressive, and asexual (Suen 1983; Tseng and Hsu 1970; Pan 2006).

Research has shown that China had a belated entry into the realm of sexual expression (Jeffreys 2006). Until the past few decades, sexual expression was inhibited due in large part to Confucianism and, later, Communism, but this inhibition was partly lifted when China began to become more westernized. Indeed, following the economic reforms of Deng Xiaoping and the Open Door Policy begun in late 1978, Chinese culture with respect to sex and

sexuality has increasingly come to mirror the attributes of western sex and sexuality, including Western-style dating, a commercial sex industry, and a growing gay and lesbian scene (Jeffreys 2006).

Much of the research in the area of sexuality in China has been devoted to understanding the transformation over time of ideas and behaviors regarding sex and sexuality. According to Pan (2006), the transformation from a more regulated view of sex to a more western style can be traced back to the May Fourth Movement of 1919, which was a catalyst for the intellectual and social revolution in China. Pan has written about a variety of longstanding norms regulating sexual behaviors, as follows:

- (1) the understanding that reproduction is the primary objective of sex; (2) the gendered principle that women exist for male pleasure; (3) the notion that sex is a marital obligation and duty; (4) the notion that mutual gratitude and appreciation are more important in regulating sexual relations than romantic love; (5) a general objection to 'seeking pleasure' as the qualitative measure of sexual activity; (6) the imposition of quantitative restrictions on sexual activity through the understanding that excessive sex causes harm to male health; (7) the existence of social prohibitions on talk of sex; (8) the existence of social controls on sexual behaviors; and (9) the existence of age restrictions on sexual conduct (Pan 2006: 25).

Pan has argued that it is virtually impossible to analyze sexuality in China using Western terminology and ideology. In fact, the word "sexuality" has no literal translation in Chinese. The sexual

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revolution in China cannot be explained in an individualistic manner; rather, sexuality should be understood in terms of “the primary life cycle” and the “relations between the most basic of human activities, such as sex, reproduction, physical sustenance, and the social and sexual interactions between members of the opposite sex” (Pan 2006: 24).

This suggestion of a primary life cycle is important when attempting to explain the culture of sex prior to the sexual revolution in China. Interestingly, prior to the sexual revolution, there was no need to control or to prohibit sex; rather, there was more of an attempt to hide or conceal it. Sex was something that should be confined to a relationship between two married heterosexual adults and had the explicit purpose of producing an heir.

Currently, China’s sexual revolution has a variety of components. These include increases in premarital sex, extramarital and commercial sex, as well as in masturbation and same-sex sexual acts. In this chapter, we discuss some of these components; we also describe results from, and explain the rationale behind, one of the most important surveys of sexuality in China, the Chinese Health and Family Life Survey.

Our general objective in this chapter is to provide an overview of sexual behaviors in China. While the United States has had a more open attitude about sexual behavior, particularly following Kinsey’s research (1948, 1953) and the sexual revolution of the 1960s, China has maintained conflicting and different notions of sexual behavior. Before discussing the general literature on sexuality, we review China’s philosophical traditions because they provide an important perspective for our later discussions of sexuality. We then go over the extensive literature dealing with sexuality in China. Then we describe the Chinese Health and Family Life Survey and conclude our chapter with some descriptive data and discussion regarding sexual identification, behavior, and desire in China. We approach our analysis using a social constructionist view of sexuality, rather than one of essentialism. We turn now to a discussion of Chinese philosophies.

Chinese Philosophies and Sexuality

The oldest Chinese philosophy is the so-called Yin-Yang philosophy, which to this day has affected most every facet of Chinese society. For thousands of years, the Yin and Yang concepts were used to reference spiritual, social, and physical attributes of the two sexes (i.e., “Yin Fu” denotes vulva, “Yin Dao” denotes vagina, and “Yang Ju” denotes penis). The Yin-Yang philosophy states that “all objects and events are the products of two elements, forces, or principles: Yin, which is negative, passive, weak, and destructive; and Yang, which is positive, active, strong, and constructive” (Ruan 1991:11). Since it is the coming together of the “one Yin” (woman) and the “one Yang” (man) that spawns everything in the universe, many believe that this philosophy promotes sexual intercourse as a natural and vital part of life (Ruan 1991:12; Ng and Lau 1990). This belief is best illuminated in two passages from the *I-Ching (Book of Changes)* of 1150–249 B.C., the manuscript that expands upon the Yin-Yang doctrine (Wei 1970; Humana and Wu 1976; Ng and Lau 1990; Ruan 1991):

The constant intermingling of Heaven and Earth gives shape to all things. The sexual union of man and woman gives life to all things. The interaction of one Yin and one Yang is called Tao (the Supreme Path or Order), and the resulting constant generative process is called “change.” (van Gulick 1961).

While many have argued that this earliest dogma reflects sexual receptivity and candor among the Chinese, others find its content to be obsolete. Given that the *I-Ching* is believed to be over 3,000 years old, Ng and Lau (1990:375) have asserted that its ideas are often regarded as “primitive” by many scholars today. According to these researchers, the ancient Chinese were powerless over nature and perplexed by their lack of knowledge. Since they could not always explain adequately their surroundings, they turned to “supernatural and magical measures,” such as the *I-Ching*. Moreover, some of these old writings are superstitions which serve to hinder sexual freedom rather than to advance it. For instance, the belief about the importance of semen

retention (Lieh-Mak and Ng 1981) and the view that homosexual activities are vulgar (Lau and Ng 1989) are both linked to the *I-Ching*.

Besides the Yin-Yang doctrine, there are certain themes dealing with sexuality in each of the three main philosophical traditions (or religions) in China, namely, Confucianism, Taoism, and Buddhism. The most prominent of the three is Confucianism, as represented in the writings of Confucius (551–479 B.C.) and his supporters (Ruan 1991). While Confucius himself seemed to have had a realistic and amicable view of heterosexuality, his thoughts on the subject were not clearly conveyed in his books, the *Li-Chi* (Book of Rites) and the *She-King* (Book of Odes). The *Li-Chi* took a rather rigid stance towards sexual relationships, whereas the *She-King* was candidly accepting of sexual affairs and behaviors (Ng and Lau 1990). These ambiguities have apparently been ignored by the Neo-Confucians (beginning in the Song Dynasty (960–1279 A.D.), and onward), who interpreted his beliefs to be sexually oppressive. For around the last thousand years, many Chinese have valued and lived within the confines of this severe form of Confucianism (Ng and Lau 1990). Sex was only tolerated for reasons of procreation within marriage and public displays of affection were seen as immoral (Bodde 1985). Instances of female subordination, such as foot binding and the modification of feminine clothing, began to appear at about the same time as the emergence of Neo-Confucianism. One of the founders of Neo-Confucianism, Ch'eng Yi, was primarily responsible for the social custom of refusing remarriage to widows while granting it to widowers.

The Taoist philosophy emerged with the *Tao Te Ching*, a classic written by Lao-tzu, and it too had a considerable impact on Chinese culture (Ng and Lau 1990; Ruan 1991). Taoism differs from Confucianism in that it focuses more on the supernatural and less on political and moral principles. While Lao-Tzu's writings per se placed little emphasis on sex, many Taoist religious sects employed sexual techniques ("fang zhong") to prolong their existence and attain immortality (Ruan 1991). Several "fang zhong" texts were written by physicians and sex experts during the

Han and Tang dynasties (206 B.C.—A.D. 907). Ruan, in his book *Sex in China* (1991: 54–55), has categorized the Taoist sexual beliefs into eight main points: (1) the belief that longevity and/or immortality are attainable by sexual activity; (2) the corollary belief that intercourse with virgins, preferably young virgins, contributes to men's health; (3) the corollary in the desirability of multiple sexual partners; (4) the notions of "cai Yin pu Yang" (gathering a woman's Yin to nourish a man's Yang) and "cai Yang pu Yin" (gathering a man's Yang to nourish a woman's Yin); (5) the notion of the preciousness of "ching," or "seminal essence"; (6) the corollary belief in the importance of "huan jin pu lau" (making the seminal essence return to nourish the brain); (7) the belief in the value of preventing and interrupting ejaculation by pressing the "point" (in the perineal area); and (8) the belief that immense sexual satisfaction may be derived from coitus without ejaculation.

Though Taoism is markedly different from Confucianism in the importance it places on sex, it is far from an egalitarian dogma. The function of sex in the many Taoist texts is to acquire longevity for the male partner by taking in the female "vital power" released during female orgasm, while retaining the "vital power" found in his semen (Bodde 1985). Thus, the purpose of the female orgasm is to serve the man rather than to satisfy the woman. Schipper (1969) has a rather compelling remark about one of the Taoist manuals:

This is only one example of all the methods of extracting the breath and essential female force. The remarkable thing is its absolute selfishness. The woman is without exception considered to be an enemy. Sexual union does not lead to creation by the other (i.e., to joint procreation by the couple). The semen must be withheld to fortify one's own body, and to create in it the immortal embryo (Schipper 1969: 24).

There was a huge backlash against some of the sexually permissive Taoist sects by Buddhists and Confucians in the sixth century, with the result that much of this type of Taoism vanished by the seventh century (Bodde 1985). Given that most Chinese were not educated and thus unable to

read and comprehend the Taoist sexual manuals, Ng and Lau (1990) have reservations about the strength of Taoist influence on Chinese sexual perspectives. Moreover, the manuals were essentially buried before the rise of Neo-Confucianism (Bodde 1985), hence casting even more doubt about their overall impact on Chinese sexuality.

Buddhism began in India with the teachings of Gautama Buddha (565–486 B.C.), and was later imported into China during the first century A.D., at about the same time that Taoism emerged (Ruan 1991; Liu 1992). Because of their simultaneous appearance in China, it was initially somewhat difficult to distinguish Buddhism from Taoism. The first “sutra” translated into Chinese was the *Sutra in Forty-two Sections*, which encouraged people “to purify their minds and to reduce their desires” (Liu 1992:35), a strategy very reminiscent of Taoist texts of the time. As other Buddhist “sutras” were brought into China and additional Taoist texts were written, their incongruities became more apparent.

In its progression, Buddhism branched into two different schools, Mahayana and Hinayana. Mahayana Buddhism became the predominant Buddhism of China, differing primarily from the original form and its inclusion of deities (Liu 1992). For the most part, the Buddhist schools renounced sexual yearning (Ruan 1991), since Buddha preached that “desires are the source of pain, and that by overcoming desires, pain can become eliminated.” Although sexual desire was discouraged and Buddhist monks were forbidden to marry, lay Buddhists could marry and acquire multiple concubines to supplement their formal wives (Ruan 1991).

Given that both Taoist and Confucian philosophies linked sex to human nature, the Chinese were sometimes cynical about the virtuousness of Buddhist monks and nuns. This skepticism resulted in a variety of literary works depicting Buddhist clergy acting on sexual impulses (Ruan 1991). There is evidence that some of these transgressions did indeed occur, one being prostitution among Buddhist and Taoist nuns (Wang 1934).

Tantrism, or Mi-tsung, which thrived during the Yuan dynasty (A.D. 1279–1368), was a Buddhist sect that actually did participate in

bizarre sexual rituals. The Mi-tsung believed that “the ‘Buddha nature’ resided in the female generative organs and stressed the mystical importance of sexual union” (Ruan 1991:26; Needham 1956). The behaviors of this sect quite obviously conflicted with Buddhist and Confucian principles.

These themes of sexuality derived from the various philosophical traditions in China continue to serve as a guide for a variety of sexual beliefs and practices in China. In the next section, we explore some of the literature on beliefs and practices in modern day China, before turning to our empirical analysis.

Sexual Beliefs and Practices in China: A Review

In this section, we review the history and current state of the Chinese view on gay men and lesbians, premarital sex, and masturbation. As noted in the preceding section, traditional Confucian ideals and cultural implications have a strong impact on how sexuality is viewed.

Confucian philosophies have typically viewed sexuality as being detrimental to social order and personal health (Ruan 1991). These beliefs persisted through the mid-twentieth century and only began to lose ground as recently as the 1980s. Since then, more academic research has focused on sexual topics such as premarital sex, divorce, prostitution, and sexually transmitted infections (Parish et al. 2007). Despite the rise in more moderate sexual attitudes, cultural discourses regarding Chinese sexuality continue to emphasize a heterosexual norm.

Homosexuality

As previously noted, a focus on the “yin and yang” highlights the importance of a heterosexual union; men are “regarded as opposites to women, masculinity the counterpart to femininity...as such, homosexuality is the opposite of heterosexuality” (Li et al. 2010: 401). East Asian countries, and China in particular, have been greatly

influenced by Confucianism and its strong son preference. Of additional importance to Chinese culture is the stress on continuing the bloodline of the family; indeed this is a major component of the transition to true adulthood, a transition that can only be made through heterosexual marriage. Chinese culture places a premium on family and familial obligations, and failing to fulfill these obligations (namely, by not marrying and not having children) was once regarded as morally wrong (Li et al. 2010).

These beliefs are particularly problematic for gay men. According to Yinhe Li (2006), while there are no codified laws in China that restrict homosexuality or any sex acts that are performed between two consenting adults in the privacy of their own homes, there does continue to be a “condemnation of homosexuality, and family pressure to marry and have children places severe constraints on the lives of homosexuals” (Li 2006: 82). Due to the familial obligations just noted, some gay men and lesbians actually marry members of the opposite sex in order to fulfill their family obligations. As a consequence, the true count of gay men and lesbians in China may be obscured if the number is based only on behavior. This idea of the multi-dimensionality of sexual identity, that is, the social construction of sexuality, is discussed later in this chapter.

Whereas at one time Chinese culture may have viewed homosexuality as an ultimately abnormal and wrong lifestyle, H. Li and colleagues (2010) have noted that gay and lesbian identities and practices have emerged in modern day China due to transcultural practices and a change in sexual knowledge and practice in China. They have estimated that approximately 30 million people in China are gay. China decriminalized homosexuality in 1997, but there are no laws that protect against discrimination based on sexual orientation. However, in 2000 the Chinese Ministry of Public Security declared that “people had the right to choose their own sexuality” (Li 2006: 83). While this statement shows that positive strides are being made for gay men and lesbians in China, it is unclear whether the realities of same-sex relationships are accepted in the society.

Cao, Wang, and Gao conducted a contemporary analysis of perceptions of, and attitudes toward, gay men and lesbians among Chinese university students in 2010. Prior research had found that “university students’ perceptions and beliefs about gay males and lesbians vary according to age, region, and cultural background” (Cao et al. 2010: 722). In general, it seems to be the case that individuals with higher education are more open-minded regarding gay men and lesbians. Likewise, the research of H. Li and colleagues (2010) showed that a tolerance of gay males and lesbians was increasing in China, mainly among younger, unmarried, and better-educated persons. In the study by Cao and colleagues (2010), the authors found no major differences in attitudes toward gay men and lesbians among both men and women. They also found, interestingly, that science students not only had more knowledge about gay individuals, but they also were more tolerant than were liberal arts students. Additionally, they reported that the earlier the students were exposed to gay men and lesbians, the more tolerant and understanding were their attitudes and perceptions.

Wong and Tang (2004) have written about some of the research in China on gay individuals and the “coming out” process. “Coming out” refers to the process whereby an individual who identifies as gay, lesbian, bisexual, or transgender (GLBT) discloses his/her sexual orientation or gender identity to others. The process of “coming out” is often one that is both emotionally and psychologically difficult for the GLBT person and those to whom they are “coming out.” This process generally begins in young adolescence, when individuals first become aware of their same-sex attractions (Wong and Tang 2004). Wong and Tang have found that the sequence of the coming out process for Chinese men was generally the same as that for Western individuals. In many cases for Chinese gay men, this process first begins with “same-sex sexual fantasy, followed by self-awareness of gay tendencies, same-sex sexual behaviors, and then commitment in gay orientation and disclosure of this sexual orientation to others” (Wong and Tang 2004: 155).

Research on lesbianism in China (Ruan and Bullough 1992) has noted that lesbians remain somewhat hidden. Research indicates that in many cases it is difficult for lesbians to find and connect with other lesbians in China, and there are rather unflattering descriptions of lesbians particularly in the media (Ruan and Bullough 1992). A survey in Taiwan conducted by a Taiwanese psychiatrist, however, found that twenty-one percent of women reported that they had had lesbian inclinations at some point in their lives (Ruan and Bullough 1992).

Unlike the situation of gay men and lesbians in the West, some have argued that gay men and lesbians in China do not face radical disapproval via extreme measures such as physical attacks and assault. Indeed Wong and Tang (2004) reported that their respondents had low levels of psychological distress related to the “coming out” process. Rather, the problems they faced seem to stem more from “misunderstanding and prejudice of mainstream society” (Li 2006: 99). While it may be preferable to be misunderstood rather than hated, the situation for gay men and lesbians in China is still not ideal.

Nonmarital Sex¹

It is widely known that most young adults in the West routinely engage in nonmarital sex. These days, around 90% of U.S. women in the child-bearing ages (15–49) report having participated in sexual intercourse prior to marriage (Poston and Bouvier 2010: 82). However, it seems that the “youth in Asia are not nearly as sexually permissive or sexually active as youth in the U.S.” (Huang and Uba 1992: 228). It is our impression, based on mainly anecdotal evidence, that while at one time nonmarital sex may have been traditionally prohibited in China, it is now

becoming more widely accepted, particularly among college students.

Unfortunately an increase in the acceptance of nonmarital sex in China does not equate to an increase in sexual knowledge. In fact, many studies on the sexual behavior of urban Chinese students show that they are unlikely to engage in safe sex practices, such as condom protected intercourse (Wang and Davidson 2006; Kaufman et al. 1996). Likewise, there is even less contraceptive use in rural areas, and the rural people are less familiar with the health risks associated with unprotected intercourse. Moreover, Tang and colleagues (1997) have found that some Chinese men still believe that “controlled sexual activity protects health, excessive masturbation weakens the body, semen needs careful conservation, and that sex with a menstruating woman causes illness” (1997: 80).

It may also be the case that some Chinese young adults have less open attitudes and hence engage in more conservative sexual activity (Tang et al. 1997; Higgins et al. 2002; Higgins and Sun 2007; Yu 2007, 2010). While there may be negative attitudes in place, the evidence concerning behavior is not necessarily as clear (Higgins and Sun 2007). Furthermore, despite the fact that there may be a slight increase in permissive attitudes regarding nonmarital sex in China, there are still society-wide norms in place that view premarital sex negatively.

Masturbation

Empirical studies of masturbation are relatively rare, especially on a large scale or using nationally representative data (Das et al. 2009). This is particularly true with regard to developing countries. Das, Parish, and Laumann (2009) conducted the first nationally representative study of masturbation in urban China. The researchers sought to answer two questions, namely, what is the relationship of masturbation to partnered sex, and what are the social sources of masturbation. They noted two main ways to view masturbation: compensatory and complementary. The compensatory view argues that masturbation is an

¹ In many areas in the West, the term “premarital sex” is actually a misnomer because in many cases it is unlikely that individuals engaging in sexual activity with each other plan to marry each other. Thus, the term now used more frequently is “nonmarital sex.”

“outlet for sexual tension, compensating for the lack of availability of either partnered sex or satisfactory partnered sex” (2009: 109). This view of masturbation is consonant with the notion that masturbation is more “common among those with little access to satisfying partnered sex” (Das et al. 2009: 109). Alternately, the view of masturbation as complementary sees the behavior as an act that can coexist with the availability of partnered sex.

Das and colleagues (2009) used two main questions regarding masturbation and showed that there were mixed results regarding whether masturbation was mainly compensatory or complementary in China. They noted that some of their results were consistent with a compensatory interpretation, while some results were consistent with a complementary interpretation. For example, they found that masturbation was more common when “there was no stable sex partner or when partnered sex was less satisfying (among men) and when the spouse or steady partner was often away during the preceding year (women and men)” (Das et al. 2009: 116). Their results varied, and the authors noted this could be due to personality differences among the respondents. They found, however, “a bimodal pattern, particularly for women” (2009: 118). This means that masturbation has a complementary function with partnered sex for some women, but is more compensatory for others, and that these functions were highly related to various background conditions such as education. Some of the men in the study reported similar patterns, but for most men, their masturbation patterns were less likely to be linked to background characteristics (2009).

Having reviewed some of the current literature on sexuality in China, we turn next to a discussion of the major Chinese sexuality dataset that we use and analyze in our chapter.

The Chinese Health and Family Life Survey

Background

In our empirical examination of sexuality in China, we use the Chinese Health and Family Life

Survey (CHFLS). The CHFLS is a collaborative project between the University of Chicago/National Opinion Research Center, Renmin University in Beijing, the Peking Union Medical College in Beijing, and the University of North Carolina. The survey focuses on “sexual behavior in contemporary Chinese society”, and the 18 sections of the survey span topics such as demography and health, attitudes toward marriage and sex, sexually transmitted infections, masturbation, and homosexuality (The University of Chicago 2000).

The CHFLS is a nationally representative survey that asked questions of a sample of the adult population of China between 20 and 64 years of age. Interviews were conducted between 1999 and 2000 in 18 widely dispersed Chinese provinces, and the sample size was 3,821. The sample design included 14 strata, 48 primary sampling units, 60 neighborhoods, and 5,000 individuals aged 20–64. Of these, 3,821 participants completed the interview, resulting in a final response rate of 76%. With the exclusion of Tibet and Hong Kong, the sample is nationally representative of the adult population of China aged 20–64 years. Details about sample design, the final questionnaire, and data used in this study are available at <http://www.src.uchicago.edu/prc/chfls.php>.

In our analyses using the CHFLS data, we adjusted them for sample design so that we can generalize to the national population from which the data were drawn (Parish and Laumann 2003). We use the “svy” suite of survey adjustment commands in the Stata-12 statistical package, so that our results may be generalized to China’s total adult population aged 20–64. Before we turn to our analyses of sexuality using the CHFLS, we first outline the paradigm we will use to study sexuality in China, namely, the social constructionist perspective of sexuality.

The Social Construction of Sexuality

Often when analyzing gender and sexuality, sociologists opt to use a social constructionist perspective. A social constructionist perspective seeks to “explore and explain social phenomena

and occurrences on the basis of their historical context and social framing...[it] thereby traces how seemingly natural occurrences are constructed through a history of human actions and interactions” (Sandvoss 2006: 569). A social constructionist perspective stands in contrast to an essentialist perspective, which argues that the human condition is formed by natural characteristics, and that there are certain essential characteristics that are the same in all of a particular group (e.g., gender or race).

Using a social constructionist perspective of sexuality, we seek to explore how sexual identification, desires, and behavior work together to frame the labeling of sexual orientation. Using any one dimension of sexual orientation, or using any of the dimensions in concert with others, often yields dramatically different results with regard to who is labeled as a gay man or a lesbian. This is important because in many studies and surveys, researchers will only use one dimension of sexuality in their designation of sexual orientation. This is obviously a problem because it seems to be the case that, depending on which dimension of sexuality that is used, one usually comes up with vastly different results regarding who is a gay male or lesbian. In our analyses of the data gathered by the CHFLS, we show the disparities and differences between the numbers of people identified as gay men or lesbians depending on which dimension, or combination thereof, of sexuality that is used.

Results

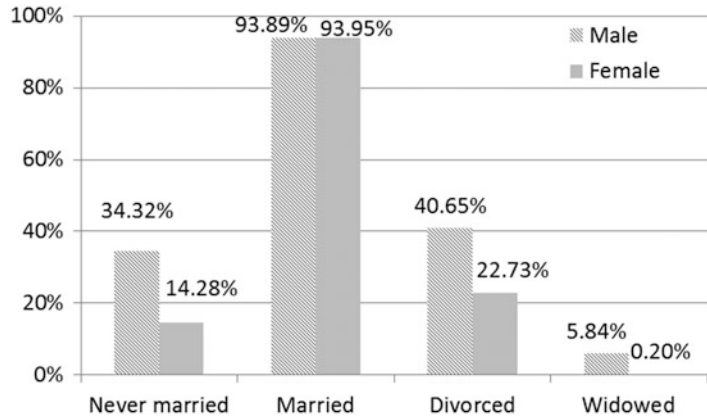
Marital status is used as an essential indicator of sexuality in China. The married population is generally regarded as sexually active, while the never-married, divorced, and widowed are typically viewed as sexually inactive. This perception follows the social norms in China that sexual behavior is only appropriate within marriage (Herold and Byers 1994). According to the CHFLS, most married individuals were sexually active in 2000. Over 90% of married males and females claimed to be sexually active, though their sexual partners were not limited to their own

spouses. However, a great number of never married and divorced people were also sexually active, especially among males. Over one-third (34%) of never married males, and 41% of divorced males, had sexual relationships. It seems that females were less active, in that 14% of never-married females and 23% of divorced females were sexually active; these percentage rates are much lower compared to the rates of males (Fig. 7.1). These data indicate that sex was not necessarily exclusive to married couples. Sex outside marriage did exist, irrespective of whether it was acceptable or preferable by social norms.

Heterosexual and Non-Heterosexual Identity, Desire, and Behavior

In our research, we were especially interested in a comparison of the heterosexual and non-heterosexual populations in China. Based on the various dimensions of sexuality and gender, all respondents in the final sample were first divided into four groups, namely, heterosexual men, heterosexual women, gay men, and lesbians. Specifically, all persons were identified according to three dimensions of sexuality: sexual identity, sexual desire, and sexual behavior. Men and women who identified themselves as “homosexual”, and/or who felt they desired only to have sex with individuals of the same sex, and/or who ever had sex with individuals of the same sex, were all classified as gay men or lesbians. According to this classification, gay men and lesbians did not have to be consistent in all three dimensions. Any one of these three dimensions indicating homosexuality would result in the assignment of the person as gay or lesbian. This approach also implies that heterosexual respondents in this study were consistent in their sexual identity, desire, and behavior. Based on this classification, 4.16% of males were gay and only 1.12% of females were lesbian (Table 7.1). The results also reflected that gay men and lesbians in China had very low consistency in their sexual identity, desire, and behavior. In fact, only 3% of the males choosing at least one gay response to the three dimensions chose the gay response to all

Fig. 7.1 Sexually active adults by gender and marital status, aged 20–64, China 2000 (Estimated percent is adjusted for survey design effects using sampling weight)



three dimensions; the corresponding percentage for lesbians was 4% (Figs. 7.1 and 7.2). Our analyses in the next paragraphs are based on these classifications (Fig. 7.3).

Gay men and lesbians differed from heterosexual men and women across several geographic and socioeconomic variables. Lesbians were heavily concentrated in urban areas, with nearly 60% living in cities. In contrast, less than 30% of the heterosexual population lived in urban areas. Lesbians were also characterized by higher educational attainment. Generally speaking, heterosexual men and lesbians had the highest educational attainment compared to heterosexual women and gay men. However, lesbians were disadvantaged in employment (Table 7.2), having a lower percentage with a full-time job than the other three categories of persons. Without reliable information on other socioeconomic characteristics, such as income or occupation, it is difficult to conclude whether gay men and lesbians in China had higher or lower socioeconomic status than their heterosexual counterparts.

Measures of Sex Education, Sexual Freedom, and Sex Equality in China

Prior to the 1980s, sex was a taboo subject in China. The Chinese were often ashamed to talk about sex, sex education was absent, and any materials relating to sex were strictly forbidden (Bo and Wenxiu 1992). In our analyses, we examined what happened to Chinese people at the very

beginning of the twenty-first century. Was sex still a taboo subject that people knew little about and deliberately avoided talking about? Did males and females enjoy gender equality and sexual pleasure? Was sex outside marriage a “bad thing” for Chinese people? Did they have basic knowledge about STIs and HIV/AIDS? What was their sexual practice? We discuss the results from our analyses below.

Gender Equality

Our results clearly demonstrate the continuing effect of traditional gender roles and social division of labor that emphasize the importance of males and that place restrictions on females. Despite their sexual preferences, the majorities in the four groups (heterosexual males, heterosexual females, gay males, and lesbians) agreed that the wife should focus on the family and the husband on his career (Table 7.3). What is more interesting is the attitude toward gender equality of social status. As found in many studies outside of China, the results suggest that Chinese gay men and lesbians were more likely to support gender equality. But surprisingly, gay men and lesbians in China were more likely to say that males enjoy higher social status. This might be caused by their higher requirement of gender equality, which is more compatible with homosexuality. For the heterosexual population, more than half accepted the notion of equal social status between males and females.

With regard to talking about sex itself, people seemed to have highly conservative and even

Table 7.1 Sexuality of males and females, aged 20–64, China, 2000^{a,b}

Sex	Heterosexual		Homosexual		Total	
	%	n	%	n	%	n
Male	95.84	1,827	4.16	78	100.00	1,905
Female	98.88	1,876	1.12	40	100.00	1,916

^aEstimated percent is adjusted for survey design effects using sampling weights

^bn is number of observations in the sample

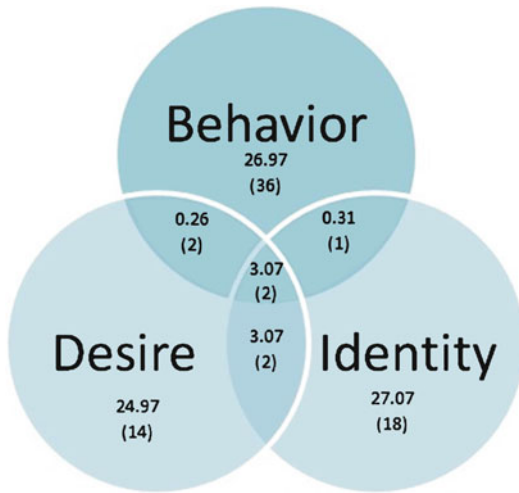


Fig. 7.2 Interrelations of components of same-sex sexuality, males aged 20–64, China, 2000 (Estimated percent is adjusted for survey design effects using sampling weights; Numbers in parentheses refer to the number of observations in the sample)

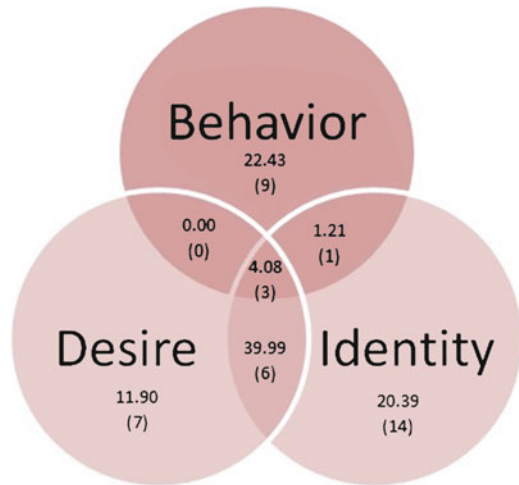


Fig. 7.3 Interrelations of components of same-sex sexuality, females aged 20–64, China, 2000 (Estimated percent is adjusted for survey design effects using sampling weights; Numbers in parentheses refer to the number of observations in the sample)

negative attitudes (Table 7.4). As a whole, sex was not favored only for pleasure, and it was believed that too much sex damages one’s health. Irrespective of whether the women were lesbians or heterosexuals, females were more constrained with respect to seeking sexual pleasure than males. However, gender equality in sexual behavior was highly preferred, which is very different from old notions that males enjoy sex while female pleasure was to be disregarded (Jankowiak 1989). Both males and females believed that sex during menstruation hurt women. Most also agreed that the husband should sexually satisfy the wife, but heterosexual women, either wives or potential wives, had the lowest amount of agreement on this issue; only a little over half reported “agreeing”. Lesbians, though, reported the highest amount of *disagreement* that husbands should sexually satisfy the wife, at almost 15%.

The results were similar when respondents were asked whether women should seek orgasm as much as men. Over 90% of heterosexual men and lesbians, and nearly 85% of heterosexual women and gay men, agreed that women should seek orgasm as much as men (Table 7.4). In addition, 75% of heterosexual men believed women should be active in sex and not only follow the lead of men; in contrast, only one-half of heterosexual women, gay men, and lesbians thought men should lead in sex (Table 7.4).

Nonmarital Sex

While most of the Chinese in the CHFLS were strongly opposed to extra-marital sex, males tended to be more tolerant than females (Table 7.5). About 90% of heterosexual women and lesbians completely disagreed with the statement that “extra-marital sex is ok,” but only 60% of heterosexual men and gay men completely disagreed. Compared to extra-marital sex, premarital sex

Table 7.2 Demographic and socioeconomic characteristics, heterosexuals and homosexuals, aged 20–64, China, 2000a

Demographic characteristics	Heterosexual			Homosexual			
	Males		Females	Males		Females	
	Mean/Proportion	Linearized Std. Err	Mean/Proportion	Linearized Std. Err	Mean/Proportion	Linearized Std. Err	
Age	40.13	0.994	37.77	1.246	38.43	3.699	2.886
Residence place							
Urban	29.62	0.029	29.11	0.025	28.01	0.087	0.183
Rural	70.38	0.029	70.89	0.025	71.99	0.087	0.183
Education							
Primary school or lower	34.82	0.047	49.90	0.052	20.51	0.116	0.175
Middle school	41.65	0.032	33.06	0.042	60.74	0.126	0.122
High school	18.29	0.023	13.23	0.016	14.87	0.053	0.113
College or higher	5.24	0.006	3.81	0.006	3.88	0.018	0.019
Employment							
Temporary job	12.36	0.019	11.76	0.013	12.39	0.048	0.111
Full-time job	78.82	0.026	70.50	0.033	83.62	0.063	0.169

^aEstimated percent is adjusted for survey design effects using sampling weights

Table 7.3 Attitudes toward division of labor and gender equality, heterosexuals and homosexuals, aged 20–64, China, 2000^a

Attitudes	Heterosexual				Homosexual			
	Males		Females		Males		Females	
	Proportion %	Linearized Std. Err	Proportion %	Linearized Std. Err	Proportion %	Linearized Std. Err	Proportion %	Linearized Std. Err
1. "Wife focus on family, husband on career"								
Don't know	0.47	0.004	0.00	0.000	0.00	0.000	0.00	0.000
Completely agree	43.58	0.031	53.85	0.019	56.92	0.123	59.36	0.142
Somewhat agree	20.55	0.013	20.09	0.018	16.73	0.055	15.56	0.069
Somewhat disagree	25.26	0.010	19.06	0.017	22.75	0.081	22.77	0.113
Completely disagree	10.14	0.022	6.99	0.011	3.60	0.020	2.31	0.018
2. "Who enjoys higher social status"								
Refused	0.18	0.001	0.10	0.001	0.00	0.000	0.00	0.000
Don't know	0.04	0.000	0.09	0.000	0.00	0.000	0.00	0.000
Men higher	25.12	0.021	36.37	0.027	52.72	0.114	61.80	0.170
More or less the same	63.73	0.019	57.10	0.029	41.66	0.118	27.06	0.106
Women higher	10.92	0.023	6.28	0.017	5.62	0.033	11.15	0.083

^aEstimated percent is adjusted for survey design effects using sampling weights

Table 7.4 Attitudes toward sex, heterosexuals and homosexuals, aged 20–64, China, 2000^a

Attitudes toward sex	Heterosexual				Homosexual			
	Males		Females		Males		Females	
	Proportion %	Linearized Std. Err	Proportion %	Linearized Std. Err	Proportion %	Linearized Std. Err	Proportion %	Linearized Std. Err
1. "Sex for pleasure is ok"								
Inappropriate	0.00	0.000	0.03	0.000	0.00	0.000	0.00	0.000
Don't know	0.93	0.000	0.16	0.000	0.00	0.000	0.00	0.000
Completely agree	2.90	0.010	1.72	0.014	4.74	0.134	1.57	0.000
Somewhat agree	5.81	0.054	2.95	0.022	5.02	0.131	0.00	0.004
Somewhat disagree	26.46	0.027	8.39	0.018	32.69	0.051	16.09	0.041
Completely disagree	63.90	0.043	86.76	0.024	57.55	0.022	82.34	0.041
2. "Too much sex damage health"								
Refused	0.01	0.000	0.00	0.000	0.00	0.000	0.00	0.000
Don't know	1.20	0.010	2.39	0.014	0.00	0.000	2.31	0.021
Agree	62.15	0.010	47.97	0.024	71.62	0.068	70.01	0.105
Mostly agree	22.54	0.020	34.56	0.021	20.99	0.057	12.64	0.047
Mostly disagree	9.61	0.016	12.12	0.021	6.63	0.036	12.89	0.082
Disagree	4.49	0.008	2.95	0.008	0.76	0.005	2.15	0.016
3. "Sex during menstruation hurts women"								
Refused	0.00	0.000	0.00	0.000	0.15	0.002	0.00	0.000
Don't know	2.83	0.012	1.79	0.008	1.21	0.013	0.00	0.000
Agree	92.01	0.022	92.85	0.019	98.64	0.013	86.80	0.084
Disagree	5.16	0.014	5.36	0.015	0.00	0.000	13.20	0.084
4. "Husband should satisfy wife"								
Refused	0.02	0.000	0.00	0.000	0.00	0.000	0.00	0.000
Don't know	0.72	0.005	1.95	0.014	0.00	0.000	0.00	0.000
Agree	66.65	0.053	54.24	0.032	73.74	0.084	72.79	0.161
Mostly agree	23.00	0.023	31.53	0.029	23.35	0.087	12.42	0.052
Mostly disagree	7.94	0.027	7.41	0.012	2.91	0.019	14.79	0.119
Disagree	1.66	0.008	4.87	0.011	0.00	0.000	0.00	0.000

(continued)

Table 7.4 (continued)

Attitudes toward sex	Heterosexual				Homosexual			
	Males		Females		Males		Females	
	Proportion %	Linearized Std. Err	Proportion %	Linearized Std. Err	Proportion %	Linearized Std. Err	Proportion %	Linearized Std. Err
5. "Women should seek orgasm as much as men"								
Refused	0.00	0.000	0.09	0.001	0.00	0.000	0.00	0.000
Don't know	0.48	0.004	1.81	0.014	0.00	0.000	0.00	0.000
Agree	92.09	0.013	83.57	0.030	84.86	0.077	96.54	0.024
Disagree	7.43	0.010	14.53	0.031	15.14	0.077	3.46	0.024
6. "Men leads, women follows"								
Refused	0.06	0.000	0.10	0.001	0.00	0.000	0.00	0.000
Inappropriate	0.05	0.000	0.00	0.000	0.00	0.000	0.00	0.000
Don't know	0.70	0.003	1.75	0.014	0.00	0.000	0.00	0.000
Agree	24.03	0.064	49.21	0.071	48.01	0.095	57.56	0.147
Disagree	75.17	0.066	48.94	0.076	51.99	0.095	42.44	0.147

^aEstimated percent is adjusted for survey design effects using sampling weights

Table 7.5 Attitudes toward sex outside of marriage, heterosexuals and homosexuals, aged 20–64, China, 2000^a

Attitudes toward sex outside of marriage	Heterosexual				Homosexual			
	Males		Females		Males		Females	
	Proportion %	Linearized Std. Err	Proportion %	Linearized Std. Err	Proportion %	Linearized Std. Err	Proportion %	Linearized Std. Err
1. "Extra-marital sex is ok"								
Don't know	0.25	0.000	0.03	0.000	0.00	0.000	0.00	0.000
Completely agree	2.29	0.010	1.42	0.014	0.31	0.134	0.00	0.000
Somewhat agree	4.44	0.054	0.93	0.022	8.25	0.131	0.39	0.004
Somewhat disagree	30.92	0.027	10.43	0.018	28.63	0.051	9.23	0.041
Completely disagree	62.09	0.043	87.19	0.024	62.81	0.022	90.38	0.041
2. "Premarital sex is not a moral issue"								
Refused	0.03	0.000	0.00	0.000	0.00	0.000	0.00	0.000
Don't know	0.13	0.001	0.63	0.005	0.00	0.000	0.00	0.000
Completely agree	25.89	0.010	16.37	0.014	41.76	0.134	21.76	0.108
Somewhat agree	34.21	0.054	30.93	0.022	43.11	0.131	24.52	0.119
Somewhat disagree	25.41	0.027	20.96	0.018	11.01	0.051	17.14	0.061
Completely disagree	14.33	0.043	31.11	0.024	4.12	0.022	36.58	0.174

^aEstimated percent is adjusted for survey design effects by using sampling weight

was more acceptable and, like extra-marital sex, was more readily accepted by gay men and heterosexual men than by lesbians and heterosexual women (Table 7.5).

STIs and AIDS

In the year 2000, some Chinese people were not familiar at all with sexually transmitted infections, including AIDS. About 75% or more were uncertain or disagreed that a condom would protect them from STIs and AIDS (Table 7.6). A sizeable proportion of all four groups, but particularly of gay men and lesbians, did not know how AIDS was transmitted. Blood transfusion seemed to be the most well-known cause of AIDS. Chinese were so eager to keep themselves away from AIDS that more than 20% of them believed that a handshake could transmit AIDS, and over 40% believed that eating together, or sneezing could transmit AIDS. Compared to heterosexual men and women, gay men and lesbians were more likely to hold those false beliefs (Table 7.6).

Sexual Practices

Irrespective of marital status, compared to heterosexual men, heterosexual women, and lesbians, gay men had the highest percentage of persons currently involved in sexual relationships, as well as having previously experienced premarital sex and extra-marital sex (Table 7.7). Almost every gay man in the CHFLS indicated a sexual relationship at the time of the interview, although that was not necessarily a requirement for our classification of the gay population. Nearly one-third of gay men had experienced premarital sex, and one-fifth of married gay men had experienced extra-marital sex sometime in their lives. Heterosexual women were the most traditional and conservative of all the groups in terms of their sexual behavior. They were the least likely to be involved in premarital sex or extra-marital sex.

Nearly 6% of heterosexual men, and 5% of gay men admitted that they had paid for sex sometime in their lives, percentages much higher than those for females (Table 7.7). This supports

the long held assumption that females were more likely to be sex workers, while males were more likely to be customers.

We have been focusing on the sexual practices of the general population. We conclude here with a focus on two of the general groups, namely, the gay and lesbian population and never-married adults. Since there is a very strong preference for marriage in China, it is interesting to see how gay men and lesbians deal with heterosexual marriage in their lives. The results of our analyses show that there is not a large difference in the marital status distributions of the heterosexual and the homosexual populations. Even after indicating a homosexual preference, nearly 90% of gay men and lesbians were in a heterosexual marriage (Fig. 7.4). This illustrates the normative importance of marriage irrespective of one's sexual identification.

Among all never-married adults, one-fourth report having had sex in the past year. However, there were differences among the groups (Fig. 7.5). Only 14% of never-married heterosexual females report having had sex in the past year, compared to 60% of never-married gay men. About 30% of heterosexual men and lesbians claim that they had sex in the past year.

Conclusion

We close this chapter with a few general observations. Our analyses reflect that, for the most part, there has been a shift in Chinese people's attitudes and knowledge and practice of sex. Most seem to value equal relationships between males and females in sexual relationships. Premarital sex is now acceptable to some extent, and males are more likely than females to have experienced premarital sex. However, married couples still appear to be highly restricted by moral codes. This is seen in the very high disapproval, by most everyone, of extra-marital sex.

In addition, although Chinese people have begun to learn more about reproductive health, their knowledge about STIs and AIDS is still very limited, if not sometimes inaccurate. Further,

Table 7.6 Knowledge about STIs and HIV/AIDS, heterosexuals and homosexuals, aged 20–64, China, 2000^a

Knowledge about STIs and HIV/AIDS	Heterosexual				Homosexual			
	Males		Females		Males		Females	
	Proportion %	Linearized Std. Err	Proportion %	Linearized Std. Err	Proportion %	Linearized Std. Err	Proportion %	Linearized Std. Err
1. "STDs can be cured"								
Refused	0.01	0.000	0.00	0.000	0.00	0.000	0.00	0.000
Don't know	19.16	0.021	16.35	0.018	7.05	0.022	46.57	0.164
Don't know the term "STD" or "AIDS"	10.96	0.010	24.58	0.016	3.98	0.025	0.53	0.006
None can fully recover	4.13	0.007	10.29	0.029	3.68	0.023	3.08	0.022
A few can fully recover	18.41	0.015	20.77	0.017	25.65	0.082	28.55	0.130
Most can fully recover	34.62	0.022	22.89	0.032	32.38	0.127	18.18	0.093
All can fully recover	12.71	0.018	5.11	0.011	27.26	0.184	3.10	0.025
2. "Condom can prevent all STDs"								
Refused	0.01	0.000	0.00	0.000	0.00	0.000	0.00	0.000
Don't know	41.73	0.022	43.58	0.013	38.43	0.147	48.50	0.160
Agree	25.13	0.039	17.08	0.037	21.06	0.113	15.69	0.087
Disagree	33.13	0.053	39.34	0.038	40.50	0.071	35.80	0.138
3. "Handshake can transmit aids"								
Don't know	39.68	0.031	42.34	0.022	29.56	0.097	46.65	0.167
Yes	21.62	0.015	27.33	0.015	54.42	0.120	33.18	0.127
No	38.70	0.031	30.33	0.021	16.02	0.046	20.17	0.075
4. "Eating together can transmit aids"								
Don't know	37.33	0.016	41.02	0.014	10.78	0.088	25.78	0.045
Yes	45.25	0.020	43.71	0.018	73.15	0.096	67.13	0.094
No	17.41	0.021	15.27	0.026	16.07	0.025	7.09	0.078

(continued)

Table 7.6 (continued)

Knowledge about STDs and HIV/AIDS	Heterosexual				Homosexual			
	Males		Females		Males		Females	
	Proportion %	Linearized Std. Err	Proportion %	Linearized Std. Err	Proportion %	Linearized Std. Err	Proportion %	Linearized Std. Err
5. "Blood transfusion can transmit aids"								
Don't know	18.68	0.029	28.00	0.020	5.45	0.041	12.65	0.057
Yes	80.78	0.033	71.76	0.020	92.78	0.045	87.35	0.057
No	0.54	0.004	0.24	0.002	1.77	0.019	0.00	0.000
6. "Sneezing can transfusion can transmit aids"								
Don't know	39.71	0.021	44.31	0.010	19.65	0.054	15.18	0.055
Yes	40.11	0.026	40.26	0.016	70.39	0.057	71.38	0.097
No	20.18	0.032	15.43	0.019	9.96	0.043	13.44	0.073

^a Estimated percent is adjusted for survey design effects using sampling weights

Table 7.7 Sexual practices, heterosexuals and homosexuals, aged 20–64, China, 2000^a

Sexual behaviors	Heterosexual						Homosexual					
	Males			Females			Males			Females		
	Proportion %	Linearized Std. Err	Proportion %	Linearized Std. Err	Proportion %	Linearized Std. Err	Proportion %	Linearized Std. Err	Proportion %	Linearized Std. Err		
Now engaging in sex	93.31	0.019	91.74	0.019	99.69	0.003	89.53	0.087				
Prenatal sex	22.36	0.042	9.82	0.010	31.19	0.108	13.07	0.059				
Extramarital sex	14.78	0.018	4.61	0.008	17.59	0.087	8.98	0.045				
Paid sex	5.95	0.014	0.60	0.005	4.74	0.019	0.00	0.000				

^aEstimated percent is adjusted for survey design effects using sampling weights

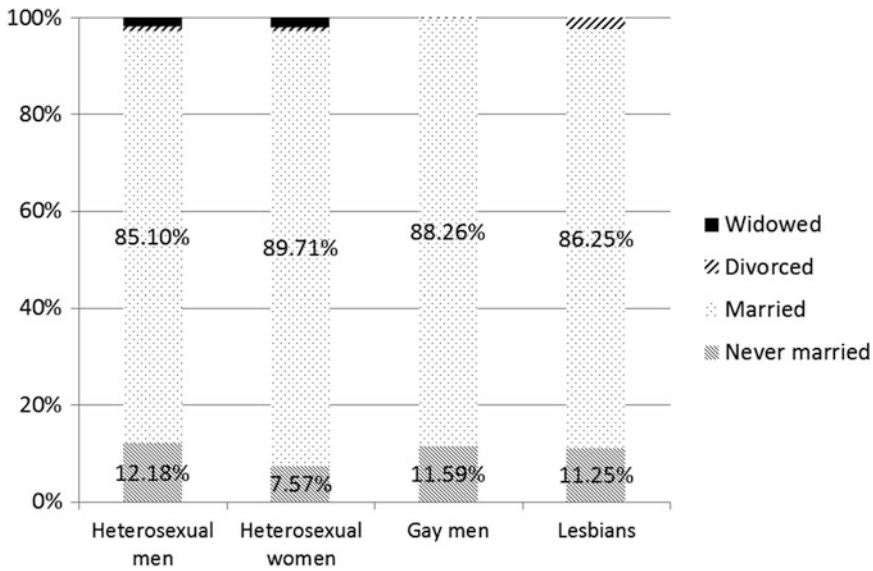


Fig. 7.4 Distribution of marital status, heterosexuals and homosexuals, aged 20–64, China: 2000 (Estimated percent is adjusted for survey design effects using sampling weights)

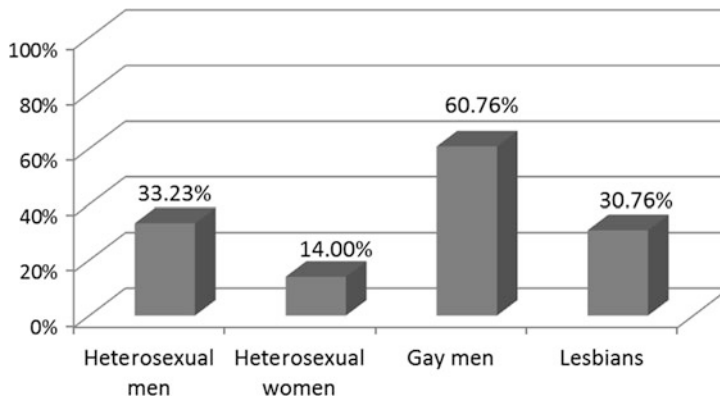


Fig. 7.5 Percentages of never-married adults who had sex in past year, heterosexuals and homosexuals, aged 20–64, China, 2000 (Estimated percent is adjusted for survey design effects using sampling weights)

gay men and lesbians appear to face more difficulties than heterosexuals in many facets of life, particularly those involving sexuality and sexual behavior in day-to-day activities and relationships. In China, there is very little legal protection for gay men and lesbians which, coupled with the strict gender norms, might contribute to the result that many engage in heterosexual marriage.

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Part III

Sexual Practices Across the Life Course

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Introduction

Sexual behavior is an integral and consequential aspect of intimate relationships. In this chapter, we concentrate on understanding the impact of sexual practices on important components of couple formation, maintenance, and devolution. We review sexuality and relationship literature spanning several decades and disciplines to demonstrate specifically what demographic and other factors influence the quality of sex within relationships, how sexuality influences the quality of couples' relationships, and whether these patterns are constant within and across different kinds of committed couples. Because the definitions of "commitment" and "relationships" are constantly redefined by both researchers and the couples themselves, we also address the literature that examines intimacy within less "traditional" contexts such as dating and less widely understood semi-committed relationships.

Why limit the focus of our review to sexual behavior within the context of the committed relationship? Of course the first reason is because the committed couple is the central reproductive and socializing building block of most, if not all, societies. What creates solidarity,

or disillusionment, and potentially abandonment, has huge consequences for culture and government. It is also true, however, that while sexuality is not restricted to couples, the vast majority of sex still occurs within committed couples. Indeed, for most heterosexual and same-sex couples, sex is anything but a rare or occasional occurrence. For example, Blumstein and Schwartz (1983) found that approximately 46% of married individuals, 38% of cohabiters, 41% of gay men, and 35% of lesbians who were coupled for at least 2–10 years reported engaging in sex between one and three times per week. Likewise, relative to non-partnered individuals, heterosexual women and men who live together in marriage or cohabitation are about twice as likely to have sex two or three times a week (Laumann et al. 1994; Michael et al. 1994). We also include in this chapter couples that live in a more ambiguous state of commitment than the above studies document. They are in a special section of this chapter because their behavior exists in a different context, and generally, involves different interpersonal negotiations. Further, the vast majority of childbearing still takes place within the context of the committed relationship and so these latter adult alliances, often fleeting in nature, have been less intensively researched

We do, however, discuss diverse kinds of couples who have varying degrees of commitment. A recurrent theme in our chapter is that sexual behavior is different depending on what

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kind of couple is being studied, and the impact of that behavior on sexual satisfaction and relationship satisfaction also varies. To be sure, the literature suggests a few universal principles: for example, in general, sex strengthens the bonds of relationships. However, the motivations for sex, how often couples have sex, and the consequences of sex vary by a host of demographic factors including one's gender, age, sexual orientation, position in the life course, as well as many contextual factors such as living arrangements. Thus, we address research on a variety of couple types and the circumstances that may define or constrain their sex lives.

Whenever possible we take a comparative perspective by summarizing key international literature on sexuality in committed relationships. Unfortunately, there is very little comparative literature published in English on many of our topics. Very few studies use global data sets with measures of sexual behavior, so we are mostly reliant on single case studies that sample from particular regions. Thus, rather than generalize how certain phenomena may vary across regions and cultures, we usually note existing differences as evidence that there is great variation in sexual behaviors.

We separate our chapter into three sections. First, we review the well-researched studies that consistently come to the same conclusion regardless of the age, gender, sexual orientation or marital status of the population: Having regular sex with a partner is beneficial for relationships. Second, because relationships are dynamic and constantly evolving, we address issues that couples may face as they try to maintain a healthy sex life over the life course. Finally, although every study mentions that the majority of people world-wide hold monogamy (especially female monogamy) to be essential, we address the incidence and relationship effects of both infidelity and negotiated non-monogamy. We also address these same issues about sexuality in semi-committed relationships such as dating and other new forms of commitment. We conclude with what seem to be the most powerful effects of sexuality on relationships (and vice versa) and some suggestions for demographers interested in advancing the demography of sexuality as a subfield.

A Note on Couples and Units of Analyses

The study of the sexual life of couples has intensified in recent decades. Many scholars now rely on large nationally representative datasets to assess how sexual behavior affects relationship well-being and how qualities of the relationship affect couples' sex lives. Although the research questions are aimed at understanding the well-being and behavior of the couple, it is somewhat ironic that most large, nationally representative datasets rely on the individual as the unit of analysis. For example, studies that are frequently used to address couples' sexuality such as the National Health and Social Life Survey (NHSLs), the General Social Survey (GSS), and the National Survey of Family Growth (NSFG), rely solely on the individual as the unit of analysis. Researchers must infer that responses regarding sexual frequency, sexual satisfaction, and relationship well-being apply also to the respondent's sexual partner. This is problematic because sex is a relational act that nearly always occurs in the dyadic context. Important information may be lost or obscured when one respondent must report on behalf of the dyad. Questions about how one partner's behavior affects the other partner's behavior or well-being are particularly error-prone using individual-level data. This may be why some authors call for a relational approach that focuses on both the individual and the dyad as units of analyses (McKinnney and Sprecher 1991; Weiderman 2004).

Despite the tendency for researchers to rely on the individual as the unit of analysis to examine couples, some important datasets have examined sexuality at both the individual and couple level. Most notably, Blumstein and Schwartz (1983) surveyed 4,314 heterosexual married and cohabiting couples, as well as 969 gay male and 788 lesbian couples. Separate interview questionnaires were sent to each couple allowing both partners to respond to an identical list of questions. A subset of 300 couples were interviewed separately and subsequently interviewed with both partners present. By privately interviewing partners, researchers were able to obtain information that

may not have been divulged had the other partner been present. By interviewing the couples with both partners present, the researchers were able to document the couple's interaction. For example, the researchers were able to record the couples as they attempted to solve a number of fictional problems that are common to committed relationships. This approach allowed the researchers to better gauge how interpersonal communication strategies are associated with relationship and sexual well-being. Since then, other researchers have approached the study of sexuality among heterosexual and same-sex couples using similar, relational strategies (see Peplau et al. 1997; Veroff et al. 1995). However, couples studies using this strategy are still uncommon.

Although we include some results derived from large datasets that use couples as the unit of analysis, we advise cautious interpretation of the data. Most statistical techniques assume that a sample of the population consists of independent observations, regardless of the designated unit of analysis. Each observation is usually assumed to be unique and independent of all other observations. However, when one includes both partners in an analysis of couples, the observations are no longer independent, and dependent observations violate the assumptions inherent in many statistical techniques (see Kenny 1988). Thus, while datasets that include both partners may help us better understand dyadic relations and increase statistical power, interpretation of those data should take the above methodological challenges into account.

The Importance and Incidence of Sexuality in Committed Relationships

Sexual Well-Being and Relationship Well-Being

Aside from some small, mostly psychological studies, there was a paucity of sexuality research on couples before the 1970s. Blumstein and Schwartz's (1983) American Couples Survey was the first large-scale survey study to systematically look at the connection between sexual

satisfaction and relationship well-being in a diverse sample of committed couples. This connection between sexuality and relationship satisfaction in married, cohabiting, and same-sex couples was further explored in Laumann and colleagues' (1994) nationally representative National Health and Social Life Survey (NHSL). Other conterminous studies that relied on large national surveys arrived at the same general conclusion: happy couples have frequent sex and satisfying sex lives (Byers 2005; Costa and Brody 2007; Deenen et al. 1994; Gossman et al. 2003; Henderson-King and Veroff 1994; Kurdek 1991; Peplau et al. 1997, 2004; Sprecher 2002; Yeh et al. 2006). Several international studies spanning nearly every developed region of the world have also found strong links between sexual satisfaction and relationship quality which lends credence to the universality of the association (Barrientos and Paez 2006; Guo and Huang 2005; Haavio-Mannila and Kontula 1997; Renaud et al. 1997).

Same-sex relationships were even more neglected before the late 1970s and early 1980s. It was not until 1983 when the Blumstein and Schwartz study first used survey data to systematically analyze same-sex committed unions. Their data indicated that sexual activity was just as important for relationship satisfaction in gay couples as it was in heterosexual couples (Blumstein and Schwartz 1983). This finding was replicated by a number of smaller studies since the 1990s (Kurdek 1991, 1994; Peplau et al. 1997, 2004). The same conclusion has been validated in two recent studies based on internet samples of lesbian women (Henderson et al. 2009; Tracy and Junginger 2007); these researchers also found that pleasure during sex, heightened arousal, and overall sexual satisfaction were positively associated with relationship satisfaction.

Most studies that document the association between sexual satisfaction and relationship satisfaction measure relationship well-being as a subjective assessment of the relationship at the time of the interview. The association remains robust, however, when researchers examine relationship well-being in a more objective manner by observing relationship stability or relationship durability. A handful of longitudinal studies have

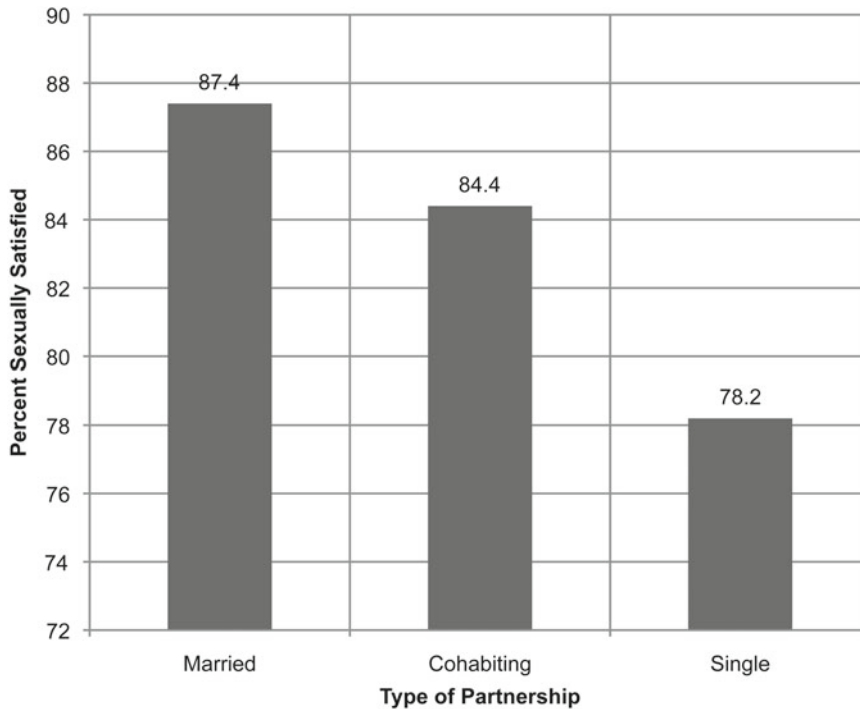


Fig. 8.1 Percent “very” or “extremely” sexually satisfied with sexual relationship by relationship status (Source: Laumann et al. (1994) using NHSL 1994)

found a significant negative association between sexual satisfaction and either thoughts of ending the relationship or the dissolution of the relationship itself (Edwards and Booth 1994; Veroff et al. 1995; White and Keith 1990). More recently, Yeh and colleagues (2006) studied 283 midlife heterosexual couples over a period of 5 years, and found that early reports of sexual satisfaction predicted later changes in marital stability. The authors found that sexual satisfaction led to stability through its positive effect on marital satisfaction. This study was limited to rural, married couples who had previously been together for many years, but studies of urban couples and studies using random samples have arrived at similar conclusions (e.g. Blumstein and Schwartz 1983; Laumann et al. 1994).

Which individual characteristics and relationship types are most likely to lead to a satisfied sex life? The short answer to the question is that, by and large, most partnered individuals are satisfied with their sex lives. However, the frequency of

sexual satisfaction varies dramatically by a few key demographic factors. Both Blumstein and Schwartz (1983) and Laumann and colleagues (1994) found that individuals who had sex within the context of a committed relationship were more likely to report satisfaction with their sex lives. Figure 8.1, adapted from Laumann and colleagues’ NSHSL (1994) data, demonstrates the strong association between sexual satisfaction and couple type. Specifically, about 88% of married, monogamous couples reported being very or extremely sexually satisfied followed by about 84% of cohabiters and 78% of singles. The researchers noted that this finding defies the stereotype of highly satisfied and sexually manic singles that dominates much of popular media (see Michaels et al. 1994).

The same study, however, did reveal a satisfaction gap by gender and age. Figure 8.2 presents the proportion of respondents who reported being extremely physically satisfied with their relationship. While women appear to be slightly

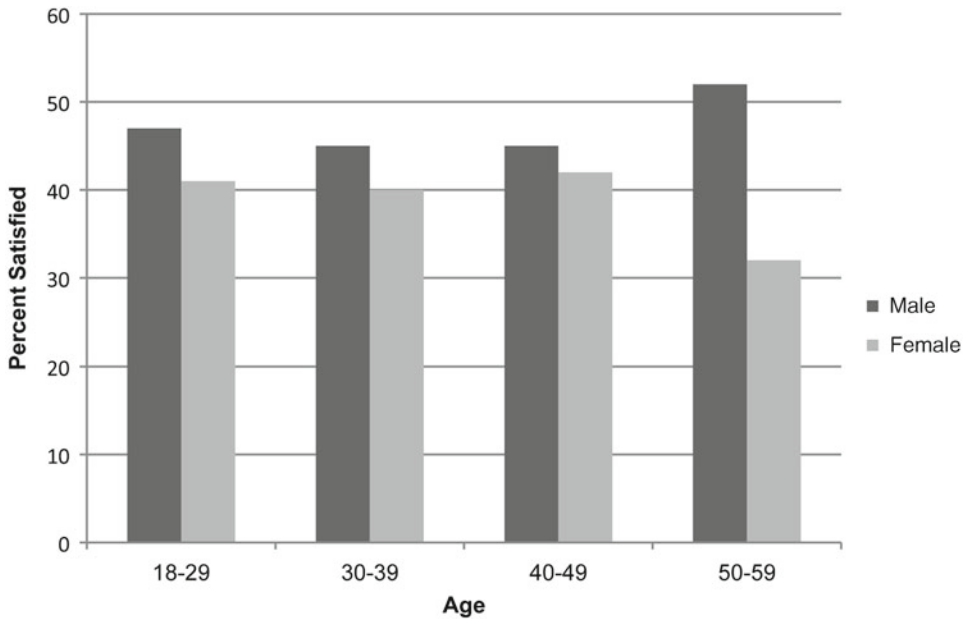


Fig. 8.2 Percent extremely physically satisfied with relationship (Source: Laumann et al. (1994) using NHSLs 1994)

less satisfied with their sex lives at all age groups, the satisfaction gap is more pronounced for women of older ages. The authors speculated that some of the discrepancy may be accounted for by different biological and cultural processes; specifically, the fact that menopause affects many women's sexual interest and satisfaction, and the cultural devaluation of older women's sexuality may affect their sexual self-image (see also Koch et al. 2005).

The quality of sex is not the only aspect of physical intimacy that affects couples' satisfaction with their relationship. The *quantity* of sexual acts (usually measured as coital frequency) is also associated with relationship well-being. Perhaps unsurprisingly, sexual frequency is strongly correlated with sexual satisfaction (Blumstein and Schwartz 1983; Fisher 2009; Greely 1991; Haavio-Mannila and Kontula 1997; Laumann et al. 1994). This finding is consistent when comparing married couples, cohabiting couples, and same-sex couples (Blumstein and Schwartz 1983; Deenen et al. 1994; Peplau et al. 2004; Richter et al. 2003). To be sure, the correlation may be driven by the fact that couples may have more frequent intercourse if the sex is satisfying

(Harvey et al. 2004). However, Schwartz and Young (2009) noted that an alternative explanation may be that frequent sex gives partners the opportunity to explore each others' desires and increase the likelihood of orgasm. Longitudinal studies that examine the effects of changes in sexual frequency and sexual satisfaction over time and how changes affect relationship well-being may shed more light on the causal order.

Some studies have examined the effects of sexual frequency on relationship well-being, apart from its effects on sexual satisfaction. Call and colleagues (1995) utilized the National Survey of Families and Households (NSFH) to examine the incidence and frequency of sexual intercourse in a large sample of married couples. The authors found that aside from the aging process, sexual frequency was most strongly associated with marital satisfaction. This finding appears to hold true for same-sex couples. Using two waves of longitudinal data, Balsam and colleagues (2008) compared 176 partnered gay men, 397 partnered lesbians, and 110 married heterosexuals and found that sexual frequency at time one was a significant predictor of relationship quality at time two. However, the positive effects

of sexual frequency on couples' relationship well-being may not be as universal as the effects of sexual satisfaction. Some researchers who have found weaker sex frequency effects in other regions of the world suggest that sexual frequency may be less relevant in cultures that do not openly emphasize sexuality as a key component of relationships (Knodel et al. 2007).

It is important to note, however, that sexual frequency is not constant through the duration of relationships. Virtually all couples—heterosexual or same-sex, cohabiting or married—experience a decline in sexual frequency over their years together (Blumstein and Schwartz 1983; Brewis and Meyer 2005; Call et al. 1995; Gossman et al. 2003; James 1981; Johnson et al. 1994; Klausmann 2002; Udry 1980). Fortunately for committed couples, most studies find that declines in sexual satisfaction do not necessarily follow declines in sexual frequency, suggesting that while the initial novelty of the “honeymoon phase” may eventually fade, most partners still enjoy their sex lives (but see Klausmann 2002; Liu 2002). Thus, it appears that although sexual frequency and sexual satisfaction are strongly associated, to some degree both operate differently in the context of the relationship.

While it has been firmly established that regular and satisfying sex is beneficial for both heterosexual and same-sex relationships, not all groups behave or benefit equally. The incidence of couples' sexual interaction and the impact of those interactions vary depending on the population studied. Key demographic variables such as gender and sexual orientation of the partner have a significant influence on what kinds of sexual behaviors occur, as well as the consequences of these behaviors, in different kinds of intimate relationships.

Variation in the Incidence and Effects of Sexuality in Different Types of Committed Couples

Even in quite diverse samples of couple types, few differences in sexual behavior or sexual satisfaction exist by race, ethnicity, income, occupation,

and education. However, as we discuss below, several researchers have found that certain social and demographic characteristics *do* matter in determining how sex affects relationships. In particular, respondent's gender, sexual orientation, and whether the couple is cohabiting versus married explain some of the variation in sexual behaviors and the impact of sex on relationships. While these variables by no means invalidate the positive relationship between frequent and satisfying sex lives and satisfying relationships, they certainly add complexity to our understanding of the role of sexuality in committed relationships.

Differences by Gender

While women and men both benefit from maintaining a frequent sex life, most research suggests that sex is more central to the health and maintenance of the relationship for men. When asked to report their ideal sexual frequencies, men report higher frequencies than women (Richter et al. 2003). Also, virtually every study conducted has shown that the positive benefits of sexual satisfaction on relationship well-being are stronger for men than for women. For example, in an analysis of premarital couples, Sprecher (2002) found that *sexual* satisfaction was negatively associated with ending the relationship for men, while for women *relationship* satisfaction was more strongly associated with relationship dissolution. In addition, changes in sexual frequency may be more closely associated with sexual satisfaction for men relative to women (McNulty and Fisher 2008). There also appear to be gender differences in the effects of different types of sexual contact; research suggests that genital contact is more important for men's perceptions of relationship satisfaction compared to women (Fassinger and Morrow 1995; Loulan 1988). We do not mean to imply that, for women, sexual satisfaction and sexual frequency are not important aspects of relationships, it is just the case that the positive effects of a healthy sex life appear to be stronger for men.

Many researchers try and parse out biological versus contextual and cultural variables as the explanation for these gender differences. To date, there is no definitive answer. Still, there are data

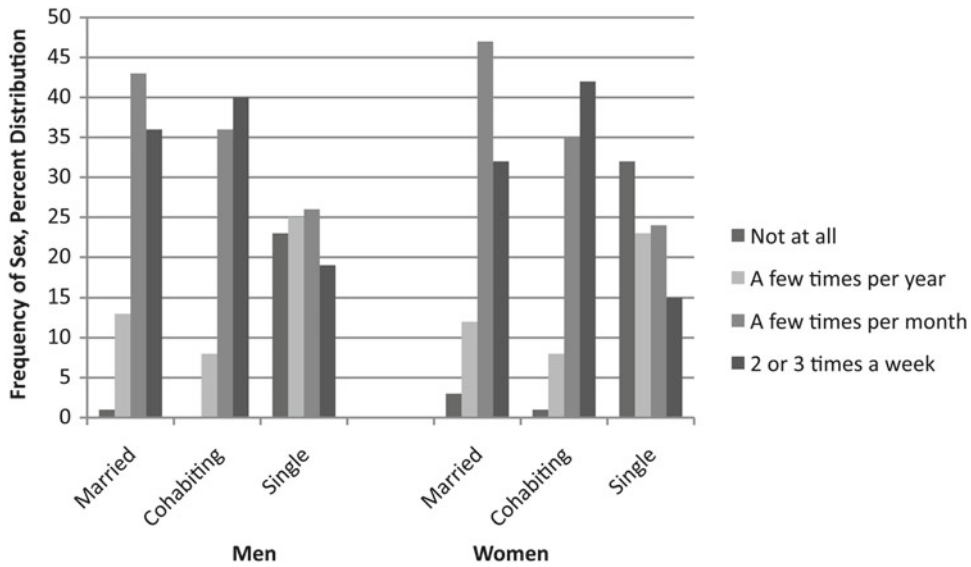


Fig. 8.3 Frequency of sex in the past 12 months by gender and relationship status (Source: Laumann et al. (1994) using NHLS 1994)

that lead us to believe that social forces such as differential socialization may account for such consistent gender differences in the desire for, and impact of, sexual behavior. A study by Carpenter and colleagues (2009) suggested that, for women, simply believing in inherent gender differences regarding women and men's sexual roles lowered their satisfaction with sex. Also, Blumstein and Schwartz (1983) hypothesized that the association between sexual satisfaction and relationship satisfaction may be weaker for women because women have absorbed the widespread cultural belief that women want sex less, can control their sexual impulses more, and that it is inappropriate for a woman to overemphasize sex in a relationship. It will be interesting to see if the changes in young women's sexual lives in uncommitted relationships (more sexual partners, "hooking up," etc.) will make sexual satisfaction more important for relationship satisfaction in committed relationships in the future (see Bogle 2008).

Differences by Couple Type

Despite the fact that cohabitation appears to be an increasingly popular context for committed relationships, there are still differences in the sexual lives

of married and cohabiting couples. Figure 8.3, adapted from Laumann and colleagues' (1994) data, shows various coital frequencies broken down by couple type and gender. Although married couples and cohabiters appear similar in terms of sexual frequency, both male and female cohabiters are more likely to report having sex two to three times a week relative to their married and single counterparts. Additionally, estimates from the NSFH suggest that cohabiters have a mean of 11–13 sexual acts per month, while their married couples have a mean of 6.3 times per month (Call et al. 1995). Additional studies have replicated this finding using large, nationally-representative datasets (Rao and DeMaris 1995; Yakibu and Gager 2009). However, as the data in Fig. 8.1 imply, it is rather intriguing that even though cohabiters have more frequent sex than married couples, they are less likely to be satisfied with their sex lives (Blumstein and Schwartz 1983; Laumann et al. 1994).

This is an especially important finding because the preponderance of studies show that sex is more important to cohabiters than it is to married couples. Blumstein and Schwartz (1983) found that declines in sexual frequency were especially problematic for cohabiting couples in

terms of relationship well-being. Similarly, Yakibu and Gager (2009) examined two waves of the NSFH and found that cohabiters, compared to married couples, were much more likely to separate over time, but a higher sexual frequency reduced the likelihood of relationship dissolution. Blumstein and Schwartz (1983) hypothesized that because cohabitation represents a less recognized and less committed context relative to marriage, declines in sexual frequency may signal to one partner that the other may be disinterested with the relationship. Schwartz and Rutter (1998) also argued that many cohabiters, especially those who are cohabiting as a trial run for marriage, may see cohabitation as an “audition” before deciding on marriage or some kind of deeper commitment. In other words, partners may view frequent and satisfying sex in cohabitation as a key predictor of what sex would be like in marriage. Yakibu and Gager (2009) pointed out that cohabiting unions are more likely to be based on immediate gratification and extrinsic rewards—an argument that is consistent with the common finding that cohabiters are, on average, more individualistic-oriented than adults who transition directly into marriage.

Differences by Sexual Identity

While there has been an increase in the research on same-sex couples, the 1983 “American Couples” survey by Blumstein and Schwartz remains one of the only large-scale studies to include a sample of paired gay men and lesbians. Laumann and colleagues (1994) included information about same-sex behavior and identities in the NHSLs, but couples were not studied and the resulting sample was far too small for any meaningful analysis. Thus, most of our recent knowledge about same-sex couples is derived from small convenience samples (see Kurdek 1991, 1994; Peplau et al. 1997, 2004).

Still there seem to be some consistent results that are replicated in both large and small studies. To begin with, same-sex couples are more similar to heterosexual couples than they are different. Same-sex couples appear to be equally as likely as their heterosexual counterparts to report being

satisfied with their sex lives (Kurdek 1991) and also benefit from having satisfying sex lives (Blumstein and Schwartz 1983; Cohen et al. 2008; Tracy and Junginer 2007). When it comes to quantity of sex, however, there are sharp distinctions between same-sex and heterosexual couples. Blumstein and Schwartz (1983) reported that gay men had the highest frequencies of sex (all genital behaviors), while lesbians had the lowest frequencies of sex (all genital behaviors). Figure 8.4, adapted from Blumstein and Schwartz’s (1983) American Couples data, displays the proportion of couples engaging in intercourse three or more times a week, broken down by couple type for various lengths of relationship duration. Gay male couples appear more likely to have sex three times a week or more compared to all other couple types, while lesbians are the least likely to report having sex three or more times a week across all stages of their relationships. A recent, well-designed study not only found similar results, but was able to add another dimension to the analysis—couple’s commitment level. Because Vermont is one of the few states to allow same-sex civil unions, Solomon and colleagues (2005) were able to use registration records to compare a sizeable sample of same-sex couples who opted for civil-unions (presumably high-commitment) to same-sex cohabiting couples (presumably low-commitment) and the married heterosexual siblings of the same-sex couples (to control for similar background characteristics). With regard to lesbian couples, the authors replicated Blumstein and Schwartz’s (1983) survey of nearly three decades earlier: lesbians at both stages of commitment had significantly less sex with their partners than did heterosexual women and the other couple types. Solomon and colleagues, however, found that gay men’s frequencies were not distinguishable from heterosexual men, regardless of whether they were in a civil union or not. Thus, it is unclear whether gay men still have more frequent sex compared to other couple types, and it appears that level of commitment (as best approximated by obtaining a civil union) is unrelated to sexual frequency for gay men.

Researchers have also speculated about why lesbians report significantly lower sex frequencies

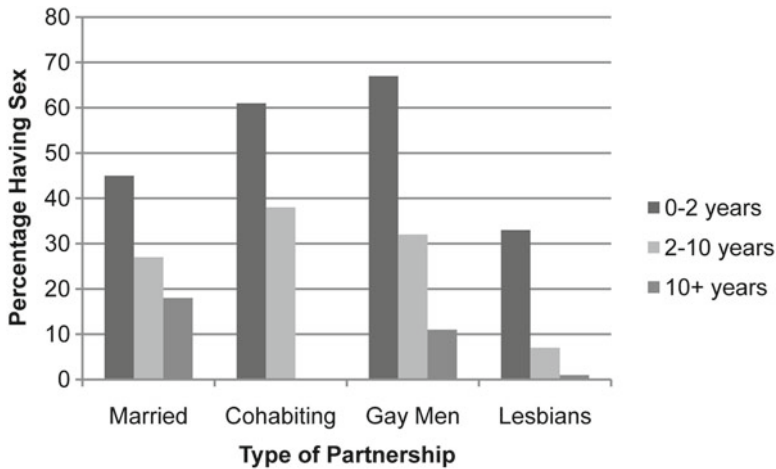


Fig. 8.4 Frequency of sex three times a week or more by partnership type and relationship duration (Source: Blumstein and Schwartz (1983) using the American Couples Survey)

relative to other couple types. Blumstein and Schwartz (1983) noted that heterosexual women in committed couples had more sexual activity and ranked it as more important than did their lesbian counterparts. The authors speculated that the presence of a male may alter the nature of the sexual relationship because men are socialized to initiate sex more and also place a greater emphasis on the importance of coital frequency. The fact that the absence of a male would result in less sexual frequency—especially coital frequency—would be consistent with the finding that women may find genital sexuality less important than men (Fassinger and Morrow 1995; Loulan 1988). An additional factor to consider would be that perhaps lesbians have more kinds of sex that we do not tabulate (most research looks primarily at coital frequency) and so lesbian sexual behavior may be inadequately represented in models that only examine coital frequency. There is certainly evidence that lesbians rely on a wide variety of sexual techniques apart from actual penetrative sexual behavior (Coleman et al. 1983; Lever 1995; Nichols 2004). For example, lesbians engage in more kissing and cuddling than other kinds of couples and their sexual play has been described as “more fluid” compared to heterosexual women (Nichols 2004). Furthermore, some evidence calls into question the claim that lesbians might be leading unfulfilling sex lives.

To begin with, it is interesting to note that while gay men may report high sex frequencies, at least one study suggests that lesbians are more likely to report higher levels of sexual satisfaction (Bryant and Demian 1994). Also, a 3 year follow-up of the Vermont study found that sexual frequency was an important predictor of relationship satisfaction for lesbians, but not for heterosexual women. This suggests that while lesbian couples may not engage in coital frequency as often as other couple types, regular sexual behavior is still an important source of relationship stability (Balsam et al. 2008).

The Effects of Relationship Well-Being on Sexual Behavior in Committed Relationships

So far our review has been focused primarily on the effects of sexual behaviors on committed relationships. However, because most of our research comes from large, cross-sectional data sets, researchers usually interpret their results using the language of association rather than causation. While it true that studies suggest that healthy and frequent sex must, at the very least, partially *cause* relationships to feel more rewarding, we cannot entirely rule out the possibility that happy couples are simply more likely to

report more frequent and fulfilling sex lives. Unfortunately, cross-sectional data cannot establish what occurs first—so we do not know for sure whether good sex leads to a satisfying relationship or a satisfying relationship leads to good sex. In this section we review several well done studies that suggest that relationship characteristics do in fact exert their own independent effects on couples' sexual well-being.

When couples are emotionally invested in each other and share similar goals, it is reasonable to hypothesize that they may have more enjoyable sex lives. Young and colleagues (1998) examined a group of 797 married couples and found that of all the possible correlates of sexual satisfaction (including orgasm and sexual frequency), overall satisfaction with the marriage and satisfaction with non-sexual aspects of the relationship, such as shared goals, respect, and recreational companionship, were the most strongly associated. A study that examined the motivations for sexual behavior found that when cohabiting and married couples have sex in order to express their love, they were more likely to report deriving physical pleasure from the act (Waite and Joyner 2001). While it is true that these studies do not imply causality, the correlation between non-sexual aspects of the relationship lends considerable evidence to the possibility that the state of couples' relationships may influence their sexual satisfaction.

The connection between relationship quality and sexual pleasure seems to be especially important for women. Basson's (2000) model of female sexuality suggests that many women rely on mental and relational stimuli for sexual arousal. The author asserted that the lack of such subjective, relational arousal often explains women's reports of low sexual desires—reports that are often mislabeled as a sexual dysfunction (Basson 2000; Basson et al. 2003). Several studies confirm the validity of this model for large numbers of women. For example, Bridges and colleagues (2004) analyzed a nationally representative survey of 2,632 women and found that feeling connected to one's partner was associated with sexual satisfaction. Some studies go further to suggest that women must be satisfied

with their relationship to enjoy sex at all (Fenney and Noller 2004; Metz and Epstein 2002). Other research has demonstrated that women in relationships characterized by egalitarian decision-making processes are more likely to have fulfilling sex lives (Blumstein and Schwartz 1983; Breznsnyak and Whisman 2004), and are more willing to experiment with new sexual positions (Blumstein and Schwartz 1983).

We are not suggesting, however, that relationship satisfaction is unimportant for men's sexual lives. On the contrary, relationship satisfaction is a significant predictor for men's sexual satisfaction; it is just not as central to their sexual well-being (Lawrence and Byers 1995). In fact two studies suggest that both gay men (Cove and Boyle 2002) and heterosexual men over the age of 50 (Schiavi 1999) are more likely to enjoy sex if they perceive their relationship as going well. Ultimately, while there are gender differences in the strength of the effect of relationship quality on sexual satisfaction, the differences are only relative. Men, like their female counterparts, are happier with their sex lives when they are content with their love lives.

When we break "a good relationship" into its component parts, communication emerges as one of the most important factors to take into consideration (Schnarch 2009). The research literature has consistently associated a couple's communication skills with sexual satisfaction. Partners who communicate regularly about their relationship and their sex lives report higher levels of sexual satisfaction and sex frequency (Byers 2005; Gossman 2003; Mackey et al. 2000, 2004; Purnine and Carey 1997). Communication skills may be especially important for couples who face constraints on their sexual lives. Good couple communication appears to increase non-sexual physical intimacy between partners when disruptions (such as the presence of young children) decrease sexual satisfaction (Alhborg et al. 2005). But good couple communication may have its limits. A study by MacNeil and Byers (1997) found that although sexual and non-sexual communication were positively associated with sexual satisfaction, the presence of both types of communication did not reduce the negative effect

of partners' real or perceived concerns about sexual intimacy on sexual satisfaction. However, the authors acknowledged that two of their samples' most commonly reported sexual concerns were disinterest in sex and trouble getting aroused, and good communication may still be beneficial for couples with more serious sexual problems. Indeed, as we discuss in a later section, good communication and partner support appears to mitigate the harmful effects of serious sexual impairments on reported levels of sexual satisfaction.

The mundane aspects of relationships also affect sexual satisfaction. The division of household tasks can affect sexual satisfaction and sexual frequency. Some recent media reports have suggested that men who assist in housework get more sex from their partners, and suggest that women reward men's egalitarian behavior with increased sexual frequency. Supporting the claim, Rao and Demaris (1995) found that women who reported an egalitarian division of household labor were more likely to report higher sexual frequencies. However, a study by Kornrich and colleagues (2013) casts doubt on the association between egalitarianism and sex. Using data from Wave II of the NSFH, the authors found just the opposite of the egalitarian-men-get-more-sex hypothesis. Couples who divided their housework tasks in a more traditional fashion reported higher sex frequencies than their egalitarian counterparts. The authors argued that participating in appropriately gender-typed activities may be an effective way to express heterosexual desire in traditional couples, while egalitarian partners do not receive "extra credit" for being equitable in their household duties. Egalitarianism, while much prized by partners who are ideologically and emotionally committed to sharing household chores and childrearing, may not be especially erotic. In a study of over a hundred egalitarian marriages, Schwartz (1995) found that more than a few partners reported an unexpected reduction in sexual frequency precisely because the couples related as close as siblings or platonic friends. However, while egalitarianism may be associated with a decline in sexual frequency, it may still be beneficial for sexual satisfaction; a recent study

of a sample of 60 married couples found that egalitarian couples were more likely to be satisfied with their sex lives (Breznyak and Whisman 2004). The authors speculated that couples who worked at maintaining equality in their relationships extended their egalitarian behaviors to ensure that both partners were equally satisfied in the bedroom.

In sum, just as there is much evidence suggesting that sexual satisfaction leads to relationship satisfaction, there is ample evidence suggesting that causality operates in the opposite direction—non-sexual characteristics of the relationship, such as relationship satisfaction, affect sexual well-being.

Summary: Sexual Frequency, Sexual Satisfaction, and Relationship Well-being

One of the main benefits of maintaining committed relationships—a benefit that is not lost on cohabiting couples—is the relatively unrestricted access to a regular sex partner. There is a general consensus that frequent and satisfying sex is critical for the maintenance of committed relationships—both for heterosexual and same-sex couples. Of course, the strength of the effects of sexual satisfaction on relationship satisfaction is not uniform across all populations (i.e. women's lower prioritization of sex in their relationship). Furthermore, the primacy of sex within committed relationships may vary across groups (i.e. cohabiters vs. married and gay men vs. lesbians). The picture becomes even more complicated when we consider that relationship characteristics such as relationship well-being, communication, and egalitarianism are likely to exert their own effects on sexual behaviors. Nonetheless, the past 30 years of research on sex and couples has firmly established the centrality of sex in the maintenance of relationships. This static approach however, does not recognize that relationships change over the life cycle: people age, relationships mature, and both carefully planned and unexpected constraints to intimacy emerge as couples navigate their lives together. It is to these life

changes and constraints that we now direct our attention.

Sexual Constraints Over Time in Committed Relationships

Opportunities for sex are partially constructed by our immediate environment, our cultural and legal systems, and our individual health, options, and values. Such contextual and individual-level characteristics place constraints on sexuality within committed relationships, and these constraints help to explain much of the within-group variation that we observe when studying couples and their sex lives. In this section we review research that has examined individual-level, relationship-level, and contextual constraints that affect couples' ability to maintain satisfying sex lives throughout their relationship.

Relationships Across Time: The Effects of Aging and Duration on Sexual Intimacy

We have indicated that both age and the duration of relationships affect sexual frequency, which in turn, can affect both sexual and relationship satisfaction. It is, however, useful to understand more than these gross associations. In particular, since western populations are aging, it is important to know the differential impacts of each decade of life across the duration of a relationship. We believe it is fair to say that no one demographic trend has influenced sexuality within committed relationships more than the emergence of a large older adult population driven by the baby boom. The youngest boomers are in their late 40s and the leading edge of the baby boomers is just turning 65. In addition, the Baby Boom cohort is expected to live longer than any adult population in U.S. history. Two possible hypotheses about sexuality in this population compete with each other: on one hand, aging has a biological and irreversible impact on the body, brain, and endocrine system and so the Baby Boomers will have less sex as they age as has been observed with

older generations. On the other hand, the Boomers are aging in a very different context than previous generations. The Boomers' experience with the Sexual Revolution, the greater discussion about sexuality in our culture since the 1960s, and the new technologies for extended sexual capability (such as erectile dysfunction drugs) could make the Boomers more sexually interested and active than the generations before them. We will take a close look at data on sexuality and aging and summarize the results of studies by age groups.

Traditionally, research has indicated that age is one of the strongest predictors of sexual frequencies for all couple types. While the effect of age on sexual frequency is most pronounced for the older-age couples, age differences in sex frequencies first emerge when adults enter their middle-age years. Laumann and colleagues (1994) found that mid-aged individuals were the least likely of the age groups to report having sex two or three times a week. However, the NHSL sample did not include older-aged adults, and the survey did not distinguish between single adults and single adults with dating partners. Fortunately, this is done in the nationally representative study conducted by the American Association of Retired Persons (AARP), a national membership group for people over 45, every 4 or 5 years since 1999 (Fisher 2009). Figure 8.5, based on the most recent wave of the AARP study, summarizes sexual frequencies (having sex at least once per week) by age categories and respondent's gender. The figure clearly demonstrates a steady decline in sexual frequency as adults age, and in general this decline is more pronounced for women compared to men. Comparing these data to previous cohorts, the AARP study does not show an increase in sexual behavior for the boomers compared to previous generations of the same age (in fact, the study shows a slight decrease in sexual activity in all age groups, perhaps accounted for by increased reported stress, particularly financial stress, in each age group).

The recent AARP data also emphasize the importance of commitment and partner presence for older adults' sex lives. Contrary to Laumann and colleagues' (1994) data, the AARP data

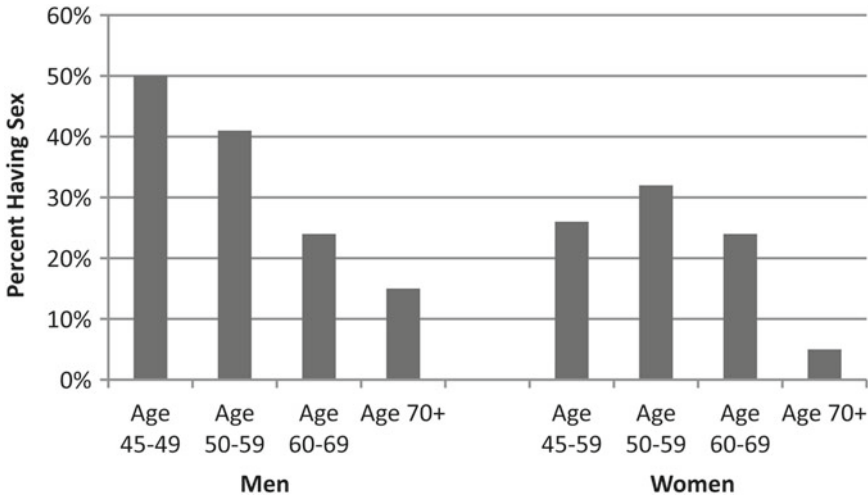


Fig. 8.5 Percent having sex at least once a week by age and gender (Source: AARP Survey of Midlife and Older Adults 2009)

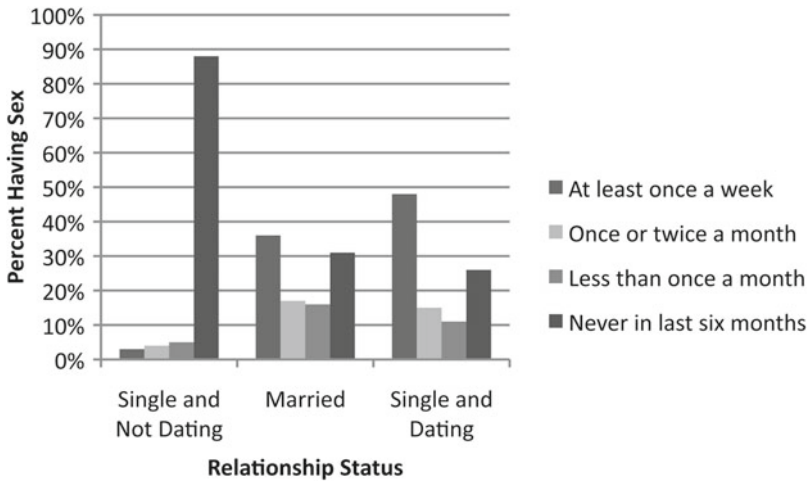


Fig. 8.6 Frequency of sex by relationship status (Source: AARP Survey of Midlife and Older Adults 2009)

suggest that when the sample is restricted to older adults, single adults who are in dating relationships appear to have more sex than married couples. In Fig. 8.6, we use the recent AARP data to show various categories of sexual frequency by relationship status for the entire older adult sample. Specifically, 48% of dating older adults reported having sex at least once a week, compared to 36% of married older adults and 3% of singles who are not dating. The figure demonstrates the striking negative effect of lacking a partner on sexual frequency; nearly 90% of the

single older adults in the sample who lacked a committed partner reported not having sex in the past 6 months. In addition, for older adults, it appears that sexual satisfaction follows a similar pattern to sexual frequency. About 60% of dating older adults reported being extremely or somewhat satisfied with their sex lives, compared to 51% of married older adults and 19% of single older adults who were not dating (Fisher 2009). However, it is important to note that small sample sizes might have affected the results—only 145 adults in the sample reported that they were dating.

Overall, there seems to be some evidence that while age is still an important predictor of sexual frequency, much of the decrease in sexual behavior among older cohorts has been due to a lack of a partner or perhaps boredom in a long-term relationship, rather than a lack of desire or capability.

Other large, nationally-representative studies have also found that age negatively affects couples' sexual frequency (Call et al. 1995; Mariglio and Donnelly 1991; Rao and Demaris 1995). Call and colleagues found that while 83% of those aged 50–54 and 57% of those aged 65–69 reported having sex with their married partner in the last month, only a little over one-fourth of those 75 or older reported having sex with their spouse during the previous month. In addition, the mean sexual frequency for spouses of the 75 and older group was only once a month. However, when the authors limited their analysis to the sample of adults 75 or older *who were sexually active*, the average frequency of sex shifted from once a month to three times a month.

As we indicated above, gender appears to moderate the effects of age on older adults' reported sexual frequencies. Laumann and colleagues (1994) found that of adults aged 40–49, 27% of men and 20% of women reported having sex two to three times a week. Similarly, for adults aged 50–59, 20% of men and only 12% of women reported sexual frequencies of two to three times a week. When we examine the number of older adults who reported not having sex within the past year, the gender differences become even more pronounced; 30% of women in the 50–59 range and only 11% of similarly aged men reported having no sex within the year. The AARP data also confirm these differences; Fig. 8.5 clearly demonstrates that older men, by and large, are more likely to engage in intercourse, and this pattern generally holds regardless of how sexual frequency is specified (i.e. once a week versus once a month).

What explains the gender difference in sexual frequency for older adults? First, the higher mortality and incarceration rates of men suggest that mid-aged and older-aged women have a declining pool of same-aged, eligible partners. Furthermore,

in an already declining pool of eligible mates, it has been argued that a combination of sexism and ageism exacerbate women's ability to find sexual partners (Carpenter et al. 2009). It is culturally more acceptable for men to partner with younger women while younger men who have sex with older women often have their motives impugned. While there has been recent glamorization (and caricature) of Cougars (older women who are attractive but predatory), in general older women are viewed as less attractive at an earlier age relative to men. According to these arguments, sexual frequency should be the lowest for the oldest groups of non-married women. Matthias and colleagues (1997) provided strong evidence for these arguments using a Los Angeles-based sample of 1,216 older-aged adults (70 or older). The authors found that younger age and education were the strongest predictors of sexual frequency for men, but for women, the strongest predictor was marital status. Indeed, married older-aged women were nearly 24 times as likely to have had sexual activity within the past month compared to their non-married counterparts.

Despite the undeniably strong evidence that age negatively affects sexual frequency for both women and men, it is possible to overstate the effects of age by confounding age and duration of the relationship. Older couples are more likely than younger couples to have been with their partner for a longer period of time simply because they have been alive longer. Many studies have documented a steady decrease in sexual frequency as relationships progress regardless of what age group is examined (Blumstein and Schwartz 1983; Brewis and Meyer 2005; Call et al. 1995; Edwards and Booth 1994; Gossman et al. 2003; James 1981; Johnson et al. 1994; Klausmann 2002; Udry 1980). Relationship duration is also negatively associated with sexual frequency for cohabiting couples (Blumstein and Schwartz 1983; Fisher 2009; Gossman et al. 2003; Stafford et al. 2004). Despite this evidence, age appears to be a better overall predictor of sexual frequency than duration, at least for married heterosexual couples. However, Call and colleagues (1995) found that duration only appears to take a dramatic toll during the first

year or two of marriage; subsequent decline in sexual frequency is much more gradual and moderate. This drop in sexual frequency probably occurs as couples transition from the “honeymoon phase” into a more routine sexual schedule. Other studies have also found relationship duration to be a more important predictor of frequency during the early years of marriage and less important in the later years—the years when age effects are more likely to take hold (Edwards and Booth 1994; James 1981, 1983). Age, on the other hand, affects couples at each stage of the relationship, and is the single strongest predictor of sexual frequency. Although there is very little research on the effects of age and relationship duration on the sex lives of same-sex couples, there is evidence that age and duration partially explain declining sex frequencies for same-sex couples (Blumstein and Schwartz 1983).

Does the fact that age is commonly the strongest predictor of sexual frequency in American samples suggest that age is universally more important than relationship duration? A large study conducted by Brewis and Meyer (2005) of 91,744 women in 19 developing countries suggests that the effects of relationship duration, as well as both women’s and men’s ages, on sexual frequency may be context-specific. While the observed decline in sexual frequency that occurs as couples age appears to be universal, there is considerable country-level variation regarding whether aging or relationship duration is more important in decreasing sexual frequency. While studies using American samples suggest that women’s age is a stronger predictor of declines in couples’ sexual frequency, this is not the case in all countries, especially Latin American countries. Also of interest, in several countries, most of which were characterized by large Catholic populations, relationship duration did not negatively affect sexual frequency when controlling for the couples’ ages. The authors suggest that trends in earlier pregnancies and the use of abstinence as opposed to contraception as a pregnancy prevention strategy may prolong the sexual novelty of the relationship.

Since age is a major predictor of sexual frequency, what is it about the aging process that causes the decline? Undoubtedly, biology and overall condition of personal and partner health plays a role (Fisher 2009). A review of the literature on the biological aspects of the aging process is beyond the scope of this review. However, a few key biological changes are worth mentioning. In the later years of their lives, women transition through menopause which can make intercourse difficult, uncomfortable, or even painful. For some women, the onset of menopause and accompanying lower sexual desire may negatively affect sexual and relationship well-being (Dennestain et al. 2006; Fisher 2009; Leiblum et al. 2006). Older men also have their share of biological concerns. Men experience a reduction in the production of testosterone which makes it increasingly difficult at older ages to achieve and maintain erections, and lengthens the amount of time it takes to become aroused post-orgasm. Indeed, 23% of the AARP male sample indicated that erectile problems were an important issue (Fisher 2009). But it is important to note that the negative effects of age are not solely due to health issues. When AARP respondents were asked to indicate what personal or social issues impeded their sexual behavior and/or sexual satisfaction, men and women in the AARP study stated personal health, general stress, partner’s health, financial stress, and lack of a partner as the top five social and personal issues that negatively affected their sex life (Fisher 2009).

Social and contextual factors that have a negative impact on older couples deserve more research (for a review see Burgess 2004: pp. 446–448) and it appears that more research will be emerging. As mentioned earlier, recent commercial drugs aimed at increasing sexual interest and ability among older men and women have spurred new research publications and highlighted the existence of a desire for a fulfilling sexual life in gerontological populations. Pharmaceutical companies like Pfizer, Lilly, Bayer, GlaxoSmithKline, and Boehringer Ingelheim either have produced a sexual performance drug for older adults or have one in development. Grants from these and other

pharmaceutical companies for research on sexual desire or sexual dysfunction have become common for both social science and medical researchers.

Relationships and Life-Course Events: The Effects of Pregnancy, Children, and Employment on Couples' Sexual Behavior

Sexuality is also affected over the life course by specific events in a couple's life together. Most couples contend with decisions about marriage, childrearing, and work—all of which impact their sexual and emotional life. Women are particularly vulnerable to the sequencing of life events since they balance pregnancy, being the primary caregiver, and labor force participation with the demands of a committed relationship. Historically, same-sex couples' life-course trajectories have been much different from heterosexual couples raising young families, but today, with greater civil rights, less prejudice (McVeigh and Diaz 2009), and the likely advent of gay marriage, more same-sex couples are likely to have or adopt their own children, or have children in their household from a previous heterosexual marriage (Baumle et al. 2009). These social factors make it likely that in this millennium, family-related, life-course events will also impact the sexual behaviors of same-sex couples. While most of the relevant life course data in this section comes from studies on heterosexual couples, we assume that similar issues will affect the sexual adjustment of some same-sex couples as well.

At some point over the life course the vast majority of Americans experience the transition to marriage. The transition to marriage usually involves a redefinition of one's self and the relationship (Berger and Kellner 1964), and this public change of status plus subsequent reductions in autonomy are among the big and broad changes that could impact a couples' sexual life. Stafford and colleagues (2004) used two waves of the NSFH to see if the transition to marriage or living in a specific type of couple affected sexual frequency. The researchers compared three couple types: couples who transitioned from cohabita-

tion to marriage, couples who did not cohabit before marriage, and long-term cohabiters. While couple type did not explain variations in sexual frequency, for all three types of couples, the passage from time 1 (the first wave) to time 2 (the second wave) had a negative effect on sexual frequency, suggesting that aging and duration were more important predictors of sex frequency than the transition from cohabitation to marriage.

The transition to marriage or some other type of public commitment might also affect the sexual behavior of same-sex couples. Since same-sex legal marriage is still relatively rare, we do not have much data on how this change in status affects the sexuality and overall relationship of those in same-sex relationships. However, the Vermont study of same-sex couples who entered into civil unions is a useful starting point. Much like their heterosexual counterparts, the same-sex couples (both lesbian and gay men) who transitioned into a civil union did not differ in sex frequency compared to the same-sex cohabiting couples (Solomon et al. 2005). Unfortunately, we cannot distinguish whether the transition to a legally recognized union lowered the likelihood of having extra-relationship sex, or if couples who are less likely to have non-monogamous sex self-select into civil unions. In sum, there is little evidence that the transition to a legally recognized status negatively affects sexual frequency independent of other effects, such as relationship duration, for heterosexual and same-sex couples.

While the transition to marriage does not seem to exert a strong effect on couples' sex lives, pregnancy and the presence of children greatly constrain heterosexual couples' sexual behavior. Most studies find that couples remain interested in sex throughout the duration of the pregnancy, but as the pregnancy progresses sexual frequency declines and usually does not return to its pre-pregnancy levels (Ahlborg et al. 2005; Bartellas et al. 2000; Borgen 1991; Elliot and Watson 1985; Hyde et al. 1996; James 1981; von Sydow 1999). This is likely due to a combination of factors but the literature on pregnancy concentrates on changes in women's perceived body image, fear of harming the fetus, physical discomfort because of weight gain, or increased pain during intercourse

because of estrogen-related loss of lubrication. Several international studies conducted in diverse settings such as Kuwait (Bustan et al. 1995), Hong Kong (Haines et al. 1996), Nigeria (Adinma 1995), New Zealand (Oruc et al. 1999) and Pakistan (Naim and Bhutto 2000) also have found that sexual frequency declines as pregnancy progresses. These international studies suggest that declines in sexual frequency during pregnancy are probably universal. However, the reasons for the decline may vary by region and culture. For example, some of the women in studies that were conducted in countries that could be reasonably classified as sexually conservative were more likely to report harming the fetus as a reason for engaging in less sex with their partner.

While most of our information regarding pregnancy and sexuality is gathered from small, convenience samples, two large-scale studies are particularly worth mentioning. Hyde and colleagues (1996) conducted a longitudinal study of 570 pregnant women that began during the fifth month of their pregnancy and ended 1 year postpartum. During the pregnancy, couples' average sexual frequency ranged between four and five times per month. However, the couples experienced a heavy drop in frequency postpartum; during the first month postpartum, most couples had little to no sex. The couples did not resume regular intercourse until between 4 and 5 months postpartum and, when they did so, the rate resembled the frequency during pregnancy rather than the couple's pre-pregnancy frequency. Ahlborg and colleagues (2005) conducted a large, cross-sectional study of 820 Swedish parents in their early 30s at the point of 6 months after childbirth. The authors found that couples did not begin having regular sex until 3 months postpartum—again, at a rate lower than pre-pregnancy. When asked why they did not engage in more regular sexual activities, 47% of mothers and 38% of fathers reported that fatigue was a major issue. It is important to note that when asked about relationship satisfaction, the parents' responses were consistent with most studies: The parents reported high levels of relationship satisfaction immediately after childbirth, but would have preferred more frequent sex. Unsurpris-

ingly, the fathers were more dissatisfied with their sex lives than the mothers; 46% of men were unsatisfied compared to 36% of women.

Clearly, as the studies indicate, the demands of an infant affect couples' sex lives. But, does the effect remain as children age? Children of all ages demand significant amounts of time and attention from their parents. When parents are asked why they engage in less frequent sexual activities they often point to the presence of children (Greenblatt 1983; Michael et al. 1994). The Call and colleagues (1995) study found that younger children (0–4 years old) had an independent negative effect on reported sex frequency, but older children (5–18 years old) had a positive effect on reported frequency. Of course, much of the negative effect of having a younger child may be driven by the inclusion of infants in the measure. It is unclear why having an older child might increase sexual frequency. The authors hypothesized that having teenagers in the house might make sex a more salient topic. One additional possibility might be that parents are making up for lost time by increasing their sex frequency as children require less attention and responsibility.

Employment and hours worked in paid labor present another possible inhibiting factor on couples' sexuality. Dual earner households have become the norm rather than the exception (Blau and Kahn 2007; Juhn and Potter 2006; Raley et al. 2006), which suggests that women and men in a majority of households are choosing to divide their time between work and their private lives. This balancing act, combined with the time spent on housework and childcare, generally takes a toll on sexual frequency. A recent study based on a national sample of married couples found that balancing work and family demands and issues about sexual frequency were the top two issues that couples negotiated in marriage (Risch et al. 2003). Although some studies have documented a decline in sexual frequency caused by stress for both heterosexual and same-sex couples (Goh et al. 2004; Otis et al. 2006), it is not clear how much of the stress penalty is due to work-related stress. Studies that directly tested for the effects of work demands have usually found that for women and men, hours worked are

not associated with couples' sexual frequency (Call et al. 1995; Hyde et al. 1998). Indeed, a recent study by Gager and Yakibu (2009) provides strong evidence that dual earner couples are more than able to balance the demands of work and their private lives. Using the first wave of the NSFH and a sample of 6,887 couples, the authors tested whether hours worked at home and in the workplace predicted sexual frequency. Contradicting many of the authors' initial hypotheses, the study revealed that both husbands and wives that spend more time on housework reported higher levels of sexual frequency—even after controlling for hours worked in paid labor. In addition, the couples who spent the most time on paid labor and housework were also more likely to report higher sex frequencies. What explains this unexpected finding? The authors argued that couples who work hard are more likely to play hard. These couples might represent a certain type of couple that the authors dubbed “go-getters”. High-performing couples may not only be more adept at integrating sex into their personal lives, they may also be more likely to place intimacy as a top priority for the sake of the relationship. Considering the time demands placed on dual earner couples, the common finding that number of hours worked does not negatively impact couples' sex lives suggests that couples make time for sex—another indication of the primacy of sex in committed relationships.

However, in cultures where women are expected to do more housework, dual earner marriages may be more vulnerable to the demands of work and home affecting their sex lives. Cheung and colleagues (2008) analyzed a survey of 1,124 Hong Kong couples and found that women who worked full-time in the labor force reported lower sexual frequencies. The authors speculated that because Chinese women are still expected to be responsible for the majority of childrearing and housework, the demands of the second shift compete with the couple's ability to maintain sexual frequencies that resembled those of women who did not work full time. Another study of mainland Chinese respondents, however, only found a weak connection between housework and sexual frequency (Ji and Norling 2004).

In sum, some life course events affect couples' sex lives more than others. The transition to marriage and women and men's decision to devote their time to paid labor does not appear to negatively affect couples' sex lives. If anything, longer hours spent on household labor and paid work appear to increase sexual frequencies for some couples. However, the decision to introduce children into the relationship appears to place strong constraints on the sexual behaviors of parents. Pregnancy reduces the frequency of sexual behavior both during and immediately after the pregnancy. The finding that the presence of young children negatively affects couples' sex frequencies, alongside the fact that postpartum sexual frequencies never return to their original pre-pregnancy levels, suggests that young parents' sex lives are especially vulnerable.

The Effects of Sexual Dysfunction and Disease on Couples' Sexual and Relationship Well-Being

We have assembled a long list of personal characteristics, gender norms and life cycle events that affect the sex lives of couples. Of the constraints on couples' sexual lives that we discuss, the presence of a partner's sexual dysfunction has the potential to have the most damaging impact on sexual frequency and satisfaction. For the most part, couples experience the aging process together, and life-course related challenges are expected. Sexual dysfunction, on the other hand, is a problem that may not be shared by both partners and might not be reversible. Furthermore, in a culture that equates sexual intercourse and sexual frequency with normality, a sexual dysfunction is disturbing and perhaps stigmatizing for both partners. Possible feelings of shame and embarrassment may help explain why many women and men do not choose to seek help for sexual problems (Laumann et al. 2009). This inability to ask for, and therefore receive, emotional and physical therapy will generally have a high negative impact on couples since studies amply demonstrate that sexual frequency and sexual satisfaction correlate with relationship satisfaction.

Sexual dysfunction has, however, definitional problems. There is quite a bit of inter- and intra-disciplinary disagreement about what should be considered a sexual dysfunction. There is also disagreement about the etiology of a given sexual issue. Medical, biological, sociological, and psychological experts disagree on whether something like the ability to be aroused or the proclivity to ejaculate prematurely have a cultural, interactional, or biological etiology. Behavioral scientists and social constructionists believe that women's lesser sexual interest can easily be misdiagnosed as a sexual dysfunction when in reality a loss of sexual interest can be the result of an unsatisfying marriage, depression, or a generally difficult life (Tieffer 2006a).

Furthermore, as we analyze the studies on sexual dysfunction, we note the relatively weak link between biological processes and the incidence of sexual dysfunction among older adults. To be sure, some biological changes, such as menopause and andropause, affect sexual behavior as people age. But both national and international surveys of adults of all ages suggest that many sexual problems are also related to one's psycho-social well-being. (e.g. Laumann et al. 1999, 2005, 2009; Lewis et al. 2004). In short, because context, gender, and psycho-social factors seem to affect the incidence of sexual dysfunctions, we cannot conclude that sexual dysfunctions are biologically inevitable.

Although sexual dysfunction is not the focus of this chapter, there are a few points worth mentioning that are particularly important for understanding couple's sexual satisfaction. Using the American subset of the Global Study of Sexual Attitudes and Behaviors (GSSAB), a sample of 1,419 adults between the ages of 40 and 80 years, Laumann and colleagues (2009) reported that men's most common sexual dysfunctions were premature ejaculation (26.2%) and erectile dysfunction (22.5%). Women's most commonly reported problems were a lack of sexual interest (33.2%) and lubrication problems (21.5%). A study using the Brazilian subset of the survey found somewhat similar results for both women and men (Moreira et al. 2005). However, in another study using a sample of 1,550 women

and 1,445 men, Laumann and colleagues (2008) found that the incidence of sexual dysfunction was more related to social-psychological factors rather than the aging process (although there was some evidence that health factors might be more important for women). These studies were limited to older Americans, so it is difficult to generalize to the entire population of adults and it is also important to note that these results are based on respondents' subjective assessment of their sexual functioning. In any case, when trying to decipher the ups and downs of sexual frequency in committed couples, it is important to factor in the possibility of health-related causes and that health-related issues may operate differently for men and for women.

Several studies have documented a decline in sexual and relationship well-being for women and men with sexual dysfunctions. Moreira and colleagues (2005) found that sexual dysfunction was associated with depression and Laumann and colleagues' (2008) study reported a correlation with lower partner satisfaction. Similarly, in their analysis of the NHSL, Laumann and colleagues (1999) found that reports of sexual dysfunction were associated with lower sexual and relationship satisfaction for both women and men. Using the Boston Area Community Health Survey, which included a sample of 3,205 women between the ages of 30 and 79, Lutfey and colleagues (2009) found that of the 38.4% of women who reported some type of sexual problem, over a third reported being dissatisfied with their sex lives. Rosen and Althof (2008) reviewed 11 studies of men who experienced premature ejaculation, and found evidence that premature ejaculation was often associated with interpersonal difficulty between partners. However, the authors noted that the strength of the association between relationship conflict and premature ejaculation varied depending on what study they examined.

These studies suggest that sexual dysfunction undermines both women and men's sexual and relationship satisfaction. However, it is important to note that while most of these studies tend to rely on large, representative datasets, we should be careful about inferring causality due to the

reliance on cross-sectional study designs. While it makes sense that sexual dysfunction should lead to dissatisfaction with sex and the overall relationship, this may not be the entire story. Sexual intimacy is a heavily psychological process and, as some studies suggest, several sexual dysfunctions such as lack of desire and premature ejaculation may be affected by the quality of the relationship and sexual encounters (Laumann et al. 1999).

The partners of individuals with sexual dysfunctions also experience decreased sexual and relationship well-being. McCabe and Matic (2008) examined 40 heterosexual men with erectile dysfunctions (ED) and their female partners and found that sexual frequency began to decline when men first started to experience symptoms of ED. But it was not just the men who were affected by the decrease in sexual frequency; the onset of ED lowered the sexual satisfaction and relationship satisfaction for both partners. Cameron and Tomlin (2007) examined three groups of heterosexual women to investigate the effects of a male partner's ED on the women's well-being: 171 women had partners on medical treatment, 183 women had partners without medical treatment, and a control group of 151 women had partners without ED. The women who had partners with untreated ED reported the lowest levels of sexual satisfaction and lower sexual communication, while the women with partners in a treatment regime reported levels of sexual satisfaction and communication comparable to the control group. In addition, the women whose partners were not treated were the most likely to report lower levels of relationship satisfaction. Even more telling, a large British study based on a convenience sample of women and men who reported sexual problems in a clinic found that at least half of the women who complained of an inability to enjoy sex or achieve orgasm had a partner suffering from premature ejaculation (Riley and Riley 2005).

One sexual dysfunction in particular is associated with women's transition into menopause—Hypoactive Sexual Desire Disorder (HSDD). The conceptualization of 'inadequate desire' as a clinical disorder is relatively recent and that alone

makes it controversial to social scientists who believe that there is an over "medicalization" of sexuality (Tieffer 2006b). Critics of the HSDD diagnosis believe that medical professionals have created an arbitrary "normality" and that this definition, rather than a biologically-caused deficit, is promoted so that doctors can "cure" women and pharmaceutical products can make them "well" (Tiefer 2004). Feminist therapists prefer a more flexible definition of sexual health and are more predisposed to dealing with subjectively expressed sexual frustrations (as opposed to presumptions of HSDD if a woman is not interested in sex) through therapy that involves more interactive, cultural, or personal etiologies. At present, the HSDD "dysfunction" is defined as "the persistent or recurrent deficiency (or absence) of sexual fantasies/thoughts, and/or desire for or receptivity to sexual activity, which causes personal distress" (Basson et al. 2000, p.890). The appropriateness of this definition, as well as when low desire is appropriately labeled HSDD, continues to be debated in the literature. Although many medical professionals believe that HSDD is usually a direct result of reduced testosterone production, this definition suggests an important psycho-social component. Indeed, several studies have demonstrated that many of the symptoms and consequences of HSDD are relational. Dennerstein and colleagues (2006) sampled 2,467 women between the ages of 20 and 70 from France, Italy, Germany, and the United Kingdom and found that women who reported the onset of low sexual desire also reported a general dissatisfaction with their sexual and personal lives—a finding that has been reported elsewhere (Graziottin et al. 2009; Leiblum et al. 2006). Whatever the etiology of the problem, some women who were willing to try hormonal recalibration (testosterone supplements) did report increased sexual responsiveness (Braunstein et al. 2005; Buster et al. 2005). However, individual motivation for change may be an important variable in the effectiveness of any treatment for HSDD. A large cross-sectional study of American and European women between the ages of 20 and 70 found that older women were less emotionally distressed about the presence of

HSDD than younger women (Hayes et al. 2007). This may be due to fewer partnered older women, or it may be that sex becomes less integral to psycho-social well-being among older women.

When one partner has a disease that affects their ability to perform intercourse, or for that matter, enjoy any form of sexuality, relationship well-being may be greatly reduced. Compared to the effects of sexual dysfunctions, there is less research examining how particular diseases may affect couples' sex lives, probably due to a bias in the health journals to focus on individual rather than couples' well-being. However, there are some relevant couples studies. Symms and colleagues (2008) surveyed 481 veterans who received an ostomy, a procedure—usually an opening in the intestinal area—used to treat rectal cancer or inflammatory bowel syndrome. The procedure often results in unpleasant side effects such as foul odors, gas, leakage, fatigue, and sleep disturbances—all effects that might harm a couple's sex life and general sense of well-being. Prospective patients who filled out an open-ended questionnaire were aware of, and feared, these possible sexual side effects—with good reason. Post-operative results found that most veterans saw a steep decline in sexual frequency. However, perceived sexual satisfaction played a large role in whether the veterans were able to adjust to their lives post-procedure. Veterans who reported satisfying sex lives were more likely to have stronger personal relationships, meet new people, and have generally satisfying lives. The authors concluded that being able to have a sexual life was a primary part of these men's identities and relationships, and that maintaining a sex life was a key to adjustment after the procedure.

Two other studies not only highlight how disease may negatively affect couples' sex lives, but also the importance of coping strategies and partner understanding. A study of 50 women who survived cervical cancer and a control group of women who had not experienced cancer found that the quality of the post-cancer women's relationships strongly predicted their reported sexual health (Donovan et al. 2007). Another study by McCabe and colleagues (1996) examined 37 men and 74 women diagnosed with multiple

sclerosis (MS) in an effort to understand how the disease affected their sex lives and what qualities of the respondents' relationships might influence their ability to cope with the disease. Many of the respondents with MS reported being dissatisfied with their sexual functioning and the decline in the frequency of sex in their lives. It was also common for respondents to report impaired sexual communication, and a more distant relationship with their partner. Respondents who reported that their partner expressed concern about sex or put pressure on the respondent to have sex were less likely to report satisfaction with their partner, and were less likely to engage in acts of sexual expression. However, respondents who reported healthy and supportive relationships with their partner were more likely to perceive that MS had actually had a positive impact on their sex life. Both studies demonstrate that having a loving partner can help patients with a chronic disease have a satisfying and fulfilling sex life.

No one would deny that sexual function and pleasure is severely challenged when serious and life threatening diseases are present. While the coping literature might be sparse, the evidence that exists can be inspiring. Many patients seek counseling and treatment and sexual medicine has begun to be more common and effective. If a loving partner is present, couples seem to be able to adjust to quite difficult situations and appear to be able to retain a sexual life together.

Non-Monogamy and Infidelity

Up to this point we have reviewed the literature on couples' sexuality under the assumption that couples intend on maintaining long-term, monogamous relationships. While it is true that the vast majority of sexual behaviors take place in the context of dyadic, monogamous relationships, it is also true that not all partners are faithful, and not all couples choose to remain monogamous. Furthermore, recent decades have seen a rise in new forms of commitment that innovate relationship rules, rather than rely on past institutionalized expectations.

Still the core concept of marriage is that when partners commit to each other, they also commit to monogamy. Data from global sex surveys suggest that monogamy is the primary context for sexual relations in cultures across the world (Wellings et al. 2006). In America, attitudes regarding extramarital sex indicate that sex outside of a committed relationship is taboo. The NHLS and the GSS have found that between 70 and 80% of Americans either completely disapprove of extramarital sex or believe that extramarital sex is always wrong (Laumann 1994; Smith 1994). Despite the popular perception that American attitudes about non-monogamy have become more permissive over the last several decades, the evidence suggests that both women and men became more disapproving of extramarital sex. During the 1990s, 90% of individuals in a national survey believed that extramarital sex was either always or almost always wrong (Thornton and Young-DeMarco 2001). This pattern of disapproval toward extramarital sex is also evident in most of Europe, but the U.S. is somewhat of an outlier in how much more conservative its stance is toward non-monogamous relationships relative to countries like England or France. Indeed, American condemnation of extramarital sex rivals historically conservative countries with large Catholic populations, such as Ireland and Poland (Widmer et al. 1998). But attitudes, as we know, are different than behavior, and American values do not accurately reflect American behaviors. Estimates suggest that extramarital sex is surprisingly more common than one might anticipate given what we know from the attitudes data. According to Laumann and colleagues' (1994) analysis of the NHLS, a full quarter of married men and 15% of married women reported engaging in extramarital sex at least once in their lifetime. Likewise, Wiederman's (1997) analysis of the GSS found similar results with 23% of men and 12% of women reporting extramarital sex at least once over the course of their life. The 2009 AARP data suggest that the incidence of infidelity might be surprisingly high for older adults. Whereas the previously mentioned studies asked respondents about infidelity across the lifetime, the AARP asked respondents

about infidelity during their current relationship. The data suggest that 21% of men and 11% of women had a sexual relationship with another partner during their current relationship (Fisher 2009). Of course, many of the respondents may have been partnered with their current partner for most of their life which would result in similar reports had they been asked to report on infidelity across their lifetime. Accordingly, when respondents are asked whether they engaged in infidelity during the previous year, the incidence of extramarital sex is much more rare; less than 4% of married respondents report engagement in extramarital sexuality in that time period (Laumann et al. 1994).

Age and gender have consistently been shown to be correlated with the lifetime incidence of infidelity. However, the relationship between age, gender, and infidelity is somewhat complex. Despite the attention given to gender differences in the incidence of infidelity, recent data suggest that for men and women under the ages of 40–45, the lifetime rates of extramarital sexuality are statistically indistinguishable (Atkins et al. 2001; Wiederman 1997). Atkins and colleagues (2001) note that more time must pass before we are able to conclude that, as they age, women and men continue to engage in similar rates of infidelity. On one hand, a cohort explanation would suggest that the younger cohorts will have equal likelihoods of engaging in extramarital sexuality as they age. For example, the economic emergence of women in the labor market may provide more opportunities for women to engage in extramarital sex by expanding their social and economic resources. On the other hand, we have already summarized evidence that suggests older women find it particularly difficult to find sexual partners relative to older men. If this cultural double-standard for older women and men persists, we might expect men to outpace women in rates of lifetime infidelity as the cohorts age.

Currently, we know that gender differences in rates of lifetime infidelity emerge when we examine respondents who represent the older cohorts at the time of data collection. The cohort of men aged 55–65 appears the most likely to have ever engaged in lifetime extramarital sexuality, relative

to the younger and oldest cohorts of men. For women, the cohort aged 40–45 is more likely to have engaged in infidelity in their lifetime, relative to the younger and oldest cohorts (Atkins et al. 2001). However, some data indicate that the age interval for women most likely to have engaged in infidelity is somewhat wider (Wiederman 1997).

There is some evidence that other demographic characteristics, such as race and ethnicity, are associated with rates of infidelity. A handful of studies have found that African Americans and Hispanics are more likely to engage in extramarital sexuality relative to whites (Amato and Rogers 1997; Cochran et al. 2004; Treas and Giesen 2000; Wiederman 1997). However, few studies have systematically tested what mechanisms may explain the association between race/ethnicity and extramarital sex. The 2009 AARP study may give one clue: Hispanics who had extramarital sex were less likely to think it harmed their relationship. If correct, lower costs (i.e. a resilient relationship because of different norms or expectations about monogamy) may make extramarital sex more likely.

An assortment of additional individual-level characteristics has also been used to predict the likelihood that a partner engages in extramarital sex. Religiosity, measured as frequency of church attendance and respondent's self-reported religiosity, is negatively associated with the incidence of extramarital sexuality. Specifically, the more a respondent appears to identify with a religion, the less likely that the respondent will report having sexual relations outside of the marriage (Amato and Rogers 1997; Atkins et al. 2001). Although some studies suggest that there are little or no differences in the rates of extramarital sex by religion or religious denomination (Forste and Tanfer 1996; Greeley 1994), a recent analysis of the GSS found that denominational differences exist among those respondents who most strongly identify with their religious group (Burdette et al. 2007). Other individual factors shown to increase the likelihood of reporting extramarital sex include reporting strong sexual interests, permissive attitudes toward infidelity, sexual opportunities such as available partners in the workplace,

having a spouse that is weakly tied to one's social network, neuroticism, pregnancy, a history of divorce, and a history of sexual abuse (Atkins et al. 2001; Laumann et al. 1994; Treas and Giesen 2000; Whisman et al. 2007; Whisman and Snyder 2007; Wiederman 1997).

The nature and type of the primary relationship also appears to affect the likelihood of non-monogamy. Cohabitors are significantly more likely to engage in extra-dyadic sex than married couples (Blumstein and Schwartz 1983; Laumann et al. 1994). Although we might expect that some of the higher risk of non-monogamy might be driven by cohabiters' liberal views toward sexuality, cohabiters remain at higher risk even after controlling for their levels of permissiveness regarding extra-dyadic sexuality (Treas and Giesen 2000). Still, this finding does not rule out the explanation that married couples may have more traditional values to begin with, and maintaining traditional values may insulate the couple from having extramarital sex. It might also be the case that the legal nature of marriage (and the norms of marriage) raises the costs of infidelity for married couples relative to cohabiters.

Another obvious risk factor is the quality of the primary relationship. Partners in an unhappy marriage may be more likely to seek sexual gratification elsewhere. However, findings from research on the association between extramarital sexuality and relationship quality are inconsistent. Greeley (1991) found that relationship quality had an indirect effect on the likelihood of extramarital sex through respondent's reported level of permissiveness toward extramarital sexuality. On the other hand, recent studies suggest that partners who are dissatisfied with their relationship are nearly four times as likely to commit infidelity compared to more satisfied couples (Atkins et al. 2001; Banfield and McCabe 2001). However, much of the literature examining the link between relationship well-being and infidelity suggests that the causality may operate in the other direction—infidelity itself predicts relationship well-being. Unfortunately, we are mostly restricted to cross-sectional research on this subject so it is difficult to discuss causal ordering. However, a handful of panel studies that in some

cases followed respondents over the course of a decade, lend considerable credence to the argument that infidelity causes relationship dissatisfaction and dissolution (Amato and Previti 2003; Amato and Rogers 1997; Previti and Amato 2004).

Sex outside of the primary relationship appears especially likely among gay males. In their sample of gay men who were either cohabiting or in civil unions, Solomon and colleagues (2005) found that over half the gay men in both the civil union group and the cohabiting group reported having sex outside of the relationship during the duration of their relationship (compared to 15.2% of heterosexual partnered men). Similarly, half of the gay men in civil unions and one-third of the gay cohabiting men reported having an agreement that sex outside of the relationships was not permissible (compared to about three-fourths of heterosexual partnered men). The finding that gay men have a high risk of engaging in extra-relationship sexuality is, of course, not a new finding (Blumstein and Schwartz 1983; Bryant and Demian 1994; Wagner et al. 2000).

Interestingly, infidelity does not appear as strongly associated with relationship dissatisfaction for gay men relative to heterosexual couples. Although based on convenience samples, there is evidence that gay men are much more likely to successfully negotiate extra-dyadic sex compared to lesbians and heterosexual couples (Blumstein and Schwartz, 1983; Bryant and Demian 1994; Solomon et al., 2005). LaSala (2004) found that gay couples' commitment levels were not undermined when the couples maintained enforceable agreements regarding non-monogamy that placed the primacy of the couple before the secondary, extra-dyadic relationships. Furthermore, even in the event that a partner reneged on the agreement, the couples were able to successfully mend the relationship if there was an open discussion about the indiscretion. These findings replicate earlier studies that found that gay men in open relationships resembled the gay men in sexually exclusive relationships in terms of levels of commitment and expressions of affection (Blasband and Peplau 1985).

Some researchers believe that this fact (that gay male couples are more non-monogamous than

other couples) shows a biological proclivity of men that is demonstrated when men are not bound by the more monogamous values of a female partner. While unconstrained male sex drive may play a role, a large group of researchers believe that cultural explanations still have high explanatory value (Brickell 2006; Gagnon and Simon 2005; Seidman 2003). Most scholars report that gay male culture is more permissive toward extra-dyadic sexuality relative to heterosexual and lesbian culture (Blumstein and Schwartz 1983; Bryant and Demian 1994). Blumstein and Schwartz (1983) found that many gay men in non-monogamous relationships felt that sex outside of the relationship was acceptable as long as the sex was of a casual, impersonal nature. Gay men in the study managed to maintain stable relationships with their primary partners because casual sex partners did not compete with the primary relationship; impersonal sexual encounters rarely developed an emotionally-charged, romantic quality. However, the authors found that despite the gay men's permissive attitudes and behaviors, non-monogamy did take its toll on sexual satisfaction within the primary relationship. Some men equated casual sex with adventure and novelty and thus found their sex lives with their primary partner less exciting. A more extreme cost, a higher relationship dissolution rate, occurred if men had an affair, as opposed to casual sexual encounters.

What explains the observed variation in the acceptance of and participation in extra-dyadic sexuality among gay men? Adam (2006) interviewed 70 gay male couples in Toronto and found both demographic and cultural explanations for gay men's perspectives on non-monogamy. The author found that younger men—men who were more likely to be new to the gay lifestyle—were more likely to follow scripts of monogamy. Adam (2006) speculated that younger men's formative years occurred during a period where homosexuality is more accepted and issues like the gay marriage debate are prominent, whereas older gay men's development occurred during the gay liberation movement—a movement that occurred contemporaneously with public debates that questioned the role of monogamy. Adam (2006)

also found that gay men who came of age in the absence of a local, indigenous gay community were more likely to practice monogamy in their relationship, a finding that lends credence to the gay sub-culture explanations from earlier research (Blumstein and Schwartz 1983; Bryant and Demian 1994)

Consensual non-monogamy is not just a phenomenon among gay male couples. Certain “experimental couples” including heterosexual, lesbian, married, and cohabiting couples participate in non-monogamous relationships. Like their gay male counterparts, the rules and expectations regarding what is permissible and what is good for the relationship are negotiated by the primary couples (Blumstein and Schwartz 1983; Parkinson 1991; Schwartz and Rutter 1998). Heterosexual swingers and heterosexuals who adopt polyamory (committed relationships between more than two consenting individuals) believe that non-monogamy can be consensual and does not undermine the commitment or stability of the primary relationship. In studies of swingers, findings suggest that there are few differences in dissolution rates when comparing sexually open couples and sexually exclusive couples. According to Rubin and Adams’s (1986) follow-up study of 82 couples, married couples with exclusive sexual relationships were statistically indistinguishable from married couples with open relationships in regard to marital stability.

It is also true, that many couples start out monogamous and the relationship evolves into polyamory, or the couples begin swinging, often introduced by one partner as a form of sexual adventure and experimentation (Blumstein and Schwartz 1983; Jenks 1998). An interest in unconventional sexuality can start during college years where formal on-campus groups help organize people of common sexual beliefs and proclivities and, in recent years, sexual networks form easily on the Internet. Early research on swingers indicated that they tended to be white, middle- to upper-middle class, and more highly educated (see Jenks 1998). Later studies have unfortunately been scarce. We do not know why many gay men and some other kinds of couples can embrace non-monogamy and keep their

relationship happy and intact, while most other couples will not consider anything but sexual exclusivity and are likely to unravel if either partner has an outside sexual relationship (Schwartz and Young 2009).

Sexuality Among Dating Couples and Casually Committed Couples

As we mentioned at the beginning of this chapter, commitment itself has become harder to measure. We believe that there is now an intermediate kind of relationship- one that we call “casual commitment”. In our view, these are couples who are not married, do not cohabit, yet can have long-term sexual relationships that establish them as a couple in other people’s eyes, as well as in their own. Long-term dating and other forms of causal commitment have become a salient part of many adults’ lives. Trends in delayed marriage and the extension of adult years spent in education and career development suggest that the early years of adult life have become more emotionally complicated. In addition, high divorce rates have created a large middle-aged group of single adults who do not want to be alone, but are ambivalent about living with someone again or opposed to getting remarried. Many adult singles thus reenter the dating market and create continuing relationships that do not entail cohabitation.

Thus, for both older and younger populations, extended dating and ambiguous commitment are new facts of life. Data from the 1980s to 1990s suggest that the majority of adults are sexually active before they marry. Two studies of pre-married men found that nearly 90% of men were sexually active before marriage. When asked about the number of sexual partners during the previous year, most men reported having one partner, but depending on the study somewhere around 15–18% had four or more partners (Billy et al. 1993; Laumann et al. 1994). Similar results were found for women, although women were somewhat less likely to report larger numbers of total premarital partners (Laumann et al. 1994; Tanfer and Cubbins 1992). Recently, using the NSFG, Lindberg and Singh (2008) found that

of the 36% of women who reported being single, 90% were sexually experienced. Furthermore, 70% of the sexually experienced single women reported being currently sexually active, and singles were more likely than cohabiters and married couples to have two or more partners within the last 12 months. Finally, data from four cycles of the NSFG found that 75% of adults had premarital intercourse by age 20; this percentage increased to 81% by age 44 (Finer 2007). Thus, it is clear that women and men are engaging in sexual activity before long-term commitments, but are not necessarily totally uncommitted. Although we cannot tease out those who are in a relationship from those who are just having sex for purely recreational purposes, it is likely that the majority of these adults are in some kind of relationship.

Dating is probably the most common method that adults use to engage in sexual behavior outside of cohabitation and marriage. As we discussed before, perhaps to the surprise of the casual observer, non-elderly, single adults are having less sex than their cohabiting and married counterparts (Blumstein and Schwartz 1983; Laumann et al. 1994), and non-elderly, single adults are also less satisfied with their sex lives (Blumstein and Schwartz 1983; Laumann et al. 1994). Sprecher's (2002) study that followed 101 intact premarital, dating couples for up to 4 years is one of the few studies that examined the role of sexual satisfaction in the maintenance and health of ongoing dating relationships. Like cohabiting and married couples, sexual satisfaction was associated with relationship satisfaction, love, and commitment. As time passed, couples' sexual satisfaction increased as feelings of love and commitment levels increased. Although we might expect that the association between sexual satisfaction and other indicators of relationship quality might decrease over time for dating couples, no such association was found. In short, it appears that a satisfying sex life is just as important for dating couples as it is for more committed couples. It should be noted, however, that the study—like most studies of dating couples—was limited to a sample of undergraduate students who may resemble adolescents more than they resemble adults.

While the Sprecher (2002) study demonstrates the importance of sex to dating couples, it does not explain why single, non-elderly adults are less likely to report satisfying sex lives. It may be that the dating relationship is inherently unstable and that this instability infects all parts of the couple's life together. We have already established that good communication and shared goals are important for couples' sex lives, and both may be absent or not well established in the early stages during dating. Following this logic, a handful of studies—again based on undergraduate dating experiences—suggest that negotiating sexual behavior may be somewhat perilous for dating couples. Two studies (Impett et al. 2008; Impett and Peplau 2003) found that some daters, both women and men, who are anxiously attached to their partner (i.e. fear that their attachment figure is unreliable or unsupportive during times of need) are more likely to engage in unwanted sex. Daters who have avoidant attachment styles (i.e. general distrust of partners and preferring emotional distance) are also likely to engage in unwanted sex because they wish to avoid the conflict that may arise if they refuse sex. Similarly, regardless of attachment style, some daters who may not want to have sex may do so anyway to fulfill a partner's needs, promote intimacy, and avoid relationship tension (O'Sullivan and Allgeier 1998). While these findings are likely to also apply to more stable forms of committed relationships like marriage, they may be most salient for dating couples who are in the early stages of self-disclosure.

Dating relationships become even more complicated when adults experiment with other types of sexual choices that blur the boundaries of traditional commitment. One such type of relationship that has received a lot of attention in the media and popular culture is the "friends-with-benefits" relationship. In some ways friends make ideal sexual partners. Friendships are based on trust and mutual interdependence, and the qualities that respondents associate with friendships and romantic relationships are more similar than they are different (Sprecher and Reagan 2002). Bisson and Levine (2009) interviewed 125 undergraduates to inquire about their experience

with friends-with-benefits arrangements; 60% of the respondents had maintained a friends-with-benefits relationship at some point in their life and 36% were currently engaged in such a relationship. Interestingly, acquiring intimacy without the burden of commitment was the number one listed advantage of experimenting with the friends-with-benefits arrangement. The most frequently cited drawback to the friends-with-benefits arrangement was a fear that one partner might develop unreciprocated feelings for the other. On the one hand, respondents appeared to engage in these relationships to avoid heavy commitment, while on the other hand respondents chose to be intimate with a friend—a relationship that does require a certain level of commitment—rather than engage in casual sex with someone they are less attached to.

Recent research by England and Thomas (2007) sheds additional light on the correlates and consequences of the “hook-up” culture that has been documented on many college campuses. The authors conducted an online survey with 615 heterosexual, undergraduate respondents and supplemented the data with 270 additional in-depth interviews. The authors found that only 20% of respondents had never experienced a hook-up, while over a third had hooked up more than ten times. When asked about the motivation to hook-up, alcohol was frequently involved; prior to the hook-up, men averaged seven drinks and women averaged four drinks. Interviews with the respondents suggested that a “friends-with-benefits” relationship might emerge after several subsequent hook-ups. The authors also found evidence of gender inequality in the hook-up scene that rivaled the sexual double-standard that often accompanied old-fashioned dating. Women who hooked up were much less likely to achieve orgasm compared to men, suggesting that the hook-up is centered more on men’s rather than women’s pleasure. Specifically, of the women and men who engaged in oral sex or intercourse during a hook-up, only 32% of women achieved orgasm compared to 84–90% for men. England and Thomas’s (2007) findings imply that, at least on college campuses, the old-fashioned date may be on the decline, and hook-ups may be becoming

an attractive way to build intimate relationships. However, insofar as hook-ups disadvantage women in their experience of sexual pleasure, we caution any argument that the hook-up is the natural consequence of the sexual revolution and its message of gender equity.

Very little is known about the longer-term dating relationships of older adults. We have mentioned that a large proportion of older adults maintain healthy, regular, and satisfying sex lives. Yet it is unclear what the actual sexual lifestyle is for older adults that most surveys continue to classify as “single”. The AARP study is one of the few studies that does ask single adults if they are in a committed, dating relationship. The data suggest that older, dating adults are having more sex than their cohabiting and married counterparts, and that they are enjoying sex more than what surveys would suggest of their younger, single counterparts (Fisher 2009). This finding might indicate that some older couples are unhappy or sexually bored in stable relationships, while dating, single older adults are in relationships that are rewarding (or they would have been discontinued). The single relationships are probably of shorter duration and that has an independent effect on sexual frequency and intensity. It is also possible that a certain level of space, separation, and autonomy eroticizes, or in other ways, supports a sexual relationship. Karlsson and Borell (2002) surveyed 116 Swedish adults between the ages of 60 and 90 who were in committed relationships but did not live or intend on living with their partner. Most of the respondents favored not sharing living quarters because it allowed them a high degree of autonomy. This independence was particularly important for the women; many women feared that sharing a residence would lead to a gendered, unequal division of household labor. The women wanted intimacy, but not the highly gendered responsibilities (e.g. cooking, cleaning, and caretaking) that they associated with traditional living arrangements.

Older adults are not the only people who are experimenting with non-residential commitment. The increasingly popular but still rare “living-apart-together” (LAT) arrangement—where partners do not share the same residence—is just one

more example of the reduction of social norms surrounding committed relationships. In Sweden, as of 2001, it is estimated that 14% of individuals who were not married or cohabiting reported being in a LAT relationship, while 60,000–70,000 Norwegian individuals reported such a relationship (Levin 2004). Figures from the Canadian General Social Survey suggest that 8% of the Canadian population is engaged in a LAT relationship (Milan and Peters 2003). The study found considerable age variation in the incidence of LATs: 19% were in their 30s, 14% were in their 40s, and 11% were 50 or over. Over half of those in LATs desired a common law marriage, suggesting a high degree of commitment. However, partners in LATs were less likely to be as future-oriented as their married counterparts. They were also less likely to agree that the presence of a child would improve their lives. Qualitative interviews with couples in LAT relationships found that many couples desired to share a residence, but were unable to make the transition because career and/or family obligations prevented them from doing so (Levin 2004). Thus, much of the increase in LAT and other experimental relationships may be driven by constraints that are external to the relationship. But external constraints are not the only motivating factor behind the LAT arrangement. Some adults reported a hesitance about moving in together after experiencing problems in prior married or cohabiting relationships (Levin 2004). In sum, the new LAT arrangements can be attributed to practical considerations at different stages of the life cycle, work and family constraints, and changing norms surrounding close relationships. Unlike previous generations, having sex with a steady partner even in a committed relationship does not always require coresidential status.

What is the impact of these kinds of separate living conditions? What happens to the sexual relationships of committed partners or spouses who are unable to live in the same residence because of work and educational obligations? These sustained long-distance, “commuter marriages” can exert strain on a couple’s sex life which could reduce their sexual and relationship well-being. One study that compared “commuter

marriages” to dual earners who shared a residence found that while the commuter couples were more likely to be satisfied with their work life and personal time, the quality of family and personal relationships (part of which included intimacy) was lower for the couples who did not live together (Bunker et al. 1992). However, other studies found that long-distance couples were indistinguishable from non-commuter couples on a number of relationship characteristics including intimacy (Guldner and Swensen 1995). A study of long-distance, student couples found that it was possible to maintain successful long-distance relationships as long as the relationship was firmly established before the separation; in addition, success relied upon trust, regular communication, and quality shared time (Magnuson and Norem 1999).

Clearly, it is becoming increasingly common for sex and intimacy to occur outside of the traditional context of marriage or even cohabitation. This is not all that surprising when one considers the dramatic shifts in cultural attitudes toward premarital sex, the trend of delayed marriage, women’s increased ability to create lifestyles independent of men, and an economy that requires adults to compromise ideal working/living situations and further extend the years they spend acquiring education. A higher divorce rate plus longer lives, coupled with a continued desire for sexual and emotional companionship, requires relationship innovation among older adults. However, we know very little about the full range of these arrangements. Most of the research concerning sexuality in dating relationships uses adolescents as the unit of analysis. This is probably because dating has traditionally been seen as a stage of adolescence that has been studied, more often than not, to analyze potential negative outcomes such as early marriage, teen pregnancy, and sexually transmitted infections (STIs). The few studies on adult dating that do exist usually rely on undergraduates as subjects, which limits our ability to generalize to the entire adult population. With an extended lifespan and the increased ability to find new partners at any point of the life cycle (through cultural permission and new institutional supports such as online

dating), the phenomenon of sex and dating in the later adult years will have a significant impact on individuals' physical and mental health. We hope there will be more scholarly attention to this new development in the life course.

Conclusion

Sexuality within committed relationships is an important topic for demographers for several reasons. First, as we have established, the majority of sexual behavior takes place within the context of a committed, dyadic relationship, and the satisfaction, health, and durability of a couple's relationship is intertwined with the functionality of their sex lives. Second, most children are born in committed relationships and patterns of fertility are closely related to how couples approach their sex lives. Finally, we might emphasize that the spread of STIs, including HIV, is not simply a result of people who have uncommitted sexual encounters. STIs are often brought into a committed relationship from a sexual connection with a third party. Demographers studying sexuality because of their interest in morbidity and mortality, need to remain alert to the possibilities of dishonesty about sexual fidelity even in highly committed couples.

There is a good deal of research to bring to bear on these and other issues, but we also have some major methodological and disciplinary limitations that have constrained scholars of sexuality for several decades. Specifically, we need more longitudinal research. A reliance on cross-sectional data has limited our ability to generalize about key causal processes that connect sexuality, personal emotional and physical health, and relationship well-being. Sexuality researchers have intermittently recognized this weakness and there are a handful of well-designed, longitudinal studies that follow couples over time. However, the management and implementation of such study designs are time-consuming, costly, and funding sexual topics is usually difficult, so findings from longitudinal studies are usually based on smaller samples across a small number of time points.

Another problem in the field is a reliance on samples of married, heterosexual couples. This is understandable: the vast majority of Americans marry, and most children are born to parents who are married or will marry. However, over the last several decades we have been witness to the advent of many other family arrangements, and these arrangements are likely to become increasingly numerous. We do not know enough about the sex lives of cohabiting couples, and our data on same-sex couples is extremely limited. We need the inclusion of detailed and well-validated measures of sexual orientation on nationally-representative surveys that include questions about commitment and sexuality. Finally, a weakness that is surely obvious to the readers of this volume is a stunningly, almost non-existent, body of comparative literature examining sexuality within couples. Of course, this is not just a critique that applies to the study of sexuality in general, but it should be noted that the large scale international studies we do have are more focused on factors tied to the health and the spread of STIs than how couples manage their sex lives. The few studies that we have touched upon in this review clearly demonstrate the importance of contextual factors at the regional and cultural level. A better understanding of commonalities and differences across countries might allow researchers to construct better public policy on fertility, morbidity, and health.

Despite these limitations, scholars of sexuality have made progress understanding the complex dynamics that govern couples' sexuality. We know that, almost universally, sexual satisfaction is important for personal health and relationship well-being. We also know that couples' sexual lives are deeply affected by contextual factors that include interpersonal relationship qualities and cultural attitudes about sexuality. Furthermore, we know that couples' sexuality is also changed by their transitions through the life course. All transitions do not affect couples the same way—for example, the labor force participation of women seems to matter in some countries, whereas in other areas it has little or no impact. Likewise, in some regions relationship duration takes a toll on sexual frequency, but in others,

sexual frequency is unaffected by duration. The inconsistency of findings across cultures and countries should motivate us to find out more about the conditions and life events that affect couples' sexual health and relationship durability and happiness.

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Jennifer Pearson and Lindsey Wilkinson

The initiation of romantic and sexual relationships during adolescence is a normative and integral part of adolescent identity development. In the United States, the overwhelming majority of young people have romantic relationships (Carver et al. 2003) and initiate sexual activity during their high school years (Guttmacher Institute 2011); this trend has continued for decades (Finer 2007). American adult attitudes toward adolescent sexual behavior, however, continue to be characterized by fear, concern, and a focus on risk (Russell 2005; Schalet 2004), as evidenced by debates surrounding sex education in schools. Similarly, research on adolescent sexuality is largely focused on preventing sexual risk-taking and negative sexual outcomes, especially in the area of demography (Tolman and McClelland 2011). For example, sexual initiation is often characterized as a problem behavior, and the focus is overwhelmingly on contraceptive use, sexually transmitted infections, and pregnancy.

Research on same-sex sexuality among young people also centers on risk, focusing on high-risk sexual behaviors of sexual minority youth or on the consequences of sexual stigma for well-being.

Youth with same-sex attractions, relationships, or a lesbian, gay, or bisexual (LGB) identity are treated as a distinct group with poorer outcomes than heterosexual youth, including multiple sexual partners, reduced contraceptive use, and higher rates of sexually transmitted infections and pregnancy. Fewer studies portray sexuality as a developmental process occurring among all adolescents (Diamond 2003; Striepe and Tolman 2003) or focus attention on the sex of sexual partners rather than orientation or identity in describing sexual health (see Chandra et al. 2011; Fortenberry et al. 2010; Glover et al. 2009 for examples of exceptions).

A growing body of research in this field recognizes that adolescent sexual relationships are a normal and expected part of adolescence, and this work is beginning to change how we conceptualize adolescent sexuality in social research. Such a turn is evident in the research questions, methodology, and interpretation of findings of studies during the last two decades (Tolman and McClelland 2011). We now know more about how young people experience emerging sexual feelings, how relationships shape sexual intimacy and sexual health, and how sexual empowerment develops (Carpenter 2002; Giordano et al. 2010; Russell 2005; Tolman 2002). However, research on adolescent sexuality within the field of demography needs to focus greater attention on *positive* sexual development in adolescence. We need to integrate data on heterosexual behaviors and same-sex sexuality as well as qualitative and

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quantitative research to develop a framework for understanding adolescent sexuality. Further, we need new measures that capture the breadth of adolescent sexuality as well as positive sexual development in our large-scale datasets. Finally, we need to pay closer attention to the social and cultural context within which adolescent development occurs. Research has demonstrated that relationship characteristics, school cultures, and larger cultural trends are key for understanding sexual desire, identity, and behaviors, yet research on adolescent sexual behaviors is often divorced from context.

In this chapter, we review recent trends in American adolescent sexual attractions, identities, and behaviors, including debut, repertoires, and partnerships, and we discuss current trends in contraceptive and protective behaviors and outcomes. In addition, we attend to the cultural context within which young people in the United States initiate sexual relationships, and its meaning for adolescent sexual desire, identity, and well-being. We also place adolescent sexuality in the United States in a larger context with an international comparison of adolescent sexuality. Finally, we summarize important data and methodological issues in research on adolescent sexuality, offering suggestions for future research areas and data needs. Given the size of the literature on adolescent sexuality, this is not intended to be a comprehensive review of research on adolescent sexual behaviors, contraceptive use, and outcomes. Rather, we attempt to (1) integrate literature on heterosexual and same-sex sexual behaviors and identities, and (2) bridge the gap between research on sexual behavior and cultural analyses of gender and heteronormativity.

Adolescent Sexual Desire and Identity

For the most part, adolescents' sexual identity is assumed to be heterosexual and to follow a normative gendered heterosexual script. Heteronormativity, or privileging of opposite-sex desire and relationships and assumption of heterosexuality, characterizes both the broader U.S. culture as well as research on adolescent sexuality. Thus,

the majority of research on sexual development is concerned with signs of variation from the heterosexual norm and how non-heterosexual attractions, behaviors, and identities emerge. There is little research on how heterosexual youth explore their gender and sexual identities or how these identities emerge (see Martin 1996; Striepe and Tolman 2003; Tolman 2002 as examples of exceptions), and it is not until adolescents show signs of deviation from the norm that sexual identity becomes salient. However, this assumption of heterosexuality plays a role in how all adolescents experience and develop their romantic and sexual relationships because of the stigma attributed to non-heterosexuality that is found among peer groups, teachers, and the larger culture (Gagnon and Simon 1973; Striepe and Tolman 2003).

Sexual Identity Development

Earlier models of sexual identity development tended to focus on the gay male experience and delineated a linear trajectory of milestones toward the formation of sexual identity (e.g., Troiden 1989). Recent research, however, has documented the diversity among sexual minorities in the timing of same-sex attractions, LGB identities, and same-sex behavior (Diamond 2008; Kinnish et al. 2005; Savin-Williams and Ream 2007). Young adults who may at some point in their life identify as LGB report feeling same-sex attractions at different points in their development (Diamond 2003), and the age at which individuals identify varies (Friedman et al. 2004). Moreover, many individuals feeling same-sex attractions may not ever identify as LGB (Friedman et al. 2004).

For example, data from the National Longitudinal Study of Adolescent Health (Add Health) show that a small minority of young men who reported only same-sex attractions in adolescence identified as gay in young adulthood. As seen in Table 9.1, 12.3% of men and 13.4% of women who reported only a same-sex attraction in adolescence identified as 100% or mostly homosexual in young adulthood. The majority of

Table 9.1 Young adult sexual behavior and identity by adolescent romantic attraction

	Young women				Young men			
	Adolescent romantic attraction				Adolescent romantic attraction			
	Opposite-sex	Same-sex	Both-sex	None	Opposite-sex	Same-sex	Both-sex	None
	Weighted %				Weighted %			
<i>Young adult behavior</i>								
Opposite-sex only	83.7	68.7	72.1	71.6	81.6	58.0	70.6	71.0
Same-sex only	0.5	4.0	1.7	0.0	0.7	16.7	4.6	0.8
Both-sexes	2.5	16.3	15.1	1.2	1.2	0.0	3.9	1.0
None	13.3	11.0	11.1	27.2	16.5	25.3	21.0	27.2
<i>Young adult identity</i>								
100% Heterosexual	86.2	59.3	52.5	90.8	95.0	82.0	86.0	92.9
Mostly heterosexual	10.4	21.6	30.1	4.7	3.0	2.5	4.5	3.1
Bisexual	2.2	5.7	11.6	1.3	0.4	3.2	1.6	0.6
Mostly homosexual	0.6	8.0	3.0	0.3	0.5	3.5	1.5	0.6
100% Homosexual	0.4	5.4	2.0	0.3	0.8	8.8	5.6	0.9
No attraction	0.2	0.0	0.8	2.7	0.0	0.0	1.0	1.9
N	6,277	93	274	759	5,375	50	398	807

Source: Waves 1 and 3 of the National Longitudinal Study of Adolescent Health

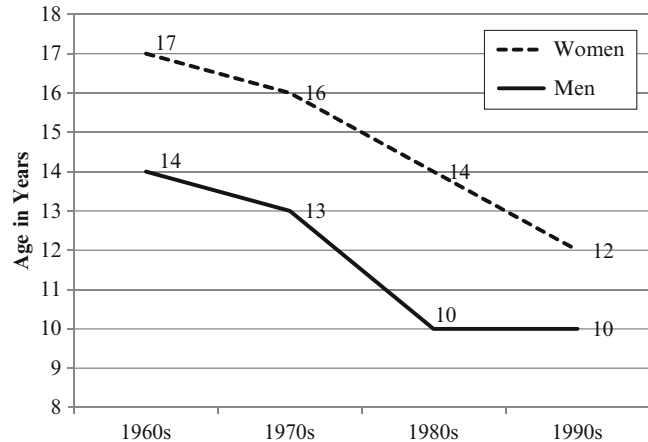
men and women who reported a same-sex attraction in adolescence reported a 100% or mostly heterosexual identity in young adulthood. Today, we see identification as a sexual minority occurring much sooner in the life course than in the past, with self-labeling occurring often by age 15 rather than during the mid-twenties as was seen 50 years ago (Savin-Williams 2005). We also see a linear decline in the age of first same-sex attraction since the 1960s (Savin-Williams 2005), as depicted in Fig. 9.1. In addition, data now indicate that more young people come out as gay or bisexual even before engaging in same-sex behavior, particularly among young men (Dube 2000), and adolescent girls are more likely to identify as bisexual or mostly heterosexual than in the past (Saewyc et al. 2007).

New research in the area of sexual identity development criticizes a linear milestones approach because such an approach often ignores the importance of context (Hammack et al. 2009). Although public discourse around the issue of same-sex marriage demonstrates that same-sex desires and relationships remain marginalized (Human Rights Campaign 2010; Rutter and Schwartz 2011), public attitudes about same-sex

sexuality have changed over time and are increasingly accepting of same-sex relationships and identities (Newport 2011; Saad 2010). Such changes within the larger culture have led to less stigmatization of same-sex sexuality and arguably less pressure on teens to repress or hide their same-sex sexuality, leading some to argue that we are now in a “post-gay” generation (Savin-Williams 2005).

Yet there is considerable variation, even within the U.S., in the acceptability of same-sex sexuality, with adolescents’ experience of sexual scripts varying by local context and social status. Moreover, while individuals may have predispositions toward a sexual orientation due to a mix of biological and social factors, individuals also experience changes in attractions, behaviors, and identities throughout the life course and across contexts (Diamond 2008; Savin-Williams and Ream 2007; Kinnish et al. 2005). Sexuality appears to be shaped by a variety of social factors. Demographic factors such as race, ethnicity, and class (Dube and Savin-Williams 1999; Diamond 2003; Barrett and Pollack 2005), as well as contextual factors such as political climate and accessibility of support services (Diamond

Fig. 9.1 Average age at first same-sex attraction (Source: Savin-Williams 2005)



2003), have been found to impact the diverse experiences of same-sex sexuality. For example, research at the macro-level has found that the percentages of women and men who report having a same-sex partner has changed over time in the U.S., Great Britain, and the Netherlands, particularly among women, and such change is hypothesized to be caused by changes in the normative context within these countries (Butler 2005; Kuyper and Vanwesenbeek 2009; Turner et al. 2005).

Women's sexuality has been found to be much more fluid and context-dependent than is men's sexuality (Baumeister 2000; Diamond 2008). For example, women are more likely to experience nonexclusive attractions (Glover et al. 2009), and to identify as bisexual (Chandra et al. 2011; Savin-Williams and Ream 2007). Research on women's sexuality has shown how sexual stigma shapes the manner in which young women interpret attractions and identify their sexual orientations, with women often becoming less restrictive in their sexual identifications as they get older (Diamond 2008; Rust 1993). Also, heteronormative high school contexts have a greater impact on young adult women's reports of same-sex attractions than those of men (Wilkinson and Pearson Forthcoming).

Identity patterns also vary by race and ethnicity. African American men may show a reluctance to identify as gay (Boykin 2005), although some research has found similar ages of gay or bisexual

self-identification among a sample of college-age Asian, Latino, and white men (Dube and Savin-Williams 1999). Young racial/ethnic minority LGB youth may delay disclosure to family and friends and be less involved in gay-related social networks compared to white teens (Dube and Savin-Williams 1999; Rosario et al. 2004). Racial/ethnic differences can also be seen in first awareness of same-sex attractions as well as in participation in gay sex before identifying as gay, with Asian American youth latest in their awareness of same-sex attractions and least likely to have sex with a same-sex partner before identifying as gay (Dube and Savin-Williams 1999). Native American Indian youth have been found to be more likely to identify as bisexual or homosexual (Saewyc et al. 1998), and some attribute this finding to the unique understanding of sexual fluidity within Native American culture. These findings illustrate the importance of social context and other demographic characteristics in shaping sexual identity and behaviors.

Just as heteronormativity shapes how young people interpret sexual desires and experiences, so do larger cultural beliefs about masculinity and femininity. Research that has explored the development of sexual desire and identity among heterosexual youth has focused primarily on young women. Young women's sexual feelings and experiences emerge within a culture and peer networks that limit and deny female sexual desire and define female sexuality as passive and

Table 9.2 Prevalence of same-sex sexuality dimensions across time by sex

	Young women (N=4,222)		Young men (N=3,398)	
	Adolescence	Young Adulthood	Adolescence	Young Adulthood
	Weighted %		Weighted %	
<i>Sexual identity</i>				
100% Heterosexual		78.7		93.5
Mostly heterosexual		16.4		3.7
Bisexual		2.5		0.5
Mostly homosexual		1.1		0.6
100% Homosexual		0.8		1.6
No attraction		0.5		0.1
<i>Experiences of same-sex sexuality</i>				
Any same-sex sexual contact	4.5	11.9	2.2	4.4
Any same-sex relationship	5.4	4.2	3.5	2.8
Any same-sex attraction	6.5	10.0	9.6	3.8

Source: Waves 1 through 4 of the National Longitudinal Study of Adolescent Health

vulnerable (Nathanson 1991; Tolman 2002). Though strong sexual desire and assertiveness are accepted and even encouraged among boys (Pascoe 2007), girls who are sexually assertive, have “too many” sexual partners, or are perceived to have strong desire are labeled sexually deviant and are less accepted by peers (Dietrich 1998; Kreager and Staff 2009; Phillips 2000). As a result of these dominant understandings of heterosexuality and femininity, young women may monitor themselves to suppress feelings or restrict behaviors that are not consistent with views of “appropriate” sexuality for women, and girls report feeling more guilt and shame about sex compared to boys (Cuffee et al. 2007). This may prevent girls from exploring their own feelings and desires, and as a result young women may have difficulty identifying their sexual desires and may privilege their male partner’s desires above their own (Phillips 2000; Tolman 2002).

Prevalence of Same-Sex Desire and Identity

The question of how many sexual minority youth there are in the U.S. is not an easy question to answer, primarily because of the multi-dimensional aspect of sexuality. In social science research, the dimensions of same-sex sexuality

measured typically include sexual or romantic attraction, sexual behavior, and sexual identity (Savin-Williams 2006). Given these multiple dimensions, some have estimated that the population of sexual minority youth in the U.S. is between 1% and 17% (Anhalt and Morris 1998; Savin-Williams and Ream 2007); Savin-Williams and Ream (2007) found that, depending on the measures used, prevalence rates of non-heterosexuality among adolescents and young adults ranged from 1 to 15% and varied by biological sex, dimension of same-sex sexuality, and the intensity of the dimension (e.g. “100% homosexual” versus “mostly homosexual”). Specifically, while only 1% of all 7th-12th graders reported exclusively same-sex behavior, 15% of females aged 18–26 indicated a non-heterosexual identity (lesbian, bisexual, or “mostly heterosexual”), and more than 13% of females aged 18–26 reported either same-sex or both-sex romantic attractions (Savin-Williams and Ream 2007).

Table 9.2 presents the prevalence of multiple dimensions of same-sex sexuality across time among young women and men in the Add Health data. In young adulthood, young women are more likely than young men to report a non-heterosexual identity, especially a “mostly heterosexual” identity, and they are more likely to report currently experiencing same-sex attraction (Wave 4). In addition, young women are more likely than

young men to report same-sex relationships and sexual contact with same-sex partners since age 18. We generally see a more positive perception of female same-sex sexuality relative to male same-sex sexuality (Kuyper and Vanwesenbeek 2009), and women tend to be more accepting of same-sex marriage than men (Sherkat et al. 2011), which may explain why we see higher rates of female same-sex sexuality than male same-sex sexuality (Kuyper and Vanwesenbeek 2009; Butler 2005). In addition, many youth report experiencing both same-sex and opposite-sex attractions (Savin-Williams and Ream 2007). As shown in Table 9.2, 6.5% of young women and 9.6% of young men reported experiencing same-sex attraction in adolescence (many of whom experienced opposite-sex attractions as well). Savin-Williams and Ream (2007) note that including same- and opposite-sex attracted individuals as sexual minorities increases the prevalence rate by nine times. Finally, same-sex sexual contact is reported by about 5% of adolescent women and 2% of adolescent men.

It is generally assumed that self-identified lesbian, gay, and bisexual (LGB) youth are a small proportion, perhaps only 10%, of all sexual minority youth (Savin-Williams and Cohen 2007), with rates of same-sex attraction or same-sex behavior much higher than rates of LGB identity. Many individuals feeling same-sex attractions may not ever identify as gay, lesbian, or bisexual (Friedman et al. 2004). However, this changes once labels such as “mostly heterosexual” are provided as options. There has been particular focus recently on the “mostly heterosexual” or “hetero flexible” group, which at different points in time and in different studies may be identified as heterosexual, bisexual, or homosexual, depending on the operationalization of the sexual identity variable. This “hetero flexible” group may be important to disaggregate from those who identify, on the Kinsey scale, as “bisexual,” “mostly homosexual,” or “100% homosexual,” not only because of its relative size (Laumann et al. 1994; Ellis et al. 2005), but also because of its theoretical relevance (Thompson and Morgan 2008; Vrangalova and Savin-Williams 2010). Moreover, this diversity and fluidity in same-sex

sexuality underscores how difficult it is to distinguish “gay” and “straight” youth, and how same-sex sexuality is an aspect of sexual development for many heterosexual youth.

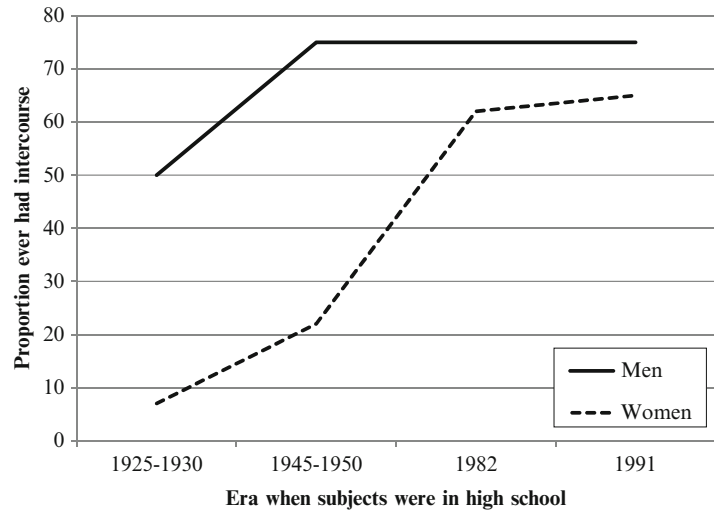
Adolescent Sexual Behaviors in the United States

Adolescent Sexual Debut

Sexual relationships have become a normal and expected part of adolescence. By the end of their teenage years, a majority of young people have had sex, and many have engaged in both vaginal intercourse and oral sex. Using data from the 2002 National Survey of Family Growth, Mosher, Chandra, and Jones (2005) found that 82% of 19-year-old males and 88% of 19-year-old females have had heterosexual sexual contact. Approximately seven in ten young people (69% of men and 78% of women) engage in vaginal intercourse before the age of 20 (Guttmacher Institute 2011; Mosher et al. 2005). These numbers stand in stark contrast to common proscriptions for adolescent sexual behavior. Despite a focus on abstinence in most sex education programs, premarital sex is nearly universal and has been that way for some time. Finer’s (2007) analysis of NSFG 2002 data indicates that 75% of young people have had premarital sex by age 20, and by age 44, 95% of Americans have had sex before marriage. Though the trend from the 1950s to the 1990s was an increase in premarital sex at younger ages, almost everyone has sex before marriage and this has been true for over 40 years. Among those who turned 15 between 1954 and 1963, 48% had premarital sex by age 20 and 88% had sex before marriage by age 44. Further, the difference between men and women is trivial, with 96% of men and 94% of women having sex before marriage (Finer 2007).

Experiencing first sexual intercourse during the early teenage years is less common. While 26% of 15-year-old females and 25% of 15-year-old males have had sex (Mosher et al. 2005), only 6% of adolescents (8.4% of boys and 3.1% of girls) have sexual intercourse before the age of 13

Fig. 9.2 Trends in heterosexual experience among teens (Source: Recreated from Schwartz and Rutter 2000)



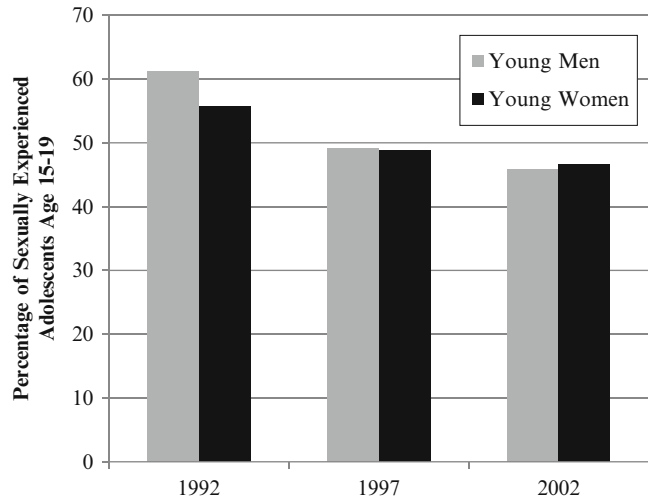
(Centers for Disease Control 2010) and only 13% of girls and 14.6% of boys have sexual intercourse before the age of 15 (Abma et al. 2004; Chandra et al. 2005). Moreover, sexual debut at early ages has declined in recent decades, with fewer adolescents reporting first sex before age 15 in 2006–2008 compared to 1995 (Guttmacher Institute 2011). African American youth, particularly males, and youth with less educated parents are more likely to be sexually active and initiate at earlier ages (Abma et al. 2004; Browning et al. 2004; Santelli et al. 2000), while Latina females are less likely than non-Latina whites and Latino males to be sexually active (Abma et al. 2004). LGB-identified individuals report earlier sexual debut (Coker et al. 2010), with young sexual minority males often finding male partners for kissing, genital contact, or intercourse before the age of 16 (Savin-Williams 2005). Research also shows that “mostly heterosexual” adolescent young women reach sexual debut at earlier ages than their heterosexual counterparts (Austin et al. 2008), and LGB-identified adolescents are also more likely to report sexual intercourse before 13 years of age (Goodenow et al. 2008).

Perhaps the greatest change in adolescent sexuality over the past 50 years has been a shrinking gender gap in young men’s and women’s sexual behavior (Schwartz and Rutter 2000). As seen in Fig. 9.2, the proportion of young women who

were sexually active during adolescence increased dramatically during the 1960s and 1970s, so that by the early 1980s young women were almost as likely as young men to be sexually active during high school. Today, the average age at first sex (vaginal-penile intercourse) is 17 for both young women and men (Guttmacher Institute 2011). This closing gap has been particularly evident in recent years among African American youth: while the gender gap in sexual debut by age 15 was 31 points among black youth in 1988 (47% of young men and 16% of young women), the gap had decreased to 6 percentage points in 2002 (29% of young men and 23% of young women).

Despite a dramatic increase in sexual experience among adolescents, particularly young women, over the last 50 years, the proportion of teens who have had sex declined from the early 1990s to the early 2000s (Manlove et al. 2009) and has recently leveled off (Abma et al. 2010). Although it was young women’s behavior that changed most dramatically with the sexual revolution of the 1960s and 1970s, recent changes have been primarily driven by young men’s behavior. Figure 9.3 illustrates this trend: the percentage of young men aged 15–19 who have had sex decreased from 61% in 1992 to 46% in 2002, so that now roughly equal proportions of 15–19 year old boys and girls have had sex (Manlove et al.

Fig. 9.3 Trends in adolescent heterosexual experience, 1992–2002
(Source: Manlove et al. 2009)



2009; Martinez et al. 2011). Young men are also increasingly likely to initiate sex within the context of a romantic relationship (Guttmacher Institute 2008), though they are still less likely than young women to initiate with a romantic partner.

First sexual intercourse most often takes place within the context of a dating relationship (Manning et al. 2000). Seventy-two percent of young women and 56% of young men from the 2006–2008 NSFG reported that they were “going steady” with their first sexual partner, while just 14% of young women and 25% of young men aged 15–19 report that they had “just met” or were “just friends” with their first sexual partner (Abma et al. 2010). Similarly, analysis of Add Health data indicate that 83% of recent initiators reported that their first sexual relationship was romantic (Manlove et al. 2007). Sexual minority youth also often experience first opposite-sex sexual experiences within a dating relationship (Baumeister 2000; Diamond 2003). However, because of the stigma associated with same-sex sexuality, many sexual minority adolescents, particularly males, do not experience their first same-sex sexual relationship within the context of romantic relationships. Although sexual minority males report a preference for sex within a relationship, these men are more likely to experience their first same-sex experience as purely sexual (Savin-Williams and Diamond 2004). In addition, when young sexual

minority males do engage in same-sex romantic relationships they are often of a shorter duration than heterosexual romantic relationships (Smiler et al. 2011) and are less likely to be supported by peers (Connolly et al. 2000).

Of course, for some young people, sexual debut is not voluntary. Eight percent of women report that first sex was not voluntary (Chandra et al. 2005), and the younger women are at sexual debut the more likely they are to report that their first sex was not voluntary or was unwanted (Abma et al. 1998). According to data from the 2002 NSFG, while 4% of women (ages 18–44) who had sex for the first time after age 20 reported that intercourse was not voluntary, 20% of women who had sex before age 15 reported that their first sex was coerced. The most common types of coercion at first intercourse reported by women are “pressured into it by his words or actions, but without threat of harm,” “given alcohol or drugs,” or “did what he said because he was bigger or grownup, and you were young,” but 3% of all women report being forced to have sex with threat of physical injury or harm, 3% report being physically hurt or injured, and 5% report being held down (Chandra et al. 2005). Experiences of sexual coercion are not uncommon for young women throughout adolescence and young adulthood: 14% of 18–19 year-olds and 19% of 20–24 year-olds report having *ever* been forced to have sex (Chandra et al. 2005). LGB-identified adolescents

are more likely to report physical, verbal, and sexual abuse (Coker et al. 2010; Garofalo et al. 1998; Goodenow et al. 2008; Saewyc et al. 2006), including forced sex, dating violence, and outing of one's partner (Freedner et al. 2002). Adolescent girls with both male and female partners are the most likely to report dating violence or coerced sexual contact (Freedner et al. 2002; Goodenow et al. 2008), and bisexual adolescents, male and female, are more likely than their gay or lesbian counterparts to be threatened with outing by a partner (Freedner et al. 2002). It is important not to assume the sex of LGB youths' partners, as Freedner and colleagues found that nearly half of the self-identified lesbians in a community-based sample who reported abuse had been abused by a male partner.

A much larger proportion of young people report that their first sex was unwanted, even if it was voluntary. Almost 10% of young women and 5% of young men say that they did not really want to have sex their first time, and another 47% of young women and 34% of young men report that they had mixed feelings ("part of me wanted it to happen at the time and part of me didn't") (Martinez et al. 2011). Young women with older partners are much more likely to say their first sex was unwanted, but young men with much younger partners at first sex were more likely to report it was unwanted (Martinez et al. 2011). Such findings suggest that a strong sense of sexual agency is lacking among many adolescents and young adults, which has consequences for positive sexual development and safer sex behavior.

Sexual Practices and Partnerships

Oral sex has received much less attention than vaginal intercourse in research on adolescent sexuality, but the little research that exists suggests that it is a common sexual practice among young people. Among 19 year-old men who participated in the 2002 NSFG, a slightly greater proportion had engaged in oral sex (74%) than had experienced vaginal intercourse (69%). Nineteen-year-old women were more likely to report vaginal intercourse (78%), but were equally

likely as men to have engaged in oral sex. Moreover, though more men reported having received oral sex than had performed oral sex on a partner (71% vs. 55%), similar proportions of women the same age also report having received oral sex (64% gave and 71% received) (Mosher et al. 2005). This stands in contrast to public perceptions and panic of young women performing oral sex on their male partners without return (Remez 2000). Table 9.3 presents data from the National Survey of Sexual Health and Behavior (NSSHB) on sexual practices among American adolescents. These findings demonstrate that the sexual repertoires of young people with opposite-sex partners in the United States are likely to include vaginal intercourse, cunnilingus, and fellatio.

Oral sex among same-sex female partners appears to be more frequent than oral sex among same-sex male partners in adolescence: 7.1% of 15–19 year old females reported having had oral sex in the past year with a female (Chandra et al. 2011), and 9% of 16–17 year old females reported ever having given oral sex to a female (Herbenick et al. 2010). Among young men 15–19 years of age, only 2.2% reported having engaged in oral sex with a male in the previous year (Chandra et al. 2011). Additionally, only 1.6% of 14–15 year old males and 2.8% of 16–17 year old males reported ever giving oral sex to another male (Herbenick et al. 2010). Giving or receiving oral sex is most likely to include opposite-sex partners (Fortenberry et al. 2010; Herbenick et al. 2010). As seen in Table 9.3, 51% of men ages 18–19 gave oral sex to a female partner in the past year, while only 4% of 18–19-year-old men gave oral sex to a male partner. Similarly, 4% of women in this age group report having received oral sex from a female partner, while 58% report having received oral sex from a male partner.

Although typically associated with men who have sex with men and not with heterosexual couples, anal sex is not an uncommon practice among young people with opposite-sex partners. Approximately 22% of young men and 20% of young women ages 15–24 report having engaged in anal sex with an opposite sex partner (Mosher et al. 2005), and 18% of young women aged

Table 9.3 Adolescent sexual behaviors

	Percent of adolescents performing certain sexual behaviors in past year (N=5,865)					
	Age 14–15		Age 16–17		Age 18–19	
	Men	Women	Men	Women	Men	Women
Masturbated alone	62	40	75	45	81	60
Masturbated with partner	5	8	16	19	42	36
Receptive oral sex (female partner)	12	1	31	5	54	4
Receptive oral sex (male partner)	1	10	3	24	6	58
Gave oral sex (female partner)	8	2	18	7	51	2
Gave oral sex (male partner)	1	12	2	22	4	59
Vaginal intercourse	9	11	30	30	53	62
Receptive anal sex	1	4	1	5	4	18
Gave anal sex	3		6		6	

Source: Data from the National Survey of Sexual Health and Behavior (NSSHB) presented in Herbenick et al. 2010

18–19 report receptive anal sex during the past year (Table 9.3). Young men who reported that their last sex event was anal sex were much more likely to have had a female partner, with 26% reporting a male partner (Fortenberry et al. 2010). Only 1.2% of 15–19 year old adolescent males report any anal sex with a male partner (Chandra et al. 2011), and receptive anal intercourse is the least common same-sex behavior reported, with less than 6% of men in any age group reporting it (Herbenick et al. 2010). Yet not surprisingly, boys with same-sex or both-sex partners are more likely than those with exclusively opposite-sex partners to have engaged in anal sex (33% versus 10%) (Udry and Chantala 2002). However, it is clear that anal sex is very much a heterosexual behavior: research using the National Longitudinal Study of Adolescent Health’s data on young adults’ sexual relationships also indicates that almost one quarter of heterosexual couples participated in vaginal sex, oral sex, *and* anal sex with their partners (Kaestle and Halpern 2007). Such findings suggest that education surrounding the health risks and use of protection during anal sex should be directed at all young people, not just men who have sex with men.

Though sex during adolescence most often takes place within the context of a relationship, many young people have multiple sexual partners during their teenage years. Among sexually experienced young women ages 15–19 in 2006–2010,

35% had one partner, 16.4% had two, 32% had 3–5, and 17% had six or more. Sexually active young men are somewhat more likely to report more sexual partners, with 30% reporting one partner, 15% reporting two partners, 33% reporting 3–5 partners, and 22% reporting six or more partners (Martinez et al. 2011). LGB-identified adolescents are more likely to report sexual intercourse with four or more partners in their lifetime and two or more partners in the past 3 months (Garofalo et al. 1998; Goodenow et al. 2008). In addition, compared to heterosexual young women, “mostly heterosexual” women ages 18–24 report a higher number of lifetime sexual partners (Austin et al. 2008).

There are sex differences in the number of same-sex versus opposite-sex partners among sexual minority youth, with sexual minority males more likely to engage in same-sex sexual behaviors and to report more same-sex partners than sexual minority females. Young sexual minority women are more likely to engage in opposite-sex sexual behaviors, including heterosexual intercourse, relative to sexual minority male youths (Rosario et al. 1996). Finally, young gay men whose sexuality is sex-centered rather than identity-centered report having more male sex partners (Dube 2000). It is important to note that only a small percentage of sexual minority youth experience *only* same-sex sexual behavior, as most adolescents and young adults who

identify as gay, lesbian, or bisexual, particularly females, engage in opposite-sex sexual behavior, sometimes having more opposite-sex than same-sex sexual encounters (Hillier et al. 1998). In addition, most of the adolescents who engage in same-sex behavior do not identify as gay, lesbian, or bisexual (Garofalo et al. 1999; Savin-Williams 2005; Savin-Williams and Ream 2007).

Non-romantic sex is also common among adolescents. For example, data from the Toledo Adolescent Relationships Study indicate that 68% of boys and 52% of girls had sex outside of a dating relationship (Manning et al. 2006). In addition, one third of recent sexual experiences reported by adolescents in Add Health were not in the context of a romantic relationship (Manning et al. 2005). We should be careful, however, not to assume that there is a clear distinction between romantic and non-romantic sexual relationships, or that sex within a romantic relationship is necessarily more positive. Most often these non-romantic sexual relationships are with a friend or an ex-girlfriend or ex-boyfriend, rather than with an acquaintance or stranger (Manning et al. 2006). Moreover, although two thirds of dating respondents in the Toledo study said that sex made them feel closer to their partner, so did one third of the non-romantic sexual partners, and many of the young people with non-romantic sexual relationships wanted their partner as a boyfriend or girlfriend (Manning et al. 2006). In addition, young people may initiate sex early in a romantic relationship, such as in the first month of dating (Manlove et al. 2007). Such research suggests that more nuanced aspects of relationships, such as feelings toward one's partner and how long the partners have known one another, may be more important predictors of the quality of the sexual relationship than whether or not it is labeled romantic.

Protective Sexual Behaviors and Outcomes

Given that sexual relationships have become a common and expected part of adolescence, contraceptive knowledge and efficacy among young

people is crucial. Although sexual activity is a normative part of this life stage in the United States, pregnancy and childbearing are not. An illustration of this is the strong link between teenage childbearing and poverty. In this section, we examine current trends in adolescent contraceptive use, safer sex behaviors, and outcomes of pregnancy and sexually transmitted infections.

Contraceptive Use

Contraceptive use at first sex has increased since the early 1980s, as has condom use (Mosher and Jones 2010; Santelli et al. 2006). As reflected in Fig. 9.4, most adolescents in the United States use a condom the first time they have sex: 72% of young women who initiated sexual activity between 2005 and 2008 reported using a condom, compared to 34% of young women who had sex for the first time before 1985 (Mosher and Jones 2010). Though using a condom at sexual debut does not ensure consistent condom use across sexual relationships, young women who do not use a condom the first time they have sex are twice as likely as those who do to become pregnant as teenagers (Abma et al. 2004). Condom use at first sex appears to vary less by race and ethnicity than in previous decades (Martinez et al. 2011; National Campaign to End Teen Pregnancy 2006). Although Latina and African American young women are somewhat less likely than non-Latina white women to have used a condom at first sex, there are few racial/ethnic differences among men in reports of having used a condom (Martinez et al. 2011). Non-Latino/a whites are still much more likely to have used oral contraceptives or dual methods at first sex (Martinez et al. 2011), and young Latino men and Latina women are less likely to use contraception consistently across sexual relationships.

Consistency in contraceptive use after sexual initiation varies across relationships and is shaped by characteristics of these relationships and partners. Sixty-three percent of adolescents report using contraceptives consistently throughout their first sexual relationship (Manlove et al. 2003), and adolescents report using contraceptives consis-

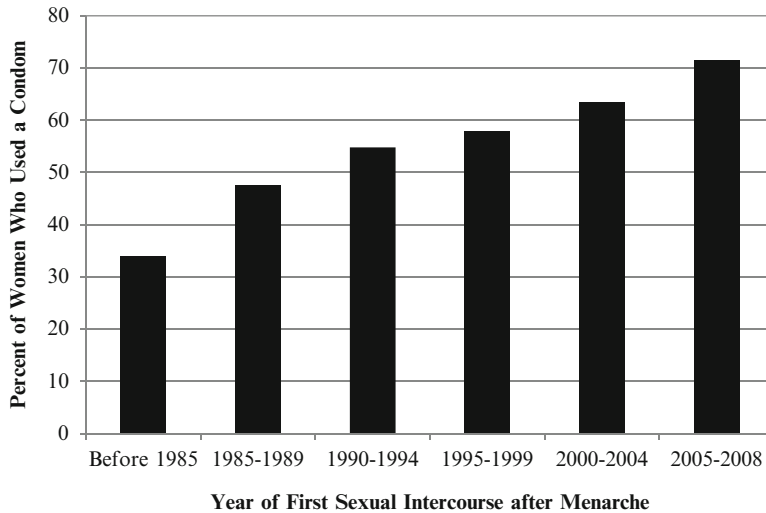


Fig. 9.4 Trends in condom use at first sex, 1982–2008 (Source: Mosher and Jones 2010)

tently in 58% of their relationships (Manlove et al. 2007). Though prior contraceptive consistency is associated with contraceptive use, young people vary their contraceptive patterns across relationships. For example, among sexually active teens, having a much older partner is associated with reduced contraceptive use and consistency (Abma et al. 1998; Ford et al. 2001; Manlove et al. 2007), reduced condom use (Ford et al. 2001; Miller et al. 1997), and a greater likelihood of contracting sexually transmitted infections (STIs) (Ford and Lepkowski 2004). Discussing contraception with one’s partner before having sex for the first time and participating in more “dating activities” (such as going out on a date or meeting each other’s parents) are associated with greater contraceptive use (Manlove et al. 2003, 2007). In relationships labeled romantic, young people are more likely to have ever used contraception but less likely to use it consistently (Manning et al. 2000; Manlove et al. 2007). This apparent contradiction may indicate that greater familiarity or comfort with a partner may lead to easier negotiation about contraception but that familiar, romantic partners may also be seen as less “risky” than non-romantic partners. Young people with a greater number of sexual relationships are less likely to use contraceptives consistently (Manlove et al. 2007), putting them at greater risk for pregnancy and sexually transmitted infections.

The majority of self-identified gay men and lesbians engage in heterosexual intercourse at some point in their lives (Einhorn and Polgar 1994; Cochran et al. 1996), and findings are mixed as to whether this intercourse is less likely to involve contraceptive use (Saewyc 2011). While results from population survey data collected in both Canada and Minnesota suggest that all LGB groups are less likely to report condom use or birth control at last intercourse (Saewyc et al. 2008; Gallart and Saewyc 2004), other studies have found that (1) high-risk LGBQ adolescents are more likely than their high-risk heterosexual peers to use condoms and contraception (Rotheram-Borus et al. 1995) and (2) that LGBQ adolescents, primarily girls, are not more or less likely than heterosexual girls to use condoms during intercourse (Goodenow et al. 2008). However, in many of these studies it is not clear what the sex of the partner is (Saewyc 2011). This is important, as some research has found that young gay men use contraception less often with female partners than with male sexual partners (Rotheram-Borus et al. 1995).

Additionally, there seems to be an important distinction between a lesbian or bisexual identity and an unsure sexual identity (Goodenow et al. 2008). Saewyc et al. (1999) found that, among sexually experienced adolescents, unsure adolescent women were the least likely to use contra-

ception, with bisexual and lesbian identified women not more or less likely than heterosexual women to use contraception. Also, young men who have both male and female partners are less likely than their peers with only same-sex or only opposite-sex partners to use condoms (Goodenow et al. 2002).

Finally, a recent study using a convenience sample of urban gay and bisexual young men who have sex with men (YMSM) found that 44% of these young men reported having unprotected anal intercourse in the last year (Garofalo et al. 2008). While unprotected anal sex is common among all racial/ethnic groups of YMSM, black YMSM are least likely to report having unprotected anal sex and white YMSM are the most likely to report having unprotected anal sex (Harawa et al. 2004). At the same time, young white men were found to participate in anal sex with other men at lower rates than other racial/ethnic groups (Harawa et al. 2004).

Sexually Transmitted Infections

Despite increased contraceptive use, young people in the United States acquire sexually transmitted infections (STIs) at relatively high rates. Though youth aged 15–24 make up only 25% of the sexually experienced population, almost half of new cases of STIs in 2000 were in this age group (Weinstock et al. 2004), and rates of infection among young people in the U.S. are higher than in other developed nations (Panchaud et al. 2000). Of course, infection rates are difficult to determine, not only because of underreporting but also because they are often asymptomatic. The National Health and Nutrition Examination Survey 2003–2004 included biological specimens that were tested for five STIs: chlamydia, gonorrhea, herpes simplex virus type 2 (HSV-2), trichomonas, and human papillomavirus (HPV). Among sexually active young women aged 14–19, 37.7% tested positive for one or more STI. While HPV was of course the most common infection, 7% of young women tested positive for chlamydia, 3.4% tested positive for HSV-2, and 2.5% tested positive for gonorrhea (Forhan et al.

2009). African American, Native American, and Latino/a youth are at greater risk of infection than non-Latino white and Asian youth, with rates highest among black youth (CDC 2011; Forhan et al. 2009).

Youth with same-sex sexuality and transgender youth are at greater risk of STIs, including HIV. Sexual minority adolescents report more high-risk sexual behaviors than heterosexual youths, including more sexual partners, alcohol or drug use before last sex, earlier age at first intercourse, injection drug use, and lower rates of condom use (Blake et al. 2001; Goodenow et al. 2008; Saewyc et al. 2006). STI risk may be highest for gay males whose same-sex attractions are sex-centered rather than identity-centered, as sex-centered attraction is associated with greater likelihood of engaging in heterosexual sex and a higher number of male sex partners (Dube 2000). In addition, young men and women who engage in bisexual behavior report higher rates of risky behavior, including illegal injection drug use and multiple sexual partners, than those with only opposite-sex or only same-sex partners (Goodenow et al. 2002, 2008; Tao 2008).

In contrast to other parts of the world, HIV infection in the United States is spread primarily through men having sex with other men (Wilson et al. 2010), as YMSM have particularly high prevalence rates of HIV (Valleroy et al. 2000; Centers for Disease Control 2008) and rates of infection among YMSM in the U.S. continues to rise (Rangel et al. 2006; Centers for Disease Control 2008). Research has documented racial/ethnic differences in prevalence rates of HIV infection, with black and Latino YMSM more likely to be infected than non-Latino white YMSM (Hall et al. 2007; Koblin et al. 2000; Valleroy et al. 2000). Valleroy et al. (2000), using data from the Young Men's Survey, found a prevalence rate of 3.3% among white YMSM ages 15–22, 6.9% among Latino YMSM of the same age group, and 14.1% among African American YMSM.

Transgender adolescents also experience increased risk of STIs, especially male to female (MTF) transgender adolescents, who engage in more risk-taking behaviors (Garofalo et al. 2006;

Grossman and D'Augelli 2006; Klein 1999). Because transgender youths often have few resources and little social support, they are more likely to drop out of school, run away, and experience homelessness, sometimes engaging in prostitution as a means of economic survival (Klein 1999). Transgender youth may also engage in the improper use or abuse of sex hormones that put these youth at increased risk of HIV infection due to the use of contaminated needles (Ryan and Futterman 1997). Garofalo et al. (2006) suggest that MTF transgender youth of color are at extreme risk of acquiring HIV and other STIs, with African American and Latino MTF individuals having the highest HIV infection rates among transgender individuals in part due to a lack of culturally appropriate health care and social support services.

Adolescent Pregnancy and Childbearing

Pregnancy rates have decreased among American youth but are still higher in the U.S. compared to other Western developed nations. The pregnancy rate among 15–19 year-old women declined from 117 per 1,000 women in 1990 to 71 in 2005, about a 39% decrease. This decline was even more dramatic among younger age groups, declining from 77 per 1,000 to 40 from 1990 to 2005 among 15–17 year-old women (Abma et al. 2010). Importantly, however, pregnancy rates among younger women include many women who are not sexually active in the denominator, and pregnancy rates among sexually active 15–17 year-olds are actually closer to 147 per 1,000 (Finer 2010). Further, the Guttmacher Institute reports that pregnancy rates among adolescent women in all racial/ethnic groups reversed this downward trend in 2006 (Kost and Henshaw 2012).

Some groups of young women are at greater risk of becoming pregnant during adolescence. African American and Latina adolescent women have pregnancy rates that are almost three times as high as non-Latina white women (Kost and Henshaw 2012). These differences are much

greater than differences in sexual behavior between groups, suggesting that other factors such as access to health services and decision-making about pregnancy play a greater role (Santelli et al. 2000). Among those with any male partners, bisexual or lesbian-identified females have higher rates of pregnancy than their heterosexual or unsure peers (Saewyc et al. 2008; Goodenow et al. 2008), and gay and bisexual males are also more likely than their heterosexual peers to be involved in a pregnancy (Forrest and Saewyc 2004).

Sexual activity and abortion rates do not explain higher pregnancy rates in the United States; abortion is higher compared to other Western developed countries, and ages of sexual debut are often similar or even later in the U.S. (Darroch et al. 2001; Russell 2005). Comparing data from the United States and the Netherlands, Schalet (2004) finds that American adolescent women are three times as likely to have an abortion as Dutch adolescents and eight times more likely to have a child, even though average age of sexual debut is about 17 in both countries. Dutch adolescent women use contraceptives more frequently and more effectively than American young women, and have fewer sexual partners. Schalet argues that cultural attitudes toward adolescent sexuality play a strong role in explaining these differences, as Dutch public policy has promoted acceptance of adolescent sexuality and easy access to contraceptives, and Dutch parents normalize adolescent sexuality and discuss it openly with their children.

The Cultural Context of Adolescent Sexuality: International Comparisons

Adolescent sexuality is experienced not in isolation but within the context of social relationships and the larger social climate (Moore and Rosenthal 2006), both of which influence adolescents' understanding of themselves and their sexuality (Martin 1996). Though sexuality may be individually experienced as natural, instinctive, and deeply-rooted, young women and men become sexual just as they become anything else: through

a process of social learning (Epstein 1994; Stein 1989). Sociologists have long argued that sexuality is socially constructed and that sexual scripts play a powerful role in individuals' labeling of their desires and sexual identities (Gagnon and Simon 1973; Plummer 1975). Families, schools, media, religion, and broad cultural beliefs and norms about sexuality shape how adolescents experience their bodies, desire, and relationships. This becomes particularly clear when we compare adolescent sexual behaviors in the United States to those in other nations.

International comparisons reveal considerable diversity in adolescent sexual experiences, including age at first sex, extramarital sexual activity, same-sex sexuality, contraceptive behavior, and early childbearing. Such differences highlight the importance of social context and environmental factors in understanding adolescent sexuality. Cultural values, taboos, and religion alter our understanding of sexuality, and poverty and gender structures are key to understanding sexual behavior. As noted by Wellings et al.:

The scale of the regional diversity in sexual behavior is matched only by the range of cultural constraints on practice. In some societies, for example, homosexual behavior is celebrated in public parades of pride; in others it carries the death penalty. In some countries, such as Brazil, condoms are available to young people in schools; in others, for example in parts of Indonesia, their possession is a criminal offence (2006; p. 1716).

In this section, we merely scratch the surface of the sizeable international literature on adolescent sexual experiences. Our goal is to provide an introduction to the variation in adolescent sexuality and cultural context across the globe. We focus primarily on regional differences in sexual debut and premarital sex, contraceptive use, and same-sex sexual experiences. Data quality varies across regions and nations, with some areas such as Sub-Saharan Africa receiving much more attention from researchers than other parts of the world (Asia and the Middle East, for example). However, Demographic Health Surveys or other national surveys have been done in many countries, which allow for some cross-cultural comparison of sexual behaviors and contraceptive use.

Adolescent Sexual Debut and Practices

Sexual activity begins for most adolescents across the world in the later teenage years (Remez et al. 2008; Wellings et al. 2006). For women, the average age of sexual debut tends to be lower when early marriage is normative, such as in south Asia and in central, west, and east Africa, and higher in Latin America, the Middle East, and southeast Asia. In most African and Asian countries, men initiate sexual activity *later* than women, because age differences between men and women partners are much higher in these regions. For example, men are on average over 9 years older than their wives in west Africa, and over 7 years older in north and central Africa (Wellings et al. 2006). This stands in contrast to gendered patterns in Latin America, where men tend to have sex earlier than women (Remez et al. 2008; Wellings et al. 2006), and in Western industrialized countries, where gender differences are less pronounced. Ages of sexual debut are higher in most of Sub-Saharan Africa than in the U.S., particularly for men (Hindin and Fatusi 2009). Rather than seeing a trend toward younger ages of first sex, as in the United States, in many parts of the world we see a trend toward later age at first sex, particularly for women and due in large part to trends toward later marriage (Remez et al. 2008; Wellings et al. 2006). These increasing ages at first marriage have led to modest increases in premarital sex.

The prevalence of sexual activity among unmarried men and women is difficult to determine in many countries, as strong norms against premarital sex lead to underreporting. Existing data demonstrate a great degree of variation in premarital sexual activity. Approximately 18–30% of unmarried young women in Central America are sexually active (Remez et al. 2008), 24% of unmarried young women and 38% of unmarried young men in Kenya have had sex in the past year (Kenya National Bureau of Statistics 2010), but only 1–8% of young women in India report having had premarital sex (Moore et al. 2009). In many parts of the world, particularly those with higher age differences between marital partners, sexual debut is most likely to take

place within marriage for women and outside of marriage for men.

As in the United States, first sex is not voluntary for many women. In Sub-Saharan Africa, between 15% to almost 40% of women report that their first sex was involuntary (Biddlecom et al. 2007; Guttmacher 2004, 2006a, b, c; Moore et al. 2007). In India, 9% of sexually active women report their first sex was forced, and another 30% said they were “persuaded” after initially refusing (Moore et al. 2009). As in the United States, experiences of forced first sex are more common for young women with much older partners, women who initiate sex at younger ages, and women with limited economic resources (Moore et al. 2007).

Monogamy is the dominant pattern across the world, with multiple sexual partnerships being much more common in industrialized countries (Wellings et al. 2006). Young men typically report more partners than young women, which is explained largely by age structure and pairing patterns (younger women with older men) but may also be driven by cultural norms that lead men to overreport and women to underreport. For example, in Sub-Saharan African countries, 17–26% of 15–19 year-old men and 6–7% of 15–19 year old women have had more than one partner (Biddlecom et al. 2007) and 2% of women and 11% of men in Kenya report multiple partnerships (KNBS 2010). This stands in contrast to the United States and other Western developed nations, where multiple partnerships are much more common.

Protective Behaviors and Adverse Outcomes

Condom use among youth has increased in developing countries as in industrialized nations, but remains low and has not increased enough to reduce the spread of HIV (Hindin and Fatusi 2009). Rates of use vary tremendously, even within region. For example, estimates from various countries in Sub-Saharan Africa range from 29 to 66% of unmarried sexually active youth reporting no current contraceptive use (Biddlecom

et al. 2007; Guttmacher 2004, 2006a, b, c). In Central America, contraceptive use is highest in Nicaragua (55%) and lowest in Guatemala (25%), and condom use at last sex varies in the region from 11 to 26% among young women and 43 to 66% of young men (Remez et al. 2008). Contraceptive use also varies substantially between urban and rural areas, pointing to access as an important factor in explaining low rates of use (Singh et al. 2004). These estimates are particularly worrisome given the high rates of HIV infection in developing countries. In Sub-Saharan Africa, 5.2% of women and 1% of men age 15–24 are HIV positive (UNAIDS/WHO 2005). HIV prevalence has reached the level of a generalized epidemic in Honduras (1.8% of 15–24 year-olds are HIV positive) and is approaching that level in El Salvador and Guatemala (Remez et al. 2008). Unlike in the United States, HIV infection is spread primarily through heterosexual intercourse in the rest of the world, and young women are much more likely than men to be HIV positive.

Men are more likely than women to report using a condom at last sex, primarily because young women’s partners are more likely to be their husbands while men are more likely to have sex outside of marriage. Although sex within marriage can be less risky, marriage does not safeguard sexual health. In Uganda, for example, HIV transmission is increasing most rapidly among married women, and in Kenya and Zambia, increased frequency of sex, lower condom use, and husband’s sexual risk behaviors offset potential benefits of marriage to sexual health (Wellings et al. 2006). Married women may find negotiating for safer sex more difficult than unmarried women, and few married women use condoms in many regions. Only 7% of married women in India use a modern method of contraception (Moore et al. 2009), and unmet need for contraception among single and married women is high in Asia, Sub-Saharan Africa, and Latin America (Hindin and Fatusi 2009; Moore et al. 2009; Remez et al. 2008). Moreover, when childbearing is expected soon after marriage, early marriage may lead to coercive sexual experiences and potential risks to reproductive health.

Adolescent pregnancy rates in developing countries are high, although the majority of adolescent women who give birth in these regions are married. In India, for example, a majority of women (63%) marry before age 20, and 45% of young women marry before age 18 (despite laws defining the legal age of marriage as 18) (Moore et al. 2009). Forty-two percent of young women in India give birth before age 20, between two in five and one in two young women in Central America have a child during adolescence (Remez et al. 2008), and about 20% of young women ages 15–19 have given birth in Sub-Saharan Africa and southeast Asia (Hindin and Fatusi 2009). Within these areas, there is a great deal of variation in early childbearing between cities and between urban and rural areas. In Western high-income nations, adolescent pregnancy and childbearing is much less likely to take place within marriage. Pregnancy rates in the United States are generally higher than in other developed nations (McKay and Barrett 2010). Twenty-two percent of young women in the U.S. become pregnant by age 20, compared to 15% in Great Britain, 11% in Canada, 6% in France, and 4% in Sweden, and abortion rates are also higher in the U.S. (Darroch et al. 2001). Though age at sexual debut is similar across these countries, more American adolescents report no contraceptive use at first or most recent sex (Darroch et al. 2001; Russell 2005).

Same-Sex Sexuality: Prevalence, Public Attitudes and Laws

It is difficult to provide specific prevalence rates of same-sexuality by country, particularly for adolescents, because of the lack of international data on the same-sex behaviors of youth. Many of the population-based surveys in specific countries are surveys of the adult population, sometimes incorporating a sample of adolescents, similar to the sampling strategy of the NHSSB and NSFG in the U.S. (Kuyper and Vanwesenbeek 2009). Moreover, in most regions outside of the west, there are little if any efforts to collect data on same-sex sexuality among adults or adolescents

(Caceres et al. 2008). Western, high income nations are somewhat unique in their acceptance of same-sex sexuality, as many African and Middle Eastern countries often deny that homosexuality exists and persecute those who engage in same-sex sexuality, including implementing the death penalty for those convicted of engaging in male same-sex sexuality (Otto 2007). South Africa and Argentina are the only countries outside of North America and Europe to have legalized same-sex marriage at the national level. Data from the World Values Survey show that in many authoritarian societies, including those in North Africa and the Middle East as well as China, over 90% of individuals surveyed reported that homosexuality is never justifiable (Inglehart and Norris 2003). Thus, the actual numbers of adolescents and young adults with same-sex attractions or behaviors is hard to assess cross-culturally because of social restrictions that make it difficult to express same-sex sexuality and to measure same-sex sexuality.

Among western, high income nations we tend to see similar prevalence rates of same-sex sexuality as well as similar trends toward increased numbers of adolescents and young adults identifying and disclosing their same-sex sexuality (Kuyper and Vanwesenbeek 2009). However, we do see slight variations in rates of same-sex sexuality among the adult population within western nations, with speculation that such variation is due to differences in attitudes toward homosexuality. For example, the Dutch have the most positive attitudes toward homosexuality, with the Netherlands being the first to legalize same-sex marriage, and also have one of the highest rates of same-sex sexuality (Kuyper and Vanwesenbeek 2009; Adolfsen and Keuzenkamp 2006).

Much of the research on sexuality in adolescence and young adulthood internationally is focused on HIV infection and risk. According to UNAIDS, there was an estimated ten million young people aged 15–24 living with HIV in the world. More than 40% of new infections occur among those in the 15–24 age group, with over 60% of HIV infected 15–24 year olds living in sub-Saharan Africa and 21% living in Asian-Pacific countries (UNAIDS/WHO 2009).

However, in many countries afflicted with high HIV prevalence rates there is an assumption that individuals do not experience same-sexuality or engage in same-sex behavior. Also, in many nations outside of the west, HIV is transmitted primarily through heterosexual intercourse or IV drug use rather than same-sex sexual behaviors (FIMA 2007; Wilson et al. 2010). Thus, in many nations, particularly African nations, there is little attention given to safe sex practices among men who have sex with men (Caceres et al. 2008; Lorway 2006; Teunis 2001; Wilson et al. 2010). In African countries, the stigmatization and criminalization of non-heterosexuality often prevents an effective HIV prevention campaign among men and boys who have sex with men (Lorway 2006). The majority of males engaging in anal sex with other males are not using contraception, primarily because there is no discussion of safe sex as it relates to non-heterosexual sex (Lorway 2006; Wilson et al. 2010). Even in South Africa, there seems to be little focus on same-sex sexuality in the public health literature because HIV/AIDS is not transmitted primarily through same-sex contact (Simbayi et al. 2004).

The denial of same-sex sexuality as a phenomenon is greater in Islamic countries, where homosexuality is highly criminalized. In Iran, Saudi Arabia, and Yemen there is a death penalty imposed for male same-sex sexuality (Ottoson 2007). In addition, it is assumed that because the primary means by which HIV is contracted (same-sex behavior, promiscuous heterosexual sex, and IV drug use) are forbidden by Islamic law, that these behaviors do not occur within Muslim countries and that HIV/AIDS does not exist in Muslim countries. However, given that HIV/AIDS is evident in countries with Muslim populations, particularly in Africa, there has been increased pressure to combat homosexuality by public health ministries in majority Muslim countries. Such pressure has included prohibiting homosexuality (FIMA 2007). Similarly, in some Asian-Pacific countries such as Thailand, the issue of male same-sex sexuality as a risk for HIV transmission is often ignored, even though the sex industry and the prevalence of “money

boys” is relatively high in many areas (Mutchler 2004). However, it is worth noting that Bangkok has developed a Youth Risk Behavior Study using the CDC’s YRBS as a template, and does assess rates of “homosexual” intercourse, with the latest data showing that 1% of adolescents interviewed who have had intercourse had homosexual intercourse (Ruangkanchanasetr et al. 2005). This is similar to prevalence rates found in South Africa. In one South African population study it was found that 0.8% of males and 1.6% of females ages 15–24 had same-sex intercourse in the last year (Simbayi et al. 2004). This is compared to 1.5% of males and 9.5% of females ages 15–19 in the U.S. reporting any same-sex sexual partner in the last year (Chandra et al. 2011). We return to the issue of collecting international data on same-sex sexuality in the next section.

Data and Methodological Issues

Throughout this chapter, we have pushed for integrating research on heterosexual and same-sex sexual behaviors using a framework of positive sexual development in social context. Doing so requires not only a shift in research questions and interpretation, but in the data we collect as well. In this section, we identify some data and measurement needs and point to some potential future directions for demographic work on adolescent sexuality.

Need for Data on Same-Sex Sexuality and LGBTQ Youth

Though research on sexual minority youth has grown dramatically over the past decade, there is still an overall lack of data on same-sex sexuality and sexual behaviors on population surveys of youth. While the state of knowledge has improved since the release of the Add Health data, this data set, as others, has its limits and is now more than 10 years old. More research on sexuality and youth needs to be population-based and less reliant on small, convenience samples of LGBTQ-identified youth. Because of the sensitive nature of

the topic, collecting data on the sexual orientation and sexual behaviors of youth is difficult, and the federal government is hesitant to fund anything that might draw criticism from parents or be seen as too sensitive. For example, federally funded surveys are often ambiguous about the definition of sexual intercourse or do not ask specifically about anal sex and oral sex because of the controversy surrounding asking adolescents about sex and resistance from conservative lawmakers (Remez 2000).

The YRBS is an example of difficulties inherent in including questions about same-sex sexuality on federally funded surveys. Though the Youth Risk Behavioral Survey (YRBS), sponsored by the Centers for Disease Control, is conducted in every state, there is no requirement for individual states to ask students about sexual orientation. The YRBS, conducted every 2 years, asks high school students a variety of questions about health, sexual behavior, nutrition, drug and alcohol use, and smoking. The CDC eliminated a question about same-sex behavior in 1999 because the question was considered controversial, and currently, states are allowed to decide if they want to include any questions about sexual orientation or not. Seven states (Connecticut, Delaware, Maine, Massachusetts, Rhode Island, Vermont, and Wisconsin) and six large urban school districts (Boston, Chicago, Milwaukee, New York City, San Diego, and San Francisco) include items about students' sexual orientation, sexual attraction, or same-sex sexual behavior at some point between the 2001–2009 survey administrations (Kann et al. 2011). School-based data collection is particularly challenging due to the need for parental consent and strict IRB provisions.

Thus nationally representative samples of youth often do not include adequate measures of same-sex sexuality, and they generally do not include oversamples of sexual minority youth necessary to explore variation among this group. Though important and innovative work dealing with issues of intersectionality using qualitative methods has been done in the broader field of schooling and sexuality (e.g., Bettie 2003; Pascoe 2007; Tolman 2002), few quantitative studies that

we are aware of have examined the intersections between sexual orientation and race/ethnicity (see Russell and Truong 2001 for an exception). In addition, most if not all of the quantitative work on LGBTQ issues that does exist ignores the T: transgender. More surveys, particularly adolescent surveys, should include questions related to gender identity and performance. In a few states the YRBS asks students whether or not they have been bullied or harassed because of their gender, but that is the extent of the questions about gender identity or performance. GLSEN's (Gay, Lesbian, Straight Education Network) *School Climate Survey* (Kosciw et al. 2008) includes as part of its sample transgender youth, yet GLSEN's sampling technique raises issues of selection and does not provide for a comparison group other than non-trans identified LGB youth.

More population-based data sets aimed at adolescents and young adults, such as Add Health, need to be designed and administered. One possible format through which this might happen is the YRBS. At this point data from YRBS can only provide local or regional estimates of sexual behaviors because of the incongruence between the questions asked; however, some of the best and most informative research in the area of sexual minority youth and their sexual practices has been gleaned from the various YRBS surveys, including those conducted in Massachusetts (Goodenow et al. 2008) and surveys modeled after the YRBS used in the Pacific Northwest (Saewyc et al. 2006).

Similarly, the Health Behavior in School-Aged Children (HBSC) project, supported by the WHO, could potentially be used to compare prevalence rates of same-sex sexuality across nations, although this would require the inclusion of questions that ask about same-sex sexuality. Similar to the YRBS in the United States, the HBSC includes mandatory and optional questions to investigate health behaviors among representative samples of 11, 13, and 15 year-old youth. However, it was not until the 2001/2002 cycle of the HBSC that questions about sexual behavior became mandatory, with many countries not including them in prior waves. These four questions were developed from the YRBS

and address whether adolescents have ever had intercourse, their age at first intercourse, condom use at last intercourse, and other contraceptive use at last intercourse. The wording of the questions is problematic because intercourse is not defined, although validity studies showed that most youth interpret intercourse as penile-vaginal intercourse. Questions regarding same-sex sexual behaviors are not mandatory, nor are questions regarding attitudes toward homosexuality. Additionally, while some countries include or exclude certain questions, other countries change the wording or do not survey the entire population (Currie et al. 2004; Layte et al. 2005).

Measuring Adolescent Sexual Experiences

When trying to estimate rates of various sexual behaviors, particularly those that are related to specific public health concerns such as the spread of HIV and other STIs, it is important that measures are specific and consistent. In some surveys that do ask about sexual behavior, there is often a wide and unspecified definition of “sex” or “intercourse” (Remez 2000; Saewyc et al. 2006). By “sex”, it is often unclear whether the researchers mean penile-vaginal penetration, anal sex, or oral sex. Further, given the prevalence of oral and anal sex among both heterosexual and LGB-identified American youth (Fortenberry et al. 2010; Herbenick et al. 2010; Kaestle and Halpern 2007; Mosher et al. 2005), surveys should include questions about a range of sexual behaviors and safer sex practices during each of those behaviors. Our understanding of adolescent sexual development and how to educate and empower youth to protect their sexual health is limited by a lack of research on the specific sexual practices in which youth engage.

In addition to clearly and consistently defining what the researchers mean by sex, it also seems imperative that researchers clearly and consistently define what they mean by sexual identity. Some of the variation in wording present in questions asking about identity include what do you “consider oneself,” “call oneself,” “describe

oneself,” etc., and some questions conflate identity, attraction and behavior. For example, the 2003 California YRBS that was administered in San Bernardino asked “Which of the following describes you (your sexual orientation)? (a) Heterosexual (straight); (b) Gay or lesbian; (c) Bisexual; (d) Not sure; (e) None of the above”. In San Diego, the survey asked “With whom have you had sexual intercourse/sexual contact: (a) I have not had sexual intercourse with anyone; (b) females; (c) males; (d) females and males”. And in San Francisco, the survey asked “How would you describe your sexual orientation/preference? (a) Heterosexual, attracted to the opposite sex; (b) Bisexual, attracted to both sexes; (c) Homosexual, gay or lesbian, attracted to the same sex; (d) Not sure”. This variation made it difficult to join data on same-sex sexuality even within a single state.

Additionally, it is important to recognize that many questions are time specific and that same-sex sexuality varies across the life course. For example, some questions ask about number of lifetime same-sex partners, while others ask about the number of same-sex partners in the past year. Even within Add Health, wording of questions about romantic attraction vary across survey years, with some questions asking whether the respondent “ever” experienced same-sex attraction and others asking whether the respondent is “currently” attracted to the same sex.

Given the inconsistencies between dimensions of same-sex sexuality and shifts in reports of same-sex sexuality over time, Savin-Williams and Ream (2007) suggest that when attempting to define the LGBQ or “gay” population, researchers should rely on multiple indicators of same-sex sexuality over time or should use a specific indicator of same-sex sexuality that is most appropriate for the research question at hand. Understanding the complex and dynamic characteristics of same-sex sexuality among adolescents and young adults is important to consider when exploring complex research questions in various disciplines. Additionally, from a population perspective, in order to measure rates and trends over time, it is important to have consistent measures of a phenomenon. While recent research

has investigated the relationships between different dimensions of same-sex sexuality (Dube 2000; Goodenow et al. 2008; Glover et al. 2009), the majority of population data sets do not include multiple dimensions of same-sex sexuality. Thus, as more surveys of youth begin to add questions about sexuality, it is important that theoretical and empirical consensus is reached to determine what measures should be constant across surveys and across disciplines.

New Directions for Research on Adolescent Sexuality

We know a great deal about how many adolescents are having sex, how many are using contraception, and how many are at risk for acquiring sexually transmitted infections or experiencing unplanned pregnancy. We follow other scholars (Diamond 2006; Glover et al. 2009; Russell 2005; Tolman and McClelland 2011; Schalet 2004) in emphasizing the need to move beyond a risk framework and to focus on positive development and empowerment. This focus on risk is particularly strong in research on adolescent sexual experiences in developing countries. While stemming from higher rates of HIV infection and lower rates of contraceptive use, the discourse often describes adolescent sexual behavior as inherently risky. For example, Hindin and Fatusi state, “Adolescent sexual activity, within or outside of marriage, can lead to negative reproductive health outcomes” (2009, p. 58). Turning our attention to positive outcomes, such as successful sexual negotiation and sexual pleasure, could reveal the conditions under which young people demonstrate sexual agency and act to protect their emotional and physical well-being. How young women and men experience sexual debut, in terms of physical pleasure, satisfaction, motivations, and reactions to the experience, may be more powerful predictors of life course outcomes than just timing and contraceptive use at first sex. More research on how sexual experiences shape attitudes and beliefs, rather than just the other way around, would further understandings of the process of sexual development. For example, research on

sexual self-efficacy and sexual subjectivity has illustrated how adolescents’ self-concept and sense of agency guide their sexual behaviors. Young women with a stronger sense of sexual self-efficacy are more likely to use contraception, perhaps because they are better able to negotiate within sexual relationships to protect their sexual health (Impett et al. 2006; Pearson 2006; Soler et al. 2000). Future research could also consider sexual attitudes, desires, and sense of self as both predictors and as outcomes, such as how sexual experiences shape one’s sense of self-efficacy or sexual self-concept. Importantly, this research should focus on the experiences of both young men and young women, as research on adolescent sexual behaviors and self-concept often excludes young men.

Following others (e.g., Russell 2005; Smiler et al. 2011), we also suggest an approach to studying adolescent sexuality that emphasizes the sexual development of all youth and that includes a wide range of sexual behaviors and feelings involving both same-sex and opposite-sex partners. Critical to this approach is the inclusion of questions pertaining to same-sex sexuality on nationally representative surveys of youth and the inclusion of “straight” youth in studies of LGBT youth, as well as a critical look at the measures and outcomes used to study adolescent sexuality. There is a tendency in the social sciences for researchers to consider and to study heterosexual youth and sexual minority youth as separate and distinct populations, but we see this as problematic for several reasons. First, as illustrated throughout this chapter, many adolescents and young adults who identify as “gay” or “lesbian” have sexual experiences with and attractions to individuals of the opposite-sex, and some adolescents and young adults who identify as “straight” have sexual experiences with and attractions to individuals of the same-sex. Moreover, sexual attractions, relationship partners, and identities change across time and contexts more often than is typically recognized by sexuality researchers. The separation of adolescents into “straight” and “gay” populations has reinforced the notion that these are distinct sexual categories and has limited our understanding of adolescent sexuality.

Research on adolescent sexuality should direct more attention to the role of sexual relationships and behaviors, including same-sex sexual experience and desires, as a normal, expected, and often positive aspect of adolescent development. For example, more recent work has begun to examine a wider range of intimate behaviors, such as kissing, meeting partners' friends and parents, and other dating activities within heterosexual and same-sex relationships. Such work is an important move forward in understanding adolescent sexual development.

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Osmo Kontula

Introduction

Sexuality is an essential feature of human life throughout the life course. It is a major aspect of intimacy and incorporates components such as sexual desire, activity, function, attitudes, beliefs, values about identity, and self-concepts. It represents an essential nexus for the interaction among social life; culturally determined beliefs and practices; psychological processes; and the biological mechanisms of aging, health, and disease. Variant expectations and interpretations focus on sexual issues related to age (González 2007; Waite et al. 2009). Age shapes the sexual body and also modifies human beings mentally.

Most people are living longer than preceding generations, and more are remaining sexually active in later life. Thus, the nature, the predictors, and the associated outcomes of sexual well-being are an increasingly important issue, particularly among older women and men. Sexual issues are becoming more prominent also in the old age care and services.

This chapter outlines an introduction to sexuality among older adults. Old age sexuality is determined not only by health status, but it is also constructed socially. The most important challenges

and determinants of sexual activities in old age, including partnership status, will be reviewed. In this chapter, special attention is paid to a national sex survey among the old age population in Finland. The data provide insight into variant sexual activities, desires, and sexual dysfunctions and of their most important predictors for the older population.

Sexuality in the Older Population

Social Construction of Old Age Sexuality

When considering the data derived from population studies on sexuality and old age, one must bear in mind that old age sexuality is, importantly, socially constructed. In general, it has been prevalent to desexualize the older body, for it is assumed that the body's erotic attributes are lost in old age, an attitude that tends to reject the sexual life of the elderly. As older people are denied erotic needs, social representations in the form of popular humor, superstitions, and taboos contribute to the exclusion of the elderly from being eroticized. Today, despite greater openness with regard to sexual issues, there are still views that portray sex in older people as abnormal, silly, or embarrassing, because society thinks of older people as asexual.

Some people are concerned about sex for the elderly because it challenges socio-cultural notions of eroticism and legitimacy; in other

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words, age-graded meanings permeate people's perceptions. Our bodies can be desexualized (in the case of the elderly), sexualized (as seen in youth), asexualized (as occurs with minors), sexually legitimated (as happens in marriage and romantic liaisons, but also in relationships that are considered abusive), and sexually dispossessed (when our body dies). These scenarios show that age and sexualities are mutually shaping and tightly intertwined in our everyday life (González 2007).

In old age, the experiences are tinged with memories of past shared pleasures (and pains). It has been argued that aging individuals passively internalize the socially constructed view that they should be asexual—a stereotype linked with older people suppressing their sexual needs or even denying their sexuality for fear of condemnation (Hinchliff and Gott 2004). “You cannot until age x”, “at age x you must”, or “act your age” are examples of how society understands the life cycle as a stage of boundaries and roles. Currently there is an erosion of social conventions regarding age, in great part due to more liberalized lifestyles and improvements in medical and cosmetic alternatives; this enables us to play masquerades with our body, which suggests that, as people can adopt a number of identities during their lifespan, they reject determinisms about age (González 2007).

Age-graded patterns contribute to give sense to sexual values. Sex with those seen as “sexless”, “non-erotic”, or “vulnerable” is considered abusive, inequalitarian, dissident, or even criminal. These age-graded meanings build strong sexual boundaries (González 2007). Aging tends to be understood as a form of “disease”, needing “healing” or “improvement”, a situation that informs our conceptions of well-being and healthy sexuality; this prejudice is strongly and continuously reinforced by the cosmetic and pharmaceuticals industry (González 2007).

Further, some public images link older people with feelings of loneliness and sexual desperation. A clear example is the common perception that younger people and the elderly can establish erotic relationships with one another only in situations of exploitation or prostitution. Because it

is visualized that their relationships are not based on sexual attraction, at least on the younger people's side, older people are represented as sexual harassers. It is perceived that the young do not just offer sex, but youthful sexuality (González 2007). Older people are assumed to exchange that youthfulness for social prestige and money. This exchange may be viewed or considered socially shameful or even immoral.

All of these social constructions regarding aging and appropriate sexual behavior can affect actual sexual desire and behavior, as well as the manner in which data on sexual desire and behavior among aging individuals are interpreted.

Sexual Challenges in Old Age

There are numerous studies and arguments finding decreasing sexual interest and action in old age (Laumann et al. 2005; Dennerstein and Leher 2004; Beutel et al. 2001; Araujo et al. 2004; Blanker et al. 2001; Marsiglio and Donnelly 1991). For example, data indicate that the prevalence of sexual activity declines with age in the United States. In a 2004 nationally representative survey, 73% of the respondents who were 57–64 years of age were sexually active, 53% of those 65–74 years of age, and 26% of those 75–85 years of age (Lindau et al. 2007). This transition has been explained by biological and psychological factors, diseases, mental condition, boredom in the relationship, and widowhood (DeLamater and Sill 2005; Thienhaus 1988). Much of the previous literature is based on a biological or medical perspective, which asserts that sexual behaviours, desire, and satisfaction are reduced and eliminated with age due to physical transformations, hormonal changes, and chronic illnesses. However, the capacity to enjoy sexual activities is not altered with age (Pennhollow et al. 2009).

A large proportion of older people remain sexually active, but the physiological changes of aging and the effects of chronic illness contribute to a significant level of sexual dysfunction. According to one U.S. study, the most prevalent sexual problems among women are low desire

(43%), difficulty with vaginal lubrication (39%), and inability to climax (34%). Among men, the most prevalent sexual problems are erectile difficulties (37%) (Lindau et al. 2007).

Sexual response alters because of hormonal changes. In men, a decline in circulating testosterone is responsible for a decrease in desire, but not erectile function. For women, menopause can bring a significant decline in estrogen production and the muscles of the vaginal wall may receive less blood flow, become less elastic, and atrophy. Decreased production of natural secretions can lead to vaginal dryness. Painful intercourse can result, which can be treated with over-the-counter personal lubricants or a prescription estrogen cream or vaginal ring (Hillman 2008). It remains unclear whether the decrease in sexual interest reported by postmenopausal women is related to hormonal changes, or internalized, ageist attitudes that older women should not be interested in sex. Some women find increased enjoyment in their sexual activity because they no longer fear becoming pregnant (Hillman 2008).

In both sexes, the speed and intensity of response to sexual stimulation tends to reduce with age. These changes develop gradually, allowing people to adjust to a less intense form of sexual activity (Bonman 2006).

Sexual Activity and Health

One of the most common reasons for people giving up sexual activity is physical illness. At times, a decline in sexual activity may result because of unfounded health anxieties (e.g., following heart disease or stroke) (Bonman 2006). Sexual intercourse may become exhausting or painful (as in respiratory disease or arthritis); disease may impair the responsiveness of sexual organs (as in diabetes or peripheral vascular disease); illness may undermine self-confidence or feelings of attractiveness (as in operations such as mastectomy or colostomy); or illness may reduce sexual desire (as in depression, or hepatic failure and Parkinson's disease).

It has been reported that sexuality helps preserve psychological and physical well-being,

which indirectly contributes to the reduction in physical and mental health problems, health care costs, and may potentially increase life satisfaction (Pennhollow et al. 2009). Many scientifically reviewed and validated epidemiological studies have revealed the beneficial health effects of sexual activity (as reviewed by Komisaruk et al. 2006). For example, a 10-year follow-up study of male subjects showed a lowered mortality risk for those who had experienced at least two orgasms per week. In another male-focused study, the DHEA hormone released during orgasm was found to reduce the risk of cardiac disease. Among women, sexual abstinence has been connected to increased risk of heart attacks (Komisaruk et al. 2006).

It has been suggested that sexual activity may lead to lowered cancer risk because, in both sexes, it increases the release of oxytocin and DHEA hormones connected with sexual arousal and orgasm. Indications of this have already been seen in cases of male breast cancer, and prostate cancer has also been shown to be less common among men who experience a higher frequency of ejaculations. The assumption is that this is a result of a reduction in carcinogens and stress that ejaculation brings (Komisaruk et al. 2006).

Orgasm also reportedly eases menstrual pain and migraines. Vaginal stimulation has been linked to an increase in overall pain thresholds, and the greatest increase was found when stimulation resulted in orgasm. The pregnancies of women who remain sexually active during pregnancy are more likely to continue to term. Women who are sexually active and experience more orgasms while menstruating were less likely to suffer from endometriosis (growth of tissue resembling uterine tissue that occurs in the wrong location) (Komisaruk et al. 2006).

Sexual behaviour also has psychological benefits. It may be a way to share intimacy and communion, a spiritual connection, or simply to have fun. Further, sexual activity and orgasms have been shown to reduce stress, promoting physical and psychological health. In an orgasm, the oxytocin and endorphins that are produced create a sedative effect that helps people sleep (Komisaruk et al. 2006).

Cohort Effects in Sexual Transition

In many analyses of sexuality and older adults, it has been problematic to distinguish the roles and impacts of aging from the roles and effects of membership in a specific generation or age cohort. Aging plays an important role in sexuality, but generations from the sexual revolution era in the 1960s/1970s onwards have considerably modified their sexual values and behavior patterns. The aging generation today is different from what it was yesterday. This transition will carry forward, apparently, in new generations.

The current cohort of older women, when compared with both their younger counterparts and older men, are less likely to have experience with birth control (e.g., condoms), are less likely to discuss sexual matters with their physician, and have lower levels of education and financial resources.

In 2011, the first baby boomers became 65 years of age and officially entered into adulthood. The role of cohort effects becomes critical when one examines the sexuality of these baby boomers. Older adults who move into a nursing home do not suddenly become asexual (Hillman 2008).

In Sweden, it has been speculated that changes in sexual issues reflect higher educational levels and better socioeconomic status in the later birth cohorts (Beckman et al. 2008). In one study, being in a later born cohort increased the odds of having intercourse, independent of marital status, sex, sexual debut before age 20, a positive attitude to sexuality in later life, depression, educational level, and 3 year mortality (Beckman et al. 2008).

Partnership and Sexuality Among Older Adults

Availability of a partner is a very important condition to prolonging sexual activities at old age. Partner availability appears to be related to type and frequency of sexual behavior, particularly for older unmarried women who significantly outnumber their older male counterparts. The likelihood of

having a current partner decreases with age, due primarily to a drop in the proportion married. In each age group, men are more likely to have a current partner than are women, with the largest difference in the oldest age group. This difference reflects the higher mortality rate among men and the age differential between spouses (Waite et al. 2009).

In Europe, aging does not usually impact the proportions of men who are married in different age groups. Based on results from the European Social Survey (2008), around 70% of men are still married in the age group of 71–80 (Table 10.1). The proportions of married men have decreased along with aging in some Eastern European countries, namely in the Russian Federation, Ukraine, Romania, and Turkey. Among women, widowhood increases in older age groups around Europe. In the age group of 71–80, only around every third woman was married. In the Russian Federation, Ukraine, Czech Republic, and Hungary, only around every fifth woman was married in the age group of 71–80. Without partners these women are in most cases sexually inactive.

Research indicates that widows have often viewed their sex life as being over and have not wanted to find an intimate partner/husband. Widows have felt that they were no longer in the position to legitimately satisfy their sexual desires (Lagana and Maciel 2010). This type of abstemious tradition among widows has been found in a number of cultures around the world. In a Western world, this tradition is losing its power and influence.

Based on the results of the National Social Life, Health, and Aging Project (NSHAP), in the U.S. the rate of acquisition of new partners in old age is relatively low, with roughly 3% of men and less than 1% of women reporting multiple partners during the previous year. Among women lacking a partner, there is a linear rise in lack of sexual interest. A woman's lack of partner seems to influence her sexual interest, whereas a man's similar lack of an intimate partner does not lower his interest in finding one (Waite et al. 2009).

Years of emotional intimacy, communication, and partnership often provide the foundation for

Table 10.1 Percentage (%) of married men and women among aging population in Europe

	Men			Women		
	50–60 years	61–70 years	71–80 years	50–60 years	61–70 years	71–80 years
Belgium	68.1	75.5	70.6	69.9	59.6	53.8
Bulgaria	74.9	78.7	72.6	74.6	58.7	34.3
Switzerland	56.5	67.9	75.7	54.0	49.2	30.3
Czech Republic	64.5	64.0	57.7	60.2	43.8	19.3
Germany	74.9	76.8	81.4	73.0	58.9	45.4
Denmark	76.3	74.3	68.5	71.1	74.8	58.6
Spain	79.9	80.7	77.5	77.8	69.9	53.9
Finland	67.5	72.1	67.5	62.1	56.3	48.6
France	58.4	72.7	75.9	56.3	61.8	49.6
United Kingdom	53.5	66.0	67.0	55.1	50.9	30.6
Greece	78.9	86.7	83.6	70.9	67.4	33.8
Hungary	75.0	74.1	75.8	68.1	50.9	22.9
Netherlands	63.7	77.8	75.3	52.3	48.6	33.7
Norway	68.3	83.5	68.6	63.0	62.5	32.1
Poland	79.6	87.7	78.1	72.6	54.8	32.1
Portugal	82.8	83.1	73.3	64.2	63.5	39.0
Romania	79.1	88.0	66.7	67.4	50.4	33.3
Russian Federation	74.8	67.5	53.2	48.5	30.5	15.8
Sweden	62.8	69.7	64.4	69.4	62.9	49.5
Turkey	94.6	87.8	76.2	78.3	55.1	38.3
Ukraine	80.9	77.4	66.0	51.9	34.3	19.3
Total	67.3	76.9	71.2	64.8	55.5	36.9

Source: European Social Survey (2008)

the most satisfying of relationships. However, there exists the paradox that an increase in intimacy may not generate an increase in sexual desire. The mystery, novelty, and risk that promote passion in new relationships are missing from these relationships (Kingsberg 2000). One important determinant explaining decreased sexual behaviour in old age has been becoming sexually accustomed or bored with a partner along even tens of years spent together. Too much familiarity or intimacy may create unwelcome outcomes to sexual interaction in the couple relationship. In addition, monotony in sexual relationships, such as predictability of sexual activities and over-familiarity with the partner, may contribute to a loss in sexual desire (DeLamater and Sill 2005).

Some may take their emotional and sexual relationship for granted and become lazy and inattentive in their sexual activities. Lifelong psychological conflicts may come to the fore as couples age (Beutel et al. 2001). External

factors, such as the needs of aging parents or grandchildren, may draw emotional energy away from a couple (Kingsberg 2000). Many older widowed women drift into a state of sexual disinterest. The death of the spouse often leads to a cessation of sexual behaviour. By denying their sexual interest, the widow prevents herself from becoming frustrated or depressed (DeLamater and Sill 2005).

Lesbian, Gay, and Bisexual Activities Among Aging Population

As the global population is aging dramatically, the number of older lesbian, gay, and bisexual (LGB) adults is likely increasing substantially. Further, as individuals come out at an earlier age in life, there is likely to be a growing number of older “openly” gay and lesbian individuals. For example, in the United States, by the year

2030, at least two to six million LGB-identified adults will be 65 years of age and older (Fredriksen-Goldsen and Muraco 2010; Baumle and Romero 2010).

The initial research on LGB aging focused on dismantling negative stereotypes. The most common stereotype that the early research sought to dispel was that older gay men and lesbians are depressed and experience accelerated aging or maladjustment to aging. The earliest wave of research, as a body of work, suggested that older gay men and lesbians are not alone, isolated, or depressed, but benefit in the aging process from having previously navigated a stigmatized identity. (Fredriksen-Goldsen and Muraco 2010; Baumle and Romero 2010).

Psychological adjustment to aging was the theme of the next wave of research. These studies examined the correlates of the psychosocial adjustment and functioning of older gay and lesbians; most concluded that LGB adults had positive psychosocial functioning, despite the presence of widespread structural inequalities and discrimination (Fredriksen-Goldsen and Muraco 2010). The third wave focused on identity development in the lives of older LGB adults. Specifically, this thematic shift focused on experiences of acknowledging and accepting a LGB identity and the shifting experiences of being LGB over time according to social context (Fredriksen-Goldsen and Muraco 2010).

The most recent wave of research examines the social support and community-based needs and experiences of older LGB adults. Studies in this area identify the need for LGB-specific services in housing, health, care giving, and other human services. One last trend in the most contemporary wave of research is the greater inclusion of bisexual and transgender experiences in studies of aging. There exists an increase in acknowledgement of the presence of both groups and our need to know more about these individuals' experiences in the aging process. (Fredriksen-Goldsen and Muraco 2010).

The psychosocial factors that been identified in the existing research as affecting successful aging in older LGB adult populations include a positive identity, socioeconomic resources, access to health care and other formal services, and

informal and community-based social support. Negative contextual effects such as institutional discrimination and victimization based on sexual orientation are likely to contribute to higher incidences of poor psychosocial adjustment. (Fredriksen-Goldsen and Muraco 2010).

The findings of Baumle and Romero (2010) suggest that elder same-sex couples are less likely to have private retirement sources or to receive income from Social Security than are different-sex couples. They are more likely to have physical and mental disabilities necessitating health care and support. Further, they are more likely to have children in the household, which necessitates both additional financial support and access to diverse social services.

These studies illustrate that although older LGB adults remain largely invisible, they have diverse experiences with respect to family structures and informal social supports. With respect to formal systems of support, large portions of the older LGB populations remain underserved and do not access services because of their individual experiences of discrimination and victimization as well as historical and institutional marginalization. Ageism in these communities further contributes to older LGB adults' experiences of marginalization and lack of access to supportive services (Fredriksen-Goldsen and Muraco 2010).

Determinants of Sexual Activity and Desire Among the Older Population

Sexual Activity Among the Older Population

An important tradition to studying sexual issues among the aging population has been to look for relevant determinants of sexual behavior. DeLamater and Sill (2005) believe that biological factors provide a necessary but not sufficient condition for sexual functioning. In a comprehensive approach to aging sexuality there is needed a bio-psychological perspective, one that combines biological, psychological, and socio-environmental factors and realms.

A variety of factors have the potential to influence sexual function as women age, including hormonal and physiological changes associated with menopause and chronological aging, changes in physical or mental health, adverse effects of medications or other health interventions, and change in availability of the partner interested in and capable of sexual activity. In addition to the aforementioned factors, depression, social networks/resources, as well as religious and cultural norms are likely to play a role in the sexual lives of older women.

In Beckman and colleague's (2008) study in Sweden, physical and mental health functioning were more strongly associated with sexual desire and activity in middle-aged and older women than age alone. The researchers thus recommend that clinicians should consider women's sexual functioning in the context of their overall physical and mental functioning, rather than considering women strictly according to age. They also suggest that lack of a partner interested in or capable of having sex may be an even stronger contributor to sexual inactivity in this population than personal health.

Women's cessation of sexual activity in later life depends on multiple of factors (Beckman et al. 2008). These include: (1) outliving men, which typically results in the lack of access to a partner and forces older women into sexual abstinence; (2) an emotionally distant relationship with an intimate partner; (3) misinformation, misconception, and prejudice; (4) the culturally induced belief that sexual activity is for the young; (5) boredom and fear of failure; (6) needs of family members that result in strained emotional energy within the older couple; (7) lack of privacy; (8) reduced levels of estrogen and other hormones (during and after menopause) resulting in lower levels of sexual desire, as well as in decreased vaginal lubrication and related painful intercourse; (9) illness and medical use, which often disrupt women's sexual functioning at all ages; (10) poor body image; and (11) erectile dysfunction in a sexual partner.

In women reporting no recent sexual activity, older women appeared more likely than younger women to be satisfied with the state of their sex

lives, after adjusting for other characteristics, a trend that may reflect a change in expectations about sex in older age (Huang et al. 2009). The main reason for men to cease intercourse was self-reported as personal reasons (mostly assumption of inability), mirroring corresponding reports by women that the reason for cessation of intercourse was due to their partner. Whether elderly couples continue to be sexually active seems to a large extent to be determined by men (Beckman et al. 2008).

Biological factors have, beyond all dispute, effects on sexual activities among the aged population but they do not directly determine them. Numerous studies have shown that as people age, adaptations in physiology and hormonal levels and sensory capacities reduce, on average, human sexual desire and activity (Bartlik and Goldstein 2001; Bortz et al. 1999). Chronic disorders, such as cardiovascular diseases, hypertension, stroke, diabetes, arthritis, Parkinson's disease, cancer, prostate disease, and depression may have negative effects on sexual functioning and response. These diseases impair sexual function both directly, by acting on physiological mechanisms, and indirectly, by limiting total body function (DeLamater and Sill 2005).

Fears about resuming sexual activity can accompany recovery from a heart attack or stroke. Decreased blood flow in diabetes can lead to vaginal dryness in women and erection problems in men. All these disorders can also impinge on older adults' body image.

Many prescription drugs, over-the-counter medications, and herbal supplements pose significant side effects that can alter or impair sexual function, including decreased libido, vaginal dryness, ED, dysorgasmia (i.e., delayed or attenuated orgasm), and anorgasmia (i.e., absence of orgasm). Some older patients may find a medication's sexual side effects more unpleasant than the original presenting problem. (Hillman 2008).

At the psychological dimension sexuality includes identity, body image, self-esteem, eroticism, emotions and their expressions and imagination (Badeau 1995). True sexual intimacy is only achievable by individuals who are mature, independent, and have good self-esteem and who

trust and respect their partners; in short, those who have the capacity for emotional intimacy (Kingsberg 2002).

At the social dimension Trudell et al. (2000) have listed a number of social determinants and factors that have their influence on sexual activity. These include social taboos, conjugal status, and knowledge about sexuality, self-esteem, and attitudes towards sexuality. In other words, the expressions of sexuality in a given society are governed also by the common ideas, norms and regulations. At the moral and religious dimensions sexuality embodies learned individual values (Badeau 1995).

At the social dimension the availability of a partner definitely influences sexual expression. So does the quality of interaction and communication with the available partner. Aging can be related to sexual desire and activities via the social influences that are due to longer duration of relationships. DeLamater and Sill (2005) found that having a partner was a significant predictor of desire among women but not among men. These results suggest that a woman's desire is attuned to her relationship context, but a man's desire is not.

Good social networks were statistically related to sexual activity among older adults in Pennhollow and colleagues' (2009) study. The study suggested that greater health status, maintenance of social activities, and positive sexual attitudes help to distinguish between older adults who are currently sexually active and those who are not sexually active.

Of particular interest was the finding (Pennhollow et al. 2009) that sexual self-confidence was the strongest predictor to account for variability in current participation in sexual intercourse for both women and men. Other factors found to have an effect on sexual intercourse for women were frequency of orgasm and relationship satisfaction. For men, other factors found to have an effect on sexual intercourse included relationship satisfaction, frequency of orgasm, health status, and social roles. Sexual self-confidence, frequency of orgasm, and relationship satisfaction appeared as the top three predictors of sexual activity for both sexes.

Findings from the same study demonstrate that cultural (sexual acceptance, sexual priority), psychological (sexual desire, sexual self-confidence, locus of control), and social factors (relationship satisfaction, social activity, social roles) further explain variance beyond biological changes that predict sexual intercourse, sexual satisfaction, and overall quality of life.

Sexual Desire Among the Older Population

There have been numerous attempts to measure the determinants of decreased sexual interest for older individuals. Bartlik and Goldstein (2001) found that retirement-diminished income, divorce, unresolved anger, separation from loved ones, medical illness, major depression, and the use of some medications can lead to diminished sexual desire. Hartmann et al. (2004) reported that decreased sexual interest was related to self-reports of negative emotional and psychological feelings, e.g., lower self-esteem, insecurity, and loss of femininity.

Powerful factors that make the individual woman vulnerable to sexual problems are an unsatisfying partner, not being touched or tenderly caressed any more, not having experienced sexual arousal for a long time, and being ashamed of age-related bodily changes (Hartmann et al. 2004). People who have sexual problems may experience negative psychological side effects, such as anxiety, depression, and lowered self-esteem. (Willert and Semans 2000).

On the other hand, participants aged 60–90 years who reported higher levels of sexual desire and fantasies had the most diversified social networks/resources, interacting with children, grandchildren and their family, and also engaging in church, volunteer, and exercise groups. (Lagana and Maciel 2010). Further, those who reported sexual desire were the most physically active, reported the lowest number of medical conditions, and took few or no medications (Lagana and Maciel 2010).

Sexual desire is a core component of sexual health, and sustaining pleasure into older age is a key sexual developmental task in later life. For partnered women and men, when age does influence sexual inactivity, it is often through

declining physical vitality—whether one’s own or a partner’s—rather than declining interest (Waite et al. 2009).

A Closer Look at Sexuality Among the Aging: A Case Study of Finland

Finland is one of few countries where there are available nationally representative survey data (FINSEX) of sexual activities and values among the aging population. In order to take a closer look at the manner in which sexuality is affected by aging, the data from Finland will be used as a case study in this chapter.

According to many international indicators, social progress is well advanced in Finland. In relation to social well-being, the European Quality of Life Survey gave the highest rates of happiness in Europe to Finland and Denmark. This has some implications for sexual values and activities—sexual images and values are evolving into a more positive and more liberal approach.

Women have a unique position in Finland in international comparison. The rate of women working full-time in Finland is the highest in Western Europe—partly thanks to extensive public childcare (a subjective right for everybody). Based on the Gender Equity Index (GEI), introduced by Social Watch, Finland is number one in gender equity in the world, together with Sweden. In education, the results of the Programme for International Students Assessment (PISA) evaluation (60 countries), OECD, Finland has several times been number one in the world. Women outnumber men in higher education, and comprehensive sex education is at the top level in Europe. This social and educational progress has created positive circumstances for sexual activities among the aging population.

The FINSEX study (Kontula 2009) has tracked Finnish sexual trends since the 1970s up to the present. Some survey questions that map out sexual behavior in youth yield data all the way from the 1940s, a wealth of knowledge that is unique even worldwide. In its last three national sex surveys in 1992, 1999, and 2007, the FINSEX study

has included age groups up to 75 years (previously only 18–54 years). The results of these three surveys are included for this discussion.

One merit of the FINSEX study is that it includes a great number of sexual measures. The results concerning the measures of the quality of couple relationship, sexual activity, sexual desire, sexual satisfaction, sexual disorders, and effects of health on sexual activity were included in this chapter. A more detailed list of measures and detailed analyses of determinants of sexual activity and sexual desire have been published previously (Kontula and Haavio-Mannila 2009).

Participants of the FINSEX Study

Three national sex surveys were conducted in Finland in 1992, 1999, and 2007. Each survey’s sample was drawn from the Central Population Register, so that all Finns had an equal opportunity to be selected into the sample. Of these three population surveys, respondents in the age group 55–74 years were included in these analyses. Their numbers were 532 (1992), 384 (1999), and 901 (2007). The number of respondents was altogether 1,817, of which 1,019 were women and 798 men.

Response rates in these surveys (in age group 18–74 years) were 76% (1992), 46% (1999), and 43% (2007). The higher response rate in 1992 was due to face-to-face interviews at respondents’ homes. In 1999 and 2007 the data collection was carried out by Statistics Finland as a mailed survey, which caused lower response rates.

The impact of lower response rates in the 1999 and 2007 studies on comparability with the 1992 survey has been evaluated by analyzing the ways in which people in a particular birth cohort have responded to the same questions concerning their own youth. The representativeness and comparability of the data in relation to 1992 data remained quite good, except in the case of male respondents over the age of 55. The 1999 and 2007 findings (mailed surveys) provide a slight underestimation of sexual activity in men above the age of 55 (sexual initiation somewhat later, and sexually a bit more monogamous in their life

time), compared with the entire age group of the respondents.

More detailed information on the sampling, interviewing, and questionnaires is available (see Kontula and Haavio-Mannila 1995; Haavio-Mannila et al. 2001; Haavio-Mannila and Kontula 2003; Kontula 2009).

Sexual Activity Among the Older Population in Finland

The crucial gender difference among the aged population is that women over the age of 60 have a permanent sexual partner less often than do men. At age 70 and older, less than half of the women in Finland have a husband or another type of steady partner. Among the males, more than four-fifths of those 70 and older lived in a couple relationship. The implication of this observation is that men have a much better chance than women to keep up their sexual activities through the aging process.

The most important determinant of sexual activities among the aged is precisely the possession of a steady partner, usually a husband or wife. This has a number of implications when comparing how, on average, the aging population lives in its couple relationship and engages in sexual activity. Respondents who were single (including widows) had sexual experiences only rarely. Two-thirds of single men over 60 years of age and four-fifths of single men over 70 years of age had no intercourse in the preceding year. On the other hand, most of these men had masturbated in the last month.

Single women were even less sexually active than single men. Of single women over 60 years of age, 90% had no intercourse in the preceding year. Approximately half of single women between 54 and 59 years of age had masturbated, and of women over 70 years of age, one-fifth had masturbated in the last month. Most of these age group differences in masturbation are due to cohort effects, where each younger cohort was more active in masturbation (or in reporting masturbation) than the older ones. There was a continuing increase in masturbation from one cohort to the next.

Table 10.2 gives an overview of the actual quality of conditions in couple relationships (including marriage, cohabitation, and living apart together (LAT) relationships) and their sexual activities in four age groups (54–59, 60–64, 65–69, and 70–74) for all survey respondents, who had a partner.

Most couple relationships had preserved their high relationship quality in old age based on the result that a great majority (75–89%) reported that they still experienced mutual love. Apart from the oldest men, three-quarters of women and men considered their couple relationship at least fairly happy. From the female point of view, the happiness in their relationship had not changed from one survey to another, but men turned out to be somewhat less happy. But all in all, the relationships among the aging population were quite happy. They also felt in most cases that there was sufficient touching and physical closeness in their relationship.

The sexual life that the aging population led was very monogamous: only 5–10% of all aging respondents reported more than one sexual partner in the past year. However, unfaithfulness had increased by approximately ten percentage points in the 2007 data. In the background of this change were cohort differences, where younger cohorts have been more often unfaithful than older cohorts. The oldest women had lived their teenage years in a society where female unfaithfulness was strongly condemned. This had resulted in abstaining from unfaithfulness.

Frequency of intercourse was lower in the oldest age groups, who reported a mean frequency of intercourse that was about half that of the younger age groups (i.e., every other week compared to every week). This was partly explained by cohort effects. The actual determinants of the individual differences in sexual activity were the cumulating health and functional capacity problems. A remarkable result was that the frequency of intercourse had not decreased from the 1990s to the 2000s among the aging population as it did among the respondents in their middle age (Kontula 2009).

In Sweden, it is possible to compare even some longer-range sexual trends among married

Table 10.2 Emotional and sexual activities among people living in couple relationships (%)

	Men			Women		
	1992	1999	2007	1992	1999	2007
55–59-year olds						
Mutual love in relationship	76	92	83	67	91	89
Relationship is very or fairly happy	82	76	73	79	79	79
Has been unfaithful to own partner	36	32	41	13	16	21
No intercourse in last year	3	7	6	11	2	8
Intercourse in last month (frequency)	5.4	5.5	4.7	3.6	4.3	3.9
Would like to have intercourse more frequently	34	56	47	13	14	29
Last intercourse very pleasant	50	36	45	24	38	34
Masturbation in last month	18	24	51	6	16	30
Watching sex videos or DVDs in last year	32	48	52	6	8	14
60–64-year olds						
Mutual love in relationship	58	83	86	68	84	87
Relationship is very or fairly happy	86	82	73	83	75	76
Has been unfaithful to own partner	24	26	33	7	7	14
No intercourse in last year	4	6	8	15	16	14
Intercourse in last month (frequency)	4.2	5.6	4.5	2.8	3.2	3.5
Would like to have intercourse more frequently	36	26	49	11	21	31
Last intercourse very pleasant	30	44	42	20	22	27
Masturbation in last month	4	26	40	1	8	21
Watching sex videos or DVDs in last year	26	27	46	0	11	11
65–69-year olds						
Mutual love in relationship	65	84	84	65	85	81
Relationship is very or fairly happy	82	87	72	75	81	73
Has been unfaithful to own partner	27	15	32	2	0	9
No intercourse in last year	8	8	18	32	13	20
Intercourse in last month (frequency)	2.7	2.9	3.5	1.4	3.3	2.5
Would like to have intercourse more frequently	27	42	45	19	40	28
Last intercourse very pleasant	30	32	40	17	28	25
Masturbation in last month	7	25	43	3	13	19
Watching sex videos or DVDs in last year	15	23	32	4	14	14
70–74-year olds						
Mutual love in relationship	58	73	75	67	87	83
Relationship is very or fairly happy	92	83	66	61	67	78
Has been unfaithful to own partner	19	22	34	3	8	5
No intercourse in last year	29	32	30	35	21	22
Intercourse in last month (frequency)	2.2	1.8	2.3	2.2	1.2	1.8
Would like to have intercourse more frequently	35	47	38	10	13	15
Last intercourse very pleasant	27	31	25	27	21	22
Masturbation in last month	4	14	28	2	0	13
Watching sex videos or DVDs in last year	13	15	29	0	7	6

and unmarried 70 year olds in Gothenburg (Beckman et al. 2008). Their sexual activity increased from 1971 to 2001. At the same time, among elderly people attitudes toward sexuality became more positive, and the proportion reporting a very happy relationship increased.

Furthermore, the proportion reporting high satisfaction with sexual activity and that sexuality was an important factor in life increased, whereas those with sexual dysfunctions (erectile dysfunction among men, orgasmic dysfunction in women) decreased.

According to the results of the FINSEX study, a significant proportion of aging couples has ceased to have intercourse. In the age group around 60 years of age, almost 10% of the couples had not had any intercourse in the last year. Among the older respondents, approximately one-fifth of all couples had not had any intercourse in the last year; the exception being men over 70 years of age, where this type of sexual inactivity was prevalent for a third of couples.

Among those below 70 years of age, the desire for more prevalent intercourse was higher in the 2007 data. Almost half of the men and a third of the women desired to have more frequent intercourse in their couple relationship (apart from the oldest women). Desire for more frequent intercourse was higher in the 2007 data for both genders by around ten percentage points. This suggests a higher reported overall sexual desire, because the frequency of intercourse had not decreased. An important finding is that aging did not have much influence on the proportion of respondents that desired more intercourse in their relationship.

Based on the reporting of satisfaction in the latest intercourse, there was a somewhat higher reported quality of sexual life among the aging population in the 2000s compared to the 1990s. Almost half of men and over a quarter of women had rated their latest intercourse “very pleasant”. In the age group of 70–74, approximately 25% of men and women considered their intercourse “very pleasant”. Further, three-quarters of men and half of women in this age group reported their last intercourse to be at least “fairly pleasant”. Men rated their intercourse somewhat more positively than women.

Reported masturbation increased substantially among the aging population across the three surveys, and the younger respondents were more active in masturbation than the older ones. For masturbation, the differences across age groups did not result primarily from aging, but from major differences between generations. Younger generations had been in their teenage years more active in masturbation than the older generations (step by step). Each of them had kept the level of their activity rather constant along their aging process.

This suggests that reported masturbation will still significantly increase among the aging population when younger generations reach old age. Women have followed men in masturbation activity (in each cohort) with the delay time of 20 years.

The use of sex videos also increased significantly among the aging population across the three surveys. Porn is adopted a great deal as a sexual stimulant for masturbation. In the use of sex videos, gender difference was as substantial as in masturbation. Men used porn significantly more actively than women. A remarkable finding was that interest in pornography did not decrease much along the years in aging. This is evidence that sexual desire and interest does not necessarily decrease while aging.

Contrary to expectations, sexual self-esteem does not seem to change much even when people age. The proportion of study subjects who considered themselves sexually attractive, skilful, or active was almost the same in these four age groups. Probably people used their age mates in these estimations as a reference group, rather than younger people.

Sexual Dysfunction Among the Older Population in Finland

Around half of the women living in a couple relationship reported that they had felt a lack of sexual desire fairly often in the last year (Table 10.3). Apart from the oldest men, only a quarter of men noticed a frequent lack of sexual desire in their partner. On the contrary, male reports of their lack of desire matched fairly well with what women reported of their husbands. Of men below 70 years of age, approximately 20% or less reported having felt a lack of sexual desire fairly often; women’s reports of their partners’ lack of sexual desire were quite similar. Only in the age group of over 70 years of age was the lack of male sexual desire almost as high as among younger women, at about 40%; further, at this age group, women were less likely to accurately perceive their partner’s lack of sexual desire.

A third of women had continuous problems in the preceding year in their sexual arousal when

Table 10.3 Own or partner's sexual desire, sexual function, pleasure and satisfaction with sex life among people living in couple relationships (%)

	Men			Women		
	1992	1999	2007	1992	1999	2007
55–59-year olds						
Lack of own sexual desire quite often	15	7	12	59	59	47
Lack of partners sexual desire quite often	27	23	26	14	14	15
Lubrication difficulties quite often	14	29	15	30	34	33
Erection difficulties quite often	17	20	12	29	25	28
A partner comes too quickly quite often				45	33	22
Orgasm in last intercourse	96	92	91	36	51	57
Very or quite satisfied with sexual life as a whole	81	67	75	67	73	70
Own or partners illness has caused problems in sexual interaction quite often	15	15	16	15	13	21
60–64-year olds						
Lack of own sexual desire quite often	14	11	18	44	57	57
Lack of partners sexual desire quite often	22	15	27	12	19	17
Lubrication difficulties quite often	9	15	21	40	40	32
Erection difficulties quite often	15	10	19	27	31	23
A partner comes too quickly quite often				37	43	29
Orgasm in last intercourse	90	91	93	31	48	50
Very or quite satisfied with sexual life as a whole	84	79	79	72	69	66
Own or partners illness has caused problems in sexual interaction quite often	13	13	20	14	23	20
65–69-year olds						
Lack of own sexual desire quite often	18	30	18	56	55	41
Lack of partners sexual desire quite often	22	35	30	21	29	16
Lubrication difficulties quite often	10	29	21	36	20	38
Erection difficulties quite often	27	12	31	30	33	40
A partner comes too quickly quite often				32	38	31
Orgasm in last intercourse	88	96	95	34	47	45
Very or quite satisfied with sexual life as a whole	82	75	69	74	85	62
Own or partners illness has caused problems in sexual interaction quite often	14	23	19	11	28	21
70–74-year olds						
Lack of own sexual desire quite often	32	50	39	53	50	61
Lack of partners sexual desire quite often	60	50	43	(00)	(10)	21
Lubrication difficulties quite often	46	23	30	30	38	42
Erection difficulties quite often	42	40	36	26	54	48
A partner comes too quickly quite often				33	44	19
Orgasm in last intercourse	79	85	84	30	38	40
Very or quite satisfied with sexual life as a whole	71	75	66	77	62	70
Own or partners illness has caused problems in sexual interaction quite often	21	56	28	11	17	30

measured by problems in vaginal lubrication. The prevalence of this problem did not differ much in different age groups. In the age groups under 65, men reported their partners' lubrication problems significantly less often. It appears that many

women succeeded in hiding this arousal problem from their husbands.

Around 20% of men below 65 years of age and around 33% of men in the age groups of 65–74 years reported frequent problems in having

erections. The prevalence of erection problems did not differ across surveys from the 1990s to the 2000s. Women reported their partners' erection problems somewhat more frequently than what men self-reported. Of aging males, 20% had used medication in the last year to improve their erection. Of the men who reported that they fairly often experienced erection problems, approximately one-third had used some medication for that purpose.

Of aging men across all age groups, 20–35% had frequent premature ejaculations based on the reporting of their partners. The reporting of this male sexual problem had decreased around ten percentage points in the 2007 survey. Sexual dysfunctions or problems increase when people age, but perhaps less than one might expect. Two-thirds of men and women did not report any frequent problems in erection and lubrication even at the age of 70.

In the 2007 survey, more women reported finding their intercourse pleasant and, correspondingly, the percentage of women who had orgasms in their latest sexual intercourse was 10–20 percentage points higher in this survey. In the 2007 survey, 50% of aging women reported orgasm in their latest intercourse. In addition, 5% of women had multiple orgasms. The aging process seemed to somewhat increase problems related to orgasms. Male orgasms were almost twice as frequent in the latest intercourse in comparison to females. This represents a great sexual inequality between genders in sexual satisfaction. This gender difference was somewhat decreased in the 2007 data.

Although reported orgasms increased in the 2007 survey, the overall satisfaction with own sexual life had somewhat decreased in the 2007 survey. This trend could be explained partly by increased expectations of own sexual activity that respondents had not been able to fulfil. In any case, around 70% of men and women considered their sex life at least fairly satisfactory. Aging did not much decrease satisfaction, even though the frequency of intercourse was lower. Satisfaction was individually evaluated in these cases by different aspects of the intimate relationship.

Around 20% of men and women lived in a couple relationship where one or the other had some illness that fairly often caused some harm or limitations to the sexual life in their relationship. These types of illnesses were reported more in the 2000s than in the 1990s. Illness that harmed sexual activities was reported by one-third of those in the age group of over 70 years of age. This fact conceivably has implications for sexual desire and sexual functions.

Sex in Relationships of Longer Duration in Finland

In previous analyses of the FINSEX study (Kontula and Haavio-Mannila 2009), the respondents who were married, cohabited, or were living apart together (LAT) were divided into three groups (0–19, 20–39, and 40–58 years) according to the years they had lived together. The aim was to study possible differences in relationships that had a shorter or longer duration. It has often been argued that in relationships of longer duration, partners get bored and their desire for sexual activities with one another decreases.

A high number of years lived together did not seem to have an impact on the quality assessments of the relationships. Regardless of the duration of the relationship, the respondents considered their relationship as happy and their assessment of touching and physical closeness was the same in the three duration-of-relationship groups. This held true even though the feeling of mutual love was somewhat less common in the relationships that had lasted over 40 years. Men considered sex life more important for the happiness of their relationship than women and they held this view still in the relationships of long duration.

There was a drop in the frequency of sexual intercourse in the relationships which had lasted at least 40 years. Only a third of men and a sixth of women had intercourse at least once a week in the past month. In the last year, 14% of men and 25% of women had had a relationship without any sexual intercourse. This was due to an increasing lack of female sexual desire, physical

Table 10.4 Characteristics of sexual life of men and women in three groups according to duration of the relationship (%)

Characteristics	Men, duration in years			Women, duration in years		
	0–19	20–39	40+	0–19	20–39	40+
<i>Quality of relationship</i>						
Mutual love in the relationship	72	75	58	70	81	68
Couple relationship is very or fairly happy	79	83	87	77	80	74
Discussing sexual matters with partner is not at all or not very difficult	90	83	83	80	81	74
There is a convenient amount touching in the couple relationship	80	79	76	79	73	75
Considers sexual life very or fairly important for the happiness of the relationship	83	84	77	68	70	51
<i>Sexual partners</i>						
Number of sexual partners in lifetime (mean)	31	12	8	8	3	2
Number of sexual partners in lifetime (median)	15	5	3	5	1.5	1
At least two sexual partners in last year	24	17	7	12	3	1
<i>Sexual intercourse</i>						
Sexual intercourse in last week	67	58	34	51	45	17
No sexual intercourse in last year	2	4	14	4	6	26
Satisfied with the frequency of intercourse	52	54	67	66	70	59
Would like to have intercourse more frequently	47	44	30	26	18	18
Latest intercourse very or quite pleasurable	91	89	88	78	78	49
Orgasm in latest intercourse	94	94	88	69	63	47
<i>Sexual desire and functioning</i>						
Lack of own sexual desire caused problems very or quite often in last year	15	12	25	31	40	59
Lack of partners sexual desire has caused problems very or quite often in last year	15	24	32	16	12	19
Erection difficulties quite often in last year	9	14	23	11	16	39
Lubrication difficulties quite often in last year	7	12	22	20	18	44
Partner comes too quickly very or quite often	5	6	6	34	26	48
<i>Health</i>						
Own illness has caused problems in sexual interaction very or quite often in last year	15	12	25	31	40	59
Partner's illness has caused problems in sexual interaction very or quite often in last year	6	5	18	9	12	32
Self-rated sexual self-esteem (mean, range 3–15)	10.4	9.8	8.7	9.8	8.7	7.9
<i>Sexual satisfaction</i>						
Very or quite satisfied with sexual life as a whole	84	84	81	83	79	76

pains, and an increasing proportion of males who had illnesses, including erection disorders, which caused problems in their sexual performance.

As reflected in Table 10.4, men seemed to be capable of keeping the quality of their intercourse very good even in the relationships of long duration. They assessed their latest intercourse as pleasurable and they reported orgasms as frequently as men in relationships of shorter duration. Women were not able to keep this high

quality of intercourse in the relationships that had lasted at least 40 years. Less than half of these women considered the latest intercourse pleasurable and as few had experienced an orgasm in their latest intercourse. Some of this gender difference could be due to the sexual patterns in the older generation in which women in their youth did not learn to value their sexuality and their experiences in the same manner as younger generations.

Thirty percent of men in long relationships and a fifth of respective women would have preferred more frequent intercourse in their relationship. A fifth of these women would have preferred less frequent intercourse. Aging women were a quite heterogeneous group concerning their interest in sexual activities.

Even though the gender discrepancy in desire surely caused continuous problems in communication between the partners in relationships of long duration, the assessment of the happiness of their relationship did not change. Among the aging population, happiness in the couple relationship was not very dependent on sexual interplay between the partners as it was among younger couples.

Predictors of Sexual Activity and Sexual Desire in Finland

In previous research, regression analyses were conducted to assess determinants of sexual activity and desire (Kontula and Haavio-Mannila 2009). The analysis was carried out for men and women separately and included only people in couple relationships, given that many questions were asked of them only.

The most important result was that the effect of age on sexual activity was weaker when other influential factors were taken into account.¹ Age was significantly related to sexual activity but not to sexual desire, after adjusting for the effects of the other variables in the regression model. Further, the aging effect on sexual activity was more important for men than for women. In addition, the duration of the relationship did not play an important role in relation to sexual activities and sexual desire, after controlling for the other variables of the study.

¹ Other variables included in the models follow: Touching and physical closeness in the relationship, considers sexual life as important for the happiness, number of sexual partners in lifetime, latest intercourse pleasurable, seldom lack of sexual desire, erection difficulties rare, own illness has seldom caused sexual problems, partner's illness has seldom caused sexual problems, high self-rated sexual self-esteem, frequent alcohol use.

In addition to age, the most important predictors of sexual activities among aging men were: a loving relationship, positive sexual self-esteem, easy sexual performance (erection), and a history of multiple partners. For women, important predictors included high sexual desire (own and partner's), and a high value given to sexual happiness in the relationship. For men, other health-related factors that had a positive outcome on sexual activities included: not smoking, drinking heavily at least sometimes, and low body mass index (slimness).

Turning to sexual desire, we found that sexual desire was not influenced by age, after controlling for other variables in the study. To express this result simply: The negative effect of biological aging on sexual desire disappears when people are satisfied with their sexual experience, sexually functioning, and healthy. Positive predictors for higher sexual desire among both men and women were: good health (own illness has not caused problems to sexual life), good sexual functioning (erection and lubrication), positive sexual self-esteem, and a sexually skilful partner (partner not too fast or too slow in sexual intercourse). For women, a loving relationship was also important for their sexual desire. Another special predictor for female sexual desire was physical exercise. Males who were satisfied with sexual life as whole had higher sexual desire.

Discussion

The knowledge of sexuality among the aging population is nowadays more important than ever before. In Europe, the proportion of people over 60 years old is expected to grow by 50% over the next 30 years, and women live one-third of their lives post-menopausally (Kontula and Miettinen 2005). The proportion of the population comprised of those who are older and sexually active will increase substantially in the forthcoming decades.

Previous literature includes many studies reporting a decrease in sexual activity among the aging population. The results of the FINSEX study confirm these essential findings. Nevertheless, it is disputable whether these findings are due to aging

as such or if they can be explained, for example, via changes in social and health status that take place in the aging population. The analyses with FINSEX data provided an important result that sexual desire was not influenced by age, when other relevant items were controlled. Another very significant finding was that even a long duration of relationship is not a determinant of decreasing sexual activities if couples are able to stay healthy and sexually functioning. Social aspects of marriage or relationships do not usually constitute a major handicap for sexual communications and activities, even after living over 40 years together.

The greatest effect of aging on sexual activities involves confronting widowhood. It produces unequal social effects on male and female sexualities. In the age group of less than 75 years of age, this affects mainly women. At the age of 70, three-quarters of men but only one-half of women had a steady sexual partner in Finland. In many European countries this proportion is only a third for women in this age group. This has marked implications for sexual issues because widowed women have not typically been sexually active without a steady partner, except in masturbation.

The obvious and confirmed implication of the earlier widowhood among women is that, on average, aging men are sexually much more active than aging women. In the FINSEX study, half of the women, but only a quarter of men, in their 70s had not had any intercourse in the past year. In older age groups this gender difference is still greater.

Aging women are sexually less active than men partly because they are less likely to remarry following the death of a spouse. In part this is a result of a demographic shortage of men of the appropriate age, but also of old moral rules that state that it is unseemly for women to remarry. The requirement to stay faithful extends in some countries beyond the grave. This situation is likely to see a transition when the Western baby-boom generation retires. For them, sex is an integral part of life, regardless of age.

Demographically the only solution to increase gender equality in sexual activities among the aging population would be for women to marry or live together with men who are several years

younger than what they themselves are. This way they would not experience widowhood significantly younger than their husbands or partners. This would require a major transition in values and traditions concerning aging, sex roles, and the selection of partners in the available "markets".

Aging critically defines the social role of human beings. Some of the change is attributable to changes in a person's resources and ability to function, while others ensue from expectations on the part of the surrounding community and culture regarding the behaviour of persons of a particular age and status. Many people ponder, for instance, whether having a longed-for relationship or experience would be seen as acceptable behaviour for someone "their age". The desire to keep appearing outwardly respectable may torpedo potential sexual temptations. Nevertheless, powered by love or an especially enticing situation, new and unexpected relationships may commence.

According to the previous analyses with FINSEX data (Kontula and Haavio-Mannila 2009), age predicted sexual activities even after controlling for the influence of other studied variables in the regression model. This is probably due to human adaptations in biological and physiological factors along the aging process which has outcomes also in sexual actions. In some relationships intercourse even ceases completely.

In addition to age, the most important predictors of sexual activities among the aging population for men were: a loving relationship, positive sexual self-esteem, easy sexual performance, and a history of multiple partners. For women they were high sexual desire (own and partner's), and high value laid to sexual happiness in the relationship. Sexual desire was more important to female sexual activities and good relationship was more important to male activities.

In order to keep up their sexual desire, both men and women combined psychological, social and biological dimensions in their life. Common predictors were good health (no chronic disorders), good sexual functioning, positive sexual self-esteem, and a sexually skilful partner. For women, a loving relationship was also important for their sexual desire. These were positive resources that

helped men and women to keep their sexual motivation high along the aging process.

One interesting finding was that oldest men and women considered their couple relationships as happy as younger people's relationships, and they were also as happy with the physical closeness and touching that they experienced with their partner. The quality of the relationship had not suffered even though the duration of the relationship was over 40 years and sexual activities had become less frequent than before. This was partly explained by the finding that older women did not value sex as much in their relationship as did younger women. At the age of 70, two-thirds of men but only a half of women considered sex life important for the happiness of their relationship. The decrease in sexual activity did not make them unhappy because they did not consider sex very important in their relationship.

There is no upper age limit to feeling sexual desire. On the basis of analyses conducted with the FINSEX data, aging by itself does not reduce sexual desire, as long as the person has a partner and he or she stays relatively healthy and functional. Having a satisfying sex life long into old age is also correlated with an appreciation of sexual matters, good sexual self-esteem, and a sexually skilled partner. When these things are in place, aging need not result in any major changes in the sexual life of a relationship.

One limitation of the FINSEX study is that it did not include in its sample respondents over 75 years of age. Waite et al. (2009) have reported sexual issues among the aging population in the U.S. By the oldest ages of the sample, 75–85 years, a minority—38% of men and 17% of women—were sexually active with a partner in the past year. They were teenagers during the 1940s, a period of more conservative sexual mores. Attitudes tend to be more conservative among older than among younger people, which could result in differing sexual activities and desires for the over-75 age group.

In the previous literature, biological factors have been considered important for decreasing sexual activity among the aging population. Of these factors, only one could be examined in the FINSEX study: chronic illness. This was an

important predictor for lower sexual desire. Good physical condition preserves the sexual drive and provides resources for preferred sexual activities. Some physical illnesses and disabilities have in earlier studies been found to have adverse consequences for sexual life. These include illnesses that distort body image, that impair or restrict physical mobility necessary for sexual contact, and/or require treatments that themselves inhibit sexual desire (Cole and Vincent 2001). Disease affects mobility and tolerance to physical activity, reducing sexual desire. Body image and perceived attractiveness are modified by aging and disease with reduced desire for relationships (Camacho and Reyes-Ortiz 2005).

In FINSEX, it was not possible to measure hormonal levels of our respondents. This is an undisputable limitation of this study but perhaps not a very serious one when we look at the findings by Dennerstein, Leher, and Burger (2005). According to their results, prior functioning and relationship factors are more important than hormonal determinants in female sexual activities in midlife. In addition, Hartmann et al. (2004) have found that hormonal changes were relatively weak in their direct effects on well-being and sexuality, whereas the major factors affecting peri-menopausal women's sexuality were feelings for the partner, partner problems, subjective well-being, and number and severity of menopausal symptoms. Altogether, age seems to affect sexual experiences for older individuals less physiologically and more emotionally.

Bortz et al. (1999) concluded that most studies that have investigated various effects of sexual functioning among aging men have failed to inform us what kind of level of sexual functioning might be possible in healthy, partnered, community-dwelling, successfully aging men. In sum, previous studies have failed to address the issue of exemplary sexual functioning from a bio-psychosocial perspective. The FINSEX study, however, does give some evidence that most aging males were fairly successful in keeping up sexual activities which they found rewarding.

Sexuality and desire for intimacy are essential and important human features from birth till

death. Gerontologists and other medical experts generally agree that continued sexual interest and activity can be therapeutic for older men and women (Willert and Semans 2000). Aged women who have a partner with whom they can enjoy intimacy have better mental health in comparison to women who do not have this kind of partner. For most aged people, sexual activity is still an important means to express love and care (Campbell and Huff 1995).

Increasing sexual activity among the aged in the Western world is partly due to more liberal values towards sexual activities among the aging population. In Finland, for example, the attitudes among the general population have been in favour of aged people's sexual activities (Kontula and Haavio-Mannila 1995). The statement "in my opinion old people should not establish sexual relationships" was disapproved by 85% of the Finnish respondents. In the age group of 55–74 years, this proportion was 75%. Accordingly, only 17% of men and 23% of women in a sample of 70–80-year-olds in 29 countries said "older people no longer want sex" (Nicolosi et al. 2004).

These issues are increasingly important also in nursing institutions and nursing homes. Generally speaking, the studies have shown that the nursing staff and resident physicians say that they have positive attitudes towards the sexual activities of elderly people. However, these favourable attitudes towards sexuality have not necessarily been accompanied by behaviours supporting them (Trudel et al. 2000). I agree with Willert and Semans' (2000) conclusions that the staff should not be embarrassed about a resident's sexual concerns, should provide information about sexual issues if asked, and should reassure residents with health problems that sexual expression is still possible.

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Part IV

Sexual Identities

The Prevalence of Gay Men and Lesbians

11

Christopher Scott Carpenter

Introduction

This chapter presents new estimates of the prevalence of self-identified gay men and lesbians (and bisexuals) from recent, population-representative datasets in the United States. The data presented in this chapter provide context for a series of chapters in this Handbook covering sociodemographic outcomes of sexual minorities, including residential location, labor market, and family/partnership outcomes. Many prevalence estimates have been reported elsewhere in the literature, but are based on sexual behavior as opposed to sexual orientation identity (e.g., Kinsey et al. 1948, Binson et al. 1995), use older data (e.g., Laumann et al. 1994; Black et al. 2000), and/or focus on just one or two individual datasets (e.g., Dilley et al. 2005; Keyes et al. 2007, and others). My goal in this chapter is to present a series of prevalence estimates in a standardized way across several recent, independently drawn datasets to document consistent patterns. I also examine whether estimates of the prevalence of gay men and lesbians differ systematically by demographic characteristics such as sex, age, race, and education.

To preview, I find remarkable consistency across six representative national and state-based

datasets: approximately 1–2.3% of adults identify as gay or lesbian, and an additional 0.7–2.9% identify as bisexual. Men and women are about equally likely to identify as non-heterosexual, though among non-heterosexual men the vast majority identify as gay while among non-heterosexual women self-identified bisexuals are about as prevalent as self-identified lesbians.

In the next section I describe the datasets used to obtain prevalence estimates and describe my approach. I then clarify limitations of the data and approach to provide appropriate context for the prevalence estimates, which I present in the next section. I discuss key patterns in the results, and I summarize and conclude by identifying remaining knowledge gaps in this area.

Data and Approach

I obtained estimates of the prevalence of gay men and lesbians from datasets that meet several conditions.¹ First, I restrict attention to datasets that were explicitly designed to be representative of the sampled population in order to obtain meaningful prevalence estimates (Binson et al. 2007). I do not consider sources of information on gay men and lesbians that rely on other types of sampling, such as convenience

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¹For an excellent source of information on available datasets with information on sexual orientation, see <http://gaydata.org>

sampling, snowball sampling, respondent-driven sampling, or others. Second, I only consider datasets that provide information on sexual orientation at the individual level (i.e., datasets that ask individual respondents direct questions about sexual orientation). Thus, I do not examine population-based datasets that allow indirect identification of sexual orientation through combinations of partnership/marital status and household sex composition, including the commonly used 1990 US Census, Census 2000, the American Community Surveys, and others. Absent solid evidence about partnership prevalence among gay men and lesbians from nationally representative samples (which would itself require large samples of individual-level data), it is difficult to obtain meaningful prevalence estimates from such couples-based samples. These types of data are of course useful for describing demographic characteristics of same-sex couples (Baumle et al. 2009; Black et al. 2000), but they are less useful for estimating the prevalence of gay men and lesbians.

Third, I require that the population-based individual-level datasets under study include information on sexual orientation as distinct from sexual behavior or sexual attraction. While some of my datasets do contain this additional information on behavior and attraction, I did not consider datasets (such as the General Social Survey) that include information on same-sex sexual behavior but do not include information on sexual orientation for the full sample. My goal here is to describe the prevalence of self-identified gay men and lesbians as opposed to the prevalence of same-sex behaving men and women (which has been documented elsewhere at length for men; see, for example, Sell et al. 1995) or same-sex attracted men and women. This is consistent with the demographic focus of this volume since I conceptualize sexual orientation as a demographic characteristic (similar to race or sex). Fourth, I focus only on datasets that provide information on adults, generally 18–64. Youth sexual orientation has been studied at length by others (see Savin-Williams 2009, and others), and evidence suggests that the dynamics there may be quite different than for adults, particu-

larly with respect to self-identification. Thus, I do not consider rich data from the National Survey on Adolescent Health (which has included various questions about sexual orientation, behavior, and attraction) or state-based Youth Risk Behavior Surveys that have included related questions on school-based surveys of youths. Finally, because I am interested in how prevalence estimates might vary across broad demographic cuts of the data (e.g., age, sex), I only consider datasets where the microdata with individual-level demographic characteristics were available at reasonable cost.

Several datasets meet these key conditions, and I describe them here. First, I use data from the National Epidemiologic Survey on Alcohol-Related Conditions (NESARC). NESARC is a two-wave panel survey carried out by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The baseline data in 2000 were designed to be nationally representative and asked over 45,000 adult respondents mainly about alcohol use and abuse. The follow-up in-person survey in 2004/05 included a core questionnaire that elicited information on several standard demographic characteristics. The second wave also included a direct question about the respondent's sexual orientation in a section covering "Medical Conditions and Practices". Specifically, individuals were given a card that read: "Which of the following on the card best describes you?" and response options included: "Heterosexual," "Gay or lesbian," "Bisexual", and "Not sure"²

Second, I use data from the 2002 National Survey of Family Growth (NSFG) (Mosher et al. 2005). NSFG is a nationally representative survey focused on family relationships and fertility of persons age 15–44 in the United States. In-person interviews included an audio CASI module about detailed sexual practices and behaviors which ended with a direct question about the respondent's sexual orientation. Specifically, individuals were asked "Do you think of yourself as..." and response options were read as "Heterosexual, homosexual, bisexual, or something else?"

²Immediately preceding the question about sexual orientation, NESARC also included direct questions about same-sex sexual behavior and same-sex sexual attraction.

Third, I use a series of state-based datasets that are based on the Centers for Disease Control's Behavioral Risk Factor Surveillance System (BRFSS). BRFSS is a random digit dialing telephone survey of individual health behaviors that is aggregated to produce national estimates. While the core BRFSS questionnaire does not include direct questions about sexual orientation, individual states can opt to add supplemental questions as part of public health surveillance. A handful of states have included direct questions about sexual orientation on these state surveys; I use data from Massachusetts, Oregon, and California.

The largest and longest state BRFS survey with questions about sexual orientation comes from Massachusetts, which has identified gay men and lesbians since 2001. I pool data from 2001 to 2008.³ The sexual orientation question in the Massachusetts BRFS asks respondents: "Do you consider yourself to be: heterosexual or straight, homosexual or (if respondent is male read "gay"; else if female, read "lesbian"), bisexual or other?" Oregon's state BRFS survey used very similar question wording. From 2003 to 2004 respondents were asked: "Now I'm going to ask you about your sexual orientation. Do you consider yourself to be: heterosexual (straight), homosexual (gay or lesbian), bisexual, other". From 2005 to 2007 respondents were asked: "Do you consider yourself to be: Heterosexual, homosexual, bisexual, or other?" I pool responses from 2003 to 2007 for the Oregon BRFS data. Finally, I use two BRFS-based datasets from California, the 2005–2007 California Women's Health Surveys and the 2006–2007 California BRFS. Both surveys ask respondents: "This next question is about your sexual orientation, and I want to remind you again that your answers are completely confidential. Which of the following best describes you? Would you say...". Response options include: "Heterosexual (straight)," "Gay or lesbian," "Bisexual," and "Not Sure."

Because my goal was to present comparable prevalence estimates across datasets, I performed

the same exclusion restrictions in each source. First, I excluded respondents who were not asked the sexual orientation questions (for example, due to age). I then excluded respondents who refused to provide a response to the sexual orientation question or who gave some other non-codable response such as "don't know". The rate of missing data for this reason varied across datasets but generally was 4–5% of the full sample which, as has been documented elsewhere, is well below the missing data rates for other commonly asked sociodemographic variables, such as income (see, for example, Conron et al. 2008). Previous research has documented that nonresponse to sexual orientation questions varies systematically by demographic characteristics: older respondents are less likely to provide a valid answer to such questions, as are racial and ethnic minorities (see, for example, Keyes et al. 2007). Because the issues surrounding adolescent sexuality are unique and have been studied elsewhere, I restrict attention to adults 18 and older. The universe for my prevalence estimates, then, is composed of adult respondents in each dataset who provided a valid response to the question about sexual orientation, where "valid" generally includes a category such as 'other', 'not sure', or 'something else'.

Limitations

Because of the many challenges inherent in obtaining estimates of the prevalence of gay men and lesbians, I describe several limitations of the approach before presenting the prevalence estimates below. First, my estimates are of the prevalence of self-identified gay men and lesbians in the respective populations from which they are drawn. That is, they are the proportion of respondents (appropriately weighted to reflect sampling design) who chose the label "gay" or "lesbian" from the list of possible response options to a direct question about sexual orientation (i.e., they are self-reports). While I conceptualize these responses as reflecting demographic characteristics, much like race or sex, it is possible that the choice of sexual orientation label conveys something more or something different (e.g., a political

³Previous work has used data from the 2002 to 2006 waves of these data and has reached extremely similar conclusions to those presented below (Keyes et al. 2007).

statement). I tried to choose datasets whose sexual orientation questions would not introduce this type of confounding factor, as some surveys ask questions about whether respondents feel affinity to the gay rights movement or have membership into the gay and lesbian community. In contrast, the surveys I study generally do not contain questions that lead in this way, and questions on sexual orientation are often included in a series of questions about demographic characteristics. This further increases the likelihood that respondents view sexual orientation as a demographic characteristic in the way I conceptualize.

Second (and related to the point above), the response options available in the surveys I may be problematic for some respondents. Younger gay and lesbian adults (e.g., 18–25), for example, may prefer terms such as “queer” to describe their sexual orientation. And racial and ethnic minorities similarly may not find the list of response options culturally meaningful or appropriate. These individuals may in all other respects “look like” gay men and lesbians with respect to same-sex sexual behavior and attraction but may not be counted in these surveys given the limited set of response options. While there is little research on these possible biases, it is likely that my prevalence estimates will be more accurate and valid for white adults 25–64.

Third, my estimates measure the prevalence of gay men and lesbians at the time of the surveys but do not account for possible changes over time in several respects. For example, I am not aware of surveys that span a long enough time period with large enough samples of self-identified gay men and lesbians to meaningfully estimate how the prevalence of sexual minorities has changed over time. And even if these data were available, it would be difficult to know how much of these changes were due to ‘true’ changes in prevalence versus changes in the willingness to self-identify on surveys or changes in cultural meanings associated with the sexual orientation terms included in surveys. Also, my estimates do not measure changes within persons over time in their sexual orientation, which research suggests may be particularly important for women (Peplau and Garnets 2000).

Fourth, the distribution of states that have chosen to ask questions about sexual orientation on their BRFs-based surveys is clearly nonrandom in ways that may matter for prevalence estimates regarding sexual orientation. It is entirely plausible that self-reported prevalence of homosexuality would be different in, say, southern U.S. states than in Massachusetts, Oregon, and California (all of which provide legal protections to sexual minorities and same-sex couples). Unfortunately, the two national datasets do not contain enough non-heterosexual respondents to meaningfully estimate differences in prevalence by state or even geographic region. These factors increase the importance of comparing the national estimates with the state-based estimates.

Fifth, I make no adjustments for differences in survey design associated with survey mode, question placement, or related survey logistics, despite that these may have meaningful effects on estimated prevalence. The NSFG, for example, uses combinations of in-person interviewing with audio computer-assisted self-administered interviews (ACASI), while the BRFs based surveys are telephone interviews. Regarding placement, the BRFs-based surveys generally include the sexual orientation question in the section on demographics, while the NESARC and especially the NSFG include the question at the end of a detailed set of questions related to sex practices and sexual attraction. Unfortunately, I do not have meaningful variation in, say, mode or placement within surveys to isolate the effects of such choices on prevalence estimates. These issues are reviewed extensively elsewhere (see, for example, SMART 2009) and should be the focus of future research.

Prevalence Estimates

I present estimates of the prevalence of gay men and lesbians in Tables 11.1, 11.2, 11.3, 11.4, 11.5 and 11.6, which all follow the same general format. For each sexual orientation category I report the sample size, prevalence estimate (expressed as a percent of the relevant population), and 95% confidence interval around the

Table 11.1 Number and percentage of respondents age 18–64 reporting gay, lesbian, or bisexual orientation by selected characteristics, NESARC II 2004/2005. Question is: Which of the categories on the card best describes you?

Response options:	Heterosexual (straight)			Gay or lesbian			Bisexual			Not sure		
	N	%	95% CI	N	%	95% CI	N	%	95% CI	N	%	95% CI
Overall	26,609	97.8	97.6–98.0	318	1.0	0.9–1.2	215	0.7	0.6–0.8	140	0.5	0.4–0.6
<i>Sex</i>												
Male	11,434	97.9	97.7–98.2	179	1.2	1.0–1.5	64	0.4	0.3–0.5	56	0.4	0.3–0.5
Female	15,175	97.7	97.4–98.0	139	0.8	0.6–1.0	151	1.0	0.8–1.1	84	0.5	0.4–0.7
<i>Age</i>												
18–25	2,620	97.2	96.5–97.9	21	0.7	0.4–1.1	43	1.4	0.9–1.9	21	0.7	0.4–1.1
26–45	13,109	97.7	97.4–98.0	172	1.2	1.0–1.4	104	0.7	0.5–0.8	58	0.4	0.3–0.6
46–64	10,880	98.2	97.9–98.5	125	0.9	0.7–1.1	68	0.5	0.3–0.6	61	0.4	0.3–0.6
<i>Race/ethnicity</i>												
White NH	14,768	97.8	97.6–98.1	208	1.1	0.9–1.3	124	0.7	0.5–0.8	56	0.4	0.3–0.5
Black NH	5,223	97.8	97.4–98.3	46	0.8	0.5–1.0	38	0.8	0.5–1.2	34	0.6	0.3–0.8
Hispanic	5,334	97.9	97.4–98.4	47	0.8	0.5–1.1	43	0.6	0.4–0.9	39	0.7	0.4–1.0
<i>Education</i>												
HS or less	10,302	98.2	97.9–98.5	58	0.5	0.3–0.7	70	0.6	0.4–0.7	82	0.7	0.5–0.9
Some coll	8,975	97.8	97.5–98.2	103	1.0	0.7–1.2	85	0.9	0.7–1.1	35	0.3	0.2–0.5
BA or more	7,332	97.4	97.0–97.7	157	1.7	1.4–2.1	60	0.6	0.4–0.8	23	0.3	0.1–0.4

Table 11.2 Number and percentage of respondents age 18–64 reporting gay, lesbian, or bisexual orientation by selected characteristics, NSFG 2002^a. Question is: Do you think of yourself as...

Response options:	Heterosexual			Homosexual			Bisexual			Something else		
	N	%	95% CI	N	%	95% CI	N	%	95% CI	N	%	95% CI
Males, 18–44	3,805	91.9	90.6–93.1	132	2.3	1.7–3.0	96	1.8	1.3–2.4	174	4.0	3.1–4.8
Males, 18–25	1,403	92.4	90.7–94.0	34	1.9	1.1–2.7	25	1.7	0.9–2.5	60	4.0	2.7–5.4
Males, 26–44	2,402	91.7	90.0–93.2	98	2.5	1.6–3.4	71	1.9	1.2–2.6	114	3.9	2.9–5.0
Females, 18–44	6,235	92.0	91.1–92.8	91	1.3	1.0–1.7	223	2.9	2.4–3.3	294	3.8	3.2–4.4
Females, 18–25	1,866	89.8	88.0–91.7	20	1.0	0.5–1.5	97	4.6	3.4–5.7	88	4.6	3.4–5.8
Females, 26–44	4,369	92.8	91.9–93.8	71	1.5	1.1–1.9	126	2.2	1.7–2.7	206	3.5	2.9–4.2

^aRace and education were not ascertained in the NSFG in a way consistent with the other datasets and so are not presented here

prevalence estimate to indicate precision. Non-overlapping 95% confidence intervals were used to determine statistical significance. I then present associated prevalence estimates separately by demographic characteristics such as sex, age, race, and education level, where meaningful and appropriate (taking into consideration sample size issues).

I begin with the nationally representative 2004/5 NESARC Wave II data in Table 11.1. Of the 27,282 respondents who provided a valid response to the sexual orientation question,

97.8% identified as heterosexual, 1% identified as gay or lesbian, 0.7% identified as bisexual, and 0.5% chose “not sure”. Men (1.2%) were more likely than women (0.8%) to identify as gay or lesbian, though women (1.0%) were more likely than men (0.4%) to identify as bisexual. There were no strong age gradients in the prevalence of gay men and lesbians, though young adults age 18–25 were more likely than older adults to identify as bisexual or ‘not sure’. There were no significant differences by race or ethnicity in the prevalence of any non-heterosexual group.

Table 11.3 Number and percentage of respondents age 18–64 reporting gay, lesbian, or bisexual orientation by selected characteristics, Massachusetts BRFSS 2001–2008. Question is: Do you consider yourself to be...

Response options:	Heterosexual or straight			Homosexual or gay/lesbian			Bisexual			Other		
	N	%	95% CI	N	%	95% CI	N	%	95% CI	N	%	95% CI
Overall	65,088	96.5	96.3–96.7	1,645	2.0	1.8–2.1	626	1.0	0.9–1.1	406	0.5	0.4–0.6
<i>Sex</i>												
Men	25,387	96.4	96.1–96.7	926	2.4	2.1–2.6	194	0.7	0.5–0.8	161	0.5	0.4–0.7
Women	39,701	96.6	96.3–96.9	719	1.6	1.5–1.8	432	1.3	1.1–1.5	245	0.5	0.4–0.6
<i>Age</i>												
18–25	5,092	94.8	93.9–95.6	100	1.8	1.3–2.4	137	2.6	2.0–3.2	41	0.8	0.4–1.1
26–45	29,285	96.6	96.3–96.8	789	2.2	2.0–2.4	292	0.8	0.7–1.0	161	0.4	0.3–0.5
46–64	30,711	97.2	97.0–97.4	756	1.8	1.6–1.9	197	0.5	0.4–0.6	204	0.6	0.4–0.7
<i>Race/ethnicity</i>												
White NH	51,920	96.7	96.4–96.9	1,415	2.1	1.9–2.2	461	0.9	0.8–1.0	251	0.4	0.3–0.5
Black NH	3,422	95.8	94.9–96.8	78	2.2	1.5–3.0	40	1.1	0.6–1.7	41	0.8	0.4–1.2
Hispanic	6,687	96.3	95.6–97.1	103	1.7	1.2–2.2	75	1.2	0.8–1.7	50	0.8	0.4–1.2
<i>Education</i>												
HS or less	21,183	96.9	96.5–97.3	284	1.4	1.1–1.6	188	1.0	0.7–1.2	180	0.8	0.6–1.0
Some coll	15,504	96.7	96.3–97.1	367	1.9	1.6–2.2	145	1.0	0.8–1.3	79	0.4	0.3–0.5
BA or more	28,320	96.1	95.8–96.4	993	2.5	2.3–2.7	293	1.0	0.8–1.2	146	0.4	0.3–0.5

Table 11.4 Number and percentage of respondents age 18–64 reporting gay, lesbian, or bisexual orientation by selected characteristics, Oregon BRFSS 2003–2007. Question is: Do you consider yourself to be...

Response options:	2003/4: Heterosexual (straight)			2003/4: Homosexual (gay or lesbian)			Bisexual			Other		
	N	%	95% CI	N	%	95% CI	N	%	95% CI	N	%	95% CI
Overall	34,740	96.8	96.5–97.0	639	1.5	1.4–1.6	494	1.5	1.3–1.7	102	0.3	0.2–0.3
<i>Sex</i>												
Men	13,787	97.3	97.0–97.6	262	1.5	1.3–1.7	127	1.0	0.8–1.2	37	0.3	0.2–0.4
Women	20,953	96.2	95.9–96.5	377	1.5	1.3–1.7	367	2.0	1.7–2.3	65	0.3	0.2–0.3
<i>Age</i>												
18–25	7,287	95.8	95.0–96.6	35	1.0	0.6–1.4	92	2.9	2.2–3.6	11	0.3	0.1–0.5
26–45	13,550	96.3	95.9–96.6	274	1.5	1.3–1.6	240	2.0	1.7–2.3	36	0.3	0.2–0.4
46–64	18,403	97.5	97.3–97.8	330	1.5	1.3–1.7	162	0.7	0.6–0.8	55	0.3	0.2–0.4
<i>Race/ethnicity</i>												
White	31,426	96.9	96.7–97.1	562	1.5	1.3–1.6	424	1.4	1.3–1.6	79	0.2	0.2–0.3
Nonwhite	3,314	96.7	94.9–96.5	77	1.7	1.2–2.2	70	1.8	1.3–2.4	23	0.7	0.3–1.1
<i>Education</i>												
HS or less	10,202	97.2	96.8–97.7	102	0.9	0.7–1.1	114	1.4	1.1–1.7	44	0.4	0.3–0.6
Some coll	9,784	96.8	96.4–97.2	154	1.4	1.1–1.7	138	1.6	1.3–1.9	26	0.2	0.1–0.3
BA or more	11,392	96.2	95.8–96.6	298	2.1	1.8–2.3	197	1.5	1.2–1.7	29	0.2	0.1–0.3

Regarding education, individuals with a bachelor’s degree or more were significantly more likely to identify as gay or lesbian than less educated individuals, while individuals with a

high school degree or less were significantly more likely to report they were ‘not sure’ about the category that best described them compared to more educated individuals.

Table 11.5 Number and percentage of respondents age 18–64 reporting gay, lesbian, or bisexual orientation by selected characteristics, California BRFSS 2006–2007^a. Question is: Which of the following best describes you? Would you say...

	Heterosexual			Gay or lesbian			Bisexual			Other		
	N	%	95% CI	N	%	95% CI	N	%	95% CI	N	%	95% CI
Overall	8,082	96.8	96.1–97.4	193	1.8	1.4–2.1	91	1.3	0.8–1.9	15	0.2	0.0–0.3
<i>Sex</i>												
Men	3,187	96.8	95.7–97.9	104	2.0	1.4–2.6	23	1.1	1.4–2.1	–	–	–
Women	4,895	96.7	96.0–97.5	89	1.5	1.0–2.0	68	1.5	1.0–2.1	–	–	–
<i>Age</i>												
18–25	656	96.1	94.4–97.8	–	–	–	22	2.4	1.2–3.6	–	–	–
26–45	3,409	96.7	95.6–97.8	77	1.8	1.3–2.4	40	1.3	0.3–2.2	–	–	–
46–64	4,017	97.2	96.5–97.9	107	1.9	1.4–2.4	29	0.8	0.3–1.3	–	–	–
<i>Race/ethnicity</i>												
White NH	4,798	96.1	95.3–96.9	149	2.5	1.9–3.1	55	1.2	0.7–1.7	11	0.2	0.0–0.4
Black NH	359	96.4	93.9–98.8	–	–	–	–	–	–	–	–	–
Hispanic	2,190	97.7	96.4–99.1	22	0.9	0.4–1.3	20	1.2	0.0–2.5	–	–	–
<i>Education</i>												
HS or less	2,636	97.7	96.4–99.0	27	0.6	0.2–1.0	23	1.4	0.2–2.6	–	–	–
Some coll	2,156	96.4	95.2–97.5	48	2.1	1.2–2.9	24	1.5	0.7–2.2	–	–	–
BA or more	3,247	95.9	95.0–96.9	118	2.9	2.1–3.7	43	1.1	0.6–1.6	–	–	–

^aPrevalence estimates are not reported when the relevant sample size was less than ten respondents

Table 11.6 Number and percentage of respondents age 18–64 reporting gay, lesbian, or bisexual orientation by selected characteristics, California Women’s Health Survey 2005–2007^a. Question is: Which of the following best describes you? Would you say...

Response options:	Heterosexual (straight)			Gay or Lesbian			Bisexual			Not sure		
	N	%	95% CI	N	%	95% CI	N	%	95% CI	N	%	95% CI
Overall	10,079	94.3	93.7–94.8	86	1.0	0.7–1.2	127	1.4	1.1–1.7	274	3.3	2.9–3.8
<i>Age</i>												
18–25	854	91.6	89.6–93.4	–	–	–	29	2.9	1.7–4.1	43	5.0	3.4–6.5
26–45	4,723	94.5	93.8–95.3	41	1.1	0.7–1.5	62	1.3	0.9–1.6	138	3.1	2.5–3.6
46–64	4,502	95.4	94.6–96.1	41	1.0	0.7–1.4	36	0.8	0.5–1.1	93	2.8	2.2–3.5
<i>Race/ethnicity</i>												
White NH	5,750	95.7	95.0–96.4	61	1.3	1.0–1.7	91	2.0	1.5–2.5	39	0.9	0.6–1.3
Black NH	536	95.2	92.8–97.7	–	–	–	–	–	–	12	2.4	0.8–4.1
Hispanic	3,039	92.0	90.9–93.1	14	0.4	0.2–0.6	21	0.7	0.3–1.0	207	6.9	5.9–7.9
<i>Education</i>												
HS or less	3,497	91.6	90.5–92.7	18	0.7	0.3–1.0	33	1.1	0.6–1.5	221	6.7	5.7–7.7
Some coll	2,789	96.1	95.1–97.1	26	1.1	0.6–1.6	33	1.5	0.9–2.2	21	1.3	0.6–1.9
BA or more	4,004	96.1	95.4–96.8	42	1.3	0.8–1.7	61	1.8	1.3–2.3	31	0.9	0.5–1.2

^aPrevalence estimates are not reported when the relevant sample size was less than ten respondents

In Table 11.2 I present the associated prevalence estimates from the only other nationally representative dataset with a direct question about sexual orientation, the NSFG. Recall that

the NSFG only sampled up to age 44, so the universe here is adults age 18–44. Also, males and females were sampled separately, so I present all results separately by sex for the NSFG.

For males, I find that of the 4,207 adults who gave a valid response to the sexual orientation question, 91.9% identified as heterosexual, 2.3% identified as homosexual, 1.8% identified as bisexual, and 4% identified as “something else”. For females, I find that of the 6,843 adults who provided a valid response to this question, 92% identified as heterosexual, 1.3% identified as homosexual, 2.9% identified as bisexual, and 3.8% identified as something else. Notably, these prevalence estimates for ‘homosexual’ and ‘bisexual’ are uniformly higher than those found in the NESARC, even when I restrict attention to same-age adults (e.g., 18–25 year olds or 26–44/45 year olds). Moreover, the prevalence of ‘something else’ responses for men is as large as ‘homosexual’ and ‘bisexual’ combined, and the same is nearly true for women. I revisit this issue below. Small samples do not permit us to say much about the differences by age in the NSFG, though the prevalence of women identifying as ‘bisexual’ in the NSFG is significantly larger among 18–25 year olds as compared to 26–44 year olds (4.6% versus 2.2%, respectively).

In Tables 11.3, 11.4, 11.5 and 11.6 I turn to evidence from the standardized state BRFs-based surveys from Massachusetts, Oregon, and California. Table 11.3 for Massachusetts from 2001 to 2008 shows that of the 67,765 individuals providing responses to the sexual orientation question, 96.5% identified as heterosexual or straight, 2% identified as gay or lesbian, 1% identified as bisexual, and 0.5% identified as ‘other’. Men were significantly more likely to identify as gay compared to women (2.4% versus 1.6%, respectively), while women were significantly more likely to identify as bisexual compared to men (1.3% versus 0.7%, respectively). Younger respondents age 18–25 were significantly more likely to identify as bisexual compared with older respondents age 26–45, while older individuals age 46–64 were significantly less likely to identify as bisexual compared with 26–45 year olds (and 18–25 year olds). There were no significant differences by race, though individuals with at least a bachelor’s degree were significantly more likely to identify as gay than less educated respondents. Although there was no

education gradient in bisexual prevalence estimates, individuals with a high school degree or less were significantly more likely to report ‘other’ than more highly educated individuals.

In Table 11.4 for the 2003–2007 Oregon BRFs data, I find that of the 35,975 individuals providing valid responses to the sexual orientation question, 96.8% identified as heterosexual, 1.5% identified as gay or lesbian, 1.5% identified as bisexual, and 0.3% identified as ‘other’. Women were significantly more likely to identify as bisexual compared to men (2% versus 1%, respectively). As in the Massachusetts data, older individuals age 46–64 were significantly less likely to identify as bisexual compared with younger individuals. There were no significant differences by race, though I again found that more highly educated individuals were significantly more likely to identify as gay or lesbian than less educated individuals in the Oregon data.

California BRFs results for 2006–2007 are presented in Table 11.5 and show that among the 8,381 adults providing valid responses to the sexual orientation question, 96.8% identified as heterosexual, 1.8% identified as gay or lesbian, 1.3% identified as bisexual, and 0.2% identified as ‘other’. Due to small sample sizes, very few of the differences in prevalence estimates by demographic group are statistically significant, though I do find that white non-Hispanic individuals are significantly more likely to report being gay compared with Hispanic individuals (2.5% versus 0.9%, respectively). I also find that individuals with a high school degree or less are significantly less likely to identify as gay compared with more educated individuals.

Finally, in Table 11.6 I present the results from the California Women’s Health Survey from 2005 to 2007, which uses the same basic questionnaire as the California BRFs. These data show that of the 10,566 adult women providing valid responses to the sexual orientation question, 94.3% identified as heterosexual, 1% identified as gay or lesbian, 1.4% identified as bisexual, and 3.3% identified as ‘unsure’. Younger adults age 18–25 were significantly more likely than older respondents to identify as bisexual. Hispanic respondents were significantly more likely than white or

black non-Hispanic respondents to report being 'unsure', while white non-Hispanic adults were significantly more likely than Hispanic adults to identify as bisexual. Finally, I find a strong education gradient in the prevalence of 'unsure' responses in the California WHS data: individuals with a high school degree or less were significantly more likely than more highly educated individuals to report being 'unsure' in response to the sexual orientation question.

Discussion

There are several notable findings and patterns in the prevalence estimates reported in Tables 11.1, 11.2, 11.3, 11.4, 11.5, and 11.6. First, there is a striking similarity in the range of prevalence estimates for gay men and lesbians age 18–64 (or 18–44 in the NSFG). Across all the datasets, the estimates of the prevalence of gay men and lesbians fall within a narrow range of 1–2.3%. The stability exhibits itself across different question wordings, different response options, different geography and slightly different time periods. Thus, there is a remarkable level of agreement regarding the prevalence of self-identified gay men and lesbians. As has been pointed out repeatedly in the literature, the true prevalence of gay men and lesbians is lower than the oft-cited but misinterpreted 10% figure commonly attributed to Kinsey. My estimate is very close to prevalence estimates from other credible representative surveys of sexual orientation identity, such as the National Health and Social Life Survey, which was fielded much earlier (1992) than the surveys studied here (Laumann et al. 1994).

Second, bisexual prevalence varies across datasets but is consistently nontrivial in magnitude. In combined adult samples of men and women, the prevalence of bisexuals was at least half as large as the prevalence of gay men and lesbians in every dataset, and in the Oregon BRFS data the prevalence estimates were identical at 1.5% of the population.

Third, there is consistency across datasets that prevalence differs by sex: men are not less likely than women to identify as gay in any of the datasets. In most surveys, men are somewhat more

likely than women to identify as gay, and in the Massachusetts BRFS data this difference was statistically significant. Conversely, women are no less likely and usually are more likely than men to identify as bisexual, and these differences were statistically significant in the NESARC, Massachusetts BRFS, and Oregon BRFS data. Moreover, women are at least as likely to identify as bisexual as they are to identify as gay in every dataset except the Massachusetts BRFS, and in the NSFG for young women age 18–44, the prevalence of bisexuals was significantly larger than the prevalence of lesbians.

Fourth, the NSFG consistently produces higher prevalence estimates for all the non-heterosexual response options, even after taking into account its younger sample (age 18–44 versus age 18–64 in the other surveys). For example, nearly 1 in 20 females (4.6%) age 18–25 identified as bisexual in the NSFG. Moreover, the prevalence of "something else" responses is as large as the combined prevalence of homosexual and bisexual responses for both men and women. Other research has found that the vast majority of these "something else" respondents report primarily different-sex attractions (SMART 2009), suggesting that lack of familiarity with the terms may be an issue in these data. It is notable, however, that there were high prevalence estimates for the 'homosexual' response option given that it did not include the words "gay" or "lesbian". It could be that the series of extremely detailed questions about sexual practices in the NSFG that preceded the sexual orientation question may have primed respondents to be thinking about their sexual orientation identity in a way that is not usually the case when the question is given little introduction in a section on demographics. This is one area where methodological research would be particularly valuable.

Finally, and related to the point immediately above, the 'other', 'not sure', and 'something else' categories are clearly important (though not necessarily advisable from a survey design standpoint) response options for understanding sexual orientation. Notably, the relative importance of these 'fourth categories' varied substantially across datasets: while just 0.2% of the California-BRFS

respondents chose the ‘other’ response, fully 3.3% of the California WHS respondents and 4% of the NSFG respondents chose the ‘not sure’ or ‘something else’ options, respectively. Whether and to what extent these responses are driven by lack of understanding of terms, dissatisfaction with offered terms, sexual questioning, or some other phenomenon is difficult to know but important for survey design and for interpreting prevalence estimates.

Conclusion and Remaining Knowledge Gaps

Many questions related to the prevalence of gay men and lesbians remain unanswered, largely due to data challenges and limitations discussed above. Chief among these are important methodological questions regarding how survey mode, question placement, question wording, and other logistical issues affect the prevalence estimates (for a discussion of these issues, see SMART 2009). Experimental manipulation of some of these features within a large survey would confirm or rule out some of the hypotheses raised in the literature and above about the best way to ask questions about sexual orientation. The differences across surveys in the relative importance of the “fourth category” of response options (i.e. ‘other’, etc.) highlights the potential benefits of standardization.

There are also many substantive questions about how prevalence estimates vary across other demographic variables not studied here, such as geographic location. The sample sizes in the NESARC and NSFG are too small to permit meaningful estimation of state-specific prevalence estimates, though inclusion of a sexual orientation question on the core of a large survey such as the BRFSS would achieve this goal. And as seen above in the tables, race/ethnicity differences in the prevalence of gay men and lesbians are also made difficult by small numbers of racial and ethnic minorities in most datasets, resulting in imprecise prevalence estimates for these subgroups. Issues with language, translation of terms, and lack of culturally relevant response options are also important, and are discussed

elsewhere (see, for example, Gates and Ost 2004; Baumle 2010, and others).

We also need much more research on how prevalence estimates vary across countries, as there are only a handful of countries that include questions about sexual orientation on large-scale surveys. The information that does exist, however, returns generally similar prevalence estimates to those reported above for the United States. Canada, for example, has included a direct question about sexual orientation in its Canadian Community Health Survey since Cycle 2.1 fielded in 2003. Those data indicated that 1% of adults identified as gay or lesbian while 0.7% identified as bisexual (Statistics Canada 2004). The UK Office for National Statistics also included a sexual orientation question on the 2009/10 Integrated Household Survey (IHS) with a sample size of over 230,000 individuals. Those data indicated that 1% of adults age 16 and older identified as gay or lesbian while 0.5% identified as bisexual (Joloza et al. 2010). The striking similarity of these figures with the U.S.-based datasets presented here is perhaps not surprising given that Canada, the U.K., and the U.S. share many cultural norms. Gates (2012) also reports similar prevalence estimates from similar datasets in Norway and Australia. For example, the 2010 Norwegian Living Conditions Survey indicated that 0.7% of adults age 16 and older reported being lesbian or gay, while 0.5% reported being bisexual. The 2001/2002 Australian Study of Health and Relationships indicated that among 16–59 year old men, 1.9% identified as gay while 0.9% identified as bisexual; among 16–59 year old women, 0.8% identified as lesbian while 1.4% identified as bisexual. Overall, the existing cross-country evidence returns quite similar prevalence estimates, though more research and data are needed from places with different language, cultural, and social norms and values.

Finally, more research is needed on the prevalence of partnership among gay men and lesbians, in part because some of the largest samples of gay men and lesbians in social science data (including many used in this volume) come from data sources that identify sexual minorities only through intra-household relationships. These

data, by construction, can only identify samples of sexual minorities in couples. The degree to which same-sex couples in these data are representative of sexual minorities more broadly is an important question for demographic research on sexual orientation and depends, in part, on partnership prevalence among gay men and lesbians. Unfortunately, there are very few credible estimates of partnering among sexual minorities; such estimates require rich data on both sexual orientation and partnership at the individual level. Carpenter and Gates (2008) used data from the 2001, 2003, and 2005 California Health Interview Surveys with information on self-reported sexual orientation and found that 37% of gay men were partnered, while 51% of lesbians were partnered (defined as living with a partner in a marriage-like relationship). In contrast, Black et al. (2000) report lower partnership rates from the earlier, nationally representative National Health and Social Life Survey (fielded in 1992): 18.5% of self-identified gay men and 41.6% of self-identified lesbians were partnered (defined as cohabiting with a partner with whom there was a sexual relationship). Finally, Black et al. (2007) use data from the 1989 to 2004 waves of the nationally representative General Social Survey, which includes information on same-sex sexual behavior, and find that 50% of men and 62% of women who had exclusively same-sex sex in the past year were partnered (defined indirectly as having a “regular” sex partner). Although the small literature has produced a wide range of estimates, partnership rates for lesbians are consistently estimated to be higher than those for gay men. Much more research is needed to understand how partnership prevalence among sexual minorities varies across geographic locations, time periods, and subpopulations; how selection into and out of partnership varies with observable characteristics for sexual minorities relative to heterosexuals; whether and to what extent the relationship between partnership and cohabitation differs by sexual orientation; and how measurement choices about marital status and cohabitation affect our estimates of partnership prevalence among sexual minorities.

Despite these knowledge gaps, the increasing availability of representative data at the state and national level have allowed a systematic look at the prevalence of gay men and lesbians both overall and by key characteristics such as age and education. Relative to previous work, my study has used more recent and larger datasets and has tried to document common patterns across multiple sources. Perhaps remarkably, similar prevalence estimates emerge: 1–2.3% of adults identify as gay or lesbian, while 0.7–2.9% of adults identify as bisexual. These estimates are lower than the anecdotally cited 10% figure but are quite similar to previous credible demographic estimates using similar data and methods (Black et al. 2000).

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Gary J. Gates

Introduction

Perhaps more than any other demographic group, the lesbian, gay, bisexual, and transgender (LGBT) population presents challenges associated with interpreting demographic patterns in relation to what is commonly referred to as “the closet.” Regardless of whether this group is measured based on sexual orientation identity, sexual behavior, or sexual attraction, the ongoing social stigma directed toward the LGBT population means that some will be reluctant to identify as LGBT or acknowledge same-sex behaviors or attractions for fear of disclosure and the perceived negative outcomes associated with it. As a result, LGBT demographic analyses must always acknowledge that the patterns apply to the “visible” LGBT population and that there may be differences between that group and those who chose not to disclose.

This challenge is perhaps no more evident than in assessments of the geographic distribution of the LGBT population. With most demographic groups, it seems reasonable to interpret geographic distributions as an indication of where people choose to live. But for the LGBT population, geographic distributions may be as much

about where people choose to disclose as they are about choice of location.

Unfortunately, U.S. national data that allow for an exploration of cross-state variation in the location patterns of the LGBT community do not exist. However, since 1990, Decennial Census data have provided fairly detailed information about same-sex couples and where they live. This chapter will explore changes in the geographic distribution of same-sex couples over time, as well as consider differences in geographic patterns by sex, age, race/ethnicity, and child-rearing. In addition to the issue of visibility and disclosure, it is important to remember that observed patterns in these analyses may be subject to bias because they only reflect the demographic characteristics of those in cohabiting relationships with a same-sex partner. As a result, they may not provide much insight into the geography of the transgender population or the bisexual population, many of whom may have a different-sex partner. While same-sex couples may offer a better proxy for assessing characteristics of the gay and lesbian population, Carpenter and Gates (2008) find that more than half of gay men and a third of lesbians are not in a cohabiting relationship. Therefore, bias is still a potential problem.

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Data and Methodology

Identifying Same-Sex Couples in Census Bureau Data

In Census 2010, same-sex couples are identified in households where Person 1 describes his or her relationship with another adult of the same sex as either a “husband/wife” or an “unmarried partner.” Procedures used by the Census Bureau to edit and process same-sex couple data have varied over time. In 1990, same-sex couples who identified a partner as a “husband/wife” were not classified as same-sex couples at all, as it was assumed that these couples were different-sex spouses where one partner’s sex was miscoded. In 2000 and again in 2010, the Census Bureau included same-sex spouses among same-sex couples.

Measurement Error within Identified Same-Sex Couples

Black et al. (2007), O’Connell and Gooding (2007), and Gates and Steinberger (2011) all show that the classification of same-sex spouses as same-sex unmarried partners creates a serious measurement problem, as evidence suggests that a portion of identified same-sex spouses are actually different-sex married couples who erred and inadvertently miscoded the sex of one of the spouses, thus appearing to be a same-sex couple. Using Census data that provides the probability that a given name is male or female, O’Connell and Feliz (2011) consider all observed same-sex couples from Census 2010 and estimate that 28% are likely miscoded different-sex couples. The report also provides “preferred” estimates for each state and the District of Columbia of the number of same-sex couples by their sex, designated relationship status (“husband/wife” or “unmarried partner”), and whether or not the household included “own” children under age 18 (biological or adopted children of Person 1 in the household). The Census Bureau has not released new estimates for these groups at the county, city, or census tract level. The procedure described below will rely on the state-level preferred estimates,

along with the original data documented in the Census 2010 SF-1 files to develop adjusted estimates at lower levels of geography.

Adjustment Procedure

The adjustment procedure involves three steps as follows:

1. Develop estimates of the rate of error (the percent of different-sex couples who miscode the sex of a partner or spouse) for each sub-state level of geography (e.g., county, city, or census tract).
2. Apply the error to different-sex couples and subtract the number of miscoded different-sex couples from comparable same-sex couples in each geographic area to create an adjusted distribution of same-sex couples across sub-state geographies in each state.
3. Apply that distribution to the Census state-level preferred estimates of same-sex couples to develop adjusted estimates for sub-state geographies.

Develop Estimates of Error Rate for Sub-state Geographies

In their assessment of changes between the 2007 and 2008 American Community Surveys (ACS), O’Connell and Lofquist (2009) report that the format of the surveys had an impact on the potential for making errors. They note that miscoding of sex was more prevalent in the 2007 survey than in the 2008 format. The 2007 survey had respondents providing information about members of the household on a grid. The name of each person in the household was at the beginning of a row and subsequent columns corresponded to questions about that person (e.g., relationship to Person 1, age, sex). The 2008 survey was formatted such that respondents placed the name of each person in the household on a separate page and questions about that person were ordered along columns on that page. On the whole, the 2008 format performed substantially better than the 2007 grid format.

In the 2010 Decennial Census, the original forms mailed to all households in the United States follow the format of the 2008 ACS.

Nationally, the Census Bureau reports that 74% of households completed these forms. The remaining 26% of households received a follow-up visit from a Census enumerator. The form completed in this process largely followed the matrix format of the ACS prior to 2008. This implies that the error rate for sex miscoding among different-sex married couples in the 2010 Census is a combination of a relatively low error among those who completed a mail-in form and a higher error among those who completed a follow-up form.

O'Connell and Feliz (2011) report a sex miscoding rate among different-sex couples of 3 per 1,000 households when respondents used the mail-in survey and 10 per 1,000 households when they used the non-response follow-up survey. The national participation rate figures imply that 74% of households used the mail-in form with a 3 per 1,000 error rate, and 26% of households used the follow-up survey with a 10 per 1,000 error rate. This implies an overall national error rate among different-sex couples of approximately 4.8 errors per 1,000 households $((3 \times 0.74) + (10 \times 0.26))$. At the completion of the 2010 Census, the Census Bureau released mail-in participation rates for states, counties, cities, and census tracts. So it is

possible to calculate an estimated error rate for all of these geographic areas.

Develop Adjusted Distribution of Same-Sex Couples Across Counties, Cities, and Census Tracts

The procedure for developing an adjusted distribution of same-sex couples across sub-state geographies relies on the following assumptions:

- The overall participation rate for a given geography is the same as the participation rate for different-sex couples
- Gates and Steinberger (2011) show that most errors are likely in the sex of the non-householder spouse. The procedure assumes that the sex miscodes occur only in the coding of the "husband/wife" or "unmarried partner", not of the householder.
- The probability of miscoding sex among different-sex married couples does not vary by the sex of the householder.

The data adjustment procedure begins with the following variables derived from official Census Bureau tabulations from the Census 2010 SF-1, PCT15 (with the exception of the mail-in participation rate).

Mailinpt	% of households who used the Census 2010 mail-in survey
SS	Same-sex couples
SSM	Same-sex male couples
SSM_ch	Same-sex male couples raising own children
SSF	Same-sex female couples
SSF_ch	Same-sex female couples raising own children
DSMARM	Different-sex married couples where the householder was male
DSMARM_ch	Different-sex married couples raising own children where the householder was male
DSMARF	Different-sex married couples where the householder was female
DSMARF_ch	Different-sex married couples raising own children where the householder was female
DSUMPM	Different-sex unmarried couples where the householder was male
DSUMPM_ch	Different-sex unmarried couples raising own children where the householder was male
DSUMPF	Different-sex unmarried couples where the householder was female
DSUMPF_ch	Different-sex unmarried couples raising own children where the householder was female

These variables are used to create a set of temporary variables. These temporary variables all reduce official estimates by the rate at which different-

sex couples in a given geographic area (g) miscode the sex of the spouse or partner. Of note, calculations that yield a negative result are coded as zero.

$error_g = (0.003 * Mailinct_g) + (0.01 * (1 - Mailinct_g))$	Error rate among different sex couples in a given level of geography (g)
$SSMt_g = SSM_g - (error_g * (DSMARM_g + DSUMPM_g))$	Official tabulation of same-sex male couples reduced by the error rate applied to the official tabulation of comparable different-sex couples with a male householder
$SSFt_g = SSF_g - (error_g * (DSMARF_g + DSUMPF_g))$	Official tabulation of same-sex female couples reduced by the error rate applied to the official tabulation of comparable different-sex couples with a female householder
$SSMt_ch_g = SSM_ch_g - (error_g * (DSMARM_ch_g + DSUMPM_ch_g))$	Official tabulation of same-sex male couples with children reduced by the error rate applied to the official tabulation of comparable different-sex couples with children and a male householder
$SSFt_ch_g = SSF_ch_g - (error_g * (DSMARF_ch_g + DSUMPF_ch_g))$	Official tabulation of same-sex female couples with children reduced by the error rate applied to the official tabulation of comparable different-sex couples with children and a female householder

The temporary variables are used to calculate the distribution of same-sex couples, adjusted according to the estimated error rate in a given geographic area(g), across all such geographic areas in the state as follows:

$$pSS_a^g = \frac{(SSMt_a^g + SSFt_a^g)}{\sum_g (SSMt_a^g + SSFt_a^g)}$$

Apply Adjusted Distribution to Census Preferred Estimates

This adjusted distribution is then applied to the preferred estimates of same-sex couples (by sex and child-rearing) in the state. So, for example, if 15% of the total number of adjusted same-sex couples (SSMt_a^g+SSFt_a^g) lived in City Y and the Census Bureau reported a preferred estimate of

1,000 same-sex couples in the state, then the adjusted figures would assume that 150 same-sex couples live in City Y.

For each geographic area (g), the number of same-sex couples per 1,000 households is then determined as follows:

$$\text{SSper1,000}^g = \left(\frac{p\text{SS}_a^g * \text{SS}_{\text{preferred}}}{\text{Households}^g} \right) * 1,000$$

The calculation applies the distribution of the adjusted same-sex couples over sub-state geographic areas to the preferred estimate of same-sex couples in the state to get an adjusted number of same-sex couples in each geographic area. It then divides that by the total number of households in the area and multiplies by 1,000 to get the adjusted number of same-sex couples per 1,000 households in each geographic area. This basic procedure is applied to male couples, female couples, and couples with children to get adjusted figures for all of these groups within sub-state geographies.

Other Data Sources Relating to the Geographic Distribution of Same-Sex Couples

This chapter also presents analyses of data drawn from the 1992 National Health and Social Life Survey (NHSLs) and the General Social Survey (GSS), which has been fielded annually or biannually since 1972. Both data sources are national probability samples of adults. The NHSLs included a sexual orientation identity question, as did the GSS, in the 2008 and 2010 surveys. Since 1973, the GSS has asked about attitudes associated with same-sex sexual behavior.

Information about the race and ethnicity and age of individuals in same-sex couples has not been released from Census 2010 data. Findings presented here about race and ethnicity and age are drawn from the American Community Survey Public Use Microdata Samples (PUMS). In order to get sufficient sample sizes at the state-level, analyses combined PUMS data from 2005 to 2010.

Location Patterns Over Time

In general, Western and Northeastern states are historically considered to be the most supportive of the LGBT community. Southern and Midwestern states have tended to be more socially conservative and are understood to have relatively lower levels of broad LGBT acceptance. In the 1991 General Social Survey, 89% of adults in the South and 85% in the Midwest said that same-sex sexual relations were always or almost always wrong. By 2010, that figure had dropped to 60% in the South and 47% in the Midwest. In Western states, the figure moved from 69% to 40% and it went from 72% to just 35% in Eastern states. Clearly, the last two decades have been a period of increasing LGBT acceptance, even in the most conservative parts of the country.

Given these patterns, it is not surprising that in the 1992 NHSLs (see Fig. 12.1), lesbian, gay, and bisexual (LGB) individuals were more than twice as likely to live in the West as their heterosexual counterparts (45% v. 21%, significantly different at $p < 0.01$) and much less likely to live in the South (22% v. 35%, $p < 0.05$) and Midwest (12% v. 24%, $p < 0.01$). In 2010, LGB people were still slightly more likely to live in the East and West when compared to heterosexual adults, but the differences were much less pronounced and none were statistically significant.

While this might reflect some broad migration patterns whereby LGB people have disproportionately moved from the West to the Midwest and South over the last two decades, evidence suggests that it is more likely a consequence of LGB individuals in Southern and Midwestern states becoming more willing to self-identify as such over time. Suggestive evidence that this may be the case is found in the 2008/2010 GSS, where LGB adults were just as likely as heterosexuals to say they live in the same city today as they did when they were age 16, suggesting that mobility does not differ very much between the two groups.

Same-sex couple data from the 1990, 2000, and 2010 U.S. Census offer further evidence of the increasing visibility of LGB people in more conservative parts of the country. In 1990, the Census

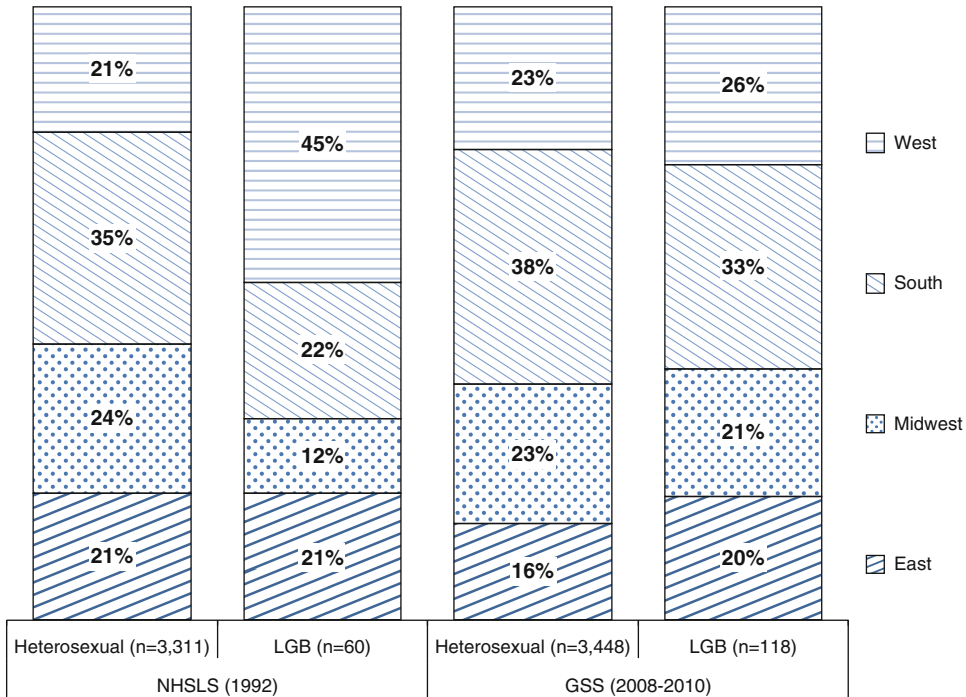


Fig. 12.1 Regional distribution of LGB versus heterosexual adults, 1992 NHLS versus 2008/2010 General Social Survey

Table 12.1 Top ten states ranked by number of same-sex couples per 1,000 households, Census 1990, 2000, and 2010

1990		2000		2010	
District of Columbia	8.9	District of Columbia	13.6	District of Columbia	18.1
California	3.5	California	5.8	Vermont	8.4
Washington	2.3	Vermont	5.4	Massachusetts	8.0
Massachusetts	2.3	Washington	5.0	California	7.8
New York	2.1	Massachusetts	4.7	Oregon	7.8
Oregon	2.0	Oregon	4.5	Delaware	7.7
Minnesota	1.9	Nevada	4.4	New Mexico	7.4
Vermont	1.8	New York	4.3	Washington	7.3
Maine	1.7	Arizona	4.3	Hawaii	7.1
Maryland	1.7	Colorado	4.1	Maine	7.1

tabulated more than 145,000 same-sex couples. By 2000, the number had more than doubled to nearly 360,000. In 2010, nearly 650,000 same-sex couples were counted. In 1990, less than half of U.S. counties reported a same-sex couple, compared to 93% of counties in 2010.

Rankings of the top ten states with the highest concentrations of same-sex couples are shown in Table 12.1. In general, the lists are dominated by Western and Northeastern states. The District of

Columbia tops the rankings in each of the 3 years. California, Washington, Massachusetts, Oregon and Vermont rank in the top ten in each of the 3 years.

Rankings of states by the factor of change in the number of reported same-sex couples between Census years are shown in Table 12.2. From 1990 to 2010, Wyoming reported nearly 22 times more same-sex couples. South Dakota reported 15 times more couples, followed by

Table 12.2 Top ten states ranked by the factor of increase from 1 year to another, Census 1990, 2000, and 2010

1990 to 2010		1990 to 2000		2000 to 2010	
Wyoming	21.9	Wyoming	12.6	West Virginia	4.3
South Dakota	15.2	South Dakota	5.1	Montana	3.4
Delaware	12.5	Delaware	5.8	South Dakota	3.0
Nevada	11.6	Nevada	5.4	North Dakota	2.9
Idaho	11.5	Idaho	4.9	Iowa	2.9
Utah	9.7	Utah	4.6	Oklahoma	2.6
West Virginia	9.3	West Virginia	2.1	Kentucky	2.5
North Carolina	9.3	North Carolina	4.2	Arkansas	2.4
Arkansas	8.4	Arkansas	3.5	Idaho	2.3
Kentucky	8.3	Kentucky	3.4	New Hampshire	2.3

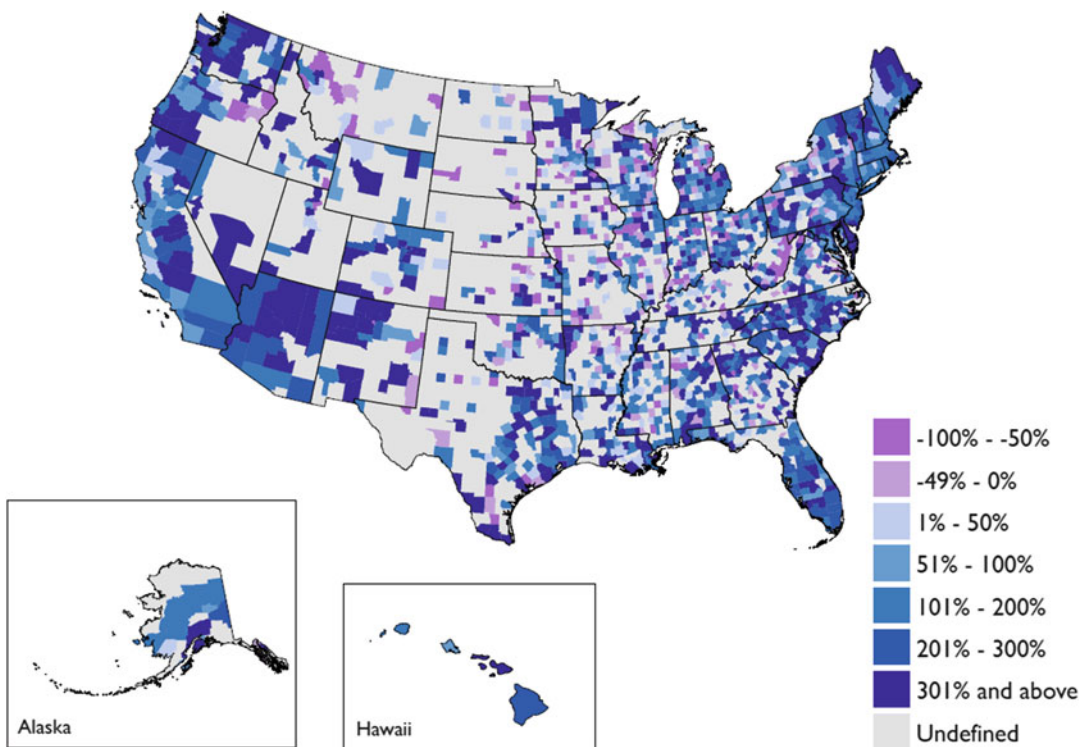


Fig. 12.2 Percent change in same-sex couples from 1990 to 2000, by county

Delaware with 12.5 times more couples, Nevada saw increases by a factor of 11.6 and Idaho was 11.5. The remainder of the top ten includes Utah, West Virginia, North Carolina, Arkansas, and Kentucky. As this list demonstrates, Mountain and Southern states (often those that are more sparsely populated) tend to report the largest increases in same-sex couples.

Between 1990 and 2000 (see Fig. 12.2), counties showing the biggest increases in reported same-sex couples tended to be those that were just inland of coastal regions on both coasts. Relatively high levels of change were observed in many Southern and Midwestern counties. More modest levels of increase were observed in New England and along the West coast.

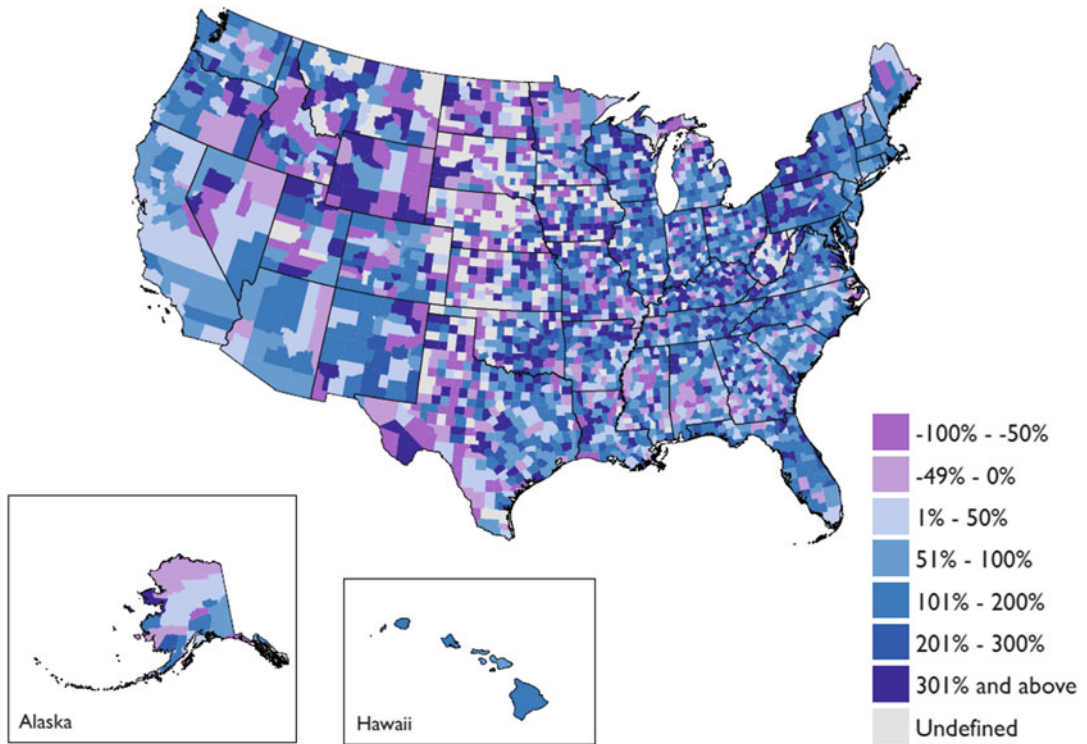


Fig. 12.3 Percent change in same-sex couples from 2000 to 2010, by county

Between 2000 and 2010 (see Fig. 12.3), high levels of change were more pronounced in the interior regions of the country, throughout counties in Southern, Midwestern, and Mountain states. Like the NHSLs/GSS comparison, the interpretation of these changes evidences an increased willingness to report being in a same-sex couple in more socially conservative parts of the country.

Location Patterns of Same-Sex Couples, Census 2010

Despite the changes observed over time, it remains true that New England and Western states are home to the highest concentrations of same-sex couples among all households (see Fig. 12.4). However, virtually every part of the country includes areas with relatively high concentrations of same-sex couples.

The top ten counties ranked by the number of same-sex couples per 1,000 households (see Table 12.3) include counties in California (San Francisco ranks first) and Oregon (Multnomah) in the West; Massachusetts (Hampshire), New York (Manhattan), Delaware (Sussex) and Washington, DC in the Northeast; Florida (Monroe) and Georgia (DeKalb) in the South; and New Mexico (Santa Fe) and Colorado (Denver) in the Mountain states.

Top ranked large cities (populations exceeding 500,000) include two cities in Texas (Dallas and Austin) along with Columbus, Ohio. Four Midwestern cities rank in the top ten among medium sized cities (populations between 250,000 and 500,000). These include Minneapolis, St. Louis, Saint Paul, and Kansas City (MO). Same-sex couples are the most concentrated in many small cities (populations less than 250,000). Most of the top ten small cities have concentrations of same-sex couples that are more than ten times higher than the national

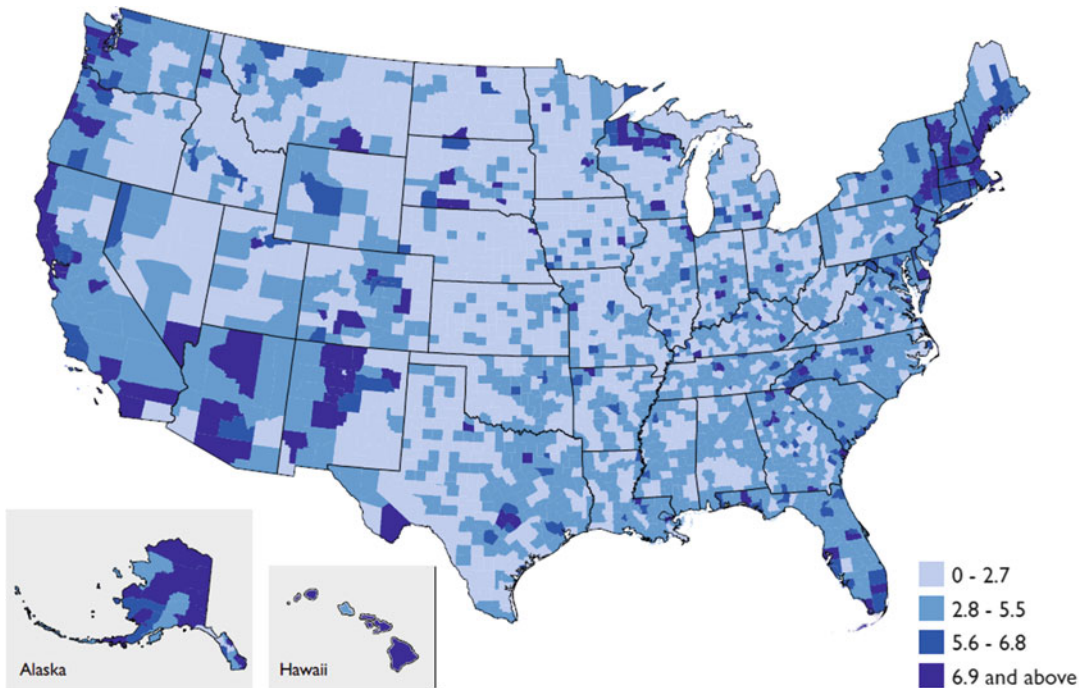


Fig. 12.4 Same-sex couples per 1,000 households, by county, Census 2010

Table 12.3 Top ten counties and large, medium, and small cities ranked by number of same-sex couples per 1,000 households, Census 2010

Counties	Cities						
	Population > 500 K		Population 250–500 K		Population < 250 K		
San Francisco County, CA	30.2	San Francisco, CA	30.2	Oakland, CA	21.8	Provincetown, MA	148.1
Hampshire County, MA	19.7	Seattle, WA	23.1	Minneapolis, MN	21.7	Wilton Manors, FL	125.3
Monroe County, FL	18.8	Portland, OR	19.2	Atlanta, GA	19.7	Palm Springs, CA	107.3
District of Columbia, DC	18.1	Washington, DC	18.1	Long Beach, CA	19.1	Rehoboth Beach, DE	100.0
Multnomah County, OR	16.8	Denver, CO	15.6	St. Louis, MO	14.1	Guerneville, CA	80.4
Manhattan, NY	16.7	Boston, MA	14.7	Sacramento, CA	13.0	West Hollywood, CA	62.1
Santa Fe County, NM	15.5	Dallas, TX	12.2	New Orleans, LA	10.7	Pleasant Ridge, MI	54.8
Denver County, CO	15.4	San Diego, CA	12.2	St. Paul, MN	10.6	Rancho Mirage, CA	52.3
Sussex County, DE	15.4	Austin, TX	11.8	Tampa, FL	10.4	New Hope, PA	50.0
DeKalb County, GA	15.1	Columbus, OH	11.4	Kansas City, MO	10.2	Oakland Park, FL	49.4

Table 12.4 Top ten counties and metropolitan areas ranked by number of female and male same-sex couples per 1,000 households, Census 2010

Counties				Metropolitan Areas			
Female		Male		Female		Male	
Hampshire, MA	16.4	San Francisco, CA	24.8	Ithaca, NY	9.0	San Francisco-Oakland-Fremont, CA	8.7
Franklin, MA	11.6	Monroe, FL	14.4	Santa Fe, NM	7.6	Santa Fe, NM	7.9
Tompkins, NY	9.0	Manhattan, NY	13.8	Springfield, MA	7.4	Santa Rosa-Petaluma, CA	5.6
Juneau City and Borough, AK	8.1	District of Columbia	13.4	Santa Cruz-Watsonville, CA	7.1	Barnstable Town, MA	5.5
Multnomah, OR	7.9	Denver, CO	11.2	Burlington-South Burlington, VT	6.6	Miami-Fort Lauderdale-Pompano Beach, FL	5.3
Windham, VT	7.7	St. Louis city, MO	10.9	Santa Rosa-Petaluma, CA	6.5	Austin-Round Rock-San Marcos, TX	5.3
Santa Fe, NM	7.6	Columbia, NY	10.1	Eugene-Springfield, OR	6.3	Ann Arbor, MI	5.1
Chittenden, VT	7.4	Arlington, VA	9.6	Olympia, WA	6.2	Kingston, NY	5.0
Santa Cruz, CA	7.1	Suffolk, MA	9.5	Barnstable Town, MA	5.7	Seattle-Tacoma-Bellevue, WA	4.9
Taos, NM	6.9	DeKalb, GA	9.5	Albuquerque, NM	5.6	Asheville, NC	4.7

average of about five couples per thousand households. In Provincetown, Massachusetts, nearly 15% of all households are a same-sex couple. These small cities also include towns in Michigan (Pleasant Ridge) and Pennsylvania (New Hope).

The small cities with high concentrations of same-sex couples are also dominated by vacation and retirement destinations. Provincetown (MA), Wilton Manors (FL), Palm Springs (CA), Rancho Mirage (CA), and Oakland Park (FL) all fall into that category.

Location Patterns Among Different Groups of Same-Sex Couples, Census 2010

Location patterns of same-sex couples differ substantially by sex, child-rearing status, race/ethnicity, and age. Many of the differences may be a function of economic status. The fact that men tend to have higher earnings than women may at least partially explain why they are more likely to live in more expensive urban locations. While 91% of male same-sex couples live in an urban area, the figure for women is 88%. Female

couples are also much more likely than their male counterparts to be raising a child under age 18 in the home (28% v. 10%, respectively). This could be another factor in why they are less likely to cluster in more urban areas that are less child-friendly. Racial/ethnic minorities within same-sex couples tend to evidence location patterns more consistent with those of racial and ethnic minority communities than with patterns observed among all same-sex couples. Similarly, same-sex couples that include seniors are more prevalent in areas frequented by retirees.

Location Differences by Sex

Female and male couple location patterns differ not only along the dimension of urban versus rural. Perhaps in part due to male couples being more urban, they evidence much higher levels of overall concentration than female couples. Rankings of counties by the number of female and male same-sex couples per thousand households are shown in Table 12.4. The top counties for male couples are substantially more urban than their female counterparts. With the exception of Monroe County in Florida (home to Key West), all of the top ten counties for male couples are within urban areas, including San

Francisco, New York City, Washington, DC, Denver, St. Louis, Boston, and Atlanta. Conversely, high-ranking counties for female couples include less urban areas in Western Massachusetts (Hampshire and Franklin), Oregon (Multnomah), Alaska (Juneau), two counties in Vermont (Windham and Chittendham), two in New Mexico (Santa Fe and Taos), and Santa Cruz county in California, which is in a less densely populated area of the state between Los Angeles and San Francisco.

Top ranked metropolitan areas by concentration of female and male couples are shown in Table 12.4. This list demonstrates that not all areas with high concentrations of male couples are large urban areas. Smaller metropolitan areas like Santa Fe, NM, Santa Rosa, CA, Barnstable (Cape Cod), MA, Ann Arbor, MI, Kingston, NY, and Asheville, NC all rank in the top ten. But so do much larger metropolitan areas like San Francisco, Miami, Austin, and Seattle, which all have populations of well over a million. None of the top ten metro areas for female couples has a population above a million. In fact, the average population of the top ten metros for male couples is nearly 1.7 million compared to just 360,000 for the top-ranked metros for female couples. Top metro areas for female couples include Ithaca, NY, Santa Fe, NM, Springfield, MA, Santa Cruz, CA, and Burlington, VT. Metropolitan areas tend to be multi-county regions that include a central urban core along with much more suburban areas that constitute the commuting shed. This may explain why the male and female couples do not evidence much difference in overall concentration since the areas tend to constitute a much wider and more consistent population distribution than that of single counties.

Location Differences by Child-Rearing

Same-sex couples are more likely to be raising children in areas with lower concentrations of same-sex couples. This pattern is best highlighted by comparing maps from Figs. 12.4 and 12.5. Darker counties in Fig. 12.5 are places where a higher percentage of same-sex couples are

raising children while darker counties in Fig. 12.4 are where same-sex couples comprise a higher portion of households. In general, child-rearing is more common in the socially conservative South, Midwest, and Mountain States, while same-sex couples are more concentrated in the Northeast and West.

The distinctive geographic patterns associated with childrearing are in part a function of how those in same-sex couples came to be parents. While more than 15,000 same-sex couples are currently raising an adopted child under age 18 (according to my analyses of data from the 2010 American Community Survey), nearly 74,000 same-sex couples are raising a biological or stepchild. The demographic characteristics of this latter group suggest that same-sex couples raising biological or step-children likely had those children when they were relatively young and probably with a different-sex partner. Compared to same-sex couples who are raising an adopted child, those with biological or step-children have far fewer economic resources, are young, more likely to a racial or ethnic minority, and are more likely to live in the more socially conservative regions of the country.¹

Given these demographic patterns and the fact that those with a biological or step-child represent the vast majority of same-sex couples raising children, the findings shown in Table 12.5 may not be that surprising. While places with more LGBT-supportive laws like California, Massachusetts, DC, Oregon, and New York are home to counties with high concentrations of same-sex couples, counties where same-sex couples are most likely to be raising children (all have at least 50 same-sex couples) are located in North Dakota, Wyoming, Indiana, and Iowa.

¹ For further discussion of this, see Gary J. Gates blog entry “For Same-Sex Couples, a Tale of Two Paths to Parenting”, available at: http://www.huffingtonpost.com/gary-j-gates/for-samesex-couples-a-tal_b_1277784.html (accessed 12 May 2012).

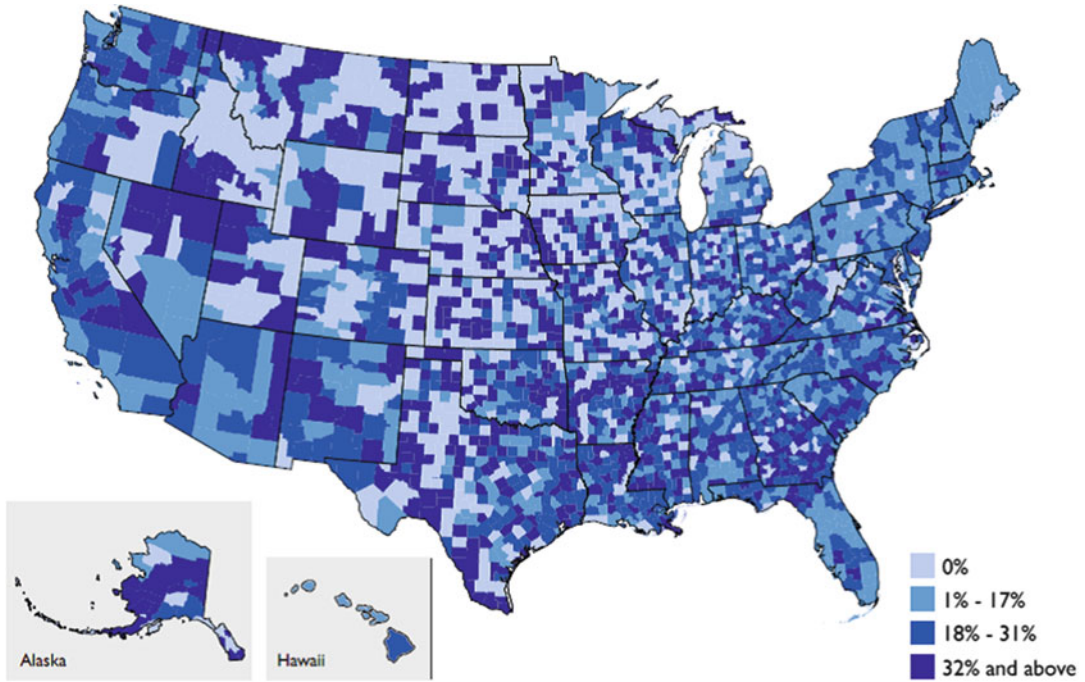


Fig. 12.5 Portion of same-sex couples raising children, by county, Census 2010

Table 12.5 Comparison between top ten counties ranked by same-sex couples per 1,000 households and the percent of same-sex couples raising a child under age 18, Census 2010

Same-sex couples per 1,000 households		Percent of same-sex couples raising a child under age 18	
San Francisco, CA	30.2	Burleigh, ND	85%
Hampshire, MA	19.7	Grand Forks, ND	81%
Monroe, FL	18.8	Sweetwater, WY	80%
District of Columbia, DC	18.1	Clinton, IN	65%
Multnomah, OR	16.8	Boone, IA	62%
New York, NY	16.7	Bryan, GA	58%
Santa Fe, NM	15.5	Starr, TX	56%
Denver, CO	15.4	Blaine, ID	55%
Sussex, DE	15.4	Fremont, WY	53%
DeKalb, GA	15.1	Jefferson, IL	52%

Location Differences by Race and Ethnicity

Nearly a third of same-sex couples include a non-White partner. For the most part, racial and ethnic minorities in same-sex couples are more prevalent in areas with relatively large racial and ethnic minority populations as opposed to areas with high concentrations of same-sex couples.

About 8% of same-sex couples include an African-American partner. These couples are most prominent in Southern states with relatively large African-American populations (see Table 12.6). The states with the highest concentrations of same-sex couples with an African-American partner include the District of Columbia, Maryland, Georgia, South Carolina, New Jersey, Mississippi,

Table 12.6 Percent of same-sex couples that include a racial or ethnic minority and the number of same-sex couples that include a racial or ethnic minority per 1,000 households, by state, American Community Survey 2005–2010

African-American			Latino or Latina			Asian or Pacific Islander		
District of Columbia	13.7%	2.48	New Mexico	45.8%	3.37	Hawaii	50.2%	3.57
Maryland	20.8%	1.21	District of Columbia	13.3%	2.41	California	12.3%	0.96
Georgia	17.0%	1.01	California	29.6%	2.31	District of Columbia	5.3%	0.96
South Carolina	21.3%	0.85	Nevada	28.4%	2.02	Mass	9.5%	0.76
New Jersey	13.3%	0.70	Arizona	29.8%	1.98	Nevada	10.5%	0.75
Mississippi	22.2%	0.69	Texas	34.1%	1.77	New York	8.7%	0.58
Tennessee	14.4%	0.63	Florida	24.0%	1.57	Washington	6.1%	0.44
Louisiana	13.4%	0.63	Colorado	24.8%	1.56	Rhode Island	5.5%	0.37
North Carolina	12.1%	0.59	New York	17.7%	1.18	Illinois	7.5%	0.36
Illinois	12.3%	0.59	Hawaii	15.5%	1.10	Oregon	4.4%	0.34

Tennessee, Louisiana, North Carolina, and Illinois. In these states, from 12 to 21% of same-sex couples include an African-American partner.

More than 17% of same-sex couples include a Latino or Latina partner. The Latino and Latina population is most prominent in the states that border Mexico and these states also all have relatively high concentrations of same-sex couples that include a Latino or Latina partner. In New Mexico, the state with the highest concentration of such couples, more than 45% of same-sex couples include a Latino or Latina. New Mexico is followed by the District of Columbia, California, Nevada, Arizona, Texas, Florida, Colorado, New York, and Hawaii.

Same-sex couples that include an Asian or Pacific Islander partner constitute more than 5% of same-sex couples and are most prevalent in Western states. States with high concentrations of same-sex couples that include an Asian or Pacific Islander include Hawaii (where more than half of same-sex couples include an Asian or Pacific Islander partner), California, District of Columbia, Massachusetts, Nevada, New York, Washington, Rhode Island, Illinois, and Oregon.

Location Differences by Age

Nearly one in four same-sex couples (24.4%) include a partner who is age 55 or older. Many of the states with high concentrations of senior same-sex couples include cities and towns that have historically been LGBT vacation destinations

Table 12.7 Percent of same-sex couples that include a partner age 55 or older and the number of same-sex couples that include a partner age 55 or older per 1,000 households, by state, American Community Survey 2005–2010

District of Columbia	13.7%	2.48
Maryland	20.8%	1.21
Georgia	17.0%	1.01
South Carolina	21.3%	0.85
New Jersey	13.3%	0.70
Mississippi	22.2%	0.69
Tennessee	14.4%	0.63
Louisiana	13.4%	0.63
North Carolina	12.1%	0.59
Illinois	12.3%	0.59

and have now become attractive to LGBT retirees. These include Rehoboth Beach in Delaware, Ogunquit in Maine, Taos in New Mexico, Fort Lauderdale in Florida, and Provincetown in Massachusetts. States with the highest concentrations of senior same-sex couples (see Table 12.7) include the District of Columbia, Delaware, Hawaii, Maine, Vermont, New Mexico, California, Florida, Nevada, and Massachusetts.

Conclusion

Consideration of changes over time both in the number of people reporting as same-sex couples and their location patterns show that visibility and willingness to report sexual orientation

constitute important considerations in interpreting LGBT geographic patterns. Changes in these patterns may have less to do with the mobility of LGBT people or same-sex couples and more to do with an increased willingness of these individuals to report themselves as such, even in more socially conservative parts of the country.

The rich demographic diversity of the LGBT community also requires any assessment of geographic patterns to consider differences by characteristics like sex, presence of children, race and ethnicity, and age. Without such consideration, the prevailing patterns tend to more reflect aspects of dominant subpopulations within the LGBT community, especially White individuals without children, who account for nearly two-thirds (63%) of individuals in same-sex couples.

By considering the demographic diversity of the community, the geographic analyses reveal that sexual orientation is hardly the only factor that determines where LGBT people might live. Couples raising children tend to live in areas where other families have children and perhaps closer to extended family. The evidence also suggests that LGBT racial and ethnic minorities tend to cluster more in areas with large racial and ethnic minority populations than in areas with large and visible LGBT populations.

The Baby Boomer generation is perhaps the first generation in the U.S. with a very large and visible LGBT population. Their location patterns seem to suggest a desire to locate in retirement

areas with historic roots as LGBT vacation destinations. As this generation comprises a larger portion of those in same-sex couples, these patterns are becoming evident not simply in an analysis of same-sex senior couples, but in the broader geographic patterns observed for all same-sex couples.

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Amanda K. Baumle

Introduction

As of June 2012, 21 states, Washington, D.C., and many localities prohibit discrimination in employment on the basis of sexual orientation.¹ In the majority of U.S. jurisdictions, however, employment decisions based on sexual orientation are not subject to state or local legal restrictions. And, although previously proposed, no federal law exists that prohibits discrimination on the basis of sexual orientation for hiring, promotion, compensation, or termination decisions. Sexual minorities are consequently legally vulnerable in most of the United States.

Whether lesbian, gay, or bisexual (LGB) individuals are actually in need of legal protection, however, is often disputed by policymakers and the public at large. In particular, the image of the professional and highly compensated gay man pervades the media, and is the subject of targeted marketing for luxury goods and services. Magazine surveys or other surveys of convenience

have provided fodder for this perception, reporting above-average incomes for gay men and lesbians (Badgett 2001; Black et al. 2000). Population-based data, however, generate a different picture of the economic situation of LGB individuals. Analyses of these data suggest that sexual orientation plays an important—but not always positive—role in several economic outcomes, including income and occupational segregation. Further, survey-based data provide estimates of the prevalence of disclosure of sexual orientation in the workplace, a variable which undoubtedly has a strong effect on income and occupational outcomes.

In this chapter, I present data from nationally representative samples to examine several labor market outcomes for LGB persons in the United States, with a focus on evaluating the evidence of inequality. Inequality in the workplace could be suggested by differences in income or occupations between heterosexual and non-heterosexual persons. Further, given that disclosure of sexual orientation in the workplace provides the opportunity for direct discrimination, data on workplace disclosure are also presented in this chapter. I conclude by presenting data on the prevalence of reported sexual orientation discrimination in the workplace.

Sexual Orientation and Income

According to descriptive data from the 2000 U.S. Census, employment differences are present between heterosexual and non-heterosexual

¹ Portions of this chapter are revised or reprinted by permission from *Same-Sex Partners: The Social Demography of Sexual Orientation* by Amanda K. Baumle, D’Lane R. Compton, and Dudley L. Poston Jr., the State University of New York Press ©2009, State University of New York.

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Table 13.1 Mean values of employment-related variables for partnered individuals who reported employment in 1999, 2000 U.S. census

	Married heterosexual men	Partnered heterosexual men	Partnered gay men	Married heterosexual women	Partnered heterosexual women	Partnered lesbian women
Earnings \$	50,216	32,136	41,527	27,509	23,876	35,531
Occupational earnings score	31.7	28.5	30.4	27.1	25.9	29.3
Number of weeks worked	49.2	47.3	48	46.9	46.3	47.7
Number of hours worked	44.8	43.6	42.8	37.5	39.3	41.6

Source: Baumle and Poston (2011)

individuals. Table 13.1 presents data of partnered individuals (married heterosexuals, cohabiting heterosexuals, and cohabiting gay men/lesbians) who reported being employed in 1999 and had earnings of \$1,000 or more from employment. Of these individuals, married heterosexual men reported the highest mean income, followed by cohabiting gay men, cohabiting lesbians, cohabiting heterosexual men, married heterosexual women, and cohabiting heterosexual women. Similarly, the data indicate that married heterosexual men report working the most weeks in a year and the most hours in a week, with gay men following closely on both indicators. Lesbians reported working more weeks in a year and more hours per week than either married or cohabiting heterosexual women. This could suggest that lesbians must work more, on average, in order to make up for the lack of a (typically higher) male income in the household.

The descriptive data, therefore, suggest both that employment differences exist between heterosexual and gay individuals, and that gay men and lesbians experience an income advantage over all partner types save married heterosexual men. Many studies have been conducted to determine whether such income differences persist when other employment-related explanatory variables are introduced.

When evaluating the effect of sexual orientation on earnings, policymakers and researchers have frequently used data gathered in surveys of convenience, such as those obtained from readers of magazines and newspapers (see Badgett 2001; Black et al. 2000). Due to the biases in these data, no generalizable conclusions may be reached

about the effect of sexual orientation on earnings. Beginning in the mid-1990s, however, social scientists began to use nationally representative data to quantify the earnings differences between gay and heterosexual individuals. They relied principally on two data sources: the General Social Survey (GSS) and the 1990 U.S. Census.

The GSS is a representative sample of the U.S. population and, presumably, of the gay male and lesbian populations, although the numbers of gay men and lesbians in the GSS are relatively small. The GSS relies on a behavioral definition of sexual orientation which may be problematic in earnings studies since those who self-identify on a survey, rather than those who are identified on the basis of behavior, may be more likely to disclose their sexual orientation in the workplace (Badgett 2001). In turn, individuals who reveal their identity in the workplace may be more subject to discrimination (see section on disclosure, below).

The 1990, 2000, and 2010 U.S. censuses and the American Community Surveys (ACS) provide another source for examining earnings differentials based on sexual orientation. Unlike the GSS, the censuses and ACS provide large samples that measure sexual orientation via identity, i.e., membership in a same-sex partnership. But the census data are limited in that only persons who choose to identify themselves as same-sex unmarried partners, and who are residing in the same households as their partners, are enumerated. Single gay men and lesbians are, therefore, uncoun- ted.

Several researchers have used the GSS or U.S. census data to examine earnings differences

between gay and heterosexual individuals, and have obtained varying results (Table 13.2). Although the magnitude of the effect of sexual orientation differs from study to study, the results suggest overall that gay men experience an earnings penalty in employment while lesbians experience an earnings advantage.

According to past findings, gay men experience an earnings penalty that ranges from a statistically insignificant 0.15–26%, depending on the heterosexual comparison group (married men, unmarried men, or both), the dataset, and the model employed (see Table 13.2; Baumle and Poston 2011; Baumle et al. 2009; Black et al. 2003; Blandford 2003; Berg and Lien 2002; Allegretto and Arthur 2001; Klawitter and Flatt 1998; Badgett 1995). An earnings penalty of some magnitude, therefore, has typically been found for gay men.

The penalty is, however, greater for gay men in comparison to married heterosexual men. For example, in Baumle and Poston's (2011) multi-level analysis using 2000 U.S. Census data, the results indicated that gay men experience a far greater earnings penalty compared to married heterosexual men (12.5%) than when compared to cohabiting heterosexual men (an insignificant 0.15%). This suggests that a large portion of the earnings difference between partnered gay and heterosexual men could well be attributable to marital status. Prior research has demonstrated that marriage results in an earnings benefit for men (Waite and Gallagher 2000). Although cohabiting heterosexuals are also disadvantaged by their unmarried status, these individuals have the option of entering into a legal marital union and gaining the benefits associated with marriage. This option is not available to most gay men and, as a result, could well be contributing to the earnings differential between partnered gay men and married heterosexual men.

Some of the earnings benefits derived from marriage for men, however, may be attributable to traditional gender roles, such as men benefitting from women's care of their homes and children. Whether these benefits would play out in the same manner for same-sex couples is uncertain. Other studies have suggested that employers tend

to engage in discrimination in favor of married men, believing married men to be more dedicated workers and more deserving of pay raises (Waite and Gallagher 2000). If employer discrimination plays a role in the marriage premium, then gay men should experience an earnings penalty regardless of whether their own marital relationships adhere to traditional gender roles.

The findings regarding sexual orientation and earnings are less consistent for women than are those for men (Table 13.2). Research suggests that lesbians' earnings are either not statistically different from those of heterosexual women (Klawitter 1998; Klawitter and Flatt 1998; Badgett 1995), or that lesbians have an earnings advantage that ranges from 2.1 to 30% (Baumle and Poston 2011; Baumle et al. 2009; Berg and Lien 2002; Black et al. 2003; Clain and Leppel 2001). For women, therefore, the effect of sexual orientation on earnings seems to be unclear. Regardless, sexual orientation does not appear to have a detrimental effect on the earnings of lesbians, as it does for gay men.

Income, Sex, and Sexual Orientation

Several explanations have been offered for the different effects of sexual orientation on earnings for men and women. Badgett (1995) hypothesized that gay men might face greater discrimination than lesbians because of associations with HIV and AIDS (see also Berg and Lien 2002). Also, lesbians may be more readily accepted into male-dominated professions as "one of the guys," permitting them to excel in areas where heterosexual women are barred (Berg and Lien 2002; Badgett 1995). Some data suggest that heterosexual men evince more hostility toward gay men than towards lesbians, indicating perhaps more of an acceptance of female than male homosexuality (Kite and Whitley 1996; Herek 1991).

Further, some have theorized that the lesbian earnings advantage could be partially explained by work and family differences (Baumle 2009; Berg and Lien 2002; Badgett 2001). If lesbians are more hesitant to interrupt their careers to have or to raise children, or if employers perceive them

Table 13.2 Summary of results of prior research regarding the economic cost of being homosexual

Author	Data source	Earnings measurement (Dependent variable)	Gay men compared to heterosexual men	Lesbians compared to heterosexual women	Definition of gay men and lesbians
Badgett (1995)	GSS 1989–1991	Reported annual earnings	–24%	Negative, not statistically significant	At least the same number of same-sex partners as different-sex since age 18.
Berg and Lien (2002)	GSS 1991–1996	Reported annual earnings	–22% for gay and bisexual men.	+30% for lesbians and bisexual women.	Any same-sex partners in past 5 years.
Black et al. (2003)	GSS 1989–1996	Reported annual earnings	–14% for gay men.	+6% to +27% for lesbians.	Same-sex sexual behavior.
Blandford (2003)	GSS and NHLS 1991–1996	Reported annual earnings	–30% to –32% for gay and bisexual men.	+17% to +23% for lesbians and bisexual women.	Same-sex sexual behavior and marital status.
Badgett (2001)	GSS and NHLS 1989–1994	Reported annual earnings	–17% for gay and bisexual men.	Negative, not statistically significant for lesbians and bisexual women.	At least the same number of same-sex partners as different-sex since age 18.
Baumle and Poston (2011)	2000 U.S. Census, 5% PUMS	Reported annual earnings from 1999	–12.5% compared to married men; insignificant –0.15% compared to unmarried men.	+3.5% compared to married women; +9% compared to unmarried women.	Same-sex unmarried partner.
Klawitter and Flatt (1998)	1990 U.S. Census, 5% PUMS	Reported annual earnings from 1989	–26% compared to married	0% compared to married (when full-time, full-year workers)	Same-sex unmarried partner.
Klawitter (1998)	1990 U.S. Census, 5% PUMS	Reported annual earnings from 1989	Not assessed	0% compared to married (when controls for full-time and children)	Same-sex unmarried partner.

Allegretto and Arthur (2001)	1990 U.S. Census, 5% PUMS	Reported annual earnings from 1989	-15.6% compared to married men; -2.4% compared to unmarried men.	Not assessed	Same-sex unmarried partner.
Clain and Leppel (2001)	1990 U.S. Census, 1% PUMS	Reported annual earnings from 1989	-22% compared to men not living with partners; -16% compared to men living with women (if college education)	+2.1% compared to women not living with partners.	Same-sex unmarried partner.
Carpenter (2004)	2001 California Health Interview Survey (CHIS) and GSS 1998-2000	CHIS: Reported earnings earned per hour from prior month; GSS: Reported annual earnings	CHIS: -2 to -3% for gay men (not statistically significant); -10 to -15% for bisexual men.	CHIS: -2.7% for lesbians and -10.6% for bisexual women; GSS: +31% for lesbians and no statistically significant difference for bisexual women.	CHIS: Self-reported gay, lesbian, or bisexual identity. GSS: Any same-sex partners in past 5 years.

to be so, then their earnings should be higher than those of heterosexuals. Potential parenting differences, therefore, have tended to dominate the possible explanations of the lesbian wage advantage.

There are many reasons to believe that parenthood could play an important role in explaining the wage difference between lesbians and heterosexual women. Recent research examining the effect of motherhood on employment outcomes has found that parental status is an important predictor of women's earnings. Findings suggest that there is approximately a 3–8% wage gap between mothers and childless women, after controlling for other relevant characteristics (Anderson et al. 2003; Budig and England 2001; Crittenden 2001). In fact, Budig and England (2001) found that the majority of the gender gap in wages can be attributed to lower earnings by employed mothers. Further, Peplau and Fingerhut (2004) conducted a study where subjects rated job applicants on measures of warmth and competency. Their findings show that parents received higher ratings on measures of warmth, regardless of sex or sexual orientation. In terms of competency, however, motherhood resulted in a lower rating for heterosexual women, but did not affect competency ratings for lesbians.

Using 2000 U.S. Census data, I examined the effect of parenthood on income for lesbian and heterosexual women (Baumle 2009). Employing Ordinary Least Squares regression analysis to estimate the effect of having a child present in the household on income, I found that the motherhood penalty is experienced primarily, if not solely, by heterosexual women. In fact, lesbians appear to experience a *motherhood advantage* that increases their wages by approximately 20%. Further, results from a Blinder-Oaxaca analysis support the notion that lesbians receive different returns to the presence of children in the household than do heterosexual women. Approximately 35% of the wage differential between lesbians and heterosexual women is attributable to differences in returns to childrearing. This indicates that some of the lesbian wage advantage is attributable to heterosexual mothers being treated economically differently than both lesbians and childless heterosexual women. Concomitantly, lesbian mothers receive

treatment that differs from heterosexual women when they avoid some, or all, of the wage penalty associated with motherhood.

The results do not, however, provide an explanation for this pay differential. Prior research has indicated that lesbians are more likely to be in the labor force and to have dual-wage earners in the household (see e.g. Baumle et al. 2009). This suggests that there might be some truth to the notion that lesbians are dependent on having both partners employed and, consequently, could be less likely to exit the labor force to raise children. If this is the case, then the fact that they do not experience a motherhood penalty would be understandable, as they would be more likely to have a stable employment history. Nonetheless, past research would suggest that employer stereotypes do play a strong role in the employment outcomes of lesbians, with lesbian mothers not experiencing a decrease in competency ratings in controlled experiments as do heterosexual mothers (Peplau and Fingerhut 2004). This suggests that assumptions are made even at the time of hiring regarding the effect that motherhood will have on the careers of women—and these assumptions differ based on sexual orientation.

Contextual Factors Affecting Income Differences

In addition to sex and the presence of children in a household, other individual and contextual factors affect the earnings difference between gay and heterosexual individuals. Baumle and Poston (2011) employed a multilevel analysis to examine the role of both individual- and state-level factors in the effect of sexual orientation on income. Prior studies had considered primarily individual-level factors in predicting earnings. Baumle and Poston found that, while most variation occurs at the individual level, nonetheless state-level factors had an effect on earnings outcomes. Findings regarding two state-level factors were of particular note: antidiscrimination laws that prohibited discrimination based on sexual orientation, and the presence of other individuals in same-sex partnerships. These two variables tend to influence the relationship

between sexual orientation and earnings (i.e. display cross-level effects).

Baumle and Poston found that the presence of a state-level antidiscrimination law decreases the earnings gap between gay men and married heterosexual men by approximately 2.5%. Research using the 1990 data indicated that antidiscrimination laws had no statistically significant effect on earnings (Klawitter and Flatt 1998), but it is possible that these laws, many of which were passed during the 1990s, have now had time to exert a positive influence on the earnings of gay men.

In addition to antidiscrimination laws, Baumle and Poston examined the manner in which residence in a state with a higher concentration of same-sex partners interacts with the effect of sexual orientation on earnings. Living in an area with a high concentration of same-sex partners could well result in the following: provide additional pressure on employers and politicians to provide domestic partner benefits and other employment perks; indicate a more liberal climate and greater acceptance (Baumle and Compton 2012); provide a needed support network which could improve mental health and work performance; and provide social contacts and business opportunities (Collins 2004), thereby increasing earnings. Findings indicate that a higher concentration of same-sex partners in a state consistently resulted in a decline in the negative effect of orientation on earnings for gay men. For lesbians compared to heterosexual women, a higher concentration of same-sex partners in the state resulted in a decrease in the positive effect of orientation on earnings. Baumle and Poston hypothesize that this sex difference could be attributable to differences in the types of enclaves that develop for men versus women, with men tending to reside in large, higher-income urban areas and women in low-income rural areas.

Income: Summary

Overall, findings suggest that gay men experience a wage penalty (particularly in comparison with married heterosexual men), and lesbians experience a wage advantage compared to heterosexual

women. These findings of an earnings differential between gay and heterosexual individuals could be due to discrimination (both against gay men, and, perhaps, in favor of lesbians). The findings could also suggest differences in occupation (Baumle et al. 2009; Baumle 2004). If gay men, for instance, tend to work in occupations that pay less than those of heterosexual men, their earnings disparities could be based on these occupational differences. Income analyses often include some measure of occupational difference, but these variables have typically been broad categories or occupational status indicators. In the following section, I consider more detailed data on occupational segregation based on sexual orientation.

Occupational Segregation

Limited data have been available to examine occupational segregation based on sexual orientation, given that the small sample sizes of LGB persons on most surveys prevented a detailed analysis of occupational differences. With the availability of large sample sizes of same-sex partners on the census and ACS, however, researchers can now take a closer look at the role of sexual orientation in occupational segregation. In this chapter, findings from occupational analyses using a variety of representative data sources are reviewed.

Occupational Segregation and Sexual Orientation

Analyses of occupational differences between gay and heterosexual individuals have been conducted using both occupational categories, and finer comparisons across specific occupations. Using the 1989–1991 GSS data, Badgett (1995) found that lesbians and bisexual women are less likely to work in managerial or clerical/sales positions, more likely to work in craft/operative and service positions, and about equally as likely as heterosexual women to work in professional/technical occupations (Badgett and King 1997; Badgett 1995). Significantly, half of the lesbians

and bisexual women in her sample fell into the craft/operative and service occupations, which are the lowest paying occupations. Blandford (2003), drawing on 1989–1996 GSS data, found a similar overrepresentation of lesbian and bisexual women within the service occupations.

Most research, however, indicates that LGB persons are overrepresented in professional and service occupations. Badgett (1995), using 1989–1991 GSS data, found that gay and bisexual men were less likely than heterosexual men to be in managerial or blue collar occupations, and more likely to be in professional/technical and service occupations. She concluded that her “results suggest that gay/bisexual men are in higher-paying occupations but earn less than heterosexual men within these categories” (1995: 736). Similarly, Blandford (2003) used 1989–1996 GSS data and found that gay and bisexual men were concentrated in managerial and professional organizations. Klawitter (1998) used 1990 census data and also found that gay men and lesbians were more likely to be in the highest paid occupations, such as managerial and professional positions, and less likely to be in technical/sales or operator/fabricator positions.

Taking a closer look at specific occupations, Baumle and colleagues (2009) used the 2000 Census data to analyze the largest professional occupations (see Table 13.3 for list of occupations). Table 13.3 displays the index of relative advantage for each profession; this index compares how over- or under-represented same-sex partners are in relation to partnered heterosexuals, controlling for the differences of each group in the labor force overall.

Non-representative surveys have typically reflected an overrepresentation of gay men and lesbians within highly paid, professional occupations. Baumle and colleagues’ analyses confirmed some of these stereotypes, indicating that same-sex partners are overrepresented in the professions as a whole relative to heterosexuals. Specifically, they are 10% more likely to be in the professions compared to partnered heterosexuals (Table 13.3). However, when results are disaggregated by sex, the data reveal that lesbians are underrepresented in the professions relative to heterosexual women, being 6% less likely to be employed in the largest professions. Gay men, on the other hand, are

overrepresented in the largest professions relative to heterosexual men; they are 26% more likely to be in the largest professions than are partnered heterosexual men.

Further, Baumle and colleagues’ (2009) analyses suggest that same-sex partners are distributed differently within the professions than are partnered heterosexuals. Relative to partnered heterosexuals, same-sex partners are overrepresented in professions concerned with physical or psychological difference and disability (e.g. psychologists, counselors, physicians, special education teachers), those connected with the computer industry, those that could be seen as focusing on effecting change (e.g. lawyers, social workers), and those connected with creative expression (e.g. designers, artists, writers, or architects) (Table 13.3). Same-sex partners are most underrepresented, relative to heterosexuals, in the engineering and teaching professions, excluding postsecondary teaching.

Lewis (2010) similarly finds that same-sex partners might be overrepresented in occupations focused on service or social work. According to his analysis of the 2000 Census data, individuals with same-sex partners are more likely than those with different-sex partners to work for nonprofit organizations. Some of this propensity can perhaps be explained by the smaller differences in pay between gay and straight men within the nonprofit sector, and/or the ability to afford the lower pay typical of the nonprofit sector due to the greater likelihood of having an employed partner and lesser likelihood of having children. Lewis notes, however, that his findings suggest “a strong desire to serve others is an important factor” in generating the observed differences.

Although findings indicate that sexual orientation plays a role in occupational outcomes, the effect that occupational differences have on income is still unclear. Antecol and colleagues (2008) used the 2000 U.S. Census data in a Oaxaca-Blinder decomposition and found that occupational sorting explained little or no variation in the wage differences between gay and heterosexual individuals. Using the GSS data, however, Badgett (1995) found that differences in occupational categories did account for some of the income difference between lesbians and heterosexual women.

Table 13.3 Indexes of relative advantage for gay individuals compared to heterosexual individuals in the 33 largest professions, U.S., 2000

Occupation	Index for all same-sex partners	Index for gay men	Index for lesbians
Overall	+10%	+26%	-6%
Chief executives	-25%	-39%	+59%
Human resources specialists	+30%	+89%	-6%
Accountants & auditors	-12%	+20%	-34%
Personal financial advisors	-9%	-34%	+48%
Computer scientists & systems analysts	+34%	+25%	+60%
Computer programmers	+18%	+18%	+30%
Computer software engineers	+12%	+4%	+50%
Network systems & data communication analysts	+67%	+44%	+148%
Architects	+90%	+105%	+100%
Civil engineers	-34%	-56%	+216%
Electrical & electronics engineers	-52%	-65%	+127
Industrial engineers	-28%	-51%	+115%
Mechanical engineers	-58%	-70%	+183%
Misc. engineers, including agricultural & biomedical	-45%	-62%	+144%
Psychologists	+235%	+158	+253%
Counselors	+67%	+79%	+50%
Social workers	+109%	+227%	+63%
Clergy	-48%	-60%	+63%
Lawyers	+31%	-2%	+127%
Postsecondary teachers	+55%	+21%	+89%
Preschool & kindergarten teachers	-41%	+1600%	-63%
Elementary & middle school teachers	-25%	+56%	-48%
Secondary school teachers	-15%	-15%	-20%
Special education teachers	+13%	+220%	-22%
Librarians	+49%	+512%	-16%
Artists	+87%	+60%	+32%
Designers	+96%	+299%	-11%
Musicians & singers	+83%	+153%	+11%
Editors	+99%	+150%	+159%
Writers & authors	+129%	+180%	+87%
Pharmacists	-29%	-13%	-44%
Physicians & surgeons	+26%	+12%	+88%
Registered nurses	-4%	+446%	-40%

Source: Baumle et al. (2009)

And Black and colleagues (1997) concluded that much of the observable pay difference between gay men and heterosexual men can be attributable to the occupational choices of gay men. Thus, the effect of occupational segregation on income differences is an area requiring additional research, particularly as data with fine occupational categories are increasingly available.

The Role of Sex, Gender, and Sexual Orientation in Occupational Segregation

Analyses of occupational categories not only reveal differences by sexual orientation, but also significant sex and gender differences. Gay men and lesbians tend to cross gender barriers in

employment more so than their heterosexual counterparts. (Badgett 2001; Blandford 2003). Drawing on census data, Black and colleagues (2007) found that the average man in a same-sex partnership is employed in an occupation that is 47% female; this is compared to heterosexual men who work in occupations that are 39% female. Similarly, the average woman in a same-sex partnership is employed in an occupation that is 55% female, as compared to heterosexual women working in occupations that are 60% female.

Baumle and colleagues (2009) reported similar results from their analysis of the 2000 U.S. census data (see Table 13.3 for details). Their analysis of data on professional occupations revealed that gay men are significantly more likely to work in female professions than are heterosexual males, although they are still underrepresented in female professions as a whole. For example, gay men are much more likely to be teachers than are heterosexual men; data show that gay men are 16 times more likely to work as a preschool or kindergarten teacher than are heterosexual men (Table 13.3; Baumle et al. 2009). This finding supports the notion that the underrepresentation of gay men within the teaching profession appears to be a consequence more of their sex than their sexual orientation. Rather, their sexual orientation actually makes them *less* underrepresented as teachers than their heterosexual counterparts.

Similarly, lesbians are more likely than heterosexual females to work in male professions, and are less likely to work in female professions than their heterosexual counterparts (Table 13.3). Returning to the teaching profession, Baumle and colleagues (2009) found that lesbians are underrepresented in the teaching professions when their sex would suggest that they should be overrepresented. Specifically, relative to heterosexual women, lesbians are 63% less likely to work as a preschool or kindergarten teacher (Table 13.3). For women, then, sexual orientation rather than sex is the better explanation of the representation of lesbians in these particular professions.

Findings from these studies, thus, suggest that gay men and lesbians are more likely to cross gender boundaries in occupations than are heterosexual men and women (Baumle et al. 2009; Badgett

2001; Black et al. 2000). At the same time, if one examines the representation of gay men and lesbians within occupations, rather than their representation relative to heterosexuals, gay men are overrepresented in the male occupations and lesbians are overrepresented in the female occupations (Baumle et al. 2009; Black et al. 2000). As a result, even though gay men and lesbians are more likely than heterosexuals to cross gender boundaries in occupations, it is notable that they still remain fairly segregated in sex-typed occupations. They are simply *less* sex-segregated than heterosexuals. In addition, Baumle and colleagues (2009) found that gay men and lesbians are more overrepresented in gender-neutral professions than are heterosexuals, providing further support that LGB individuals may be less wedded to occupations with strong sex segregation.

Causes of Occupational Segregation

Analyses of population-based data support the notion that sexual orientation plays a role in occupational outcomes. It is unclear, however, exactly how one's orientation translates into the selection of a particular occupation. Human capital theory would suggest that LGB persons might possess, or lack, certain skills or education, leading to their being sorted into different occupations than heterosexuals. Socialization theory, in contrast, would support the notion that gay men and lesbians are socialized to believe certain careers are more appropriate for their sexual orientation and might, consequently, develop only the skills to pursue those occupations. Some studies suggest that human capital differences (especially education) explain much of the income disparities between heterosexual and gay individuals (see e.g. Antecol et al. 2008; Baumle and Poston 2011). These same human capital differences might then account for occupational variation, but the cause of the human capital differences remains unclear.

Actual discrimination or fear of discrimination could also lead gay men and lesbians to work in particular occupations. Escoffier (1975) suggests that gay individuals might choose a particular

occupation where they felt comfortable disclosing their sexual orientation with few repercussions. Similarly, gay men and lesbians could be more likely to be hired into more tolerant (often lower-paying) occupations (Badgett 1995). In this way, discrimination in some occupations would act to limit available choices (Elliot 1993). For instance, past studies have shown low levels of acceptance of gay men and lesbians working as teachers, especially in elementary schools (Elliot 1993; Fassinger 1993; Klawitter and Flatt 1998). In contrast, college and university environments are more accepting of sexual minorities (Fassinger 1993). These different levels of tolerance could well encourage gay men and lesbians to teach at universities, rather than in primary or secondary schools.

Similarly, gay men and lesbians have been limited in their ability to pursue occupations in various branches of government. Legal decisions in the 1960s, 1970s, and 1980s excluded gay individuals from government positions requiring a high security clearance, citing as a justification the notion that they are susceptible to blackmail with the threat of revealing their sexual orientation (*McKeand v. Laird* 1973; *Adams v. Laird* 1969; *Padula v. Webster* 1987). The prior ban on gay individuals in the military also served as a deterrent to many gay men and lesbians when selecting an occupation, and its legacy continues to be a deterrent to serving (or serving openly) in the military.

Some occupations, therefore, are more friendly to gay individuals than others. Opportunities and choices hence play a significant role in the segregation of the workforce. Gay individuals may not freely choose stereotypical or lower-paying occupations, but might settle for positions that they believe will accept them.

Disclosure

The ability to disclose one's sexual orientation on the job could play an important role both in income and in occupational choice. Without disclosure, it becomes more difficult for individuals to discriminate on the basis of orientation. Income, then, could be positively affected by failing to disclose (and negatively affected by disclosure)

depending on the environment. Further, individuals might select an occupation based on the perceived ability to disclose their orientation. Even without disclosure, however, there could be economic "costs" associated with remaining in the closet. As Badgett (2001) noted, an individual attempting to remain in the closet might choose not to participate in "career-advancing social situations", distance him or herself from co-workers, or switch jobs in order to avoid disclosure and/or the pressure of secrecy.

On the flip side, disclosure might be beneficial in some cases. Badgett (1996: 43) notes that: "Lesbians disclosing their sexual orientation could conceivably benefit by removing employers' fears or prejudices about their likelihood of marrying and quitting to raise a family."

Several surveys have attempted to capture the degree to which gay men and lesbians disclose their orientation to their employers. According to GSS data, over a third of lesbian, gay, and bisexual respondents indicated that they had not disclosed their identity to anyone in the workplace (Sears and Mallory 2011a). Only around a quarter of respondents had disclosed their orientation to all of their co-workers. Of those who had disclosed their orientation in the workplace, 38% indicated that they had experienced some form of discrimination in their employment within the five previous years. In contrast, only about 10% of those who had not disclosed their orientation reported experiencing discrimination within the past 5 years. These data support the notion that disclosure can be hazardous, perhaps affecting income and/or occupational choice.

Possibly due to these repercussions, Badgett (2001) found that gay men and lesbians who responded to a non-representative survey were more likely to disclose their sexual orientation when an employer had a nondiscrimination policy in place. This suggests that individuals are more likely to disclose in environments where they feel protected and safe. On a more macro level, Baumle and Poston (2011) report similar findings. Living in a more socially conservative state actually increased one's earnings, as compared to living in a more liberal state. This suggests that individuals living in environments where they felt less protected

could well choose to avoid disclosure and, paradoxically, avoid discrimination in the workplace by hiding their sexual orientation.

Conclusion

The research reviewed in this chapter reveals the important role that sexual orientation plays in labor market outcomes, suggesting that sexual orientation is a useful demographic variable to include in analyses of income and occupation. The degree to which the reported differences can be attributed to employment discrimination, however, is difficult to determine in the absence of direct evidence. Reports of discrimination and legal complaints of discrimination provide some guidance in evaluating the prevalence of discriminatory experiences for LGB individuals.

According to the 2008 GSS, approximately 27% of lesbian, gay, and bisexual respondents reported experiencing discrimination on the job (Sears and Mallory 2011a). This discrimination primarily took the form of workplace harassment, but 7% reported having lost a job due to their sexual orientation. As previously noted, reports of discrimination were greater for those who disclosed their orientation to their colleagues.

Complaints filed with state or local equal employment agencies also provide evidence of the prevalence of discriminatory experiences. These serve more as a baseline of discrimination, given that only a limited subset of individuals who experience discrimination go on to file a formal complaint. Research indicates that complaints are filed under sexual orientation discrimination laws at a rate similar to that of complaints based on sex, although less than those based on race or ethnicity (Ramos et al. 2008; Rubenstein 2007). Sears and Mallory (2011b) assessed whether complaints were filed at a similar rate by public and private employees. They estimated that approximately three out of every 10,000 lesbian, gay, or bisexual state or local employees filed a discrimination complaint, whereas approximately four out of every 10,000 private employees did so. All of these studies, then, indicate that

experiences with employment discrimination are relatively common for LGB individuals, and that nondiscrimination laws (where available) are used at a similar rate to those protecting other categories of persons.

Data from demographers provide a representative picture of the existence of differences in employment outcomes based on sexual orientation. These findings raise further questions regarding the causal mechanisms that produce these differences, particularly the role of discrimination. In order to generate a more complete picture of the role of sexual orientation in producing employment outcomes, new data are needed that allow both individual and contextual factors to be considered in income and occupation analyses. In particular, datasets with sufficient sample sizes of LGB identified persons are needed, as well as representative data on disclosure in the workplace. These data would permit analyses that could shed light on the existence of workplace inequalities, thereby assessing the need for additional employment protection for LGB individuals.

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Introduction

In the last 10 years, there has been increased attention given to the demographic analysis of same-sex couples and their families. This attention may be attributed to multiple factors, including current debates and social movements regarding issues of sexual orientation and legislative rights. Additionally, one paramount factor contributing to the increased attention is the availability of better data on same-sex households. While these data are limited, the inclusion of various measures and indicators of sexual orientation and access to large-scale nationally representative data gives demographers a starting point to examine issues of sexual orientation. Currently, there is growing support for the argument that sexual orientation does have an effect on demographic processes and life outcomes. This chapter presents an overview of the current demographic research on same-sex families. It describes how same-sex families are understood by demographers, limitations to this demographic research, and demonstrates how demography can illuminate issues of same-sex families. This chapter also draws on research outside of demography, primarily from family studies, to further

highlight substantive concerns and future directions for demographic research.

Overall, there has been very little academic research conducted on same-sex couples and families. While some empirical data, most of which is qualitative, has been collected on gay and lesbian families (primarily within psychological and sociological family studies), this research is quite limited, resulting in gay men and lesbians being effectively ignored within family studies (Allen and Demo 1995; Demo and Allen 1996). Some undergraduate family studies textbooks suggest that the primary reason for this is due to the relatively small population of sexual minorities (Starbuck 2002; Benokraitis 2011). However, one might also speculate that the social stigma of homosexuality, stereotypes, and issues of social tolerance could play a part in the types of questions considered and data collected on gay and lesbian families.

The population size of gay and lesbian families is still in question. Sociological family studies texts cite conservative estimates on gay and lesbian families, suggesting that they comprise at least 5% of families in the United States (Baca Zinn and Eitzen 1999). Demographic literature has suggested there are just over 600,000 same-sex unmarried partner households in the U.S. as of the 2000 Census (Smith and Gates 2001), the 2008 American Community Survey estimates 565,000 households (Gates 2009), and most recently the 2010 Census has released estimated counts of 646,464 same-sex partner

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households (O’Connell and Feliz 2011). These estimates, as will be discussed later, are conservative, given that they do not include single-parent families headed by gay men or lesbians, and do not include couples who choose not to identify their relationship as a “same-sex partnership” on census surveys. These data nonetheless indicate that there is a notable subpopulation living in gay and lesbian families, warranting an assessment of their demographic characteristics and outcomes. This chapter explores many of these issues, including prevalence, demographic characteristics, and outcomes, relative to heterosexual families.

Background on Same-Sex Families

The family plays an important role in society and for individuals. It is in the family that we spend the most time and where we learn how to participate in society. Often, our strongest social and emotional attachments are to our families. However, there is great diversity among families just as with the individuals that comprise them. Macro factors such as urbanization, the presence of market economies, education structures, and the move towards individualism, have all had an effect on how families are defined and organized (Waite 2005). Additionally, social tolerance, legislation and public policy, and social movements have a strong influence over who is allowed to marry, when individuals are likely to marry, and who is expected to make decisions in the family.

As with heterosexual families, same-sex families come in many shapes and sizes. They are influenced by similar contextual factors, such as education and workplace expectations. However, same-sex families may also face issues that are not always applicable to heterosexual families. For example, since most jurisdictions deny same-sex couples the right to legally marry, they do not share the same legal rights and protections as married heterosexual couples and, because of this, nor do their children (Demo et al. 2000; Cahill et al. 2002). Moreover, there are many laws, policies, and practices in the U.S. and internationally concerning the regulation of adoption, foster care, child custody, and visitation issues

which are biased in favor of heterosexual people, their relationships, and their families—also limiting constructions of families (Cahill et al. 2002).

Same-sex relationships and families often face more social biases; they are frequently taken less seriously and are less accepted than their heterosexual counterparts. Same-sex partners may feel less free to show affection towards one another in public or to talk about their home life while at work. Also, compared to heterosexual couples, they are less likely to be extended “couple” privileges with respect to invitations, occupational benefits, and so forth, or to be viewed as authentic couples (Baca Zinn and Eitzen 1999, 2008). Such factors influence the organization and health of families and relationships.

A discussion of issues related to sexual orientation leads to many important questions for social scientists and demographers wishing to have a greater understanding of same-sex families. For example, many who object to the marriage of same-sex individuals argue that marriage is a necessary environment for the raising of children and that since gay men and lesbians cannot procreate naturally, they should not be permitted to marry. Nonetheless, many same-sex partners are raising children despite these “biological” limitations. The presence of children in same-sex households then raises questions such as: How do children come to be in the household? Are they adopted or are same-sex partners employing other means to have children biologically? How are children and families affected by the lack of legal and social recognitions afforded their heterosexual counterparts? While demographic research may not yet be able to answer all of these questions, the discussion in this chapter lays the foundation to present a more complete picture of same-sex families and enhance what has already been learned from family studies research.

Family Studies Research on Same-Sex Families

Family studies research on same-sex families tends to concentrate primarily on individuals within same-sex families—their attributes, feelings,

and behaviors. The social and emotional effects on children growing up in Gay, Lesbian, Bisexual, and Transgendered (GLBT) families have also been examined (Allen and Demo 1995; Stacey and Biblarz 2001; Biblarz and Savci 2010). Although there are many reasons to study same-sex families and relationships, it could be argued that the literature has been concentrated in areas that have also been the center of the “family values” debate in mainstream America. Many of the research questions posed tend to focus on proving or disproving elements of this debate, such as examining the effects of these relationships on children or assessing how same-sex families affect or may affect heterosexual society.

Most findings on same-sex couples and families have come from a few large-scale family studies (see Blumstein and Schwartz [1983] or the Lawrence Kurdek series [1987, 1992]), and various other small-scale studies, all of which used convenience samples consisting of respondents who were overwhelmingly white, middle-class, young adults with above-average levels of education (Blumstein and Schwartz 1983; Kurdek 1987, 1992). They have found that, like most heterosexual individuals, gay men and lesbians seek and desire secure, intimate relationships. Gay men and lesbians also look for the same relationship qualities as their heterosexual counterparts, such as spending time together, sharing intimate feelings, having equal power in their relationships, and being monogamous (Starbuck 2002; Kurdek 1992). The majority of current research indicates that there is little difference between same-sex partners and heterosexual cohabiting couples when it comes to issues of stability, conflict, problem-solving, decision-making, interpersonal violence, and the division of household labor (Demo et al. 2000; Sarantakos 1996; Carrington 1999). Likewise, rates of relationship dissolution are about the same for gay men, lesbians, and cohabiting heterosexuals, all of which are higher than those for married heterosexual couples (Starbuck 2002). These findings support the notion that same-sex households and families are similar to unmarried heterosexual households and families. The findings could also lend support to the idea that a marriage contract does provide an increased barrier to

dissolution, something to which most gay men and lesbians do not have access.

It is also argued that same-sex partners and their families may be more stable than has been suggested in the family literature (Gottman et al. 2002). The National Gay and Lesbian Task Force has asserted that same-sex partners exist in large numbers, and they are “stable, productive households and have many of the same needs as do opposite sex couples” (Bradford et al. 2002: iv). There have been no clear explanations provided in the current literature to account for the lower levels of stability of same-sex unmarried partners in comparison to married partners. For instance, dissimilarities in rates of stability between heterosexual married couples and same-sex couples cannot be definitively attributed directly to sexual orientation. Instead, additional factors, such as external stresses stemming from heterosexual norms, lack of social privileges, legal rights, and other issues may also be contributing to the observed instability.

Methodological issues in family research may also be contributing to overstated or inaccurate instability measures for gay male and lesbian families. Findings within family studies rely heavily, or in some cases solely, on data that are often well over 15 years old and are not nationally representative. Moreover, research has been based on the ideal of the traditional marriage construct. This may well affect the manner in which researchers have undertaken analyses (Brines and Joyner 1999). Frequently, they tend to view cohabitation as a form of “trial marriage” rather than as its own form of relationship, with unique attributes and characteristics (Brines and Joyner 1999). These views are likely to affect how surveys are designed and how behaviors are interpreted. For example, it is often assumed that couples have a higher level of commitment to one another and to their relationship by the mere fact that they are married. In contrast, unmarried cohabiters are viewed as less committed and their relationships as less serious compared to married couples. This has implications for same-sex couples who cannot legally marry and whose relationships go unrecognized or are viewed as illegitimate.

However, in a recent review of new scholarship on GLBT families, Biblarz and Savci (2010) note the rapid growth of work in the past decade within family studies. They assert that this is due to an increase in available data that include questions and measures of sexual orientation (including both nationally representative data collection projects and more focused qualitative studies), and better research designs being employed by social scientists (Biblarz and Savci 2010). This increase in research and its diversity regarding researchers, questions of interests, and methodologies (longitudinal, surveys, interviews, etc.) has led to a more cumulative knowledge regarding GLBT families.

Moreover, it should be noted that findings and conclusions from prior family studies research has overwhelmingly indicated that gay male and lesbian parents are just as capable of raising children as are their heterosexual counterparts (Stacey and Biblarz 2001; Cianciotto and Cahill 2003; Biblarz and Savci 2010). Likewise, most of the major child advocacy organizations recognize “gay and lesbian parents as good parents, and assert that children can and do thrive in gay and lesbian families” (Cahill et al. 2002: 69). These organizations include: the American Academy of Pediatrics, the American Psychological Association (APA), the National Association of Social Workers in conjunction with the APA, the American Psychoanalytic Association, and the American Academy of Family Physicians (Cahill et al. 2002).

Demographic Research on Same-Sex Families: Substantive Concerns

As a fledgling field, the social demography of same-sex families is inundated with many issues including the lack of nationally representative data sets, concerns of measurement and conceptualization, and the social stigma and assumptions surrounding sexual minorities. In addition, these issues directly affect one another and what is demographically known about same-sex families.

Defining Family

In studying same-sex families, one large issue derives from the diverse definitions and conceptualizations of families, and more specifically same-sex families. Academically, family has been defined as individuals having either biological or marital associations that are culturally recognized (Waite 2005; Baca Zinn and Eitzen 1999). Families have also been described as being responsible for the bearing and the raising of children, for comprising the structure within which individuals reside, and for being the means by which property is shared and passed down (Waite 2005; Baca Zinn and Eitzen 1999). However, others have asserted that these sorts of definitions, often based on legal or structural terms, are quite problematic in reference to families outside of the ideal nuclear heterosexual family type. They are often too narrow or are not inclusive of some of the increasingly more common “alternative” family types, such as cohabiting couples without children, GLBT families, and “families of choice” (Weston 1991; Cahill et al. 2002; Waite 2005). Most typically, GLBT families refer to families that consist of at least one gay male, lesbian, bisexual, or transgendered parent with one or more child, or to a gay or lesbian couple irrespective of whether children are present (Cahill et al. 2002). Also popular in family studies, is the term “gay families”—where gay is employed as an umbrella term for GLBT and holds to the same definition as GLBT families (Baca Zinn and Eitzen 2008). However, these terms have been criticized because families do not have sexual orientations, rather it is individuals who make up families that have sexual orientations (Baca Zinn and Eitzen 2008). Nevertheless, these terms persist in family literature.

Conversely, “families of choice” are defined more by emotional ties rather than legal terms or blood relations; they can include friends, lovers, co-parents, children and/or relatives from prior relationships—most anyone, who provides emotional and/or material support (Weston 1991; Cahill et al. 2002). Weston (1991) notes that “families of choice” have become a very real option for

many gay, lesbian, bisexual, and transgendered people who have been shunned from their own biological families. Most notably, “family of choice” does not include an actual parameter for sexual orientation, such as with gay or GLBT family terminology. It could be argued, however, that the notion of choice delegitimizes this conceptualization of a family as a “real” family further making this term problematic and controversial too.

In the 1970s researchers began to focus more on the household form and its variations, due in part to social changes in the life course, such as increases in age at first marriage and in the percentage of single-headed households (Seidman 1993; Weston 1991). This created a shift in the understanding of definitions and roles associated with the family and, consequently, affected how scholars studied the family. This new way of looking at the family resulted in changing conceptions of family and, thus brought a greater visibility of gay male and lesbian families. However, the major challenge for gay male and lesbian families is still confronting the ideology of dominant American culture. As Weston (1991) notes, homosexuality is associated with deviance, singleness, and unnaturalness, all of which directly counter the traditional image of the family that encompasses heterosexuality, morality, and nature (Weston 1991). Moreover, in application to topics of the family, this ideology has been especially resilient to change. This resilience also speaks, at least in part, to the lack of available data on GLBT families, as there is a significant cultural lag between these understandings and empirical research.

In addition to the aforementioned terms and issues, demographic research has also drawn on same-sex families, along with same-sex couples, same-sex partners, and same-sex unmarried partners to reference gay and lesbian families (Baumle et al. 2009; Gates 2009; Black et al. 2000). However, the conceptualization of these terms differs based on the survey parameters under which the data are collected (as will be discussed in more detail in the next section). Given that the majority of demographic research on same-sex families has come from census data that do not specifically address sexual orientation, definitions

are limited to households which encompass “same-sex unmarried partners.” As such, this definition is a subset of gay and GLBT families, since most definitions of a family would also include single parents. In accordance with this demographic work drawing on census data, this chapter utilizes same-sex families and gay and lesbian families to speak to households that are organized around two same-sex unmarried partners, regardless of the presence of children. This phrasing is in line with most of the economic and social demographic research that employs the census data (Black et al. 2000).

Data and Measures

To date, there are only five nationally representative datasets in the U.S. from which we are able to demographically examine issues of homosexuality and same-sex families in the United States. There is the General Social Survey (GSS), the National Health and Social Life Survey (NHSLs),¹ National Survey of Family Growth (NSFG),² and the Census and American Community Survey (ACS). Depending on the survey, the manner in which homosexuality and families are measured varies due to how sexual orientation has been defined and conceptualized by researchers. Sexual orientation can be defined in terms of sexual behavior, sexual desire, and self-identification, or any combination of the three (Laumann et al. 1994). Most commonly, analyses draw on self-identification and behavioral measures of sexual orientation (Baumle et al. 2009). For example, the GSS includes only behavioral measures of homosexuality, while the NHSLs and NSFG has measures of all three conceptualizations.

¹ The National Health and Social Life Survey (NHSLs) was conducted in 1992 by Edward O. Laumann and his associates (see *The Social Organization of Sexuality: Sexual Practices in the United States* [1994]).

² The Cycle 6 and, the newly released, Cycle 7 of the National Survey of Family Growth were conducted in 2002 and 2006–2008 respectively, by the National Center for Health Statistics (National Center for Health Statistics 2004, 2010).

The U.S. Census and ACS only allow for the analysis of self-identified same-sex unmarried partners who lived in the same household.

Regarding the demographic analysis of same-sex families, the census and ACS data are arguably the best, and certainly the largest, datasets on same-sex partners (Black et al. 2000; Baumle et al. 2009; Gates 2009). The U.S. Census seeks to enumerate all American households decennially, while the ACS samples the population yearly. Both surveys are conducted by the Census Bureau and provide wide-ranging information concerning demographics, economics, and the spatial distribution of the U.S. population (Gates 2009). Gates (2009) asserts that the census and ACS data “provide vital and widely trusted information about same-sex couples and their families that cannot be acquired from any other data sources” (Gates 2009: 1).

It is via the “unmarried partner” response that individuals are able to identify as being unrelated and living in a household in a “marriage-like” relationship with one another. It is assumed that these data represent same-sex households (male-male or female-female) occupied by partnered individuals in a gay relationship (Baumle et al. 2009; Black et al. 2000, 2003; Simmons and O’Connell 2003; Walther and Poston 2004; Gates and Ost 2004). While they do have limitations, the census and ACS data have given researchers the ability to examine under-explored issues regarding sexual orientation. These data are not generalizable to the entire GLBT population. For one they do not include single individuals. They do not encompass those who do not identify as living in a “marriage-like” relationship, nor do they directly address sexual orientation or transsexuality. To draw on these data, one must understand and employ the same clear-cut definition of what a same-sex partner is, as dictated by the Census Bureau (Black et al. 2000; Smith and Gates 2001; Gates and Ost 2004; Walther and Poston 2004). These data, however, are very useful for the study of same-sex families as long as researchers are clear about to whom the data refer. The importance of this cannot be overstated.

There are obvious methodological limitations regarding the conceptualization and measurement

of sexual orientation, and its application to demographically studying same-sex families. First, there is a lack of a common, consistent definition in surveys, as noted in the “Defining Families” section of this chapter. Second, there are problems obtaining sufficiently representative sample sizes, as the GLBT population is considered to be relatively small and hidden. Third, and most notably, there is the absence of questions that address sexual orientation in large-scale data collections. These limitations are related to the social stigma attached to homosexuality that affects survey design and the manner in which individuals respond to survey questions about sexual orientation and behaviors (Laumann et al. 1994; Baumle et al. 2009).

These methodological problems are the same problems that are inherent in gathering and analyzing data on most stigmatized groups. While data and analyses have been highly criticized due to these methodological limitations, the research derived from these data, in combination with the fact that the American public has become more socially tolerant of homosexuality, has led to increased discourse and greater visibility of GLBT populations and issues. All of these factors have resulted in a cycle that creates more conversations, controversies, questions, and research that culminates in better data and better understanding of the GLBT population and sub-populations.

Empirical Findings

Same-Sex Parents and Their Children

Thus far, most demographic research analyzing same-sex partners and their children has been largely descriptive—limited to summations of various parenting rates and general demographic breakdowns (Smith and Gates 2001; Cahill et al. 2002; Simmons and O’Connell 2003). As with the family literature, there have been very few demographic studies specifically addressing same-sex families, or the children of gay male and lesbian parents. Once again, this is largely due to the lack of quality data addressing these

Table 14.1 Data sources of demographic same-sex family research

	Data source	
	Adults	Children
Badgett (2001)		Voter research surveys, Yankelovich monitor, GSS, NHLS, Census
Baumle et al. (2009)	Census, ACS	Census
Black et al. (2000)	Census, ACS	GSS, NHLS, Census
Black et al. (2003)	Census, GSS	
Cahill et al. (2002)		Black Pride Survey
Cianciotto and Cahill (2003)		Kaiser family foundation poll, Census
Gates and Ost (2004)	Census	
Gates (2009)	Census, ACS	
Gates et al. (2007)	Census	Census
Laumann et al. (1994)	NHLS	
Gates and Ost (2004)	Census, ACS	
Simmons and O'Connell (2003)	Census, ACS	Census
Smith and Gates (2001)	Census	
Walther and Poston (2004)	Census, ACS	

subjects. There are relatively few quality surveys from which to estimate the number of children with gay male and lesbian parents and it is difficult to draw reliable conclusions from these studies, as most of them are not based on representative samples. Table 14.1 contains a list of data sources for demographic research on same-sex families.

Regarding children in same-sex households, Badgett (2001) notes that according to the Voter Research Surveys and the Yankelovich Monitor, the proportion of children in lesbian households is roughly equal to that in heterosexual women's households, whereas gay male households are about half as likely as heterosexual male households to have children. However, data from the General Social Survey/National Health and Social Science Life Survey (GSS/NHLS) and the 1990 Census suggest that there are somewhat lower numbers of children in same-sex households (Badgett 2001). According to work done by Black and his associates (2000), the combined GSS-NHLS data indicate that 28% of lesbians and 14% of gay men have children in their households (Black et al. 2000). Data from the 1990 U.S. census indicate lower percentages of children in same-sex, as compared to heterosexual, households. According to the 1990 census, only

20% of female same-sex households and 5% of male same-sex households have children, compared to 57% of married households (Black et al. 2000; Badgett 2001). Badgett (2001) asserts that this sizable difference in the census data between same-sex and heterosexual families is perhaps a reflection of the exclusion of single-parent households, or a bias in reporting patterns for same-sex households where couples with children may be less likely to disclose their relationship on the census questionnaire.

In a report on educational policy and issues affecting GLBT youth, Cianciotto and Cahill (2003) state that estimates range between two and eight million gay and lesbian parents in the U.S. With respect to the number of children with one or more gay, lesbian, or bisexual parent, a range of from one to fourteen million has been estimated (Cianciotto and Cahill 2003). A poll conducted in 2000 by the Kaiser Family Foundation indicates that 8% of the 405 self-identified gay, lesbian, and bisexual respondents had children under 18 in their households (Cianciotto and Cahill 2003). The Black Pride Survey 2000 indicates that 21% of the black gay, lesbian, bisexual, or transgendered participants reported being biological parents, while 2.2% reported being adoptive or foster parents (Cahill et al. 2002). Moreover, 12%

reported currently living with children, while 25% had at least one child (Cahill et al. 2002).

Drawing on the 600,000 same-sex unmarried partners enumerated in the 2000 U.S. Census, Simmons and O'Connell (2003) find that 34% of the female same-sex unmarried partner households and 22% of the male same-sex unmarried partner households contained at least one child under 18. Cianciotto and Cahill (2003: 1) assert that for female same-sex unmarried partner households, this rate "is not that much lower than the percentage of married opposite-sex households with children (46%) or the percentage of unmarried opposite-sex households with children (43%)." They observe, however, that male same-sex partner households "parent at about half the rate of married couples (22% vs. 46%)" (Cianciotto and Cahill 2003: 1).

Using the 5% Public Use Microdata Sample of the 2000 U.S. Census, my coauthors and I (Baumle et al. 2009) explored demographics related to same-sex families and their households. The next three sections draw on, and expand, this work.

Prevalence and Composition of Same-Sex Families

The census data permit an exploration of the prevalence and characteristics of same-sex families. Drawing on the 5% PUMS sample for the 2000 Census (at current the 2010 data is not fully available for analysis), we found that same-sex unmarried partner households contain 31,972 male and 32,756 female partners, for a total of 64,728 same-sex unmarried partners. There are 30,973 other members in these households including 21,111 individuals under the age of 18. Of those under the age of 18, 20,868 can be identified as children in same-sex unmarried partner households.³ Overall, 15% of male same-sex partners and 21% of female same-sex partners have children present in their household.

The same-sex partners in this sample are predominantly white and have attended at least some college. On average the male partners are 45 years old with a household income of \$79,000 and the female partners are 43 years old with an income of \$67,000.

Over 57% of the male unmarried partners and 50% of the female unmarried partners are categorized as "never married." With regard to children in the household, 85% of the male households and 78% of the female households, report having no children. A comparison of some of the demographic characteristics of same-sex households to different-sex households appears in a later section.

With regard to other household members, children are the primary co-residents with same-sex partners (as compared to other familial or non-familial household members). Table 14.2 shows the relationship of all individuals in the household to the householder. Excluding the unmarried partners, the next five largest categories of people in the households are: "children" (21%), "other non-relatives" (1.6%), "stepchildren" (1.6%), "grandchildren" (1.5%), and "housemates/roommates" (just over 1%).

One challenge faced when drawing on the census data is that the census question about children is not phrased in a manner that permits a distinction between biological or adopted children. Moreover, it cannot be determined whether the children belong to another member in the household (Badgett 2001). These data limitations restrict a complete understanding of the relationships within the families of gay men and lesbians. However, children can be identified *in relation to the householder* and children have been categorized as being an adopted child or a natural-born child of the householder. This, of course, does not reflect how the child might or might not be related to the unmarried partner who is not listed as the householder on the census form.

In Table 14.3, we take a closer look at the children in same-sex households and their relationship to the householder. As previously mentioned, there are 20,868 children in the sample. There are 8,381 children in gay male partnered households and 12,487 in lesbian partnered households.

³ The other 243 individuals under 18 were identified as: head/householder (33), unmarried partners (111), boarders (72), and housemates (27).

Table 14.2 Relationship to head of household of same-sex households (2000)

Relationship to head	All ages		Under 18	
	Frequency	Percent (%)	Frequency	Percent (%)
Head/Householder	32,364	33.8	33	0.2
Child	20,167	21.1	16,169	76.6
Adopted child	867	0.9	723	3.4
Stepchild	1,490	1.6	1,200	5.7
Child-in-law	291	0.3	11	0.1
Parent	675	0.7	0	0.0
Parent-in-law	216	0.2	0	0.0
Sibling	994	1.0	137	0.6
Sibling-in-law	244	0.3	19	0.1
Grandchild	1,436	1.5	1,279	6.1
Other relative	255	0.3	101	0.5
Grandparent	31	0.0	0	0.0
Aunt or Uncle	69	0.1	0	0.0
Nephew, Niece	555	0.6	358	1.7
Cousin	187	0.2	33	0.2
Unmarried partner	32,364	33.8	111	0.5
Housemate/Roommate	1,073	1.1	27	0.1
Roomers/Boarders/Lodgers	691	0.7	72	0.3
Foster children	156	0.2	156	0.7
Other non-relatives	1,576	1.6	682	3.2
Total	95,701	100.0%	21,111	100.0%

Table 14.3 Relationship of children to head of household of same-sex households (2000)

Relationship to head	Frequency in gay households	Frequency in lesbian households	Total	Percent of children (%)
Child	6,657	9,512	16,169	77.5
Adopted child	258	465	723	3.5
Stepchild	472	728	1,200	5.8
Child-in-law	6	5	11	0.1
Sibling	68	69	137	0.7
Sibling-in-law	11	8	19	0.1
Grandchild	494	785	1,279	6.1
Other relative	36	65	101	0.5
Nephew, Niece	149	209	358	1.7
Cousin	17	16	33	0.2
Foster children	40	116	156	0.7
Other non-relatives	173	509	682	3.3
Total	8,381	12,487	20,868	100.0%

Although the 5% PUMS data include 21,111 individuals under the age of 18, 243 individuals whose indicated relationships were inconsistent with that of a parent/child relationship were dropped. These individuals appeared to fall outside the “child” category, either because (1) they

were living as adults, as indicated by their assignment to the “head/householder” or “unmarried partner” relationship categories, or (2) their relationship to the householder was indicated as “housemates/roommates” or “roomers/boarders/lodgers,” suggesting a non-parental relationship.

However, the “other non-relatives” category was included due to its size and the ambiguity of the category in association with a parental relationship. For example, this may be a logical choice for categorizing children who have been informally adopted by the householder.

The majority of the children in the sample are white; however, the racial and ethnic breakdown of children is more diverse when compared to the racial and ethnic breakdown of the same-sex unmarried partners in the sample. On average, children are 8 years old, with an education level between the first and fourth grades. As shown in Table 14.3, “children,” “adopted children,” “stepchildren,” “grandchildren,” and “other non-relatives” comprise the top five relationships for children to householder; these categories account for just over 96% of all the children in these households. Children identified as the “children” of the householder likely include children who are the biological offspring of the householder. They may also be children who were products of artificial reproductive technologies and/or surrogacy. In such a case, even if the householder did not contribute biologically to the birth of the child, he or she still might consider the child his or her “natural child.”

The “adopted child” category is most likely used by an individual who has engaged in the formal legal adoption of a child (in the past or during the current relationship), or who has adopted the child of their partner (Baumle et al. 2009). Children in this category could also be the natural born child from a previous heterosexual relationship or a child resulting from artificial reproductive technologies (i.e. in the case of a female same-sex couple, one woman might bear the child and the other might formally adopt the child). It is further assumed that the “stepchild” category refers to children of one partner who are from prior relationships—irrespective of type, whether heterosexual or same-sex.

The above-mentioned categories are the more easily reasoned and recognized categories, whereas the “other non-relatives” category poses a greater challenge because we are unable to ascertain the actual relationship between the children and same-sex partners. Past work has sug-

gested that this is a reasonable category for children who have been informally adopted by the head of household (Baumle et al. 2009).

Specifically addressing adopted children, Gates et al. (2007) find that 4% of adopted children in the United States are being raised by gay or lesbian parents—3% of which are in single parent households and 1% in coupled same-sex households. They, further, estimate that 14,100 children are fostered by a gay or lesbian parent (Gates et al. 2007). This number represents close to 3% of children in all forms of foster care. In considering just non-kin foster care, the percentage doubles to 6% where 5% are estimated to be in a single gay or lesbian parent home and 1% in same-sex coupled homes (Gates et al. 2007).

Factors Affecting the Presence of Children in Same-Sex Households

In examining factors affecting the presence of children in same-sex households, it is important to consider both individual and contextual characteristics of same-sex partners. As such, demographic characteristics of same-sex parents and their households (race, ethnicity, household income, age, previous marital status) could be important predictors of children in same-sex households. In addition, contextual characteristics such as region of residence and whether households were located in a state with restrictive state-level family laws could play a role.

Baumle and colleagues (2009) drew on the 2000 Census Public Use Microdata sample and found that the odds of having a child present in the household are 40% higher for lesbians compared to gay men, controlling for other demographic characteristics. Results also indicate that racial or ethnic minorities are more likely to have children present in their households. With regard to household income, partners in households where children are present earn slightly less than those who live in households where there are no children. Regional location did not appear to have a significant effect on the presence of children in same-sex households.

The largest predictor of children being present in a same-sex household is whether individuals had indicated a previous marital relationship on the census. According to the census data, approximately half of same-sex unmarried partners may be categorized as having been previously married, which could indicate a heterosexual relationship. Individuals who indicated a previous marital relationship were almost three times more likely to have a child in their household than those who marked the “never married” or “not applicable” category. While this result does not speak to how the children come to be in same-sex households, it does lend support to the notion that many children present in same-sex households may be from previous heterosexual marriages and relationships.

Continuing this line of research, we sought to further investigate the effects of state-level variables on the odds of children being present in same-sex households (Baumle and Compton 2011). Specifically, we examined whether formal law plays a central role in family formation outcomes for gay men and lesbians when considering the effect of both positive and negative family laws (such as whether gay men and lesbians are able to adopt and foster, and matters of surrogacy and second parent adoption irrespective of sexual orientation), as well as “pro-gay” and “anti-gay” legislation outside of family laws (i.e. the presence of sodomy and antidiscrimination laws).

Employing a multilevel analysis, we found that negative formal laws appeared to play little or no role in family formation outcomes. Laws prohibiting same-sex couples from adopting, fostering, or surrogacy had no statistically significant effect on the presence of children in households. However, laws prohibiting second parent adoption did result in lower odds of children being present in a household. Further, positive laws – measured as a combination of adoption and second parent adoption laws⁴ – increased the odds of

children being present. Overall, these results are compatible with prior sociolegal research finding that individuals are less likely to consult formal law in decisions regarding their everyday lives – particularly with regard to family matters – but are more likely to do so with regard to family issues concerning “business” matters, such as wills, estates, guardianship, and transfers of property (Baumle et al. 2009).

These results further indicate that, overall, living in a state with antidiscrimination legislation increases the odds of a child being present, and that higher concentrations of same-sex partners in the state increases the odds of children being present. The presence of an anti-sodomy law did not have a statistically significant effect on the presence of children in same-sex households. These findings lend further support to the notion that a “friendly” environment might increase the prevalence of children in same-sex households, but that negative laws are less powerful predictors.

Overall, these analyses show the importance of considering both individual and contextual characteristics when examining outcomes for same-sex families, especially considering the current legal and political climate and controversies surrounding the GLBT population.

Demographic Comparisons Across Couple Types

Another goal in demographically studying same-sex families and households is to assess the degree to which same-sex partnerships are comparable to heterosexual married and unmarried partnerships. Politically, it has been argued that providing legally sanctioned marriages to gay men and lesbians is unnecessary because they provide no real benefit that cannot be gleaned through contractual agreements. However, research indicates that married individuals are healthier, live longer, and tend to have more assets and accumulate more wealth than individuals who are not married (Waite 1995; Waite and Gallagher 1999; Blumstein and Schwartz 1983). In addition, and as previously discussed, the stability of same-sex relationships has been

⁴ The same states had positive laws for both types of adoption, thus we were unable to distinguish whether the adoption or the second parent adoption laws might be playing a greater role in producing this positive effect.

questioned and same-sex relationships are generally considered by family studies literature and society as less stable with lower levels of commitment than relationships where individuals are married.

In work with Baumle et al. (2009), we found that same-sex couples largely fall between unmarried heterosexual couples and married couples with regards to their demographic characteristics and their standard of life and relationships commitment variables. These include social and economic indicators of relationship commitment and stability, most notably home ownership, the presence of children, and living in a dual-income household. While the rates for the presence of children in their same-sex homes are considerably lower compared to heterosexual couples and lesbian partners appear to be slightly more educated than the all other partner types, these data suggest that same-sex households may be more similar to married households than previously suggested by family studies. For example, it appears that same-sex couples have greater financial commitments and dependence on one another than do heterosexual unmarried partners, although these do appear to be less than those of heterosexual married households. Sixty-seven percent of same-sex partners own their homes, compared to 46% of unmarried heterosexual partners and 82% of married households. On average, same-sex unmarried partner households report \$77,708 in household income, whereas unmarried heterosexual partner households report \$55,798 and married households report \$77,669. On the surface it may appear that same-sex households make more than cross-sex households. However, compared to married heterosexual men, partnered gay men earn significantly less, but slightly more than heterosexual unmarried partnered men. Conversely, partnered lesbians earn more than both their married and unmarried counterparts (Baumle et al. 2009).

Additionally, 71% of same-sex unmarried partner households have dual labor force participation, compared to 74% of unmarried partner households and 64% of married partner households. These results also could support the notion that there may be an income or wealth advantage

for those who are married compared to those who are not or cannot marry.⁵

Findings from more recent data sources, like the 2007 and 2008 American Community Survey (ACS), further support the notion that same-sex couples differ from heterosexual cohabiting partners. Drawing on the 2007 ACS data, O'Connell and Lofquist (2009) found that heterosexual unmarried partners tend to be younger, less educated, and have lower household incomes than same-sex partners and heterosexual married partners. However, heterosexual married couples are least likely to be in an inter-racial relationship, least likely to both be employed, and most likely to own their homes according to the 2007 ACS data (O'Connell and Lofquist 2009).

In addition to assessing how same-sex and opposite-sex couples compare, demographic analyses using census data have also been concerned with examining how "married" same-sex partners might differ from "cohabiting" same-sex partners. These questions arise particularly in relation to the self-selection of the "unmarried partner" versus "spouse" categories of the "relationship to the head of household" question on the U.S. Census. Before 2004, same-sex couples did not have access to legal marriage. This does not mean that same-sex couples did not endeavor to organize their relationships as if legally married; indeed, some couples identified on surveys as "married" even in the absence of a legal marriage. In 2004, Massachusetts became the first state to legalize same-sex marriage. Connecticut and California (which briefly allowed same-sex marriage, but currently does not) followed suit in 2008. As of January 2012, Iowa, Vermont, New Hampshire, the District of Columbia, and New York have also legalized same-sex marriage, while Rhode Island, Maryland, New Mexico, and Illinois recognize same-sex marriages granted from other states (NGTFL 2010).⁶

⁵ For more discussion on issues related to income and same-sex families and households see Chap. 13.

⁶ This list does not speak to civil unions or domestic partnerships, rather it solely refers to same-sex marriage recognition.

Currently, the U.S. Census Bureau does not allow same-sex partners to indicate a spousal relationship on the census due to guidelines set forth by the 1996 Defense of Marriage Act (DOMA) which defines “marriage” and “spouse” for federal purposes. As such, same-sex partners that do identify a spousal relationship are edited into the “unmarried partner” category in public use files. However, the internal data files do contain the edited responses, allowing data to be teased out via imputation flags in the more recent ACS data and in the upcoming 2010 Census (O’Connell and Lofquist 2009).

So, are households that indicate “unmarried partner” different from households that indicate “spouse”? According to the most recent ACS data, they are in fact different. Drawing on the 2007 ACS data, partners that indicate a spousal relationship are slightly older, more likely to have children, and more likely to own their homes compared to partners that indicate an unmarried partner relationship (O’Connell and Lofquist 2009). Moreover, same-sex spouses are less likely to have an inter-racial partner and less likely to have both partners employed (O’Connell and Lofquist 2009). The 2008 ACS data also indicate that same-sex spouses are different from same-sex unmarried partners (Gates 2009). Consistent with the 2007 data, same-sex spouses are older, twice as likely to be raising children, more likely to be homeowners, and have lower employment rates than their unmarried partners. Additionally, same-sex spouses are most likely to be female, to have lower education levels, and lower incomes than their unmarried counterparts (Gates 2009).

Compared to heterosexual married spouses, same-sex spouses are similar in age, education levels, income levels, homeownership rates, and whether they were in an inter-racial relationship. However, they differed in that they were less likely to be raising children and they are slightly less likely to have both spouses working compared to the heterosexual spouses (Gates 2009).

Lastly, it is important to note the theoretical and methodological concerns about comparisons among these couple types. For example, it is possible that a small proportion of same-sex couples

may be different-sex couples that miscoded their or their partner’s sex. Likewise, these numbers do not capture couples who do not self-identify as unmarried partners, due to the stigma or concerns of confidentiality, nor are we able to infer relationship of children in the household to anyone other than to “person #1.” This last issue is perhaps the most problematic for studies of same-sex families drawing on the census data. As such, caution should be used when drawing conclusions about same-sex couples and their families. Nevertheless, these analyses do shed light on same-sex families, their children, and the manner in which their relationships compare to those of heterosexual relationships. They also draw attention to issues of same-sex marriage and how marital status (whether couples are legally married or perceive themselves to be married) may be an especially important variable of interest for future demographic summaries of same-sex couples and their households.

Theoretical Issues and Research Directions

Kinsey argued that it was impossible to enumerate how many gay men and lesbians are in the population (Baca Zinn and Eitzen 2008). This was primarily due to the lack of data and the difficulty in counting a hidden and stigmatized population. Although strides have been made, to date, we still have no count of the gay male and lesbian population and are still grappling with the same theoretical and methodological issues. Available data are limited and are prone to criticism. However, with an understanding of the data limitations and conceptual assumptions, reliable counts at the household level are increasingly possible, allowing better access to same-sex partners and their families.

The 2000 Census gave us the largest-ever nationally representative dataset with which to study same-sex households. It may have even spurred the increased attention given to demographic analyses of same-sex partners and their families in the last 10 years, along with growing

social movements related to issues of sexual orientation. It is expected that the 2010 Census will improve upon the 2000 data, giving us better counts and descriptions of same-sex households. As with the 2000 questionnaire, the 2010 questionnaire will not explicitly address sexual orientation of individuals, but it will continue to allow the census to recognize relationships of same-sex partners. It will also mark the first official count of same-sex couples who self-identify as spouses (Conant 2009). Data released to the public will essentially be edited to show only unmarried partners (as with the 2000 data) and same-sex spouses will not be recognized in accordance with Federal DOMA guidelines, however, supplementary data and special reports have been released regarding the numbers of same-sex households—married and unmarried. According to the Census Bureau's preferred estimates, as of April 2010, there were 131,729 same-sex married households and 514,735 unmarried partner households for a grand total of 646,464 same-sex partner households. This is an 80% increase from the 2000 estimates of total same-sex partner households (O'Connell and Feliz 2011).⁷

The 2010 Census marks the first census since the inception of state-recognized same-sex marriage. Moreover, it will better capture the impact of state-level legislation concerning gay and lesbian families (such as non-discrimination laws, and laws regarding fostering, adopting, and reproductive technologies) that have been in effect for more than 10 years. This is significant because even though legislation may take effect, there is generally a lag between when it is enacted and its impact.

Future work should consider, and continually assess, the changing social and legal landscape and its impact on same-sex families. As demographers, we know that context is important for understanding social behavior and outcomes. For example, it will become more important to sepa-

rate same-sex unmarried partners and same-sex married partners as more jurisdictions enact same-sex marriage, granting married couples access to certain rights and privileges that are attached to legal marriage. However, caution should also be taken when considering the same-sex married partners and their characteristics as their numbers do greatly exceed the administrative data on same-sex marriages (O'Connell and Lofquist 2009; Leff 2009). In 2000, 30% of same-sex couples indicated a spousal relationship at a time when none of them could have been legally married to one another (Leff 2009). At present, there are approximately 35,000 couples that have been legally married, primarily in California and Massachusetts, and 10 times this rate are identifying spousal relationships (Leff 2009). This suggests that same-sex couples may be applying their own conceptualizations of marriage to represent their relationships (many may have had commitment ceremonies or feel that they live as if they were married), rather than the very formal legally defined definition of marriage that the census employs.

Findings such as the over-estimation of spouses illuminate the complexities of working with surveys that do not consider issues of sexual orientation during their construction. Future population and family surveys should consider this population and related issues of sexual orientation during their construction. Furthermore, future demographic research should be willing to draw on qualitative and multi-method analyses in order to improve our understanding of same-sex families and their understandings of the category meanings related to surveying. Drawing solely on quantitative surveys does not provide a complete picture and we are still unable to ascertain some of the most basic questions about same-sex families. While researchers can be more confident in enumerating how many children are in same-sex households (or those who choose to identify as same-sex households), very little is known about how they come to be in these households and the complexities of their relationships to household members and the state.

⁷ Only summary file counts and preferred estimates have been released at time of publishing.

Nevertheless, drawing on nationally representative survey data has allowed us to shed light on the presence of same-sex families and their children, and has given us insight to how they demographically compare to heterosexual families. Given the current social, political, and legal climate, this may be especially important because there are many social assumptions that surround same-sex families and sexual orientation. For example, same-sex partners are often associated with privilege—being white, educated, and wealthy. However, income analyses have found that, at the individual level, gay men earn less than married men (Baumle et al. 2009), and approximately 20% of children belonging to gay couples live in poverty compared to 10% of children belonging to heterosexual couples (Conant 2009). Likewise, one might assume that external structural (legal and social) barriers and added financial resources may render it challenging for two individuals of the same-sex to have children, absent a prior heterosexual relationship. However, there is not a notable difference in income between same-sex households with children and those without (Baumle et al. 2009). With large-scale nationally representative data, stereotypes can be replaced with factual information.

Conclusion

This chapter has reviewed the demographics of the families of gay men and lesbians, including conceptualizations of family, obstacles in studying same-sex families, and some suggestions for future research. It is evident that the environment for demographically studying same-sex families is much better now than compared to 10 years ago. Descriptively, we know a great deal more about same-sex families and their households. We have also begun to make inferences about how same-sex families are organized and how issues related to being a sexual minority affect them. However, within family demography, the study of same-sex families is still a very minor

subset of the field. Most demographic research does not consider issues of sexual orientation in relation to greater demographic processes and transitions (largely due to the lack of data). As such, many gaps and questions remain. Nevertheless, there are reasons for continued optimism that our access to this population will continue to open up (especially via the 2010 Census). Reliable counts and portrayals of same-sex families are possible, as is the on-going access to improved measures and data. Hopefully, this will further develop to a point where demographic research on same-sex families contributes to an overall understanding of demographic processes and transitions and, ideally, lead to a point where most, if not all, family demographers will consider issues of same-sex families when they think about survey and research designs, and demographic behaviors.

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Anthony F. Bogaert

Introduction

Asexuality has begun to receive both academic (e.g., Bogaert 2004, 2006a, 2008, 2012a; Prause and Graham 2007; Brotto et al. 2010; Poston and Baumle 2010) and public (e.g., *New Scientist*; Pagán Westfall 2004) attention. Why does the study of asexuality matter, aside from the scientific and public curiosity about a sexual minority that has been overlooked until recently? A person's sexuality, particularly as basic as whether he or she is asexual or not, may play a profound role in their social circumstances and life choices, including whether they marry or not, whether they have children or not, and their mental and physical health (e.g., atypical hormonal profile; lower STI risk, etc.). Thus, the study of asexuality is relevant to a number of demographic issues such as health, marriage, and fertility.

In this chapter, I review definitions of asexuality, summarize past literature on its prevalence, and review some research on the predictors of asexuality. I also present a case study examining new data on the prevalence and predictors of asexuality. This case study is a follow-up to the first modern, large-scale empirical study on asexuality (Bogaert 2004).

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Definition of Asexuality

In Bogaert's (2004) original study of asexuality, the phenomenon was defined as a lack of sexual attraction to anyone. This definition of asexuality partially emerged out of conceptual models of sexual orientation. Storms (1980), for example, defined heterosexuality as sexual attraction (or eroticism) for the other sex; homosexuality was defined as sexual attraction (or eroticism) for the same-sex; bisexuality was defined as sexual attraction (eroticism) for both sexes; and asexuality was defined as a low sexual attraction for both sexes. An asexual orientation, as in the other orientations (heterosexuality, homosexuality, and bisexuality), implies an enduring or relatively persistent pattern across time.

Aside from low or no sexual attraction, asexuality has also been characterized as very low or no sexual desire (Prause and Graham 2007). This definition of asexuality is similar to a clinical diagnosis of some forms of Hypoactive Sexual Desire Disorder (HSDD). However, a HSDD diagnosis is only applied to an individual if he/she is distressed by their condition, and many individuals with low or no desire likely do not meet this clinical criterion. Presumably, like a lack of attraction, one would expect that low or no desire is more or less consistent across time for someone to be designated as asexual.

The definitions of asexuality mentioned above—as a lack of sexual attraction and a lack of

sexual desire—are similar. Thus, many individuals who lack all sexual desire will likely also exhibit a lack of sexual attraction for others or vice versa (also see the discussion section of this chapter). However, these definitions are also important to distinguish. For example, some individuals lacking in sexual attraction for others may still retain some level of excitement and desire for nonpartnered sexual activities (e.g., masturbate; Bogaert 2006a). It is also important to distinguish both a lack of sexual attraction and a lack of sexual desire from a lack of sexual behavior. Thus, asexual people, although typically lower in sexual experience with a partner, may still engage in some forms of partnered sexual behavior (e.g., as a form of experimentation or perhaps to please a romantic partner). Similarly, a lack of sexual behavior with a partner may not reflect asexual orientation/disposition per se, but rather may reflect a lack of opportunity, or perhaps be a conscience moral choice (celibacy). Finally, a distinction should be made between asexuality and a lack of romantic or affectionate bonding, as asexual people are not necessarily *aromantic* (see Bogaert 2006a; c.f. Diamond 2003). For additional examination of these conceptual/definitional issues, along with others—e.g., whether asexuality should be viewed as a unique sexual orientation, and whether it should be considered a pathological condition—see Bogaert (2006a, 2008).

Past Research on Asexuality

Bogaert's (2004) original study of asexuality employed a national probability sample of British residents, the National Survey of Sexual Attitudes and Lifestyles, NATSAL-I ($N > 18,000$; Johnson et al. 1994; Wellings et al. 1994). One important finding concerned the rate of asexuality. Approximately 1% ($n = 195$) of the sample was asexual (i.e., reported never having felt sexual attraction to anyone at all). This rate was very similar to the rate of same-sex attraction in this sample. However, the rate of same-sex attraction in NATSAL-I was one of the lowest relative to other recent national samples (see, for example, NHSL; Laumann et al. 1994).

Aside from prevalence issues, Bogaert (2004) revealed that a number of factors were related to asexuality, including sex (i.e., more women than men), short stature, low education, low socioeconomic status, religiosity, and poor health. Asexual people also reported fewer sexual partners and less frequent sexual behavior relative to sexual people, and asexual women had a later onset of menarche relative to sexual women. In addition, multivariate analyses revealed that a number of these variables independently predicted asexuality. For example, physical development factors – e.g., later menarche, a shorter stature – predicted asexuality independent of all other factors, including current health and social circumstances such as educational attainment and social class. This suggested that early development factors (e.g., prenatal hormones) may affect both the physical growth and sexual proclivities of asexual people. These findings also add to a growing body of literature showing that the development of sexual attraction to adult men and women, along with some atypical sexual proclivities, may be partly biologically based and determined prior to birth (e.g., Bogaert 2001, 2003a, 2006b; Ellis and Ames 1987; Lalumière et al. 2000; LeVay 1991; Williams and colleagues 2000). In addition, the fact that social circumstances (e.g., social class) predicted asexuality independent of these physical development factors also suggests that a unique pathway to a lack of sexual attraction may be a social environment different from a traditional middle-class or upper-middle class.

Since Bogaert (2004), additional empirical studies of asexuality have appeared (Prause and Graham 2007; Brotto and colleagues 2010; Poston and Baumle 2010). In contrast to Bogaert (2004) and Prause and Graham (2007) did not observe differences in the frequency of sexual behavior (e.g., number of partners) between asexual and sexual people. They also did not find sex differences between asexual and sexual people, and their asexual group was more highly educated than their sexual comparison group. Further, they found that low sexual desire/excitability seemed to best characterize the majority of their asexual sample, although at least 40% of their sample reported a lack of sexual attraction

for others. However, Prause and Graham (2007) did not define asexuality in the same way as Bogaert (2004), as a lack of sexual attraction, and instead used a self-definition of asexuality. Thus, their findings may not be directly comparable to Bogaert (2004). Prause and Graham (2007) also used a convenience sample; thus, generalizations to a larger population should be cautioned. As an indication that Prause and Graham's sample may have been atypical is the fact that, as mentioned, there were no sexual behavior differences (e.g., number of sexual partners) between the asexual and sexual people, a basic difference one would expect to find if there is validity to the concept of (self-identified) asexuality.

Similar to Prause and Graham (2007) and Brotto and colleagues (2010) used two different but complementary methodologies (qualitative and quantitative), along with an Internet sample, to investigate individuals who reported being asexual (i.e., identified as asexual). Brotto and colleagues (2010), like Bogaert (2004), found evidence that more women than men were asexual. Also, one of Brotto and colleagues's (2010) main findings was that the asexual group had a very low level of sexual activity (e.g., many had had no sexual partners in their lifetime), but a significant number reported masturbating despite low arousal/excitement and attraction toward others. Brotto and colleagues (2010) concluded that a lack of sexual attraction should be used to describe/define asexuality (similar to Bogaert 2004, 2006a).

Another recent study on asexuality was conducted by Poston and Baumle (2010). Like Bogaert (2004), they examined an archived national sample (National Survey of Family Growth; NSFG; Mosher et al. 2005), although this one was of the United States and not Britain. Unlike Bogaert (2004), however, they used three definitions of asexuality: behavioral, desire, and identity. One of Poston and Baumle's (2010) main findings concerned the possible prevalence of asexuality. For example, for sexual identity, a sizable minority (3.9%) of the participants chose "something else" as their sexual orientation (over the three traditional categories—heterosexual, homosexual, bisexual), while another 1.8% of the

sample did not endorse any of these categories (heterosexual, homosexual, bisexual, or "something else"). To what degree these responses actually represent an "asexual" identity is unknown, but they are intriguing findings. Poston and Baumle (2010) also found that a number of predictors, such as lower education, shorter height, and poor health, predicted asexuality, although these demographics were not necessarily consistent across gender or across all definitions of asexuality.

In this chapter, results from a follow-up study to Bogaert (2004) are presented. This study uses a second probability sample ($N > 11,000$) of British residents (NATSAL-II; National Centre for Social Research and colleagues 2005), conducted 10 years later (2000–2001) but containing very similar measures to the original data (NATSAL-I). In addition to the measures available in Bogaert (2004)—partner-oriented sexuality (e.g., frequency of intercourse; # of partners), physical characteristics (e.g., height and menarche), demographic/social factors (e.g., education), religiosity, and health—NATSAL-II contained a measure of masturbation frequency. This sexual behavior is important because it can reveal the potential variety of individuals who report a lack of sexual attraction. For example, Bogaert (2006a) suggested that, although a large percentage of people lacking sexual attraction likely have a very low sex drive/interest, there may be a group of asexual people who still have a sex drive/interest but who just do not direct their sexual interest/drive toward anyone or anything. As such, some asexual people may masturbate, showing evidence of a sex drive/interest even though they may have little attraction for others. Interestingly, Prause and Graham (2007) did not find masturbation differences between asexual and sexual people. Brotto and colleagues (2010) too, as mentioned, found relatively high levels of masturbation in asexual people. However, the limitations of their studies (e.g., convenience samples) and the fact that Prause and Graham (2007) defined asexuality differently than Bogaert (2004) suggests further investigation of this issue is warranted. Thus, along with attempting to replicate Bogaert's (2004) original findings,

the case study presented in this chapter examines the issue of autosexuality in asexual people (i.e., those who lack sexual attraction).

Method

Sample

Like NATSAL-I (Johnson and colleagues 1994; NATSAL-I), NATSAL-II used a probability sample of households in Britain (England, Wales, and Scotland; National Centre for Social Research and colleagues 2005). However, the age range in NATSAL-II was restricted to 16–44, whereas the first survey (NATSAL-I) had an age range of 16–59. Participants had a face-to-face interview and most were given a self-completion questionnaire. Some of the sexual questions were administered during this self-completion questionnaire phase, which used a computer-assisted technology. Unfortunately, many asexual people were not eligible for the self-completion questionnaire because they did not report sexual experience with a partner. This was the main criterion the investigators used to determine who would complete this questionnaire. The variables used in Bogaert (2004) were largely unaffected, except for menarche. The menarche question was not completed by about half of the female asexual participants (16/35). In addition, about half of the asexual people (26/52) did not respond to masturbation questions, again because of their lack of sexual experience with a partner.

There were two samples (“core” and “ethnic-boost” sample) gathered in NATSAL-II. The core or general population sample was used in the present study because it is the main sample and broadly represents the population of Britain. There were 11,161 people interviewed in this core sample. Like NATSAL-I, NATSAL-II can be weighted (National Centre for Social Research and colleagues 2005) to adjust for inequities in sampling (e.g., residence differences in inner versus outer London, along with sex and age disparities). In Bogaert (2004), only the original NATSAL data were presented, as the results were very similar for the weighted and the original

data. The results for the weighted and unweighted data are also very similar here, so the results from original data are again presented in this study. However, some differences did emerge between the weighted versus the original data, and they will be noted in the results. Like in Bogaert (2004), participants (81) who the interviewers reported had “severe” language, literacy, or other problems during the interview and questionnaire process were eliminated. Of the remaining 11,080 participants, 4,717 were men and 6,363 were women.

Measure of Sexual Attraction and Asexuality

As in NATSAL-I (Bogaert 2004), the measure of sexual attraction in NATSAL-II was introduced as follows: “I have felt sexually attracted to...” Six options followed: (a) “only the opposite sex” (male $n=4,240$, female $n=5,544$); (b) “more often to opposite sex, and at least once to same-sex” (male $n=305$, female $n=658$); (c) “about equally often to males and females” (male $n=31$, female $n=61$); (d) “more often to same-sex, and at least once to the opposite sex” (male $n=61$, female $n=31$); (e) “only same-sex, never to opposite sex” (male $n=52$, female $n=17$); and (f) “I have never felt sexually attracted to anyone at all” (male $n=17$, female $n=35$). Eleven men and 17 women did not answer this question, and were thus eliminated from further analyses.

As in Bogaert (2004), “asexuals” were those who responded to this sexual attraction question with “I have never felt sexually attracted to anyone at all.” I categorized as “sexuals” the remaining participants: those reporting that they had felt attraction to either males, females, or both (male $n=4,689$, female $n=6,311$).

Predictors of Asexuality

As in Bogaert (2004), three measures of partner-oriented sexuality were included: age of first experience, total partners, and sexual frequency.

For the first of these measures, both men and women were asked about their age at their first sexual experience with the other sex: “How old were you when you first had *any* type of experience of a sexual kind – for example, kissing, cuddling, petting – with someone of the opposite sex?” They were also asked about their first same-sex experience: “Have you ever had *any* kind of sexual experience or sexual contact with a male? (or “female” if the respondent was a woman)?” and “How old were you the first time that ever happened?” If the respondent had experience with both sexes, the earlier of the two ages was used; if the respondent had experience with only one sex, only that score was used. This measure was recorded in full years. Interviewers also asked for their total number of male and female sexual partners (“Altogether, in your life so far, with how many men [women] have you had sexual intercourse [vaginal, oral, or anal]?”). If the respondent had both male and female partners, the total of the two counts was used; if the respondent had only male or female partners, then only that score was used. For frequency of sexual experiences with a partner, the participants were asked about their frequency of sexual activity with men and/or women over the past week [“On how many occasions in the last 7 days have you had sex with a man (woman)?”]. Unlike Bogaert (2004), there was a question relevant to masturbation. This question was: “When, if ever, was the last occasion you masturbated. That is, aroused yourself sexually?” Options ranged from 1 = “In last 7 days” to 7 = “Never masturbated or aroused myself sexually.” This variable was reverse coded, so a high score indicated a more recent masturbation experience.

Three measures assessed participants’ health. One was “For your age, would you describe your state of health as...,” with response options from 1 = “very good” to 5 = “very poor.” A second measure was “Do you have a permanent disability?” (1 = “yes” and 2 = “no”). The last measure was “In the last 5 years, did you have any illness/accident that affected your health for at least 3 months?” (1 = “yes” and 2 = “no”). These measures were coded so that those with ill-health had higher scores. Then they were summed to form

an aggregate measure of health. Unlike in NATSAL-I, there was no question asking about medical conditions requiring medical treatment in NATSAL-II. Thus, instead of four questions, which comprised the aggregate in Bogaert (2004), only three questions were summed to form a health aggregate in the present study.

Assessment of physical development included age of onset for menarche, which was recorded in full years. Men were not asked about their age of puberty. Also, as mentioned, many asexual women did not answer the question on menarche because they did not have sexual experience with a partner. Participants were asked for their height and weight. Responses were converted to meters and kilograms, respectively.

Unlike Bogaert (2004), which used two questions on religiosity, the present study used three. One was the frequency of attendance at services, where 1 = “once a week or more” and 7 = “never.” This variable was recoded so that 1 = “never (or not applicable; no religious affiliation)” and 7 = “once a week or more.” A second measure asked the respondent whether he/she had a religious affiliation (“Thinking of the present time, do you regard yourself as belonging to any particular religion?” 1 = “yes;” 2 = “no; none”). This variable was recoded so that 1 = “religious affiliation” and 0 = “no religious affiliation.” The third variable asked the participant “How important are religion and religious beliefs to you now?” (1 = “very important” to 4 = “not important at all”). This variable was reverse coded so that 4 = “very important” and 1 = “not important at all.”

Demographics

Demographic variables included age (in years); marital status (1 = “married,” 2 = “cohabitation, opposite sex,” 3 = “cohabitation, same sex,” 4 = “widowed,” 5 = “divorced/separated,” or 6 = “single”); education (1 = “degree,” 2 = “higher education, but below degree level,” 3 = “O (“Ordinary”) level or equivalent,” 4 = “other/foreign,” or 5 = “none/no exams passed”); and social class or SES (1 = “professional,” 2 = “intermediate,” 3 = “skilled non-manual,” 4 = “skilled manual,”

5=“part-skilled,” 6=“unskilled,” or 7=“other”). Both education and social class were reverse coded so that those with high levels of education and social class had high scores (i.e., 1=“none/no exams passed” to 5=“degree;” and 1=“other” to 7=“professional”). Finally, the interviewers assessed race-ethnicity (1=“White,” 2=“Black,” 3=“Asian,” or 4=“other”). Race-ethnicity was recoded so that 0=“White” and 1=“non-White.”

Results

Fifty-two people (.47%) reported being asexual. As in Bogaert (2004), I compared this rate to the rate of same-sex attraction (both exclusive same-sex and bisexuality combined; 253 or 2.29%). Binomial tests indicated that there were more people with same-sex/bisexual attraction than people with no attraction, i.e., asexual ($p < .001$). In addition, this difference held across sex, such that there were more gay and bisexual men than asexual men ($p < .001$) and more lesbian and bisexual women than asexual women ($p < .001$).

Sexuality

Similar to Bogaert (2004), asexual people were found to have fewer sexual partners and less frequent sexual activity with a partner currently relative to sexual people. They did not have a later onset of sexual activity, however. This comparison is only partially meaningful, because many asexual people did not report sexual experience and thus did not have a valid “age of onset of sexual activity” to compare to sexual people. Asexual people also reported less frequent masturbation (see Table 15.1). Note, however, that, as mentioned, about 50% of the asexual people did not respond to this question because they did not report sexual experience with a partner. However, of those who did have sexual experience, a minority (11; or 42%) did report having masturbated in the past 4 weeks.

As also shown in Table 15.1, consistent with Bogaert (2004), fewer asexual people than sexual people were currently in a long-term relationship. Asexual individuals were also more likely

than sexual individuals to come from lower socioeconomic conditions and were, on average, less educated. A higher percentage of the asexual participants were also non-White relative to the sexual individuals, again consistent with the findings of Bogaert (2004). However, contrary to Bogaert (2004) who found asexual people were somewhat older, asexual people did not differ in age relative to sexual people in the present study; in fact, in the weighted analyses, they were somewhat younger ($p = .04$). Also, contrary to Bogaert (2004), a gender difference did not emerge, despite men representing only 32% (17/52) of the asexual group. This is an instance, however, in which the results from the weighted analyses varied from that of the original data; in the weighted analyses, a significant gender difference did emerge, with more women than men being asexual ($p < .05$).

Health, Physical Development, and Religiosity

Consistent with Bogaert (2004), asexual people were found to be shorter than sexual people; however, they did not weigh less. Asexual women were not more likely to have a later menarche relative to sexual people. However, as mentioned, the number of asexual women with valid information on menarche was very low (i.e., about 50%); thus, this measure had weak power and was very likely an unreliable estimate of menarche status in asexual people. Also, in contrast to Bogaert (2004), asexual people were not significantly more likely to have adverse health. Finally, asexual people were more religious than sexual people, consistent with Bogaert (2004).

Multivariate Analyses

Similar to Bogaert (2004), logistic regressions were conducted, one for men and one for women, with asexuality (0=“sexual,” 1=“asexual”) as the criterion and the significant demographics (except for gender and marital status/cohabitation and SES), religiosity (an aggregate of the three measures), and health and physical development

Table 15.1 Comparisons of asexual and sexual people on predictor variables

Variable	Asexuals (<i>n</i> = 52)		Sexuals (<i>n</i> = 11,000)		t or <i>X</i> ²	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Sexual activity						
Age first sex	15.85	6.06	13.94	2.86	1.64	= .114
Total partners	0.78	1.29	3.34	1.54	13.32	< .001
Sex frequency	0.69	2.17	1.36	1.86	2.60	= .009
Masturbation	3.23	2.70	4.79	2.28	2.94	= .007
Demographics						
Age	30.13	10.01	30.99	7.94	0.62	= .541
Gender (% men)	32.69	–	42.62		2.09	= .148
Marital Status						
(% non-single)	26.92	–	51.71		12.74	< .001
Education	2.50	1.27	3.44	2.00	5.65	< .001
Race/ethnicity						
(% White)	69.23	–	89.61	–	22.91	< .001
SES	3.58	1.37	4.79	1.34	5.25	< .001
Religiosity						
Affiliation (%)	59.61	–	46.21	–	3.74	= .053
Attendance	3.19	2.70	2.07	1.94	3.00	= .004
Religion Import	2.90	1.12	2.11	0.99	5.03	< .001
Health/physical characteristics						
Menarche	13.16	1.61	12.98	1.63	0.48	= .631
Height	166.20	9.75	170.03	9.97	2.66	= .008
Weight	72.48	20.58	71.08	15.15	0.45	= .658
Health problems	0.04	0.64	0.01	0.693	.315	= .752

Note. Total partners varies from 0 (no partners) to 5 (10 or more); sex frequency is the number of occasions in the last 7 days; education varies from 1 (none/no exams passed) to 5 (degree);

SES varies from 1 (other) to 7 (professional); Race/ethnicity refers to the percentage of participants who were White (versus non-White); Religious affiliation refers to the percentage of participants who reported having a religious affiliation; Religious attendance refers to the frequency of attendance at religious services, and varies from 0 (never) to 7 (once a week or more); Health problems refers to an aggregate of three standardized items of health, with a higher score indicating more problems. The *ns* may differ for some contrasts because of missing data.

factors as simultaneously entered predictors. Given the high number of asexual women with missing data on age of menarche, this variable was excluded from this analysis. Similarly, given the similarity between social class and education and that social class had a fairly high number of missing cases (greater than 10%), only education was entered. The results of these analyses are shown in Table 15.2. For women, the majority of the predictors – age, race-ethnicity, education, height (marginal; $p = .099$), weight (heavier), and religiosity (marginal; $p = .061$) – were significant and thus accounted for unique variation in the prediction of asexuality. Using the weighted analyses, the same predictors were significant, with

religiosity ($p = .015$) and height achieving a conventional level of significance ($p = .009$).

For men, education and religiosity were significant, and therefore these variables accounted for unique variation in the prediction of asexuality.

Discussion

As detailed in this chapter, the prevalence and predictors of asexuality in various populations is largely unknown, as are the consequences of asexuality for various demographic outcomes. In this chapter, I explore asexuality, defined as a

Table 15.2 Logistic regressions of sexual attraction (0=sexual; 1=asexual) in women and men, with all predictors entered

Predictor	<i>B</i>	<i>SE</i>	<i>Wald</i>	<i>p</i>	<i>e^B</i>
Women's analysis					
Age	-0.14	0.03	0.33	= .565	0.99
Education	-0.51	0.15	11.13	= .001	0.60
Race/ethnicity	1.10	0.46	5.80	= .016	3.01
Health	0.11	0.24	0.21	=.646	1.18
Height	-0.04	0.03	2.73	= .099	0.96
Weight	0.02	0.01	3.93	= .047	1.02
Religiosity	0.41	0.22	3.51	= .061	1.51
Men's analysis					
Age	0.02	0.03	0.28	= .596	1.02
Education	-0.63	0.21	8.97	= .003	0.53
Race/ethnicity	0.59	0.70	0.71	= .398	1.80
Health	-0.76	0.52	2.13	= .144	0.47
Height	-0.03	0.04	0.65	= .422	0.97
Weight	0.00	0.02	0.00	= .999	1.00
Religiosity	0.65	0.31	4.57	= .032	1.92

Note. Education varies from 1 (none/no exams passed) to 5 (degree); SES varies from 1 (other) to 7 (professional); race/ethnicity is 0=White and 1=non-White; Religiosity refers to an aggregate of three standardized items of religiosity; Health problems refers to an aggregate of three standardized items of health, with a higher score indicating more problems. *B* represents the change in the logarithmic odds of asexuality for a one-unit increase in the corresponding predictor, with all other predictors in the model controlled for; *SE* is the standard error for each *B*; *Wald* statistic is the statistical quantity used to determine the significance level (*p*) of each predictor variable; *e^B* is the multiplicative change in the odds of asexuality for a one-unit increase in the corresponding predictor.

lack of sexual attraction for either sex, in a national probability sample. A small minority (.47%) of people reported that they had never felt sexual attraction to anyone at all. This rate was about half of the percentage of asexuality found in Bogaert (2004), and unlike this previous report, this rate was lower than the rate of same-sex attraction in the sample. Part of the reason for the discrepancy between these findings may be the small but potentially meaningful differences between the two samples. Participants in NATSAL-II may have been a more sexually liberal group relative to NATSAL-I. There is evidence that those who choose to participate in a sexual study typically have more sexual experience (e.g., more partners), are more sexually liberal in attitudes, and are more interested in sexual activity than those who do not participate (e.g., Bogaert 1996; Morokoff 1986; Saunders et al. 1985). As such, fewer people with minimal sexual experience, including asexual people, may have been recruited in NATSAL-II relative to

NATSAL-I. In contrast, a greater number of participants higher in liberal sexual attitudes and behavior may have been recruited in NATSAL-II relative to NATSAL-I. This may have included a relatively higher number of gay people in NATSAL-II versus NATSAL-I. Small differences in recruitment may partly account for why differences in liberal sexual attitudes and behaviors may exist between the two surveys. For example, there was more extensive surveying of greater London in NATSAL-II relative to NATSAL-I (see National Centre for Social Research and colleagues 2005), although the researchers did attempt to adjust for the over-sampling of the London region in NATSAL-II (Johnson et al. 2001; Copas et al. 2002).

It is also important to consider that in the 10 years between NATSAL-I and NATSAL-II, there may have been some relevant changes in aspects of the social/psychological environment affecting sexual development, or at least in the willingness to report aspects of sexuality

(e.g., same-sex attractions; see Johnson and colleagues 2001 for a discussion). The age difference between the two samples may also be important in the discrepancy in the prevalence rate of asexuality. The age range in NATSAL-II was restricted to 16–44, whereas the first survey (NATSAL-I) had an age range of 16–59. Although the present study did not find strong evidence that age was related to asexuality, Bogaert (2004) found that older people were more likely than younger people to report being asexual. Thus if a more extensive range of ages had been recruited in NATSAL-II, perhaps the rate of asexuality would have increased.

Aside from the above-mentioned issues that may differ between the two samples, it is interesting to consider other, more general factors that may increase or decrease the reporting rate of asexuality. One is the recruitment method. As mentioned, those who choose to participate in a sexual study are typically more sexually liberal than those who do not participate (e.g., Bogaert 1996; Morokoff 1986; Saunders and colleagues 1985). Thus, the rate of asexuality may be higher than reported in both NATSAL-I and II given that there are always some participants who decline to participate in sexual studies, even in national probability samples. For example, the refusal rate in NATSAL-I was about 30%; in NATSAL-II, even slightly higher (approximately 35%). Thus, there may in fact be a high number of asexual people who did not agree to participate because they felt uncomfortable with, or uninterested in, the sexual subject matter of the survey. Recent U.S. national probability data from the National Survey of Family Growth (NSFG; Mosher et al. 2005; Poston and Baumle 2010) may support this view. The NSFG investigators asked respondents to define their sexual orientation. As mentioned in the Introduction, instead of endorsing the traditional three categories (heterosexual; homosexual; bisexual), a sizable minority (3.9%) choose “something else” as their sexual orientation, while another 1.8% of the sample did not endorse any of these categories (heterosexual, homosexual, bisexual, or “something else”). This was a broad “health” and physical growth survey, and thus an interesting possibility is that the NSFG investigators

may have recruited people with a wider range of sexual experiences/interests, including more asexuals, than standard sexual surveys (see Poston and Baumle 2010, for further discussion of the NSFG data and asexuality).

The present study examining NATSAL-II replicated most of the predictive factors that were observed to relate to asexuality in Bogaert’s (2004) examination of NATSAL-I. One was sexual frequency, with asexual people having less sexual experience (e.g., fewer partners), than sexual people (see also Brotto and colleagues 2010). As noted by Bogaert (2004), this gives validation to the concept of asexuality, as one should expect less sexual behavior (particularly partnered experience) from people who report no sexual attraction to others. On the other hand, some level of sexual experience was still observed to occur in asexual people, suggesting that some asexual people may feel compelled to engage in sexual behavior at times (e.g., out of curiosity, wanting to please a romantic partner).

Interestingly, 11 asexual people had relatively recent masturbation experience (e.g., in last 4 weeks). This figure may have been higher if all the asexual people (not just those who had sexual experience) had been able to respond to the question. As Bogaert (2006a) indicated, this level of autoeroticism among asexual people suggests that, although a large percentage of people lacking sexual attraction likely have a very low sex drive/interest, there may be a group of asexual people who still have a sex drive/interest (e.g., masturbate) but who just do not direct this sexual interest/drive toward anyone. Thus, they may masturbate for physical pleasure or tension release without invoking partner-oriented thoughts or fantasies. Support for this type of “functional” explanation for masturbation emerged in qualitative responses from asexuals in Brotto and colleagues (2010). Another possibility is that some asexual people (i.e., those who report no sexual attraction to people) may have unusual (nonpartner-oriented) sexual attractions, and may masturbate to satisfy these paraphilic desires (see Bogaert 2004, 2012a, b, for a discussion).

As in Bogaert (2004; see also Brotto and colleagues 2010), more women than men reported

having no sexual attraction, although the sex effect was not as large as the previous study (i.e., only occurred in the weighted analyses in the present study¹). Numerous sex differences occur in the expression of sexuality (e.g., Baumeister 2000; Oliver and Hyde 1993), and thus this is another relatively consistent one that should be noted. Perhaps this sex difference is not surprising given that women tend to exhibit patterns of sexuality that are typically on the more conservative or low end of the distribution of sexual behaviors (e.g., low sex interest, less interest in casual sex). Thus, one might expect more asexual women than asexual men because asexuality represents an extreme low end of the sexuality continuum. Baumeister (2000) has suggested that women's sexuality (or, at least, their sex drive) is inherently more "plastic" than men's sexuality. If so, situational/cultural influences may have a more profound effect on women's sexuality than on men's; as a result, more women than men may become asexual if life circumstances are atypical. Other factors may be relevant as well. For example, Bogaert (2004) noted that women relative to men may be less likely to label males or females as salient sexual objects. Consequently, women may report themselves as having no attraction to either sex because they may not be as aware of their own sexual arousal as men are, even under conditions when genital responses are occurring (e.g., Heiman 1977; Laan et al. 1994).

As in Bogaert (2004), evidence of physical development differences (i.e., height) also occurred between asexual and sexual people. The effect was stronger in women; however, perhaps this was only because there were somewhat more asexual women than asexual men and thus the women's analysis had more statistical power. It is interesting that adult height has also been investigated within the context of the development of traditional sexual orientation research, with some evidence that gay men and lesbians are shifted toward the pattern typical of the opposite sex—i.e., gay men are shorter and lesbians are taller—relative to

heterosexual comparisons (e.g., Blanchard and Bogaert 1996; Bogaert and Blanchard 1996; Bogaert 1998; but see Bogaert and Friesen 2002). Although alternative explanations exist, these differences provide some support for a biological origin to sexual orientation (including asexuality) insofar as height is relatively stable after puberty and is influenced by early biological factors such as prenatal hormones (e.g., Grumbach and Styne 1992). Such early biological factors may lead to an alteration of basic structures of the brain (e.g., hypothalamus; pituitary gland) which, in turn, alters both physical growth and basic sexual and/or attraction mechanisms in some asexual people. Additional support for such an explanation was provided in Bogaert (2004), as menarche onset was found to be relatively delayed in asexual women. Atypical menarche in asexual women also suggests an early alteration of basic structures of the brain (e.g., hypothalamus; pituitary gland) affecting both physical growth and basic sexual and/or attraction mechanisms in some asexual people. Unfortunately, the present study had a very low response rate for menarche onset in asexual women, and thus new data need to address whether an atypical menarche onset in asexual women is a reliable finding.

A recent explanation advanced to explain atypical physical development in sexual orientation is developmental instability (Lalumière and colleagues 2000)—vulnerability to early developmental stressors (Yeo and Gangestad 1993; Yeo et al. 1993). For example, developmental instability has been argued to be a possible cause of increased non-right handedness in gay men and lesbians (Lalumière and colleagues 2000). Recent evidence suggests that extreme right handedness is also more prevalent in gay versus heterosexual men, and this pattern too may reflect evidence of developmental instability in some gay people, although other factors such as atypical prenatal hormones may be relevant (Bogaert 2007). As such, it would be interesting to investigate handedness patterns in asexual people, as handedness is a good marker of early biological influences.

Genetic factors may also play a role in the development of asexuality. There is evidence that

¹ A significant gender difference emerged in both the weighted and unweighted analyses in Bogaert (2004).

variation in traditional sexual orientation (e.g., gay versus straight) is influenced by genetic factors (e.g., Bailey et al. 2000). There is also evidence that sex drive and sexual interest is related to genetic factors (e.g., Comings 1994). It would be interesting to conduct a molecular or behavioral genetic study (e.g., using a twin design) and thus assess potential genetic factors in asexuality directly.

Unlike Bogaert (2004), no evidence was found that current or recent health issues discriminate between asexual and sexual people. However, the health measures were somewhat different between the two studies so some level of caution in comparing them should occur. Even in Bogaert (2004), though, the health effects were not strong effects, suggesting that current or recent health problems may not be strongly related to asexuality. As such, negative health effects, operating through, for example, lower mood or altered neuroendocrine profiles, may not be a significant cause of asexuality.

Demographic variables (e.g., lower education, nonwhite ethnicity) were related to asexuality and suggest that one pathway to a lack of sexual attraction may be an environment different from a traditional middle-class or upper-middle class white home (e.g., one with fewer resources). However, it is difficult to know what aspects of the educational and home environments may contribute to asexuality. Bogaert (2004) speculated that processes related to exposure to and familiarity with peers (see Bem 1996; Storms 1981) are altered when the home and educational environment are atypical. Processes related to acculturation to western society may also play a role, as it has been argued to be important in explaining ethnic differences in sexuality in North America (e.g., Brotto et al. 2005). Bogaert (2004) also noted that an “atypical home environment” (e.g., low education; low SES) may be a proxy for atypical events (e.g., stressors) prior to and during gestation, as might be expected if an altered prenatal milieu (e.g., altered prenatal hormones) partly underlies asexuality and other atypical sexual inclinations (e.g., Bogaert 2001; Ellis and Ames 1987; Lalumière and colleagues 2000; Williams and colleagues 2000).

As in Bogaert (2004), a strength of the case study presented in this chapter was that it used a national probability sample to explore factors associated with asexuality, a growing but still relatively uncharted area of sexual variability. The relative novelty of such an investigation, however, means that numerous limitations remain unaddressed. One of these limitations is that this study [and Bogaert (2004)] used data from only one part of the world; thus, there is a need for replication in new samples from different countries. In addition, questions directly relevant to the developmental history of sexual and asexual people (e.g., early sexual life, fantasy) were not included in the present study. Thus, questions relevant to the formation of asexuality need to be included in future research. Related, a number of factors (e.g., masturbation, menarche) assessed in NATSAL-II were not given to a large number of asexual people. A third issue is that the data do not allow for causal or directional interpretations. For example, does extreme religiosity sometimes lead to asexuality, or is it a consequence of being asexual for some asexual people (see Bogaert 2004, for a discussion)?

Bogaert (2004) discussed both the strengths and limitations of the measure of asexuality used in the NATSAL-I survey. Similar issues are relevant in the present study using NATSAL-II. A measure of sexual attraction, relative to those of sexual behavior and sexual self-identification, is often the preferred method for assessing sexual orientation because it is likely to form the psychological core of one’s partner-oriented sexuality and is less open to interpretation than these other measures (e.g., Bailey and colleagues 2000; Bogaert 2003b; Money 1988; Zucker and Bradley 1995). Thus, using a sexual orientation framework to understand asexuality (see Bogaert 2006a, for a discussion) would include sexual attraction as a main measure of assessment. However, expanding this research to include a measure of self-identification of asexuality, along with other aspects of sexuality (such as sexual desire), is important, as Prause and Graham (2007) and Poston and Baumle (2010) have recently done. Prause and Graham’s (2007) work supports the idea that those who report a lack sexual attraction are highly likely to identify as

“asexual” (i.e., 89.5%). On the other hand, Prause and Graham’s (2007) research also suggests that those who identify as asexual may be diverse, with sexual desire/excitability issues as key correlates of an asexuality identification. In Bogaert (2004) and in the present study, desire issues were not included because they were unavailable or unavailable in an analyzable form in NATSAL-I and NATSAL-II, respectively.² Thus, note that a comparison with Prause and Graham’s findings on desire can not be made.

More research needs to be done on desire issues in asexual people. One issue that needs to be clarified is what asexual people mean by “no sexual desire” and “no sexual attraction,” along with how they discriminate between these two aspects of sexuality. Most sexologists would likely indicate that desire refers to sex drive and interest and sexual attraction refers to one’s sexual inclination toward others. Most sexologists would also likely indicate that there is a fair degree of overlap in what these two aspects capture about sexual expression for most people (see Bogaert 2006a, for a discussion). However, some (perhaps many) lay people may use the terms “desire” and “attraction” differently than most sexologists. For example, some people who identify as asexual may prefer to describe their asexuality as a low/no desire issue because they are more familiar with the word “desire” (rather than “attraction”) within the context of sexuality, and prefer the word “attraction” to describe romantic and affectionate orientations (and not necessarily a “sexual” inclination or orientation). Thus, these asexual people may have felt little “sexual” attraction for a partner of a particular gender (in the traditional sexual

orientation sense), but still have strong romantic and affectionate attraction for these partners (see Diamond 2003, for a distinction between romantic and sexual attraction). Consequently, they still describe that they have (sexual) “attraction” for partners of a particular gender because of their romantic feelings/inclinations towards them. If this speculation is correct, then the number of asexual people lacking sexual attraction, at least as many sexologists would describe it, may be underestimated (see also Chasin 2011).

However, assuming these terms are defined by people in similar ways as sexologists think they are [and assuming that self-identification should be the criterion for defining asexuality and that Prause and Graham (2007) can be replicated on more diverse, representative samples], those who lack sexual attraction may comprise only one “form” of asexuality. A more prevalent form of asexuality, from a self-identification point of view, may be the low/no desire/excitability variety. However, additional conceptual questions are raised about such a form of asexuality. For example, can someone truly have a strong “sexual” attraction for partners (of a particular sex), but also have an enduring lack of interest/desire in having sex with them? Again, the distinction between romantic versus sexual attraction may be important here. Also, should someone who lacks desire but still has sexual attraction for partners (of a particular sex) be described as having a separate or unique sexual orientation that differs from the traditional three main categories—homosexual, bisexual, and heterosexual (see Bogaert 2006a, for a discussion)?

Clearly, there remain many questions to be answered, including basic conceptual ones, on asexuality. Additional studies using national surveys, like the present one, along with additional studies specifically targeting self-identified asexuals, would help to move this research forward.

² Unlike NATSAL-I, there was a question on sexual interest/desire in NATSAL-II. Unfortunately, 44 of the asexual people were coded as having inapplicable responses, either because they did not have sexual experience or because they did not report sexual desire issues (or any other sexual issue) as a problem. Thus, the investigators did not make a distinction as to how they grouped people as having “inapplicable” responses. Even if the investigators did make a distinction, however, a more appropriate question in the context of this research issue is whether asexual people *experience* no/low desire (not whether they consider low desire or lack of interest a problem).

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The Demographics of the Transgender Population

16

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Introduction

We want to stress at the outset of this chapter that the task of representing the transgender population is nothing if not daunting. The difficulties, as we see them, stem from two main sources: (1) though a general “trans” sensibility exists in both the United States and worldwide, there are currently few measurable and/or standardized criteria (e.g. physical, social, political, etc.) regarding what might or *should* constitute a transgender person; and (2) problems with locating and accounting for this population are compounded by the relative invisibility through which many transgender individuals exist in their daily lives. Marginalized by political, religious, legal, medical, and other cultural institutions, transgender persons encounter levels of discrimination that range from simple misapprehension and exclusion by an uneducated public, to explicit acts of sexual and physical violence (Mizock and Lewis 2008; Richmond

et al. 2012). Indeed, many in what is often referred to as the mainstream, including transgender individuals, are first exposed to the idea of “transgender” through media that sensationalize and misrepresent the issues most salient for this population.

In this chapter, we attempt to correct, as well as explain the bases for many of the unfounded and problematic assumptions made about transgender persons in the contemporary U.S. Transgender politics and visibility in the U.S. are uniquely, almost contradictorily, contoured: at the same time that celebrity culture brings the faces of RuPaul and Chaz Bono into the homes of many Americans, private and market-driven health insurance (which, outside the context of the Affordable Care Act, is tied to employment and/or marital status) leaves many transgender persons without adequate resources to manage their general medical and transition needs. In contrast, the single-payer healthcare systems of Northern Europe and Canada have covered these services for several decades, allowing researchers in these countries to produce some of the most useful and accurate data regarding this population. In line with Valentine (2007), we suggest that such disparities index how the category *transgender* is imagined by various communities, and that an understanding of these local inflections is a crucial element in grasping the contemporary significance of a transgender identity.

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Transgender identity has long been characterized as sexually or socially deviant; it has also been labeled a “natural diversity in human sexual formation.”¹ Theories about trans identity and practices have ranged from nineteenth century ideas about inherited and familial degeneracy to decidedly twenty-first century neurophysiological accounts of brain and hormonal sex differentiation in utero. Demographic populations are only as stable as the socially recognized variables through which they are defined, some of which are more fixed (e.g. chronological age) than others (e.g., “race”). Winters and Conway (2011) argue that “minorities do not count until they are counted.” Because the trans population has long been (mis)recognized in terms of sexual orientation, rather than the bodily incongruity that dominates many contemporary trans narratives, we argue that the population itself is in an almost constant state of redefinition and refinement.² This assertion is meant to discount neither the importance nor utility of a demographic overview of the trans population; rather, we wish to underscore that the population under review is one that is broadly in transition, and that any relevant facts about it should be interpreted in socially and historically-specific terms.

A Guide to Terms

In their work *Same-Sex Partners: The Social Demography of Sexual Orientation*, Baumle et al. (2009) begin their analysis by asking readers to consider what it would require to “bring the study of sexuality more into the mainstream of demography” (3). Noting that “the field of sociology has long suffered from a lack of focus on issues of sexuality,” (3) the authors argue that it is high time for this to change, and for sex and sexuality

to occupy more prominent roles in contemporary demographic analyses. Sexual orientation, they continue, is not only a factor that can influence one of demography’s core processes (i.e., fertility—via behavioral practices), but should also be understood as “an important personal characteristic that can shape and inform [other] demographic processes” (4), such as residential patterns and income levels.

Demographers who agree with these authors recognize both the importance of and the difficulties inherent in collecting meaningful data about groups often labeled as sexual “minorities.” Indeed, when Laumann and colleagues (1994) sought, over a decade ago, to include homosexuality in their volume called the *The Social Organization of Sexuality*, they grappled explicitly with the challenges of accurately representing a group whose identity was—at least partially—constructed through specific cultural and historical context(s):

To quantify or count as something requires unambiguous definition of the phenomenon in question. [...] When people ask how many gays there are, they assume that everyone knows exactly what is meant. [But h]istorians and anthropologists have shown that homosexuality as a category describing same-gender sexual desire and behavior is a relatively recent phenomenon [...] peculiar to the West. [...] E]ven within contemporary Western societies, one must ask whether this question refers to same-gender behavior, desire, self-definition, identification, or some combination of these elements. In asking the question, most people treat homosexuality as such a distinctive category that it is as if all these elements must go together. On reflection, it is obvious that this is not true. (290)

In this chapter, we argue that what was true for homosexuality in the mid-1990s is true for transgenderism almost two decades later. That is, given both the socially constructed—and thereby unstable—nature of a category like transgender, as well as the intensely material ways through which transgender individuals live their identity (e.g. restroom challenges, hormonal side effects), demographers interested in researching this population face a peculiar set of analytical and descriptive challenges. Whether and to what extent transgender constitutes the type of “distinctive category” posited by Laumann and colleagues about which knowledge can be accurately generated

¹ <http://www.truecolours.org.au/publications/development.html>

² To this end, the American Psychological Association is set to release its fifth version of the Diagnostic and Statistical Manual of Mental Disorders in 2013, in which the diagnosis Gender Identity Disorder will more than likely be renamed Gender Dysphoria. See the Mental Health section for further discussion of this issue.

and about whom demographic statistics and claims can be reliably asserted, are questions taken up in the following section.

Trans as Gender Identity

A key issue facing the transgender population is nomenclature, i.e., which terms or categories best reflect the population itself (ALGBTIC 2009; Bockting and Coleman 1991; Green 2004; NCTE 2009). Since 1949, the word *transsexual* has referred to individuals who had a clear sense of being “[born] in the wrong body” (Meyerowitz 2004). More specifically, a *transsexual* lives full-time in a cross-gender social role: a person assigned male at birth that lives full time as female would be identified as a male to female (MTF) transsexual, while a birth-assigned female that lives full time as male would be identified as a female to male (FTM) transsexual. Represented by celebrities such as Renee Richards, Christine Jorgensen, and Chaz Bono, this is an identity characterized by beliefs about body-mind incongruity and (most typically) a desire to have one’s body align with one’s gender identity or *reassigned* into the other sex.

The term *transgender* has become increasingly popular in the past decade and reflects a less restrictive or binarized set of beliefs (Green 2004; Valentine 2007). More specifically, *transgender* describes persons who do not feel like they fit into a dichotomous sex structure through which they are identified as male or female. Individuals in this category may feel as if they are in the wrong gender, but this perception may not correlate with a desire for surgical or hormonal reassignment. For example, people who were assigned female at birth who enjoy stereotypically masculine (per their cultural norms) attire, activities, and presentation may identify as transgender because their gendered preferences and expression are incongruent with the cultural expectations of females. While these female assigned people are gender non-conforming, they may identify as transgender without feeling trapped in or wanting to modify their bodies. A *transgender* person may dress, behave or self-identify anywhere along a culturally defined gender *spectrum*, i.e., a

non-binarized and three-dimensional palette of gender and sex expression. The primary difference between the two is often described in terms of the restrictiveness of the category *transsexual*, which implies that a person desires body modification and to be socially recognized as the “other” gender. Indeed, after physically transitioning, many transsexual people consider themselves men or women and no longer identify as transsexuals (Bolin 1988; Devor 1993; Newfield et al. 2006).

Theories about the etiology of transgender and transsexual identity are numerous. Many of the most recent focus on “brain sex” or “brain gender,” i.e., specific anatomical sites and/or brain-regulated hormonal processes that “sex” a person as either male or female (Gooren 2006; Hines 2004; Kruijver et al. 2000; Moir and Jessel 1989; Zhou et al. 1995). Although there has been a marked increase of research in this area within the past decade, there is a range of opinion about its explanatory power. Some of this disagreement extends to terminology. Research has thus far failed to attribute gay and lesbian identities and/or behaviors to biological causes (Frankowski 2004; Herrn 1995), and many in the transgender community interpret their experience along the same lines, i.e., as a complicated and overdetermined mix of biological, social, psychological, hormonal, and possibly neuro-anatomical factors. Others, however, believe that theories of “brain sex”—that anatomical sex differentiation can occur along separate brain and genital trajectories—are more resonant with the experience of transgender persons. According to this argument, gender identity is (biologically) located in the brain rather than the genitalia (Rametti et al. 2011), and altering one’s body and/or lifestyle to more properly align with this sex should not be understood in terms of a transition, but rather an affirmation. This at times contentious dynamic within the community itself has led one activist and researcher to label the terms MTF and FTM “prejudiced, inaccurate and genitocentric”³ and

³ <http://www.truecolours.org.au/publications/ypwts.html>. See also: http://www.annelawrence.com/brain-sex_critique.html for a critique of the brain-sex theory.

to propose acronyms that better reflect this approach: *affirmed females* (AF) and *affirmed males* (AM) for individuals whose brains are sexed female and male, respectively (Fenway Health 2010). A leading adolescent medicine expert suggests referring to transgender youth as *asserted males* and *asserted females* because *asserted* does not imply that someone else has to affirm their gender identity for it to be authentic (Olson, personal communication, 2012). Notably, these terms could include women and men whose genitals align with their brain and who choose to stay that way; these individuals are often referred to by gender activists, however, as *cisgender* persons (i.e., non-transgender persons). *Cis* women and *cis* men (the latin *cis* means “same”) live in and identify with the same body in which they were born.

Many transsexuals feel strongly about making a commitment to a gender identity, where transitioning marks a clear move across, i.e., *from one gender to the other* (Namaste 2000). For these individuals, there is an unambiguous divide between men and women, one dictated by anatomy, hormones and an overall “sense of self.” For others, the line between genders is less clear, and many may not require genital surgery, hormones, or any changes in clothing, partner choice, occupation, or social role(s) in order to feel as if they are living in the gender with which they most closely align. For others still, the line between genders is not a line at all. Rather, the binary between male and female is illusory and, for them, playing with sex and gender is a creative, political, or rebellious way to express that on a daily basis (Bornstein 1994; Feinberg 1997; Nestle et al. 2002). Importantly, it is not only trans people who believe in deconstructing this binary; many cisgender and transgender people live the details of their lives in ways that purposely and consciously challenge the often restrictive categories of male and female. A person with an active disinvestment in the gender binary who does not identify as either “male” or “female” per say might call themselves *gender-queer* in order to indicate that what is getting “queered” is the gender binary itself, not the sexual orientation of the person in question.

Also of importance is that none of these terms have historically included individuals born with bodies that could not be easily categorized as male or female by parents and/or physicians. In fact, these people have been historically excluded from the DSM-IV-TR diagnosis of Gender Identity Disorder in order to separate the “typically-sexed” transgender population from those born with more “ambiguous” sex characteristics (APA 2000). This latter group, currently described as *intersex*, may be surgically “assigned” a single sex shortly after birth (Kohler et al. 2012); some grow up to reject that assigned sex, however, owing to some of the same factors that transgender persons cite: an incongruence between chromosomal, hormonal, anatomical, and/or affective experiences of their sexed and gendered selves. Some intersex persons prefer to be included as *trans*, while others would rather distance themselves from this population. Again, this population remains relatively unquantified, despite a decade-old uptick in both writing and research about intersex persons. This research includes important works by critical biologist Anne Fausto-Sterling, who attempted to enumerate and quantify five “sexes” in 1993 (though she has since revised this taxonomy), as well as historian Alice Dreger, whose book *Hermaphrodites and the Medical Invention of Sex* (2000) has been praised for bringing the voices of intersex individuals and clinicians into critical dialogue with one another. Suzanne Kessler (1990, 1998) and Katrina Karkazis (2008) have each conducted long-term ethnographic research with families and clinicians and intersex activists, including Cheryl Chase (1998, 2003) and Riki Wilchins (1997, 2004) have written scores of popular, clinical, and scholarly publications on the subject.

There are divisions among clinicians about which disorders of sexual development/differentiation should be counted as *intersex*, and most surgeons, wanting to “leave well enough alone,” have neglected to conduct long-term follow-up research with the individuals they have assigned at birth (Karkazis 2008). As with trans issues, word choice and terminology are profoundly political within this population, reflecting dynamic

notions of identity informed by new information, the perfection of surgical techniques, and shifts in social attitudes (Dreger et al. 2005). Terms that have been used thus far—hermaphrodite, ambiguous genitalia, intersex, and disorders of sexual development/differentiation (DSD)—do not capture the complexity of many of these individuals' identities. Many who feel that their surgery was performed improperly have become politically active and have vociferously called for an end to what they understand as genital mutilation. There are also adults living far more quietly in their sex of assignment, to varying degrees of contentment, who remain invisible and uncounted. Many of these individuals would consider themselves to have transitioned if their gender identity is different from the sex they were assigned. Many, perhaps because of the acute way that their own bodies signal the inadequacy of the gender binary, choose to live in terms closer to *genderqueer* (Nestle et al. 2002). What is most relevant here is that regardless of ideological positioning, this population experiences many of the same issues as the transgender population under consideration in this chapter.

In order to capture the largest population of gender variant individuals, we will use the broader term *trans* to refer to persons who wish to be socially recognized as a gender distinct from their assigned sex, with or without the desire for body modification. For reasons of order and containment, we will limit our presentation of data and discussion to populations—however inconsistently defined—that have either transitioned from one gender to another or who present with a desire to do so. Much of what is both exciting and challenging to document is the shifting nature of the population itself; there is currently no uniform definition of what it means to be *transgender*, partly because the various communities prefer it this way. Research that purports to represent a *transsexual* or *transgender* group or population should be critically evaluated for inclusion and exclusion criteria (surgery, hormones, lifestyle changes, social and legal identities) before conclusions are drawn from the results or generalizations are made. Indeed, it is likely that by the time this chapter goes to press,

another term or set of terms will have emerged, rendering those employed here irrelevant or even politically incorrect!

Sexual Orientation and Sexual Behavior

One of the more unfortunate ways that trans people are publicly imagined are as objects of erotic curiosity and gratification, a subculture organized around transgressive and fetishistic sexual behaviors; this reality is underscored by any Google search, including images, of the word “transgender.” However, trans identity does not correlate with any particular primary object(s) of desire. Rather, a trans identity reflects the *gender* that a person feels, lives, and wishes to express, including all of its non-sexual aspects. Although elements of one's gender are influenced by one's object(s) of desire, gender scholars are careful to stress that conflation of gender identity and sexual orientation fix, rather than unsettle, heteronormative assumptions about sex and sexuality (Halberstam 1998; Karkazis 2008). Contemporary attitudes about homosexuality reflect increasingly tolerant scholarly and social discourses, both of which include the understanding that same-sex desire does not inevitably correlate neatly with dominant definitions of masculine or feminine. It is important, therefore, that we disrupt beliefs that even some trans people might have about *why* they are in the wrong body/sex/gender: were a same-sex attraction the *only* criteria leading people to believe they were trans, we might caution them to think their desire through more carefully, stressing the inadequacy of that attraction as the sole criteria for changing genders. In other words, in order to most adequately apprehend the bodily *and* affective experiences of trans people, including their varied approaches to change via surgical, hormonal and behavioral means, we must de-naturalize many of the habitual assumptions made about the relationship between gender identity and any particular “sexuality.”

Carefully separating sexual orientation from gender identity as well as from physical sex draws attention to the ways that each of these domains is socially constructed, or at least informed

(Bornstein 1994; Denny and Green 1996; Diamond 2001). This is a key issue for many individuals who want to make a socially recognized gender transition that is unrelated to her or his object(s) of sexual desire; a person assigned female at birth who transitions to male may have male, female, trans, all, or no sets of these people as sexual partners. Moreover, labeling inconsistencies complicate the scientific literature because early research frequently used birth-assigned sex rather than current gender identity as the basis for assigning a sexual orientation to transsexuals. For example in one study, FTMs who were attracted to women were labeled homosexual and in another, more recent, study, FTMs who were attracted to men were labeled homosexual (Bockting et al. 2009; Chivers and Bailey 2000). This presents a problem in discussing research because sexual orientation labels, which are often organized around birth sex, are frequently more complex and nuanced with the transgender population, rendering any conclusions about the “sexual orientation” of *any* trans person questionable at best. FTMs who identify as men (and no longer as trans men) and who are attracted to males may identify as “homosexual;” whereas male-attracted FTMs who may be somewhat earlier in the transition process, or who still identify strongly with a trans component to their male identity, may identify as “queer” or as a “tranny fag” (Pardo 2008; Valentine 2007).

At least part of this confusion can be attributed to the fact that the 4th of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), published in 2000 by the American Psychiatric Association, classified Gender Identity Disorder (GID) in terms of sexual attractions, despite a growing body of research to the contrary (APA 2000; Coleman et al. 1993; Meier et al. 2013; Rachlin 1999). (Much of this research has been conducted by trans and known trans-ally researchers, an epistemic shift that should not be overlooked; we will return to this point below). As the ultimate arbiter of psychiatric and normalizing categories, the DSM produces knowledge around which individuals and groups are encouraged to conform, and through which many of us come to understand specific populations. This authoritative

discourse finds its way into the general population, leading many trans individuals—and their sexual partners—to worry unnecessarily about the success or stability of their transition if they find their partner choices changing. By making sexual orientation part of its diagnostic specification for GID, the DSM-IV-TR conflated two elements of experiential identity that both trans activists and gender scholars endeavor to keep distinct. For these groups, the more important questions to pursue involve the ways that sexual orientation and gender identity intersect not only with each other, but also with other aspects of identity, including race/ethnicity, socioeconomic status, and education. Not only has recent research demonstrated that, at least for many cis women and trans men, sexual orientation is far more fluid and shifting than previous studies have reported (Diamond 2008; Meier et al. 2013), but also that the lived experience of a “gendered sexuality” is far more complex and varied than criteria-based profiles can adequately represent.

Further, research attempting to examine the psychological differences between trans people who reported differing sexual attractions (to females, to males, to both, to neither) has produced mixed results (Lawrence 2010a, b; Meier et al. 2013; Nuttbrock et al. 2010). The World Professional Association for Transgender Health, Inc. (WPATH), formerly the Harry Benjamin International Gender Dysphoria Association, issued a response to the proposed DSM-5 GID replacement disorder Gender Dysphoria (De Cuypere et al. 2010). The WPATH committee stated that they supported the removal of sexual attraction specifiers as Gender Dysphoria criteria, as sexual identity is irrelevant to a distress-focused disorder. The DSM-5 will be published in 2013 and its Gender Dysphoria diagnosis will not have sexual attraction specifiers. It is anticipated that clinicians will have to specify whether the patient is intersex. Unfortunately many of the non-medically trained clinicians who use the DSM for diagnostic purposes including psychologists, therapists, and social workers, may not be able to determine this.

It is reasonable and important to note that trans individuals engage in the same varieties of

sexual behaviors as do heterosexual and LGB (lesbian, gay, bisexual) individuals; this can include kissing, manual and oral stimulation of the genitalia, vaginal and anal penetration, frotage, mutual masturbation, phone or cybersex, watching or performing in sexually explicit media, BDSM practices, a variety of what are referred to as “paraphilias,” sex work, partial/total celibacy, or abstention from sexual activity all together (Bauer et al. 2012; Meier et al. 2010a). What might be considered unique about this population is that its behavior often disrupts assumptions about the relationship between genitals and gender. Though many trans men (FTMs) employ strap-on dildos or other penetration aides, many others do not and, in fact, many trans men incorporate the penetration and stimulation of their own vaginas and vulvas into their sexual behavior (Bauer et al. 2012; Meier et al. 2010a). Similarly, many trans women enjoy penetrating their partner(s) and/or do not desire vaginal penetration even if they have gone through surgical “reassignment.” These genital-gender incongruencies can be confusing to uninformed healthcare providers or other well-meaning individuals, leading to awkward and embarrassing exchanges or even denied access to healthcare when, for example, a trans man presents at a clinic for vaginal discharge or an abortion.

Baumle et al. (2009) note that sociology has typically attended to “sexuality” via the ways that it interferes with the traditional demographic category of fertility; that is, homosexual behavior and sexually transmitted infections become categories of analytical interest because of the effects that they have on reproduction. This emphasis, they argue, forces us to think about sexual orientation as a set of behaviors rather than an identity (3–4). Though we have used the previous section to “complicate” the stability of such an identity when it comes to the category transgender, we stress that the remainder of the chapter takes such a category at (relative) face value. The following discussions of prevalence, medical and mental health, family and relationships, discrimination, and work issues are all grounded in the real-life experiences of individuals who are seeking

to or have already “transitioned” to the best of their ability. Though, again, we believe that the contemporary transgender experience resonates with Laumann and colleagues’ description of homosexuality, i.e., as “a multidimensional phenomenon that has manifold meanings and interpretations” (1994: 301), we bracket the open-ended nature of the category for the remainder of the chapter in order to offer the most useful and up-to-date information possible.

Prevalence

In general, we might think about prevalence in two ways, either as: (a) a snapshot that can answer questions such as: How visible is a particular population or identity-based group of individuals? How likely are members of a society to encounter trans individuals in their daily lives or believe that they are “real,” possibly even a part of their existing world?; and (b) demographic prevalence that is driven by statistics on a particular set of variables in a population.

Snapshot Prevalence

Thomas Beatie made headlines in 2008 when he was popularly dubbed “the pregnant man.”⁴ Beatie, a Filipino-American former beauty queen, posed for photographs, was interviewed by Oprah, and was featured in a number of print and web-based media during the months of his pregnancies providing a particular kind of “face” to the trans man population. As we have noted, Beatie’s body breaks with the conventions of a *transsexual*, but the combination of his male gender identity and (procreative) female reproductive organs is consistent with the category of *transgender* with which we are working in this chapter.

⁴ Though perhaps the first to go public, Beatie was not the first trans man to become pregnant. Beatie has since had his second and third babies and is in the process of divorcing his ex-partner who is a cis woman. See: <http://www.dailymail.co.uk/femail/article-2197581/Worlds-pregnant-man-Thomas-Beatie-finds-love-prepared-conceive-FOURTH-time-new-lover-cant.html>

Media stars like Oprah have the power to redefine and recontextualize marginal populations; a televised interview with someone like Beatie can provide a cultural legitimacy that is unavailable through (previously) popular discourse. The 20/20 production of “My Secret Self,” featuring Barbara Walters exploring the lives of transgender children, had a similar effect in 2007. Sensitive produced, the program resonated throughout much of the trans community and continues to be used as a resource in public relations, education, and training efforts. Though this chapter will not deal extensively with transgender children, it is worth mentioning that there may be an increasing prevalence of GID among younger people, including children (Möller et al. 2009; Reed et al. 2009; Rosin 2008; Zucker et al. 2008). Studies of young children find that parents report that 0.5 to 1.4% of birth assigned male children and 0.6 to 2.0% of birth assigned female children wish to be the other gender (Verhulst et al. 1997; Yu 2009). Internationally, between 0.7 to 0.9% of birth assigned male college students and 2.2 to 2.9% of birth assigned female college students report that they wish they were the other gender (Chi in preparation; Lai et al. 2010 as cited in Winters and Conway 2011). Zucker et al. (2008) report that their number of referrals of children with GID has nearly tripled from 2000 to 2004. It still remains to be seen, however, whether that increase is: (a) real; (b) related to greater social tolerance and visibility; or (c) causally connected to other biocultural events (e.g., industrial pollutants and endocrine disruptors) through which embryological brain and genital development is being affected.

For reality-TV fans, entertainer RuPaul is the face of the trans population, and his MTV-produced show *Drag Race* has a loyal and diverse audience (Stanley 2009; Wieselman 2010); for political aficionados, it is Amanda Simpson, the Senior Technical Advisor to the Department of Commerce, and the nation’s first transgender presidential appointee.⁵ For economists, it is Deirdre (formerly Donald) McCloskey, an

internationally renowned economist and University of Illinois professor who published a memoir about her very public transition in 1999.⁶ And for the parents of young children, it is the availability of a book called *10,000 Dresses* (Ewert 2008), which chronicles a transgender girl’s struggle to be recognized by her family.

Though much of this media celebrity, along with the popularity of trans-specific procedures on surgical reality shows, might cater to the more prurient interests of the general public, many members of the trans population take comfort in any measure of public recognition that does not actively advance discriminatory attitudes or behaviors. Transsexual, transgender, and trans ally scholars, activists, and researchers have also begun to take greater control over how the trans community is represented by conducting and disseminating their own research and media, aided by the inception of *The International Journal of Transgenderism* in 1997.

Our purpose in providing this “snapshot” overview is to provide a social and representational context to the prevalence data in the next section. Though we do not suggest that there is any particular correlation between the recent visibility of the trans population and the numbers that follow, we do encourage the reader to use both kinds of data in their own attempts to better understand the populations under consideration here.

Demographic Prevalence

Difficulties with measuring the trans population stem from the definitional dilemmas that we have discussed thus far. Though numerous researchers have reported prevalence statistics, they must be cited with caution because of the inconsistency with which “transsexual” and “transgender” have historically been defined. Prevalence estimates have traditionally come from gender clinics, where patients have been: (a) seeking body and hormonal modifications not necessarily sought by *all* trans-identified people; (b) compelled to

⁵ Appointed by Barack Obama in January, 2010.

⁶ *Crossing: A Memoir*, University of Chicago Press.

identify in a particular way in order to access the clinic services offered (van Kesteren et al. 1996; Weitze and Osburg 1996). Compounding the second problem are the verbal commitments to a sexual orientation that some of these patients have had to make in order to either secure services or be considered to have transitioned “successfully” (Lev 2005). Moreover, the personal and professional investments made by individual researchers in defining this population often play a significant role in their inclusion/exclusion criteria. In other words, because the community itself remains divided as to the “nature” of a trans-identity—its relationship to “brain sex,” culturally constructed gender roles, and homosexuality, for example—research conducted among this population reflects the multiple lenses through which transgender individuals are understood. Indeed, at least one researcher has suggested that most trans-children are cis and homosexual, and that behaviors consistent with GID are the child’s way of “coming out of the closet” (Zucker et al. 2008).

The prevalence data most frequently cited come from a gender clinic in the Netherlands and demonstrate that 1 in 11,000 (.009%) persons are MTF, and 1 in 30,400 (.0032%) are FTM (van Kesteren et al. 1996). A recent study from Singapore found 1 in 2,900 (.034%) MTFs and 1 in 8,300 (.012%) FTMs, while a study in Belgium found 1 in 12,900 (.0077%) MTFs and 1 in 33,800 (.0029%) FTMs (Winter et al. 2009). The American Psychiatric Association, using GID criteria, suggested that MTFs had a 1 in 30,000 (.0077%) prevalence rate, while FTMs were 1 in 100,000 (.0029%) (APA 2000). In contrast, another investigator suggests that if inclusion criteria were broad enough to cover everyone on the transgender identity spectrum (e.g., cross dressers with no desire for body modifications, intersex persons, genderqueer persons, masculine females, feminine males, etc.), we would find 1 in 2,000 (.05%) people to be trans (Conway 2002). Finally, researchers presenting at an annual transgender conference in 2007 estimated that “recent incidence data and alternative methods for estimating the prevalence of transsexualism [sic] [...] indicate that

the lower bound on the prevalence [...] is at least 1: 500 [for all combined], and possibly higher.”⁷ A research brief from the Williams Institute estimates that there are around 700,000 trans people in the U.S. (0.3% of the population; Gates 2011). See Table 16.1 for a summary of prevalence estimates.

Although still significantly smaller, the 1 in 500 (0.2%) ratio comes closest to the estimate provided by the U.S.-based National Transgender Advocacy Coalition: that 2–3% of the (U.S.) population is transgender, some of whom overlap with the lesbian, gay, or bisexual (LGB) population and many that do not. This overlap is notable because it indexes the difficulty in neatly classifying the trans population into categories of sexual orientation—how the person and/or researcher defines LGB in the context of a trans identity will determine the manner in which the prevalence rate will accordingly shift. In Iran, this articulation is even more intriguing. Though it is currently illegal to be openly LGB in Iran, it is legal and, to a degree, socially acceptable to undergo gender transition. This has led to Iran having one of the highest known “transgender” prevalence rates in the world, somewhere between .12 and .18% of the population (MTF and FTM combined) and it is likely that many of these individuals would not identify as trans in other geopolitical contexts (SAFRA 2009). Based on their review of trans prevalence literature, Winters and Conway (2011) estimate that there are over 15 million trans people in the world.

These prevalence estimates are useful to a degree as they repeatedly demonstrate that vastly greater numbers of birth-assigned men appear to transition to another gender than do birth-assigned women (with the exception of Poland, Sweden, Iran and Japan) and that the overall percentage of the trans population across geographical areas is typically less than 1% of the population. The difference between these small estimates, however, and those larger estimates cited by Conway and others, point to the possible

⁷ <http://www.truecolours.org.au/publications/ypwts.html#15>. Paper presented at the WPATH 20th International Symposium, Chicago, Illinois, September 5–8, 2007.

Table 16.1 The prevalence of transsexualism

Country	Year reported	Incidence (per 100,000 age 15 or above)	Total	MTF	FTM	MTF:FTM	Method	Reference
Australia	1981	4.9		1 in 24,000	1 in 150,000	6.1 to 1	Reports from psychiatrists on transsexual patients seen from 1976-1978	Ross et al. (1981)
Belgium	2007	10.7		1 in 12,900	1 in 33,800	2.6 to 1	Reports from plastic surgeons and gender teams on transsexual patients seen from 1985 to 2003	De Cuypere et al. (2007)
Germany	1996	2.1		1 in 14,400	1 in 33,200	2.3 to 1	Data from German courts regarding legal name and sex changes from 1981 to 1990	Weitze and Osburg (1996)
India	2009	167		1 in 600	Not available	Not available	Community estimate	Winter (2009)
Iran	2009	72		1 in 555	1 in 833	1.5 to 1	Community estimates	SAFRA (2009)
Iran	2009	45.5	1 in 2,200 to 3,300	Not available	Not available	Not available	Clinic studies	Winter (2009)
Iran	2010	8	1 in 13,000	Not available	Not available	Not available	Clinic based data	Alizadeh (2010)
Iran	2011	1.4	1 in 141,000	1 in 145,000	1 in 136,000	1 to 1.1	Reports on GID diagnoses from the Tehran Psychiatric Institute from 2002 to 2009	Ahmadzad-Asl et al. (2011)
Ireland	1982	1.9	1 in 52,000	1 in 71,400	1 in 214,300	3 to 1	Gender clinic cases of GID for 14 years: 21 MTFs and 7 FTMs Calculated from author's North Ireland 1982 population estimate of 1,500,000	O'Gorman (1982)
Ireland	2006	1.4		1 in 84,400	1 in 542,500	6.4 to 1	Gender clinic cases of GID from 2000 to 2004: 45 MTFs and 7 FTMs. Calculated from Ireland's 2000 population estimate in 3,797,257	De Gascun et al. (2006)
Japan (Western)	2008	1.4		1 in 173,913	1 in 114,613	1 to 1.7	Gender clinic cases of GID from 1997 to 2005: 349 FTMs 230 MTFs. Calculated from the authors Western Japan population estimate 40,000,000	Okabe et al. (2008)

Malaysia	2001	500 (MTF only)	Not available	1 in 200	Not available	Not available	Community estimate	Jamaludin (2001)
Malaysia	2009	1,333	1 in 75 to 150	Not available	Not available	Not available	Community estimate	Winter (2009)
Netherlands	1993	11.7	1 in 11,900	1 in 11,900	1 in 30,400	2.6 to 1	Gender clinic cases with gender dysphoria from 1975 to 1993	Bakker et al. (1993)
New Zealand	2008	31.9	1 in 3,639	1 in 22,714	6.2 to 1	Passport data obtained from the New Zealand Passports Office		Veale (2008)
Poland	2000	0.26	1 in 1,692,000	1 in 497,700	1 to 3.4	Gender clinic data obtained from 1980 to 1998		Dulko and Inielinska (2004), as reported in Herman-Jeglinska et al. (2002)
Scotland	1999	8.2	1 in 61,000	1 in 15,200	4 to 1	Data from general medical practices on patients with gender dysphoria		Wilson et al. (1999)
Singapore	1988	35.2	1 in 2,900	1 in 8,300	2.9 to 1	Cases from the Department of OB/GYN at the National University of Singapore and three private surgeons		Tsoi (1988)
Spain (Andalusia)	2006	16.8	1 in 5,954	1 in 9,685	1 in 15,456	1.9 to 1	Clinic study	Esteve et al. (2006)
Spain (Catalonia)	2006	6.83	1 in 14,632	1 in 21,031	1 in 48,096	2.6 to 1	Clinic study	Gómez-Gil et al. (2006)
Sweden	1996	0.17	1 in 1,030	1 in 1,008,400	1 in 1,411,700	1.4 to 1	Data from the Bureau of Social Welfare files from 1972 to 1992	Landen et al. (1996)
Taiwan	2009	97.1	Not available	Not available	Not available	Not available	Clinic studies	Winter (2009)
Thailand	2002	599 (MTF only)	Not available	1 in 167	Not available	Not available	Community estimate	Winter (2002)
Thailand	2009	333	1 in 214	1 in 300	Not available	Not available	Community estimate	Winter (2009)
United States (Massachusetts)	2011	476	1 in 214	Not available	Not available	Not available	Telephone health survey	Conron et al. (2012)
DSM-IV-TR	2000	4.3	1 in 30,000	1 in 100,000	3.3 to 1	Data from Europe and referrals		APA (2000)

limitations of these data and the definitional dilemmas discussed earlier. Sample sizes for these studies are often small, making it difficult to generalize the results, and since they typically come from gender identity clinics, they represent what many would call the narrowest end of the trans-identity spectrum (Horton 2008). It has also been suggested that many of these clinics have used coercive methods in order to recruit subjects, compelling hormone or surgery-seeking patients to define themselves in terms they might not otherwise in order to receive services (Lev 2005; Meyerowitz 2004). Indeed, in an ethnographic study conducted in New York City in the 1990s, Valentine (2007) found that many of the gender variant individuals that he came to know only identified as “transgender” after they were labeled as such by a social service or health-care agency. It is difficult to know if such methods contribute to an over-representation of the population because of padded data or an under-representation, due to the subsequent avoidance of clinics by trans folks who learned to obtain services elsewhere (see section below on “Health and Healthcare”). There are also anecdotal data to suggest that many trans persons avoid research/gender clinics because they are asked to pay for the psychological assessments that are performed on them or do not want their transitioning related data to be used for research studies (Anonymous transgender patients, personal communication, 2009).

Some trans people who make a medical and social gender transition choose to not disclose their history, preferring to be perceived only as their asserted gender. Indeed, a portion of these individuals may have never identified as trans, leading them to sometimes be referred to as *stealth* (colloquially) or *non-disclosing* (Green 2004). Though for some, a stealth identity might be asserted as “I’m (just) a woman, not a trans woman,” it might be more accurate to say that there are levels of disclosure—from people that completely disavow their past to people who simply do not make it public.

It is easy to see that numerous trans people are flying under the proverbial radar. One group that “avoids” gender clinics, and may therefore not be

counted, are people without the financial resources to access body modification, psychotherapy, or the social programs through which many transgender people are located and quantified. Some of these people will pursue surgery and/or hormones in another country, online, or through an informal market, and through these channels may occasionally find their way to a researcher. But just as many will affirm their gender within quite limited means (e.g. shaving instead of waxing or electrolysis for the removal of body hair), a situation that may make it easier for them to “pass” in and out of a trans-identity when and if necessary (Valentine 2007). These sometimes invisible members of the trans community are one more reason why clinic-based prevalence estimates should be understood as limited underestimates. Moreover, the tenacious relationship between socioeconomic status (SES) and race/ethnicity means that the majority of transgender persons securing more permanent (and aesthetically acceptable) forms of body modification are white/Caucasian, leaving trans people of color and of limited economic means less visible to demographers but perhaps more visible to a public that easily perceives an incongruence. In an all-too-familiar vein, trans people of color often show up in data focused on HIV, substance abuse, sex work, and other risk factors associated with lower SES. Some researchers have critiqued this (often) uncritical pooling of “risk” factors (Boehmer 2002; Valentine 2007), as it is typically more connected to structural inequality than to any sex or gender-based identity. Clearly, much work remains to be done in finding methods that can most adequately represent the complexity of this population (Mikalson et al. 2012), as “our lack of knowledge about how to identify transgender respondents on general population surveys hinders efforts to improve the health and socioeconomic status of this marginalized community” (SMART 2009, p. iv).

The regularity with which trans women outnumber trans men in these estimates remains a compelling pattern, and one that remains insufficiently explained. One set of theories suggests that birth-assigned females transition less because there is greater social room in

which they can maneuver with more masculine behavior (e.g. clothing, occupation). Even these categories have their limits, however, and trans men have been increasingly articulate about both the difficulties and the rewards of making bodily changes that more fully secure their positions as men (Schilt and Connell 2007; Valentine 2007). Valentine has argued that this non-transitioning space in which “masculine” and other women navigate is unavailable to men and that this may partially explain why more birth-assigned men make the bodily commitment to affirming their female identities. In other words, Valentine suggests that there is no socially acceptable equivalent to the butch straight woman for men who wish to live a feminine identity that does not correlate with an LGB one. He concludes that gender “reassignment” may be the only way for men to gain access to this space. Confounding these more speculative theories, however, are compelling data from Poland that demonstrate a significantly higher rate of FTMs than MTFs (Herman-Jeglinska et al. 2002; Levy et al. 2003) than do data from the Netherlands and other reporting countries. And though explanatory models remain scarce, some researchers have long questioned MTF/FTM disparities and find the Polish data neither new nor surprising (Herman-Jeglinska et al. 2002; Hoenig and Kenna 1974). In fact, many researchers and clinicians believe that FTMs are more likely to “go under the radar,” even from researchers, and therefore have been routinely underestimated in prevalence data (Green J, Meyer M, Schilt K, 2008–2010, personal communication).

Importantly, when trans researchers start measuring members of their own population, larger sample sizes are typically collected. Samples of trans people in research conducted by cis researchers have historically ranged from 1 to 100 (Van Borsel et al. 2000; Chivers and Bailey 2000; Cohen et al. 1997; Lothstein 1984), yet recent research by trans researchers produce data sets from 200 to over 1,000 (Davis and Meier, submitted; Dickey 2007, 2010; Meier et al. 2010a, 2013; Veale et al. 2008). Trans researchers tend to be more aware of the community’s needs

and potentially offensive language than even well-meaning cis researchers. Participants in the trans author’s (of this chapter) thesis and dissertation research have consistently expressed relief that the study in which they are participating is being conducted by “one of us.” Trans participants also have far less to lose when disclosing atypical gender-related desires if the research is not being conducted within the context of a gender clinic; this may lead to the collection of more accurate information. Lastly, because the trans community has a strong Internet presence, they are well connected and can refer many other trans people to studies that they deem “sensitive” and “worthwhile,” whereas they may also warn others not to participate in studies not considered “safe.”

Prevalence in the DSM-IV-TR Gender Identity Disorder (now Gender Dysphoria) and Children

The DSM presents yet another definitional challenge to establishing prevalence. One major concern that arises from the lack of a standardized definition for the term *transgender* is whether and how to include children and adolescents in this category. Because GID is the most measurable and longest running set of criteria related to being trans, there has been a significant degree of conflation between gender dysphoria and the category of transgender when these individuals are being assessed and evaluated. While a GID diagnosis exists for children and adolescents, experts have noted that many of those who meet the criteria for GID in childhood grow up to identify as LGB and not transgender (Wallien and Cohen-Kettenis 2008; Zucker et al. 2008). Further, many transgender people report that they were not aware of their transgender identity until adulthood or that they hid their gender non-conforming expressions and behavior from others due to shame and would not have met criteria for GID in childhood (Seil 2004). As such, using the criteria for GID in childhood for prevalence estimation of transgender children and adults is clearly limited.

The DSM is used to help researchers calculate the prevalence of mental disorders and it continues to carry a great deal of authority for researchers, clinicians, and insurance providers; this presents a major problem for many both in and outside of the transgender community who do not view a gender identity that is incongruent with one's birth-assigned sex as inherently disordered. Largely for this reason, the DSM has recently revised both the criteria and the nomenclature for GID and it will be re-named Gender Dysphoria.⁸

Currently, there are two leading schools of thought concerning how trans children should best be approached: (1) Ehrensaft's acceptance—based on Brill and Pepper's ideas of unconditional love and Ryan's model of Family Acceptance, this approach involves helping the child to be comfortable in his or her asserted gender identity (Brill and Pepper 2008; Ehrensaft 2011; Ryan et al. 2008); (2) change—based on Zucker's research, this involves attempting to change the gender non-conforming expression, roles, and preferences of the child (Dreger 2008; Rosin 2008). Supporters of the latter approach caution about the difficulty and cost of a transgender identity, arguing that being LGB is preferable.⁹ In a study with children labeled as transgender, Wallien and Cohen-Kettenis (2008) found that the most common outcome of this childhood pattern is an LGB non-transgender identity.

Though the "disordered" language of the DSM has long been a target of criticism, some of it has been assuaged by the nomenclature and criteria-based revisions underway. For some, however, Gender Dysphoria continues to index a malady or discordance that the phrase "normal expression of gender variance" does not. Others have a categorical critique, and are concerned about GID's inclusion in a section (Sexual and Gender Identity Disorders) that includes pedophilia and other

"paraphilias" such as voyeurism and fetishism. Gender Dysphoria is set to be placed in its own section in DSM-5. Further, many of the current criteria for children are written with what seem to be narrow interpretations of behavioral patterns. The pathologization of boys who avoid "rough and tumble play," for example, indexes a set of culturally-specific gendered stereotypes through which all kinds of "gendered" behavior can be misunderstood. Some critics, and not just transgender ones, go even farther and argue that the DSM cannot adequately represent mental or emotional disorders from the narrow perspective of the U.S., as it remains unclear whether the difficulties related to GID are intrinsic to persons with GID or whether they are the outcomes of feeling discriminated against, socially rejected, or stigmatization (APA 2009; Winters 2009).

Some see a DSM diagnosis as a possible path to legitimacy, awareness, protection in discrimination lawsuits, and greater insurance coverage, but this has been questioned as countries that now cover gender affirmation treatment often only do so if the patient agrees to a "full" complement of therapies (chest and genital surgery, hormones etc). The revisions to the GID diagnosis will be published in DSM-5 and will affect prevalence calculations for at least the next 10 years. Though it is too early to tell, with both U.S. healthcare reform and DSM revisions in the coming decade, it is possible that the relationship to a childhood or adult diagnosis of GID—and the prevalence rates derived from it—will look vastly different than they do now.

Social Complications and Context

There are multiple layers of social complications that make prevalence estimates challenging. Demographers attempting to count the number of people who legally change their gender should be aware of the procedures and barriers involved in this process. Those who are attempting to separate LGB and T persons for prevalence estimates may not realize the political ramifications of such a separation or the fact that many trans people identify with an LGB sexual orientation. Also, any prevalence estimate of this population must take

⁸ The latest DSM will be its 5th revision, and a new name for gender dysphoria will constitute the "condition's" 3rd revision. It is worth noting here that homosexuality was a DSM-certified disorder until 1973 (Drescher 2009).

⁹ J Cantor, 2009, personal communication.

into account the overwhelming rates of suicide among, and hate crimes against, trans people. We compile these complications here as a guide toward generating better estimates that are urgently needed in order to inform the policies and regulations that aid trans people in accessing medical, legal, and social recognition and services.

One way researchers are attempting to calculate the prevalence of trans people is by counting the number of people who have had their gender changed legally on identification documents (Bauer 2012; Veale 2008). Currently, the procedures through which an individual can legally change his or her name or gender vary widely, both within the U.S. and across other countries. In some U.S. states, individuals can simply check a box on a form in the Department of Public Safety, while other states require the individual to pay hundreds of dollars, stand before a judge, and present a psychological evaluation report or physician's letter endorsing their suitability for name/gender change (Transsexual Road Map 2010). Still other states do not allow one's gender to be legally changed without having undergone a specified complement of gender affirmation treatment, including chest and genital surgery. Further, a few jurisdictions simply refuse to recognize a gender change on a birth certificate, regardless of social or medical transitions. Demographers should also take note that once a trans person obtains a legal gender change on identification documents, they may be less likely to indicate that they are transgender on surveys, as they are socially recognized as their gender identity and may not wish to disclose their trans history. This may also be the case for those trans people (regardless of legal gender status) who do not identify their gender to be "transgender," but rather male or female.

Name change is an issue that relates directly to legal identification documents (passport, driver's license, birth certificate, social security card), all of which need to be congruent in a variety of situations, such as acquiring a bank loan, receiving one's inheritance, working for particular institutions, or receiving federal subsidies for education or housing. Gender change, while related to these issues, can also lead to charges of fraud. Numerous trans persons have had inheritances challenged by the children of a deceased

spouse who argue that their parent was the victim of gender fraud (Bratter and Schilt 2009; Flynn 2001). To date, these cases are typically handled on a case by case basis, and no widespread legal precedent currently exists to protect trans individuals from these types of suspicion and exclusion. Finally, trans men may not attempt to obtain a gender marker correction to 'M' on their drivers license, as once they are legally recognized as male, they are commonly denied insurance claims for hysterectomies, pregnancy, and/or government funded student loans, as most have never applied for the draft. These complications, coupled with the fact that some trans people will never attempt to legally change their name and/or gender, complicate this method of prevalence estimation.

For some lawyers and legal scholars, trans issues are a unique opportunity to redefine and reconceptualize categories of personhood, rights and privileges. Some advocate for trans issues to be conceptualized within a framework of human rights, while others define the trans legal experience in terms of discrimination (Flynn 2001). Different legal conceptualizations of trans people have implications for prevalence calculations (e.g. should we estimate the number of LGBT people or LGB and T people?). Trans activists and the trans community itself are also multiply positioned, with some preferring to identify within the identity-based umbrella of "LGBT," and others who feel that, because a trans identity is not organized around sexual orientation, the "LGB" movement has little to offer in the way of political protection or advocacy and sometimes trans people even face trans-negativity within the LGB community (Currah et al. 2006). Indeed, this divide was brought into clear focus when the gay and lesbian-focused Human Rights Campaign (HRC) elected to exclude "trans" from their list of identities deserving of special protection against employment-based discrimination.¹⁰

¹⁰ See especially Valentine (2007) for an excellent history of this episode. Though beyond the scope of the chapter, it is worth noting that some of the discourse surrounding this decision was related to the (formal) LGB political community's desire to appear to be as "normal" as possible, a move that some argue sacrificed allegiance with the trans community for mainstream social acceptability.

Another complexity concerning estimating the prevalence of the trans population is the incredibly high rates of suicide and homicide (See section below on “Population Health: Mental Health” for a more in-depth discussion of suicide and Table 16.5 for rates). Recent research has demonstrated that LGB youth and adults may be at significantly higher risk for suicide attempts than their heterosexual peers (King et al. 2008; Marshall et al. 2008), yet research on the prevalence of these problems within trans populations is rare. As many as 16–45% of trans individuals have attempted suicide (Bockting et al. 2005; Clements-Nolle et al. 2006; Grossman and D’Augelli 2007; Kenagy 2005; Meier et al. 2011; Xavier et al. 2005); it is unknown how many more have been successful. Lobato and colleagues (2002) found that, compared to heterosexual and gay cis individuals, trans individuals had higher rates of completed suicide attempts than any other group except for lesbians (Lobato et al. 2002).

Homicidal and non-fatal hate crimes also occur at high rates in the trans population (Marzullo and Libman 2009). An expert affiliated with the Harvey Milk Institute in San Francisco estimates that “transgender individuals living in America today have a 1 in 12 chance of being murdered.” (Brown 1999). In contrast, the average person has about a 1 in 20,000 chance of being murdered (FBI 2009).¹¹ Taken together, this implies that trans people may be more than one and a half thousand times more likely to be murdered than cis people, a startling statistic that has obvious implications for attempting to quantify the trans population. From November 2011 to November 2012, the murders of over 265 trans people were reported, over 100 of them were trans women who were living in Brazil (TGEU 2013). As trans people are dying at higher than average rates due to suicide or homicide, overall prevalence numbers are thought to be a gross underestimate of the true prevalence.

¹¹ Based on the FBI’s “Uniform Crimes Reports, Crime in the United States 2000,” showing the murder rate of 5.5 people per 100,000.

Population Health Issues

For all the reasons outlined thus far, it has been challenging to collect data regarding trans-specific health care problems: representational categories dealing with this population have shifted, many trans people have been reluctant to participate in research, and there remains little to no consensus on the “biological” nature of a trans identity. What does exist, however, are a set of health problems related to transitioning itself, as well as a set of concerns among this population regarding access to affordable and adequate health care. This section will focus on the types of problems for which trans people most often seek trans-specific care (e.g., hormones, surgery), how clinicians can provide the most effective and the least discriminatory care possible (primary or specialized), as well as the vulnerabilities experienced by trans people whose access to health insurance is limited or compromised. Each of these variables can impact the health of the population as a whole.

An unfortunate number of healthcare providers have declined to provide care—comprehensive or episodic—to the trans population for reasons related to personal prejudice (Grant et al. 2010; Transgender Law Center 2004; Lambda Legal 2010). The National Transgender Discrimination Survey report on health and health care of over 7,000 trans respondents reported that 19% reported being refused care, 28% were harassed in medical settings, and 50% reported having to teach their provider about trans care (Grant et al. 2010). An even greater number, many of whom deny any such feelings, remain uneducated (Obedin-Maliver et al. 2011) about trans-specific healthcare needs, arguing that either: (a) the relatively small size of the population precludes the likelihood that they will see trans patients in their practice; and/or (b) there are no special needs about which to learn. For the authors of this chapter, neither of these explanations is an acceptable alternative to keeping a medical practice open and referring (as appropriate) patients that go beyond a practitioner’s level of expertise. Indeed, it

Table 16.2 Trans healthcare resources

Organization/Author	Resource/Title	Website/Publisher
World Professional Association for Transgender Health (WPATH)	Standards of care	http://www.wpath.org
Vancouver Coastal Health	Guidelines for transgender care	http://transhealth.vch.ca/resources/careguidelines.html
Vancouver Coastal Health	Clinical protocol guidelines for transgender care	http://transhealth.vch.ca/resources/careguidelines.html
The Endocrine Society	Clinical practice guideline	http://jcem.endojournals.org/cgi/content/full/94/9/3132
Fenway Health	Bibliography and resources	http://www.fenwayhealth.org/site/PageServer?pagename+FCHC_srv_services_trans_bibliography
Tom Waddell Health Center (San Francisco Department of Public Health)	Protocols for hormonal reassignment of gender	http://www.sfdph.org/dph/files/reports/default.asp
University of California at San Francisco (UCSF), Center of Excellence for Transgender Health	Primary Care Protocol	http://transhealth.ucsf.edu/trans?page=protocol-00-00
American Medical Students Association (AMSA)	Transgender health resources (includes guidelines from: WPATH, The Tom Waddell Center, The Endocrine Society, Vancouver Coastal Health, UCSF, Fenway Health)	http://www.amsa.org/AMSA/Homepage/About/Committees/GenderandSexuality?TransHlth.aspx
W.O. Bockting and J.M. Goldberg	Guidelines for transgender care	The Haworth Press, 2006
H.J. Makadon, K.H. Mayer, J. Potter, Hilary Goldhammer	Fenway guide to lesbian, gay, bisexual, and transgender health	American College of Physicians Press, 2007
G.E. Israel and D.E. Tarver II	Transgender care: recommended guidelines, practical information, and personal accounts	Temple University Press, 1998
J. Olson, C. Forbes, and M. Belzer	Management of the transgender adolescent	http://archpedi.jamanetwork.com/article.aspx?articleid=384321

is possible and even likely in some cities that healthcare providers have attended to non-disclosing trans patients in their practice who chose not to return because of unfriendly practices or attitudes and sometimes feeling burdened to educate their providers. Not only does this poor communication further complicate prevalence estimates, it can also perpetuate clinicians' skewed beliefs about the actual size of the trans population, and the likelihood that they will encounter a trans person in their practice. Additionally, since the clinical needs of the trans population vary widely—from basic and preventive screenings and services, to the monitoring of hormone regimens, to surgery-specific follow-up care—it is

unlikely that even an uneducated provider will have nothing to offer a trans patient.¹²

The LGBT community has produced a number of excellent documents and guidelines meant to educate and train providers, many of which include specific suggestions about training staff, office logistics (e.g., forms, bathrooms), basic

¹² Indeed, two recent developments regarding U.S. military veterans demonstrate the degree to which trans concerns have entered the “mainstream” of health care: the Department of Veterans Affairs’ decision to cover the cost of transition-related counseling and hormones for eligible veterans (Department of Veterans Affairs 2011), and research finding the rate of trans veterans is higher than the general public (Shipherd et al. 2012).

trans-specific medicine (types of surgery, risks of hormone therapy), and acceptable standards of care. We strongly recommend these guidelines, available in Table 16.2, as we have found that materials produced outside of the trans community, even when well-intentioned, sometimes sacrifice sound clinical information for a focus on the exotic and curious aspects of the population. Too often, these texts feature a number of photographs of surgically-altered genitalia but neglects to inform the reader about the medical benefits, risks, and/or follow-up related to that same surgery.

The 2001 documentary *Southern Comfort* chronicles the story of Robert Eads, a trans man who died from ovarian cancer in 1999.¹³ Eads identified as a man, but had never pursued genital surgery after he underwent chest reconstruction; in other words, he was a man with the internal reproductive organs of a woman. Eads bore two children with an ex-husband (both were uncomplicated pregnancies and deliveries), but stopped receiving routine gynecological care after he transitioned. Though annual exams may not have prevented his cancer, early detection and treatment may well have reduced the major morbidity and mortality that he subsequently suffered. Due to a combination of some of the factors that we have raised thus far—e.g., a lack of trust in and comfort with providers, a lack of education on the part of his provider(s), and the virtual non-existence of trans-specific screening programs—Eads' cancer remained unmanaged until it had progressed significantly. Even when Eads became aware of his cancer, his search for a provider that was willing and able to manage it was virtually fruitless.¹⁴ *Southern Comfort* chronicles his eventual death over a period of less than a year

and documents added barriers to care faced by trans individuals in rural communities.

Though extreme and particularly poignant, Eads' story is far from unique. Rather, it indexes the difficulty that trans patients and bodies pose to the healthcare community: an incongruence between the gender through which they present and live (including to providers) and the "reproductive" anatomy that their bodies may contain. In short, the fact that many trans men have uteri, cervixes, vaginas, and possibly breasts and that many trans women have prostates, testicles, and penises challenges the sex-specific assumptions upon which much healthcare is based. Medical schools have not taught students how to care for a pregnant man, nor how to manage the benign prostatic hypertrophy of a woman; they are even less prepared to offer guidance about how such treatment would be coded and covered by health insurance.

For some trans persons, the preservation of internal/external reproductive organs or secondary sex characteristics is related to a direct challenge to the gender binary; for others, it is related to a lack of access to the healthcare and resources required to secure such physical changes. For a sizeable, and perhaps increasing minority, it is about preserving the genitalia and body parts through which one derives (sexual) pleasure and/or through which one might procreate; and for still others, it is about submitting one's body to as little surgical intervention as possible (Meier et al. 2010a). Regardless of the reasons, the trans population is diverse, which provides challenges to clinicians' assumptions regarding the prevalence of the population, as well as whether and how they could provide care to these individuals.

While at least a minimum amount of training about the trans population for students and clinicians would be ideal (Bradford et al. 2012), this is a group of patients whose bodies disrupt the sex/gender binary in which most of U.S. culture is grounded. Clinicians do not fall outside of these assumptions and, in fact, carry tremendous cultural authority regarding the ways that all of us understand the categories of male and female (Karkazis 2008). For this reason, this chapter is not intended to chastise cis clinicians or readers

¹³ Information about Eads sometimes reports his cancer as ovarian and sometimes as cervical; it is unclear which was the primary cancer and if the other was a metastasis but regardless of which, the issues that his story raises (e.g. appropriately targeted screening and prevention efforts) remain the same.

¹⁴ In the film, Eads movingly describes the difficulties that several physicians and their staff had with accommodating him as a patient; he was told, among other things, that other patients (in the waiting room) would be offended or made uncomfortable.

for whom this population may pose a fair to significant amount of cognitive or affective dissonance. Rather, we review some of the barriers in access to healthcare for the trans population in order to provide an opportunity to consider ways in which the health concerns of this population can be more effectively addressed. With that goal in mind, we review five major components to providing care for this population, and then provide a discussion of insurance data and concerns for the trans population.

Health Care

Body Parts

Appropriate screening and clinical management of the trans population requires that clinicians shift their understanding of male and female bodies. In the way that HIV taught many of us to think about risky *behaviors* versus risky *categories*, we need to think similarly about body *parts* in need of screening or intervention rather than sexed bodies themselves. Only in this way can stories like Robert Eads' be avoided. Beginning with patient forms that allow a transgender person to identify themselves outside of a box marked "male" or "female," clinicians can learn to ask patients (particularly those who feel comfortable enough to come out as trans) about which types of body modifications (if any) they have pursued thus far, in addition to inquiring about which might be planned or desired. Open-ended questions that allow the patient to describe the extent of their bodily transitioning will provide the clinician with the most accurate information regarding the optimum medical management of the patient. When this is not done, men who need mammograms or a Gardasil vaccine and women who need prostate-specific antigen (PSA) bloodtests will be ignored and preventable disease conditions will likely go undetected.

Whether and to what extent such procedures will be covered by insurance or federal or state-sponsored healthcare subsidies is an entirely different set of questions. Because federal healthcare reform was passed as this chapter was being

written, it is impossible to delineate the effects that new regulations will have on the trans population. However, we can say that clinicians who are increasingly willing to provide these services in an unbiased manner will likely contribute to greater overall access and acceptance. Insurers often take their cues from clinicians and will likely respond to a market that demands and requests services. With President Obama's appointment of a trans woman to work in the federal Department of Commerce, many in the trans community are hopeful that insurance regulations will be written with a sensitivity to some of these issues.

Hormones

Regardless of surgical alteration, many trans people use some kind of exogenous hormones as part of their gender affirmation treatment, each of which entails particular risks and health consequences. Just as we stressed in the last section, clinicians should evaluate the hormones in combination with the particular body/body parts of the patient: since exogenous estrogen has been correlated with both uterine and breast cancers *as well as* with strokes and other thrombotic events, it is important that clinicians sort through the potential risks that are specific to each patient's hormonal and clinical profile. Notably our present discussion is limited to the use of hormones in adults, and will not include the use of hormone blockers in trans teens hoping to offset the physical and physiological changes associated with puberty and with the advantage of being "reversible" if one should wish to discontinue if discomfort ensued. Though data collected thus far have shown the practice to be safe and effective in alleviating gender dysphoria, it remains a highly controversial topic.¹⁵

Because peri- and post-menopausal women have been using exogenous estrogen as a part of their Hormone Replacement Therapy (HRT) for some time, many of its risks and benefits have been

¹⁵ Interested readers are encouraged to consult: Cohen-Kettenis and van Goozen (1998), Delemarre-van de Waal and Cohen-Kettenis (2006), Olson et al. (2011) and Rosin (2008) for further discussion of the hormonal suppression treatment of trans children and adolescents.

well researched and delineated; we can therefore draw some conclusions about the use of estrogen therapy by trans women. Like (peri)menopausal women, trans women using exogenous estrogen will carry an increased risk for particular problems and side effects, all of which should be thoroughly discussed with the prescribing or managing provider. And also like these women, trans women must weigh these risks against the benefits that, though distinct, make a material and daily difference in their bodily experience.

In general, estrogen use is associated with the following side effects: a redistribution of fat to the hips and breasts; an (eventually) lessened production of body hair, and slowed loss of scalp hair; and a likely decrease in spontaneous penile erections. Estrogens have also been shown to increase bone density. In addition to these (mostly) desired effects, hormones can lead to other effects that can be problematic if not managed properly. Estrogens can increase the risk of uterine and breast cancers, and can lead to an increased incidence of thrombosis, strokes, and other cardiovascular events (Asscheman et al. 1989; Levy et al. 2003; Moore et al. 2003). However, the long-term effects of exogenous estrogen in birth assigned males have yet to be delineated (Gooren 2005; Gooren et al. 2007; Moore et al. 2003).

For trans men, androgens can carry the following side effects: a redistribution of body hair (to the face, chest and limbs); a deepening of the voice; an emptying of fat from the breasts¹⁶ and a thickening of the waist; and an increase in the size of the clitoris. There is also some data to suggest that spatial sensibilities will be improved (van Goozen et al. 1995), and both men and women have been shown to have increased libido with the use of exogenous testosterone. Though regular use will likely lead to a cessation of menstruation in two to six months after initiation (WPATH, 2011; Olson et al. 2011), the overall effects of

testosterone on the female reproductive organs are less clear. Some researchers assert that there is little to no effect; others argue that because testosterone is aromatized to estrogen in the body, there is a theoretical increased risk of breast and uterine cancers (Baba et al. 2006; Mueller et al. 2008). In a recent study of 134 FTM's, Rachlin and colleagues found that a significant number of trans men undergo hysterectomy and/or oophorectomy due to concerns about the effects of testosterone on female reproductive organs, though their review of the data found no evidence that these concerns were substantiated. What they did find, however, was that though trans men are advised to decrease their levels of exogenous testosterone after these surgeries, a reasonable majority do not (Rachlin et al. 2010). A recent article in the *International Journal of Transgenderism* speculates about the still-unknown impacts of testosterone on the quality and/or production of eggs in trans men (van Trotsenburg 2010). Though individuals like Thomas Beatie have demonstrated that trans men can indeed conceive and bear children using their still-intact "female" reproductive organs, it is too early to determine whether long-term use of testosterone will complicate or mitigate this possibility for the larger population of trans men. There is also speculation about the psychological side effects associated with the use of both exogenous testosterone and estrogens (Gorton et al. 2005); it is difficult, however, to disentangle psychological side effects of hormonal therapy from the psychological issues that often accompany transitions at all stages.

Finally, many trans people take hormones without a prescription (Gooren 2005; Moore et al. 2003), usually because it is either more affordable or is more geographically accessible. Clinicians must take care not to pass judgment on these individuals but rather inquire about the patient's reasoning and seek to establish a system of monitoring if the patient cannot participate in a more clinically supervised regimen. Buying hormones over the internet is common, but this situation is not unique to trans patients—the purchase of less expensive pharmaceuticals for depression, hypertension, contraception, and a

¹⁶ For the vast majority of trans men, this will not satisfy their desire (if they have it) to remove their breasts. Testosterone cannot eradicate breast tissue; only a mastectomy can do that. Some trans men may lose enough mass with testosterone that binding can be enough for them, however.

host of other conditions has become quite commonplace in the first decade of the twenty-first century. Clinicians should explain the risks of side effects and inquire as to whether s/he wishes to be routinely monitored and have their risks clinically managed (e.g., with appropriate screening and early detection methods).

Research on hormone use is likely to yield continued surprises, including that the use of hormones may enable smoother transitions for some trans people. For example, for the sub-population of trans individuals who choose to go “stealth,” (i.e., not disclose their transgender status), many in the trans population believe that the constant need to “hide” their identity can provoke significant amounts of anxiety. This has recently been challenged, however, by preliminary data from Meier and Hughes (2010), who found that individuals who consider themselves stealth reported higher levels of quality of life than their more open counterparts, a finding that was mediated by testosterone use. This may indicate that testosterone use contributes to higher quality of life, regardless of stealth status. Indeed, this research suggests that, on average, these people were extremely well-adjusted.

As with other clinical regimens, the *Endocrine Society* has published standards that clinicians can use for guidance (Hembree et al. 2009; Bockting and Goldberg 2006; Feldman and Goldberg 2006; Gorton et al. 2005; Leli and Drescher 2004; Lombardi 2001; Nesteby, n.d.).

Gender Identity Does Not Equal Sexual Orientation

It is important for clinicians to understand this fact (Diamond 2002). As we reviewed in our first section, there is little to no consistent data regarding the sexual orientation of this population; indeed, data collected by the transgender community is beginning to demonstrate that transgender individuals are as sexually diverse as any other demographic “group” (Meier et al. 2013). As with any other patient population or individual, clinicians must continually work to undo the assumptions that they have about what kinds of sexual behavior and partners these patients are likely to have.

Gender Affirmation Treatment (GAT)

There are many trans individuals who will pursue what might be thought of as a “traditional” course of treatment, i.e. one through which they desire to transition from one clearly defined sex/gender to *the* other (as opposed to *another*). For trans women, this may include: breast augmentation, penectomy and orchiectomy, vaginoplasty with or without labiaplasty, and daily/maintenance use of exogenous estrogen. Supplemental therapies may include facial feminization procedures, chondrolaryngoplasty (tracheal shaving), voice retraining, and hair removal procedures (electrolysis, waxing). For some trans men, a “complete” transition may include mastectomy (possibly with nipple repositioning), hysterectomy and salpingo-oophorectomy, androgen/testosterone supplemental maintenance, phalloplasty or metoidioplasty with urethral extension, vaginectomy, and scrotoplasty.

It is important that physicians are aware of which aspects of gender affirmation treatment (GAT) are and are not reversible; surgical alteration is obviously irreversible, although depending on the patient’s resources, additional procedures can be performed to restore or reconfigure bodily changes. Hormonal effects vary—most of the effects of both estrogens and androgens are eventually reversible, although the effects of testosterone are less reversible than estrogen. For example, changes that testosterone induces to the skeletal structure including the jaw and pelvis, the voice, male-pattern baldness, additional body and facial hair, and clitoral growth are not thought to be reversible (Dahl et al. 2006; Gorton et al. 2005; Meyer et al. 2001). In the event that patients were concerned about reversibility, it would be important for a primary care clinician to carefully assess their reasons why, and to refer them to a trans-specialist psychotherapist whether these concerns are raised before or after treatment. It is possible that a patient might seek out GAT for reasons other than a “true” transgender identity, e.g., a belief that if one has a homoerotic sensibility, then one must need to make one’s sex/gender somehow congruent. It is also possible that other forms of mental illness/

pathology (e.g. schizophrenia) might manifest as a desire to change sex or gender (Cohen-Kettenis and Gooren 1999; Mizock and Fleming 2011) for this reason, major concerns about reversibility should be carefully assessed and properly referred in order to provide the best care for the individual in question.¹⁷

In summary, treating a transgender patient requires a reorientation in clinical and personal assumptions about sex and gender; it is vital that clinicians unseat as many of their own as they can in order to best care for this population. Questions such as “What is your gender identity? Gender expression?” and “Have you had any kinds of body modification? If yes, can you describe them to me and do you wish to have any in the future?” cannot only demonstrate a fundamental respect for the transgender patient, but can also assist the clinician in providing the most comprehensive care for the unique healthcare needs of each transgender patient. For a trans man featured in Frameline’s short film “TRANSforming Healthcare” by Ethan Suniewick, the distressing fact that his doctor literally did not know what to do with his body left him feeling profoundly medically neglected (Suniewick 2007). After being told “Well, if you were a girl, I’d have you lay down like this, but . . .,” he left the office and told the filmmakers, “So I was pissed because I didn’t receive health care.” In order for this trans man to not become another Robert Eads, clinicians should consider incorporating new cognitive, affective and psychomotor skills (Ross 1984) that adequately address the needs of the transgender population.

Insurance

In general, GAT is not covered by insurance. Costs for typical procedures and transition aids can be quite high, as reflected by the estimated costs in 2010 that are listed in Table 16.3. However, as we have stated, many of the health-

Table 16.3 Cost of transitioning aids (in U.S. dollars)

	Price range
<i>Surgical</i>	
Breast augmentation	\$3,000–\$6,000
Breast reduction/chest reconstruction	\$6,000–\$10,000
MTF genital reconstruction	\$12,000–\$30,000
FTM genital reconstruction	\$5,000–\$75,000
Hysterectomy	\$10,000–\$20,000
Facial feminization	\$5,000–\$100,000
<i>Non-surgical</i>	
Breast forms	\$100–\$2,000
Chest binders	\$30–\$75
Electrolysis (facial hair removal)	\$800–\$5,000
Packers	\$20–\$100
Stand to pee devices	\$35–100
Penile prostheses	\$700–\$2,000
Vocal coaching	\$20–\$1,500

care needs of the trans population have nothing to do with “reproductive” or sex-specific body parts or systems. In other words, a trans man or woman who is able and willing to work with a knowledgeable therapist and to be given a diagnosis of GID or Gender Dysphoria may ultimately be able to secure insurance coverage for their GAT. A trans person unable or unwilling to be diagnosed as such, or who is less invested in “transitioning” from one side of a binary to another, will still have unique health care needs outside of genital or hormonal transitioning. It is likely that this care will remain uncovered, even as health care reform is instituted in the U.S.

Given the difficulties that trans people have in work situations and in securing the legal right to marry, it is likely that a majority of the population will not have adequate healthcare coverage. Currently, it is estimated that 32–87% of trans people are insured, (Table 16.4; Transgender Law Center 2008; Xavier et al. 2005, 2007). However, FTMs may be more likely to be insured than MTFs, with one study of trans people of color finding that 15% of MTFs and 58% of FTMs have insurance (Meier et al. 2010a; Xavier et al. 2005). Having health care insurance does not guarantee access to trans related health care, and 10% of the time trans people with insurance report

¹⁷ Interested providers can access primary care protocols and provider trainings from: www.transhealth.ucsf.edu

Table 16.4 Statistics from insurance-related studies of trans people

<i>Meier et al. 2010a</i> (n=1067; all FTMs)	
Have insurance	74%
Of the uninsured: Do not have insurance due to associated costs	31.6%
Of the insured: Insurance covers trans related health care	20.5%
<i>Transgender Law Center 2008</i> (n=646; 375 MTFs, 271 FTMs)	
Have insurance	86.5%
Were denied surgery	33%
Were denied hormones	27%
Were denied counseling and mental health services	21%
Were denied gender-specific care (such as pap smears for trans men and prostate exams for trans women)	15%
Were denied primary health care	10%
Delayed healthcare due to finances	42%
Health condition worsened because they postponed care	26%
<i>Xavier et al. 2007</i> (n=350; 229 MTFs, 121 FTMs)	
Have insurance	72%
Have a regular doctor	62%
Educated their doctor about their healthcare needs	46%
Experienced discrimination from healthcare provider	24%
Non-disclosing with regular doctor	29%
<i>Xavier et al. 2005</i> (n=248; 188 MTFs, 60 FTMs)	
Have insurance	32%
Have access to annual physical exams	54%
Have access to gynecological care	10%
Experienced caregiver insensitivity	33%

that they have been denied primary health care. Twenty-one percent of FTMs in one sample reported that their insurance covered trans related health care (Meier et al. 2010a). In another sample of trans people, 33% of those surveyed reported having been denied coverage for surgery, 27% for hormones, and 21% for counseling and mental health services (Transgender Law Center 2008).

These data regarding coverage could result in trans individuals using what little money is available for healthcare on surgery and/or hormones, or other costs associated with maintaining their congruent gender expression. Without insurance, hormones may be acquired through non-medical

channels or sources, and there is a reasonable risk of using doses higher than what are recommended by regulating institutional bodies. It is also true that many trans individuals pursue GAT, especially surgical procedures, in countries where the cost is much lower (e.g., Thailand, Mexico). Indeed, there is anecdotal evidence suggesting that some trans women acquire industrial-grade silicone in order to increase the size of their breasts at a lower cost. Available in liquid form, and used by some transgender sex workers in parts of Brazil, silicone can be directly injected into the chest, buttocks and thighs by the individual and/or an accommodating friend. This cannot only pose problems for the U.S.-based physicians who later manage these patients, but also pose significant legal and re-entry problems for patients whose gender identity and/or expression has changed while they have been out of the country. Similarly, a transgender person wishing to undergo sex-specific GAT procedures, such as a hysterectomy or mastectomy, may find that the surgeries are uninsured if they legally changed their gender beforehand.

These practices could not only put these individuals at risk, but could also further alienate them from clinicians who disapprove of non-compliant patients. Twenty-four to thirty-three percent of trans people report experiencing discrimination or insensitivity from health care providers (Xavier et al. 2005, 2007). Though physicians have the right—and at times responsibility—to withhold services or treatment from patients who do not follow their treatment guidelines, it is vital that clinicians cultivate an appropriate sensitivity to the plight of trans patients—a lack of economic access and the desire to avoid discriminatory attitudes are just two of the reasons that trans patients may not readily “comply” with particular clinical recommendations. Ironically, anecdotal evidence has demonstrated that trans patients can be quite compliant when cared for by educated providers. Not only is it in their clinical interests (e.g. better managed side-effects and/or surgical outcomes), but “good behavior” is also more likely to secure the letters and authorizations that many trans people need in order to obtain legal and institutional-level changes.

Population Health: Mental Health

Many mental health providers are hesitant to work with transgender clients because they do not feel informed on the population's specific needs (Meier and St. Amand 2010). Without a better idea of the demographics of this population, these providers may feel justified in never working with trans people with the thinking that "there aren't very many of them." With more demographic data, as well as scientific studies on the efficacy of treatment and updated treatment guidelines, providers can feel more fully informed and competent and less inhibited to work with members of this population. This section, therefore, explores current data regarding the prevalence of mental health concerns within the trans population. Further, we detail some of the precautions that must be taken when using these data to estimate prevalence, as well as for developing mental health interventions.

The history of mental health research on the trans population is rife with two sets of claims: that trans people are delusional or have gross forms of psychopathology, and that trans people are actually quite normal and are often of above average intelligence (Huxley et al. 1981b; Gomez-Gil et al. 2008). Many of these claims are ideologically charged, making the task of "proving" their relative truth challenging at times. But it is safe to say, based on a preponderance of psychological research, that trans people demonstrate consistently high levels of psychological/mental health despite high incidences of risk for negative outcomes (Meier et al. 2011; Rachlin 1999; Ross and Need 1989).

Certain groups of trans people have been studied more than others, as most past research has tended to focus on trans women (MTFs) rather than trans men (FTMs). At this time, there are extremely limited data on trans people who identify as genderqueer. This disparity may be due to MTFs requesting medical services such as genital surgery more often than FTMs or genderqueer people (refer to the Prevalence section) or it may reflect that more FTMs are non-disclosing than MTFs (Rachlin 1999).

Conducting research among the trans population is difficult due to the relatively small size of the population, but also because many trans people are wary of researchers. Aware of the fact that they have historically been presented in a negative, pathologized light, many are hesitant to participate in studies. This is especially true for trans people of color, who are rarely represented in large studies (Erich et al. 2010). Participants in a workshop conducted at a gender conference for trans people of color voiced that they would prefer not to be "guinea pigs" for research studies. However, once they were informed about how research can change both legal and medical policies and the "you don't exist unless you are researched" phenomenon, the participants spoke of how they would be more willing to participate in studies, especially if the investigator is a person of color (Erich et al. 2010).

Higher Incidence of Psychological Problems

Do trans people really suffer from a higher incidence of psychological problems? The answer to this depends largely on the research that one is consulting. Older formal studies measuring hospital patients and sex workers, for example, provide vastly different results from studies conducted over the Internet and more recent studies of patients at gender clinics, regardless of which population is being described (APA 2009; Hoshiai et al. 2010; Meier et al. 2011). Critical readers should therefore look carefully at who is being measured by the research (how they define the population), who is doing the measuring, the temporal location of the population ("stage of transition", "puberty"), and the methodology, all of which provide important interpretive context.

Increased rates of depression, anxiety, substance use and abuse, rape, intimate partner violence, suicidality, and self-injurious behavior have been reported to occur in the trans population as compared to the cis population (Clements et al. 1999; Cole et al. 1997; Courvant and Cook-Daniels 1998; Dickey 2010; Grossman

Table 16.5 Rates of suicidal ideation/attempts and problematic substance use

Assessment	Source	Participants	Rate	Reference
<i>Rates of suicidal ideation/attempts</i>				
Lifetime attempt(s)	Community and clinic	392 MTF; 123 FTM	32%	Clements-Nolle et al. (2006)
Lifetime attempt(s)	Internet	448 FTM	44%	Meier and Pardo (2010)
Lifetime attempt(s)	Community	113 MTF; 69 FTM	30.1%	Kenagy (2005)
Lifetime attempt(s)	Gender clinic	318 MTF; 117 FTM	15%	Cole et al. (1997)
Attempt(s) and ideation	Community; trans people of color	188 MTF; 60 FTM	38%; 16%	Xavier et al. (2005)
Attempt(s) and ideation	LGBT youth services; age 15–21	31 MTF; 24 FTM	26%; 45%	Grossman and D’Augelli (2007)
Attempt or ideation (past year)	Community	141 MTF; 34 FTM	52%	Bockting et al. (2005)
<i>Rates of problematic substance use</i>				
Alcohol and Marijuana use	Community agency; youth of color age 16–25	51 MTF	65%; 71%	Garofalo et al. (2006)
Heavy alcohol use	Community, Latino GB and T persons	549 GB; 94 MTF	26%	Ramirez-Valles et al. (2008)
Alcohol and drug problems	Internet	448 FTM	23%; 19%	Meier (2010)
Substance abuse problems	Gender clinic	318 MTF; 117 FTM	28%	Cole et al. (1997)
Self reported substance abuse	Community; trans people of color	188 MTF; 60 FTM	48%	Xavier et al. (2005)
Alcohol or drug treatment	Community and clinic	392 MTF; 123 FTM	28%	Clements-Nolle et al. (2006)

and D’Augelli 2007; Hendricks and Testa 2012; Kenagy 2005). Some researchers have suggested that risk factors that increase these negative outcomes may consist of being denied access to care (Meier et al. 2011), stigma (Bockting et al. 1998), as well as the loss of social support from loved ones (Meier et al. 2010b).

It is important to complicate these findings, however, as we should not assume that these rates derive straightforwardly from a trans identity. The APA Task Force on Gender Identity and Gender Variance states, “Studies on the mental health of transgender individuals are limited by the use of convenience samples and may not be generalizable to the overall transgender population” (APA 2009: 42). Further, the results of these studies vary widely, yet there is some evidence to suggest that trans people who have experienced violence or victimization are at greater risk for suicide attempts (Goldblum et al. 2012; Testa et al. 2012). For

example, research has suggested that anywhere from 16 to 52% of trans individuals have attempted suicide and that rates of “recent heavy alcohol use” within both MTF and FTM populations have ranged from 8 to 31%; illegal drug use, when measured, has ranged from 3 to 71%, depending on the drug (Bockting et al. 2005; Clements-Nolle et al. 2006; Garofalo et al. 2006; Grossman and D’Augelli 2007; Hendricks and Testa 2012; Kenagy 2005; Ramirez-Valles et al. 2008; Xavier et al. 2005). See Table 16.5 for an overview of the research studies on rates of suicide and problematic substance use.

While we recognize the importance of collecting these data in order to better understand the association between a trans identity and high risk behaviors, we also acknowledge that prevalence rates can and do determine interventions and analyses. Though compelling in its own right, addressing a suicide attempt rate of 16% may require a

distinct set of tools from that required to address a 52% rate. As a result, it is important to take a critical look at the methods of psychological studies on trans people, focusing on the sample and data collection process (i.e., age, genders, recruitment method, hormone/surgery status, race/ethnicity, geographical location, etc.) in order to have a context for how to interpret the data and the generalizability of the results. Scholars should critically evaluate findings so as to not overlook important mediating and moderating variables. For example, an Internet study on mostly white and highly educated trans men found normal to mild levels of depression and anxiety, which varied based on whether the trans men were on testosterone or not (Meier et al. 2011). This could suggest that demographic factors, including race and education, moderate the effects of a trans identity on mental health outcomes.

Psychotherapy Concerns

Trans people also seek mental health services for reasons unrelated to their gender identity and expression or their desire for letters of support. They may desire therapy to address depression, anxiety, grief over the death of a loved one, sexual assault, or any number of concerns. They may also seek couple's therapy or career counseling. Regardless of why trans people come to therapy, they always have a choice of whether or not they are going to disclose a trans history. More accurate demographic information will aid researchers in obtaining grant funding to determine which pre-existing evidence-based interventions are effective for trans clients and to develop novel evidence-based interventions that are inclusive of trans clients and their partners and families.

As we stated earlier, it is possible that a clinician who does not believe that they have seen a trans client actually has (see discussion of stealth status in the Prevalence section). Clinicians working with someone they perceive to be trans need to determine if it is clinically relevant to ask questions concerning the client's body or desire for body modification. Nonetheless, it is

important for providers to consider their reasons for asking the question. If the answer is curiosity, it is likely that it is not clinically relevant and asking prematurely could damage rapport with the patient (though making assumptions about someone's trans status can be equally damaging). For example, if a therapist is working with a trans woman who has neither had nor desires genital surgery and that therapist makes the assumption that all trans people desire genital surgery, the therapist may inadvertently behave in a manner that pressures the client to pursue surgery or to end therapy as she may not feel understood. This mistake could be avoided more often if clinicians had a better idea of the prevalence and costs of GAT in FTMs and MTFs (see Tables 16.1 and 16.4).

Due to lack of education, training, and exposure to trans people, many therapists unknowingly assume that there is a single or "correct" trans history and identity where trans patients report feeling trapped in the wrong body since childhood and that they are 100% the "other" gender. While that might be a common narrative, there is no single or correct trans history or identity, as the population is more diverse than most imagine. There are some people whose gender identity is fluid and changes over time, others report feeling "trapped in the wrong body" since early childhood, still others do not discover their gender identity until late in life. Historic accounts of the treatment of trans people who did not report a "classic" history (i.e., genderqueer persons or trans people reporting a post-transition gay orientation), demonstrate that many of these individuals were not given letters for treatment and thus denied many of the services they sought (Lev 2005). For these reasons, it is important to collect additional data so as to generate information regarding the diversity of transition experiences (IOM 2011).

Organizations that promote the idea of "changing" or "repairing" a person's sexual orientation and/or transgender identity are still in existence; they are most typically affiliated with religious organizations. Despite a lack of solid empirical evidence demonstrating the efficacy of these

treatments, many of these groups promote their success on websites and through self-published materials. Indeed, it is easy to encounter one of these websites when casually searching online for transgender information. It is important that those invested in the transgender population keep abreast of these trends and “treatments” as at least one scientist has demonstrated that they are associated with notable negative outcomes (Drescher 2002). In fact, the APA has issued a press release stating that these “treatments” do not have evidence supporting their effectiveness and that psychologists should not tell clients that they can change their sexual orientation (Glassgold et al. 2009).

In 2009, the American Counseling Association published important new guidelines for professionals who counsel and/or conduct research with trans people (ALGBTIC 2009). The World Professional Association for Transgender Health also released suggestions for therapy with trans people (WPATH 2011). Such guidelines hopefully can address a vital issue affecting the competent mental health care of this population, which is the lack of training and the lack of incorporation of the LGBT literature into mainstream psychology (Goldfried 2001). Numerous trainings exist to educate straight cisgender people; however, many of these focus so heavily on LGB issues that trans issues seem like an afterthought. Some trainings neglect to mention the trans population at all or when they do, emphasize that “those people” are inherently different than the “regular” LGB population. One of the authors is part of a network that exists to address this problem. The 44th Division of the American Psychological Association recently created a list of professionals who are available for comprehensive LGBT trainings.¹⁸ Also, many valuable resources have already been created for educating clinicians on culturally sensitive trans affirming care (APA 2009; Lev 2004; Maguen et al. 2005; Raj 2002). Hopefully these resources,

and future resources which may be better informed by demographers, can help mental health practitioners to provide competent care to this population.

Family Demographics

Relationships

Historically, researchers have been openly shocked that cisgender people would want to form or continue meaningful romantic and sexual relationships with trans people (Brown 2009; Fleming et al. 1985, 1984; Huxley et al. 1981a). In fact, historical anecdotal reports from trans people who were treated at gender clinics claim that married trans people were encouraged to divorce before starting their transition (Samons 2009). Empirical data show that about half of the partners of trans men stay with their partner through transition, and, of the half that do not stay together, half of them (25% of the overall sample) end the relationship due to their partner’s transition (Meier et al. 2010c).

More recently, many qualitative interviews have focused on partners who stayed with their transgender partner through transition (Brown 2009; Ehrbar 2010; Kraemer et al. 2010). Partners of trans people provide important social support to their trans partner (APA 2009; Ehrbar 2010). However, partners also benefit from having their own social support and accessing resources related to transition (Ehrbar 2010; Meier et al. 2010c). Partners who stayed with their trans partner through transition attributed the success of their relationship to open communication, education on transgenderism and the transition process through accessing resources, community support, and keeping their focus on the reasons they fell in love with their partner in the beginning of their relationship (Meier et al. 2010c). Kraemer and colleagues (2010) encourage professionals who work with the trans community to cite many positive and healthy examples of trans relationships in which a cis partner accepts and affirms their trans partner as they identify.

¹⁸ Interested readers can contact Division 44 of the American Psychological Association for an updated list of resources and contacts.

Trans people can have relationships with all types of partners: cis males and females, as well as with other transgender people. In a study of over 500 FTMs, about half of the participants reported being in relationships at the time of the survey, with 42 participants reporting being legally married (Meier et al. 2010c). Over one-third of the trans women in an Irish research study reported being married currently or previously (De Gascun et al. 2006). In some cases, depending on the legal precedence where the partners reside, these relationships may be legally recognized in marriage or domestic partnerships. Some partners conceptualize their relationship as LGBQ and some as straight/heterosexual based on the gender identities of the partners, as opposed to their birth-assigned sexes. As such, demographers should be mindful of the way they attempt to quantify these relationships.

Family

One in five to one in three trans people are parents, with trans women more likely to be parents than trans men (De Gascun et al. 2006; Freeman et al. 2002; Meier and Hughes 2010). Depending on the state or country, trans people may be allowed to marry and/or adopt children within the context of a heterosexual relationship or marriage; when some do not identify as heterosexual, trans individuals encounter obstacles to both of these practices that are similar (though perhaps heightened) to those encountered by gay men and lesbians. These include: discrimination, inadequate legal rights (e.g., parental decision-making, legal privileges on behalf of children and partners), and accusations of gender fraud. Even with these obstacles, having a trans parent has not been found to be harmful for children (Green 1978).

As with Thomas Beatie, people that delay or opt out of genital surgery may father or bear children within the context of a trans body and relationship. It should also be noted that some trans people bear and raise children before they transition, in which case many of the issues faced by these individuals are more personal than legal.

Children and other family members do not always understand nor accept the trans person's desire to express their gender identity, and sometimes sever ties as a result. Overall there is a paucity of published research "on the family issues of adult transgender people, in spite of the importance of social support from families for satisfactory mental health" (p. 3; APA 2009). Though preliminary data (Meier and Hughes 2010) suggests that trans parents experience fewer symptoms of depression, anxiety, and stress than trans non-parents, these measures of well-being seem to be correlated with age, hormone usage, and/or time since transition, indicating that older trans people experience fewer psychological symptoms (Meier and Pardo 2010). Many families eventually become accustomed to having a trans parent (or aunt, uncle, etc.) as much of the initial disruption evens out over time; indeed, family members sometimes become politically active as a result of witnessing the discrimination and obstacles faced by their loved ones.

Many other trans individuals are not as fortunate, however, and lose the support of their families of origin and/or that of their partner/spouse and children. Though not unique to this population, such a loss can leave trans people without a fundamental component of a social "safety net." Without legal access to a family of choice, it can be crucial to have one's family of origin in place for financial and emotional stability, particularly when one is routinely subjected to discriminatory tactics and attitudes. A potential negative ramification of being diagnosed with a "mental disorder" is that an ex-spouse may use that diagnosis against a trans person in a custody case as evidence "proving" the trans parent to be an unfit parent, as they "are mentally ill," (Ehrbar 2010). Scenarios like this will likely be lessened when research findings demonstrating the "normal" and competent parenting and relationships of trans people become more widely available. Loss of family support has been found to have deleterious effects on the mental and physical health of trans people, as family support can act as a buffer to stigma and discrimination (APA 2009). Data show that loss of family support is related to lower general physical health and functioning

quality of life ratings in FTMs, a result similar to the findings from the Family Acceptance project's work with LGB youth (Meier et al. 2010b; Ryan et al. 2008). The converse also holds for both sets of data: the higher the social support ratings of families that do accept their children, the higher the quality of life results for those children. Findings from a recent study of Canadian trans youth demonstrate that trans youth with strong parental support report higher satisfaction with life, higher self-esteem, less depression, fewer suicide attempts, and adequate housing compared to trans youth without strong parental support (Travers et al. 2012). Organizations such as PFLAG (Parents and Friends of Lesbians and Gays), which for over a decade has incorporated a transgender arm (T-Net), COLAGE, a national support and advocacy group for children with (at least) one gay, lesbian and/or trans parent, TYFA (Trans Youth Family Allies) and Gender Spectrum (see Brill and Pepper 2008), both groups for families of trans youth, are working to educate the greater population about these issues.

Labor Demographics

The experiences of trans people in the workplace have begun to reveal that all experiences of trans people are not equal, and that broader social phenomena such as masculine privilege can override the discrimination that a trans person might experience on the job. In a sociological, interview-based study with trans men, Schilt (2006) found that white, tall trans men who transition on the job are more likely to keep their employment and to get promoted than are short, trans men of color and/or those trans men who are not on testosterone. Furthermore, cis men appear to recognize trans men who make a gender transition on the job as simply *men*, whereas cis women are more likely to recognize these individuals as *trans* men (or someone who once was a woman) (Schilt and Westbrook 2009). Schilt (2010) records a workplace experience of a gay trans man who works as a kindergarten teacher in Texas. This trans man does not disclose his trans history to most of his

colleagues. During teacher meetings, he noticed being treated differently than the other (mostly female) teachers. Specifically, he noticed that because he is a socially recognized male, other teachers often stop talking when he speaks and that when he presents an idea, even if it was first raised by a female colleague, he is listened to and taken more seriously.

Survey research has thus far borne out such findings. Schilt and Wiswall (2008) tested the concept of "gender/appearance-neutral" performance reviews and pay structures. They hypothesized that if this theory holds true, people who transition should be paid the same amount for the same work both before and after they transition. What they found was that trans women, on average, lose \$12/h after they transition and trans women also make more than do the average male and female workers before they transition. Trans men, on the other hand, did not lose money related to their transitions; indeed, some even made a small amount more afterwards.

Because of these demonstrable and gendered disparities, Schilt and Wiswall (2008) encourage scholars to use caution when speaking about the trans population and to not generalize about the "transgender experience" at work. Moreover, most research focuses on trans people at the time of their gender transition; the workplace experiences of people who transitioned in the more distant past are still relatively unknown.

Gender Alterity in a Broader Context

We conclude with both a restatement and an elaboration of our opening position: that this chapter is written from a (primarily) U.S.-based set of facts, beliefs and organizational frameworks about a trans reality. It is important to restate this because both authors believe strongly that the aspects of sex and gender that are socially constituted and contoured cannot be disentangled from those that may not be, i.e., that may originate from a more "natural" source. This means that we encourage the reader to understand this demographic profile as representing an experience of trans that is both historically and geographically

specific, one possible way that gender alterity can be lived and expressed. Anthropologists in particular use both historical and cross-cultural evidence to suggest that other societies and cultural groups often hold an affirmative place for people and bodies who are not neatly categorized by either male or female. In order to underscore this final point, we will outline a few of the ways that sex and gender expression are and have been lived across other parts of the world and at other points in time.

As we have mentioned, the terms *transgender* and *transsexual* already connote a binarized understanding of gender; the fact that one can “cross” from one to the other is implied within the words themselves. For the *travesti* in Brazil, however, there is no such easy crossing. Travesti are what many in the U.S. would call MTF: birth-assigned men who dress, act, and self-identify as feminine (including calling themselves “girls”), and who define their male partners in heteronormative terms (Kulick 1998; see also Prieur 1998 for similar findings in Mexico). A hallmark of travesti identity is the injection of industrial-grade silicone directly into the hips, buttocks and breasts, a set of procedures that typically fortifies the incomes many of them make doing sex work. Travesti are subjected to discrimination and harassment, frequently from the police, and often live at or below the poverty line. Given these parameters, it is tempting for even gender scholars to label these Brazilian women *transsexual* but the travesti interviewed by Kulick spoke clearly and openly about how that concept does not represent their experience. Indeed, the idea that a man could “become” a woman through surgery and/or hormonal therapy is quite unthinkable, and many of the travesti in Kulick’s ethnographic study report a bodily investment in their penis that would preclude its excision or even subordination. Moreover, in both Kulick’s and Prieur’s studies, the category of transgender articulated with particular forms of masculine or “bisexual” expression, in that many of the steady sexual partners of the transgender sex workers were men who considered themselves to be heterosexual.

Indian *hijras*, on the other hand, have no such investment in their male genitalia. Rather, the

nirvan surgery that many of these birth-assigned males undergo consists of the complete excision of both penis and testicles. Although the *hijra* might also be loosely translated in MTF terms—they dress as women, take female names, and participate in female-gendered activities—their gender alterity is rooted in a very specific set of spiritual and religious practices. Often referred to as India’s “third sex,” *hijras* sacrifice their genitalia to a goddess in exchange for the power to confer fertility and blessings on (heterosexual) newlyweds and newborn children (Nanda 1990; Reddy 2005). An important similarity that the *hijra* have to *travesti* is that, contrary to what the trans community is articulating in the U.S., they understand their gender alterity at least partially through their sexual practices. Both groups have primarily male sexual partners; their understanding of themselves as not exclusively male does not arise from their identifying as “gay,” however. Rather, both *travesti* and *hijra* conflate the (anally) receptive position in sexual intercourse with femininity and female comportment, an understanding that endows their male (and penetrative) partners with a clearly defined masculinity.

In a widely cited study of female “homoerotic” identities in ancient India, Penrose (2001) claims that though a variety of alternate genders existed in what is now South Asia, the majority have disappeared through the effects of Muslim and Christian invasions, colonialism, and a decline in Buddhist practice. These historical developments are important to underscore as they illuminate the sometimes precarious relationships between sex/gender systems and wider cultural and political institutions and practices. Penrose discusses female warriors, for example, who served as bodyguards to precolonial South Asian royalty, and the *yellamma* who served as porters of sacred objects. Some, though not all, of these identities were organized around the birth-assigned females’ disinterest or unwillingness to engage in sexual relationships with men; such a predilection could open up “male” opportunities for these women, allowing them to maintain a social role outside of marriage. It is unclear whether and to what degree any of these individuals experienced

a feeling of gender incongruence the way that many contemporary transgender individuals do. What is clear, however, is that sex and gender have most likely always been experienced—by both individuals and groups—outside the domain of a (heteronormative) male/female binary. The elaboration of this simple fact with cross-cultural and historical research can have an extremely normalizing therapeutic effect on individuals struggling to come to terms with their gender variance.

Numerous other examples exist: Albanian sworn virgins, Thai *maa khii*, Hawaiian *mahu*, Native North American (Navaho) *two-spirit*, Jamaican *tombois*, Sobar *Xanith*, Tiwi Islands *sistagirls*, and South Asian *jogamma*, *jogappa* and *sadhin*. Much of the archival and ethnographic research conducted with and about these groups is being done by queer and trans scholars, leading to what some view as an ever-expanding acronym to adequately capture the contemporary “smear” of gender and sex expression (e.g. the initials “I” and/or “TS” are sometimes appended to LGBT in order to recognize intersex and “two spirit”). Though challenging for those attempting to standardize and quantify this population, the seemingly boundless nature of this terminology indexes one of the most salient elements of a trans identity: its culturally constructed nature.

As with phenotypical variation, and the shifting cultural meanings associated with the word “race,” trans is an unstable analytical category (Goodman 2006). At the same time, the individuals discussed in this chapter represent a mode of sex/gender expression marginalized by contemporary heteronormative society, leading to a set of very measurable consequences, including a lack of health care, increased suicide rates, and/or workplace and housing discrimination. In other words, though conceptually fluid, transgender is a category that remains acutely material, and one that is often contoured by inadequate legal, medical, and juridical recognition. It is vital that those of us invested in both understanding and transforming the kinds of vulnerabilities that this population routinely confronts keep our analytical focus trained on both aspects of this shifting and dynamic identity.

Conclusion

Though it is impossible to predict what might constitute a transgender identity by the end of this century, it is likely that the one outlined in the previous pages is a mere skeleton of what is to come. As bodily sites upon and through which an increasing number of researchers are re-imagining contemporary gendered relations, the trans population signifies some of the latent possibilities still unrealized by both the feminist and LGB movements of the past decades (Valentine 2007). The daily lives of many transgender individuals are often lived in far less heady and radical terms, however. Mired in worlds that do not “fit” their own bodily experience(s), trans people are acutely and disproportionately challenged by societal expectations regarding gender presentation and expression. These daily struggles are eloquently summed up by the Transgender Foundation of America’s (TFA’s) Cristan Williams in a response to the murder of a trans woman in Houston in early 2010: “For most trans women who get ready to leave the house, for whatever reason, it takes about two hours to get ready. It’s not to look like a diva, it’s taking time to look passable so that you’re not beaten or harassed.... You’re spending that much time just to get out of your house, month after month, day after day. That is the reason why most of the clients we work with have symptoms of Post Traumatic Stress Disorder. [They] know[...] friends who’ve been beaten, murdered, [and they] fear[...] those things themselves.”¹⁹

This grim reality is reason enough for demographers and social scientists to improve our understanding of the trans population. The kinds of concerns voiced by Williams can be effectively addressed by not only psychologists interested in PTSD or “niche” sexuality scholars, but by anthropologists, economists, legal scholars, or philosophers, in addition to interdisciplinary teams who

¹⁹ Interview with Cristan Williams, director of the Transgender Foundation of America; Laura Richardson, SWGS conference 3/26/10 at Rice University. “Displacing and Distancing Myra Ical.”

seek a more comprehensive understanding of the trans community. Demographers hoping to generate this research must be mindful of the issues raised in this chapter—inconsistent nomenclature, intra-population differences regarding inclusion and exclusion criteria, the full spectrum of bodily and lifestyle changes that correlate with a trans identity, invisibility and the choice to “go stealth,” mistrust of researchers—as they formulate research questions and design methodological instruments. And as they grapple with the associated complexities of doing so, they can take heart that the trans community itself is in almost constant dialogue about these very issues. This was evidenced most recently for one of the authors by her participation in a days-long listserv discussion about the best ways to reformulate the line regarding sex/gender categories when formatting questionnaires: should it be an expanding series of boxes/choices? Should it be a blank space for the person to fill in?

Furthermore, in addition to the overt forms of violence described by Williams, transgender people face ubiquitous—and often more insidious—forms of structural violence every day; these include multiple forms of personal and institutional discrimination. Whether and to what extent transgender individuals are denied housing, bank loans, promotions, health insurance or healthcare, college admission, adoption services, or access to any part of the social safety net is a set of questions ripe for investigation. Moreover, it is critical that we investigate how these forms of discrimination articulate with other aspects of identity, including gender, race, socioeconomic class, and ability. The ways that these variables intersect can produce a number of distinct—and unequally experienced—“versions” of the category trans. There may be more differences than similarities, in other words, between an upper-middle class white male attorney who cross-dresses only in the context of a socially exclusive group and a trans man whose masculine identity feels compromised by his inability to afford a mastectomy. This means that it is vital, as it is with any categorical identity, that researchers working with this community remain cognizant that such differences amount to more than variations on a theme.

Trans people make plain the limits of a sex/gender binary; attentive researchers can use the experiences of this population to better understand how cis people are similarly limited by the notion that genitals and hormones make us either one *or* the other. Demographers can remember that the category “sex” is not that different from gender-coded bathrooms: each time it is measured or reported, it constrains a complex mix of variables and lived experience belied by the terms “male,” “female,” and even “other/trans.” Noticing the ways that each of us participate in these conceptual and physical reductions is an important step in improving the representational capacity of our research with this (and other) populations.

Acknowledgements The authors would like to thank Jamison Green, Sean Moundas, Sari Reisner, Lauren Mizock, and Kristen Schilt for their thoughtful comments on earlier editions of this chapter.

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Part V

**Applied Demography of Sexuality:
Perspectives on Policy**

Patterns of Relationship Recognition by Same-Sex Couples in the United States

17

M.V. Lee Badgett and Jody L. Herman

Introduction

Since 1997, 19 states and the District of Columbia have extended legal recognition to the relationships of same-sex couples. The form of legal recognition has varied to include marriage, civil unions, state-registered domestic partnerships, and limited-rights statuses, such as reciprocal beneficiary relationships. These varied forms of recognition entail different packages of legal rights and responsibilities for the couples entering them. This study provides a demographic analysis of the same-sex couples who marry, enter civil unions, or register their partnership in these states, covering the full range of legal statuses.

To date, little direct analysis has been conducted on same-sex couples and their legal statuses. Here we draw on data from state administrative agencies and the U.S. Bureau of the Census to analyze the legal recognition patterns of same-sex couples as their options have multiplied rapidly. Earlier studies by Gates et al. (2008) and Badgett (2009) were conducted at a time in which one-quarter of the U.S. population lived in states with such

options. As of January 1, 2012, 42% of U.S. residents will live in states that offer same-sex couples a way to acquire some legal rights. Therefore, this study has more states and more time to draw on to assess patterns than earlier studies.

As the number of same-sex couples who have access to legal recognition expands, we have the opportunity to learn more about the demand for such statuses by looking at the sex, age, and timing of marriage or registration by same-sex couples. The data also demonstrate that couples will travel to other states to marry if they cannot marry in their home state. We also are able to compare the demand for marriage to the demand for other non-marriage statuses by analyzing data in two groups of states: those that have gone from a non-marriage status to opening up marriage to same-sex couples, and those that also allow different-sex couples to enter non-marriage statuses.

We found that over 140,000 same-sex couples, or 22% of all same-sex couples in the United States, have formalized their relationship under state law within the United States. Forty-seven percent of all same-sex couples who live in states that offer some form of legal relationship recognition status have entered into such a status at some point in time. If current marriage trends hold, the marriage rate of same-sex couples in Massachusetts eventually will reach parity with the marriage rate of different-sex couples in Massachusetts by 2013.

Same-sex couples prefer marriage over civil unions or registered domestic partnerships, even

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when these statuses extend almost all of the rights and obligations of marriage under state law. When other legal statuses are available to them, different-sex couples also prefer marriage. In the states with available data, dissolution rates for same-sex couples are slightly lower on average than divorce rates of different-sex couples.

As of the time of this writing, same-sex couples can marry in six states and the District of Columbia. In the three states that track residency among same-sex couples who marry, those states report that 60% of same-sex couples marrying are from other states. The states that contribute the most out-of-state couples are those with large populations (such as Texas, New York, and Florida) and those in close proximity to the state allowing same-sex couples to marry. Women are more likely to marry or formalize their relationships by entering an alternative legal status than are men. Same-sex couples who marry or enter other legal recognition statuses tend to be younger than the general population of married different-sex couples in those states. However, when one compares same-sex and different-sex couples who are newly married, newly-married same-sex couples tend to be older than newly-married different-sex couples.

The Legal Landscape of Same-Sex Couple Recognition in the U.S., 1997–2011

In 1997, Hawaii became the first state in the U.S. to offer legal recognition to same-sex couples. Seventeen states and the District of Columbia have followed suit and now offer some form of legal recognition to same-sex couples, including state-registered domestic partnerships, civil unions, and marriage.¹ Currently 41% of the U.S. population lives in a state where these legal

statuses are offered.² Delaware and Hawaii have both recently passed civil union legislation that will go into effect January 1, 2012, which will expand the total number of states where same-sex couples can enter legally-recognized relationships to 19, raising the figure to 42%.³

Currently, same-sex couples can marry in six states and the District of Columbia. As described in Table 17.1, there are other forms of legal recognition available to same-sex couples, which are categorized here into two groups: (1) civil unions and broad domestic partnerships that carry rights and obligations comparable to marriage under state law, and (2) limited domestic partnerships,

Mun. Regs. tit. 29, §8000 (1992) (domestic partnership); Hawaii: Haw. Rev. Stat. ch. 572C (1997) (reciprocal beneficiary); Illinois: S. 1716, 96th Gen. Assem., Reg. Sess. (Ill. 2010) (enacted) (civil union); Iowa: Varnum v. Brien, 763 N.W.2d 862 (Iowa 2009) (marriage); Maine: Me. Rev. Stat. Ann. tit. 22, § 2710 (2011) (domestic partnership); Maryland: S. 566, 425th Gen. Assem., Reg. Sess. (Md. 2008) (enacted), S. 567 425th Gen. Assem., Reg. Sess. (Md. 2008) (enacted) (limited domestic partnership); Massachusetts: Goodridge v. Dep't of Public Health, 798 N.E.2d 941 (Mass. 2003) (marriage); Nevada: Nev. Rev. Stat. § 122A.100 (2011) (domestic partnership); New Jersey: N.J. Rev. Stat. § 37:1–29 (2011) (civil union), P.L. 2003, c. 246 (domestic partnership); New York: A. 8354, 2011–2012 Assem., Reg. Sess., (N.Y. 2011) (marriage); Oregon: Or. Rev. Stat. § 106.310 (2009) (domestic partnership); Rhode Island: H.R. 6103, 2011 Gen. Assem., Jan. Sess. (R.I. 2011) (civil unions); Vermont: Vt. Stat. Ann. tit. 15, § 8 (2011) (marriage); Washington: Wash. Rev. Code § 26.60.030 (2011) (domestic partnership); Wisconsin: Wis. Stat. § 770.05 (2010) (limited domestic partnership).

In this study, we do not include domestic partnerships that are registered at the local level, such as in a city or county registry. We also do not include domestic partnerships that are reported to an employer to obtain benefits to cover an employee's partner. The term "domestic partnership" in this report refers only to state-registered domestic partnerships that are recognized for purposes of state law.

² Percent of total U.S. population living in the following states: California, Colorado, Connecticut, District of Columbia, Hawaii, Illinois, Iowa, Maine, Maryland, Massachusetts, Nevada, New Hampshire, New Jersey, New York, Oregon, Rhode Island, Vermont, Washington, and Wisconsin. Calculated using total population figures from the 2010 Decennial Census, U.S. Bureau of the Census.

³ Delaware: S. 30, 146th Gen. Assem., Reg. Sess. (Del. 2011) (civil union); Hawaii: S. 232, 26th Leg., Reg. Sess. (Haw. 2011) (civil union).

¹ California: Cal. Fam. Code § 297 (2011) (domestic partnership), *In re Marriage Cases*, 43 Cal. 4th 757 (2008) (marriage); Colorado: Colo. Rev. Stat. § 15-22-103 (2010) (designated beneficiary); Connecticut: Conn. Gen. Stat. § 46b-20 (2011) (marriage); Delaware: S. 30, 146th Gen. Assem., Reg. Sess. (Del. 2011) (civil union); District of Columbia: DC Code § 46–101 (2011) (marriage), D.C.

Table 17.1 Current relationship recognition in the United States

Partnership recognition type		State/District	Effective
Marriage	Available to both same-sex and different-sex couples	Massachusetts	2004
		California	2008 (June 16 to November 5)
		Connecticut	2008
		Iowa	2009
		Vermont	2009
		New Hampshire	2009
		District of Columbia	2010
		New York	2011
Civil union/broad domestic partnership	All state-level rights and responsibilities associated with marriage. Available to same-sex couples and some unmarried different-sex couples	California	2000, 2005
		District of Columbia ^a	2002, 2006
		New Jersey	2007
		Oregon	2007
		Washington	2007, 2009
		Nevada	2009
		Illinois	2011
		Rhode Island	2011
		Delaware	2012
		Hawaii	2012
Limited domestic partnership/ reciprocal beneficiary/ designated beneficiary	A limited set of rights and responsibilities that vary by state. Sometimes available only to same-sex couples, sometimes also to unmarried different-sex couples, and sometimes to two individuals who may not be a couple	Hawaii	1997
		Maine	2004
		New Jersey	2004
		Maryland	2008
		Colorado	2009
		Wisconsin	2009

^aThe District of Columbia is categorized here as a broad domestic partnership, based on the Domestic Partnership Equality Amendment Act of 2006, DC Law 16–79, effective April 4, 2006. However, subsequently in this report the District of Columbia is categorized as having a limited domestic partnership. Data that we were provided by the District from 2002 to 2007 cannot be disaggregated for the time period before and after April 4, 2006. Therefore, we will include data from the District of Columbia under limited statuses only

reciprocal beneficiary registrations, and designated beneficiary agreements that carry limited rights and obligations under state law.

The diversity of state laws governing the relationships of same-sex couples is even more complicated, however. As noted, seven states and the District of Columbia currently offer civil unions or domestic partnerships with legal rights comparable to marriage. Five of the seven states have either constitutional amendments or statutes that prohibit marriage for same-sex couples.⁴ New Jersey and Rhode Island, in contrast, have opted to offer same-sex couples a non-marriage

status despite the lack of any constitutional or statutory prohibition on opening marriage to them. Six states offer legal recognition with limited rights and obligations for same-sex couples, such as limited domestic partnerships and designated beneficiary agreements. New Jersey offers limited domestic partnerships for some same-sex couples and civil unions for all same-sex couples, while the District of Columbia offers both broad domestic partnerships and marriage to all same-sex couples. California, the District of Columbia, and Washington both initially created domestic partnership registries with limited rights acquired by registration (indicated by the first year listed in Table 17.1), but later increased the rights and obligations of those who register to the full range

⁴ Human Rights Campaign (2010).

of state-law rights and obligations afforded to married spouses (indicated by the second year listed in Table 17.1).⁵

When a same-sex couple enters into a legal relationship, it sometimes is unclear whether their relationship will be recognized in other states. For instance, when a same-sex couple enters a civil union, their union likely will not be recognized in states that do not allow same-sex couples to marry or enter a broad legal status.⁶ Currently, 41 states have constitutional amendments and/or statutes that restrict marriage to different-sex couples.⁷ Eighteen of these states have language designed also to prohibit other forms of relationship recognition, such as civil unions or domestic partnerships.⁸

This variation in state law recognizing same-sex relationships poses challenges for same-sex couples not encountered by married different-sex couples, such as for those wishing to end their relationship. As a general matter, states only entertain requests for a divorce from their own residents. For instance, New Jersey requires one

or both members of a couple wishing to dissolve their civil union to have been a resident of New Jersey for at least 12 months prior to filing for dissolution.⁹ For couples who entered a marriage or civil union but do not currently live in a state that will recognize their legal status, one member of the couple may have to move and establish residency in a state that does recognize the status in order to obtain a divorce or dissolution order.

The federal government does not recognize civil unions or state-registered domestic partnerships and, as a result of the Defense of Marriage Act (DOMA), which became law in 1996, limits the definition of marriage in federal law to different-sex couples.¹⁰ Benefits, protections, and obligations of married different-sex spouses at the federal level do not apply to same-sex spouses, nor to civil union spouses or registered domestic partners, regardless of the extent of legal recognition at the state level.¹¹ Therefore, while limited protections for same-sex partners have started to emerge within certain federal policies and regulations, the rights and obligations of same-sex couples discussed in this report exist under state law due to the various forms of legal recognition offered by states.

⁵ California: AB. 26, 1999–2000 Leg., Reg. Sess., (Cal. 1999); AB. 25, 2001–2002 Leg., Reg. Sess., (Cal. 2001); S. 1049, 2001–2002 Leg., Reg. Sess., (Cal. 2001); AB. 2216, 2001–2002 Leg., Reg. Sess., (Cal. 2002); AB. 2777, 2001–2002 Leg., Reg. Sess., (Cal. 2002); S. 1575, 2001–2002 Leg., Reg. Sess., (Cal. 2002); S. 1661, 2001–2002 Leg., Reg. Sess., (Cal. 2002); AB. 205, 2003–2004 Leg., Reg. Sess., (Cal. 2003); AB. 2208, 2003–2004 Leg., Reg. Sess., (Cal. 2004); S. 565, 2005–2006 Leg., Reg. Sess., (Cal. 2005); S. 973, 2005–2006 Leg., Reg. Sess., (Cal. 2005); S. 1827, 2005–2006 Leg., Reg. Sess., (Cal. 2006); AB. 2051, 2005–2006 Leg., Reg. Sess., (Cal. 2006); AB. 102, 2007–2008 Leg., Reg. Sess., (Cal. 2007); AB. 2055, 2009–2010 Leg., Reg. Sess., (Cal. 2010). District of Columbia: DC Law 9–114 (1992), DC Law 15–17 (2003), DC Law 15–176 (2004), DC Law 15–307 (2004), DC Law 15–309 (2004), DC Law 16–79 (2006). Washington: SB. 5336, 2007–2008 Leg., Reg. Sess., (Wash. 2007); HB. 3104, 2007–2008 Leg., Reg. Sess., (Wash. 2008); SB. 5688, 2009–2010 Leg., Reg. Sess., (Wash. 2009).

⁶ Currently, Maryland and New Mexico, which do not allow civil unions or marriage for same-sex couples, will recognize marriages of same-sex couples that have occurred in other states. Maryland: 95 Op. Md. Att’y Gen. 3 (2010); New Mexico: 2011 Op. N.M. Att’y Gen. No. 11–01 (Jan. 4, 2011).

⁷ See *supra* note 4.

⁸ See *supra* note 4.

⁹ N.J. Code § 2A:34–9 (2009) (Jurisdiction in nullity proceedings or dissolution proceedings; residence requirements; service of process).

¹⁰ Defense of Marriage Act, Pub. L. no. 104–199, 110 Stat. 2419 (1996), codified at 1 U.S.C. § 7 (2010), stating that “In determining the meaning of any Act of Congress, or of any ruling, regulation, or interpretation of the various administrative bureaus and agencies of the United States, the word ‘marriage’ means only a legal union between one man and one woman as husband and wife, and the word ‘spouse’ refers only to a person of the opposite sex who is a husband or a wife.”

¹¹ The future of federal enforcement of DOMA is uncertain. The Department of Justice submitted a brief in July 2011 in a case pending in U.S. District Court, *Golinski v. U.S. Office of Personnel Management*, explaining the Obama Administration’s conclusion that DOMA unconstitutional discriminates based on sexual orientation. See Defendants’ Brief in Opposition to Motions to Dismiss, *Golinski v. OPM*, No. C 3:10-00257-JSW, at 6–13 (N.D. Cal. July 1, 2011), available at http://data.lambdalegal.org/in-court/downloads/golinski_us_20110701_defendants-brief-in-opposition-to-motion-to-dismiss.pdf (last accessed November 7, 2011).

How Many Same-Sex Couples Have Entered a Legally-Recognized Status?

Since 1997, over 140,000 same-sex couples (22% of all U.S. same-sex couples) have formalized their relationship under state law in the United States.¹² Nearly 50,000 same-sex couples have married.¹³ In California alone, an estimated 18,000 same-sex couples married in 2008 and nearly 57,000 same-sex couples have registered as domestic partners, although some couples might have done both.¹⁴

¹² The 22% figure was calculated using counts of same-sex couples from the 2010 Decennial Census and administrative data collected from each state. See Appendix 1 for more information on sources of and adjustments to state data. Data collected from the states are from varying time periods, so cannot be described as current to the date of publication of this report. This 140,000 figure does not adjust for couples who may have entered multiple legal relationship statuses in the District of Columbia, New Jersey, or Vermont. This 140,000 figure also does not adjust for couples who may have entered legal relationship statuses in multiple states and does not account for those who have dissolved their legal relationships (see Table 17.6 for take-up rates adjusted for dissolutions).

Data on same-sex couples from the 2010 Decennial Census do not capture the actual total number of same sex couples in the United States or individual states over the same period of time as our state-level administrative data (in most cases). Except where we examine just the first year of data or where we adjust for dissolutions later in this report, state administrative data is cumulative over the period of time indicated in Table 17.2. Data on same-sex couples from the 2010 Decennial Census provide a cross-sectional total only for 2010. It is likely that the actual total number of same-sex couples that existed during the period of time covered by the state administrative data is higher than the number provided by the 2010 Decennial Census. To the extent that the actual number is higher, our 22% figure here and the figures provided in Table 17.3 are larger than one would find if the true number of same-sex couples could be known. In the absence of data on the true total number of same-sex couples over these time periods, the 2010 Decennial Census provides the best available data for use in the denominator.

¹³ This 50,000 figure includes only marriages entered into within the United States, and includes couples who entered civil unions that were automatically converted to marriages in Connecticut and New Hampshire.

¹⁴ The estimate of 18,000 same-sex couples married in California, of which 15,000 were residents, comes from an unpublished update to the following research note: The Williams Institute (2008). See also Badgett (2010).

Table 17.2 provides the number of same-sex couples who have registered, entered a civil union, or married by state and recognition type. States vary in whether they allow different-sex couples to enter a non-marital form of legal recognition.¹⁵ Totals that appear in Table 17.2 have been adjusted to include only same-sex couples. Furthermore, all states, with the exception of Colorado, Maine, Oregon, and Wisconsin, allow non-residents to enter into the legal status(es) they offer to same-sex couples. Table 17.2 provides resident-only totals as well as the overall total for each state.¹⁶ Appendix 1 provides a detailed description of how data provided to us by the states have been adjusted to account for different-sex couples and for residency.

Figure 17.1 shows the cumulative counts of same-sex couples who have married, entered a civil union, or registered under a broad domestic partnership law in the United States.¹⁷ The large leap in marriages in 2008 is largely attributable to the marriages performed in California that year. Regardless, the overall trend shows an increasing number of same-sex couples formalizing their relationships within these comprehensive statuses over time. Furthermore, since 1997, nearly 46,000 same-sex couples entered a state status affording a lesser degree of legal

¹⁵ The following states allow some or all different-sex couples to enter non-marital legal recognition statuses: California, Colorado, District of Columbia, Hawaii (reciprocal beneficiaries and civil unions), Illinois, Maine, Maryland, Nevada, New Jersey (domestic partnerships), and Washington.

¹⁶ Due to the lack of centralized record keeping in Colorado, we have only included the three most populous counties.

¹⁷ Couples from California and Washington were not included in Fig. 17.1 before the rights of domestic partners in those states became comparable to those of spouses (2005 for California and 2010 for Washington). Only couples who registered their domestic partnerships after the rights became comparable to marriage in California and Washington are included in Fig. 17.1 as “civil unions or broad DPs.” Civil unions that occurred in Connecticut and New Hampshire were removed from the cumulative total for civil unions and added to the cumulative total for marriages upon their conversion to marriages.

Table 17.2 Number of marriages/civil unions/registrations by same-sex couples in the U.S.^a

Type of couple recognition	State/county/district (date range for data)	Total	Residents (percent)
Limited domestic partnership/reciprocal beneficiary/designated beneficiary	Hawaii (1997–2010)	1,778	1,422 (80)
	District of Columbia (2002–2007)	674	667 (99)
	Maine (2004–2010)	731	731 (100)
	New Jersey (2004–2010)	4,955	4,905 (99)
	Washington (2007–2009)	5,893	5,852 (99)
	Arapahoe County, CO (2009–2010)	53	53 (100)
	Denver County, CO (2009–2010)	238	238 (100)
	El Paso County, CO (2009–2010)	39	39 (100)
	Wisconsin (2009)	1,329	1,329 (100)
Civil union/broad domestic partnership	California (2000–2010)	56,864	54,021 (95)
	Vermont (2000–2009)	8,972	1,631 (18)
	Connecticut (2005–2008)	2,136	2,136 (100)
	New Jersey (2007–2010)	5,153	5,153 (100)
	Oregon (2008–2010)	3,757	3,757 (100)
	New Hampshire (2008–2009)	819	819 (100)
	Nevada (2009–2010)	1,252	1,252 (100)
	Washington (2010–2011)	1,698	1,666 (98)
Marriage	Massachusetts (2004–2009)	16,129	13,771 ^b
	California (2008)	18,000	15,000 (83)
	Connecticut (2008–2010)	4,616	1,899 (41)
	Iowa (2009–2010)	2,099	866 (41)
	Vermont (2009–2010)	1,425	557 (39)
	New Hampshire (2010)	986	394 (40)
	District of Columbia (2010)	3,500	–

Note: Appendix 1 provides a detailed description of how data provided to us by the states have been adjusted to account for different-sex couples and for residency

^aCivil unions in Connecticut and New Hampshire are listed separately from marriages; however, civil unions were automatically converted to marriages in both states. Civil unions in Vermont were not automatically converted to marriages. Residency data was not provided for DC marriages due to insufficient data regarding residency of couples. Some states allow some or all different-sex couples to enter into non-marital legal relationship statuses. In this table, those states are: CA, CO, DC, HI, ME, NV, NJ (domestic partnerships), and WA. In those states, counts of same-sex couples were determined either from data collected directly from the states or by creating an estimate based on the experiences of similarly-situated states. Counts of same-sex couples were estimated for the states of NJ (from 2007 on), ME, and NV. Residency rates were established either through examination of residency data provided by the state or by creating an estimated rate based on the experiences of similarly-situated states. Residency rates were estimated for the following states: NJ (both civil unions and domestic partnerships), CT (civil unions only), NH (both civil unions and marriage), and NV. Civil union residency rates were estimated at 100%, which is a conservative assumption when comparing take-up rates for civil unions versus marriage. More detailed information on how we adjusted the data to account for different-sex couples and residency appears in Appendix 1

^bMassachusetts did not allow non-resident same-sex couples to marry in Massachusetts until 2008. See Mass. Gen. Laws ch. 207, § 11 (repealed 2008). We estimate that 54% of marriages were for non-residents after the prohibition on out-of-state couples was removed

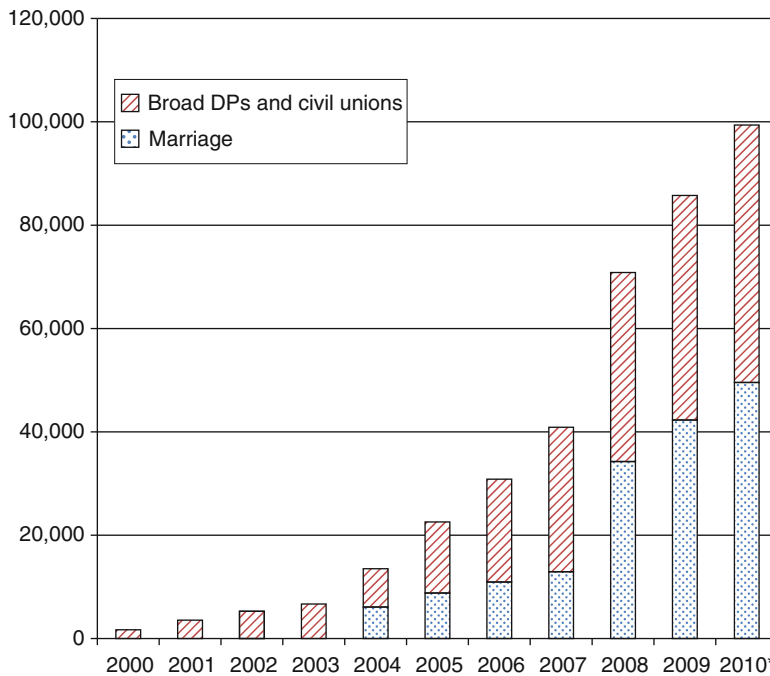


Fig. 17.1 Cumulative counts of broad domestic partnerships, civil unions, and marriages of same-sex couples, 2000–2010 (*2010 data are incomplete)

recognition, such as limited domestic partnerships or designated beneficiary agreements.¹⁸

A 2010 Williams Institute online survey of 600 people living with a same-sex partner provides alternative estimates of the proportion and number of same-sex couples marrying.¹⁹ Across the United States, 29% of respondents said they were either legally married to their same-sex partner (14%) or in a civil union or domestic partnership (15%). Applying those percentages to the number of same-sex couples in the survey suggests that approximately 80,000 are married nationwide.²⁰ This survey-based number is higher than our estimate based on administrative data. However, the survey-based data would include couples not captured by the administrative data,

namely those who have married in Canada or another country. Thus, the two figures are roughly comparable and not necessarily inconsistent. The totals from the administrative data provide the most accurate data on the count of couples who have officially married or registered their relationship in the United States.²¹

¹⁸ That total includes about 30,000 couples who registered as domestic partners in California and Washington before those statuses were enhanced to be similar to civil unions. These registrations are not included in Fig. 17.1.

¹⁹ Gates (2010).

²⁰ See *supra* note 19. Additional calculations for the 80,000 figure completed by Gary Gates, The Williams Institute, UCLA School of Law.

²¹ The U.S. Census Bureau reported that 646,464 same-sex couples were tabulated in Census 2010. In addition, the Census Bureau reported that 131,729 of those same-sex couples designated one partner as a “husband” or “wife.” Gates (2010) shows that designations of same-sex “husband/wife” versus “unmarried partner” couples used in Census Bureau surveys are not a very accurate indicator of the legal status of couples. The national survey of same-sex couples (Gates 2010) showed that among couples who designated a partner as “husband” or “wife,” about 70% were legally married and 15% were in civil unions or registered domestic partnerships. The remaining 15% said that despite the fact that they were not legally married, they considered the terms to be the best description of their relationship. The survey also found that 4% of couples who designated themselves as unmarried partners were, in fact, legally married. They said that they opted for the unmarried partner designation because their marriage was not recognized either by the federal or state government. O’Connell and Feliz (2011). See also Gates (n.d.).

Percentage of Same-Sex Couples Who Entered Legally-Recognized Statuses

Many factors influence the total number of couples who have sought legal relationship recognition in a state. These factors include the state's population, the length of time same-sex couples have been offered a formal status, and the type of relationship status(es) offered. California, being the most populous state and among the first to offer legal recognition for same-sex couples, has registered more than half of all same-sex couples who have registered domestic partnerships under state law in the United States. In this section we will discuss take-up rates that account for population size and length of time at least one status has been offered.

As noted earlier, the U.S. Census Bureau collected data on same-sex couples in the 2010 Decennial Census, and here we use those figures as a reference point to control for the state population size and to estimate the take-up rate, which is the percentage of couples formalizing their relationships. Using those data and administrative data provided by the states, we calculated the percentage of same-sex couples who have entered a legal status in the United States and in each state.²² Twenty-two percent of all same-sex couples within the U.S. have formalized their relationships under state law. In states that offer same-sex couples a way to do so, 47% of resident same-sex-couple have formalized their relationships legally.²³

At the state level, the percentage of couples who have entered a formal relationship status is highest in states that have offered such a status

for a longer period of time, not surprisingly. Table 17.3 below provides the type of status and percentages of same-sex couples who have ever entered the status by state. Each relationship type is listed by years of available data.²⁴

Table 17.3 demonstrates that the amount of time a status has been offered is important but is not the only factor influencing the take-up rate. Hawaii has allowed same-sex couples to register as reciprocal beneficiaries since 1997, the longest period of time of all states. Forty-four percent of Hawaii's same-sex couples have registered. Fifty-five percent of California's same-sex couples have entered domestic partnerships, though offered for a shorter period of time than Hawaii's reciprocal beneficiary agreements.²⁵

Two New England states have the highest take-up rates, which are probably explained by the fact that they have offered their statuses the longest. Vermont was the first to offer civil unions, doing so in 2000.²⁶ Seventy-six percent of Vermont's same-sex couples have entered into a civil union at some point since then. Unlike in Connecticut and New Hampshire, Vermont civil unions did not automatically convert to marriages after the state opened marriage to same-sex couples in 2009. Twenty-six percent of Vermont's same-sex couples have since married, a figure that includes marriages by couples who had previously been in a civil union as well as those who had not. Similarly, in 2004 Massachusetts was the first state to allow same-sex couples to marry, a shorter period of time, yet 68% of Massachusetts's resident same-sex couples have done so.

²² Data on the number of same-sex couples nationally and in each state come from U.S. Census Bureau (2010). Those 2010 Census figures are used as the denominator when calculating the percentage of same-sex couples that have entered a legal recognition status nationally or in a particular state.

²³ This 47% figure does not include in the denominator states or counties for which we have no administrative data on counts of couples who have entered legally recognized relationships (Delaware, Illinois, New York, Rhode Island, and all counties in Colorado except Arapahoe, Denver, and El Paso counties).

²⁴ New Jersey and Vermont are listed twice in Table 17.3 because they have offered multiple legal relationship statuses over time. Unlike other states where couples have entered into an earlier form of legal recognition, these two states did not automatically shift couples to the new status. Therefore, there may be double-counting of couples who entered the earlier status and then later entered the new status.

²⁵ California and Washington did not offer broad domestic partnerships when they first enacted their registries. Rights and obligations were increased by these legislatures over time and now are comparable to those of marriage. Vermont offered civil unions with the same state-law rights as spouses for all the years of data presented here.

²⁶ Vermont: Vt. Stat. Ann. tit. 15, §1201-07 (2000) (civil unions).

Table 17.3 Percentage of same-sex couples who have entered a legal recognition status

Type of couple recognition	State/County/District (years of available data)	Percent of same-sex couples who ever entered a status (%)
Limited domestic partnership/ reciprocal beneficiary/designated beneficiary	Hawaii (13.25)	44
	Maine (6.75)	18
	District of Columbia (6.5)	14
	New Jersey (6.5)	29
	Arapahoe County, CO (1.5)	4
	Denver County, CO (1.5)	5
	El Paso County, CO (1.5)	3
	Wisconsin (0.5)	14
Civil union/broad domestic partnership	California (10.75)	55
	Vermont (9)	76
	New Jersey (3.75)	30
	Washington (3.75)	40
	Oregon (2.75)	32
	Nevada (1)	18
Marriage	Massachusetts (5.75)	68
	Connecticut (3) ^a	51
	New Hampshire (3) ^a	37
	Vermont (1.25)	26
	Iowa (1)	21

^aIncludes civil unions, which were automatically converted to marriages

Demographics of Couples Who Enter Legally-Recognized Statuses

Gender

Women are more likely to marry or legally formalize their partnership than are men, as two comparisons demonstrate. First, in eight states that provided us with data on gender and offer some form of legal status to same-sex couples, 62% of all same-sex couples who entered a legal status were female couples.²⁷ However, only 54% of couples living in those states were female couples. Figure 17.2 shows the percentage of same-sex couples who are female out of the total who have entered a legal status in selected states. New Hampshire reported the highest percentage, with 72% of married same-sex couples being female couples.

Second, not only are couples in a formal legal status more likely to be female, but female couples

are more likely than male couples to legally formalize their relationships. Demonstrating the higher demand among female couples, Fig. 17.3 shows the percentage of all female couples and percentage of all male couples in the 2010 Decennial Census who have entered a legal status under state law in those states that provided us with data by gender.

In all states represented in Fig. 17.3, a larger percentage of female couples have entered a legal status than male couples. For instance, in Washington, DC, where female couples make up only 26% of all same-sex couples, female couples registered a domestic partnership at a higher rate than male couples (18 and 12% respectively). In Massachusetts, which was the first state to allow same-sex couples to marry, 75% of female couples have married compared with 59% of male couples. In all states for which we were able to obtain data, a higher percentage of female couples have entered a legal status. Figures 17.2 and 17.3 support the conclusion that female couples demand legal relationship recognition to a greater extent than male couples.

²⁷ Calculations for gender were completed using administrative data provided by the states using total counts of same-sex couples by state and by gender provided by the 2010 Decennial Census, U.S. Census Bureau.

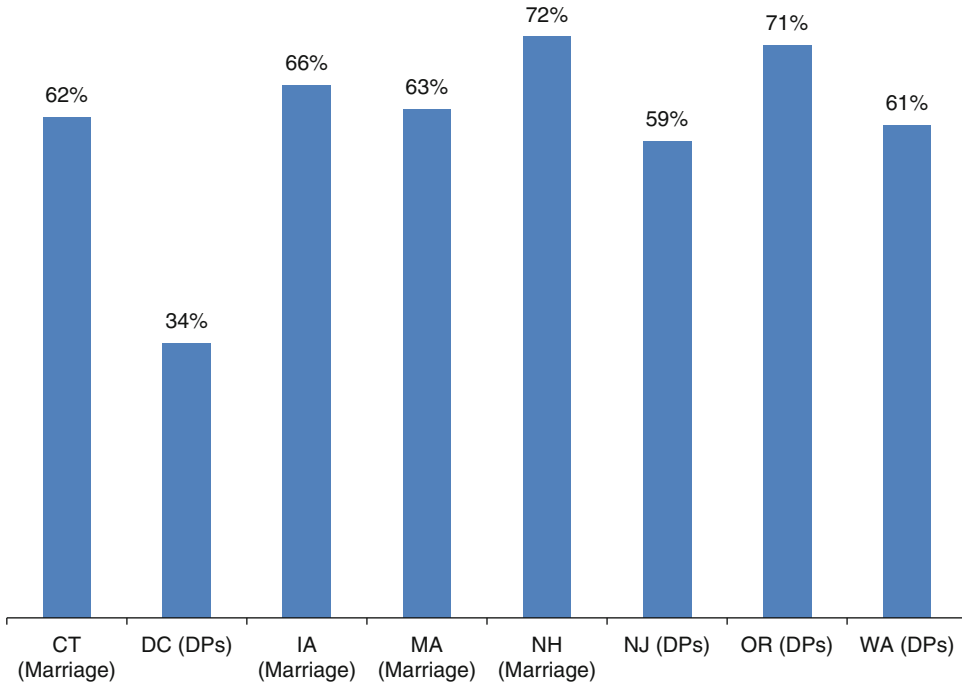


Fig. 17.2 Percent female out of all same-sex couples legally recognized in selected states

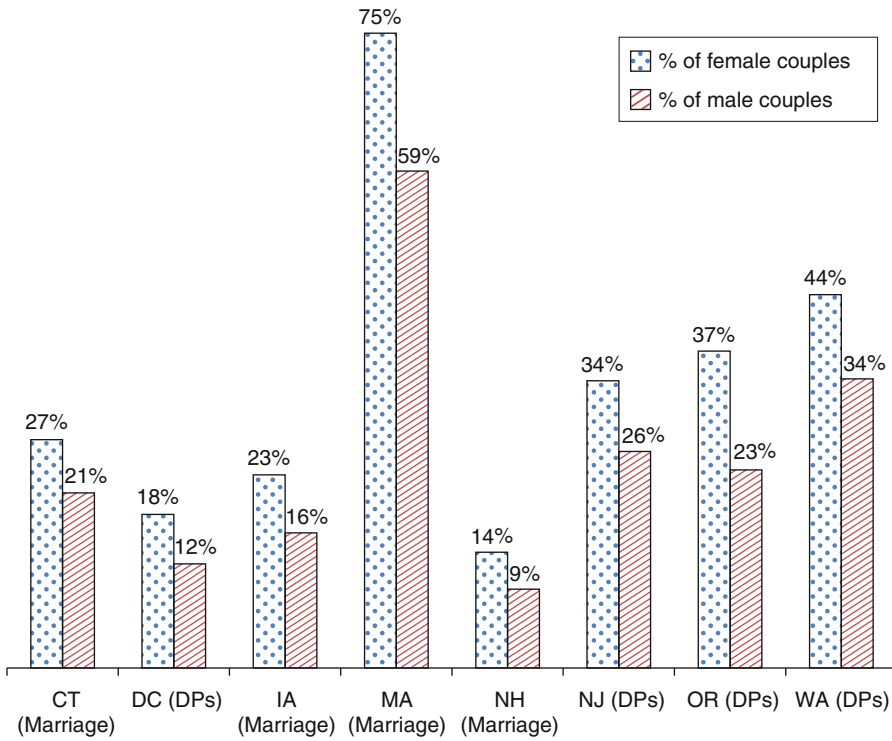


Fig. 17.3 Percentage of resident male and female couples who entered legally-recognized statuses

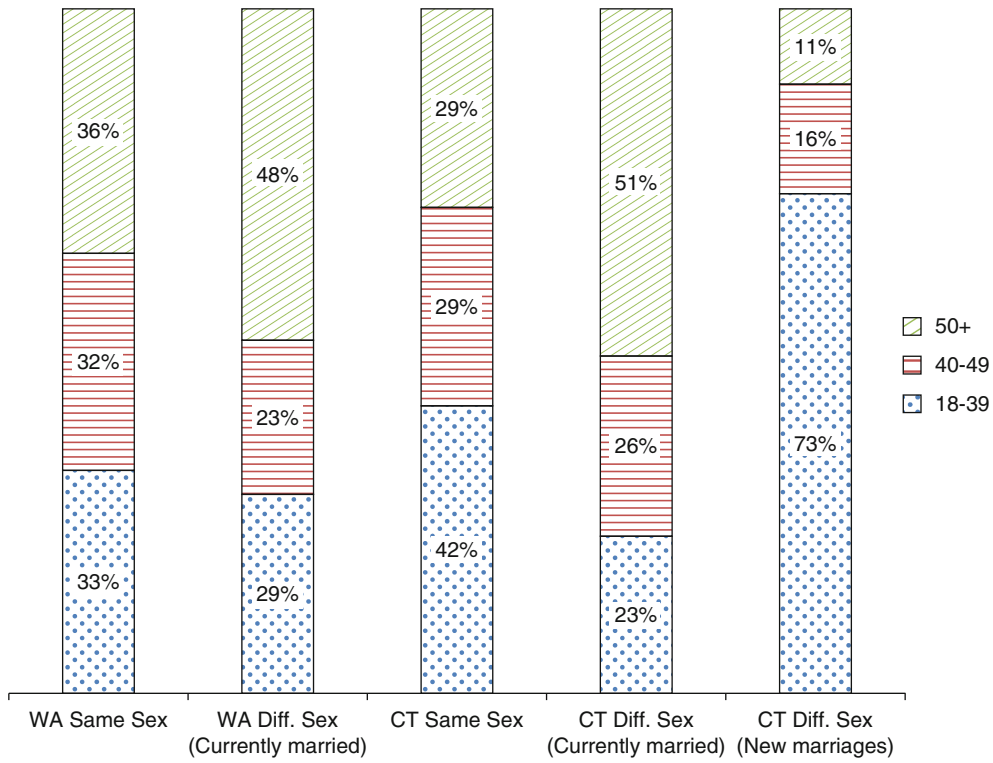


Fig. 17.4 Age of same-sex and different-sex couples who marry or register

Age

Prior research suggests that same-sex couples who marry or enter other legal recognition statuses tend to be younger than married different-sex couples in those states.²⁸ We have new data on the age of same-sex couples for only two states, Washington and Connecticut. Figure 17.4 provides age categories for same-sex couples who have registered domestic partnerships in Washington or have married in Connecticut, as well as age categories for currently married different-sex couples in those states.²⁹ In Connecticut, 51% of different-sex married couples are age 50 or older, while only 29% of married same-sex

couples are age 50 or older. In Washington, 48% of different-sex married couples are age 50 or older, while only 36% of registered same-sex couples are age 50 or older. This difference can be explained by the fact that the existing pool of married different-sex couples has some who have been married for a relatively long time.

However, when we compare same-sex and different-sex couples who have married during the same recent time period, those newly-married same-sex couples tend to be older than newly-married different-sex couples. The State of Connecticut provided us with data on recently married same-sex and different-sex couples, also shown in Fig. 17.4. Seventy-three percent of newly-married different-sex couples were under age 40, whereas 42% of newly married same-sex couples were under age 40. This finding is not surprising given that many same-sex couples have had to wait longer into their relationships to enter a legal marriage.

²⁸ Gates et al. (2008).

²⁹ Age ranges for currently-married different-sex couples were created using data from the U.S. Bureau of the Census, 2009 American Community Survey. Age ranges for same-sex couples were calculated using administrative data provided by the states.

Residency

In states where same-sex couples can marry, about 60% of all marriages are by couples from other states. The states that contribute the most out-of-state couples are those with large populations (such as Texas, New York, and Florida) and those in close proximity to the state with marriage for same-sex couples. Table 17.4 shows the top ten states whose residents married in Massachusetts, Iowa, and Connecticut.³⁰ In Iowa, for instance, the top five contributors of out-of-state couples are surrounding states in the Midwest, Illinois being the largest contributor. Illinois couples make up 10% of all same-sex couples married in Iowa. Seventeen percent of all out-of-state couples married in Iowa came from Illinois.

Figure 17.5 puts the information from Table 17.4 into a map to represent the data for Iowa. The non-resident couples who married in Iowa come mostly from the states shaded with lines, and the larger circles represent larger numbers coming from those states. The map shows that most same-sex couples go to Iowa from the middle of the country, but Florida and Texas are also sources of many couples.

New York has been a major contributor of same-sex couples to New England states where same-sex couples can be legally married, measured in two ways: their contribution to the total of same-sex couples marrying in these three states (residents plus non-residents) and their share only of out-of-state couples marrying in those states. For instance, in 2008, New York resident couples accounted for 22% of all same-sex couples who married in Massachusetts and contributed 44% of all out-of-state couples who married in Massachusetts during that time. Similarly, 28% of all same-sex couples who married in Connecticut were New York residents,

while 47% of all out-of-state couples who married in Connecticut were residents of New York.

The importance of New York residents is clear. Indeed, those marriages of New York residents in Massachusetts in 2008 and in Connecticut account for 4% of all New York same-sex couples. Since New York now allows same-sex couples to marry in the state, it is likely that its contributions to the marriage statistics of other states will decrease significantly.

Is Marriage Different than Other Statuses?

As described earlier and in further detail in Appendix 1, states that offer legal recognition to same-sex couples do so in a variety of ways: marriage, civil unions, domestic partnerships, and other limited-rights statuses. An important question is whether civil unions and broad domestic partnerships, which offer legal rights and responsibilities comparable to those available through marriage, are seen as socially equivalent to marriage. One way to measure possible equivalence is to assess the demand for those statuses by same-sex couples and, in a few states, by different-sex couples who also have the non-marital option.

More specifically, in this section we consider the demand for marriage as compared to the demand for non-marital legal recognition in the first year that each status was offered. Here we will be comparing only figures for couples who live in the state in question. The first year appears to capture same-sex couples' enthusiasm for a legal status, as the recent rush to marry by many same-sex couples in New York suggests.³¹

³⁰ Data for Table 17.4 were provided by the states for the time periods indicated for each state. Data provided for Massachusetts and Connecticut were for non-resident individuals who married. Therefore, the denominator for the calculations in the first column (percent out of all same-sex couples for each state) was multiplied by 2 to reflect individuals. We assume here that both members of a couple are residents of the same state, and therefore, the rates of residency by state would hold true for couples.

³¹ New York City had to establish a lottery for marriage licenses to accommodate the demand for weddings for same-sex couples on the first day they were offered, Sunday, July 24, 2011. The state of New York requires a 24-h waiting period between the time the marriage license is issued and when the ceremony occurs. New York clerks' offices had 70 volunteer judges on hand to grant couples exceptions from the 24-hour waiting period so they could marry on July 24. See Hernandez (2011). The New York Times reported on July 25, 2011 that at least 1,200 marriage licenses had been issued by Monday July 25, 2011. See Kaplan (2001).

Table 17.4 Top ten states for marriages by non-resident same-sex couples in Massachusetts, Iowa, and Connecticut

State	Massachusetts (08/08 through 12/08)		Iowa (04/09 through 03/10)		Connecticut (11/08 through 09/10)	
	% of all SS couples married	% of non-resident SS couples	State	% of all SS couples married	% of all SS couples married	% of non-resident SS couples
New York	22	44	Illinois	10	28	47
Florida	3	7	Missouri	8	3	6
Rhode Island	3	6	Nebraska	5	3	4
Pennsylvania	2	5	Minnesota	5	2	4
Maryland	2	3	Kansas	3	2	3
Texas	1	3	Texas	3	2	3
Maine	1	3	Wisconsin	3	2	3
New Jersey	1	3	Oklahoma	2	2	3
California	1	2	Colorado	1	1	3
Connecticut	1	2	Florida	1	1	2

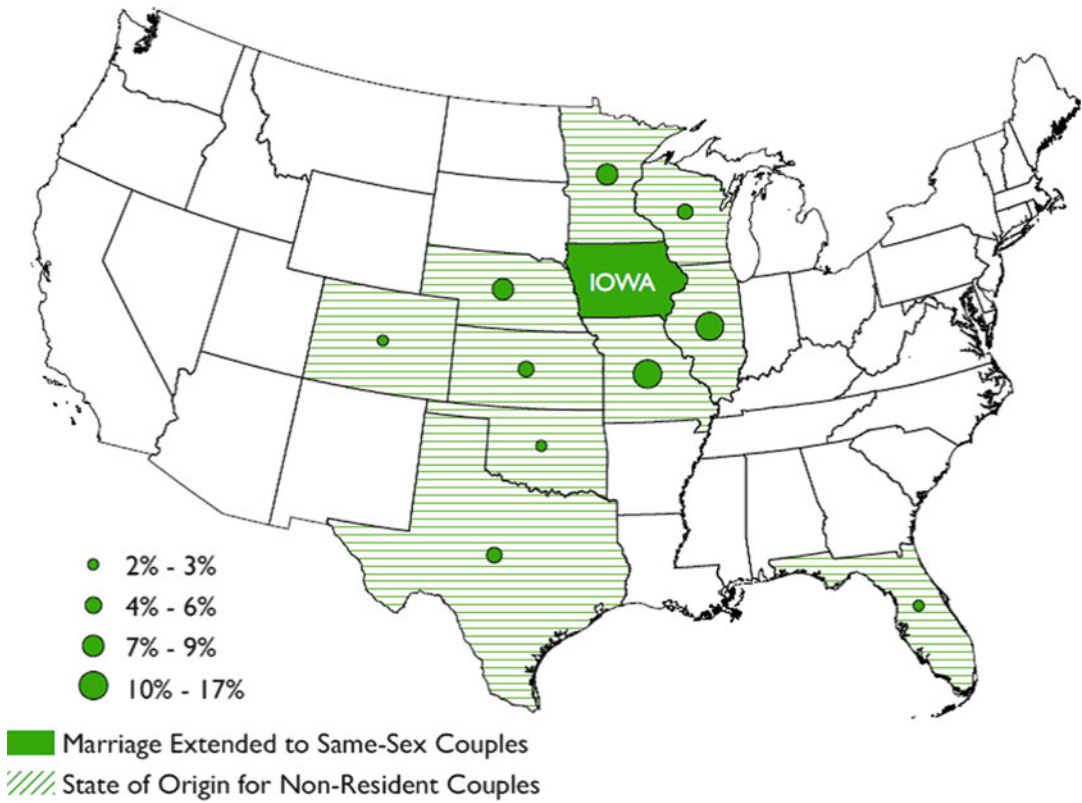


Fig. 17.5 Map of top ten states who contribute to Iowa marriages of same-sex couples, ranked by share of non-resident same-sex couples married in Iowa

Figure 17.6 shows the total percentage of same-sex couples that entered into each legal relationship status in that first year, a comparison that also controls for the influence of the number of years the status has been available and the relative state population size.³²

³² This figure includes only those same-sex couples who were residents of states that offered legal recognition. States that have offered multiple legal relationship statuses over time or had significant policy changes over time (California, Connecticut, New Hampshire, and Washington) were only included for the type of relationship they offered in the first year. Two exceptions are Vermont and New Jersey. Vermont is included in both the marriage and civil union categories because civil unions in Vermont did not automatically convert to marriages. New Jersey is included in both the limited statuses and civil unions because both statuses are offered concurrently and limited statuses (New Jersey domestic partnerships) did not automatically convert to civil unions once civil unions were allowed. Calculations were made using the

Figure 17.6 demonstrates that marriage attracts many more same-sex couples in the first year of availability than do the other statuses. In states that allowed same-sex couples to marry (Iowa, Massachusetts, and Vermont), 30% of same-sex couples did so in the first year. In states that allowed couples to enter civil unions or broad domestic partnerships with rights and responsibilities comparable to marriage (Connecticut, New Hampshire, New Jersey, Nevada, Oregon, and Vermont), 18% of same-sex couples entered these legal statuses in the first year. Finally, in states that allowed legal relationship statuses with

total number of resident same-sex couples who entered the legal status listed in all the relevant states in the first full year that status was offered. These totals were divided by the total number of same-sex couples in those states where that status was offered according to the 2010 Decennial Census, U.S. Census Bureau.

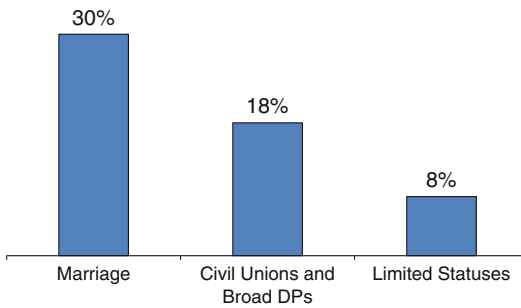


Fig. 17.6 Year-one take-up rates by legal recognition status

limited rights (California, the District of Columbia, Hawaii, Maine, New Jersey, and Washington), only 8% of same-sex couples entered these types of limited-rights statuses in the first year.

It should be noted that the 30% figure for marriage is a conservative one and the true figure may actually be higher. Data provided by the state of Iowa include 721 Iowa resident couples who did not state their sex, so it cannot be determined if these are same-sex or different-sex couples. However, if some of the 721 resident couples of unknown sex are same-sex couples, and it seems reasonable to assume that at least some are, the average year-one take-up rate for marriage would rise, potentially increasing to 33% if all of the unknown couples were same-sex couples. Furthermore, if we were to include all the civil unions of New Hampshire and Connecticut residents that converted into marriages in the first year marriage was offered, the 33% figure would jump to 44%.

Overall, the higher first year take-up rates for marriage seen in Fig. 17.6 suggest that same-sex couples prefer marriage over other non-marital legal statuses. Figure 17.6 shows that the lowest demand is for statuses with limited rights and obligations. Several factors might account for some of this difference in demand across legal status types. Some of the statuses offer a set of rights, responsibilities, and benefits that might not meet the needs or expectations of some couples. That hypothesis is consistent with the finding that statuses with greater levels of rights and benefits see higher take-up rates. Another reason for less interest in non-marital statuses is that couples may be confused about the rights and obligations

associated with those forms of recognition, especially when the nomenclature is new and unfamiliar and when the rights and duties change with successive legislation. In addition, couples may worry about how that status interacts with federal tax or estate law. However, qualitative evidence and other studies suggest that the main reason for the greater demand among same-sex couples for marriage is that it comes with an important symbolic meaning in our society.³³ The value of the symbolic statement of commitment, the public understanding of that statement, and related social meanings appears to go above and beyond the specific legal rights and benefits entailed. The higher take-up rates for marriage than for legally similar statuses provide evidence that those cultural and social meanings of marriage are highly valued by same-sex couples.

We see similar evidence that marriage is more highly valued than civil unions or broad domestic partnerships in state-level first year take-up rates. Figure 17.7 shows the year-one demand for civil unions or broad domestic partnerships and the year-one demand for marriage among residents of several states.³⁴ Because some states have moved from having only civil unions to allowing same-sex couples to marry, simple comparisons are difficult.³⁵ We do not show first-year marriage rates for Connecticut and New Hampshire because those states automatically converted civil unions

³³ For instance, see Badgett (2011).

³⁴ Calculations for Fig. 17.7 were made using the total number of resident same-sex couples who entered the legal status listed for each state in the first full year that status was offered, divided by the number of same-sex couples in that state according to the 2010 Decennial Census, U.S. Census Bureau. These figures differ from those reported in the prior study, *Marriage, Registration, and Dissolution by Same-Sex Couples in the U.S.*, due to a change in the denominator we used. We believe the counts of same-sex couples provided in the 2010 Decennial Census reflect the best available data on the number of same-sex couples in the states. This prior study used counts of same-sex couples from the American Community Survey (2000 through 2007).

³⁵ Connecticut, New Hampshire, and Vermont all previously offered civil unions before enacting marriage for same-sex couples. Connecticut: Conn. Gen. Stat. §46b-38aa (2005) (civil union); New Hampshire: N.H. Rev. Stat. §457-A (2008) (civil union); Vermont: Vt. Stat. Ann. tit. 15, §1201-07 (2000) (civil union).

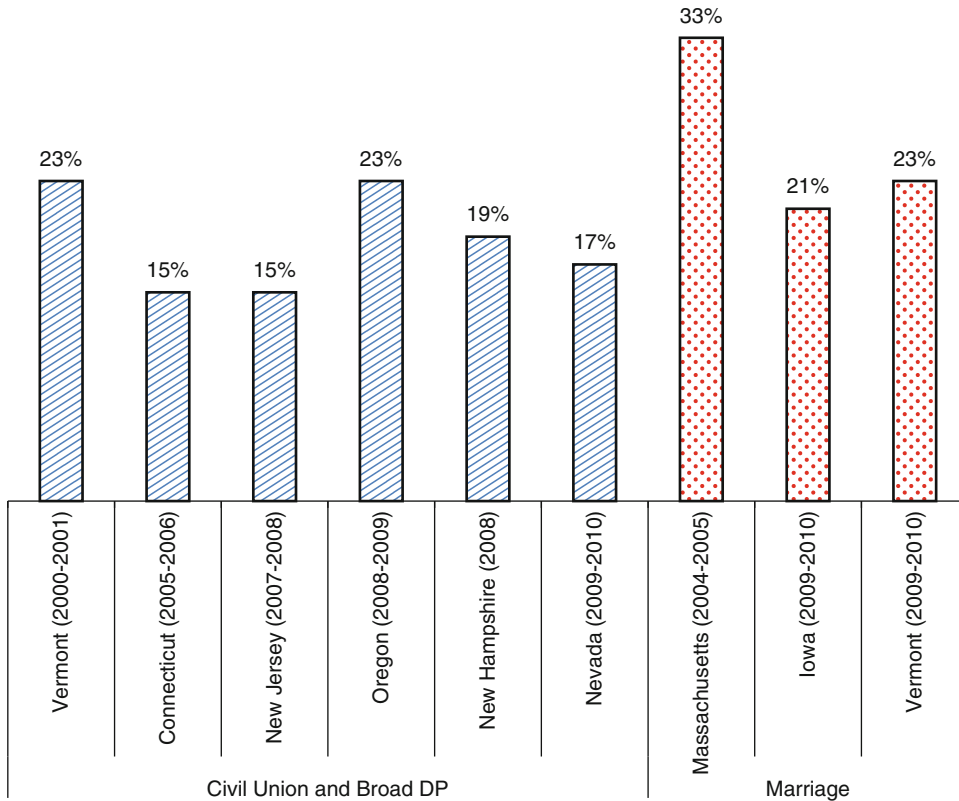


Fig. 17.7 Year-one take-up rates for marriage, civil unions and broad domestic partnerships by state

into marriages, making a clean year-one comparison of demand impossible. The take-up rate for Vermont civil unions was higher than in most other states, perhaps because Vermont was the first state to offer same-sex couples any broad legal status. Even so, same-sex couples in Vermont reacted equally strongly once marriage was an option, perhaps at least in part because that state’s civil unions were not automatically converted to marriages as in Connecticut and New Hampshire. Massachusetts was the first state to offer marriage for same-sex couples. Notably, year-one demand for marriage in Massachusetts was higher than year-one demand in Vermont for both civil unions and marriage. Demand for marriage in Iowa in year one seems to have been comparable to civil unions or broad domestic partnerships. However, as described above, if some of the 721 Iowa resident couples of unknown sex are same-sex couples, the year-one take-up rate for marriage in Iowa would rise, potentially jumping as high as 39% if all unknown couples were same-sex couples.

The preference for marriage over a broad, non-marriage legal status also is evident from analyzing trends in two different situations: states that have opened up marriage after having a broad, non-marriage status first, and states where rights and obligations have been increased over time. Looking at specific states more closely adds to the evidence that same-sex couples see these statuses as very different.

New Jersey began offering domestic partnerships for same-sex couples with limited rights and obligations in July 2004. In February 2007, New Jersey began offering civil unions for same-sex couples.³⁶ In the 3 years before the state made

³⁶ When civil unions became available, New Jersey maintained its domestic partnership registry but changed the requirements so that both members of the couple must be 62 years of age or older to be eligible to register. New requirements for New Jersey domestic partnerships were outlined in the civil union statute. New Jersey: N.J. Rev. Stat. § 37:1–29 (2011) (civil union).

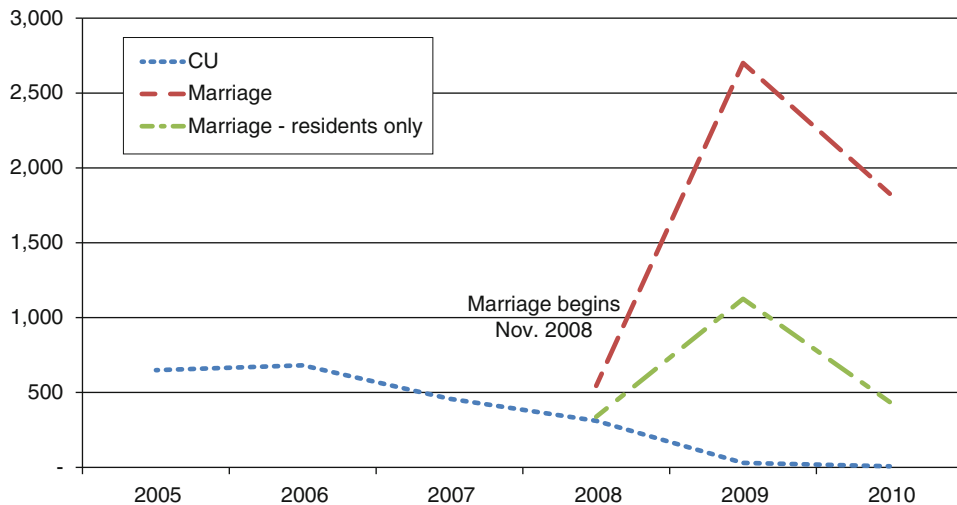


Fig. 17.8 Demand for civil unions and marriage in Connecticut

civil unions available, about 4,900 New Jersey same-sex couples had registered their domestic partnerships. In the first full year civil unions were offered (Feb. 2007 through Jan. 2008), nearly 2,600 New Jersey couples entered one.³⁷ Over the 3 years civil unions have been available, from 2007 through 2010, more than 5,100 New Jersey same-sex couples have entered this status. These 5,100 couples consisted of two groups: those who were already in a domestic partnership and those who were not. Those who were already in a domestic partnership clearly preferred the civil union status. Those who were not already in a domestic partnership may have been waiting for a more complete legal status, and one that includes solemnization, to become available before formalizing their relationship legally. In any event, both groups of couples preferred civil unions to limited domestic partnerships.³⁸

³⁷ Non-residents comprise 1% of all domestic partnerships in New Jersey. We assume civil unions are all New Jersey residents.

³⁸ Other possible explanations for the higher numbers of couples opting for civil unions or marriage in the states we analyze here include population change and shifting social norms that encouraged more same-sex couples to formalize their relationships. The short timescale involved suggests that those long-term factors are unlikely to explain the greater interest in statuses with more legal rights and responsibilities.

Connecticut offers an example of the greater demand for marriage over civil unions. Connecticut began offering civil unions in October of 2005. Beginning in November 2008, same-sex couples could marry in Connecticut. Civil unions were still offered in Connecticut until October 2010, after which time all remaining civil unions automatically converted into marriages.³⁹ In Connecticut, slightly more resident same-sex couples were married in the first full-year that marriage became available (1,206) than entered civil unions in the first year civil unions were offered (1,160).⁴⁰ However, the relatively small difference in first-year take-up hides the significance of the 1,206 new marriages: those couples had long had the option of civil unions but deferred formalizing their relationship until they could marry. Additionally, we see a preference for marriage in the many same-sex couples who came from out of state to marry. Out-of-state residents comprise 59% of those married in Connecticut, while we estimate that 100% of civil unions in Connecticut were for residents. Figure 17.8 plots the number of civil unions and marriage in each calendar year and shows that

³⁹ Connecticut: Pub. Act. No. 09–13, Sec. 11 (civil unions convert to marriages).

⁴⁰ We assume all civil unions were of Connecticut residents.

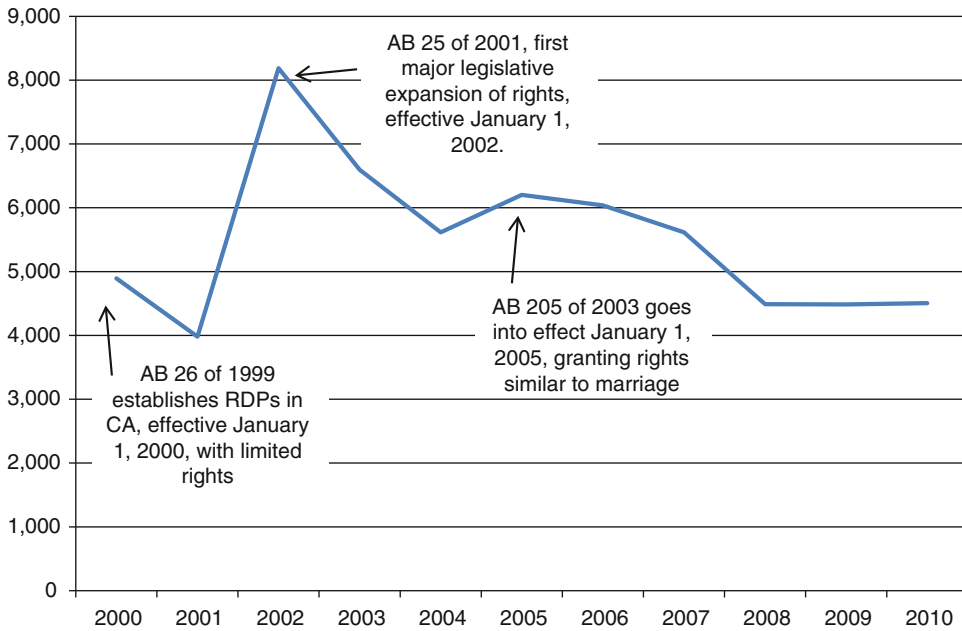


Fig. 17.9 California registered domestic partnerships (RDPs) across policy changes

many residents and non-residents had waited for the opportunity to marry in Connecticut.⁴¹

We can also gauge demand for rights and obligations similar to marriage by looking at take-up rate changes when policies change over time. Both Washington and California began by offering limited domestic partnerships. But as the result of a series of legislative steps over time, registered domestic partners now have state-law rights and responsibilities comparable to those of spouses in both states.⁴² Figures 17.9 and 17.10 present a timeline for each state, where one can see a jump in new registrants at each stage where rights and obligations were added to the existing domestic partnership laws.

Different-Sex Couples

Another way to assess couples' relative demand for marriage and non-marital legal

statuses—and, therefore, the relative value of those statuses—is to see what different-sex couples do when they have both options. Currently, nine states and the District of Columbia allow some or all different-sex couples to enter into civil unions, domestic partnerships, or designated/reciprocal beneficiary agreements.⁴³ Hawaii will allow different-sex couples to enter into civil unions beginning January 1, 2012.

Eligibility for different-sex couples to enter these legal relationships in three of these states is limited to couples in which one or both partners are age 62 or older. In California and Washington, at least one member of a different-sex couple must be age 62 or older in order to register a domestic partnership. In New Jersey, both members of a different-sex couple must be age 62 or older.

⁴¹ The numbers in Fig. 17.8 are by calendar year, while the numbers in the text of the paragraph look at the first 12 months of marriage and civil unions.

⁴² See *supra* note 5.

⁴³ This includes the state of Hawaii. Hawaii's statute allows different-sex couples to enter reciprocal beneficiary relationships if they cannot marry and meet all other eligibility requirements for the reciprocal beneficiary relationship.

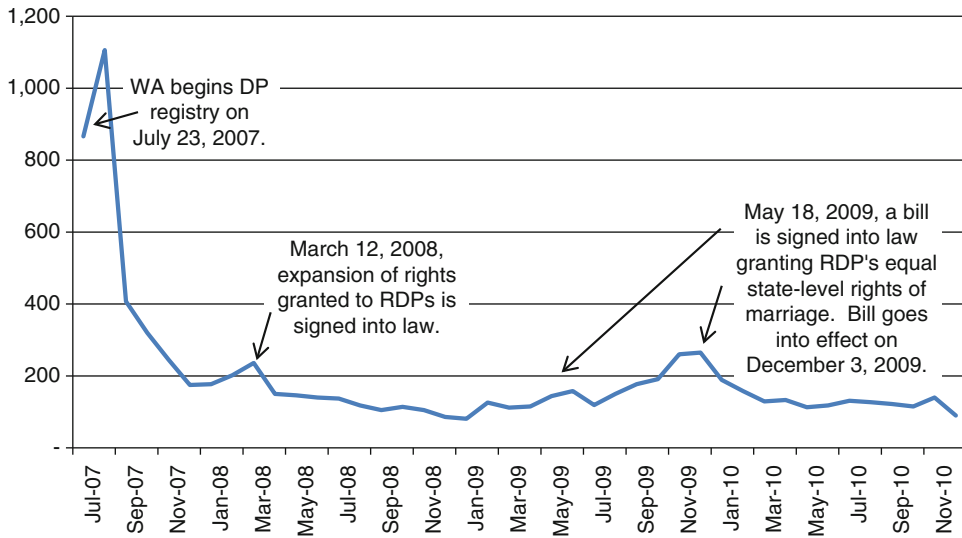


Fig. 17.10 Washington registered domestic partnerships (RDPs) across policy changes

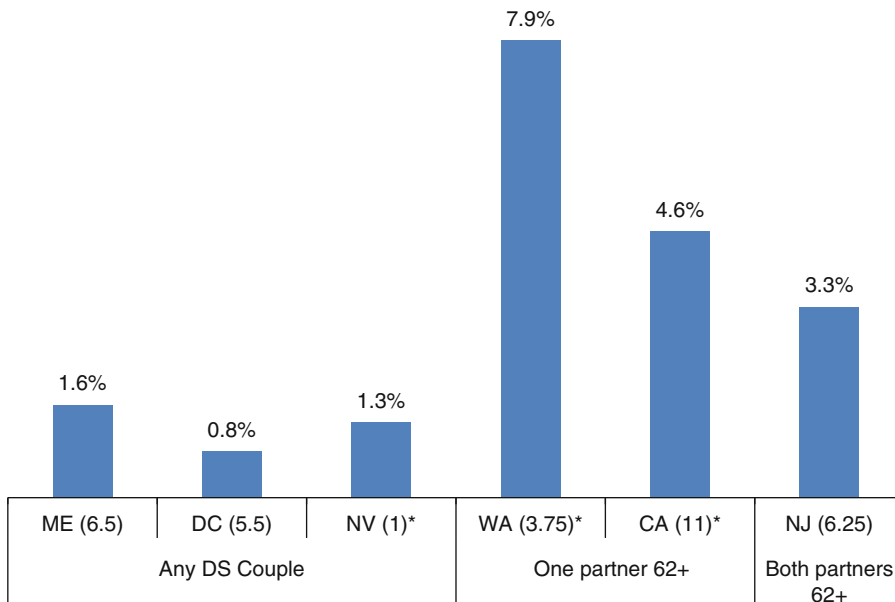


Fig. 17.11 Percent of different-sex couples ever entering a non-marital form of legal recognition, by state (years of data) and eligibility

*These states afford registered couples rights and obligations of married spouses. Other states listed offer limited rights and obligations

It is becoming increasingly common for states to allow different-sex couples of any age also to enter into the legal status offered to same-sex couples, as is true for civil unions in

Illinois and Hawaiï. Figure 17.11 suggests that unmarried different-sex couples enter these forms of legal recognition at much lower rates than same-sex couples (percentages for same-sex

couples are shown in Table 17.3).⁴⁴ Demand seems highest among those unmarried different-sex couples where one or both members are age 62 or older. The higher take-up rates for older different-sex couples might reflect a desire to secure specific rights pertaining to medical and other decision-making while retaining retirement pensions.

Marriage is a much more popular choice for different-sex couples than civil unions or state-registered domestic partnerships. In Maine, Nevada, and the District of Columbia, where different-sex couples age 18 and over can register domestic partnerships, 85–88% of such different-sex couples are married. In California and Washington, 96–97% of different-sex couples who could register because they have at least one member age 62 or older are married. In New Jersey, 98% of different-sex couples with both partners age 62 or older, who thus could register, instead are married.

Of course, the option for civil unions or domestic partnership is a relatively recent one for these different-sex couples, which might account for some of the higher rates of marriage. But the dramatic difference in take-up rates is also evidence that many more couples who have a choice—in these states that would be different-sex couples—choose marriage.

We can see that different-sex couples also prefer statuses with more rights and responsibilities, just as same-sex couples do. Our analysis of the administrative data on couples registering their domestic partnerships in the State of Washington

found that about 11% of registrations were for different-sex couples. An analysis of these data over time shows that different-sex couples increased their representation among those who registered domestic partnerships after that status entailed more legal rights. Before December 3, 2009, when those in domestic partnerships were granted all state-law rights and obligations of marriage, 9% of all domestic partnerships were for different-sex couples. After December 3, 2009, this rate increased to 16% of all domestic partnerships.

Different-sex couples in Washington were over-represented in domestic partnership terminations in data provided by the state. While different-sex couples comprise 11% of all domestic partnerships in Washington, they comprise 21% of all domestic partnership terminations. That higher rate of terminations for different-sex couples could reflect either a higher rate of ending relationships or the fact that different-sex couples might terminate a registered domestic partnership in order to marry.

Overall, the data on the choices of same-sex couples and of different-sex couples shows that marriage is the favored status. Those with the option to marry are more likely to choose marriage over an alternative legal status.

Divorce and Terminations

States that offer legal recognition to same-sex couples vary in how recognized couples can dissolve their legal relationships. In the case of limited statuses acquired through registration, couples can generally file a notice of dissolution or termination with the appropriate state agency. Those in a civil union or a registered domestic partnership with rights and responsibilities similar to marriage usually must go through a dissolution proceeding similar to a divorce.⁴⁵ As discussed above, those proceedings most often require residency in order for the state

⁴⁴ The actual or estimated number of different-sex couples who entered legally recognized relationships in each state (as appear in Fig. 17.11) was divided by the number of different-sex unmarried couples in each relevant age group for each state. The number of unmarried different-sex couples in each state came from the 2010 Decennial Census, U.S. Census Bureau. The most recent data on the age of unmarried different-sex couples comes from the 2009 American Community Survey (ACS), U.S. Census Bureau. The percentage of unmarried different-sex couples in the relevant age groups in each state was calculated using the 2009 ACS and was then applied to the total number of unmarried different-sex couples in each state as reported in the 2010 Decennial Census, U.S. Census Bureau. For detailed information on how the number of different-sex couples was estimated, see Appendix 1.

⁴⁵ In California and Washington, before registered domestic partners were afforded the same state rights and obligations of marriage, couples terminated a domestic partnership by filing a notice of termination with the appropriate

court to consider the divorce or dissolution request. Furthermore, states that do not offer a particular legal status to same-sex couples, or do not recognize such a status from another state or country, often will not end the status.⁴⁶ Therefore, if a same-sex couple married in Vermont but now lives in a state that will not grant them a divorce, one member of the couple may have to move to a state that recognizes the marriage and meet the residency requirement for that state before requesting the divorce. Needless to say, terminating a legal relationship can prove very difficult for some same-sex couples.

A limited number of states have tracked dissolutions of legal relationships of same-sex couples. Those data reveal that the percentage of same-sex couples dissolving their relationships is slightly lower on average than the percentage of married different-sex who divorce. Table 17.5 provides total dissolution rates and average annual dissolution rates for same-sex couples with states grouped by type of legal status.⁴⁷ To calculate the total dissolution rate, we divided total dissolutions for same-sex couples in each state by the total number of same-sex couples' marriages, civil unions, broad domestic partnerships, or limited-status relationships that occurred in the state. Average annual rates of dissolutions, which are the total dissolution rate divided by years of data, range from 0 to 1.8%, or 1.1% on average across all listed jurisdictions.⁴⁸ This is slightly lower

state agency. In California, now only couples who meet strict criteria can terminate their domestic partnerships in this way. All others must go through the California Superior Court. In Washington, all domestic partnerships are now terminated through court proceedings similar to divorce.

⁴⁶ Eskridge and Hunter (2011) and Rubenstein et al. (2011).

⁴⁷ For the following states, it was not possible to disaggregate different-sex couples from same-sex couples in the dissolution data: California, District of Columbia, Maine, Nevada, and New Jersey. For purposes of this analysis, we make the conservative assumption that all dissolutions in these states are for same-sex couples.

⁴⁸ Seventy percent of the dissolutions listed for New Hampshire were for civil unions or marriages that originated in Vermont and Massachusetts. We assume for all other states that the dissolutions listed in this table were of marriages or civil unions that originated in the state where the dissolution occurred.

than the annual rate of divorce among different-sex couples, which is about 2% annually.⁴⁹ The dissolution rates do not seem to vary in any substantial way by type of legal status.

The fact that some couples have dissolved their legal relationships means that our estimates of the percentage of couples who have ever formalized their relationship will not equal the percentage of couples currently registered or married. Table 17.6 adjusts the cumulative total of legally recognized couples by subtracting the number of dissolutions.⁵⁰ We then divide the estimate of currently legally recognized couples by the total number of same-sex couples in the 2010 Decennial Census to get the percentage of couples who are currently legally recognized. Not surprisingly, those states that have offered legal recognition for the longest period of time have had (relatively speaking) the most terminations or divorces. In Table 17.6 we see the biggest change in take-up rates for Vermont, where 76% of all same-sex couples entered a civil union at some point since the status was enacted in 2000 (see Table 17.3). After adjusting for dissolutions, though, 65% of Vermont-resident couples are currently in a civil union. In California, 55% of same-sex couples registered a domestic partnership at some point in time since the state registry opened in 2000. Currently, 48% are in a registered domestic partnership.

⁴⁹ The U.S. divorce rate for different-sex couples was determined by using the rate per 1,000 of the total population provided by the Centers for Disease Control, National Center for Health Statistics, National Vital Statistics System, available at http://www.cdc.gov/nchs/nvss/marriage_divorce_tables.htm (last accessed November 7, 2011). That rate was applied to the total U.S. population to calculate the total number of divorces. The total number of divorces was divided by the total number of marriages to determine the divorce rate of different-sex married couples.

⁵⁰ The number of dissolutions was estimated for New Jersey (civil unions), Oregon (domestic partnerships), Massachusetts (marriages), Connecticut (marriages), and New Hampshire (marriages). The number of divorces was estimated by applying each state's divorce rate of different-sex couples each year to the cumulative total of marriages/civil unions for same-sex couples in that year in each state. No divorces were estimated for the first year that marriages/civil unions for same-sex couples were offered. Divorce rates of different-sex couples came from the Centers for Disease Control, National Center for Health Statistics, National Vital Statistics System.

Table 17.5 Total terminations or divorces by state

Type of relationship status	State	Total dissolutions	Total dissolution rate (%)	Avg. annual dissolution rate (%)	Years of data
Marriage	Vermont	4	0.3	0.3	1.00
Civil unions or equivalent	California	7,433	12.4	1.1	11.00
	Connecticut	109	5.1	1.0	1.50
	Nevada	28	1.2	1.2	1.00
	New Hampshire ^a	64	7.8	2.8	2.75
	Vermont	236	2.6	0.3	8.50
	Washington	305	3.6	1.0	3.75
Limited statuses	Colorado (3 counties)	0	0.0	0.0	1.50
	District of Columbia	34	4.2	0.8	5.50
	Hawaiï	256	14.4	1.1	13.25
	Maine	174	11.9	1.8	6.50
	New Jersey	299	5.8	1.2	4.75

^aIncludes 45 terminations for civil unions/marriages that originated in Vermont and Massachusetts

Table 17.6 Percent of same-sex couples who are currently legally recognized

Type of relationship status	State/county/district (years of available data)	Percent of couples ever legally recognized (%)	Percent of couples currently legally recognized (%)
Reciprocal beneficiary/ domestic partnership (limited)	Hawaiï (13.25)	44	38
	Maine (6.75)	18	16
	District of Columbia (6.5)	14	13
	New Jersey (6.5)	29	27
	Arapahoe County, CO (1.5)	4	4
	Denver County, CO (1.5)	5	6
	El Paso County, CO (1.5)	3	4
	Wisconsin (0.5)	14	14
Civil union/domestic partnership (broad)	California (10.75)	55	48
	Vermont (9)	76	65
	New Jersey (3.75)	30	29
	Washington (3.75)	40	38
	Oregon (2.75)	32	31
	Nevada (1)	18	18
Marriage	Massachusetts (5.75)	68	65
	Connecticut (3) ^a	51	49
	New Hampshire (3) ^a	37	37
	Vermont (1)	26	26
	Iowa (1)	21	21

^aIncludes civil unions, which were automatically converted to marriages

Will the Marriage Rate for Same-Sex Couples Equal that of Different-Sex Couples?

The first year that a legal status is offered to same-sex couples produces the largest annual count of new couples entering that status in a

particular state. This figure is usually referred to as the “pent-up demand” within a state for legal recognition. However, after this initial rush, demand seems to taper off and might eventually plateau at a lower level as new couples form and decide to marry, enter a civil union, or register. If one looks at the cumulative totals of these rela-

tionship statuses over time, one can see that the numbers continue to increase and trend toward the rate of marriage for different-sex couples. Here we predict how long it will take same-sex couples to reach the same marriage rate as different-sex couples if present trends continue.

Massachusetts was the first to offer marriage for same-sex couples, allowing us to assess the trend over several years of data. Figure 17.12 shows the annual totals of new marriages for Massachusetts-resident couples, the cumulative total of marriages (with estimated divorces removed from the cumulative total), and the number of total marriages same-sex couples would have to reach in order to match the rate of different-sex couples who are married (91%).⁵¹ So far, after more than 6 years of data, same-sex couples are nearly three-quarters of the way to the same cumulative take-up rate for marriage as different-sex couples in the state.⁵²

Prior research estimated that if same-sex couples seek marriage and other forms of legal recognition in states that already offer these statuses at the pace they had established from 2000 through 2007, the percentage of same-sex couples in legally-recognized relationships would equal the percentage of different-sex couples who are married by the year 2028.⁵³ Based on the experience of Massachusetts, if that legal status is marriage, same-sex couples would reach parity with different-sex couples much faster. If Massachusetts's same-sex couples continue to marry at the pace established from 2004 through 2009, the percentage of same-sex couples who are married

would reach 91%, for parity with Massachusetts different-sex couples, in 2013.⁵⁴

We see a similar trend toward parity when examining civil unions in Vermont over time in Fig. 17.13. Vermont was the first state to offer civil unions for same-sex couples in 2000, 4 years earlier than Massachusetts opened marriage. Over eight and one-half years, same-sex couples entered into 71% of the total civil unions needed to reach parity with the marriage rate of different-sex couples in the state.⁵⁵ Notably, Massachusetts reached this percentage 2 years sooner than Vermont. Civil unions were no longer offered in Vermont after September 1, 2009, at which time same-sex couples could legally marry in the state. In the first year same-sex couples could marry, 23% of Vermont's same-sex couples married, a factor that appears to counteract the slowing down of interest in civil unions seen in Fig. 17.13. Adding marriages to civil unions in Vermont would clearly boost that state's movement toward marriage parity with different-sex couples.

Conclusion

The best available administrative data provide a dynamic picture of the demand for legal recognition among same-sex couples, as well as a snapshot of which same-sex couples are entering the various statuses. As the number of states that offer these statuses grows, same-sex couples will enter these legal relationships in substantial numbers. As seen in prior research, these couples will

⁵¹ The rate of marriages for different-sex couples was calculated from the U.S. Census Bureau, 2005–2009 American Community Survey, Tables B11001 and B11009 and was found to be 91%.

⁵² The total number of same-sex couples in Massachusetts (20,256), according to the 2010 Decennial Census, U.S. Census Bureau, was multiplied by .91 to yield the total number of married same-sex couples needed to reach parity with the marriage rate of different-sex couples (91%). To get to that rate, 18,433 total same-sex couples would need to be currently married. After taking out an estimate of the number of divorces, there were 13,090 same-sex couples were married as of the end of 2009, which is 71% of the total needed to reach parity with different-sex couples.

⁵³ See *supra* note 28.

⁵⁴ This prediction is based on a simple linear projection of the cumulative total of marriages for same-sex couples from 2004 through 2009.

⁵⁵ The total number of same-sex couples in Vermont (2,143), according to the 2010 Decennial Census, U.S. Census Bureau, was multiplied by .87 to yield the total number of married same-sex couples needed to reach parity with the marriage rate of different-sex couples (87%). One thousand eight hundred and sixty four total same-sex couples would need to be currently married to reach parity with the marriage rate of different-sex couples in Vermont. Taking into account estimated divorces, 1,319 same-sex couples were in civil unions as of the end of 2008, which is 71% of the total needed to reach parity with different-sex couples.

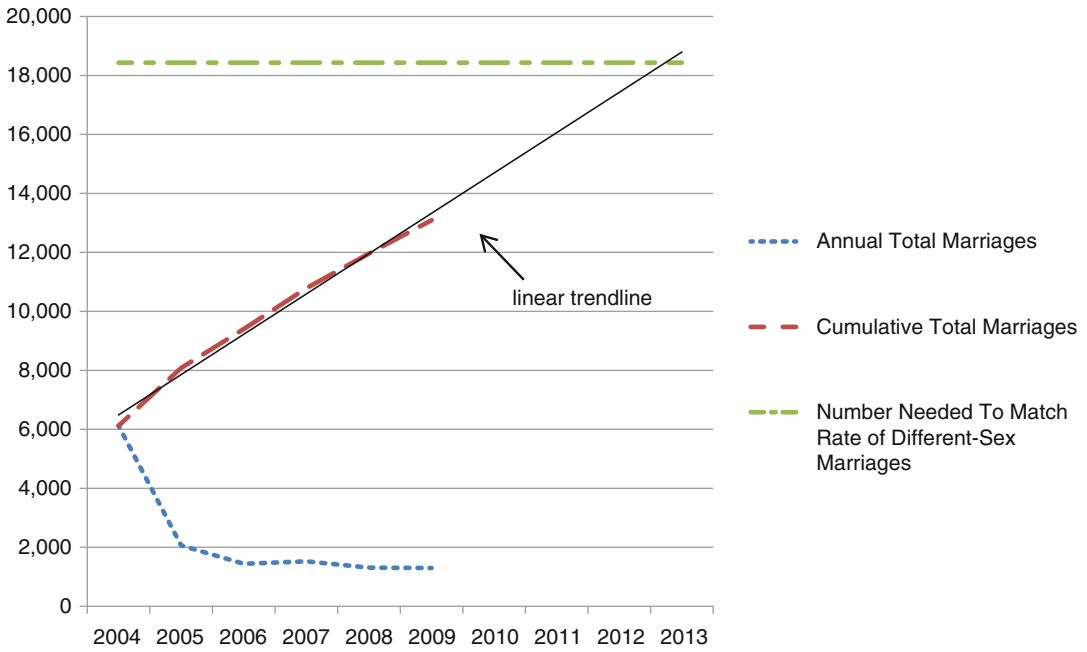


Fig. 17.12 Annual and cumulative totals of Massachusetts marriages for same-sex couples*

*(This figure includes resident couples only. We account for divorce by removing the estimated number of divorces each year from the cumulative total. *See supra* note 49)

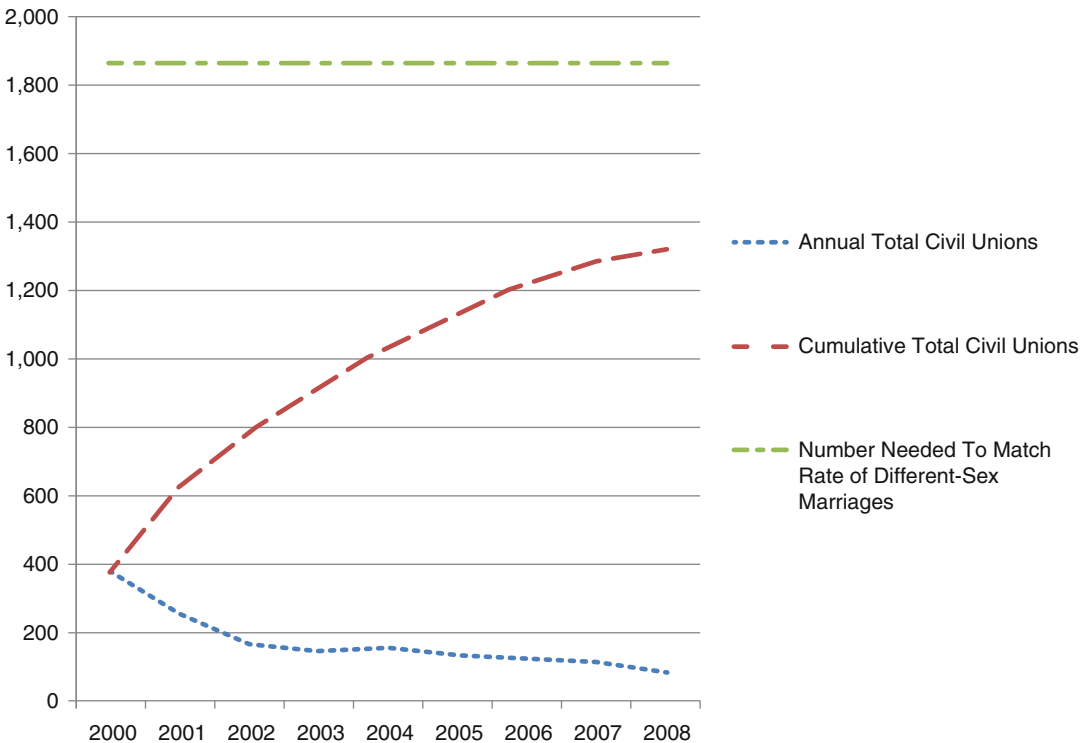


Fig. 17.13 Annual and cumulative totals of Vermont civil unions for same-sex couples*

*(This figure includes resident couples only. We account for civil union dissolutions by removing the actual number of dissolutions (provided to us by the state) each year from the cumulative total. The rate of marriages for different-sex couples was calculated from the U.S. Census Bureau, 2005–2009 American Community Survey, Tables B11001 and B11009 and was found to be 87%)

likely be predominantly female, will be younger than currently married different-sex couples, and will be older than newly-married different-sex couples.⁵⁶ When a state allows marriage for same-sex couples, couples will travel to that state to marry from nearby states and from large states in which they do not enjoy that same opportunity.

These data provide support for the conclusion that same-sex couples prefer marriage over other legal recognition statuses. When marriage is offered, same-sex couples marry at substantial rates. Nearly 50,000 same-sex couples have married in the U.S. since 2004. If present trends continue, same-sex couples in Massachusetts will reach parity in marriage rates with different-sex couples in two more years, after a mere 9 years after such couples first were allowed to marry. Clearly, marriage matters to same-sex couples as

it does for different-sex couples. The more states that open marriage to same sex couples in the future, the sooner same-sex couples in the United States will resemble their different-sex counterparts in marriage rates.

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Acknowledgements The authors thank Brad Sears, Gary Gates, Jenny Pizer, Amanda Baumle, Christy Mallory, and Angel Kastanis for thoughtful reviews and contributions to this study.

⁵⁶ See *supra* note 28.

Appendix 1: Statutory Notes and Data Notes by State

State	Current legal recognition type(s)	Eligibility and timing	Data notes explaining adjustments
California	<p>Domestic partnership</p> <ul style="list-style-type: none"> Provides same state-level rights and responsibilities as afforded to married spouses <p>Marriage (from June 16, 2008 to Nov 5, 2008 only)</p>	<p>California first passed a domestic partnership statute in 1999, effective January 1, 2000. This statute included very limited rights for same-sex couples and some different-sex couples (at least one member of a different-sex couple must be age 62 or older). As of January 2002, about two dozen additional rights were added. As of January 2005, domestic partnership was expanded to include nearly all rights and responsibilities of marriage. Same-sex couples could marry for less than 5 months in California beginning June 16, 2008, after a California Supreme Court ruling. That ruling was overturned through a ballot initiative (Proposition 8), halting the issuance of marriage licenses for same-sex couples as of November 5, 2008. Marriages that took place from June 16, 2008 through November 5, 2008 are still valid.</p>	<p>Based on prior research, we estimate that 5% of registered domestic partnerships are non-resident couples and that 5% of domestic partnerships are different-sex couples.⁴ Therefore, we estimate that 90% of all domestic partnerships registered in California are for resident same-sex couples. We estimate that 18,000 same-sex couples married in California in 2008. Data from the City and County of San Francisco suggest that 19% of same-sex couples marrying there were from other states, so we use that to estimate that 15,000 same-sex couples who married in California in 2008 were residents⁵.</p>
Colorado	<p>Designated beneficiary agreements</p> <ul style="list-style-type: none"> Provide limited rights and benefits, such as estate planning, end-of-life decisions, inheritance, protections related to health care and medical emergencies, and certain financial protections <p>Marriage</p>	<p>Colorado began offering designated beneficiary agreements on July 1, 2009. These agreements may be entered into by same-sex and different-sex couples, and by any two individuals of legal age. There is a residency requirement. The agreement must be filed in the county in which at least one party resides.</p>	<p>Data are kept at the county level and are not provided in aggregate figures by the state. Online lists of those who have entered these agreements were downloaded for the three largest counties in Colorado (Denver, Arapahoe, and El Paso). Different-sex versus same-sex couples were determined by analyzing the names of those who had entered these agreements. This analysis determined that about 10% of all agreements filed were for different-sex couples⁶.</p>
Connecticut	Marriage	<p>Connecticut offered civil unions for same-sex couples from October 2005 through September 2010. No civil unions were granted in Connecticut after October 1, 2010. All civil unions were automatically converted to marriages as of that date. Marriage for same-sex couples went into effect November 12, 2008.</p>	<p>We utilized a state-provided database of all marriages performed (same-sex and different-sex) from November 2008 through September 2010. The database provided a variety of data, including residency, age, and gender. All figures in this report on Connecticut marriages come directly from the database. Data on civil unions did not include residency of couples. We assume that 100% of civil unions were for Connecticut residents. We make this assumption due to the availability of civil unions and marriage for same-sex couples in other nearby states at the time Connecticut civil unions were offered. Based on the experiences of other states, we assume couples are no longer likely to travel to a state to enter any non-marital form of legal recognition⁷.</p>

Delaware	Civil unions	Civil unions for same-sex couples were signed into law on May 11, 2011. The law will go into effect on January 1, 2012.	Delaware civil unions will become available on a future date as of this writing, so no data have been collected.
District of Columbia	Marriage	The District of Columbia passed legislation establishing a domestic partnership registry in 1992, but the U.S. Congress prohibited enactment of the law until 2002. The rights and responsibilities associated with domestic partnership have been gradually expanded since 2002 and as of April 4, 2006 include almost all that are afforded to married spouses. Domestic partnerships are available to same-sex and different-sex couples. Marriage for same-sex couples went into effect on March 3, 2010. Domestic partnerships are still available and are unchanged by the opening of marriage to same-sex couples.	Data on domestic partnerships by gender of the couples was provided to us by the District from 2002 through 2007. These data establish that 84% of domestic partnerships are for same-sex couples. Prior research suggests that 99% of all domestic partnerships are for DC residents. ^c DC does not keep records on the gender of those who marry. A representative from the DC Superior Court estimated there were about 3,500 marriages of same-sex couples in the first year since enactment. ^f We have no further information on the residency or other characteristics of these couples.
	Domestic partnership <ul style="list-style-type: none"> Provides almost all rights and responsibilities in the District as afforded to married spouses 		
Hawaii	Civil unions Reciprocal beneficiary relationship <ul style="list-style-type: none"> Provides limited rights and benefits, such as hospital visitation, decision-making in health care, rights of inheritance, and health insurance and pension benefits for state employees 	The civil union bill was signed into law on February 23, 2011. It will go into effect on January 1, 2012, and will make civil unions available to both same-sex and different-sex couples. Reciprocal beneficiary registration has been available since 1997 and is limited to those pairs of individuals who cannot marry in Hawaii (including same-sex couples and blood relatives of same or different sexes).	Hawaii civil unions will become available on a future date, so no data exist as of this writing. Due to reciprocal beneficiary registration only being available to those who cannot marry, we assume that 100% of all such agreements are for same-sex couples. Data provided to us by the state for 1997 through 2007 show that about 80% of these agreements are for Hawaii residents.
Illinois	Civil unions	The civil union bill was signed into law on January 31, 2011 and went into effect on June 1, 2011. Civil unions are available to both same-sex and different-sex couples.	According to research conducted by the organization Equality Illinois, 1,618 civil union licenses were issued in the state in June 2011. Due to the effective date of the civil unions law being so close to the date of this writing, data from Illinois have not been included in this report.
Iowa	Marriage	Marriage was opened to same-sex couples as the result of an Iowa Supreme Court ruling on April 3, 2009. Marriage licenses began being issued to same-sex couples on April 27, 2009.	Data on marriages provided to us by the state are broken down by residency and gender. Data covered roughly the first 11 months since same-sex couples began to marry (4/27/09 through 3/31/10), and show that 2,020 couples have married. We projected out to a full year by adding the average of the first 3 months of 2010, or 79 couples. This gave us a total of 2,099 marriages in the first year. We then applied the residency rate (41%) found in the first 11 months to our projected full-year count. Notably, the Iowa data include 1,015 couples who did not state their gender, so these couples could not be classified as same-sex or different-sex and are only included in this report as explicitly noted in the text.

(continued)

(continued)

State	Current legal recognition type(s)	Eligibility and timing	Data notes explaining adjustments
Maine	Domestic partnership <ul style="list-style-type: none">Provides limited rights and benefits, such as in the areas of probate, guardianships, conservatorships, inheritance, and protection from abuse	Domestic partnership registration became available to both same-sex and different-sex couples on July 30, 2004. There is a residency requirement. Partners must be domiciled together in the state for at least 12 months prior to registering their domestic partnership.	A knowledgeable observer made a rough estimate that 50% of domestic partnership registrations in Maine are for same-sex couples. This estimate is similar to findings in Washington for couples who are 62+ in age (45% are different-sex) and our estimate for all Nevada domestic partnership registrations (45% are different sex).
Maryland	Domestic partnership <ul style="list-style-type: none">Provides limited rights and benefits, such as hospital visitation, end-of-life and healthcare decision-making, and the ability to add or remove a partner from a housing deed without penalty	Domestic partnerships became available to both same-sex and different-sex couples on July 1, 2008. Maryland does not maintain a domestic partnership registry. Domestic partnership is available to same-sex and different-sex couples.	Maryland does not maintain a domestic partnership registry, so no data were collected for this state.
Massachusetts	Marriage	Marriage for same-sex couples was restricted to couples who reside or intend to reside in Massachusetts from the date same-sex couples first were permitted to marry, May 17, 2004, through July 31, 2008. The same-sex-couple-specific residency requirement was rescinded as of August 1, 2008 ^e .	Based on prior research, we estimate that 46% of couples who married from August 2008 through the end of 2009 were residents. ^h We divided the figure obtained in that prior research for marriages of non-residents, 2,063, by the total number of marriages of same-sex couples from August 1, 2008 through September 31, 2009, or 3,803 marriages. This yielded 54% non-resident marriages. We therefore assume that 54% of all marriages that occurred in 2009 were of non-residents. This 54% figure is similar to the rate of non-resident marriages in Connecticut, Iowa, and Vermont, which is about 60%. We assume marriages prior to August 2008 were only of residents or those who became residents to marry.
New Hampshire	Marriage	New Hampshire offered civil unions for same-sex couples from January 2008 through December 2009. Marriage for same-sex couples went into effect January 1, 2010. As of January 1, 2010, civil unions are no longer granted in the state. Couples in civil unions had until January 1, 2011, to convert their civil union into a marriage, dissolve the civil union, or annul the civil union. On January 1, 2011, all remaining civil unions were converted to marriages.	New Hampshire did not provide us with data on residency for marriages. Based on the experiences of Connecticut, Iowa, and Vermont, we estimate that 40% of marriages of same-sex couples in New Hampshire were of residents. We assume that 100% of civil unions were of New Hampshire residents. We make this assumption as described for the state of Connecticut.

Nevada	<p>Domestic partnership</p> <ul style="list-style-type: none"> Provides same state-level rights and responsibilities as afforded to married spouses 	<p>Nevada's registry of domestic partnerships became available to same-sex and different-sex couples on October 1, 2009. Different-sex couples in Nevada may register their domestic partnerships without limitation based on the age of the partners.</p>	<p>Based on prior research, we estimate that 55% of Nevada's domestic partnership registrations are for same-sex couples.¹ This estimate was based on the experience of Oregon, which has a similarly broad domestic partnership status but for same-sex couples only. Twenty-two percent of same-sex couples in Oregon registered domestic partnerships in the first year they could do so. We assume the same percentage of Nevada's same-sex couples registered domestic partnerships in the first year, constituting 55% of the total domestic partnerships in Nevada. This compares with observed findings from Washington for couples where at least one member of the couple is of 62 years of age or older (also 55% same-sex couples). The state of Nevada did not provide us with data on residency. We assume that 100% are Nevada residents. We make this assumption as described for the state of Connecticut.</p>
New Jersey	<p>Civil unions</p> <p>Domestic partnership</p> <ul style="list-style-type: none"> Provides limited rights and benefits, such as hospital visitation, healthcare decision-making, income and transfer tax protections, and health insurance benefits 	<p>New Jersey enacted a domestic partnership registry for same-sex couples and different-sex couples in which both partners are aged 62 or older, in 2004. Civil unions were established for same-sex couples on February 19, 2007. As of that date, only couples where both members are age 62 or older (both same-sex and different-sex) are allowed to register as domestic partners and a residency requirement for domestic partnership went into effect. Domestic partners must share a common residence in New Jersey or at least one partner must be in the New Jersey state-administered retirement system.</p>	<p>New Jersey did not provide us with data on whether couples in domestic partnerships are same-sex or different sex after the domestic partnership policy changed on February 19, 2007. Prior to this time, 98% of all domestic partnerships were for same-sex couples, according to data provided by the state. After February 19, 2007, we estimate that 55% of domestic partnerships were for same-sex couples, which is our estimate for the state of Washington. We estimate in both time periods that 99% of domestic partnerships are for residents, which is based on the experience of Washington state. We assume that 100% of civil unions are for New Jersey residents. We make this assumption as described for the state of Connecticut.</p>
New York	<p>Marriage</p>	<p>The bill opening marriage to same-sex couples was signed into law on June 24, 2011, and the law took effect immediately.</p>	<p>Because the effective date of the marriage law was so close to the date of this report, no data were available from New York. The New York Times reported that at least 1,200 marriage licenses for same-sex couples had been issued in the first 2 days after marriage licenses were available for same-sex couples.¹</p>
Oregon	<p>Domestic partnership</p> <ul style="list-style-type: none"> Provides same state-level rights and responsibilities as afforded to married spouses 	<p>The registered domestic partnership law went into effect on February 4, 2008. The status is limited to same-sex couples only. There is a residency requirement. One partner must be an Oregon resident.</p>	<p>Because there is a residency requirement and only same-sex couples are allowed to register their domestic partnerships in Oregon, no adjustments were needed on residency or percent of same-sex versus different-sex couples.</p>

(continued)

(continued)

State	Current legal recognition type(s)	Eligibility and timing	Data notes explaining adjustments
Rhode Island	Civil unions	The bill creating civil unions for same-sex couples was signed into law on July 2, 2011 and went into effect immediately.	Because the effective date of the civil unions law was so close to the date of this writing, we have not included any data from Rhode Island in this report.
Vermont	Marriage	Vermont offered civil unions for same-sex from July 2000 through August 2009. Marriage for same-sex couples went into effect September 1, 2009. While civil unions that were entered into at that time continue to be recognized, no new civil unions have been granted after September 1, 2009. Vermont civil unions do not automatically convert to marriages. Couples in a civil union must go through the formal process of marriage in order to be considered married in Vermont.	Only same-sex couples were allowed to enter civil unions in Vermont. The state provided us with data on residency for both civil unions (18% resident) and marriage (39% resident).
Washington	Domestic partnership <ul style="list-style-type: none">Provides same state-level rights and responsibilities as afforded to married spouses	After the original domestic partnership law went into effect on June 22, 2007, two later bills expanded the rights and responsibilities of registered domestic partners. The first, effective June 12, 2008, added 170 different rights and responsibilities. The second went into effect on December 3, 2009, and expanded domestic partnerships to include all of the rights and responsibilities of spouses under state law. Domestic partnerships are for same-sex couples and different-sex couples in which at least one member is age 62 or older.	We utilized a state-provided database of all registered domestic partnerships (same-sex and different-sex) filed from July 23, 2007, through March 1, 2011. The database provided a variety of data, including residency and age. The database did not provide the gender of the domestic partners. Different-sex versus same-sex couples were determined by analyzing the names of the partners. This analysis determined that overall about 11% of domestic partnerships were for different-sex couples (9% different-sex before December 3, 2009 and 16% different-sex after December 3, 2009). When only looking at couples who have one partner age 62 or older, 45% of couples are different-sex. ^c All figures in this report for Washington domestic partnerships come directly from the state-provided database.
Wisconsin	Domestic partnership <ul style="list-style-type: none">Provides limited rights and benefits, such as hospital visitation, inheritance, probate, real estate, healthcare decision-making, and end-of-life decision-making	Domestic partnerships went into effect on August 1, 2009 and are limited to same-sex couples only. There is a residency requirement. Partners must have resided in the Wisconsin county where they will file their partnership for 30 days prior to filing.	Because there is a residency requirement and only same-sex couples are allowed to enter domestic partnerships in Wisconsin, no estimates were needed on residency or percent of same-sex versus different-sex couples.

^aSee *supra* note 28

^bSee *supra* note 12

^cNote on name-matching procedures for the states of Colorado and Washington:

The states of Colorado and Washington did not specify the sex of those couples entering designated beneficiary agreements or domestic partnerships. Both states allow same-sex and different-sex couples to enter these legally-recognized relationships. In order to determine whether a couple is different-sex or same-sex, as well as if the same-sex couples are male or female couples, we analyzed the names of the individuals listed and determined whether individuals were most likely to be male or female based on their names. Due to the small number of couples entering designated beneficiary agreements in Colorado, we completed that analysis by manually reviewing each name for each individual listed and coding whether the individual is male or female. When a sex could not be determined by analyzing the name, such as in the case of a gender-neutral name, we used internet research to make a more precise determination: (1) we consulted online searchable databases of names by gender, such as “Behind the Name” or “Babyz Names”; (2) we entered the name into Google Images and analyzed the images related to the name; and (3) we searched for the actual person through Google to see if we could determine that person’s gender through search results. If internet research did not provide a clear determination of sex, the person was coded as having an unknown sex. In the case of Washington, the database of names from the state was large enough to prohibit manual coding of each individual. We utilized lists of male and female names and their percent frequency from the 1990 Census, available at http://www.census.gov/genalogy/names/names_files.html. We combined the male and female lists to generate a probability that a particular name is female. When we could not determine an individual’s sex based on the probability female, such as in cases where the name did not appear on the Census rolls or the probability female was around 50% for both the first and middle name, we first made a determination that those couples where both were under age 62 must be same-sex couples because of Washington state law. Therefore, when both partners were less than 62 years of age, if one partner’s sex was determined and the other’s was not, the known sex of one partner was applied to the partner whose sex could not be established with Census data. For those couples where one partner was 62 years of age or older and had an undetermined gender, we analyzed the individual names and conducted internet research, such as described for the state of Colorado.

^dWe did not consider Vermont civil unions, California domestic partnerships, or Hawaii’s reciprocal beneficiary agreements when making this assumption. Since they were the first jurisdictions to offer their respective legal statuses, they are considered outliers due to the initial pent-up demand for these statuses

^eSee *supra* note 28

^fMorello and Thomas-Lester (2011)

^gAn exception to the residency rule was made in 2006 for same-sex couples from Rhode Island. Another exception to the residency rule was made in 2007 for same-sex couples from New Mexico. For a more detailed narrative on the court proceedings that led to these exceptions, see Grossman (2006)

^hBadgett (2010). See footnote #93

ⁱHerman et al. (2011). A detailed description of the Nevada estimate can be found on page 5

^jSee *supra* note 31

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Introduction

The changing demographics of American society directly impact the composition of today's All-Volunteer Force. As the American population becomes increasingly diverse, the military, in turn, reflects these changes through its own recruitment and retention goals, leading to a military population more diverse than forces grown and managed under selective conscription (Segal and Segal 2004). Yet, the demographics of military personnel are not a direct reflection of American society, particularly for those groups, such as women and gay men and lesbians, whose presence and participation in the military is regulated by explicit legal restrictions (Bourg and Segal 2001). Formal policy change, however, is on the horizon for both military women and gay men and lesbians, although these formal changes may not have an immediate impact on military demographics, which also are influenced by a military culture that privileges heteronormative masculinity.

As a group, women have increased their proportional presence in the American military, yet they remain a significant minority and are excluded from offensive ground combat positions

due to institutionalized beliefs grounded in gender appropriateness, sexuality, and combat. The same increase has taken place in other Western nations, some of which have moved ahead of America in terms of opening combat specialties to women. Likewise, as a group, openly gay men and lesbians currently are prohibited from serving in the American military due to institutionalized beliefs that the potential for homosexual conduct, particularly towards heterosexual men, threatens good order and discipline. Some other Western nations have ended sexual orientation discrimination in their armed forces. Although not the same, the arguments used against the full integration of women and open homosexuals (including lesbians) stem from similar concerns regarding sexuality, and accompanying issues such as cohesion, harassment, privacy, public health, unprofessional relations, and the preservation of the military as a distinctly male domain (Iskra 2007; Segal and Kestnbaum 2002). These arguments, which shape formal policy and informal norms, influence the gender and sexuality demographics of the American military.

Further, the underrepresentation and occupational prohibitions against women in the military, and the forced suppression of open homosexuality, partly reflect a masculine military culture which privileges the gender and sexuality of heterosexual men. By effectively restricting or prohibiting the service of certain groups of people, the combination of formal regulations and informal expectations not only shapes the

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demographics of the force, but also further entrenches constructions of sexuality and gender among service members (Arkin and Dobrofsky 1990). As it builds and retains its own population, the military is an institution that, in a dialectical manner, both defines and depends upon socially created and internalized definitions of gender and heteronormative sexuality (Lorber 1994).

Organizational Structure, Culture, and the American Military Population

The demographics of the American military certainly are shaped by pragmatic security concerns. During peacetime, military leaders have more time and resources to focus on personnel issues and policies, and they also may have less recruiting and retention pressures, allowing them to be more selective in shaping the force. However, in times of war, particularly when there are shortages of young, qualified men and manpower needs are high, the military is more likely to increase women's military roles, to accept openly gay men and lesbians, and to overlook homosexual behavior (Herek 1996; Segal 1995). Thus, the service of both women and openly gay men and lesbians is accepted during times of national emergency, yet their service is restricted during peacetime. The issue then is not about skills or military effectiveness—for women and gay men and lesbians are qualified enough to serve during the most grave times—but about the framing of gender and sexuality, and how these conceptions shape the military population.

At the structural level, the American military is a hierarchical, gendered organization modeled around the male body and certain conceptions of masculinity and heterosexuality. This critical perspective suggests that the structures, processes, and distributions of power that guide military life, including those that shape what bodies are acceptable for military service, are categorized along gender and sexuality lines and are determined by the images, needs, and strengths of the male body (Acker 1992). The military does not present itself as gender-neutral, but rather explicitly presents itself as a male domain, defined by the absence, or the reduced presence, of women, and in opposition

to femininity. Gender and sexuality are ways of ordering who has access to membership and power in the American military (Acker 1992).

In addition, the small numbers of women and the forced invisibility of gay men and lesbians, shape group dynamics and the larger group culture in predictable, visible ways (Kanter 1977). Women currently are approximately 15% of the American military force, making them a token population, while the proportion of gay men and lesbians can only be estimated. Within skewed groups, which are groups where the ratio of the dominants to the tokens is approximately 85–15, there are certain perceptual phenomena and typical responses that shape the culture (Kanter 1977). Thus, perceptions about “women’s behavior” or “men’s work” may be because of their positions within the social structure and the overall effect of proportions on group culture. The impact may be further exacerbated in situations, such as the military, where women occupy high prestige occupations typically associated with men and masculinity (Yoder 1994).

The organizational structure of the military, both in its hierarchical form and in the demographic composition of its workforce, directly shapes American military culture, which constructs and then reproduces constructions of gender and sexuality (Bourg and Segal 2001). Masculinity and femininity are not static, uniform constructions, but are stratified on a spectrum, with dominant and subordinated forms (Connell and Messerschmidt 2005). Individuals situated within certain social institutions, such as the military, must encompass institutional and culturally specific constructions of gender and sexuality to gain acceptance into the institution.

Within the military, hegemonic, heteronormative masculinity is the dominant form, leading to a culture that privileges certain forms of heterosexuality and that denigrates subordinate gender constructions, including all that is feminine. This stratification of gender and sexuality marginalizes the military service of groups whose bodies and performances do not fit the script. It also targets the sexual availability of women, including lesbians, and gay men, whose presence creates the potential for increased disorder within the

ranks because of the perceived threat of sexual tension and decreased social cohesion (Iskra 2007). Thus, all military women, who risk being sexualized as ready partners and gendered as either too masculine or too feminine, as well as effeminate and gay men whose sexualities and gender are constructed as threatening, subordinate forms, are undesirable as military bodies (Iskra 2007; Kanter 1977). In particular, lesbians, who exist at the intersection of gender and sexual deviance, become simultaneously invisible and hypervisible, as women in male-dominated occupations. As such, they stand out as gender deviants and potential sexual deviants (Bonner 2010). This shapes the demographics of the force, as certain groups turn to military service as a masculine ideal, while others, who must negotiate a culture at odds with their ascribed group characteristics, may choose to limit their service, or not to serve at all.

The military's social role extends beyond its primary responsibility of providing national defense. In line with its broader security roles and as a major American institution, the military contributes to national, cultural definitions of what it means to be a man by furthering a "cult of masculinity," defined by the warrior hero (Dunivin 1994; Lorber 1990). This "cult of masculinity," which includes constructions of both acceptable gender and sexuality, is embedded within a "combat, masculine-warrior paradigm." Even though this paradigm contradicts the increasingly diverse model of military culture, particularly with the increased presence of women, the military embraces the masculine paradigm. As a consequence, social changes, many of which come from external forces, may be partly accepted, but the military will go to great lengths to protect its underlying paradigm (Dunivin 1994). The military plays a large role in the construction of masculine forms within society generally; at the same time, it is influenced by changing social forces, such as the increased presence of women in the paid labor force, which shape expectations of who serves and in what capacity. However, the cycle of influence may be limited due to the staying power of the underlying paradigm which,

ultimately, keeps heterosexual men as the dominant demographic group.

Policy, Public Opinion, and the Gender Demographics of the American Military

Although military culture has a significant role in shaping the military population, it is not the only social force responsible for the demographics of the American military. As the quintessential bureaucratic organization, the American military is characterized by a hierarchical chain of command regulated by federal law, a focus on occupational specialization, and a management culture that privileges formal policy (Segal 1989). It is also inherently conservative and adverse to change, particularly change mandated from external rather than internal sources (Zellman 1996). In an organization with approximately 2.2 million active duty and reserve personnel, the military must select, train, and maintain the force through formal policies that cover large numbers of people (OSD 2009). However, even though the end goal of such policies is to manage service members evenly and efficiently, policies directing who is able to serve and in what capacity are largely shaped by social attitudes, particularly those surrounding gender and sexuality (Herek 1996).

In the case of women and openly gay men and lesbians serving in the military, the formal policies regulating their participation have largely been shaped by broader social currents that dictate which genders and sexualities support military effectiveness. As such, a historical perspective on the military service of women, including lesbians, and gay men demonstrates how their military participation is shaped by these currents as well as the broader political climate, organizational need, and commander discretion. In particular, the history of who serves, the timing of their service, and where in the organization they do so demonstrates how gender and sexuality intertwine to produce formal policies that, by way of a gender and sexuality hierarchy, shape the demographics of the force over time. It also shows how male dominance, both numerically

Women in the Military, 1967 - 2007

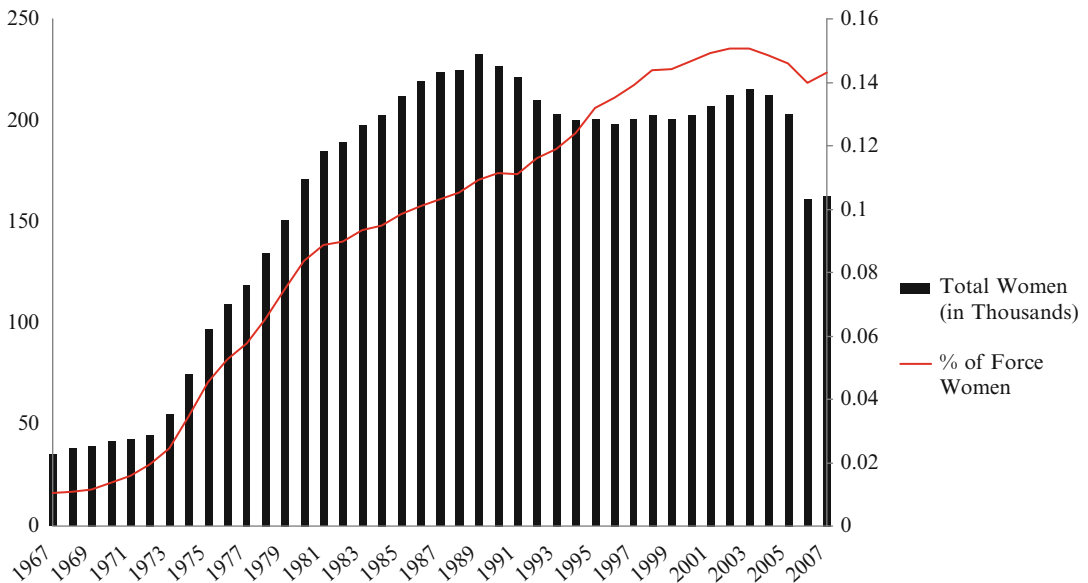


Fig. 18.1 Proportion of women service members by year, beginning with 1967 (Sources: DOD 2006; OSD 2009)

and culturally, creates ongoing challenges for the integration of groups whose identities, bodies, and behaviors do not fit the dominant paradigm.

Women, including lesbians, have participated in every major American conflict, yet their service remains limited by legal exclusion from certain occupations. Women did not achieve permanent military status until the 1948 passing of the Women's Armed Services Integration Act, which, in addition to formalizing their military standing, established quotas for their participation and limited their occupational opportunities. From 1948 until 1967 as part of the Women's Armed Services Integration Act, women could only constitute up to 2% of the active duty peacetime force and, among other provisions, they were forbidden from commanding men, were denied spousal benefits for their husbands, and were forced to separate if they became pregnant (Manning 2008). These rules stemmed from broader social views that military service remained the province of men and that women's roles were limited to the domestic sphere. It also limited their sexuality to a heteronormative, reproductive

role. Even though this limitation did not apply to the composition of wartime forces, approximately 120,000 women, or still about 2%, served in the total force of 5,720,000 personnel who participated in the Korean War (Leland and Oboroceanu 2010; Manning 2008).

With the 1973 transition from selective conscription to an all-volunteer force, women became an important labor pool, even though federal law still prohibited them from serving in the most combat-oriented occupations. This transition occurred in the context of the broader societal change of women's increased participation in the paid labor force (Bianchi and Spain 1996). Beginning with the 1967 removal of the 2% cap followed by the implementation of the labor-market oriented all-volunteer force in 1973, women's military presence has grown, although they remain a significant minority.

As seen in Fig. 18.1, women's participation has increased from about 1.6% in 1973 to about 14.3% of the active duty force for Fiscal Year 2008 (Manning 2008). Although the percentage has peaked above 15%, it steadily has remained

Fig. 18.2 Proportion of positions and occupations open to women by service branch (Source: Manning 2008: 15)

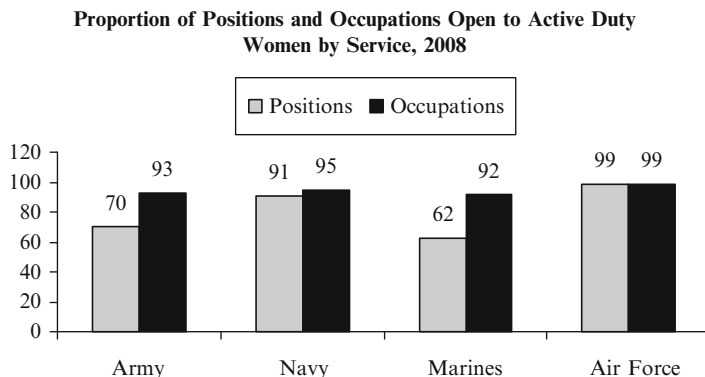
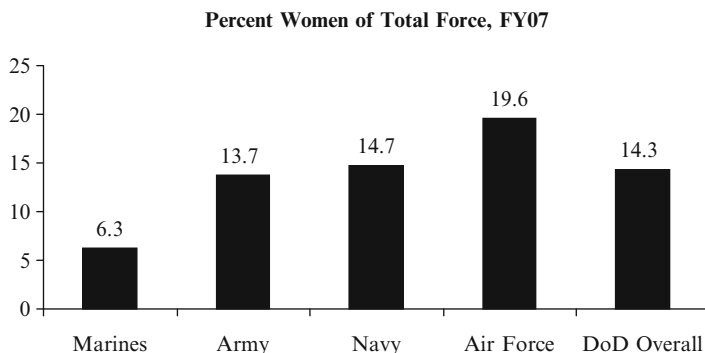


Fig. 18.3 Gender demographics by service branch (Source: Manning 2008: 14)



around 10–15% of the total force. Women, then, remain a token population in the American military, despite changing policies which have increased their military opportunities.

Significant policy changes concerning women’s military participation, which tend to occur during and after major wars, continue to shape the gender demographics of the force. In 1988, the Department of Defense announced its Risk Rule, which set a single standard for the services to use in determining which positions to open to women; this change led to the opening of 30,000 additional positions. Further, the deployment of 40,000 women during the first Persian Gulf War influenced the decision to open for the first time combatant ships and combat aircraft to women in 1993 (Manning 2008). The Risk Rule since has been rescinded, and women are now restricted only from serving in enlisted submarine positions and in offensive ground combat positions at the brigade level, which is a large organization of anywhere from 3,000 to 5,000 soldiers, or lower.

These restrictions continue despite the nonlinear nature of today’s battlefield and the necessity of women’s participation in community patrols due to cultural restrictions on male–female interactions in Iraq and Afghanistan (Alvarez 2009).

Although there is a wide variation in occupational opportunity by service branch, currently over 92% of military occupational specialties have been opened to women, with more changes looming (Manning 2008). As seen in Fig. 18.2, the Air Force has the greatest number of open occupations for women at 99% while the Marine Corps, which relies upon the Navy for a large proportion of its support services and is the most ground combat-oriented, has the lowest at 62%.

The different proportion of occupations open to women among the service branches also influences the gender composition of each service branch.

As shown in Fig. 18.3, the Air Force, which has the greatest number of positions open to women, has the greatest proportion of women in

the ranks, at approximately 19.6%. In contrast, the Marine Corps, which as the most combat-oriented of the services has the lowest amount of positions open to women, also has the lowest percentage of women in the ranks, at approximately 6.3% (Manning 2008). This difference in women's representation across the service branches may be due to both occupational opportunities and service culture, with the Air Force having a more technical focus, while the Marine Corps is more expeditionary, and grounded in the belief that "Every Marine a Rifleman."

Although women serve at lower levels than their male peers, there is evidence that they have a high desire to serve, even if they do not expect to actually do so (Segal et al. 1999). Thus, there is a disconnect between women's inclination to serve, at least as high school seniors, and their actual enlistment behaviors. The reason for this difference is unknown; however, as discussed earlier, it may be related to the limited occupational opportunities of women, to the male-dominated culture of the American military, or to the concerns of balancing the unique combination of demands experienced in the military lifestyle with other social roles, such as being a spouse and mother (Segal et al. 1999; Segal 1986).

In addition to accession trends, women's representation in the military also is shaped by their retention behaviors. Across all of the services, women officers are less likely than men to stay in the military past their initial service commitment. The specific reasons why women leave the military are unknown, although it may be related to increased social pressures, particularly from conflicting social roles. For example, some women may find that the military lifestyle, which includes demands such as frequent relocation and deployments, is difficult to manage with family roles (Segal 1986; Smith 2010). Men certainly have similar family considerations, yet they are less restricted by the physical demands of child-bearing and may experience less social pressure to give considerable time and energy to their family (Segal 1986). Thus, although exact causes of women's proportional presence in the military is unknown, there is the potential that both formal policies, such as occupational limitations, and

informal norms, such as service culture and conflicting social roles, reduce women's participation, thereby shaping the gender demographics of the force.

Emerging Trends in the U.S. Military

Traditionally, military service has been seen as a masculine rite of passage, capable of transforming boys into men through the rigors of training and the ultimate test of bravery through combat (Bourg and Segal 2001). Even with policy changes opening opportunities for military women, formal military policy still prohibits them from serving in the ground combat positions which most embody military power and provide the ultimate image of the warrior (Dunivin 1994). Ostensibly, the policy is about preserving social cohesion and military effectiveness, yet it is also about preserving an arena where male service members may demonstrate indisputable masculinity through service in the combat arms. However, current experiences in the Iraq and Afghanistan wars, as well as twenty-first century organizational and technological changes in the military, demonstrate that formal assignment policy does not always match battlefield realities or previously articulated concerns regarding the possible deleterious effects of gender integration. Whereas past conventional wars were fought on a linear battlefield, today's counter-insurgency and civil affairs missions do not have a clear line demarcating rear and forward positions, thus making it difficult to determine which positions actually are on the frontline. Further, today's wartime realities often require community patrols and outreach, making the availability of military women to interact with and search local women an essential component for mission accomplishment.

These wartime realities, paired with women's demonstrated skill, reopen the debate of whether women should be allowed to serve in offensive ground combat positions. Overall, 72% of Americans favor allowing women to serve anywhere in Iraq and 67% of those polled support allowing women to serve in combat areas in

support positions, with men favoring the change at a slightly higher rate than women (Carlson 2005). Yet public opinion remains against women's service in the combat arms specifically, or as "serving as ground troops who are doing most of the fighting," with only 44% expressing support for this change and 54% opposing it (Carlson 2005). Thus, public support for removing the formal combat exclusion laws is not likely to change soon. However, the American public also trusts military commanders to make the best use of personnel resources based on battlefield demands, and if necessary, will condone their increased use of women in combat zones if the mission demands it.

Currently there is no suggestion that Congress will rescind combat exclusion laws; however, there is change occurring in submarine assignment, another all-male occupation. Although at the initial stages of the transition, Secretary of Defense Robert Gates recently notified Congress that the Navy will repeal its ban on women serving aboard submarines (Associated Press 2010). Although women have served on surface warfare ships for several decades, they have been prohibited from serving on submarines because of concerns about privacy, heterosexual relations, and possible medical issues, such as pregnancy and exposure to nuclear power, that are exacerbated by the cramped, shared quarters of submarine living (Iskra 2007). The current change has been met with some resistance from the submarine community, most notably from the wives of submariners who fear that the presence of women will create an environment of sexual temptation for their husbands, yet the policy change has the formal backing of Department of Defense and Navy leaders who see this as a pragmatic change (Iskra 2007). The first round of women, all newly commissioned officers, began the 15-month training in summer 2010, followed by an assignment to the large Ohio-class submarines; they are now part of the military's force of 13,000 active duty submariners (Whitlock 2010; Witte 2010). Thus, whereas the intellect and talents of women service members have not changed, perceptions of their appropriate role in the military, which are largely shaped by social constructions of gender and sexuality have, leading to changes in formal policy regarding their occupational placement.

Military Participation of Women Internationally

As with the United States, there has been an international trend towards greater military participation of women. Sandhoff et al. (2010) argue that there are both enabling and driving factors that affect the participation of women in armed forces. Enabling factors steadily facilitate the participation of women in the military over time and act fairly consistently across cases. They include trends in fertility, women's civilian labor force participation, and military mission changes. Driving factors are case-specific and dramatically affect women's participation in the short-run and include armed conflict, legislative changes, judicial rulings, and military personnel shortages such as often result in the early years of a transition from a system of conscription to an all-volunteer military force.

Depending on social, cultural, political, and military factors, women's opportunities to participate in the military of a country may be broad or narrow. Table 18.1 provides an overview of the situation of women in the military around the globe including whether there are formal restrictions on the positions women can hold in the military.¹ The most common restrictions are prohibitions on women serving in offensive ground combat and on submarines. Although service in combat positions has opened to women in some militaries, currently only Australia, Canada and South Africa permit women to serve on submarines. Some countries, including India and Turkey, allow women to serve only as officers or, like the Jordanian Armed Forces, maintain separate women's corps within the military (Central Intelligence Agency 2010). It is also important to note that there is often a difference between the

¹ The data in the table were drawn primarily from the NATO Committee on Women in NATO Forces and supplemented with additional sources where they could be located. Due to the lack of a comprehensive review of the role of women in the militaries outside North America and Western Europe, these data are by necessity incomplete. The development of a comprehensive analysis of the role of women in the militaries of Africa, Asia, Latin America and the Middle East is an area for further investigation.

Table 18.1 Overview of participation of women in the militaries of selected NATO countries

Country	Year women admitted into military	Current restrictions on women's participation	% women constitute of military ^a
Belgium	1975	No ^b	8.0
Denmark	1962	No ^b	5.2
France	1951	Yes ^{c, d}	14.0
Germany	2000 ^e	No	8.9
Greece	1979 ^f	Yes ^d	13.5
Italy	1999	No	3.4
Hungary	1945	No ^b	20.0
Luxembourg	1987	No ^b	5.8
Netherlands	1944	Yes ^{c, d}	9.0
Norway	1938	No	8.6
Poland	1988	No	1.5
Portugal	1992	No	14.1
Spain	1988	No	12.3
Turkey	1955	Yes ^g	1.6
United Kingdom	1941	Yes ^{c, d}	9.5
United States	1948	Yes ^{c, d}	15.5

Data from CIA (2010), Kronsell (2005), NATO, and Norwegian Armed Forces (2009)

^aAll data from 2006–2009

^bCountry does not have submarines

^cRestrictions keep women out of many or all combat positions

^dRestrictions on women in submarines

^eWomen were allowed to serve in the medical (and music) corps starting in 1975, all other positions opened to women in 2000

^fWomen were allowed to serve as Nurses in the Greek military starting in 1946, in 1979 other positions opened to women

^gWomen serve in women's corps or can only serve as officers

positions legally open to women and the positions women hold.

The twentieth century saw the formalization of women's military roles in many countries and increases in the percent women constitute of the armed forces have been a transnational trend. Building on and updating the data on participation of women reported by Sandhoff et al. (2010), Fig. 18.4 presents data from the International Institute of Strategic Studies (IISS) with data from NATO and country-specific annual reports to outline the trend in increased participation of women in the militaries of ten countries.

With these broad overviews of the participation of women in the military internationally in mind, in the next section we use example cases to illustrate the four ways women's military participation is increased: enabling factors, the driving factors of war and revolution, legislative and judicial decree, and personnel shortages.

Enabling Factors

Enabling factors work slowly over time to steadily facilitate the participation of women in the military and work similarly across cases. Three such factors, fertility, labor force participation, and changing military mission have followed a similar trajectory in the industrialized West in the past century with declining fertility, increasing paid labor force participation of women, and a move away from traditional war-fighting. After World War II, many countries experienced a "baby boom" that peaked in the 1950s and 1960s. By the 1970s however, fertility rates began to decline due in part to the introduction of effective, easily used contraception. Since the 1980s, this decline has slowed and we have entered a period marked by relatively stable, if low, fertility rates and rising age of women when they first marry (Caldwell 2006).

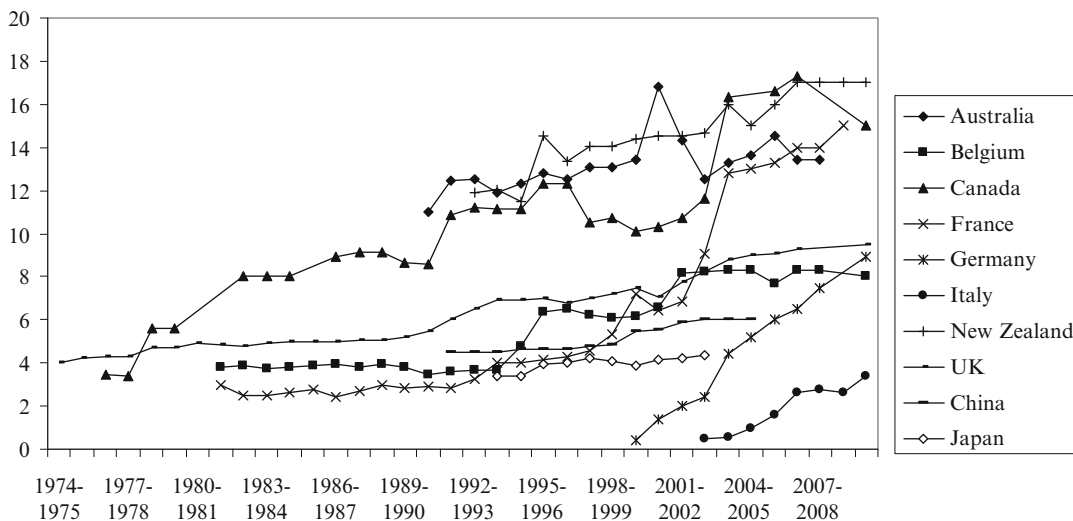


Fig. 18.4 Military participation of women transnationally (Data from IISS; NATO; NZDF Annual Reports)

As fertility has declined, women’s labor force participation has increased. In part both trends reflect the same contraceptive advances that allowed women to postpone and plan pregnancies, permitting them to complete the education needed to find good employment and allowing them to participate consistently in the labor force. In addition, the introduction of antidiscrimination and equal opportunity legislation promoted women’s labor force participation. The European Union in 2000 set a goal of 60% employment for women by 2010 (European Commission 2007).

Changing military mission is also an enabling factor that affects women’s military participation. As military forces move away from traditional war-fighting to new missions such as peacekeeping and humanitarian aid, barriers to women’s participation in the military decrease (Segal 1995). Moskos et al. (2000) argue that since the end of the Cold War the changed strategic situation and increased globalization have led to the ascendance of the “postmodern military”. Included in the postmodern military is a change in core mission from war fighting to peacekeeping and humanitarian missions, as well as an increased participation in international missions sanctioned by supra- or extra-national organizations.

Enabling factors can be seen in Fig. 18.4 in the slow and steady increases in the participation of women during periods without any of the following driving factors that prompt swift and dramatic change.

War and Revolution

Segal (1995) identifies a common pattern of women’s participation in armed revolutionary movements, citing the examples of Algeria, China, Nicaragua, Rhodesia (Zimbabwe), Russia, and Vietnam. Although women often took on nontraditional roles of combatant in these conflicts, once the new government was established and an official military organized, women were returned to traditional roles at home and relegated to auxiliary and support positions in the military. Although women’s participation in revolutionary movements does not grant them equality once the conflict is ended, these conflicts still serve as turning points for the participation of women in the military. Having proven themselves in the field of battle, women revolutionaries may be able to make for themselves a place in the institutions of the nation, including the military that, if not equal

to their male counterparts, are greater than their participation prior to the revolution. In the militaries resulting from these revolutionary conflicts, women often have a position, though mainly in auxiliary and support roles, from the inception of the institution; this differs from the experience of national militaries with longer histories that were often founded on the complete exclusion of women. Examples of this type of military participation by women are found in China and Israel.

Women were involved as combatants during periods of strife and revolution throughout China's history including during the Communist Revolution beginning in 1927. In the early years of the movement, women were actively involved as combatants, but as the Red Army became formalized as a national military women were relegated to support positions. Women remained in auxiliary and support roles as the revolutionary armed forces became the People's Liberation Army (PLA). In the early 1990s women constituted about 8% of the PLA and were excluded from combat positions and submarines (Segal et al. 1992).

In Israel, women served in the pre-state armed forces, including in combat, during the 1948 war. Although some women were removed from combat after a mixed patrol was killed, others remained in combat throughout the war (Bloom et al. 1991). Since the creation of the Israel Defense Forces in 1949 women have been subject to military conscription in Israel, but they have faced many restrictions. Due to differences from men in required service, women have had difficulty obtaining positions requiring extensive training because it is seen as a poor investment. Women have also historically been limited to non-combat positions. Women remain barred from combat positions in infantry, armor, and reconnaissance units with the exception of the Karkal infantry battalion which allows men and women to serve together in combat (Sasson-Levy and Amram-Katz 2007).

Legislative and Judicial Decree

Another driving factor that can quickly and dramatically change the military opportunities available to women is rulings and decrees coming from

national or international legislatures or judiciaries. Internationally, particularly in the European Union, there has been a trend towards the increased application of civilian anti-gender discrimination laws and policies to the military. As the military becomes more like an occupation with the decline of conscription, the application of civilian regulations becomes more pervasive. Germany is a case that demonstrates the importance of anti-discrimination regulations, while the United Kingdom provides an example of a country exercising its national rights to exempt the military from these rules.

Germany maintains conscription of young men, but excluded women until recently. Although women could serve in the medical and music corps of the Bundeswehr starting in the 1970s, they have been constitutionally excluded from all other military service since the end of World War II. In 2000 the European Court of Justice's ruling in *Tanja Kreil v. Bundesrepublik Deutschland* led the German government to change its constitution to open all positions to women, including combat positions. Women first entered the Bundeswehr in 2001.

Unlike Germany, the U.K. exercises their national right under European Court of Justice ruling to keep the British military exempt from civilian anti-discrimination legislation, and mandates all-male posts on basis of combat effectiveness (NATO 2001). Women remain excluded from certain positions, including those in regiments whose primary duty is "to close with and kill the enemy" (although they can serve in administrative and support positions in these units). Women are also not allowed to serve on submarines.

Personnel Shortages

The final driving factor that prompts the opening of positions to women is personnel shortages. As the use of conscription has declined, especially in Europe, national militaries must figure out how to recruit the number of quality personnel needed to maintain their force. As happened in the U.S., many countries turn to women to meet these recruiting goals, and open increased positions to women. A case that exemplifies this is Italy.

In Italy women were excluded from military service until recently. Women could not serve in the Italian armed forces until a law passed in 1999 opened all positions in the armed forces to women starting in 2000. The opening of the military to women coincided with the decision in 2000 to end conscription (which was done in 2005) (Caforio 2007).

International Trends

Enabling factors, such as changes towards later and fewer family responsibilities for women, and increased participation of women in the civilian labor force have led to slow and steady increases in women's military participation. Women's military participation is also affected by the roles of women in war and revolution, legislative and judicial decrees, as well as by the need for personnel that accompanies the end of conscription. These driving forces have led to country-specific differences in women's military participation as well as to differing levels of openness of the military to women's participation. In those countries where women served in revolutionary armed forces during the twentieth century, most maintain bans on the participation of women in combat positions under the aegis of the new national military. Among those countries without recent revolutionary histories however, there seems to be a more accelerated increase in women's representation in nations making the transition more recently. Those opening positions to women only recently have swiftly opened all positions (including combat), while in those countries that permitted women to serve earliest, such as the United States, the United Kingdom and Australia, integration has been completed in phases rather than all at once. Notably, in those countries with the longest history of women's participation, all but Canada retain prohibitions on women's service in offensive ground combat. Whereas in those countries, such as Germany and Italy, that until recently barred women from all military service, women were granted access to the military and either immediately or shortly thereafter were permitted to serve in all positions, including ground combat.

Military Participation of Gay Men and Lesbians

Before any limitations were ever placed upon the service of gay men and lesbians in armed forces in any nations' military, it is likely that gay men and lesbians were serving in multiple capacities and within many different armed forces (Devilbiss 1994). Unlike the historical cyclical patterns noted in the service of women across nations, gay men have historically served in armed forces across the globe during peacetime as well as during conflict. Also, as the politics of sexual respectability amongst the middle-class rose, the visibility of gay men and lesbians in social and/or professional spaces declined (Foucault 1978; Mosse 1985; Puri 2004).

Historically, the American military, as well as the military forces of other nations, have benefited from the service of gay men and lesbians. In the American case, one of the most noteworthy contributions came from the efforts of Edward Von Steuben, an openly gay Prussian officer who developed what eventually came to be known as the American Army's doctrine on Drill and Ceremony (Shilts 1993). However, as the politics of sexual respectability advanced throughout Western societies, the open presence of gay men and lesbians in societies decreased. With time, nearly every nation banned gay individuals from military service, thus banning gays and lesbians from most, if not all, of the promises and protections associated with full first class citizenship (Phelan 2001; Puri 2004: 53).

The contentious nature of the topic of gays in the military was dramatized in the early 1990s by the campaign promises of then presidential candidate, William Clinton, to lift the ban on gays in the military. As a result of Clinton's campaign promise, military leaders, politicians, and academics pondered the wide range of consequential effects and differences such a change might have in regard to the structure of social, political and American national culture. The Congressional hearings generated by President Clinton's desire to lift the ban on gay men and lesbians serving openly in the U.S. armed forces led to the policy

of Don't Ask, Don't Tell (DADT), which did not prohibit gay men and lesbians from serving, as long as their sexual orientation was kept secret. The phrase Don't Ask, Don't Tell was coined by sociologist Charles C. Moskos (Northwestern University). Both Moskos and David R. Segal (University of Maryland) had been consulted by the Army as it dealt with President Clinton's campaign promise, and both testified to the Senate Committee on Armed Services, as did sociologist David F. Burrelli (Congressional Research Service) (Committee on Armed Services 1994). Segal was also called to testify to the Committee on Armed Services of the House of Representatives (1993).

Under DADT, gay men and lesbians served in the military in non-trivial numbers. Using data from the 2000 U.S. Census, Gates (2004) derived estimates of gay men and lesbians serving in all components of the American military. For the active duty military, Gates (2004) estimated that there were more than 36,000 gay men and lesbians serving, representing about 2.5% of the force. When the ready reserves were included, he estimated that 65,000 personnel in uniform were likely to be gay men or lesbians, representing 2.8% of the force. Thus, there were proportionally more gays in the reserves than in the active force. More recently, Gates (2010) updated his estimates drawing on the American Community Survey (ACS) and the General Social Survey (GSS). These more recent data suggest that 13,000 gay men and lesbians were serving in the active forces, or 0.9%, which reflect a reduction from his earlier estimate, while nearly 58,000, or 3.4%, were serving in the reserve components. Across all components, he estimated that 2.2% of personnel were gay or lesbian, a small decrease from his earlier estimate, which can be explained in part by his use of a lower estimate of the prevalence of male homosexuality in the general population in his more recent analysis. The 2010 analysis reaffirms that a larger percentage of reserve than active duty personnel were sexual minorities (or identify as such).

Demographic analyses consistently suggest that a larger percentage of women in the military are lesbians than men are gay. These differences

also are magnified in Gates' analysis (2010). While women comprise only 14% of active duty military personnel, they comprise an estimated 43% of gay personnel on active duty. Men, who comprise 86% of the force, account for only 57% of gay personnel on active duty.

There are racial as well as gender correlates to the prevalence of gay men in the military. Segal and Segal (2004) tell us that while African Americans are over-represented in the enlisted ranks, a larger proportion of enlisted women than enlisted men are members of minority groups: particularly African Americans. However, researchers have noted that white women are three times more likely to be discharged for homosexuality than African American women and white men are two times more likely to be discharged for homosexuality than African American men (Belkin and Bateman 2003). Gates' research suggests, however, that since 1997 the proportion of discharges that include racial and ethnic minorities has increased from a quarter to a third of discharges, even as the proportional presence of racial and ethnic minorities has not changed significantly (2010).

The debate about gay men and lesbians in the military most often focuses on the experiences of heterosexual and homosexual men and the policies have been constructed from the perspectives of military men. The Congressional debates in 1993 focused on the impact of male homosexuality on the cohesion and effectiveness of ground combat units, from which women are excluded. Heterosexual men in the American armed forces originally cited homophobic fears about their personal privacy being violated in the presence of men known to be gay, thus making simple activities such as showering, sharing a living space, or sharing a fox hole very complicated. Therefore, the debates on gay individuals in the military were about gay men. However, the "gays" most likely to be discharged as homosexuals are lesbians and heterosexual women accused of lesbianism (Beneke and Dodge 1996; Bonner 2010). The most ironic outcome of DADT is that heterosexual women and lesbians in the military are more likely to be discharged for homosexuality

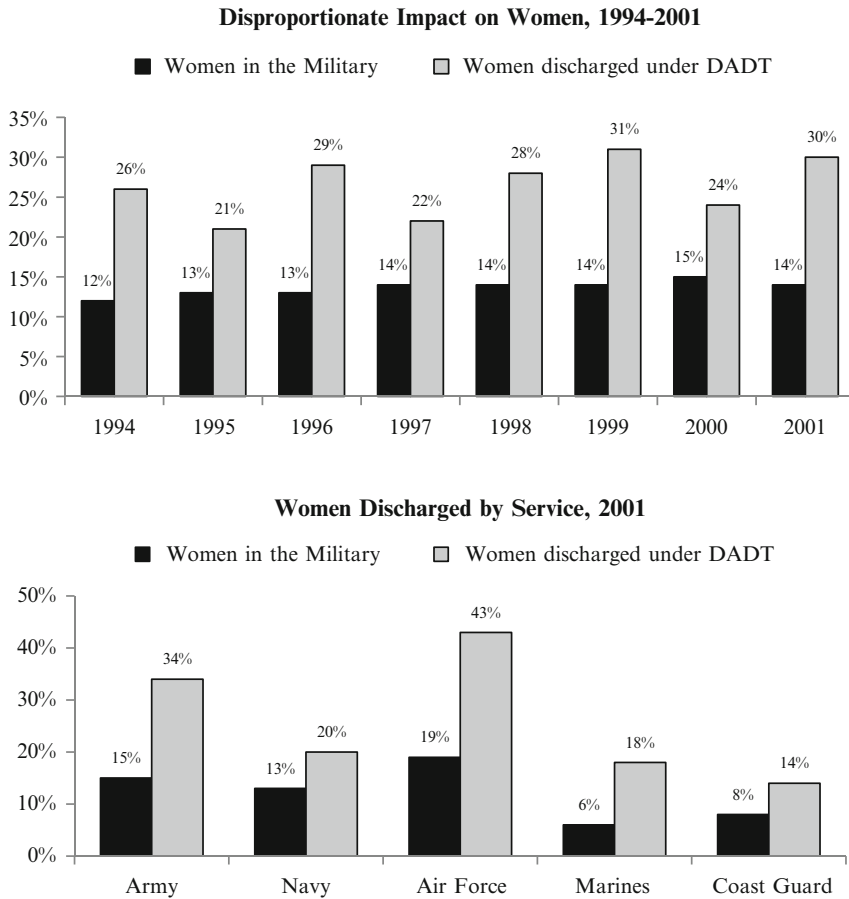


Fig. 18.5 Pattern of discharges under DADT (Source: Servicemembers Legal Defense Network Annual Update 2004)

than are military men, gay or heterosexual. In Fig. 18.5, two graphs show us how the policy of DADT affects women disproportionately relative to their actual numbers in the military. From 1994—the year after DADT was established as policy—to 2001—the year that the Global War on Terror was initiated—discharges under DADT disproportionately affected women, frequently over-representing them by 100% or more (Gates 2010).

As the second panel shows, the over-representation was lowest in the sea services—the Navy and the Coast Guard (The Marine Corps, as part of the Navy, is also a sea service, but since the first Gulf War has increasingly taken on a land warfare role.)

As was the case with gender integration, a military faced with the task of raising a wartime force is less likely to impose closure on previously excluded social groups, and more likely to expand its recruitment pool (Segal and Kestnbaum 2002). As Fig. 18.6 shows, the number of DADT discharges increased from 1994, after establishment of DADT, to 2001, and the beginning of the Global War on Terror. In 2001, we see that 1,273 service members were discharged, the most DADT-related separations since the codification of DADT in 1994. However, the following years were during the start of the wars in Iraq and Afghanistan and we see that the number of gay individuals discharged from the military dropped to 906 and in the following year, the number dropped to 787.

Total "Don't Ask, Don't Tell" Discharges, 1994-2003

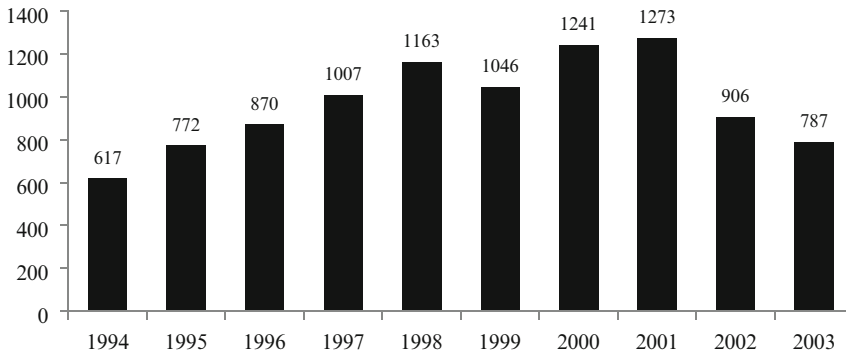


Fig. 18.6 Annual DADT discharges—military wide (Source: Servicemembers Legal Defense Network Annual Update 2004)

Military Participation of Gays and Lesbians Internationally

When the United States debated lifting the ban on gays in the armed forces in the early 1990s, much attention focused on how other nations, particularly our NATO allies, dealt with the issue. Although questions were raised about the relevance of the experience of foreign militaries for the development of U.S. policy (Belkin and Bateman 2003: 103–138), studies were undertaken by the RAND Corporation (1993), the General Accounting Office (1993), the Army Research Institute for the Behavioral and Social Sciences (Segal et al. 1993), and several academic researchers. Sociologists were involved in most of these studies. It is important to recognize that these studies were done before the European courts began to apply civilian equal employment opportunity laws to European military forces.

In general, it was found that across nations, sexual orientation integration in military forces was correlated with gender integration in these same forces, reflecting movement away from a hegemonic, heteronormative model of the military along two dimensions (Segal et al. 1999). Interestingly, the United States and Great Britain were outliers to this pattern, having among the most gender-integrated armed forces, but being closer to nations like Turkey and Greece than to

Canada, the Netherlands, and the Nordic nations with regard to sexual orientation integration. Most modern nations had sexual orientation policies regarding accession, conditions of service, or both in their forces, ranging from treating gay men and lesbians as a privileged population, through full integration, to exclusion. However, the actual practices in these countries deviated markedly from their official policies. For example, in Great Britain, homosexuality officially was grounds for denial of enlistment or for instant dismissal, but the military practiced extreme tolerance. By contrast, Germany did not regard sexual orientation as a relevant criterion for conscripted military service, but very few gay men or lesbians seemed to serve (Segal et al. 1993).

Since the early 1990s, when the United States debated its policy on sexual orientation in the military, the presence of gay men and lesbians in armed forces has continued to change cross-nationally.

Table 18.2 presents cross-national data on when a sample of countries discontinued excluding gay men and lesbians from their military forces, the size of these forces, and their experiences with regard to the major arguments that have been raised against lifting the ban on military service by openly gay personnel. These arguments include concerns that gay personnel will “come out” in large numbers, that there will be

Table 18.2 “Concern Rubric”: international comparison of actual outcomes of anticipated problems after anti-gay military policy change

Country	Ban discontinued	Size of military force-structure ^a	Mass “Coming Out” ^b	Increases violence towards known or suspected homosexuals	Mass resignations of heterosexuals	Declination in recruiting	Deterioration of cohesion, morale, military effectiveness
Australia	1992	68,000	None	None	None	None	None
Belgium	N/A	85,000	None	None	None	None	None
Canada	1992	78,000	None	None	None	None	None
France	N/A ^c	453,000	None	None	None	None	None
Germany	1969 ^d	476,000	None	None	None	None	None
Great Britain	2000	300,000	None	None	None	None	None
Israel	1993	141,000	None	None	None	None	None
The Netherlands	1974	92,000	None	None	None	None	None
Norway	1972/1979	53,000	None	None	None	None	None
Sweden	1944/1976	33,000	None	None	None	None	None

Source: Data compiled from information reported in GAO 1993; Kahan et al. 1993; RAND 1993.

^aTo provide context of the size of each nation listed here and how they compare to the U.S., the American military has an estimated 1.4 million servicemembers on active duty alone (Segal and Segal 2004). Therefore, some entire military structures of a nation may be equivalent in size to a couple of large brigades in the American army.

^bThough individuals have not come out in large numbers or publically, Herek (1996) finds that in the American military context, gay men and lesbians sometimes come out to peers they feel they can trust.

^cFrance has never had a policy for or against the service of gay individuals. However, the French military implements restrictive rules for those who come out and/or are considered disruptive (Segal et al. 1993; Kahan et al. 1993; GAO 1993).

^dGermany never cultivated civilian laws regulating sexuality. However, the German military practiced informal measures to exclude the service of gay men and lesbians primarily through channels of the German military medical field.

major increases in “gay bashing,” that heterosexual personnel will leave in large numbers, that military recruiting will become more difficult, and that unit cohesion, morale, and combat effectiveness will all decline. None of these phenomena have been observed in those nations that do not discriminate on the basis of sexual orientation with regard to military service. While the experiences of nations whose military forces are less likely to have expeditionary missions than do the U.S. forces cannot necessarily be applied to the American case, the data at least suggest that the negative consequences anticipated by some if military forces are integrated on the basis of sexual orientation have not been observed in other nations.

Although in place for the past 17 years, “Don’t Ask, Don’t Tell” was repealed in December 2010 through legislative action. This repeal came after an intensive 9-month study that solicited the views of over 400,000 active duty and reserve servicemembers as well as 150,000 family members. The panel also interviewed current gay men and lesbians serving in the Armed Forces. A number of sociologists also have been involved in providing information and writing the review, including comparative analyses of the integration experiences of past minority groups, including women. This study was the largest personnel-oriented research ever conducted by the Department of Defense, which stands as a testament to the attention and discretion surrounding this topic (DOD 2010).

After considering these data, legal policy, and the integration experiences of American allies, the panel concluded that the risk of repealing “Don’t Ask, Don’t Tell” on military cohesion, effectiveness, and readiness was low. Although the panel recognized potential for short-term negative effects, it did not see these disruptions as being long term, and thought they could be managed through leadership and military professionalism. These conclusions stem from the study’s results, which revealed that around 50–55% of all servicemembers believe that the repeal of “Don’t Ask, Don’t Tell” would have either a mixed or no effect on the military, 15–20% who thought it would have a positive

effect, and 30% who thought it would have a negative effect (DOD 2010: 4). There is a clear difference of opinion among Marine Corps personnel and those serving in the ground combat arms, with 43% of surveyed Marines, 48% of Army combat arms personnel, and 58% of Marine Corps combat arms personnel expressing that the repeal would have a negative effect (DOD 2010: 6). These results were of particular concern to military and political leaders due to the military’s ongoing involvement in two wars at the time of the repeal. However, data also suggest there is a difference between expectations and actual experiences, with those who have actually served with gay men and lesbians overwhelmingly stating that the experience had little to no effect (DOD 2010: 6).

The legislative repeal of “Don’t Ask, Don’t Tell” allows the Department of Defense to manage the implementation of the change in a slow, calibrated manner. As of this writing, the repeal must be certified by Congress, the Secretary of Defense, the Chairman of the Joint Chiefs of Staff and the President before it can go into effect. For this to occur, all parties must concur that the Department of Defense has prepared the necessary policies for implementation and that the repeal will not have a negative impact on the Armed Forces (SLDN 2011). Currently, there is no set date for certification or on the full repeal of “Don’t Ask, Don’t Tell,” although President Obama vowed in his 2011 State of the Union address that these steps will happen this year (O’Keefe 2011).

Conclusion

The culture and the workforces of military institutions remain predominantly male, although less hypermasculine than in the past. While the gender and sexuality of heterosexual men is still privileged, social change has brought us well past when military women could not have children while in the military, were completely excluded from serving, were restricted to gender-appropriate occupations like nursing, were regarded as auxiliaries, or were segregated in women’s branches.

In the United States, as well as in other western industrial nations, there has been an increase in the representation of women in military forces, and in the jobs they are allowed to perform. The changes have taken place in part because of shortages of male personnel, e.g., in times of war, or after changes in accession policies from conscription to volunteer forces. They also have reflected changes in patterns of women's employment in the civilian labor force, in contraceptive technologies, and in the increasing application of civilian equal opportunity laws to military forces, as these forces have increasingly become regarded as major participants in national labor markets. This latter is itself an outgrowth of the trend toward volunteer rather than conscripted forces.

Women remain under-represented in military forces relative to the composition of national labor forces, but an increase from 2 to 14%, as in the United States, is a quantum change, if only to bring the representation of women to a level at which they have to be acknowledged as visible tokens. And there is little doubt about the direction of continuing social change. Even in those cases where women are excluded by law from the traditional core mission of armies—ground combat in which the mission is to close with, engage, and defeat enemy forces—the nonlinear nature of twenty-first century wars has required departures from the spirit of the law. Even as women are excluded from serving in ground combat specialties, they are increasingly required by the nature of the mission to be collocated with male combat soldiers in the battle space.

The United States was one of the first western nations to move toward gender integration, but has been passed by some of its allies, particularly in terms of lifting restrictions on combat specialties. Interestingly, the ongoing gender integration of military forces has been more contentious in most nations than has sexual orientation integration, although this has not been the case in the United States. And while the United States moved early on the issue of gender integration, it has come later to the process of sexual orientation integration. By contrast, this process either had not been an issue (as in the case of France), or

was well advanced (as in Canada and the Netherlands), or exclusionary laws were not firmly enforced (as in Great Britain), by the time it became an issue in the United States. If manpower need is a major driver in favor of reducing closure and accepting diversity in military forces, President Clinton may have chosen exactly the wrong time to try to lift the gay ban in the American military. We were not at war, and military recruiting was experiencing high success rates in all services. By contrast, at the end of the first decade of the twenty-first century, America is involved in two protracted wars, and has not been able to wage them with its active armed forces alone. Instead, America has had to depend on its reserve forces more than at any time since World War II, and for the first time without having another group of citizen-soldiers—conscripts—join them in the battle space. Both women and gay individuals are more heavily represented in the reserve components than in the active force. This may be exactly the right time for the American military to expand its recruitment base by accepting openly gay and lesbian soldiers. If America shares the experience of nations such as Canada and the Netherlands which moved early to integrate gays and protect their right to serve in the military, it will find that even in the most supportive environments, gay individuals will elect not to be public about their sexual orientation, as a reflection of the dominant heterosexual norms.

Acknowledgments The writing of this chapter was supported in part by the Army Research Institute for the Behavioral and Social Sciences under Contract W91WAW 09 C 0077. The views expressed are those of the authors and not necessarily of the Army Research Institute, the Department of the Army, or the Department of Defense.

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Mary Ann Davis

Introduction

This chapter explores demographic factors related to gay male and lesbian adoptions, and corresponding family policies. First, I provide background on adoption law and policy. This history and background will summarize the current state of law in the U.S., with a comparison to gay and lesbian adoption policy elsewhere in the world. The second half of the chapter draws on both survey and census data to examine policy issues surrounding same-sex adoption. I first examine the prevalence of adopted children in same-sex households in the United States, using census data. Next, I present survey data exploring the acceptance of same-sex adoptions, using two national surveys: The National Survey of Family Growth, Cycle 6 (2002) and the Evan Donaldson National Survey. These surveys sampled the informal acceptance of adoption for both placing agencies and the general female population of child-bearing age in the U.S.

An examination of these topics is important for inclusion in this volume for three reasons: First, although these adoptions represent a small portion of adoptions, from a demographer's point of view they are a significant indicator of a changing family trend. Second, the prevalence of adoption by gay

men and lesbians is supported by data sufficiently significant to warrant a more specific inclusion in governmental censuses. Although the U.S. Census data have captured the number of same-sex unmarried couple adoptions since 1990, these data are limited in that adoptions are recorded only in relation to the householder. Thus, the data do not capture adoptions by other household members, including second parent adoptions by the same-sex partner. Third, a demographic analysis of gay male and lesbian adoptions contributes to a better understanding of the manner in which sexual orientation affects family demography. This lens of a demographic analysis could be useful for those addressing adoption policy and family law. There is a need for adoptive homes for "hard to place" children who need permanent homes, which some contend could be met if adoptions by gay men and lesbians were legally permissible in all 50 states. Arguably, part of the increase in gay male and lesbian adoptions is due to adoption agencies being willing to turn a blind eye to legal and agency obstacles in order to find homes for "hard to place" children. This raises the argument that these "hard to place" adoptive placements could be greatly increased if they were actively solicited from gay men and lesbians.

Background

A discussion of gay male and lesbian adoptions in the U.S. requires a brief background on the cultural norms regarding families; the changing

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norms of sexual and gender tolerance; and the gay rights movement. Stereotypical concepts of “family” are in flux. Over 60 years ago, when family sociologist Goode (1964) posed that the U.S. family unit was a legally sanctioned nuclear unit composed of heterosexual partners with children, he was arguing that this definition of the family was an ideal and not a reality. The norms and societal discourses about “family” have rapidly changed in the past three decades so that “family” now includes sequential marriages due to higher divorce rates, older and childless families due to an increased age at first marriage, cohabiting couples, and families resulting from nonmarital child-bearing (Bumpass and Lu 2000). Thus, the current discourse on normalization of the legal rights of gay males and lesbians, including the right to marry and adopt children, is part of these larger societal and cultural changes affecting the “family” (McVeigh and Diaz 2009).

The Stigma of Homosexuality and the Gay Rights Movement

The recognition of gay rights, including the right to marriage and adoption, has been hampered by the general stigma associated with homosexuality. This stigma was bolstered by the clinical classification of homosexuality as a mental illness. From 1968 to 1973, the first two editions of the Diagnostic and Statistical Manual of the American Psychological Association considered homosexuality a diagnosable mental illness, as discussed in the section headed: “302.0 Sexual orientation disturbance or Homosexuality” (American Psychological Association 1973). Stigmatizing beliefs included those viewing gay individuals as being more likely to be HIV positive and to engage in pedophilia, opportunistically seeking to sexually exploit children. These beliefs led many to conceal their sexuality in order to avoid discrimination.

The Gay Rights social movement, similar to the civil rights movements of the 1960s, grew as a means of ending discrimination directed toward gay men and lesbians. The movement

pursues the same legal rights to marriage, inheritance, child custody, employment, and military service for gay men and lesbians as are afforded heterosexuals (Eng 2003). Public awareness of gay issues and public support for gay individuals were sparked during the 1980s with the HIV/AIDS epidemic. HIV/AIDS was first linked to gay males and thought to be a gay male disease (named GRIDs or Gay Related Immune Deficiency) (BBC 2006). The rapid spread of AIDS raised awareness that gay individuals were living in long-term committed relationships that functioned as families. AIDS facilitated discussions about the need for legal support for caregiver partners who needed financial security and medical decision making capacity for their heretofore unrecognized family relationship (Chauncey 2005). These concerns justified a new discourse, a normalization of gay male and lesbian relationships as family relationships, contending that gay male and lesbian families function much like heterosexual families: They are in long-term committed relationships, they financially support each other, and they share responsibilities for caring for the sick and burying the dead.

The right to adopt for gay men and lesbians is a viable part of this overall gay rights movement, as the movement frames gay males and lesbians as full citizens and legitimate families. In the 1980s, the social movement to legitimize gay male and lesbian adoptions gained momentum, leading to a “lesbian baby boom”. Chauncey (2005) noted lesbians initiated the “baby maybe” movement, holding demonstrations in New York, Portland, San Francisco, and Boston. Advocates of “baby maybe” discussed the possibility of lesbians becoming parents, spreading advice about multiple methods of having children, including adoption, artificial insemination, and heterosexual relationships. The movement was supported by changes in medical technology, particularly the development in the 1980s of in-vitro fertilization (IVF). Sperm banks became available to lesbians; in 1982, the sperm bank in Berkley opened to lesbians (The CQ Researcher 2009). The

intended outcome of the “baby maybe” discourse was a raised consciousness about the need for gay families to be socially accepted as normal, and for legal clarity regarding financial support, insurance, medical coverage, and the ability of both partners to be included in major child decisions (Chauncey 2005).

Connolly (2002) argued that adoption by both same-sex partners versus single parent adoption is necessary for legal (wills and succession, eligibility for governmental programs, income tax exemptions, privacy of information standards), medical (private and public health and life insurance, access to medical records, medical decision making), and financial provisions for families. Advocates for gay male and lesbian adoption suggest that adoption does more than provide children for the family. Adoptions secure the legal protections and benefits for the children that are generally provided by biological parents. These include: access to health insurance, securing medical treatment, access to the confidential educational and medical information of minor children, and the ability to maintain custody of children if the custodial partner is disabled or deceased. The additional benefit for gay parents is that a legal adoption provides an acknowledgment that, whether or not the couple has a legal marriage, the couple is, by statute, considered to be a family. Thus adoptions are legitimizing, providing a public statement of social support for the couple, when other venues for social acceptance are rare or nonexistent (Patterson and Friel 2000).

This movement, however, has created a strong cultural anti-gay family backlash. In effect, there are two conflicting movements. One supports gay rights, including the right to marry and adoption and the other, a reactionary conservative “defense of family” movement, seeks to repeal laws that have allowed these rights and create laws that oppose them. These conflicting movements and societal antigay discrimination are driving forces in current legal battles over the status of gay male, lesbian, bisexual, and transsexual (GLBT) issues surrounding both adoption and marriage (Chauncey 2005).

Outcomes of Adoptees with Gay or Lesbian Parents

One of the primary arguments addressed by both sides of this issue concerns the outcomes of children raised by gay and lesbian parents. Gates and colleagues (2007) report that, although there is societal controversy about the effect on children of being raised by gay male and lesbian parents, professional and research communities¹ support these adoptions. The consensus is that there are no negative consequences evidenced by children from these family structures (Erich et al. 2009). Professional scrutiny into possible detrimental results from gay male and lesbian adoption has resulted in policy statements of support for gay male and lesbian adoptions from medical, social, and psychological organizations (see e.g. Policy Statement of the American Academy of Child and Adolescent Psychiatry on Gay, Lesbian and Bisexual Parents [1999]²).

¹ American Academy of Child and Adolescent Psychiatry (1999); the American Academy of Pediatrics (2002); the American Bar Association (1999, 2003); the American Psychoanalytic Association (2002); the American Psychological Association (2004); the Child Welfare League of America (2006); the National Association of Social Workers (2002); and the North American Council on Adoptable Children (2005)

² Policy Statement of the American Academy of Child and Adolescent Psychiatry.

All decisions relating to custody and parental rights should rest on the interest of the child. There is no evidence to suggest or support that parents who are lesbian, gay, bisexual, or transgender are per se different from or deficient in parenting skills, child-centered concerns, and parent-child attachments when compared with heterosexual parents. There is no basis on which to assume that a parent’s sexual orientation or gender identity will adversely affect the development of the child.

Lesbian, gay, bisexual, or transgender individuals historically have faced more rigorous scrutiny than heterosexual people regarding their rights to be or become parents. The American Academy of Child & Adolescent Psychiatry opposes any discrimination based on sexual orientation or gender identity against individuals in regard to their rights as custodial, foster, or adoptive parents.

Researchers Stacey and Biblarz (2001) examined 21 psychological studies that addressed parental sexual orientation and found no differences between lesbian (the term used by Stacey and Biblarz to designate lesbian, bisexual, or gay sexual orientation) and heterosexual parents in the child outcome variables studied, including “(1) gender behavior/gender preferences, (2) sexual behavior/sexual preferences, and (3) psychological well-being” (p. 167). One of these was a 14 year longitudinal study of 27 heterosexual single mothers and 27 lesbian mothers, each group having 39 children. Most of these studies had the limitation of studying an urban white population (living in Los Angeles, New York, and San Francisco and university communities) so that the children were socialized in areas less likely to evidence social prejudice towards lesbian families.

Meezan and Rauch (2005) were critical of much of the research conducted on children in same-sex households due to the difficulty in finding a representative sample, reliance on secondary analysis, and the limitations of statistical analysis with small samples. However, their meta-analysis supported the notion that there is no scientific evidence that children with gay male and lesbian parents differ in development or psychological adjustment from children in heterosexual families.

Lobaugh and colleagues (2006) studied gay male adoption through a comprehensive review of media, historical, and scientific data. They countered arguments that adoptions by gay men would affect a child’s sexual orientation, mental health status, or increase their risk of suicide. They found that while sexual orientation is complex and affected by multiple factors, and while prenatal hormonal influences and childhood socialization both appear to influence sexual orientation, multiple studies show that children raised by gay male and lesbian parents have the same rates of homosexuality as do those raised by heterosexual parents.

Another concern not often explicitly addressed, although inferred in much of the anti-gay male and lesbian rhetoric, is that there are connections between homosexuality and pedophilia. Research demonstrates, however, that the majority of child

molesters are heterosexual men (Kenyon et al. 2003; Brooks and Goldberg 2001). Thus, Patterson’s conclusions remain:

...not a single study has found children of gay or lesbian parents to be disadvantaged in any significant respect relative to children of heterosexual parents. Indeed, the evidence to date suggests that home environments provided by gay and lesbian parents are as likely as those provided by heterosexual parents to support and enable children’s psychosocial growth (Patterson 1992: 1036).

Legal and Policy Background

The reality of parenthood for gay men and lesbians is changing faster than the social norms and the legal system. Since children enter gay male and lesbian households in ways other than adoption, limiting gay men and lesbians’ adoption rights is almost a moot point. The children raised by gay men and lesbians may be from a former or current heterosexual relationship, be biologically related to one or both partners, be conceived through assisted reproduction via artificial insemination or surrogacy, or be either foster or adoptive children (Baumle et al. 2009).

Appell (2001) finds that most of the children in same-sex families are the biological children of one of the partners. Second in number are the children from a prior heterosexual marital or sexual relationship which resulted in children. Lesbians may become biological parents through artificial insemination, either through donated sperm or banks or through known sperm donors. Dalton and Bielby (2000) suggest that lesbian mothers may also enter into parental agreements to seek donated sperm and then co-parent with the sperm donor. Gay men may become biological fathers through using a surrogate mother. However, the nonbiological parent has no legal authority in many of these procedures. Lesser numbers of children are the result of assisted reproduction, perhaps due to lack of legal authority, cost, and access.

Nonetheless, adoption remains an attractive option for family formation for gay men and lesbians, and might prove even more important in the future. As individuals “come out” at an earlier

age, they could be more likely to bypass heterosexual unions that produce children (Baumle et al. 2009). Further, cost prohibitions for surrogacy and some other means of reproduction make adoption a more viable option, particularly for gay men.

The Legality of Same-Sex Adoptions in the United States

Prior to examining the prevalence of same-sex adoption in the United States, this section presents a background of the state of adoption in the U.S., including a brief history and current legislation, and an international overview of adoption laws in general. The legality of same-sex adoptions in the U.S. varies, since family laws, including those related to adoption, are state laws where each state determines the requirements for adoption and marriage for its residents (Appell 2001). Currently, the U.S. is debating, legislating, revising legislation, or judicially reviewing the right of gay men and lesbians to adopt on a state-by-state basis. In addition, the debate over access to marriage explores the rights and responsibilities of the couple, and how this might affect any children involved in the relationship. Issues include protecting the rights of both parents in matters involving child custody, medical consent and the right of gay men and lesbians to adopt. Family laws regarding adoption require separate action from laws regarding marriage. This is due primarily to the view that marriage is considered a right while adoption is a statutory privilege (Lavelly 2007).

There are four common elements in adoption statutes: First is the assumption that adoptees will be a heterosexual married couple. Dalton and Bielby (2000) argue that, with the exception of single parent adoptions, there is a basic anti-gay bias in all adoption statutes in that they assume a legal marriage. This is especially problematic, as judges are expected to narrowly interpret adoption statutes.

Second, since adoption laws generally require that the legal rights of the biological parents be terminated, parental rights of both parents are terminated upon adoption. This poses a challenge

for gay male or lesbian partner adoptions where one of the unmarried partners is the biological parent and the statutes do not allow for the biological parent to retain rights in the adoption process. This would be the case whether or not the couple was same-sex or different-sex. Conversely, this biological link to one of the gay male and lesbian partners generated some of the most successful gay male and lesbian adoptions, "second parent" adoptions (Connolly 2002). Second parent adoptions have been processed through the judicial system with gay and lesbian couples presenting themselves as family units similar to a commonly accepted heterosexual family unit.

Third, adoptions require that the judicial system follow the principle of the "best interests of the child." The "best interests of the child" element is the only part of the law that favors gay males and lesbians. Gay males and lesbians who have an existing relationship with a child (either a biological or a foster parent relationship) are advantaged because it is deemed in the best interest of the child to not disrupt a relationship. Another "best interest" issue, which may also favor gay male and lesbian families, is the fact that there are a large number of children available for adoption who are deemed less desirable because they are older, have health or emotional problems, are siblings, or are minorities. In this case, the issue then becomes whether the child's best interests are protected in a family setting or by remaining in foster care or in an institution. Professionals agree that family placement, including gay male and lesbian family placement, is preferred (Evan B. Donaldson Adoption Institute 2006; Brodzinsky et al. 2002; Brodzinsky 2006).

The need for placement of children removed from their homes by child welfare has led to gay males and lesbians becoming foster parents as a pathway to adoption. Foster care placement decisions, like adoptive placement decisions, are legally made by judicial decisions based on what is considered by the court to be in the best interest of the child (Ryan et al. 2004). Child placing agencies prefer foster care over institutional placement, as foster placement provides the dependent child with a normalized life in the least restrictive setting with greater opportunities for

bonding or attachment and strengthening of emotional well-being. Due to the perception that foster care is precipitated by crisis and is short-term, together with the limited supply of foster homes, the regulations regarding who can become a foster parent are more flexible. Agencies are recruiting single parents and lesbian and gay male parents as foster parents due to the need for foster homes.

The American Civil Liberty Union's (ACLU) support of gay individuals' right to adopt targeted this mutually beneficial union between gay men and lesbians and the hard to place child. Cooper and Cates (2006) report the ACLU bases its support for gay male and lesbian adoptions on the argument that there are around 119,000 foster children, many of whom are "hard to place" and in need of long-term adoptive families. Therefore, the ACLU argues that it would be negligent to deprive these children of adoptive homes based on the sexual orientation of the adoptive parents. They supplement their argument with research findings showing that children in gay male and lesbian adoptive homes have the same physical development and psychological benefits as those placed in heterosexual homes.

Legal Structure of Adoptions by States

Since laws that are applicable to families (including adoptions) are state laws, this creates a great deal of inconsistency across the states regarding their stance on gay male and lesbian families. In 1977, Florida became the first state to prohibit adoption by gay individuals; this prohibition remained until overruled by a court decision in September 2010 (Florida Department of Children and Families v. In re: Matter of Adoption of X.X.G. and N.R.G. 2010). During this time, the family structure in the U.S. was changing, coinciding with increased divorces and remarriages based on the advent of new legislation pertaining to divorce. New Hampshire followed with a law banning same-sex adoptions in 1986, although the ban was removed by this state in 1999. Currently, this issue is undergoing transformation as statutes are

contested, together with the "elastic" status of social acceptance of gay male and lesbian adoptions (Appell 2003).

Table 19.1 presents an overview of current state laws that address gay male and lesbian adoption, adoption by single persons, and gay male and lesbian marriages as of July 2009 (Appell 2003; Human Rights Campaign 2009). Column one in Table 19.1 lists the states; the second column lists whether the state allows or prohibits single parent adoptions; column three lists whether the state allows joint adoptions by gay males and lesbians; column four lists whether a second parent adoption by a gay male or lesbian unmarried partner is allowed; column five lists those states with pending statutes; and the sixth column lists those states that allow same-sex marriage, domestic partnership, or civil unions.

Table 19.1 documents, as suggested by Baumle et al. (2009), that gay men and lesbians face minimal legal resistance to adopt as single parents. Thus, there is no real legislation preventing gay male and lesbian adoptions in most of the U.S. Only Arkansas clearly prohibits adoption by single parents, although statutes in Missouri and Nebraska are unclear about single-parent adoptions. Florida was the first state to prohibit adoption by single parents; however, on May 14, 2009, the Florida Court of Appeals ruled in *Embry v. Ryan* (2009) that Florida must recognize adoptions which were granted to same-sex couples in other states. Joint adoptions by unmarried persons, as indicated in column three, are prohibited in five states. However, they are allowed in ten states and, additionally, same-sex couples have jointly adopted in some jurisdictions in Nevada and New Hampshire. Second parent adoptions, shown in column four, are allowed in ten states. Second parent adoptions have been allowed in some jurisdictions of 15 states.

Marriage statutes in states that allow same-sex marriages or civil unions also affect the legality of adoptions, as most adoption laws are written with the assumption that those who adopt are married. Six states allow same-sex marriage, and five states allow domestic partnerships or civil unions. However, the absence of anti-gay legislation does not necessarily mean a state is

Table 19.1 Adoption and marriage laws by states July 2009^a

State	Single	Joint	2nd parent	Pending	Marriage
Alabama	X		X		
Alaska	X		X		
Arizona	X		Unclear		
Arkansas	Prohibits	Prohibits	Prohibits		
California	X	X	Allows	X	DP
Colorado	X		Allows		
Connecticut	X	X	Allows		X
Delaware	X		X		
District of Columbia	X	X	Allows		
Florida	Prohibits	Prohibits	Prohibits		
Georgia	X		Unclear		
Hawaii	X		X		RB
Idaho	X		Unclear		
Illinois	X	X	Allows		
Indiana		X			
Iowa	X		X		X
Kansas	X		Unclear		
Kentucky	X		Prohibits		
Louisiana	X		X		
Maine	X	X	X		X(9/09)
Maryland	X		X		SOME DP
Massachusetts	X	X	Allows		X
Michigan	X	Prohibits	Prohibits		
Minnesota	X		X		
Mississippi	X	Prohibits	Unclear		
Missouri	Unclear	Unclear			
Montana	X		Unclear		
Nebraska	Unclear		Prohibits		
Nevada	X	(Some)	X		DP
New Hampshire	X	(Some)	Unclear	X	CU
New Jersey	X	X	Allows	X	CU
New Mexico	X	X			
New York	X	X	Allows		(Recognizes)
North Carolina	X		Unclear		
North Dakota	X	Unclear			
Ohio	X		Prohibits		
Oklahoma	X		Unclear		
Oregon	X	X		X	DP
Pennsylvania	X		Allows		
Rhode Island	X		X		
South Carolina	X		Unclear		
South Dakota	X		Unclear		
Tennessee	X		Unclear		
Texas	X		X		
Utah	X	Prohibits	Prohibits		
Vermont	X	X	Allows		X(9/09)
Virginia	X		Unclear		

(continued)

Table 19.1 (continued)

State	Single	Joint	2nd parent	Pending	Marriage
Washington	X		X	X	DP(7/09)
West Virginia	X		Unclear		
Wisconsin	X		Prohibits		
Wyoming	X		Unclear		

Source: Human Rights Campaign (2009) and Appell (2003)

^aCourt decision in September 2010 allows gay adoptions (Florida Department of Children and Families vs. In re: Matter of Adoption of X.X.G. and N.R.G. 2010)

DP Domestic Partnerships, CU Civil Unions

accepting of same-sex adoptions. For example, second parent adoptions may also be declined or refused to be heard. Further, it is possible that adoptions will be made to gay male or lesbian individuals despite prohibitive law, or that adoption will be denied even in the face of protective laws. Baumle and Compton (2007) suggest that already some gay male and lesbian couples are willing to function “outside of the law” in order to adopt children. Thus, the legislation itself is not a definitive indicator of access to adoption within a state (Ireland 2007).

International Legal Structure for Adoptions by Gay Males and Lesbians

Internationally, each nation has both formal and informal family structures which function to care for children. Couched within laws are cultural, political, and economic forces which further direct the actual practice of adoption. Currently, a “comparative overview has shown that although the majority of legal systems do not yet accept same-sex parentage, the international trend is to legally recognize not only same-sex partnerships, but also same-sex parentage” (Dethloff 2005: 204). As it is beyond the scope of this chapter to address the complexities involved in the international legality of family and child laws, please refer to Merlin (2002) and O’Halloran (2009) for a more comprehensive overview of international same-sex adoption laws.

Table 19.2 presents a brief overview of the timelines of those nations that allow registered partners, same-sex marriage, and same-sex adoptions

Table 19.2 International legality of same sex family structure by year

	Registered partners	Marriage	Adoption
Argentina		2010	
Australia			2000
Belgium	1998 ^a	2003	
Canada	2000	2005	
Denmark	1989		1999
Finland	2001		
France	1999 ^a		
Germany	2001		
Hungary	1996 ^a		
Iceland	1996		2001
New Zealand	2001		
Norway	1993		
Portugal	2001 ^a		
South Africa	1999		2002
Spain		2005	
Sweden	1995		2003
The Netherlands		2001	1998
United Kingdom	2004		2002

Sources: Andersson et al. (2006), Amnesty International (2010), Festy (2006) and Merin (2002)

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^aRecognition with limited rights

(either single parent or couple). This table shows legal recognition appears to follow the path of first legalizing same-sex partners, followed by same-sex marriage and, with this, legal rights of adoption. Additionally, within each nation there may be areas with more liberal policies possibly due to influences of international travel and urbanization. Andersson and colleagues (2006) report that the Nordic countries (Denmark, Finland, Iceland, the

Netherlands, Norway, Sweden) first accepted same-sex families. In 1989, Denmark was the first country to recognize same-sex marriage, followed by Norway in 1993, and Sweden in 1995. “Belgium followed in 2003, and Spain and Canada approved same-sex marriage in 2005” (Andersson et al. 2006: 79). Germany and three regions in Spain (Navarra, the Basque Region and Aragón) also permit same-sex adoption. The United Kingdom laws followed the Swedish model. France allows a single gay male or lesbian to adopt, but not same-sex couples, so there is no relationship between the adopted child and the same-sex partner (O’Halloran 2009). The pathways are further affected by the religious preferences in the countries. The primarily Catholic countries of Italy, Ireland, and countries in Latin America remain opposed to adoption by same-sex couples.

Intercountry Adoptions by Gay Males and Lesbians in the United States

Just as domestic adoptions are legally complex and subject to the laws of the 50 states, each nation determines the legality of intercountry adoptions and the criteria for who is available for adoption and who can adopt. A limitation of the data from sending countries is inconsistency and lack of documentation as to the sexual orientation of all who adopt. Table 19.3 presents the U.S. Department of State (2008) criteria for adoption. Immediately evident are two selection criteria which are similar to those who are preferred candidates for domestic adoptions. Twenty-eight of the thirty-nine countries consider the age of the adoptive couple as criterion for adoption. This is based on the assumption that the children will need parents who are young enough to survive to provide for them until they reach adulthood and self-sufficiency. Eighteen countries require that the adopters be a married couple. While only ten nations allow single parent adoptions as “special” criteria, only two prohibit single parent adoptions, China and the Dominican Republic.

Table 19.4 comes from the U.S. Department of State Immigration Data. It presents the list of

the countries of origin for the greatest number of intercountry adoptions. Since 1990, the top four countries of origin are China, Korea, Guatemala, and Russia. China is the top sending country to the U.S.; in the last decade, 61,512 adoptive children came from China. Viewing U.S. television and media presentations of gay male and lesbian adoption, one would assume that intercountry adoption of a child from China is the preferred route for adoption by gay male and lesbian couples. However, supply and demand economics enter into the picture. As discussed earlier, there is a gradient of preferred adoptive parents as well as preferred adoptive children. Gay men and lesbians are viewed as less desirable, so as the demand for infants from China has increased, the regulations for adoptive parents have become more stringent. Note in Table 19.3 that China has recently limited adoptions to married couples. Other criteria for adoptions from China are that one parent must travel to China to complete the necessary paperwork, the family must have an income of at least \$80,000, and the couple must be between 30 and 50 years of age (U.S. Department of State 2008). Korea, which has no restrictive adoption criteria, has been the top intercountry adoption sending country to the U.S. for over 50 years.

The National Survey of Adoptive Parents (NSAP)³ is the first large, nationally representative survey of adoptive families in the United States. Although this survey did not specify sexual orientation, NSAP’s exploration of motivations for adoption among the three types of adoptions, intercountry, foster care, and private domestic the findings are relevant in the discourse of why gay men and lesbians would select intercountry adoptions. Respondents were given a forced choice of answering “yes” “no” or “don’t know/refused” for their motivation for selection of a type of adoption. I obtained weighted frequencies, using STATA 11, of public use NSAP data available from the

³ The NSAP was a follow-up survey to the 2007 National Survey of Children’s Health. The NSAP surveyed 2,089 households who had adopted children, up to age 17, between 1990/1992 and 2007/2008 (Bramlett et al. 2010; Vandivere et al. 2009).

Table 19.3 Summary of the requirements by countries sending adoptees to the U.S.

	Residency	Married	Single	Gay/Lesbian	Income	Health	Age
Armenia	–				–	–	Yes
Belarus							
Brazil	Yes				–	–	Yes
Bulgaria	Yes				–		Yes
China	Travel	Yes	No	No	Yes	Yes	Yes
Colombia	–	Yes	Limited	No	–	–	Yes
Dominican Rep.	Yes	Yes	No	No		–	Yes
Ecuador	Yes	Yes	Limited			–	Yes
El Salvador	Yes				Yes	–	Yes
Ethiopia	–	Yes	Females	No	–	–	Yes
Georgia							
Guyana	Yes	Yes			Yes	–	
Haiti	–	Yes			–	–	Yes
India	–				–		Yes
Jamaica	–				–	–	Yes
Japan	Yes				–	–	Yes
Kazakhstan	Travel				–	–	Yes
Kenya	Yes	Yes	Female	Not allowed	–	–	Yes
Korea							
Latvia	Yes				–	–	–
Liberia	–				–	–	–
Mexico	Yes				Yes	–	Yes
Moldova	–	Yes	Yes		Yes	Yes	Yes
Nepal	–	Yes	Female		–	–	Yes
Nicaragua	Yes				–	–	Yes
Nigeria	Yes	Yes	Same-sex		–	–	Yes
Pakistan	–	Yes	Yes		–	–	Yes
Peru	–	Yes	Yes		–	–	Yes
Philippines	Yes	Yes			Yes	–	Yes
Poland	–	Yes	Yes		–	–	Yes
Romania	Only biological grandparents						
Russia	–				–	Yes	Yes
Sierra Leone	Yes				–	–	–
Taiwan	–	Yes			Yes	–	Yes
Thailand	–	Yes			Yes	–	Yes
Ukraine	–	Yes			Yes	–	Yes

Source: U.S. State Department 2008 (Cambodia Guatemala, and Vietnam not allowed in 2008)

Centers for Disease Control (2007–2008). Results of the top reasons for intercountry adoptions were: “Thought it would be too difficult to adopt a child from the U.S.”, 64.6%; “Wanted an infant”, 62.68%; “Wanted a closed adoption, that is, no information exchange or contact with child’s birth family”, 51.2%; and “Thought it would be quicker”, 48.66%. I would argue that gay men and lesbians would select intercountry adoptions for similar motivations.

There is more flexibility in the ease, legality, speed, and there are fewer domestic infants available for adoptions.

A disadvantage of intercountry adoptions is they also face intercultural and interracial issues. International adoptions by gay male and lesbian couples face additional challenges to what is a family because the adopted child not only has no biological connection with the adoptive parents, but also the family might dif-

Table 19.4 Top countries of origin of U.S. adoptees 1997–2007

	2007	2006	2005	2004	2003	2002	2001	2000	1999	1998	1997	Total
China	5,453	6,493	7,906	7,044	6,859	6,119	4,681	5,053	4,101	4,206	3,597	61,512
Russia	2,310	3,706	4,639	5,865	5,209	4,939	4,279	4,269	4,348	4,491	3,816	47,871
Guatemala	4,728	4,135	3,783	3,264	2,328	2,419	1,609	1,518	1,002	969	788	26,543
S. Korea	939	1,376	1,630	1,716	1,790	1,779	1,870	1,794	2,008	1,829	1,654	18,385
Ukraine	606	460	821	723	702	1,106	1,246	659	323	180		6,826
Kazakhstan	540	587	755	826	825	819	672	398				5,422
Vietnam	828	163			382	766	737	724	709	603	425	5,337
India	416	320	323	406	472	464	543	503	499	478	349	4,773
Romania				57	200	168	782	1,119	895	406	621	4,248
Ethiopia	1,255	732	441	289	135	105	158	95		96	82	3,388
Columbia	310	344	291	287	272	334	407	246	231	236	233	2,955
Philippines	265	245	271	196	214	221	219	173	195	200	163	2,362
Haiti	190	309	234	356	250	187	192	131		121	142	2,112
Cambodia					124	285	266	402	249	249	66	1,641
Bulgaria				110	198	260	297	214	221	151	148	1,599
Liberia	314	353	183									850
Mexico	89	70	88	89		61	73			168	152	790
Poland	84	67	73	102	97	101	86	83		77		770
Thailand	67	56	72	69	72	67	74	88		84		649

Source: U.S. State Department

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fer from the family of origin in sexual orientation, race, and/or ethnicity.

The Prevalence of Same-Sex Adoption in the U.S.

The second half of this chapter focuses on an analysis of the prevalence of same-sex adoptions, with the caveat of data limitations. The first challenge faced by researchers interested in the prevalence of same-sex adoptions is to calculate the number of same-sex unmarried partner households who might have children. Using census data, Simmons and O'Connell (2003) found there were 594,391 same-sex unmarried partner households, about 1% of all coupled households. Of these households, 162,000 were found to have one or more children. One-third of lesbian-headed and one-fifth of gay male-headed households reported they had children under age 18 living with them, compared to one-half of heterosexual couples. The Evan B. Donaldson Adoption Institute (2006) estimated this number to be low. For example, households

are not included who did not identify their relationship as gay male or lesbian single parents, or those who have a noncustodial gay male parent. Patterson and Freil (2000) used the National Health and Social Life survey definition of homosexuality as being composed of identity, behavior, and desire and found a higher range, estimating that 1.6–14 million children living in same-sex households. Evan B. Donaldson Adoption Institute (2006: 5) agrees with Stacey and Biblarz's (2001) more conservative estimation of from 1 to 9 million children (this estimate based on National Survey of Families assuming an equal portion of dependent children in the households who are raised by gay males and lesbians).

U.S. Census Data on Same-Sex Unmarried Partners

Changes in U.S. Census data have aided both the study of the extent of same-sex couples and the presence of adoptees in these same-sex partnered households. The Hobbs and Stoops

(2002) reported that although asking about the relationship with the householder has been a part of the census since 1880, it was only recently revised in response to changes in family relationships to include measures of cohabitation. In 1990, the category “unmarried partner” was added. Black and colleagues (2000) provide a justification for demographic analysis of the same-sex population by comparing several demographic characteristics of same-sex partners on the 1990 Census with findings regarding gay male and lesbians from the General Social Survey and the National Health and Social Life survey. These surveys support census findings through comparisons with other variables such as veterans’ status, education level, and income.

In both 1990 and 2000, individuals of the same sex could identify as unmarried partners. In 2000, individuals who were of the same sex and identified as spouses were recoded as unmarried partners, whereas in 1990 these individuals had the sex of one partner changed, reassigned to be counted as a heterosexual partner. The “relationship to head of the household” question that allows for same-sex analysis is one of seven so-called 100% census questions asked of all persons. This relationship to the householder question also asks about the relationship of children in the household to the householder, and thus one can identify whether the householder has adopted a child living in the household. However, data do not indicate whether the child is adopted by the other same-sex partner or parent (Hobbs and Stoops 2002). Thus, one can examine children in gay male and lesbian households only via exploring whether a child is adopted by “person #1” on the census form, and whether “person #1” is in a same-sex unmarried partnership; there is no information of whether the child is adopted by “person #2”, the same-sex partner.

Methodology

I use data from the 5% Public Use Microdata Sample of the 2000 U.S. Census, a sample of 14,081,466 (Ruggles et al. 2008). I use the variable

PERWT, or person weight for a weighted analysis, as it provides the weight of the population represented by each individual or person in the 5% sample. Weights allow for the sample to be expanded to the relevant total population (U.S. Census Bureau 2000). I follow the assumptions of Baumle and colleagues (2007) and Walther and Poston (2004) that these data represent same-sex households (male-male or female-female) and reflect a “marriage-like” relationship, which is in part the result of a concerted effort by the gay male and lesbian community to document their presence via the unmarried partner relationship variable on the 2000 Census.

The analysis is divided into same-sex female unmarried partners, same-sex male unmarried partners, and different-sex unmarried partners. I then include measures of child relationship to the householder, including the three census categories for children: child, step-child, and adopted child. I combined the unmarried partner household relationships with children, using three census categories for children: child, step-child, and adopted child. I used the racial categories of White, Black, Asian, and other.

Results

The 2000 Census data provide frequency data pertaining to same-sex adoptions. I selected those householders with an unmarried partner, and examined their relationships with three child categories: child, step-child, and adopted child. Table 19.5 shows the relationship categories of the children to the householder in both different-sex and same-sex unmarried partner households. Table 19.5 clearly shows that the percentages of children in partnered households are almost identical across the three household types (heterosexual, gay, and lesbian). About 93% of the children are biological, with an average of 5% step-children, and only 2.5% of all children are adopted, in the 5% sample. Although it is difficult to know how individuals might choose to categorize children on the census, these data suggest that biology rather than adoption is the primary

Table 19.5 Adopted child in unmarried partner household by race: Frequencies and weighted percentages

		White	Black	Asian	Other	Total
Gay	Child	24,715	1,833	920	2,228	29,696
		75.7%	6.4%	3.2%	7.6%	92.9%
	Adopted child	669	53	22	63	807
		2.0%	0.2%	0.1%	0.2%	2.5%
Step-child	1,228	94	46	101	1,469	
	3.8%	0.3%	0.2%	0.3%	4.7%	
Total	26,612	1,980	988	2,392	31,972	
	81.6%	6.9%	3.4%	8.1%	100.0%	
Lesbian	Child	25,441	1,919	821	2,132	30,313
		76.1%	6.6%	2.7%	7.0%	92.4%
	Adopted child	682	59	10	54	805
		2.1%	0.2%	0.0%	0.2%	2.5%
Step-child	1,360	128	39	111	1,638	
	4.1%	0.4%	0.1%	0.4%	5.1%	
Total	27,483	2,106	870	2,297	32,756	
	82.3%	7.2%	2.9%	7.6%	100.0%	
Heterosexual	Child	339,604	27,437	11,356	31,476	409,873
		75.4%	7.0%	2.8%	7.6%	92.8%
	Adopted child	9,149	695	298	867	11,009
		2.0%	0.2%	0.1%	0.2%	2.5%
Step-child	17,158	1,435	625	1,594	20,812	
	3.8%	0.4%	0.2%	0.4%	4.7%	
Total	365,911	29,567	12,279	33,937	441,694	
	81.2%	7.5%	3.0%	8.2%	100.0%	

Source: IPUMS (2000) 5% files

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Table 19.6 Percentages: Adopted child in unmarried partner household by race

	Gay	Heterosexual	Lesbian	Total
White	2.53	2.52	2.5	2.52
Black	2.71	2.42	2.49	2.44
Asian	1.79	2.18	3.47	2.25
Other	2.42	2.43	1.94	2.41
Total	2.52	2.49	2.46	2.49

Source: IPUMS (2000) 5% files

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way children enter into same-sex unmarried partnered households.

Table 19.6 presents the frequencies and percents (of the weighted analysis) of those who adopted, by sexual orientation and the race of

the householder in the IPUMS 5% sample. There were a total of 506,422 unmarried partner households with children. Almost equal percentages, 2.5%, of the children in white gay male, lesbian, and heterosexual unmarried partners were adopted. Black unmarried partners had greater variability; a slightly higher percentage of children in Black gay male unmarried partner households were adopted at 2.7%, compared to only 2.4% in heterosexual unmarried partner households, and 2.49% in lesbian unmarried partners. The lowest percentage of children were adopted in Asian gay male unmarried partner households, at 1.79%, while the highest percentage of all children were adopted children in Asian lesbian unmarried partner households, at 3.47%.

Bramlett and colleagues (2010) reported on the results of The National Survey of Adoptive Parents (NSAP), discussed earlier. Although data did not include sexual orientation, data serve as evidence of changes in the norms of who adopts in the U.S. Results found that adopters were more racially and ethnically diverse. In spite of the survey selecting only English speakers, 15.28% were Hispanic; 37.25% Non Hispanic White; 23.19% were Non Hispanic Black; 15.37% were Non Hispanic Asian; and 8.91% Other. Private, domestic adoptions are no longer the norm. The survey noted there were almost even percentages of foster care and domestic private adoptions, 37 and 38% respectively, with fewer intercountry adoptions (24.3%). Household income levels of adopters covered a broad range; 10% of adopters had household incomes of under \$19,999; 15.4% between \$20,000 and \$39,999; 21.6% had incomes from \$40,000 to \$59,999; and 53% \$60,000 or above. This diversity in socioeconomic status is also evident in the education level attained with only 75% having above a high school education. Adoptions are not limited to the married couples; 65% of the households had two adults and 76.8% of the adoptees were married. Arguably, this suggests that family formation by adoption has broadened to be more inclusive, which bodes well for increased acceptance of gay male and lesbian adoptions.

The U.S. Census 2000 data reveal that the same-sex partner households with adopted children in the household have higher socioeconomic status than different sex married and unmarried adoptive parent households. Gates and colleagues (2007: 11) found the median household income for both gay male and lesbian adoptive households is over \$102,000 compared to \$81,900 for different-sex married households and \$43,746 for different-sex unmarried households. The median education level is also higher: 76% in same-sex partnered households have some college or above education (65% in gay male and 79% lesbian partner households) compared to 64% in different-sex married households and 36% in different-sex unmarried households (Gates et al. 2007: 11).

Attitudes Toward Same-Sex Adoption

Adoption Agency Attitudes Toward Same-Sex Adoption

The Evan B. Donaldson Institute (2006) conducted a national survey of adoption agency policies and practices. This survey revealed increasing agency placements of children in gay male and lesbian foster and adoption homes. These placements indicate that the agencies' actions were based more "in the best interest of the child" than the formal laws of the state. Interestingly, when agency directors were questioned concerning their awareness of the legality of adoptions by gay men and lesbians, not all agency directors were aware of the adoption statutes in their states. Over 5% of the agency directors erroneously reported that gay men and lesbians were banned from adopting in their states and almost 10% reported uncertainty about their state statutes. They found that while almost two-thirds of the agencies had specific policies concerning gay male and lesbian adoptions, these policies focused primarily on the private agency's religious funding stream and the regulations pertaining to the country of origin of intercountry adoptions.

The Evan B. Donaldson Institute considers that gay men and lesbians are valuable assets and should be targets for both foster parent and adoptive home recruitment for children in the child welfare system that need placement (Evan B Donaldson 2006). Gates and colleagues (2007) estimated, from U.S. Census and Adoption and Foster Care Reporting System data, that 6% (14,100) of foster children live with gay male and lesbian parents. About 80% of the households are single parent households, 20% are same-sex unmarried partner households, and about three-fourths are female.

This is not to say that the Donaldson survey found an absence of discrimination against gay men and lesbians. Although agencies and social workers tend to follow the legal imperative of what is in "the best interest of the child" in adoptive placements, there is a valuation of both adoptive children and adoptive parents. The most

acceptable parents are young, married, have high income and educational levels, and are professional. The most valued children are infants and toddlers. Since gay men and lesbians are not the most desired as parents, programs that focused on placing “hard-to-place children” (older children, sibling groups, or children with physical, emotional, and learning challenges) are more likely to accept gay males and lesbians as adoptive parents than programs that placed infants and toddlers.

Public Attitudes Regarding Same-Sex Adoption

The National Survey of Family Growth (The NSFG) is a longitudinal, nationally representative survey in the U.S. of fertility and family growth issues, including fertility and infertility, contraception, adoption, and maternal and child health. The NSFG 2002 Cycle 6⁴ included attitudinal questions concerning adoption and provides additional information concerning gay male and lesbian adoptions (Martinez et al. 2006). The NSFG asked: “Gay or lesbian adults should have the right to adopt children” with forced choice responses of “Agree”, “Neutral”, or “Disagree” (Martinez et al. 2006: 113).

Table 19.7 summarizes the responses by selected social characteristics. Attitudes favoring gay male and lesbian adoptions followed sex and class lines. Overall, females (55.4% compared with 46.9% of males) and those with higher social status were more likely to accept gay male and lesbian adoption. The characteristics of the females who agreed that gay males and lesbian adults should have the right to adopt were: 63.8% of those aged 15–25 and 59.1% of those aged 25–29; 65.3% of those females who had never married and were not cohabiting; 66.3% of those who had no children; 77.2% of those who had no religious preference; 83.8% of those who reported that they were homosexual or bisexual; 61.2% of

those who had a bachelor’s degree or above; 60% of those who were 300% or higher than the poverty level; and 59.1% of those who were non-Hispanic White. The demographics of the males who accepted gay male and lesbian adoptions were: 56.3% of males aged 15–24; 56.6% who had never married; 54.4% of those who had no children; 64.2% of those with no religious preference; 56.3% of males with a bachelors degree or higher education; 49.6% of males who were non-Hispanic White; and 70.4% of males who were homosexual or bisexual. Most notably, the religious characteristics are a strong predictor of whether males and females disagree with the right of gay men and lesbians to adopt, with 80.1% of Fundamentalist Protestant males and 61.6 of Fundamentalist Protestant females indicating that they disagreed. Overall, this suggests a changing climate with growing acceptance of gay male and lesbian adoptions that is especially evident in the Non-Hispanic whites who are educated and have a higher income.

Although the Donaldson survey focused on professional agency attitudes and behaviors and the NSFG on the general public, viewed together both of these surveys suggest changing attitudes and increasing support of gay male and lesbian adoptions.

Conclusion

This chapter presented a history and background on adoption law and policy in the U.S. and used both survey and census data to examine same-sex adoptions. While census data indicate that most of the children in same-sex households are biological children, both past prevalence estimates and the 2000 Census data report gay men and lesbians are currently adopting children. The presence of adopted children in same-sex households lends additional support to a movement by child advocates, researchers, and agency staff supporting gay male and lesbian adoptions.

This movement is bolstered by the weight of scientific research supporting gay male and lesbian adoptions that has led professional child health, social services and medical professional

⁴ This cycle had a response rate of 79% for males and 78% for females, and a total of 12,571 interviews, including 7,643 women aged 15–44, and 4,928 men.

Table 19.7 Percentages of male and female responses to the NSFG Cycle 6 statement “Gay and lesbian adults should have the right to adopt” by characteristics

	Male			Female			
	Agree	Neutral	Disagree	Agree	Neutral	Disagree	
Age	Total	46.9	3.7	49.5	55.4	5.3	39.4
	15–24 years	56.3	3.2	40.5	63.8	4	32.1
	25–29 years	47.5	4.5	48	59.1	5.2	35.7
	30–44 years	40.8	3.7	55.5	49.3	6.1	44.7
Marital status	Currently married	37.3	3.9	58.9	46.8	6.2	47.1
	First marriage	38.7	4.2	57.2	47	6.7	46.3
	Second or later marriages	30	2.6	67.4	45.5	4.3	50.3
	Cohabiting	48.2	5.4	46.4	60.6	6.2	33.2
	Never married not cohabiting	56.6	3.4	40.1	65.3	4	30.8
	Former married not cohabiting	46.3	1.7	52.1	56.1	4.6	39.2
Parity	No children	54.5	3.4	42.2	66.3	4	29.7
	one or more children	38.3	4	57.7	47.6	6.2	46.2
Religion	None	64.2	2.3	33.6	77.2	3.5	19.3
	Fundamentalist protestant	15.9	4	80.1	33	5.4	61.6
	Other protestant	41.1	3.3	55.6	47.6	5.7	46.7
	Catholic	46.2	5.3	48.5	58.1	5.9	36.1
	Other religion	54.2	2.7	43.1	73.1	3.5	23.4
Sexual orientation	Heterosexual	46.2	3.7	50.2	54.7	5.5	39.9
	Homosexual or bisexual	70.4		24.6	83.8	2	14.2
	Other or did not report	43.2	2.6	54.3	45.8	4.7	49.5
Education	Less than high school	28.4	3.2	68.4	41.3	5.7	53.1
	High school	37.7	4.3	58	47.3	6.4	46.3
	Some college	45.9	3	51.1	53.8	6.5	39.7
	Bachelor’s degree or above	56.3	5	38.7	61.2	4.8	34.1
Poverty level	0–149 %	35.8	3.7	60.5	46.8	6.3	47
	0–99 %	38.1	4	57.9	44.1	7	48.8
	150–299 %	39.7	3.6	56.7	48	6.8	45.4
	300 % or higher	50.8	4.2	45	60	5	35
Hispanic	Hispanic	37.2	4.1	58.6	46.7	5.6	47.7
	Non-Hispanic White	49.6	3.6	46.8	59.1	4.9	36
	Non-Hispanic Black	41.8	3.9	54.4	45.5	6.4	48.1

Source: Martinez et al. (2006)

Number: Male=61,147; Female=61,561

organizations to support gay male and lesbian adoptions. The social movement has reached the legislative stage. Congressman Pete Stark of California introduced HR 3827: Every Child Deserves a Family Act on October 15, 2009, which seeks “to prohibit discrimination in adoption or foster care placements based on the sexual orientation, gender identification, or marital status of any prospective adoptive or foster parent” (U.S. Congressional Record 2009). Stark’s bill proposes that since the federal government spends eight

million dollars funding the approximately 500,000 children in the child welfare system, with over 125,000 waiting to be adopted, federal standards should promote eliminating barriers to the placement of children in gay male and lesbian adoptive (and foster) homes. Stark’s legislation is backed by research that shows no negative effects from gay male and lesbian adoptions under current debate. The only real issue appears to be whether legislation will be based on the research evidence indicating only positive benefits to adoptees in gay male

and lesbian families, or anti-gay discrimination that views gay male and lesbian adoptions as threats to children.

There is a severe national need for placement of foster children in adoptive homes. The Donaldson's survey of child placing agencies found that placement of adoptive children in gay male and lesbian adoptive (and foster) homes has already occurred. These placements are supported by agency directors as they are working to providing homes for children, especially the "hard-to-place" children and there have been no indications of negative effects to the children. Further, Martinez and colleagues' (2006: 113) analyses of the National Survey of Family Growth reveals that over half of those surveyed, 55.4%, agree with the statement: "Gay and lesbian adults should have the right to adopt", with an additional 5.3% "neither agreeing nor disagreeing", totaling 60.7%. Thus, it appears that social and political forces are combining, setting the stage for an increase in gay male and lesbian adoptions.

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Introduction

As mandated in Article 1, Section 2 of the U.S. Constitution, those residing in the United States are asked to fill out a census questionnaire every 10 years for the purpose of enumeration of the population. Over time, the U.S. Census Bureau has needed to target particular demographic groups in order to encourage their completion of the census questionnaire. In 2000, a multiple group collaboration of some LGBT (lesbian, gay, bisexual, and transgender) groups implemented an educational campaign which was informally coordinated with the Census Bureau (Williams Institute 2010). The purpose of this campaign was to encourage those who are living in a romantic relationship with someone of the same sex to “be counted” on the census via the “unmarried partner” category which is used to measure cohabitation.

Despite some efforts to increase the identification of LGBT families through the cohabitation question, the Census Bureau continues to struggle over what constitutes the definition of a family, relative, or nonrelative.¹ The Census Bureau defines a household as inclusive of “all of the people who occupy a housing unit as their usual place of residence,” whereas a family is defined as a “group

of two or more people who reside together and who are related by birth, marriage, or adoption” (U.S. Census Bureau 2000). For same-sex couples in 2000, most were not related by marriage because they could not legally marry. Thus, those gay male and lesbian couples who marked a marriage relationship (“husband/wife”) on the 2000 census form were edited to the “unmarried partner” category and measured as part of a household, but not as a family, by the Census Bureau.

Many LGBT families live in a complex household. Complex households are those households that are not simply a nuclear family. Complex households can be very difficult to describe using a census questionnaire. The households may have relatives that do not necessarily fit the census categories provided (e.g. parent, spouse, biological child, or biological sibling). Examples of complex households include, but are not limited to: nonrelatives; unmarried partners; gay partners; more distant kin such as grandparents, cousins, uncles; classificatory kin; fictive kin; children or others who are shared across households; people who may be mobile or ambiguous in terms of household membership (Schwede 2000: vii). Ultimately, these definitions of families and households are rooted in how the state determines measurement of complex households.

Because laws are changing at the federal and state levels concerning gay marriage, civil unions, and domestic partnerships, and because the definitions of categories on the census form are in flux with changes in the family and household

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categories (Smith 1992), I examine in this chapter how lesbian and gay males made sense of familial or nonfamilial categories on the 2000 census questionnaire. I interviewed 28 gay men and lesbians who discuss the 2000 census questionnaire as a legal form and a misenumeration of the LGBT population. I argue that these gay men and lesbians discuss the census form in legalistic terms. Specifically, I ask: How do individual gay and lesbian couples respond to the various census categories available to them? To this end, I discuss how gay and lesbian couples defined the census form as a legal document.

The Census Bureau data are often seen as the best, nationally representative data to which many researchers have access in order to inform political and social policies. Census data influence many policies such as boundaries for redistricting, suggestions for new schools and fire departments, and monies to states for low income people. It is important to have accurate data, which includes enumerating same-sex² couples to make informed policy changes and implementations.

Background of the Census Questionnaire

The Census Bureau follows legal and societal definitions of what is a family or a household. To better enumerate and depict ongoing changes within U.S. families, the Bureau has reorganized and added different categories to the census at different times in history. In the 1970s, different-sex cohabitation increased. To count the number of different-sex cohabiting couples, the 1990 census added an “unmarried partner” category on the census questionnaire for the first time (Bunting 1987); this category was one of those used to describe a non-relative. The 2000 and 2010 census questionnaire and the American Community Survey (ACS) continue to use the “unmarried partner” category to enumerate couples.

In the 1990 and 2000 censuses an “unmarried partner” response was added to the other responses (husband, wife, son, grandfather, etc.) to the census question pertaining to the standard

“relationship to the householder,” i.e., the person in the household designated as person #1. Person #1 is typically “the member of the household in whose name the home is owned, being bought or rented” (Barrett 1994: 16). Every person in the household, except for person #1, thus responds to a question about his/her relationship to person #1. The “unmarried partner” response enables the identification of persons in the household who are unrelated to person #1, but who have a “marriage-like” relationship with person #1. Census procedures allow respondents to check the “unmarried partner” response irrespective of whether the person’s sex is the same as that of person #1. There has been an assumption by many researchers (Baumle et al. 2009; Black et al. 2000, 2004; Gates and Ost 2004; Simmons and O’Connell 2003; Walther and Poston 2004; Walther et al. 2011) that the census numbers are measuring the population of male and female same-sex partnerships. Because of the practice of utilizing the unmarried partner category, there could be numerous issues with census data measuring same-sex couples.

First, the census schedule does not ask about sexual orientation, or the sexual behavior, or the sexual desire(s) of a respondent (which may all vary over one’s lifespan) (Kinsey et al. 1948; Laumann et al. 1994), but asks for the identity to one’s relationship with another such as unmarried partnership. Furthermore, an undercount of the same-sex couples counted in the census may have occurred. For instance, Walther and colleagues (2011) found that Census 2000 undercounted over 41,000 coupled gay men living in the U.S., for an undercount of 11.0%, and undercounted almost 134,000 lesbian partners, for an undercount of 27.9%. Other scholars (Gates and Ost 2004; Badgett and Rogers 2003; Smith and Gates 2001) have also estimated a similar undercount of same-sex couples. Even when a variety of methodologies have been used to test the validity of the census data, the undercount estimates have been surprisingly consistent.

However, some literature suggests that same-sex households may be overcounted in the census and ACS data (U.S. Bureau of the Census 2009; O’Connell and Lofquist 2009; Gates and Sell 2006).

The Census Bureau follows the Federal Defense of Marriage Act which defines marriage as occurring between one man and one woman. Because gay marriage, civil unions, and domestic partnerships are not federally recognized under the Defense of Marriage Act, the Census Bureau allocated all same-sex couples who mark "husband/wife" on the 1990 or 2000 censuses to the unmarried partner category.³ On reexamination of this editing process, O'Connell and Lofquist (2009) estimate that over 40% of the 2000 same-sex households had marked their relationship as a legal married relationship and not as an unmarried partnership relationship. This legal married relationship could be either a same-sex couple who is legally married within a particular state, or a heterosexual couple who is legally married who mismarked their sex on the questionnaire. For different-sex couples, this would not result in a large error; however, for same-sex couples, a relatively smaller group than different-sex couples, this could result in a sizeable overcount of same-sex male and female relationships. Alternately, there is other evidence that the numbers of different-sex couples may have been overcounted, hence resulting in an undercount of the numbers of same-sex couples.

Additionally, the Census Bureau has had difficulty enumerating complex households which may have led to the misenumeration of numerous households in the U.S. (Blumberg and Goerman 2000; Craver 2000; Hewner 2000; Holmes and Amisshah 2002; Kang 2001; Tongue 2000). Schwede (2000) finds that five themes account for the misenumeration of complex households. Misenumeration of complex households can include issues with the relationship question (How are you related to person 1?) and the household type variable (assessing whether the people are a household or a family). For instance, the census questionnaire asks only the relationship of all household members to person #1. A child living in a same-sex household, therefore, could be identified as the biological child of person #1 or, if the child is the biological child of the other partner, s/he could be identified as an adopted child of person #1. A household like this would appear in the census counts to have one parent,

one child, and one unrelated adult living in the household.

In addition to these relationship factors, definitional issues can create problems with capturing the intended population. For individuals who filled out a Spanish census questionnaire, the translation of "unmarried partner" can mean "friend" rather than "a close, personal relationship" (U.S. Census Bureau 2000); this could result in individuals misclassifying their friendship as an unmarried partnership on the census form. Another issue with measuring this type of complex household is that individuals may fear and mistrust the government and its pledges of confidentiality. Badgett and Rogers (2003) found that lesbian and gay couples who disguised their relationship on the 2000 census indicated that one of the reasons for doing so was due to mistrust of the government's pledge of confidentiality. Similar, Cainkar (2009) finds that many Muslim and Arab Americans mistrusted the pledge of confidentiality of the Census Bureau.

These limitations of census data can be further influenced by the policies that the Census Bureau may follow.

Policy Forces upon the Census Bureau

Three main policies impact the census questionnaire and enumerating same-sex households: (1) cultural norms; (2) federal and state laws; and (3) religious attitudes directed at homosexuality. Cultural norms around sexuality have historically assumed and privileged heterosexuality and heteronormativity (Giuffre and Williams 1994; Ingraham 2008). One impact of the dominant structuring power of heteronormativity relates to family formation in the ideology of the Standard North American Family (SNAF). SNAF is described as an adult male who is in the paid labor force and the woman's primary responsibility is caring for her husband and children (Smith 1993). Although the nuclear family type comprises only about 10% of the 2000 U.S. population (Lichter and Qian 2005), its ideological force infuses a wide range of discourses and institutions, such as the Census Bureau and

census schedules. Specifically, the “unmarried partner” category remains on the “non-family” column of the census schedule, suggesting that both different-sex and same-sex unmarried couples are “non-family” members living within the same household.

Secondly, federal and state laws deter the Census Bureau from modifying the census form to incorporate gay and lesbian couples. Perceived assaults on the primacy of heterosexual marriage and SNAF via same-sex marriages, civil unions, and domestic partnerships in the 1990s prompted national legislation, the Federal Defense of Marriage Act (DOMA). Section 3 specifically defines marriage and spouse, stating:

In determining the meaning of any Act of Congress, or of any ruling, regulation, or interpretation of the various administrative bureaus and agencies of the United States, the word “marriage” means only a legal union between one man and one woman, a husband and wife, and the word “spouse” refers only to a person of the opposite sex who is a husband or a wife (Federal Code 2419).

Contrary to usual federalist precedents that uphold legal declarations in other states, including marriage certificates, wills, and adoptions, Section 2 of this same act nullified this provision, again stating:

no state...shall be required to give effect to any public act, record or judicial proceeding in any other state...respecting a relationship between persons of the same sex that is treated as a marriage under the laws of such other state,...or a right or claim arising from such relationship (Defense of Marriage Act of 1996).

Additionally, at the state level, over 30 states have a state DOMA or a constitutional amendment that defines marriage as occurring between one man and one woman. While some states have modified their laws about marriage (New York for example allows gay marriage; Illinois allows civil unions between individuals of the same gender), the federal DOMA still defines marriage between one man and one woman. Since the Census Bureau is a federal institution, the Census Bureau must follow federal laws and codes and therefore not modify the census schedule to enumerate same-sex couples. It was not until 2008, that

the Census Bureau began publically publishing married same-sex couple numbers and unmarried partners of the same-sex numbers (Chamie and Mirkin 2011). Badgett and colleagues (2011) suggest that the Census Bureau is currently trying to analyzing how to best measure gay and lesbian couples with so many different federal and state laws and codes.

Thirdly, a tremendous amount of research has examined religion and sexualities. In general, conservative Christians do not support same-sex marriage (Olson et al. 2006). Researchers demonstrate that an increase in religious attendance to conservative churches decreases one’s tolerance for homosexuals. Furthermore, individuals who have high religious attendance and affiliation with Protestant conservative denominations are less tolerant of homosexuals (Sherkat 2001; Ellison and Sherkat 1990, 1995; Hunt and Hunt 2001; Finlay and Walther 2003). Moreover, conservative Christian social movements and think tanks (such as Focus on the Family) do not support same-sex marriage. Many conservative Christian denominations and groups would not support enumerating same-sex couples using the census schedule. In summary, these three policies would suggest that it would be difficult for the Census Bureau to modify the census schedule to enumerate both same-sex couples who are cohabitating and same-sex couples who are legally married or in a civil union.

Methodology

I interviewed 28 self-identified gay and lesbian individuals who were in relationships in 2000. One male couple and one female couple were interviewed together. Twenty-four gay and lesbian individuals were interviewed separately, but were in a relationship at the time the 2000 Census was conducted. After asking the interviewees about demographic characteristics (year of birth, race/ethnicity, etc.), how they met their partner and how long they had been with their partner, I gave each interviewee a 2000 census schedule short form, and I asked the interviewees to verbally answer the question about the relationship

to "Person 1" for their partner. The interviewee acted as if they were Person 1 and the interviewee was answering for their partner. I followed with questions about their selection of a category for Person 2, i.e. the selection they made for their partner. Specifically, I examined why they would select a certain category (spouse, unmarried partner, etc.), with follow-up questions about why they may have selected that category. Additionally, I asked their opinions of the census schedule and how they might improve the census form.

I utilized purposeful sampling of male and female same-sex couples from various networks (Babbie 2009). I recruited subjects from gay and lesbian events in urban, suburban, and rural communities in a southwest state, such as LGBT dances, Christian churches who had LGBT congregants among their membership, and LGBT professional organizations. The communities in which I conducted these interviews have extensive gay and lesbian networks. Many of the interviewees for this study have sold houses to each other, watched their children together, and sent their children to the same schools. The interviews lasted from one hour to two and half hours. Once saturation point occurred, that is, I was not gaining any new information, I analyzed the interviews. In order to provide a more comprehensive understanding of and effectively analyze the interviews, I first began by transcribing all my interviews and read the text of the interviews. As I reread the text from the interviews, I employed the constant comparative method to discern central and recurring themes (Glaser and Strauss 1967). I grouped ideas about themes together to discern and form broadly encompassing categories and metacategories. These encompassing categories and metacategories led to the themes I discuss below.

Constant comparative method is generally associated with Glaser and Strauss' (1967) grounded theory methodology, in which it is used to develop substantive theory (Charmaz 2006; Harry et al. 2005; Strauss and Corbin 1990). However, it is also "compatible with the inductive, concept-building orientation of all qualitative research," (Merriam 2009: 199) and is thus a useful tool for data analysis for many qualitative researchers. Denzin and Lincoln (2005) also state

that the constant comparative method focuses on constructing meaning from the patterns emerging from data.

Demographically, my interviewees were predominately white female same-sex couples, with higher than average household incomes when compared to the 2000 national census same-sex data. There are 7 men (25%) and 21 women (75%) among the interviewees. The average age is 39 years for the 28 interviews. The average household income for the subjects is almost \$75,000, with a maximum of \$400,000 and a minimum of \$20,000. Seventy percent of the interviewees self-identify their race or ethnicity as white. The interviewees are highly educated, with all interviewees having at least some college (one interviewee has an associate degree), and 23% of the interviewees having a PhD or professional degree (Table 20.1).

Limitations of the study include the number of interviews and the demographic characteristics of the interviewees. Furthermore, because this study was conducted via networks, many of the interviewees have similar demographic characteristics. Future research should examine more diverse LGBT individuals, as exemplified by Moore's (2011) recent study of Black lesbian families.

In this chapter, I discuss three themes from the interviews. I discuss specifically how gay men and lesbians marked the 2000 census questionnaire, struggling over how to define their relationship into fixed census categories. Secondly, I examine the way in which the interviewees utilize legalistic language when discussing how they marked their relationship. Third, I explore how the interviewees discuss the misenumeration of gay men and lesbians on the 2000 census form.

How Did Gay Men and Lesbians Mark the 2000 Census Questionnaire?

The interviewees marked their relationship on the 2000 census form based upon how they defined their relationship to their partner or how they disguised their relationship to their partner. Some marked that they were single and thus did not

Table 20.1 Demographic characteristics of interviewees

Pseudonym	Age	Education	Income	Race/ethnicity	Prior heterosexual marriage	Children's ages	Partnered with
Tristan	43	Bachelor	62,500	White	No		Matthew
Matthew	42	Bachelor	62,500	White	No		Tristan
Madeline	52	Bachelor	90,000	Texan	No	12	
Heather	45	Master	12,000	White	No	8,6, 3	
Leigh	40	Bachelor	75,000	White	No	8	
Ryan	44	Bachelor	44,000	Hispanic	No		
Natalie	39	MD	400,000	White	Yes	6, 14 months	
Jenny	42	Bachelor	47,000	White	No		Ava
Ava	37	PhD	47,000	White	No		Jenny
Candace	35	Master	40,000	Caucasian	No		
Brianna	34	Bachelor	Middle class	Caucasian	Yes		Jasmine
Jasmine	53	Master	Middle/upper class	Caucasian	Yes	Adult	Brianna
Chloe	35	Master	40,000	Caucasian	Yes		Aimee
Aimee	40	PhD	Upper class	Caucasian	No		Chloe
Larry	36	Master	100,000	White	No	Trying to adopt	David
David	31	Bachelor	100,000	Hispanic	No	Trying to adopt	Larry
Abigail	28	Master	21,600	Black	No		
Barbara	41	Master	95,000	African American	No	15	Christina
Christina	38	Master	95,000	Chicana	Yes	15	Barbara
Sam	57	Associates	25,000	German	No		Toby
Toby	34	Master	35,000	Asian	No		Sam
Randi	29	Bachelor	20,000	Chinese American	No		
Becky	29	PhD	40,000	White	Yes		Emma
Emma	45	Bachelor	30,000	White	No		Becky
Jessica	30	Bachelor	30,000	Hispanic and Asian	No		
Michelle	24	Bachelor		Caucasian	No		Lori
Lori	27	Bachelor		Caucasian	No		Michelle
Xavier	41	PhD	60,000	Hispanic	Yes		

mark a relationship to Person 1 on the census questionnaire. Other interviewees marked their partner on the 2000 census questionnaire in three ways, in relationship to Person 1: (1) husband/wife; (2) unmarried partner; and (3) roommate/housemate. Significantly more people marked "single" or "unmarried partner," than "housemate/roommate" or "husband/wife." Fifty-four percent (N=12) of the interviewees marked "single" on the 2000 census, even though the person was in a relationship at the time the census was conducted. Of these interviewees, they either did not mark down that a second person lived in the household or they asked for a second census form. The next most marked category was "unmarried partner" with almost 32% (N=7) of the interviewees marking this category. Very few (N=3) of the interviewees marked the "husband/wife" category. These results are much different than Gates' (2010) findings for the 2010 census data. In his survey, Gates (2010: 3) found that 71.3% of respondents marked unmarried partner; 9.7% marked roommate/other; 4.7% marked neither partner as person #1; and 14.2% marked husband/wife. Additionally, those couples who were living in states where gay marriage is allowed consistently marked their relationship in the husband/wife category.

For my interviewees, the biggest factor in picking a category was the duration of the relationship. If the relationship was new, then the couples tended to mark housemate/roommate or single. For instance, Margaret and Joanne had recently started a relationship and had just moved in together. At the time of the 2000 census questionnaire, they lived in separate households. Margaret suggests that because of the newness of their relationship she would have picked housemate/roommate. Margaret stated,

Well, I'm not sure but I would either pick for Joanne or I mean Joanne and I would talk about it.... I would either say housemate or roommate or unmarried partner depending on how she felt about it and... I imagine we would talk about what it would mean to say unmarried partner and if there would be any ramifications for that and...if there might be positive reasons to say unmarried partner so that we were counted as lesbians and not as assumed straight people, straight women living together. Housemates/roommates, ...but

also we have not been together that long so I wouldn't necessarily apply the term partner to her in other circumstances. They don't give the option girlfriend so...either partner or roommate I guess would be the closest answer.

Margaret struggles to define the category that her relationship is in. She varies from filling it out herself without a discussion with Joanne, to having an in-depth discussion with Joanne, to choosing "either partner or roommate."

The struggle over which category to choose was common. At work and among heterosexual friends, one couple was known as housemates, but on the census questionnaire Paula defines her relationship as an unmarried partnership. She states:

Well, I don't know if we should say married, but probably, well, but everybody knows us as housemates, but I don't know. I would, in my personal opinion? Okay, then I'm an unmarried partner.

In these cases, respondents could not categorize their relationship into set census categories, but waffle on how to mark their relationships.

Others were adamant about their choice and had few problems defining the significance of their relationship. For these respondents, the emphasis was placed upon the strength of the relationship. For example, Candace, a white graduate student attending seminary, and Andrea had been in a relationship for 5 years. As Candace examined the census questionnaire, she stated that she marked unmarried partner. She says that she chose unmarried partner "because she is more than householder, roommate, more than roomer or boarder. She's not an other, non-relative. I thought about putting other relative, and putting partner, to put exact relationship. But unmarried partner probably comes closest." Candace provides significance to the category of partner. She examines all of the categories and determines the best category for her significant other is partner. Aimee, a White counselor who had been with her partner for over 20 years, made similar comments. She stated:

Aimee: Is there a partner choice? I picked that one.

Interviewer: The unmarried partner.

Aimee: Yea yea, that's what I put.

Interviewer: Okay, so why did you pick that one?

Aimee: Because that's the truth. You know, ten years ago I would talk about my roommate. She's not my roommate, she's not my friend, she's my partner.

For Aimee, 10 years ago she would have classified her partner as a roommate, not a partner. Aimee suggests that she picked unmarried partner because of the length of the relationship, but she could have also chosen unmarried partner because of cultural shifts in society. However, because she has been with her significant other for 10 years, she defines her as a partner. Aimee places significance upon the category of partner. Because at the time of my interview, very few states allowed gay men and lesbians to marry and because the census categories are viewed as fixed categories, many of the interviewees marked unmarried partner. However, as I will discuss later, many of the interviewees saw the form as a legal document that needed to be filled out in accordance with federal definitions of marriage.

Three interviewees defined their relationship to the head of household as "husband/wife." Larry and David had met in college and been together for 10 years at the time of the interview. They were pursuing adoption of a child. When Larry and David were shown the 2000 census questionnaire, Larry stated he would choose "husband," because "that's *how I perceive ourselves to be*, and I filled out other forms the same way" (italics added). Because Jeff and John perceived themselves as a married couple, they marked their relationship as if they were married at the time of the census.

At the time of the interviews, very few interviewees could legally marry. Thus, many of the interviewees used census categories to fit their relationship into a category that may not fit their relationship in everyday life (Badgett and Rogers 2003). The categories of relationship or non-relationship on the census form suggest that couples make a decision on how they will mark their relationship even if it is not congruent with everyday life.

Others had various problems with filling out the census form. Two people had just recently moved. A few couples had recently moved into a

shared living space. For instance, Xavier had accepted a new job in a different city. He felt that his home was with his partner, Don. He assumes that Don filled out the census form. Xavier states, "Don got it in [another city]?... See I was moving March or April of 2000. See we probably got it in [another city]. Don probably filled it out." In this case, Xavier believes that Don counted him in his household in another city.

Kenneth Pewitt (2003), previous Census Bureau Chief, notes that he had a similar problem. His family was living in a different location while he was living in Washington D.C. While his home was with his family, he also received a short form of the 2000 census questionnaire at his apartment. Romero (1993) found that although multiple families often lived within the same household, only one family/home was listed on the mailbox and residential documents, e.g. utility bills and apartment leases. This one family would be counted in the census, while missing all the others. In all of these cases, specific contextual factors such as poverty, temporality, and deportation fears led to the creation of unique households in different U.S. locations.

In another complicating situation, Brianna's partner was legally married to her separated husband at the time the census questionnaire reached their door. Both Brianna and Jasmine had previously been heterosexually married. When filling out the census form during the interview, Brianna commented that,

Well, I don't know cause she is still married. I don't know if you have to do this legally. Probably. Everyone knows us as housemates. I don't know. I...would...let's see. I'm Person 2. Then, I am unmarried partner. Yes.

Many households are in flux when the census occurs. In one case, in the town of Woodland, Oregon, Montoya (1992) observed the establishment of "ad hoc" households, created in response to poverty and a lack of affordable housing. The relationships to each other in these households were maintained based on the allocation of money. In some cases, people living within the ad hoc households did not know the identities of others. Those who were enumerated were those who coincided with the enumerator's visit.

In another situation, in Florida, a high degree of fluctuation and mobility influenced Haitian households, such that some household members were described by others as “just passing through.” Residence by any one household member ranged anywhere from 2 weeks to 4 years (Wingerd 1992). As such, in both instances, those who were enumerated were those whose residence coincided with the enumerator’s visit. Although at the time of the interview, Brianna might have chosen the unmarried partner category, her partner was legally in a heterosexual marriage. This caused Brianna trouble in determining how to mark their relationship on the census questionnaire.

Legal Interpretation of the 2000 Census Questionnaire

In my interviews, the continual discussion about gay marriage framed how the interviewees viewed the census questionnaire. Some interviewees made legal distinctions on which category they chose. When I asked if interviewees would fill out the census form in a different manner, the interviewees tended to respond in legalistic terms. For instance, Tristan and Matthew, who met at a university that they attended as undergraduates and have been a couple for over 20 years, stated that they marked the ‘unmarried category’. But when I asked if they would ever mark ‘husband,’ they responded as to why they would not by stating:

Matthew: Because they won’t recognize gay marriage.

Tristan: Recently I was doing a survey by Jack in the Box, the ones that you go to the web and do the number off the receipt, and I actually wrote them in the comments box because they had significant other on there. And I feel that significant other is much more meaningful than unmarried partner. Or civil unions; we don’t have a problem with ‘other’ because from our standpoint we want marriage for the legal benefits, and that goes back to what you believe; that you should be showing your commitment through your actions. So that other people can see that you are committed to each other. Most people don’t know us as anything other than Matthew and Tristan. Because they always see us together. And it is in part that we are always together, as you can tell we talk in stereo together.

And so I was very happy with the significant other option on there, rather than having to check other or none sometimes. Unmarried partner isn’t used a lot. Usually it is single or married...

Matthew: Single, married or divorced. Since it’s a legal document, probably not. But we refer to ourselves as husbands.

Tristan: When we are asked for a beneficiary on an insurance form and they ask the relationship, at the point we put husband. If it is an IRS form, and we know what definition they are going by, then we follow the definition because we feel that it is important.

For Matthew and Tristan, they would mark single on the census questionnaire, because the census questionnaire was interpreted as a legal form. Matthew and Tristan suggested that they understood the question, but decided to not mark their relationship on the census questionnaire. Another couple discussed not marking unmarried partner or wife on the census questionnaire, because they were suspicious of the government knowing about their relationship. In Matthew and Tristan’s case, they did not mark their relationship because they constructed it as a legal document that should not be falsified.

Badgett and Roger (2003) found two reasons that gay men and lesbian couples camouflage their relationship. First, gay men and lesbians have concerns about confidentiality of their responses on the census questionnaire and may camouflage their relationship to their partner by not marking a relationship to their partner on a census form. Second, the census category does not accurately reflect their relationship. These data suggest support for both of Badgett and Roger’s (2003) findings.

Furthermore, Madeline, a white working class woman who has been in a relationship with her partner for over 20 years and raising a daughter, referred to her partner as a spouse in their everyday lives. On the census questionnaire, she marked ‘unmarried partner.’ She indicated she selected ‘unmarried partner’ because: “[W]e aren’t married because the law won’t allow it. So we have to call it a partnership. Because the law sucks.” She is aware of the law and even describes it as “suck[ing]” because she feels as if they are married.

Additionally, Heather, a white university professor who is raising three children, was not clear

about the marriage law in the state. She marked “unmarried partner” on the census questionnaire, but when I asked if she would have considered marking wife as a census category, she stated:

I have referred to her as my wife, and I suppose now in certain states, then yes a person could refer to them as wife. In 2000 I can’t remember if it was legal in certain states. I affectionately refer to her as my wife, but I know that I am not legally married to her, and that I wouldn’t on a census form refer to somebody as my wife.

During the interview Heather divulged that although she and her partner were recently separated, they had included each other on insurance forms, and her partner had a guardian ad litem for their three children. In everyday life, they had labeled their relationship as spouses, but on the census form Heather did not mark ‘wife’ because she was not “legally married” to her partner. Furthermore, she is unsure of her legal status in the state about being married. She falsely (at the time of the interview) asserts that in some states she and her partner would have the option to be married. Heather’s interview demonstrates the difference between personal and public spheres; differing social practices, contexts, and laws require different language. Insurance and guardian *ad litem* forms can come to the public sphere, however, the census questionnaire remains anonymous for more than 70 years. Thus, the legal forms that are the least secure, gay men and lesbians fill out with a marriage-type of relationship validated on the form, while the census questionnaire that is considered the most secure is not.

In a similar manner, Chloe refers to her partner, Brooke, as unmarried partner. She defines their relationship on the census questionnaire as “unmarried partner.” When asked if she would ever mark wife, she states:

Not seriously. Because I think the most accurate term is unmarried partner. In legal terms we are unmarried partners, but if anything were to happen to one of us, I would call her my wife because that’s how we are emotionally.

In the above quote, Chloe labels her relationship as spouse, indicating she is “my wife because that’s how we are emotionally,” but on

a census questionnaire, she clearly delineates the relationship as an ‘unmarried partner.’ Again, Chloe demonstrates legal language in the public sphere, while in the private sphere Chloe calls her partner “wife.” In all of these quotes, interviewees understood the legal climate and their status as not legally married. In all the above quotes, people understood what the relationship question was asking, but defined the census questionnaire as a legal document.

Enumeration and Misenumeration: Power in Numbers

Many of my interviewees want to be counted as same-sex couples by the Census Bureau, however others argued against being counted as same-sex couples. I first discuss those who expressed a willingness to be counted. Some interviewees would like the Census Bureau to collect data about gay men and lesbians. Christina, for example, believes that the 10% figure that estimates the number of gay men and lesbians living in the United States (Kinsey et al. 1948) is too low. She states,

Yes, because I think that 10 percent is a low number. But that is kind of out there, and I really think that there are more, and that data can really affect the laws that are being created and those laws can improve the lives of gay people. Particularly the poor, I know a lot of gay people at the poverty level, and there could be laws that would improve their lives, like getting tax breaks. And it could bring an awareness that everybody isn’t heterosexual.

Christina asserts that policies and laws can be changed by being enumerated by the Census Bureau. Gay men and lesbians could gain resources related to being counted by the Census Bureau.

Madeline also believed there is value in being counted on the census questionnaire. She asserts,

Personally, yes. I don’t think there is anything wrong with it. I think that anonymity is our biggest downfall. I don’t see any reason why anybody would want to count how many Blacks, how many Asians, how many queers. But if they wanted to, I don’t have any reason why I wouldn’t stand up and say “Yes, I am.” However, most of my friends

are professionals, and they don't want the closet door open. And will not be counted.

Interestingly, Madeline's partner is a teacher in a rural district and must walk a line between being "out" and too "out." Furthermore, Madeline compares queers with Blacks and Asians, in that if racial groups are counted then queers should also be counted. For Madeline, being counted suggests being out of the closet and having others aware of her sexual identity. Madeline judges others as living in the closet and thus would not be counted by the Census Bureau.

Leigh argues that gay men and lesbians should be counted by the Census Bureau, but does not believe that all gay men and lesbians would be willing to be counted. As we saw above with Madeline, Leigh states,

Yes. Because I think we are under-counted. People don't think there are very many of us. I think the stereotypical 10% of us is very low. But I don't think that everyone would honestly do it.

Conclusion

How does one represent a relationship that is not categorized on the census schedule? Not very well, according to these findings. Many people decided to be counted as single, with a few of my interviewees requesting additional census schedules to hide a same-sex relationship. Additionally, many of the interviewees could not just pick one category and state that it was the category that represents their relationship.

Phua and Kaufman (1999) postulated that lesbian and gay couples did not understand the relationship question on the 1990 census schedule. I find no support for this suggestion. The people in my study understood the relationship question on the census schedule, but did not support the categories in which they could mark their relationship or laws deterred them from marking their relationship on the census form. Therefore, these findings suggest that the number of same-sex couples may be under enumerated with the current census form, similar to previous work (Gates and Ost 2004; Badgett and

Rogers 2003; Smith and Gates 2001; Walther et al. 2011).

Overall, there are numerous problems with "being counted" on the census schedule. Once the Census Bureau gets beyond just counting bodies, representation of that individual becomes an issue. The couples in my study thought authentically about their relationship to their partner and they believed that the census form categories did not recognize their relationship to each other. Similar results are found about race and ethnicity and representation on censuses (Rodríguez 2000; Williams 2006).

Badgett and her colleagues (2011) suggest that the census form should be fundamentally changed to reflect the changes in household and family structures. Other countries, such as Canada, France, Denmark, and other Nordic countries, have changed their census schedules to reflect the change in union laws and household formations (Noack et al. 2005). If the census schedule had better measures of same-sex relationships, various analyses of social policies could occur, such as divorce rates among same-sex couples. For example, Noack and colleagues (2005) found that "pioneer couples," couples in Norway who became married as soon as the laws were changed, were more likely to remain married. Others (Andersson et al. 2006; Gallagher and Baker 2004) find that lesbian couples are more likely to divorce than gay male couples in Norway and Sweden. Other analyses, such as educational attainment of children raised by same-sex couples (Rosenfeld 2010), could have more validity with improved measurement of same-sex relationships. While census data remain the best national data for same-sex couples, this chapter suggests that the data may be potentially flawed. These data, thus, call into question how to formulate social and political policies surrounding gay and lesbian couples when the data have been shown to be potentially flawed.

Notes

1. The census questionnaire does not ask about sexual orientation identity, behaviors, or desires. Since the 1970 census form, individuals can

answer the census questions themselves. Individuals marked their race, ethnicity, gender, family or household relationship to the head of the household (Person 1) (U.S. Census Bureau 2000).

2. In the chapter, I use same-sex, same-sex, and gay men and lesbians interchangeably. As many scholars point out “sex” is usually referring to a biological designation such as a child born XX or XY (Fausto-Sterling 2000). Gender has usually referred to individuals performing a specific gender role such as wearing a dress or a suit (West and Zimmerman 1987). Even though I have interviewees who are transgender (biological born as one sex, but living as a different gender than birth) who were self-identified as gay or lesbian, I use same-sex throughout the chapter because it is the most commonly used in demographic literature. Additionally, all my interviewees self-identified as gay, lesbian, or queer. Therefore, I utilize gay men or lesbian in the chapter.
3. Similarly race and ethnicity identification on census forms suggests that people’s ideas about race and ethnicity may change at the individual level, but also could be edited once received by the Census Bureau (Kertzer and Arel 2001; Rodríguez 1992, 2000). Categories of race and ethnicity have changed throughout the history of the census questionnaire (Anderson 1988; Lee 1993).

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Part VI

Conclusion

Amanda K. Baumle

Introduction

Demography is an ever-evolving field of study, which has moved well beyond the core fields of fertility, mortality, and migration.¹ As evidenced in Poston and Micklin's (2005) *Handbook of Population*, the discipline now includes at least two dozen subfields, such as marriage and family, the labor force, biodemography, historical demography, race and ethnicity, and gender. The incorporation of population research on sexuality, therefore, is in many ways simply a continuation of the expansion of the field. As described in this handbook, demographic research increasingly reveals insight into both population patterns on sexual behaviors and identities, as well as the manner in which sexuality affects other demographic outcomes. These findings are likely to contribute to a growth in data collected, and research conducted, on population sexuality.

In this concluding chapter, I draw upon some of the research presented within the handbook

chapters in order to explore the ways in which sexuality research can contribute to the field of demography and to policy concerns. In addition, I consider some of the future research needs – particularly data needs – for the demography of sexuality.

The Contributions of a Demography of Sexuality

In this handbook, the chapter authors have demonstrated the importance of gaining a greater understanding of sexual behavior and identity. Certainly, the information gleaned from demographic analyses of sexual behavior is notable in terms of its health and reproduction implications. For example, Djamba's (Chap. 6) discussion of sexual practices in Africa highlights the ways in which cultural differences in sexual behaviors could raise new health concerns; this is particularly true for practices such as "dry sex" that have important implications for risks of STIs. Similarly, Farris and colleagues (Chap. 7) find that gay identity translates into different behaviors and risks for individuals in China than in some other parts of the world, due in large part to the strong normative importance of heterosexual marriage in China.

Gayet and colleagues (Chap. 5) also examine the manner in which health and fertility outcomes are affected by cultural differences in sexual behaviors. For example, they note that there is a great

¹ Portions of this chapter are revised or reprinted by permission from *Same-Sex Partners: The Social Demography of Sexual Orientation* by Amanda K. Baumle, D'Lane R. Compton, and Dudley L. Poston Jr., the State University of New York Press ©2009, State University of New York.

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deal of cultural variation in age at first intercourse (i.e. length of virginity) within the Latin American and Caribbean countries which affects exposure to disease, as well as fertility outcomes. Chandra and colleagues (Chap. 4) present the ways in which sexual behaviors vary across sex and race and ethnicity in the United States, which lead to different outcomes regarding disease risk and pregnancy. These, and other, findings from studies of population sexuality are important for health policy and fertility planning. Although the use of sexuality data for studying health and reproduction is not new, demographic studies can make significant contributions in terms of gathering data on a wider range of sexual behaviors (such as suggested by Djamba, for example) in order to better capture cultural variations which could contribute to health and reproduction outcomes.

In addition to the more standard use of population data for health and reproduction issues, demographers have much to offer in terms of gaining a better understanding of the role of sexual behavior throughout the life course. Pearson and Wilkinson (Chap. 9) detail the manner in which adolescents experience sexual coming-of-age. These data not only provide information about exposure to sexual risks, but also can highlight the manner in which important cultural messages regarding gender and relationships are transmitted to adolescents and, subsequently, translated into action. Schwartz and colleagues' (Chap. 8) description of sexuality within relationships illustrates that one's satisfaction within a relationship, and the longevity of that relationship, is often dependent on the sexual interaction. These findings have important policy implications for family and marriage stability. Kontula's (Chap. 10) analysis of sexuality among older adults is significant not only in terms of health risks for this population, but also in understanding the role of sex in producing psychological well-being among an aging population.

A significant focus of this handbook lies in examining whether and how non-heterosexual individuals have different demographic outcomes than do heterosexuals. It is this area in particular that has seen a surge in research in recent years – particularly by those who are not “demographers”

per se. And it is in this area that demographers still have much to contribute. Gaining a greater understanding of the prevalence of various sexual orientations and gender identities (as discussed by Carpenter on gay men and lesbians (Chap. 11), Bogaert on asexual (Chap. 15), and Meier and Labuski (Chap. 16) on transgender persons) can provide important policy contributions in terms of establishing the existence and size of identity groups. For instance, as detailed by Meier and Labuski, better data on the transgender population are desperately needed to both better serve the population's health requirements, but also to establish the need for laws protecting gender identity.

Further, studies on prevalence allow us to unwrap the notion of sexual orientation as an identity label versus as a behavior. By studying the differences in prevalence between those who engage, for example, in same-sex sexual behavior versus those who identify as gay or lesbian, we are able to better understand whether behaviors versus identities have implications for other demographic outcomes. For example, would an individual who engages in same-sex sexual behavior, but does not identify as gay or lesbian, be exposed to the same risk of discrimination? Data on prevalence that can separate these two dynamics of sexuality are able to shed light on questions such as these.

In addition to prevalence, demographers are able to study the role of sexual orientation or gender identity in affecting demographic outcomes. In this handbook, summaries of the current state of knowledge on sexual orientation and geographic distribution (Gates, Chap. 12), labor market outcomes (Baumle, Chap. 13), and family composition (Compton, Chap. 14) are explored. Much like demography of gender, this research illustrates that sexual orientation serves to shape one's mobility, economics, and family decisions. Research on these topics of population sexuality has played a vital role in several policy arenas. Data on geographic distribution have recently been used in policy-related work that explores the economic impact of same-sex marriage for states (see e.g. Badgett et al. 2009). Studies on economic outcomes for LGBT persons have also been recently used to analyze the merit of the proposed Employment Non-Discrimination Act

of 2011 (The Williams Institute 2012). Also studies on the characteristics of same-sex couples as parents have served as fodder for those arguing both for and against same-sex marriage or gay adoption (see e.g. Regnerus 2012; Bos et al. 2012; Baumle and Compton 2011).

The use of data on population sexuality for policy considerations is more directly examined within this handbook in the fourth section of the book. As detailed by De Angelis and colleagues (Chap. 18), data on military service of same-sex partners from the U.S. Census, as well as data from directly surveying current military members, played a fundamental role in the repeal of the Don't Ask, Don't Tell policy. Similarly, Badgett (Chap. 17) highlights the manner in which same-sex marriage, civil unions, and other partnership recognition methods have been utilized within the states which permit them; this analysis demonstrates the potential use and efficacy of an extension of marriage laws. Davis (Chap. 19) looks to international adoption laws and policies that affect the type of families constructed by gay and lesbian individuals. And Walther (Chap. 20) considers the manner in which current legislation affects both how we ask questions about sexual orientation on the U.S. Census, and how individuals choose to answer those questions.

Studies on population sexuality, therefore, carry a number of implications for health, economics, and families, as well as related policies. Given this, demographic analyses such as the ones reviewed in this handbook are an important step toward generating a representative picture of sexual behaviors and identities. In the following section, I highlight some of the ways in which better data and methods might permit demographers to make additional contributions to the current body of knowledge about population sexuality.

Data and Methods

Throughout this handbook, but particularly in the chapters written by Michaels (Chap. 2) and Gates (Chap. 3), some of the methodological limitations that have contributed to the scarcity of demographic

research on sexuality are highlighted. Few datasets which examine demographic issues incorporate questions designed to capture sexual behaviors or identities. And there is a virtual absence of questions on gender identity in representative population surveys. For those surveys which do contain questions regarding sexual behavior or identity, many were not designed with the purpose of sexuality research in mind. For example, the U.S. census data, referenced throughout this handbook, are limited because capturing data on same-sex unmarried partners is a by-product of a variable that was developed to measure cohabitation. Rarely are issues of orientation a primary focus in quantitative data collection, and even when more direct questions are asked, the motivations tend to be more political than demographic. As explored by Michaels and Gates, then, there is a real need to move to datasets with more focused questions on sexual behaviors and identities.

The censuses in some countries have attempted to address some of the uncertainty in data collection regarding same-sex couples. This has been spurred, particularly, by the changes in the legal status of the relationships of gay men and lesbians. The Canadian census questionnaire includes a category for same-sex couples who have entered into common-law marital relationships to differentiate such relationships on the census. And in the United Kingdom, the marital status question on the 2011 census was expanded in order to incorporate changes in the legal recognition of same-sex relationships (Townley 2006). In the United States, movement has been made toward releasing data that more directly highlight the differences between married and unmarried same-sex partners (O'Connell and Lofquist 2009), but due to the Defense of Marriage Act there continues to be a prohibition on directly collecting data about legal same-sex marriages.

For demographic research that goes beyond same-sex relationships, the ideal dataset would incorporate questions that ask specifically about sexual behavior or sexual identity. For example, a question about sexual orientation included on national censuses would permit demographers to analyze fundamental population questions with large sample sizes. Some have advocated for the

inclusion of such a question on national censuses in order to both collect demographic data and to “monitor equality legislation and improve the service provision to lesbian, gay and bisexual people” (Townley 2006; see also McManus 2003). Although some have expressed concerns regarding privacy if such questions were added to censuses, many census questionnaires have for decades included questions about other personal, private demographic characteristics such as race, ethnicity, ancestry, and age. Further, censuses regularly include questions regarding income, which has been found to have a higher non-response rate than do questions about sexual orientation (see Chaps. 2 and 3). The chapters in this handbook have demonstrated that sexual orientation in particular is a characteristic that, much like race, ethnicity, ancestry, and age, has a strong influence on demographic outcomes. This suggests that it would perhaps make sense to collect such data.

As explored by Gates in Chap. 3, it is important to recognize that the type of population data sought will play an important role in shaping the best way in which to ask survey questions on sexual orientation. Questions related to identity might prove most useful in scenarios where the possible effects of discrimination are being measured (McManus 2003). For instance, in a labor market analysis, it might be more important to look at whether individuals identified as gay men or lesbians in order to determine whether they are likely to have disclosed their identity in the workplace and, thus, made themselves vulnerable to discrimination (Baumle and Poston 2011; Badgett 2001). In analyses attempting to assess the way in which sexual orientation affects individual decisions, however, identity might not be the best measure of orientation. In a study of parenthood, for example, one’s orientation could affect the likelihood of children being in the household based on actual identity, e.g. gay identity leading to inability to adopt a child. But sexual behavior itself might be a stronger predictor of whether a child is in the household, as lack of different-sex sexual experiences could lead to the absence of a child in the household; this would be the case regardless of whether the individual *identified* as gay or lesbian. Thus, the particular research question being asked plays a strong role in framing the best way in which to ask about sexual

orientation. These considerations should enter into the construction of new datasets on sexuality.

Although demographers typically operate within the realm of survey data and quantitative analyses, the role of qualitative research in fleshing out the quantitative should also not be overlooked (see e.g. Baumle and Compton 2011; Baumle et al. 2009). As Riley (2005) observed in the case of gender demography, qualitative research methods can provide important expansion on the findings from large-scale surveys. This is particularly the case for sexuality, where the data on sexual identity or behavior might be gathered only incidentally. Large-scale survey data, thus, might be able to suggest a particular relationship between sexuality and a demographic outcome, but qualitative research could prove useful in further exploring this question.

One example of this is demonstrated by research that I conducted with my coauthor which examines the role of the law in generating parenthood outcomes for same-sex couples (Baumle and Compton 2011). Drawing on the U.S. Census data, we demonstrated that state-level laws that prohibited adoption, fostering, or surrogacy by gay or lesbian persons had no statistically significant effect on the presence of children in same-sex households. Our research raised a number of questions regarding why state-level laws might have little or no effect on gay or lesbian parents, but the census data were unable to speak to these particular questions. We are currently conducting a nation-wide follow-up study in which we are interviewing gay parents regarding the role of the law in their parenting decisions. Through this study, we are learning more about the mechanisms by which family structure is affected by sexual orientation. Demographers might similarly benefit from incorporating qualitative methods into their work on population sexuality, where quantitative data fail to provide the full story.

Conclusion

As demonstrated throughout this handbook, there already exists a strong foundation of research in the field on sexuality. With future investments in data collection, analysis, and a reevaluation of

our models and theories, demographers will be able to provide important insight into population sexuality. And, perhaps even more importantly, a self-conscious inquiry into the manner in which our models, theories, and analyses might be grounded in a heteronormative perspective could result in stronger demographic research as a whole. For, as brought to the forefront by queer theorists (e.g. Jagose 1996), when studying those who fall outside of the mainstream, we often learn the most about our normative practices.

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