

THE NEGATIVE HEALTH CONSEQUENCES OF  
TRADITIONAL SEXUAL MORALITY

A Public Health Perspective

by

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### ABSTRACT

Traditional sexual morality is characterized by its negative valuation of sexual pleasure. This valuation remains at the heart of most existing attitudes toward sexuality and is responsible, directly and indirectly, for negative health consequences on a scale sufficient to warrant its designation as a major public health problem. Evidence in support of this proposition is presented and its wider implications explored, including possible effects upon mental health, intimacy, generational conflict, race relations, community mental health, and distorted economic priorities. A program for community sexual health is outlined.

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## INTRODUCTION

The history of public health education reveals many instances where a culture has accepted poor health conditions as natural, inevitable, even desirable. Thus the cross-culturally employed health educator may arrive in a community where worms are accepted as a natural inhabitant of the human digestive tract. The contaminated water supply may be endowed with religious significance. General debilitation is conceived as the human condition.

While examples such as the above typically occur in the context of small, isolated societies or subcultures, the same basic cultural mechanisms function across large and complex societies. We are much less equipped to recognize such situations in our own culture. Intellectually, we know that ours is only one culture among many. We nevertheless act as if it were somehow a given or standard. Accordingly, where individuals exhibit stress in response to cultural demands, we are inclined, when the culture is our own, to view the stress as an indication of poor adjustment on the part of the individuals, rather than as a sign that something is amiss in our culture.

In the last two decades, a considerable body of evidence has accumulated linking various negative health consequences, including coronary heart disease, to occupational stress and the performance of culturally approved roles calling for high achievement.<sup>1</sup> Because of the

strength of our emphasis on achievement, it will be difficult for us to accept this link. And because individual achievement is the basis for advancement in our society, it will be even more difficult to do anything about it.

The theme of this study is that a similar situation exists in the area of sexuality. That is, very deeply rooted cultural values and institutional norms are responsible, directly and indirectly, for negative health consequences on a wide scale. The situation represents a challenge to the public health professions because deeply held values are at stake, considerable anxiety is attached to the subject, and yet the potential gains for improved physical and mental health are enormous.

Many writers have sought to call attention to some of the harmful effects of our anti-sexual heritage and of the existing confused and conflicting sexual value system.<sup>2</sup> Our purpose here is to examine the negative impact of traditional sexual morality over a wide range of health-related situations. By reviewing available evidence and considering possible implications, this study seeks recognition of the legacy of traditional sexual morality as a major public health problem.

The effort to secure such recognition faces two sizeable obstacles. The first of these is the relative lack of scientifically verified knowledge in the field of sexuality, particularly relating to sexual morality and health consequences. The second, perhaps unique to the subject of sexuality, is the degree of emotional involvement on the part both of the target population and of members of the public health professions.

The dearth of sex research is itself a negative health consequence of traditional sexual morality. Understanding of the basic physiology of sexual processes has come only recently, long after comparable knowledge has been available in regard to other basic processes of human physiology. It is not that the study of sexual processes awaited new techniques and instrumentation, although William Masters' and Virginia Johnson's landmark research did develop new techniques using advanced technology. The most important cause for the delay has been the taboo against studying sex, a taboo that has persisted long after similar proscriptions against the study of anatomy in general have been all but forgotten.

The history of the Masters and Johnson research is illustrative. When Masters, 28 years old and about to receive his medical degree, weighed the decision to make sex research his major scientific interest, he consulted one of the country's foremost anatomists and authorities on the biology of sex, George W. Corner. Corner, a member of the Committee for Research in Problems of Sex (of the National Academy of Sciences--National Research Council) which had recently provided funds for the first years of Kinsey's work, advised Masters to wait until he was at least forty, had earned a reputation in some other scientific field, and could secure the sponsorship of a major medical school or university.<sup>3</sup>

Even so, Masters and Johnson, as the Kinsey researchers before them, deemed it prudent to conduct some of their work as a carefully guarded secret and encouraged a blackout by the news media on the rest.<sup>4</sup> Moreover, despite Masters' patient accumulation of the recommended credentials and the huge gap in medical knowledge that his research was

directed toward filling, public funding has been minimal.<sup>5</sup> Kinsey, who has been credited with having opened the door to the scientific study of sex, spent the last years of his life in a fruitless search for funding after political pressures induced the Rockefeller Foundation to discontinue its financial support.<sup>6</sup>

Many topics of public health concern carry a degree of anxiety among the population at risk. What is striking about the topic of sexuality is not only the level of anxiety but its considerable presence among the public health professionals themselves. It is entirely possible, as we shall see presently, that the majority of the people in this country, including a similar proportion of our health professionals, experience a significant degree of dissatisfaction of sexual origin. For many, sexual dysfunction will have contributed to strong feelings of inadequacy and failure. For others, an awareness of life's promise unfulfilled lurks as a source of sorrow or resentment. It is uncomfortable to be reminded of our resentments and disappointments, so few of us maintain a continuous, conscious awareness of these feelings. But their underlying presence makes it difficult to establish an objective perspective and to keep disquieting issues in focus.<sup>7</sup>

Despite these obstacles, the progress in the scientific study of sex that has been made and the enormous social changes that have taken place since the end of the Victorian era have weakened the hold of traditional sexual morality dramatically, so that it may now be possible to confront these issues. Greater freedom to talk about sexual matters has expanded awareness that sexual problems are widely shared. Knowing that problems are widely shared reduces the stigma, so that more progress may now be possible.

Although there are many gaps in basic knowledge and a scarcity of controlled, scientific investigations, considerable evidence has been accumulated. Our approach here will be to look at a range of health consequences, considering evidence available in connection with each. Even though none of the data is decisive by itself, the overall weight of the evidence is substantial.

Some of the causal relationships will be reasonably well established, others much more tentative. The former may be viewed as evidence for supporting the contention that traditional sexual morality is responsible for negative health consequences on a wide scale. The latter suggest the broader implications and possible fundamental social problems that may derive, at least in part, from the lack of a fuller acceptance of sexuality.

Before embarking upon our review, we will first consider traditional sexual morality as it persists today--as an underlying theme common to various current sexual attitudes, patterns of behavior, and institutional practices.

## II

### SEXUAL MORALITY

It is difficult if not impossible to describe in precise terms the norms of a large, heterogeneous society. Standards may vary among different groups, between what is professed and what is practiced, and in their application for different classes of individuals. Moreover, all these difficulties are compounded during a period of rapid change.

At the turn of the century, it would at least have been possible to define certain generally (though not universally) accepted standards for sexual conduct in the United States. Chastity before marriage, fidelity within marriage, and modesty at all times would have ranked prominently among these standards, though with a milder application, sometimes even a reversal, for men. Generally held beliefs included the harmfulness and sinfulness of masturbation, the sinfulness and repugnance of homosexual relations, and a low valuation of sexual pleasure, distinctly lower for women. To be sure, these standards were not practiced in private to the same extent as they were professed publicly. But they were nevertheless widely practiced.<sup>1</sup>

Today, such a general statement would be impossible. Variation among different groups is too great. Moreover, even the standards in any particular group are often confused and in a state of flux.

The range of sexual standards is commonly visualized as embodying a restrictiveness-permissiveness continuum. Regarding premarital

intercourse, Ira L. Reiss has defined standards of formal abstinence, double standard, permissiveness with affection, and permissiveness without affection.<sup>2</sup> His convenient classification has been adopted by others and has the advantage of reflecting the way people themselves conceptualize their standards.

But this scheme often overlooks another important dimension of sexual standards. That dimension concerns the underlying valuation of sexual pleasure. Historically, Christianity and later the Victorians, enunciated a very negative valuation of bodily pleasure. Despite the enormous changes that have taken place in this century, that negative valuation lingers as a relatively consistent theme underlying many of the standards currently in force and pervading our society's approach to sexuality.

The very concept of "permissiveness with affection" contains an implicit negative valuation of sexuality. "Permissiveness" implies the presence of a prohibition, affection serving to legitimize sexual feelings and behavior. In the more restrictive standards, engagement or even marriage are required to legitimize sexuality.<sup>3</sup>

Another indication of the continuing negative valuation of sex becomes visible when we note that the general loosening of restrictions (about contraception, abortion, premarital intercourse, divorce, media treatment of sexual topics) that is often referred to as the "permissive society" has not been accompanied by a significant and public affirmation of the positive value of sex. There is less willingness to condemn behavior of one sort or another, but this is not matched by a corresponding advocacy or endorsement of ideals for sexual behavior.

This mood is reflected in the results of a questionnaire survey of undergraduates at the University of North Carolina at Chapel Hill.<sup>4</sup> Responses to three survey items are presented in Table 1. The traditional moral stance embodied in the first statement has been abandoned by 74 percent of respondents. Yet only 39 percent endorsed the opposing norm expressed in the third statement, while 33 percent expressed uncertainty.

TABLE 1

Responses to Selected Items from a Questionnaire Survey of Undergraduates at the University of North Carolina at Chapel Hill, 1972.

<u>Statement</u>	Percent responding:				
	<u>SA</u>	<u>A</u>	<u>UN</u>	<u>D</u>	<u>SD</u>
1. "Premarital intercourse is morally undesirable"	6	10	10	43	31
2. "Virginity among unmarried women should be encouraged in our society"	8	9	23	42	18
3. "Women should have coital experience prior to marriage"	9	30	33	24	6

SA=Strongly agree, A=Agree, UN=Uncertain, D=Disagree, SD=Strongly disagree. Percentages have been rounded. N=192.

Lack of endorsement of a particular life style might connote a high degree of freedom for each individual to choose his or her preferred life style with a minimum of external pressure. In comparison with the recent past, it most assuredly does. This "hands-off" approach, however, leaves the individual with little to set against the very considerable pressure frequently embodied in his or her upbringing, law and regulations, and the negative reactions of many of the people with whom he or she interacts. There is also the marked contrast with the definite encouragement and high valuation placed on any number of other activities and interests, such as earning money, studying hard,

engaging in sports, sleeping eight hours a night, eating a balanced diet, learning to appreciate art, literature, music, etc.

One result is an attitude characterized by Alexander Lowen as "sexual sophistication."<sup>5</sup> This attitude, which Lowen regards as the dominant one in our society, refers to a surface, intellectual and behavioral acceptance of sexuality that masks underlying unconscious guilt and anxiety.

Underlying guilt and anxiety at the individual and social level are not difficult to discover. One manifestation, for example, is widespread concern about sexual performance and accompanying fear of failure. In Lowen's words, "the sexually sophisticated person covers up his anxieties, his hostilities, and his guilt by transposing them into a 'fear of failure.'"<sup>6</sup> Fear of failure and performance orientation have been identified by Masters and Johnson and others as a primary mechanism in sexual dysfunction.<sup>7</sup>

Attitudes toward masturbation offer another illustration of basic lack of acceptance of sexuality. Albert Ellis notes:

The point is continually made that masturbation is not as bad as it was once said to be; but the concomitant point that it is actually good and beneficial is rarely stated.<sup>8</sup>

He continues:

In a recent communication, for example, the staff of the Child Study Association of America, consisting largely of trained psychiatric social workers, tells us that certainly masturbation "does not lead to blindness, brain fever, impotence, or any other physical or sexual ill-effects." This Child Study Association staff then goes on, however, to point out that because children in our culture do get the idea that masturbation is dangerous and consequently become guilty about their autoerotism, "perhaps the best course is for the parents reassuringly to ally themselves with the child's own conscience in this matter and while assuring him that the practice will not harm him, also help him to find ways to grow out of it."<sup>9</sup>

In recent years, there has been a greater acceptance, if not encouragement, of childhood and adolescent masturbation. But concern remains regarding masturbation that is "excessive" or that takes place after adulthood or marriage. After noting that 40 percent of a sample of medical students reported current conflict and anxiety about masturbation, Sherwyn Woods explains:

Most students are sophisticated about masturbation as a non-pathologic accompaniment of normal sexual development in childhood and adolescence, but are much more uncertain about its role in adult life. As one student put it, "I know it's okay for kids, but after college age or marriage--I just don't know if it's sick or not."<sup>10</sup>

Such concern would, unfortunately, not be allayed by the following from a college textbook published in 1972:

Almost everyone has been confronted with the desire to masturbate, and each must work out his or her own solution to this question. . . .

In childhood and adolescence, masturbation frequently serves as a substitute for normal sexual outlets. This is especially true during adolescence when sexual maturity has been attained and sexual desire is difficult to master or sublimate. . . .

The chief danger in masturbation that continues excessively into adulthood is that it is not the normal adult sexual pattern. . . .

If an individual becomes emotionally dependent on masturbation, practicing it--let us say--daily, the problem is an emotional one which should be discussed with a doctor or counselor. Masturbation in this case is a sign, not a cause, of emotional difficulty. (My italics)<sup>11</sup>

Interestingly, one motive for increased willingness to accept and even to encourage masturbation in the teenage years is that it is seen as a lesser evil than sexual intercourse.<sup>12</sup> In a recent instance, James McCary, sex educator and author of a highly respected textbook on human sexuality, indicates that he would tell his daughter:

. . . basically, I think one is usually significantly better off if he or she avoids premarital sexual intercourse, especially in the teens, and would in most cases be better off to use masturbation or petting when sexual expression is necessary.<sup>13</sup>

While there are unquestionably defensible, logical reasons for deferring sexual intercourse until after the teenage years, the lesser of two evils concept is suggested by his use of the phrase "when sexual expression is necessary" as well as by a subsequent paragraph where he refers to his real daughter, now married:

I do not know whether or not she had premarital sexual intercourse --and frankly, I couldn't care less; I respect her and love her too much even to question her, although I could ask and she could answer without embarrassment to either of us.<sup>14</sup>

Why should inquiring about his daughter's decision indicate a lack of respect or love? Such propriety is often justified on the grounds that sex is a private matter. In a bestselling book for parents, Lee Salk, Director of Pediatric Psychology at the New York Hospital, poses the question "Is it natural for my child to inquire about my sexual activities?" and follows it with "How do I handle that question?" His very reassuring answer to the first is:

Yes. A child begins to wonder whether his parents engage in sexual activities as soon as he knows about sex and reproduction. If you have been casual and open in talking about sex, your child may directly inquire whether you have intercourse, and how often.<sup>15</sup>

In giving parents advice on how to handle the child's question, however, Salk too seems to reflect traditional morality rather than psychological knowledge:

The only way [to handle this question] is to tell your child that this is a private matter, not open for discussion. Remind him that sexual experiences do have a personal and private quality. In fact, they are regarded as so private that not even members of the family are permitted to discuss them. If the question is asked by a very young child, you may be able to deal with it superficially. If you are dealing with an adolescent, you may want to refer him to literature on the subject to give him some ideas of the sexual norms.<sup>16</sup>

Most parents do consider their sexual experiences as a private matter and would be most uncomfortable discussing them with their

children. Should their children inquire, there is no reason why these parents should not explain their feelings about the privacy of sexual matters. But is this the "only way" to respond?

Moreover, to state that sexual experiences are "so private that not even members of the family are permitted to discuss them" is at best misleading. Many people do in fact discuss their sexual experiences with peers, spouses, professionals, and even strangers (through magazine letters columns, for example). The inhibition about discussing sexual experiences comes not from their "private quality" so much as from the extension of the incest taboo (where the family is concerned) and from real and imagined fears of social censure. Even so, sex discussion among siblings as well as between parent and child occurs. Indeed, inability to talk about sexual matters has been cited as a factor contributing to difficulty in marital sexual adjustment.<sup>17</sup>

Moreover, the inhibition of open discussion of sexuality and sexual norms has profound implications for the development of consensus about acceptable sexual behavior and for parent-child interaction.<sup>18</sup>

An interesting juxtaposition to our own society's practices in regard to sexual privacy is offered by Bronislaw Malinowski's description of Northwestern Melanesia. In the Trobriand Islands, Malinowski writes, "meals are never taken in public, and eating is altogether regarded as a rather dangerous and delicate act."<sup>19</sup> Young Trobrianders enjoyed considerable freedom in sexual matters, but even a couple that slept together every night in the boy's "bachelor hut" had to return to their respective families for meals.

A need for privacy about a particular activity may reflect a

culturally or family-induced feeling of vulnerability or shame about engaging in it. Such a need can result in considerable discomfort in situations such as dormitories, barracks, or even modern apartments, where provision for privacy is insufficient. Thus Warren Johnson writes that "many girls and women prefer painful constipation to 'being heard' in a school or other public toilet."<sup>20</sup> Similarly, where living situations do not permit complete privacy for sexual expression (including masturbation), a taught need for privacy may interfere with an individual's adjustment and well-being.<sup>21</sup>

One further expression of the general uneasiness about sexuality among those who do not condemn it entirely is an unwillingness or inability to take an encouraging, affirmative attitude toward sexual enjoyment on the part of young people. Justification for this hesitancy often takes the form "It's their own decision" or "I don't want to impose my views." But such an attitude overlooks the very considerable imposition of negative stimuli that young people are constantly exposed to. Consider the following partial list:

1. Existing and occasionally enforced laws prohibiting, in most states, sexual intercourse and cohabitation between unmarried individuals, sexual intercourse involving a legal minor, sexual contact other than intercourse, and books and films judged as "obscene" (i.e., more sexually oriented and explicit than the tastes of those who would rather others did not view them);<sup>22</sup>
2. Regulations and practices of landlords, educational institutions, and other authorities that prevent or interfere with

sexual relations and cohabitation of unmarried persons subject to them;<sup>23</sup>

3. **Unavailability** and restriction of information, materials, and professional help for making decisions about sex (except along traditional lines) and for working out problems encountered;<sup>24</sup>
4. Parental anxiety about revealing aspects of their own sexuality, thus depriving the young of the benefit of parental experience and communicating an implied message of inhibition, shame, and/or guilt.<sup>25</sup>

In such an atmosphere it is exceedingly difficult for young people to reach their "own decision." Not to acknowledge the importance of that atmosphere in the decision-making process leaves the individual with nothing to set against this negative input. True, the young person may feel competing pressures to be sexual (from the media, from peers, and, of course, from his or her own sexual drives). But in the atmosphere of sex-negativism and absence of factual information and open discussion, it is often more a matter of conflicting pressures than of weighing advantages and disadvantages and evaluating reasoned arguments. Moreover, genuine encouragement for someone to make his or her own decision involves a clear demonstration of unconditional positive regard, to use Carl Roger's term, rather than a "hands-off" attitude.<sup>26</sup>

The reluctance to take an encouraging, affirmative attitude toward sexual pleasure, exaggerated concern for privacy in sexual matters, continued uneasiness about masturbation, and widespread concern over sexual performance provide evidence of considerable underlying guilt and anxiety about sexual matters. This anxiety reflects the negative

valuation of sexuality implicit or explicit in prevailing norms and standards. We will now elaborate the negative health consequences of this sex-negative atmosphere.

### III

#### HEALTH CONSEQUENCES; VENEREAL DISEASE

In recent decades there has been a growing awareness of the role of social factors in the etiology of diseases that were once conceived of as purely physical events. Thus rheumatoid arthritis, essential hypertension, coronary heart disease, tuberculosis, and other respiratory diseases have all been associated with social factors. Of particular interest, perhaps, is the growing evidence that disordered interpersonal relationships may increase the susceptibility of the individual to a wide range of environmental insults.<sup>1</sup>

At a broader level still, individual fulfillment with life experience can be taken as a dimension of health both in itself and in the effects that fulfillment or lack of fulfillment has on other individuals. If lack of fulfillment motivates an individual to criminal or anti-social acts, the health of others suffers. If frustration or lack of fulfillment in living is expressed in negligent or reckless driving behavior, the health of others suffers.

Nor are we concerned only with conscious or unconscious anti-social acts. In our increasingly interrelated world we depend more and more on cooperation and socially conscious actions of others. Whether we are dealing with race relations, energy conservation, solid waste recycling, inflation restraint, or international cooperation, our welfare depends in good measure on cooperation. The freer individuals are from

inner conflicts and frustrations, the more energy they have available to give to others and the more agreeable they are to compromise. All of this has profound implications for health.

In reviewing the health consequences of sexual morality, we will therefore want to consider not only illness as conventionally defined but also broader health implications. Only in this way can we obtain some appreciation of the magnitude of the possible impact. We will begin our review, however, with a relatively straightforward example involving the infectious diseases syphilis and gonorrhea.

Throughout the century, public health efforts to control the spread of venereal infection have been continually hampered by the precepts of traditional sexual morality. Proponents of traditional morality have viewed venereal disease, somewhat contradictorily, as both too disreputable to mention and as "God's little helper" for its role as a punishment for non-marital sexual intercourse. During the World Wars, military necessity breached the barrier against venereal disease education and prophylaxis (perhaps an ironic twist to the slogan "Make Love Not War").

But after declining considerably following the Second World War, and the introduction of penicillin, gonorrhea has reached epidemic proportions in both the United States and the Western World, despite the availability of highly effective diagnostic, therapeutic, prophylactic, and epidemiologic understanding and techniques. Our efforts to control the current epidemic, like previous efforts to control or eliminate venereal disease, are hampered by the societal attitude that seeks to retain the risk of infection as a deterrent and punishment for illicit

sexual intercourse:

The public's attitude toward the infected person also contributes to the venereal disease epidemic. There is a tendency to feel that an infected individual is a second rate member of society, that he deserves what he got, and no special effort should be directed to assist him. In short, the patient with gonorrhoea is persecuted. A new attitude toward venereal infection is needed.<sup>2</sup>

It should be mentioned at this point that if the traditional sexual codes restricting sexual intercourse to marriage were adhered to by the vast majority, then venereal disease control would not be so difficult. In fact, to the extent that it is observed in practice, the restrictive moral code reduces or eliminates the spread of venereal disease. But where that code has ceased to govern the behavior of a substantial portion of the population, it then becomes an obstacle to the requirements of venereal disease control. Thus, as we will have occasion to note in other contexts as well, it is often not the code itself that leads to negative health consequences, but rather the degree of congruence between it and existing social conditions.

The official history of the U.S. Public Health Service offers this account of an early attempt at venereal disease prevention:

In 1908 Dr. Claude H. Lavinder was instructed by Surgeon General Wyman to prepare a simple pamphlet on venereal diseases for distribution to persons coming for treatment to the Marine Hospitals and outpatient dispensaries. The manuscript of this proposed pamphlet was carefully edited by a board of officers including Doctor Lavinder and later reviewed by Surgeon General Wyman. The publication of this pamphlet was refused by the Assistant Secretary of the Treasury on the ground that such literature was not sufficiently dignified to bear the imprint of the Treasury Department.<sup>3</sup>

World War I, and to an even greater extent World War II, overrode such objections to venereal disease control. Numerous pamphlets were published, and members of the armed forces were instructed in methods of venereal disease prophylaxis and provided with condoms, antiseptic

washes, and antibiotics.

But while venereal disease in the post World War II armed forces has remained under control, greater geographical mobility and changing patterns of sexual behavior have led to a continual yearly increase in gonorrhea since 1957. In the face of what has become an alarming situation in view of the dramatic increases in the early 1970's, efforts to introduce venereal disease education programs continue to founder on objections that derive from restrictive sexual morality. A report from the American Social Health Association offers the following comment from a health officer in West Palm Beach, Florida, as an example of the U.S. situation:

A formal and structured VD information and education program has now lapsed in the public school system. We are informed that there has been parental resistance and objection expressly over sex information and education. The only VD programs presented in the school system were directly provided by the health department staff. Usually, the total content was a VD lecture and film for a one-hour period.<sup>4</sup>

Critics of sex education in the public schools have often asserted that the appropriate place for sex education is in the home. Yet many parents themselves lack reliable knowledge in this area. Moreover, a substantial portion of teenagers say they are afraid to ask their parents for information about venereal disease because their parents would then question them about their sexual relations.<sup>5</sup>

Governmental and institutional policies are one component of a program to limit the spread of venereal disease. The other component concerns changes in individual behavior involving prophylaxis, detection, treatment, and notification of sexual contacts. For each of these activities, sex-negative morality interferes with the response most conducive to individual and social health.

Organizations and individuals concerned about the spread of venereal disease have long warned about the dangers of "promiscuity." If such warnings did in fact have the intended impact of limiting the number of sexual partners, then the spread of venereal disease would be reduced. But since a large number of people do not follow this advice, the approach to venereal disease control through decrying "promiscuity" has the principal effects of reinforcing guilt about sexual activity and discrediting the speaker. In the latter case, useful information the speaker hopes to convey loses its impact. In the former, increased guilt only worsens the prospect for control through other measures.

Many people are uninformed about venereal disease in general and about methods of prophylaxis in particular. Their ignorance results largely from the overall social attitude that seeks to give a "red light" or at best a "yellow light" to sexual behavior rather than a "green light." Thus most venereal disease education that has occurred concentrates on symptoms and treatment, usually omitting entirely methods of prophylaxis such as the use of a condom, certain contraceptive preparations, prophylactic suppositories, soap and water cleansing of the external genitalia promptly after intercourse (for the male), visual inspection of the male genitalia prior to intercourse and examination for the presence of discharge. Secondly, the "yellow light" keeps many couples from making use of methods of prophylaxis that they do know of.

Because of their anxiety regarding venereal disease and sexual activity, prospective sexual partners often resort to denial of the possibility of infection rather than consider the use of methods of prophylaxis. Others cannot bring themselves to discuss the matter with

the prospective partner for fear of having their concern taken as an insult, as a covert confession of being themselves infected, or of thereby increasing their partner's anxiety to the point where the hoped for sexual exchange will not take place.<sup>6</sup> It is as if the driver's suggestion that his passenger put on the seatbelt constituted an admission that the driver was accident prone or the automobile mechanically defective.

Even where mutuality in precautions would not occur prior to intercourse and possible transmission of infection, a substantial improvement in disease control would be effected if infected persons were prompt to seek diagnosis and treatment and reliable in informing their sexual contacts. But here again, the stigma attached to venereal disease and sexual activity interfere. First, guilt, shame, anxiety, or the anticipation (too often borne out) of a disagreeable experience at the clinic or doctor's office may delay recourse to medical assistance. Second, similar emotions plus the disrespect encouraged by traditional sexual morality toward the sexually active female may delay or inhibit patient notification of previous sexual partners.

Overall prudery with regard to sex (and sexual words) and the continuing concern about encouraging sexual intercourse outside of marriage (and the more extreme version, the desire to retain the risk of venereal disease as a punishment for illicit intercourse) together with their impact on individual behavior thus constitute a major force in hampering control of venereal disease.

This is a particularly serious situation with regard to women's health, since symptoms of infection in females often go unnoticed

until the disease has progressed to the stage of pelvic inflammatory disease with accompanying jeopardy to future fertility. Furthermore, the spread of gonorrhoea and the escalation in antibiotic dosage recommended for treatment raises the specter of resistant strains that would dramatically reverse our present therapeutic effectiveness. Reducing the influence of our Victorian inheritance would enable us to place venereal disease control on the same footing as other disease control programs. This would not in itself solve the venereal disease problem completely but should permit a major reduction in its severity. We will now examine another area of health where present knowledge and technology could permit a major advance if the influence of traditional morality were reversed.

#### IV

#### UNWANTED FERTILITY

The history and current status of birth control offer an equally striking portrait of the influence of restrictive morality on health. Despite a range of important health-related aspects of fertility, traditional morality, buttressed by laws and the practices of the health professions, has restricted access to means of fertility limitation even to the present day.

Health-related aspects of fertility include medical (such as high maternal mortality rates for diabetic women, greater risk of fetal and infant mortality and increased incidence of prematurity in teenage pregnancy), economic (poverty status is associated with above average fertility, and with children born to single women and teenagers), and population factors (the 1.7 million unintended births in 1969, for example, represent a substantial contribution to U.S. population growth).<sup>1</sup> Moreover, the Committee on Preventive Psychiatry of the Group for the Advancement of Psychiatry write that "there is hardly a single more effective tool for the prevention of emotional disorders than the prevention of unwanted pregnancies and unwanted parenthood."<sup>2</sup>

Traditional morality, on the other hand, has been guided less by these considerations than by the Biblical prescription to "be fruitful and multiply" mediated by a rejection of sexual pleasure. Thus the birth control movement in the last century became the target for public

defamation and legal prosecution. In 1873 Congress passed the Comstock law prohibiting the distribution through the mails of contraceptive information and materials (this law remained in effect, though narrowed in its application by court decisions until its repeal in 1971, nearly one hundred years later).<sup>3</sup> Many states passed Comstock-inspired laws of their own.

Not until the 1920's did the New York Court of Appeals interpret laws against contraception in such a way as to permit physicians to give contraceptive advice "for the cure and prevention of disease,"<sup>4</sup> while U.S. Customs Authorities banned the importation of contraceptives until federal court rulings in the late 1930's. In 1937 Massachusetts closed all birth control clinics then operating and a year later "the courts held that physicians could not legally sell contraceptives at a clinic, even if their purpose was to protect the health of their patients."<sup>5</sup> The sale of condoms by pharmacists was later upheld as long as the purpose of the sale was to prevent disease rather than conception.

In 1961 Dr. C. Lee Buxton, Professor of Obstetrics and Gynecology at the Yale Medical School, and Mrs. Griswold opened a birth control clinic in New Haven to test the operability of Connecticut's birth control statute. They were arrested eight days later, the start of a legal battle that led to the U.S. Supreme Court's invalidating the Connecticut law some years later. Massachusetts' law against distributing birth control devices to unmarried persons was not ruled unconstitutional until 1970. Similarly, only in the last decade has access to abortion become legal for any but the most limited of motives, while even after the 1973 Supreme Court decision many statutory and quasi-legal restrictions remain (for example, restrictions on the use of Medicaid funds,

hospital policies, discriminatory state regulatory procedures for clinics).

Undoubtedly, married couples in Connecticut and unmarried couples in Massachusetts did in fact obtain contraception prior to the successful court challenges to their respective laws. But legal restrictions have had a restrictive impact on the availability of information and services for fertility limitation, especially for lower income groups. For example, concerned physicians might prescribe contraceptives to their patients, but family planning clinics, welfare departments, and hospital obstetrics departments were all barred from offering contraceptive services.

Another area of legal restraint concerns legal minors. In a rather extreme interpretation of the law, birth control activist William Baird was prosecuted in Huntington Long Island for acting "in a manner likely to be injurious to the physical, mental, or moral welfare" of a child. He was arrested while giving a lecture on contraception at which a 14-month old baby girl was sleeping in the care of its mother.<sup>6</sup> The case was dismissed but the possibility of prosecution under such laws has discouraged public and private organized efforts to provide contraceptive information and services to minors.

Finally, in a society where nearly everything is sold with elaborate media advertising, expensive packaging, and sexual stimuli, the marketing of contraceptives is extensively restricted or prohibited:

Twenty-nine of the 50 states now have laws on the books which regulate either advertising or distribution of condoms. . . .

In about half the states, vending machines for condoms are illegal. Many limit condom sales to pharmacies only, and 14 other states require special licensing. . . .

Paradoxically, New York, one of the first states to legalize

abortion, may be the last state to encourage condom sales. New York's 100-year-old Comstock law still prohibits condom advertising and displays and discourages sales by anyone other than a pharmacist or to anyone under 16 years of age. . . .

. . . U.S. newspapers and magazines are reluctant to carry condom advertising. Although creams and jellies have been advertised since the 1930's, no ads were accepted which mentioned contraception. The first professional journal advertisement, published in the Journal of the American Medical Association in February 1958, carried no reference to either venereal disease or contraception and instead recommended the condom "in persistent vaginal trichomoniasis" in order "to forestall conjugal reinfection." . . .

Radio and TV stations subscribing to the National Broadcasters' Code cannot advertise any contraceptives.<sup>7</sup>

In addition to its possible considerable impact on access to contraceptive information and supplies (the above report notes that advertisements that have appeared in several popular magazines, a few major newspapers, and local and college publications have generated two million requests for free information), advertising also helps to create a climate of cultural acceptance of sex and contraception which would contribute to its wider and more effective use.

The legal and institutional barriers to obtaining contraceptives are one reason for the high degree of risk-taking among teenagers. A study by John Kantner and Melvin Zelnik of 4,611 never-married women aged 15-19 found that 28 percent had had sexual intercourse. Of these sexually active teenage women, fewer than one out of five reported that they "always" use some method to prevent conception during intercourse. Over half failed to use any kind of contraception the last time they had intercourse.<sup>8</sup>

As with venereal disease, unintended pregnancy results from both social and behavioral variables. At the social level, remaining institutional and legal barriers are supplemented by limited or non-existent sex education in the public and private school systems.<sup>9</sup> Lack

of adequate knowledge is reflected in the fact that although most teenage women in Kantner and Zelnik's sample had heard about the rhythm method of contraception, fewer than half knew the period of greatest risk of conception within the menstrual cycle. Kantner and Zelnik note that the "most common fallacy among both blacks and whites is that the period of greatest risk is right before, during or after the menses--a dangerous belief."<sup>10</sup>

On the behavioral level, the use of contraception is reduced by such factors as the episodic nature of sex among unmarried teenagers and young adults. Kantner and Zelnik raise this possibility, while in his study of teenage sexual behavior in England, Michael Schofield found that:

. . . social disapproval means that many of their sexual adventures are unpremeditated and therefore adequate precautions have not been taken beforehand.<sup>11</sup>

Similarly, Karl Bauman's 1968 study of undergraduates at the University of North Carolina found that those women whose first intercourse was planned were more likely to have been adequately protected than those whose first intercourse was unplanned.<sup>12</sup>

It is possible, of course, to have contraceptive means available even without the expectation of intercourse. Such a "be prepared" approach accounted for Bauman's finding that contraception on first intercourse by males was not related to whether or not it was planned because most of those who had not planned the event had nevertheless equipped themselves with a condom. For women, however, the greater stigma attached to sex, especially to "premeditated" sex, inhibits them from having contraception available "just in case." This inhibition

can continue even after first intercourse, as noted by Ira Reiss:

Many females cannot use a diaphragm or "pill" because they cannot conceive of themselves as being prepared for coitus all the time. They must be emotionally carried away for coitus to occur. Such a self-image is common and blocks the effective use of many contraceptive devices. Contraceptive information can lessen somewhat the number of unwanted pregnancies, but a full solution requires deeper attitudinal changes regarding the acceptability or non-acceptability of premarital coitus.<sup>13</sup>

Nevertheless, the highest risk situations are first intercourse and first intercourse with a new partner. In both of these, the anxiety about the event, the fear of bringing up any subject that might interrupt and thereby jeopardize the flow of interaction, and the stigma on coming prepared (making the deed a premeditated act instead of a "crime of passion") combine to yield the lowest likelihood that contraception will be used.<sup>14</sup>

As the barriers to contraception for the married have fallen away, and changing attitudes have lowered marital fertility, unintended teenage pregnancy stands out as a major contributor to unwanted births and abortions. Morris estimates that eight percent of 1969 unintended births are accounted for by unwed teenagers, or nearly twice the unwed teenage contribution to total fertility.<sup>15</sup> Many of these 135,000 unintended births are associated with guilt, shame, social ostracism, discontinuance of highschool education, inadequate prenatal care, parenthood by persons financially and emotionally unprepared for the task, and injury to the child as an expression of resentment or emotional stress. For the reluctant mothers who have resorted to illegal abortion, consequences may be even more serious.

Despite the unavailability of reliable statistics on mortality and morbidity from illegal abortion, a reasonable estimate for the

years prior to the recent increased access to legal abortion in the United States would be on the order of 1,000 fatalities and 50,000 major physical complications per year.<sup>16</sup> Serious physical complications and adverse psychological reactions might involve tens of thousands more. The 1973 Supreme Court decision invalidating restrictive abortion laws offers the prospect of reducing both mortality and morbidity by a factor of five or more.<sup>17</sup> When and whether this potential will be realized depends upon how soon full access to properly equipped and staffed abortion facilities can be implemented in the face of institutional conservatism and a frontal assault on the legality of abortion itself by the "right to life" movement.

With all their ramifications, venereal disease and unintended pregnancy alone provide considerable evidence of the negative health consequences of existing sexual morality. The more restrictive moral positions operate at the institutional level to interfere with the provision of sex education and contraceptive services, especially to young people. The underlying anxiety and guilt discussed in chapter two operate at the behavioral level to interfere with the effective use of available methods for avoiding negative health consequences and for dealing effectively with those that occur. Even so, these relatively concrete issues, most of which fall into even a very narrowly drawn definition of health, account for only a portion of negative health consequences attributable to traditional sexual morality. We will now turn to some of the less publicized ones.

## MEDICAL SEX EDUCATION AND IATROGENIC DISABILITY

One result of the prevailing uneasiness about sex and low social valuation of sexual pleasure is the omission of education about sexuality from the training of most professionals who might be called upon to assist individuals troubled by sexual concerns. Inadequate training, both regarding factual knowledge and the development of appropriate attitudes, can result in misdiagnosis, omission of referral, aggravation of patient distress, and even in injury to patients.

The situation in the medical profession has been described by Harold I. Lief:

The truth is that medical students bring to medical school the same conceptions and misconceptions, the same information and misinformation, the same confidences and anxieties, regarding sex that any group of educated people have; then in medical school, little is done to inform the students or to teach them new attitudes.<sup>1</sup>

One survey found that half of the 1959 graduates of the five Philadelphia medical schools believed that mental illness is frequently caused by masturbation. Moreover, a fifth of their faculty members believed that.<sup>2</sup>

In 1967, a study of senior medical students at one medical school disclosed that over half felt that medical education had failed significantly to increase their intellectual comprehension of human sexuality. Of even greater concern, though, was the students' own estimate

of their clinical effectiveness;

A majority of the students felt that they would expect considerable difficulty in working as a nonpsychiatrist physician with patients complaining of impotence or frigidity. Most feel that this would be mainly due to their own emotional reactions rather than to intellectual deficiencies, and slightly more than half report current conflict or problems with their own potency. In the original sample, 10% of the students spontaneously reported that they were virgins. As one student stated: "I am so concerned with my own potency problem, I don't think I could keep from confusing myself with the patient." Anxiety over penis size is very common; as a rule, these students intellectually accept and emotionally reject the fact that penis size is virtually without meaning in terms of a man's ability to satisfy his partner. They have read Masters and Johnson but emotionally they don't believe it. As with masturbation, the problem is not merely one of factual knowledge, but the statement "My penis is too small" is a symbolic expression of inner feelings of masculine inferiority and often of a sense of general competitive inadequacy.<sup>3</sup>

Except for the fact that they will be called upon to assist others with problems of sexual functioning, these medical students probably do not differ greatly from graduate students in other fields. Nor are the reasons for feelings of inadequacy exclusively of sexual derivation. In fact, the medical school appears as one etiological factor:

The sociology of the medical school situation . . . is a setting in which there is a great deal of realistic dependency, lack of autonomy, and daily confrontation with how inadequate one is in comparison with those above. At the same time there is a great deal of competitiveness within the system; teachers traditionally use humiliation to motivate learning, and it is literally impossible to ever learn enough. This is tailor made to prolong the circumstance of adolescence, and the student frequently feels himself to be a child masquerading as a man in physician's clothing. This is a difficult situation in which to maintain a solid sense of masculine self-esteem. It is not difficult to understand how in the unconscious this can be generalized and then symbolized in sexual terms, particularly if there is even minor sexual inadequacy or problems upon which to focus.<sup>4</sup>

The results of medical education that does not effectively deal with these anxieties and conflicts are that they are carried from school

into medical practice. Thus nearly one-third (eighteen) of the physicians in a sample of sixty interviewed in a study by Donald Burnap and Joshua Golden were judged to have behaved "in a manner which seemed unusual for an interview conducted in a professional medical context."<sup>5</sup> "Unusual activities" included obvious blushing, fidgeting and looking away, jokes, conspicuous avoidance of medical terms, acting overly suspicious of the interviewer, or expressing open resentment. Burnap and Golden found a striking difference between the mean proportion of sexual problems seen by this group (2.7%) and the proportion seen by the remaining forty-two physicians (15.0%).<sup>6</sup>

Burnap and Golden's sample of sixty physicians reported a total estimate of 13,687 sexual problems seen in the previous year, a mean of 228 per physician, corresponding to four cases per six-day week. Concerns about sexual response and sexual responsiveness led the list (see Table 2).<sup>7</sup> These figures presumably understate the extent of sexual concerns among the patients of this group of physicians. Dividing the respondents into two groups, one of physicians who routinely inquired about sexual problems while taking a history, usually as part of a review of systems, and a second group who did not inquire, Burnap and Golden found that the average proportion of sex problems seen by the physicians who did inquire was 14 percent, nearly twice the average proportion for the other group (7.9 percent).<sup>8</sup> Herndon and Nash have also noted that the patient is much more likely to ask for counsel on sexual problems if the physician brings up the subject.<sup>9</sup> Thus, inadequate preparation or procedure may result in a significant number of patient concerns not coming to the physician's attention.

TABLE 2

Types of Sexual Problems Defined and Ranked According to Frequency

<u>Problem as stated to the Physician</u>	<u>Estimated Cases Seen per year by 60 Physicians</u>
1. Lack of orgasm during intercourse	1,917
2. Frigidity, or lack of desire for intercourse	1,830
3. Frequency of intercourse, concern of the patient over how often intercourse occurs	1,146 [sic]
4. General sex information, no specific problem	1,438
5. Impotence, lack of erection during intercourse	1,335
6. Dyspareunia, or painful intercourse	1,212
7. Lack of affection in intercourse, whether or not orgasm occurs	1,016
8. Premarital counseling	648
9. Extra-marital intercourse including premarital	633
10. Premature ejaculation	571
11. Sex education of children, including the parent who asks for advice	520
12. Lack of satisfaction with intercourse, whether or not orgasm occurs	419
13. Sexual problems with disease or surgery, such as a woman contemplating hysterectomy	414
14. Sexual problems related to the menopause	410
15. Homosexuality (presented as a problem)	85
16. Perversions, all types, except those given in No. 15, and in No. 17 through No. 20	35
17. Masturbation	32
18. Nymphomania, or excessive desire for intercourse by the female	16
19. Incest, sex relations with other family members	5
20. Satyriasis, excessive desire for intercourse by the male	5

But if the physician is misinformed, anxious, or expresses inappropriate attitudes, bringing the concern to the attention of the physician may result in little relief. Consider the following incident recounted by James Mathis:

Marcia, a married woman in her late twenties, consulted her family physician about a routine sexual problem. She casually mentioned during the course of the interview that she was reading a book which mentioned fellatio, and that she did not understand the meaning of the word. The physician explained it briefly and reassured her that it was a practice confined to homosexuals and other perverts. Marcia never told the doctor that she and her husband had practiced fellatio (in ignorance of its fancy name) infrequently but with mutual pleasure for several years. She later consulted a psychiatrist for her overwhelming feelings of guilt and shame, and asked him never to divulge the information to the family physician. No great harm resulted since this patient had the sophistication and the ability to ask for help, but the incident caused considerable anguish and another medical bill.<sup>10</sup>

All too often, sexual, emotional, and even physical problems may have their source in a consultation with an improperly trained physician. Philip Sarrel, obstetrician-gynecologist, sex therapist, and sex educator at Yale University Medical School has reported sexual concerns of female patients resulting from their experiences during their first pelvic examination.<sup>11</sup> William Masters and Virginia Johnson write with regard to their experience in treating secondary impotence:

Careless or incompetent professionals inadvertently may either initiate the symptoms of sexual dysfunction or, as is more frequently the case, amplify and perpetuate the clinical distress brought to professional attention.

There have been 27 cases in the total 213 units referred for treatment of secondary impotence that have been told at first consultation with selected authority for relief of symptoms that nothing could be done about their problem. These cases are represented in all categories of etiological influence described previously in the chapter as prime initiators of the symptoms of secondary impotence.

When the sexually incompetent male finally gathers his courage and reaches for the presumed security of authoritative consultation only to be told that nothing can be done about his problem, the psychogenic effect of this denial of salvation is devastating.<sup>12</sup>

The professionals involved in most of these cases were physicians, but there were also several psychologists and several clergymen. The most common misinformation communicated as the cause of impotence was the patient's age (the average age of males in this category was 53). Other "diagnoses" attributed the onset of secondary impotence to masturbation after the age of thirty, a homosexual experience after adolescence, retribution for adulterous behavior, and penance for a premarital abortion.<sup>13</sup>

In addition to the above, Masters and Johnson cite six instances in which they regard the professional consulted as directly responsible for the onset of symptoms of secondary impotence. The following two histories illustrate such iatrogenic sexual dysfunction and also provide a revealing picture of a less celebrated aspect of the "mystery of sex."

A man in his early thirties married a girl in her midtwenties. Both had rather extensive premarital sexual experience. His was intercourse with multiple partners, hers was mutual manipulation to orgasm with multiple partners, but never vaginal penetration. She had retained her hymen for wedding-night sacrifice. However, the honeymoon was spent in repetitively unsuccessful attempts to consummate the marriage. The husband and wife felt that the difficulty was the intact hymen, so she consulted her physician for direction. She was told that it was simply a matter of relaxation, to take a drink or two before bedroom encounters. By relieving her tensions with alcohol she should be able to respond effectively. The drinks were taken as ordered, but the result was not as anticipated. The marriage continued in an unconsummated state for three years, with the wife's basic distress (in retrospect) a well-established state of vaginismus (see Chapter 9). Throughout the three-year period, the husband continued penetration attempts with effective erections at a frequency of at least two to three times a week. There usually was mutual manipulation to orgasm, when coitus could not be accomplished.

As a second consultant, her religious adviser assured the marital unit that consummation would occur if the husband could accept the wife's (and the adviser's) religious commitment. The husband balked at this form of pressure.

Finally, a gynecologist, third in the line of consultants, suggested that the difficulty was an impervious hymen. The wife immediately agreed to undergo minor surgery for removal of the hymen.

(It is not only the human male that is delighted to find some concept of physical explanation for sexual dysfunction.) When the physician spoke with the husband after surgery, the husband was assured that all went well with the simple surgical procedure and that his wife was fine. The physician terminated his remarks to the husband with the statement, "Well, if you can't have intercourse now, the fault is certainly yours."

Obviously, surgical removal of the hymen will provide no relief from a state of vaginismus, so three weeks after surgery, when coital connection was initiated, penetration was still impossible. For two weeks thereafter, attempts were made to consummate the marriage almost on a daily basis, but still without success. By the end of the second week both husband and wife noted that the penile erections were no longer full nor well-sustained.

The symptoms of impotence increased rapidly over the next few weeks. Three months after the hymenectomy, the husband was completely impotent. Both partners were now fully aware that the inability to consummate the marriage was certainly the husband's fault alone, for so he had been told by authority. The problem presented in therapy two-and-a-half years later by this marital unit was not only the concern for the wife's clinically established vaginismus but additionally the symptoms of secondary impotence that were totally consuming for the husband.

In another instance, the husband and wife in a three-year marriage had been having intercourse approximately once a day. They were somewhat concerned about the frequency of coital exposure, since they had been assured by friends that this was a higher frequency than usual. Personally delighted with the pleasures involved in this frequency of exposure, yet faced with the theoretical concerns raised by their friends, they did consult a professional. They were told that an ejaculatory frequency at the rate described would certainly wear out the male in very short order. The professional further stated that he was quite surprised that the husband hadn't already experienced difficulty with maintaining an erection. He suggested that they had better reduce their coital exposures to, at the most, twice a week in order to protect the husband against developing such a distress. Finally, the psychologist expressed the hope that the marital unit had sought consultation while there still was time for his protective measures to work.

The husband worried for 48 hours about this authoritative disclosure. When intercourse was attempted two nights after consultation, he did accomplish an erection, but erective attainment was quite slowed as compared to any previous sexual response pattern. One night later there was even further difficulty in achieving an erection, and three days later the man was totally impotent to his wife's sexual demands with the exception of six to eight times a year when coitus was accomplished with a partial erection. He continued impotent for seven years before seeking further consultation.<sup>14</sup>

The males in these histories might be regarded as unduly suggestible with regard to their sexual functioning. On the other hand, Masters and

Johnson comment that the "susceptibility of the human male to the power of suggestion with reference to his sexual prowess is almost unbelievable."<sup>15</sup> They also report that fears of sexual performance in connection with erectile adequacy were expressed, under interrogation, "by every male study subject beyond forty years of age, irrespective of reported levels of formal education."<sup>16</sup>

Nevertheless, males have fared well in the hands of clinicians in comparison with the treatment accorded women. The struggle for access to methods of contraception was initially directed at the indifference or hostility of the medical profession.<sup>17</sup> Even today a single woman must exercise care in choosing a physician in order to be assured that her request for contraception or treatment of venereal disease will not be met with a lecture on morality. Several years ago, it was the practice at Florida State University for students requesting contraceptives to be told they needed a letter from their parents. Whether or not the student wished to pursue the matter, the health service then wrote to the student's parents informing them that their daughter had requested contraceptives.

Only in recent years has the social and professional debate swung in favor of the female's right to her sexual heritage:

In addition to the age-long taboo on the study and understanding of sex, until recent times it was taken for granted, at least in most of the Western world, that the majority of females had neither the desire nor the capacity for sexual gratification<sup>18</sup> and in the minority who did, it was a defect that should be denied or somehow eliminated. . . . According to Havelock Ellis (52), Acton, a leading authority on sexual matters in England during the latter part of the last century, condemned the idea that women have sexual feelings as a "vile aspersion." . . . Apparently there were still some "decent women" who found pleasure in sex, because about this same time an English surgeon by the name of Dr. Isaac Brown Baker performed numerous clitoridectomies on women in order to prevent sexual stimulation

which, in turn, he was convinced would "cure" or prevent various "insanities," "epilepsy," "hysteria," "catalepsy," and other diseases.

Marie Robinson (138) points out that many authorities, up to World War I, agreed that sexual feeling in young women in love was pathological and abnormal. . . . And as recently as 1957 P. D. Klingensmith (94) referred to a modern textbook in psychosomatic gynecology that implies that the majority of women derive little or no pleasure from the sex act.

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(52) Ellis, H., Little Essays of Love and Virtue. New York: Doran, 1922.

(94) Klingensmith, P. D., "Sexual Adjustment as Seen by the Gynecologist and Obstetrician," in Emily H. Mudd and A. Krich, eds., Man and Wife. New York: Norton, 1957.

(138) Robinson, Marie N., The Power of Sexual Surrender, Garden City: Doubleday, 1959. 19

Warren Johnson writes that "in 1967 a well-known obstetrician-gynecologist told a medical gathering that women do not have a sex drive and he blamed modern 'immorality' on the myth that they do."<sup>20</sup> Persistence of these attitudes is a definite hazard, which may occasionally have extreme consequences. Warren Johnson reports that he personally has been instrumental in preventing "more than one clitoris removal which had been medically prescribed to stop little girls 'masturbating.'"<sup>21</sup>

Our discussion in this section has focused on the medical profession. In fact, despite the shortcomings noted, the medical profession has probably done more in this regard than most or all of the remaining professions that might be expected to share in dealing with sexual problems of patients or clients. While physicians are generally regarded as the profession of first resort for persons seeking assistance for a sexual problem, psychologists, nurses, social workers, guidance counselors, teachers, physiotherapists, pharmacists, and clergymen all

have occasion to deal with sexual matters. Their level of preparation is similarly often inadequate.

As serious a problem as inadequate professional training of clinicians represents, only a very small proportion of sexual concerns are ever brought to a clinical setting. We will now consider the much larger population troubled by sexual concerns.

## VI

### GUILT, SHAME, AND ANXIETY

In this section we will consider the impact of sexual morality on which might be termed "innocent victims." That is, while other categories involve individuals actively seeking coital or sexual pleasure (either outside or inside marriage), many of the "innocent victims" have merely been growing up in our society and attempting to obey the precepts of the more restrictive forms of traditional morality.

All societies must react in some way to the arrival of the menarche in their adolescent females. The menarche may be an occasion for a joyous celebration and welcome of the pubescent female into tribal womanhood, or at the other extreme she may be made to feel guilty, ashamed, and dangerous. While there is a great deal of variation in our society, the median response would be located somewhere along the negative half of the scale.

The effects of the uneasiness or unwelcomeness with which the onset of menstruation is greeted may remain with the woman until menopause relieves her of "the curse." Menstrual disorders not traceable to organic causes affect a sizeable percentage of women.<sup>1</sup> Although the etiology of premenstrual tension and dysmenorrhea remains an unsettled question,<sup>2</sup> there are indications that psychological and perhaps specifically sexual factors play a part.<sup>3</sup> Moreover, shame, embarrassment, and anxiety can constitute a significant burden for the adolescent

female who has not been fortunate enough to receive an accepting and affirmative view of this natural bodily function or who finds herself in a situation (such as being a house guest) where an untimely menstrual flow catches her unprepared and forced to break the taboo against talking about menstruation in order to ask for assistance.

In many areas of commercial activity, environmental concerns have prompted us to take a new look at the existing emphasis on growth and consumption. Until very recently, for example, utility companies spent considerable sums encouraging the public to consume more electricity; they have since begun to encourage conservation. It is perhaps an indication of our backwardness in the sexual area that the profit motive continues to fulfill a positive social role.<sup>4</sup> Indeed, the sex educator might wish additional commercial opportunities existed.

Warren Johnson has noted:

We should not underestimate our indebtedness to the companies which market products making possible at least a semi-graceful disposal of menstrual flow. Their advertising has encouraged a popular acceptance of at least a little sex education for girls. Unfortunately, no one has yet discovered a commercial value in any exclusively male function at puberty which might give an impetus to comparable sex education for boys. So the boys are usually on their own. This is in spite of the fact that many men consider their first "wet dreams" among the most terrifying experiences of their lives, brought on, they may conclude, by their masturbating.<sup>5</sup>

Though Kinsey et al found that the condemnation of nocturnal emissions has not been great and that most boys have learned that they are usual and normal,<sup>6</sup> he adds that especially in some religious schools and in some penal institutions, authorities "may reprimand the individual who 'allows' emissions to occur, and there are records of at least two disciplinary schools where the boys were punished for having nocturnal

emissions."<sup>7</sup> Of course, since it is impossible for a boy to prove (if he were ever to be given the opportunity to attempt it) that the tell-tale stains on pajamas or sheets are not the result of "willful" masturbation, an adolescent male is in danger of punishment in any family or institution where masturbation is condemned.<sup>8</sup>

That masturbation remains a source of anxiety and concern can be credited to the prodigious efforts of the medical and spiritual professions in the last century. In the middle of the eighteenth century, Samuel Auguste Tissot, a Swiss physician and the Pope's advisor on the control of epidemics, introduced into European medicine the doctrine that willful masturbation caused blindness, impotence, insanity, and a host of other maladies. This doctrine was spread widely by William Acton, an eminent London urologist, and received general support among both physicians and parents.<sup>9</sup>

Inasmuch as no scientific evidence has ever been adduced in support of this doctrine, its formulation and widespread acceptance can probably be attributed to the severe condemnation of masturbation by the Talmudic Jews and later, by the Catholic and Protestant religions.<sup>10</sup> In any case, the efforts to give masturbation a better name have not yet succeeded as thoroughly. For a report concerning the first half of the twentieth century, we can turn to Kinsey et al;

The older males who have contributed to the present study were adolescent in a day in which there was widespread teaching against the sin of self-abuse (e.g., . . .<sup>11</sup>). Every conceivable ill from pimples to insanity, including stooped shoulders, loss of weight, fatigue, insomnia, general weakness, neurasthenia, loss of manly vigor, weak eyes, digestive upsets, stomach ulcers, impotence, feeble-mindedness, genital cancer, and the rest, was ascribed to masturbation. Feeble-minded and insane individuals in the neighborhood were held up as horrid examples of the result of masturbation, and the authorities in mental institutions maintained

separate wards for those whose insanity was supposed to have originated from such practices. Patients in such institutions were observed to engage in frequent masturbation, and this seemed sufficient proof that the insanity was a product of the sexual behavior. Since the lives of university scholars were not so easily observed, it was not so generally known that masturbation occurred quite as frequently among them. Thousands of patients in mental institutions were put into straitjackets or other restraints, on the assumption that they had no chance of recovery unless the masturbation was controlled and cured. There are mental institutions which are operated on the same theory today. In many penal institutions inmates may still be punished severely if found masturbating, and in some homes for children and in some other institutions the older attitudes are still enforced. The United States Naval Academy at Annapolis rules that a candidate "shall be rejected by the examining surgeon for . . . evidence of . . . masturbation" (U.S. Navy Dpt. 1940).

Millions of boys have lived in continual mental conflict over this problem. For that matter, many a boy still does. Many boys pass through a periodic succession of attempts to stop the habit, inevitable failures in those attempts, consequent periods of remorse, the making of new resolutions--and a new start on the whole cycle. . . . The record does include thousands of cases of boys living in continual conflict, fearful of social disgrace, oftentimes disturbed over the effect of such behavior on their ultimate sexual capacities, occasionally attempting suicide--as a result of the teachings concerning masturbation.<sup>12</sup>

Though the quarter century that has elapsed since the above was written has seen greater acceptance of masturbation, informed observers still find widespread concern and anxiety about this ancient practice.<sup>13</sup> Indeed, Kinsey's description of the cycle of attempts to stop, failure, and remorse would be familiar to many young men today (judging from audience reaction in lectures and discussions I have conducted among undergraduates), though in the contemporary formulation, resolutions to stop would instead be the feeling that it is somehow preferable to reduce the frequency, while remorse would be replaced by shame.

As noted earlier, concern about masturbation currently is most likely to involve masturbation that is judged "excessive" or that is practiced after adolescence or marriage. In Masters and Johnson's group:

For the men forty years or younger, fears of performance centered about questions of excessive ejaculatory experience and concerns for premature ejaculation. The problem of too frequent ejaculation was associated in the minds of many study subjects with possible loss of physical strength and not infrequently was presumed to be a basis for emotional instability if not severe neurosis. These misconceptions have grown from the culturally centered fear that frequent or excessive masturbation may lead to mental illness. No study subject could provide a secure personal concept of what constituted frequent or excessive levels of masturbation, nor could anyone describe an instance known to them, even by report, of mental illness resulting from masturbation. The superstition that physical or mental deterioration results from excessive masturbation is firmly entrenched in our culture, if returns from the team questioning of the total male group of study-subject applicants are any criterion.<sup>14</sup>

Nor are homosexuals spared these concerns:

The author has encountered homosexuals of each sex who were as guilt-ridden and fearful about masturbation as any who follow the heterosexual pattern. Indeed, several stated that they were seduced into homosexual activity by clergymen on the pretext that they were being saved from the dangers of masturbation.<sup>15</sup>

While the clergymen referred to are exceptional for the remedy they endorse, their attitude toward masturbation is by no means so rare. The Minority Report of the Papal Commission on Birth Control warned that if the traditional link between intercourse and procreation is set aside, "the door is opened easily to the licitness of masturbation among youths."<sup>16</sup> David R. Mace notes that

. . . the Catholic Church finds itself still unable to compromise its ancient position. The best amelioration of judgment that can be offered by a relatively liberal moral theologian is that "the average adolescent who has a fairly deep-rooted habit of masturbation is not guilty of mortal sin in every act."<sup>16</sup>

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<sup>14</sup>Dedek, John F., Contemporary Sexual Morality (New York: Sheed and Ward, 1971), p. 64. 17

Our focus on negative emotions should not lead us to overlook the loss to those who because of society's attitude do not masturbate. Sexual expression, including masturbation, is both a source of considerable

pleasure and a harmless (often beneficial) way to release somatic and psychic tension. In our frequently sexually frustrating (and frustrated!) society, the ability to masturbate enjoyably and without negative emotions can be a personal resource of considerable value for males and females. The case for masturbation has been stated in humanistic terms by Walter Stokes:

The author has observed that among unmarried young adults the ability to masturbate without feelings of guilt is correlated with a more dignified and discriminating way of relating to the opposite sex than is seen among many who fear and shun masturbation and are compulsively driven toward the opposite sex as their only permissible outlet. In this sense masturbation may be said to have a genuinely affirmative moral and social value. Nevertheless, it is surprising, in the course of clinical counseling, to note how many young people shy away from masturbation because of a deeply rooted conviction that it is degrading or harmful and inferior to any intercourse experience, even one of very poor quality. Such a view ill serves human dignity and tends to push those who hold it into stupidly judged, miserably unhappy liaisons.<sup>18</sup>

Rivaling masturbation as a prime source of concern among young males is homosexuality. Similarly, fear of being labelled, or of labelling oneself, a "homo" keeps many males from expressing affection and receiving physical stimulation from other males.

A ten-year review of students seen at the Yale Mental Hygiene Clinic during the 1930's found that nearly 40 percent presented;

. . . histories of emotional difficulties connected with sex. . . . About one-tenth of the students in the whole group had vague fears of homosexuality, or engaged in homosexual activity and feared becoming permanently homosexual, or were homosexual.<sup>19</sup>

Half of these students had had no overt homosexual experiences at all but were nevertheless troubled by fears about their sexual orientation. Fry and Rostow add;

Fear may appear in connection with excessive masturbation; or dreams and fantasies; or an attachment to a teacher or student; . . . or in a real indifference to girls, or an imagined

indifference related to social awkwardness and self-consciousness.<sup>20</sup>

For the approximately 25 percent of males whom the Kinsey researchers found to have "more than incidental homosexual experience or reactions . . . for at least three years"<sup>21</sup> and for a smaller percentage of females, social rejection of their sexual orientation may be a constant source of conflict both in emotional life and in day to day living.<sup>22</sup>

In its severe form, concern about sexual orientation can express itself in an acute psychotic reaction that has been labelled "homosexual panic." This condition may occur following a dream or feelings of sexual arousal from visual or physical contact with another male. The unstable defenses crumble and the individual is overwhelmed by anxiety in a profound questioning of his entire sexual identity.

More common, as many male readers will recognize, is the uncomfortable feeling that a boy may develop when he is approached homosexually by an adult male. The boy may worry that he is a "latent" homosexual and has sent out a "radar signal" to the other person.<sup>23</sup> Anxiety in relation to homosexuality may result in a vicious attack on the homosexual individual, either "provoked" as in the example above, or unprovoked, as in the phenomenon of "queer bashing."

Many male readers will also recognize the incident described below. Mary Calderone and others have noted the avoidance of physical contact by males in our society out of fear of homosexuality. She describes the situation when her husband Frank, who has a Sicilian background, will get into a passionate debate with an American and he'll reach over to grab the man's hand and hold onto it while arguing. And I sit there and watch the man shrink.<sup>24</sup>

On the way home, she jokingly tells Frank to "please keep your hands off

Anglo-Saxons."

Physicians and medical students, of course, are expected to be unaffected by our cultural teachings about physical contact and by the experience itself. Not surprisingly, this is somewhat unrealistic:

The initial seeing and touching of patients' bodies runs counter to over 20 years of conditioning via the taboos of our society against such behavior, and each has strong sexual associations to the idea of seeing and touching the nude body. The process of divorcing this special medical condition from the general human condition is not an instantaneous one, and it takes time and clinical experience. This has a high potential for producing guilt and shame and significantly undermines the student's attempts to solidify his identity as a professional. One freshman student was ready to leave school, certain he was "the worst sort of pervert" because of his arousal and stimulation during his first encounters with physical examination.<sup>25</sup>

Concerns about "inappropriate" sexual feelings afflict a much wider constituency than medical students. The rather narrow definition of acceptable sexual feelings has disconcerted many a man who found himself becoming aroused by a woman not his wife, a teenager, an infant crawling over him, or his own daughter or son. But girls and women face an even greater potential conflict since they have been taught that any sexual feelings they might have grow out of feelings of love;

One problem women face is how to handle spontaneous sexual feelings experienced in fantasies and dreams. We often see adolescent girls at Planned Parenthood who feel guilty simply because sexual feelings arise independent of a love relationship. Many spend a great deal of energy trying to censor or ignore these feelings because they believe that they represent an abnormal experience for a female, when in fact they are natural occurrences.<sup>26</sup>

One love relationship where sexual feelings are not traditionally viewed as acceptable is that between mother and baby. In the absence of specific teaching to counteract the prevailing negative atmosphere about sexual feelings, women who experience sexual arousal while nursing their infants may feel guilty or uneasy. Masters and Johnson's study

group included 24 women who nursed their babies two months or more. When reporting sexual feelings related to nursing, six of these women expressed guilt feelings.<sup>27</sup> Guilt, anxiety or stress may make the nursing mother unlikely to continue breast feeding or even inhibit her ability to do so, thereby depriving the infant of nutritional and emotional benefits.<sup>28</sup> Even if she does not break off breast feeding, anxiety or tension can be communicated to the infant.

Here again we are concerned not only with the explicit negative consequences of the rejection of sexuality, but also with the loss of positive experiences. Niles Newton, who has studied lactation and childbirth extensively, reports considerable evidence about the sexual components of breast feeding (for example, both lactation and coitus involve uterine contractions, nipple erection, skin changes, and emotional responses).<sup>29</sup> After asserting that our concepts of female sexuality have been distorted and restricted to conform to male experience, Niles Newton writes:

In practical terms, this [close interrelation of the psychophysiologic functions of coitus, parturition, and lactation] implies that what occurs on the delivery table is very pertinent to what will transpire later in the marital bed and that mother-baby relationship without enjoyable lactation is in a somewhat similar psychophysiologic position as a marriage without enjoyable coitus.<sup>30</sup>

Finally, upon termination of the reproductive years, women are again victims of the omission of sex education;

It would seem that the maladjustments and abnormalities of sex drive shown by states of hyper- or hyposexuality which develop during and after the menopause might best be treated by prophylaxis. If satisfactory counseling of sexual content were made more available to sexually insecure, uneducated, or inadequate women in the premenopausal years, there is reason to believe that the unresolved tensions of the later years might be reduced or, to a large extent, avoided.<sup>31</sup>

Of course, the cessation of menstruation does not mean the end of sexual concerns. In fact, it may mean a worsening of the woman's situation, since she then takes on the burden of social teachings that postmenopausal women ought to have no interest in or desire for sexual activity. Sexual interest on the part of the aging male is at least acknowledged, if not honored, in the expression "dirty old man." For the aging female, the concept has not even been verbalized.

No discussion of sexual difficulties that occur quite independently of coital experience would be complete without at least mentioning some of the anxiety causing myths and misconceptions that flourish in the absence of adequate sex education. Some of the more common ones are:

- the fear that there is only a fixed amount of sperm available in the male, and that excessive sexual activity (including masturbation) will lead to the individual's "running dry" later in life;
- the belief that a small penis is inferior to a large one in terms of sexual ability and "masculinity";
- the belief that impotence inevitably comes with aging;
- the belief that women lose their interest in sex following menopause;
- the belief that sexual intercourse during the menstrual period is dangerous or unhealthy.

It is probably true that even in the absence of specific information refuting these misconceptions, none would be so common were it not for the overall atmosphere of anxiety and mystery that surrounds sexuality. The same would be true for the anxiety described earlier regarding masturbation, homosexuality, and sexual feelings. And yet, despite anxiety and mystery, most people do in fact engage in sexual activities. Official morality may condemn, but it does not deter the behavior

itself. We shall now consider some of the effects of this discrepancy between official morality and sexual behavior.

## VII

### SEX OFFENDERS

If the last section dealt with the "innocent," this one deals with the guilty. For the vast majority, "guilty" means that they experience some emotional stress from desiring or engaging in sexual behavior outside the relatively narrow limits prescribed by official morality. For a small but severely penalized minority, "guilty" means that they have actually been convicted and punished for an act judged criminal in statutes and the courts but which resulted in no harm to anyone until official morality intervened.

So widespread are guilt feelings about sex that they are regarded almost as a "natural" part of growing up. To have avoided all guilt over sexual behavior would for many have entailed avoiding all sexual behavior. So working through guilt, often with professional help, becomes part of the rite-de-passage of the teens, the twenties, or for those who get a late start, the thirties or forties.<sup>1</sup>

A suggestive study of college students by Ira Reiss<sup>2</sup> found that:

47 percent of those who currently accept kissing had previously felt guilty about it; 52 percent still felt guilty;

78 percent of those who currently accept petting had previously felt guilty about it; 55 percent still felt guilty;

97 percent of those who currently accept coitus had previously felt guilty about it; 49 percent still felt guilty.

Oral-genital contact similarly often evokes guilt feelings even among

married couples.

Another source of guilt and anxiety for the married is extra-marital sexual desires and relationships. According to Kinsey and associates, one fourth of married women and one half of married men experience extra-marital coitus by age forty. An additional 17 percent of married females indicated they intended to or might consider extra-marital coitus at some future time.<sup>3</sup> Nevertheless, despite this and other evidence of the widespread nature of feelings of sexual attraction toward other partners, extra-marital relations and even desires remain widely unacceptable, to the extent that marriage counselors still find it necessary to assure couples that it is normal even within a happy marriage to experience sexual attraction toward another person or to think of someone other than one's partner during marital coitus.

Since the publication of the Kinsey studies over twenty years ago, there has been convincing evidence of the considerable discrepancy between the sexual behavior of the vast majority of Americans and the morality prescribed in the laws of most states. In 1948, Kinsey noted that more than 95 percent of the male population had engaged in sexual activities that were punishable as crimes under the law.<sup>4</sup> Inasmuch as most states retain statutes against fornication, adultery, homosexuality, and "unnatural acts" (commonly interpreted to include oral-genital and anal contact), the figure would not be lower today.

Most prosecutions for these victimless crimes involve homosexual acts or solicitation in public places. The "innocent" party is often a plainclothes policeman who loiters in a public restroom frequented by homosexuals. When he succeeds in attracting the interest of an

unsuspecting male, the arrest is made. One police department in Ohio installed a detective with a movie camera behind a one-way mirror in a public lavatory, a technique that led to a score of arrests and extended prison sentences.<sup>5</sup>

Statutory penalties for homosexual acts can be harsh. As of 1966, 20 states set a maximum of between 10 and 15 years imprisonment, another 13 states had a 20 year maximum, while in 5 states a convicted offender could be sentenced for life.<sup>6</sup> These severe sentences in the absence of demonstrable harm or threat to society reflect the emotions aroused in law enforcement authorities, legislators, and the public.<sup>7</sup>

Legislative emotions also result in imprecise statutes referring to "unnatural acts," the "crime against nature," and so forth. Such vagueness would ordinarily not be tolerated by the courts. But even the courts apply a double standard in this area. As the Maine Supreme Court noted in a 1938 case:

The statute gives no definition of the crime but with due regard to the sentiments of decent humanity treats it as one not fit to be named, leaving the record undefiled by the details of different acts which may constitute the perversion.<sup>8</sup>

Enforcement of the sodomy laws is sporadic. More frequently, male homosexuals are prosecuted under misdemeanor statutes for solicitation, disorderly conduct, lewd and lascivious behavior, and vagrancy.<sup>9</sup> Homosexual acts or "tendencies" can also lead to "dismissal of any federal employee, rejection at draft induction, separation from the military with a less than honorable discharge, and, among immigrants, deportation."<sup>10</sup> Summarizing the impact of law and law enforcement policies on homosexuals, Weinberg and Williams conclude:

. . . the sometimes arbitrary and unpredictable nature of law enforcement practices . . . create a built-in instability in the

social situation of the American homosexual. While it is our contention that this difference [from Denmark and the Netherlands] has been overemphasized in accounting for the homosexual's difficulties, nonetheless it is a persistent irritant for the majority of American homosexuals and the source of ruination for many of them. In addition, it symbolically buttresses a negative evaluation of their sexual orientation.<sup>11</sup>

Heterosexual behavior may also be the subject of prosecution.

Where the female (and sometimes the male) is under a specified age (usually sixteen, eighteen, or twenty-one), the older party may be convicted of statutory rape, corruption of a minor, or a similar crime.<sup>12</sup> If the female is married, one or both partners may be convicted of adultery. Finally, fornication--sexual intercourse between two unmarried persons of any age and in any circumstance--is prohibited in all states but ten.<sup>13</sup>

Although these laws may date back a hundred years or more, they continue in force. A New Jersey county judge recently upheld the state's 1796 anti-fornication law under which a twenty-year old Newark laborer was convicted in February, 1974, and fined fifty dollars. The New Jersey Supreme Court had upheld the statute several years ago in a case involving an unwed mother and father.<sup>14</sup>

Since studies of sexual behavior demonstrate that many persons have engaged in behavior prohibited by these laws, the question arises who is prosecuted and why. The Institute for Sex Research study of individuals convicted of sex offenses found that in the category of (non-violent) offenders against adults, the commonest situation (47 percent) was for the authorities to be notified by disturbed relatives or friends of the girl. The complaint usually arose from the failure of the girl to come home early enough.<sup>15</sup>

As an example of a complaint filed by a relative of a woman of legal age (less frequent), the authors write:

One example was a situation in which an unmarried man of twenty-nine began living with a married woman of twenty-three whose husband was away in military service. The woman's brother was shocked by her behavior, and when she ignored his protests he reported the matter to the police. The twenty-nine year old was convicted of adultery, sentenced to 60 days, and fined \$15 and court costs.<sup>16</sup>

While in some of these cases, a teenage female may in fact be "taken advantage of" by an older male, this conceptualization primarily conceals the underlying rationale for punishing the behavior--i.e., that sex is defiling, damaging, and immoral--as well as the historical basis for the prohibitions--to protect the property rights of husband and father. The unfortunate results are considerable fear by the sexual partners of teenage women whose parents disapprove of the relationship and occasional prosecutions of these males. The possibility of prosecution of her boyfriend can also lead a teenage woman to use a false identification in order to secure an abortion without having to obtain parental consent. In addition to the guilt she may feel, such a procedure inhibits the readiness with which follow-up medical care will be obtained if needed.

Occasionally, prosecutions under the sex laws are undertaken against married couples engaging in sexual activities that are recommended in many marriage manuals. In 1971, for example, an Indiana man received a five to twenty year prison sentence for engaging in oral-genital sex with his wife. Feeling guilty, the wife had told her minister, who recommended she tell the police. The sentence was upheld by the Indiana Supreme Court. In such cases, even if the wife changes her mind about pressing charges, the police may be able to subpoena her

and continue prosecution.<sup>17</sup>

Married people also come into court when their marriage breaks down. Here, as Robert Veit Sherwin notes, as a result of the sex laws and judicial attitudes, an earlier source of marital felicity becomes part of the weaponry in a contested divorce proceeding. For example, the wife may seek a divorce on the ground of extreme cruelty, charging that her husband forced her to participate in an illegal sex act. Or, a husband anxious to keep down the level of support his wife asks for may declare in court (or threaten to declare) that his wife is a criminal because of the forms of sexual expression she enjoys, and is therefore an unfit mother and should not be allowed custody of their children. The occasional prosecutions under the sex laws and occasional rulings in divorce proceedings reinforce the more widespread impact on estranged couples. Robert Sherwin explains:

Nobody wants to be a test case. It does not comfort a client to say: "Let him bring an action and let him tell all that he threatens to. I really do not believe that a judge would deprive you of your children because of this."<sup>18</sup>

Sometimes the court does in fact find against the mother, and the children as well as the wife may be the losers:

In one case, for example, where the father had admitted that the two children were well brought up, that they were unaware of any adulterous act on the part of their mother, the highest court of the particular state held that because the mother had merely expressed in an affidavit that her adulterous acts were a valid channel of gratification for a woman who was dissatisfied with her own husband, she was, without further reasoning, an unfit mother. The court, in stating that such thoughts were . . . repugnant to all normal concepts of sex, family, and marriage was in fact saying that the wife's opinion of her own behavior was so repugnant to the court's own subjective standard of morality that it went without saying anything further that she was an unfit mother and that to allow her to have a continuing custody of her children would be against the best interests of the children. This, in spite of the fact that both the lower

court which had heard the evidence and the Appellate Court had decided without question that the mother was a fit mother.<sup>19</sup>

It is similarly difficult to imagine what harm could have resulted from the following unconventional parental approach to sex education that could be greater than the results of depriving a child of both parents for an extended period and in a context in which the child is very likely to feel himself the cause of his parents' punishment. In this case, a Florida woman was sentenced to six to eighteen months imprisonment for demonstrating the sex act to her eight year old son. The boy had told school friends that his parents were showing him how to make babies. School authorities notified the juvenile authorities. The Florida Supreme Court upheld the conviction and the boy's mother served nearly eleven months in prison. Her husband, the child's stepfather, was not brought to trial but was committed to the state hospital as a criminal sexual psychopath.<sup>20</sup>

The existence of the various laws and their occasional invocation may also have a chilling effect on the exercise of their rights by many of the people who live in otherwise socially tolerated violation of these laws. For example, an unmarried couple living together may feel unable to assert their rights as tenants out of fear that the landlord will introduce their marital status in any proceeding which might ensue.

The sex laws have also interfered with clinical programs for treating sexual dysfunction in unmarried individuals. Following a lawsuit which was settled out of court, Masters and Johnson were forced to discontinue their use of "partner surrogates," sexually healthy persons who were paired with dysfunctional individuals for the duration of the treatment program. Without the possibility of a partner surrogate,

dysfunctional individuals face the dilemma of not being able to enter Masters and Johnson therapy without being in a relationship, yet being unable to form a relationship while handicapped by sexual dysfunction. Where the local legal climate is favorable, some clinics employ partner surrogates; others have avoided treating single persons out of fear that they might be prosecuted for pandering or prostitution.

The laws against prostitution may also interfere with therapeutic functions outside the context of the clinic. A social worker who covertly observed and recorded interactions between 1,242 men with New York call girls writes:

Looking at the range of functions performed by the call-girl-client transactions, it becomes apparent that call-girl prostitution has been operating unrecognized as an underground sexual health service. Fifty-two percent of the clients I observed put the call-girl in the position of meeting a definable therapeutic need for crisis intervention, for ventilation of problems, for the expression of suppressed desires, or for sexual counseling. Many others appeared to be using sessions with the call girl to obtain temporary relief from feelings of stress, to raise their sense of self-esteem, to restore their confidence in their own sexuality, and, by receiving all these benefits, to help them deal with the problems of middle life.<sup>21</sup>

Prostitutes were of considerable importance in the beginning of the Masters and Johnson research program and suggested stimulative techniques many of which "have been found to have direct application in therapy of male and female sexual inadequacy and have been integrated into the clinical research programs."<sup>22</sup>

Obviously, prosecution and imprisonment is attendant with many negative health consequences and the inhibition and restriction of harmless activities through fear of prosecution also may have a negative impact. In the case of most of these laws, the American Law Institute has recommended their removal from the statute books. The recommendation,

made over a decade ago in the Institute's Model Penal Code, has been followed by only a handful of states. No compelling social purpose has been demonstrated for these laws, and their ecclesiastic origins would ordinarily make them suspect. But no politician wants to be known to his constituents as the legislator who made fornication or sodomy legal.

The sex laws and the attitudes which keep them in existence both result from and contribute to the sex-negative atmosphere we described in an earlier chapter. This atmosphere also has an impact on sexual functioning itself, and in turn an effect on the relationships in which sexual functioning does or does not take place. We will now examine the state of sexual function and dysfunction.

## VIII

### SEXUAL FUNCTION AND DYSFUNCTION

Any concept of dysfunction depends upon an understanding of what constitutes health or adequate functioning. If the expectation, for example, is that "in sorrow thou shalt bring forth children," then pain in childbirth will not be regarded as dysfunctional. Such pain may even come to be regarded as necessary or desirable. The use of anesthesia for women giving birth was originally opposed by many who felt that pain and travail were appropriate for the occasion.<sup>1</sup>

Progress in refining and improving concepts of healthy function and of accompanying pathology, has come largely from the systematic observation, often with increasingly powerful instrumentation employed in a laboratory setting, of bodily processes. New knowledge has made possible new conceptualization. New conceptualization has in turn made possible new cultural assumptions, and new cultural assumptions have further altered conceptualization and the discovery of new knowledge. The process is, of course, even more complex, since "new" knowledge may have been known in earlier times, its rediscovery and subsequent acceptance reflecting cultural factors.

Not only is the process more complex, but it is also not always welcomed. Anxiety is aroused by challenges to existing cultural forms. Material advantages that accrue to individuals and institutions from existing cultural forms may also be jeopardized. Both possibilities

motivate resistance at each stage of the process of discovery of knowledge and reshaping of cultural assumptions.

Some examples from the late Middle Ages are provided by G. Rattray Taylor:

In 1600 Giordano Bruno was burnt for holding, what the Greeks, Romans and Chaldeans had realized ages before, that the universe evolved. (When in 1889, a statue was erected to Bruno opposite the Vatican, the Pope seriously considered leaving Rome.) The already dead body of Archbishop Antonio de Dominis, a Dean of Windsor, was formally burnt, together with his writings on the nature of light. Galileo was tortured and imprisoned by the same man who, as Cardinal, had befriended him. Campanella was tortured seven times for defending Galileo. Descartes, whose Principia had narrowly escaped the charge of being heretical, was so discouraged by the fate of Galileo that he abandoned his plan for a magnum opus, the Treatise on the World. When G. P. Porta, inventor of the camera obscura, Founded a society for experimental research, Pius III banned it-- probably because he was the first man to write a treatise on meteorology, whereas the Church held that storms were caused by God or by witches.<sup>2</sup>

Even after the physical sciences had acquired a measure of acceptance and freedom of inquiry, the biological sciences continued to be subject to persecution at the hands of the Church and the people. The study of anatomy depended on the willingness of "body-snatchers" to raid graveyards for the subjects of study. Darwin became the *bête noire* of organized religion when he published his Origin of Species, giving birth to a controversy that surfaces from time to time to this day.

In the latter half of the twentieth century, we like to think of ourselves as scientific and enlightened. But in the area of sex, we are all too often caught with our past showing. Both Kinsey and associates, and Masters and Johnson, incurred highly emotional critical reaction, which while it did not lead to their being burned or their books being burned, had a strong restrictive impact on their work.<sup>3</sup>

The emotional reaction to sex research has waned considerably.

But even if sex research were fully accepted (and fully funded), we would still be handicapped by past restrictions. The immense value of Masters and Johnson's laboratory research is due partly to the scarcity of previous knowledge. Much research remains to be done; until it is carried out it will be impossible to place the epidemiology of sexual dysfunction on anything approaching a sound footing.

We can illustrate some of the difficulties involved in defining sexual dysfunction by considering female sexual response. It is probably widely accepted at the present time that a woman in a loving relationship with her husband ought to enjoy sexual intercourse most of the time, and that if she does not something is amiss.<sup>4</sup> But enjoyment itself is difficult to measure and not necessarily a valid indication of sexual functioning. A woman who has never heard about or experienced sexual orgasm may enjoy intercourse but might enjoy it much more if she did experience orgasm. The same woman might enjoy intercourse less if she learned about sexual orgasm but still did not experience it, because her expectations would be changed.<sup>5</sup> Moreover, her reported enjoyment might constitute an accommodation which might conceal underlying dissatisfaction.

Because of the difficulty in defining and measuring such concepts as enjoyment and satisfaction, researchers have relied primarily upon occurrence of physiological responses such as vaginal lubrication and distension, pelvic vasocongestion, and orgasm.<sup>6</sup> This approach does not entirely avoid problems of definition and measurement. Orgasm, for example, can have various intensities (objective, as measured by recording apparatus, and subjective, as reported by the individual;

subjective and objective ratings do not necessarily agree), may be more or less pleasurable, may require more or less effort to attain, and the effort required may be more or less enjoyable.

There is, moreover, the added dimension of the context or relationship in which the sexual response takes place. Few would regard a woman who did not enjoy sexual intercourse and did not experience orgasm while being raped as suffering from sexual dysfunction. But evaluation is less unanimous where pleasure and/or orgasm are absent in self-masturbation or in consensual sexual intercourse involving, for example, a stranger, a casual friend, a close friend, a fiancé, a loved husband, or for that matter another woman.<sup>7</sup>

For an individual or couple concerned only with their personal adjustment, these questions are of secondary importance. For that matter, they may be quite disconcerting, since they are taken as reflecting on our adequacy as females or males, and our self-esteem in general. In order to reduce anxiety, invidious comparisons, and aggravation of our "performance orientation," we feel considerable pressure to set the standards for sexual functioning within reach, so to speak. But while this method eases anxiety and may be in the interest of present harmony, it does have the potential to mask a great deal of disturbance of sexual function.

Turning for a moment to male sexual response, premature or rapid ejaculation has long been a matter of concern to many men and their sexual partners. Criteria for how soon an ejaculation had to occur to be classified as premature ranged from 30 seconds to two or more minutes. The only situation which produced wide agreement was ejaculation

that occurred prior to penetration of the vagina, where a judgment could be based upon the interference with the procreative function. Using a similar rationale, Kinsey went so far as to declare that there was no basis for judging intravaginal ejaculation premature regardless of how quickly it occurred.<sup>8</sup> Earlier conceptualizations have been rendered obsolete, however, by Masters and Johnson's ability to enable nearly all males who enter their treatment program to delay ejaculation as long as twenty minutes while simultaneously enhancing their receptiveness to sexual stimulation. Similarly, Masters and Johnson's 75 percent success rate in enabling women consistently to achieve orgasm through coital stimulation casts a new light on earlier conceptualizations of female sexual functioning.

Increased ability to improve sexual function has thus led to a revised conceptualization of inherent capabilities for human sexual function. Though the ability to improve sexual function does not itself imply that the previous level of functioning was impaired (it may merely have been undeveloped), the strong impression of clinicians is that this is indeed the case.<sup>9</sup> Moreover, though therapeutic success does not demonstrate causation, clinical impressions again assign considerable weight to the isolation in ignorance of couples embarking on their sexual relationship, the lack of socio-cultural support for (and frequent prohibition against) expressing and enjoying sexuality, and the associated cultural demands for performance.<sup>10</sup>

Sexual dysfunction undoubtedly reflects multiple factors. Empirical associations have been found between consistency of female orgasm and educational level, social class, decade of birth, and the influence

of culture or subculture.<sup>11</sup> Devout Catholic women experienced orgasm in a lower percentage of marital coitus than did inactive Catholic women or Protestant women.<sup>12</sup> Masters and Johnson and other clinicians have stressed the importance of feelings about the relationship on the part of both partners. The role of unconscious factors has been asserted by psychoanalytic writers. Seymour Fisher has adduced evidence signaling the importance of the woman's feelings regarding the dependability of love objects and her past relationship with her father.<sup>13</sup> Finally, the nature of women's role in other areas of life and their feelings about that have been suggested as interfering with sexual function and intimate relationships.

Many of these possible causes are consistent with the view that traditional sexual morality carries a significant share of the responsibility for existing sexual dysfunction. From a public health standpoint, we can make a much stronger statement. Whatever the causes of sexual dysfunction, the principal reasons for the lack of research, training, and provision of therapeutic opportunities lie in the negative valuation of sexual pleasure. Virginia Johnson has noted that "sexual dysfunction often has been compounded by the fact that sexual expression has been put aside for other demands, or given lesser priority [than] shopping, cleaning, crying babies, telephones, the relatives, neighbors, and so on."<sup>14</sup> This observation is closely paralleled at the societal level. Finally, the various taboos inhibit couples experiencing difficulties from talking about them and interfere with the sex education that might prevent or alleviate sex difficulties before they become rooted.

With these considerations in mind we now review the existing data on the prevalence of sexual dysfunction. Despite the lack of truly representative studies of the incidence and prevalence of various forms of sexual dysfunction, enough evidence exists to warrant their classification as a major public health problem. Masters and Johnson have ventured an overall estimate that "conservatively" one out of two marriages are currently sexually dysfunctional or rapidly becoming so. Though they have acknowledged that figure to be a pure "guesstimate," available data supports the order of magnitude.

Five clinical categories of sexual dysfunction have been identified: anorgasmic response, impotence, premature ejaculation, dyspareunia (painful intercourse), and vaginismus (an involuntary spastic contraction of the vaginal muscles). Other types of complaints, such as general lack of enjoyment of sex, low sex drive, and sizeable and unreconcilable differences between husband and wife in preferred frequencies for intercourse may affect many couples, but are more difficult to categorize. While some forms of sexual dysfunction may result from physical or medical conditions, psychosocial factors predominate and it is with these that we shall be dealing.<sup>15</sup>

The research of Kinsey et al, published a quarter of a century ago, remains the most comprehensive and most nearly representative survey of sexual practices and experience available. Though the Kinsey interviews did not include a series on sexual dysfunction, they did include material on impotence, speed of male ejaculation, and attainment of female orgasm.

The Kinsey data on impotence was collected primarily to study the

effects of the aging process, and is based on cases "which are more or less totally and, to all appearances, permanently impotent," ruling out "instances of temporary incapacity in younger individuals."<sup>16</sup> From a clinical point of view, Masters and Johnson classify a male as secondarily impotent when he is able to maintain an erection on fewer than 75 percent of coital opportunities.<sup>17</sup> Since many of these males would occasionally be able to accomplish coitus, they would presumably not be included in the Kinsey data despite their lack of coital effectiveness. Moreover, males who were capable of successful intercourse with prostitutes or in extra-marital relations but not with a loved spouse would also not be included in the Kinsey data. Even so, over one percent of the Kinsey sample aged 35 or older had become impotent by that age, and fully one-quarter of those aged 65 or over were impotent.<sup>18</sup> The work of Masters and Johnson indicates that most of the impotence of these older males is a result of psychosocial and relationship factors rather than aging per se.<sup>19</sup>

Impotence, of course, is a relatively severe disturbance in that it prevents coitus from taking place. Historically, it has been a matter of social concern since it prevents the begetting of children. It has been suggested that if female sexual response were similarly essential to reproduction, society's attitude toward female sexuality would have been markedly different. According to the Kinsey data, fully one out of ten women at every age never experienced orgasm during marital coitus. Moreover, one out of four had not experienced orgasm during marital coitus during the entire first year of marriage.<sup>20</sup>

Since Kinsey found a positive association between decade of birth

and percentage of marital coitus with orgasm, we will take the latest figures he makes available. For females born during the decade 1920-29 (most of whom would have been in their twenties when interviewed) the Kinsey findings are presented in Table 3.<sup>21</sup>

TABLE 3

<u>Percent of Marital Coitus with Orgasm</u>	<u>In First Year of Marriage % of Females</u>	<u>In Fifth Year of Marriage % of Females</u>
None	22	12
1-29	8	14
30-59	12	19
60-89	15	19
90-100	43	36
Number of cases:	484	130

Thus, even after four years of marriage, one quarter of married females born during the latest decade surveyed by Kinsey experienced orgasm less than one-third of the time.<sup>22</sup>

The Kinsey data refer to female orgasm as part of a coital incident. By this criterion, orgasm could have occurred before penetration, during intromission, or following withdrawal, and may have resulted from penile stimulation, manual stimulation, oral stimulation, or a combination of methods.<sup>23</sup> As noted earlier, Masters and Johnson view human female sexual response as including the capacity to experience orgasm from manual stimulation, either through masturbation or partner stimulation, and from penile stimulation in coitus. Inability to experience orgasm without manual stimulation, or inability to achieve orgasm in masturbation is thus designated a form of anorgasmic response which Masters and Johnson seek to reverse through their treatment program.<sup>24</sup>

Not all contemporary sex therapists have adopted Masters and Johnson's clinical criteria. Helen Kaplan, for example, believes that there is as yet insufficient evidence to conclude either way on the question of whether orgasm only with direct clitoral stimulation is other than a normal variation in female orgasm. In contrast to Masters and Johnson, her working hypothesis is that it is a normal variation.<sup>25</sup> Should Masters and Johnson's therapeutic success be replicated on a wide scale, or should new evidence confirm their clinical criteria, the acknowledged prevalence of orgasmic dysfunction will be dramatically higher than that reflected in the studies that have been carried out.

The reported high rates for absence of female orgasm, particularly from coital stimulation alone, do not necessarily imply female sexual dysfunction. One reason for the low rate of female orgasmic response is the brief duration of coitus for many couples. According to Kinsey et al:

For perhaps three-quarters of all males, orgasm is reached within two minutes after the initiation of the sexual relation, and for a not inconsiderable number of males the climax may be reached within less than a minute or even within ten or twenty seconds after coital entrance.<sup>26</sup>

In contrast, most females require longer to achieve orgasm during coitus.<sup>27</sup>

Here again, the questions of expectations and context arise. A couple feeling the impulse to make love before leaving home for work or an appointment may be quite fully satisfied with a "quickie." Similarly, if the couple make love on retiring, fatigued and having to get up early the next morning, if they are seizing a brief opportunity

during a lunch break or in some semi-public place, quick male response may indeed be welcomed. Or, if both partners prefer non-coital forms of love-making, brief intromission may involve no disappointment.

In a somewhat different light, concepts of love-making earlier prevalent and still widespread in certain subcultures and social classes emphasize procreation or male sexual release as the goals for sexual interaction, assigning little value to female pleasure and satisfaction. Kinsey et al report that:

At lower educational levels, it is usual for the male to try to achieve an orgasm as soon as possible after effecting genital union. Upper level males more often attempt to delay orgasm.<sup>28</sup>

Where both partners share this concept, they may be quite satisfied with brief coitus even in situations where other couples would prefer and expect a more leisurely approach.

On the other hand, the concept of sex and of male-female interaction behind the male-release approach to sexual intercourse may interfere with greater intimacy and closer communication between the couple.<sup>29</sup> It must also be recognized that one motive for setting rapid ejaculation as a goal of sexual interaction is that it reduces the likelihood of failure. Attempting to delay ejaculation may, if unsuccessful, lead to a feeling of failure, which for a man with low self-esteem or under significant stress may be a risk to be avoided.

Even when successful, some approaches to delaying ejaculation entail substantial sacrifice in sexual pleasure and communication. Masters and Johnson report, and marriage manuals have recommended, that the male engage in such diversionary maneuvers as thinking about business problems, pinching himself, or constricting the anal muscles in

order to delay his climax. Such diversionary maneuvers may even inhibit the female partner's sexual response if she is aware of or senses her partner's preoccupation. Whether the physiological responses that accompany these types of sexual interaction would be clinically defined as dysfunctional or not, we may legitimately question whether the quality of the sexual relationship fulfills the couple's reasonable expectations.<sup>30</sup> Similarly, concern about penile erection, vaginal lubrication, onset of male orgasm, or likelihood of female orgasm may easily interfere with a couple's enjoyment whether or not their physical responses themselves are impaired.

When concerns about sexual performance overshadow the giving and receiving of pleasure, the sexual relationship shifts from a source of intimacy to one of estrangement. As Masters and Johnson explain:

The ultimate level in marital-unit communication is sexual intercourse. When there is marital-unit complaint of sexual dysfunction, the primary source of absolute communication is interfered with or even destroyed and most other sources or means of interpersonal communication rapidly tend to diminish in effectiveness.<sup>31</sup>

Even in the absence of representative prevalence studies and of a more complete understanding of what constitutes full sexual functioning, it is apparent that marital sexual dysfunction and dissatisfaction are widespread. But to appreciate more fully the implications of this wide prevalence of sexual dysfunction, we must consider its impact on marital relationships and other interpersonal relationships.

## MARITAL AND OTHER INTERPERSONAL RELATIONSHIPS

It is ironic that sex, a most powerful force for bringing people together, functions in our society as an even more powerful force for keeping them apart. How many couples, because of conflicts over sex, have wished that it did not exist so that they might live together in peace. Indeed, how many have managed to pretend just that, only to experience the closing off of other channels of intimate communication as well. For sex, as long as it remains unwelcome in our lives, will continue to frustrate and estrange. We will observe this first in the sexually dysfunctional marital relationship, and later for non-marital, adolescent, parent-child, and even inter-group relationships.

Rising divorce rates have prompted concern for the future of the institution of marriage. But the conditions that result in divorce have usually existed for some time before an actual break takes place. If we are concerned with the maintenance of marital relationships, we must focus on the quality of marital interaction. Consider the following portrait, reported by a New York sex therapy team, of a couple experiencing sexual dysfunction:

Our usual couple is married about eight years. He ejaculates prematurely and she has orgasms only through manipulation, never during intercourse. They both feel robbed. They've withdrawn from one another physically and psychologically, have intercourse maybe once a month, watch a lot of TV, and, when they first come to see us, they sit on opposite sides of the waiting room and read magazines. We saw a couple like that yesterday. It was their seventh

visit. Now they come in and sit alongside each other. They talk. Their whole relationship has opened up.<sup>1</sup>

A relationship like the one described can result from a variety of impediments to intimate communication beside sexual dysfunction. Indeed, sexual dysfunction itself often reflects other problems in the relationship. But in a significant proportion of marital problems, sexual difficulties are a compounding problem or even a primary cause:

. . . Lief has reported that 75% of the married couples who seek counseling at the University of Pennsylvania's Marriage Council of Philadelphia have a significant sexual problem. In 15% of the total cases, a sexual problem is the primary cause of the marital problem.<sup>2</sup>

Another study found that of 600 couples applying for divorce, 17 percent of the spouses complained of sexual incompatibility and 22 percent complained of infidelity.<sup>3</sup>

But studies of divorce may not adequately reflect the importance of sexual problems on marital break-up and on the quality of marital relationships that are not dissolved. On the whole, our society does not recognize sexual satisfaction as an essential component of living or of marriage. Accordingly, disappointments and dissatisfactions that arise from sexual interaction have tended to be ignored or de-emphasized. Especially when the sexual problem occurred at the outset of their relationship and so been long since accepted, estranged spouses are likely to give their reasons for divorce in terms of socially recognized complaints. But had the sexual side of their marriage worked out, their other difficulties might not have loomed so important.

In the absence of available and acceptable therapeutic assistance, accommodation to early sexual difficulties may be almost automatic, laying the basis for marital break-up at some future time:

Let's say that two people who have little knowledge about sexual interaction marry and the sexual part of the marriage goes badly. But they have chosen one another for reasons that are important to them; they have common goals; the reasons for the marriage are well chosen, well structured. But they may share backgrounds which do not consider sex something you freely communicate about, so each partner goes about protecting the other and the relationship by defending the situation from any kind of destructive reaction. Consequently, they don't talk about it and they don't deal with it. But they go on being very kind, very thoughtful, very considerate of each other; they work at the marriage, but they walk tippy-toe around the sexual component because it hasn't worked. They are afraid it won't work again. They don't want to hurt one another or the marriage, so they do this day after week after month after year until such time as they have developed techniques of interaction that make it impossible for them to be together sexually.<sup>4</sup>

While it may founder for some other reason, a marriage such as the above might have developed very differently had the couple received early assistance in learning to interact sexually.<sup>5</sup>

As external pressures from economic necessity and social restriction continue to diminish, satisfactory sexual interaction is likely to assume greater importance as a determinant of the fate of marital relationships. But traditional sexual morality undermines marriage in yet another way. By distorting interaction between males and females before marriage, restrictive sexual morality fosters emotions, experiences, and expectations that are poor preparation for mature relationships.

The traditional double standard has been the basis for much miscommunication between men and women, boys and girls. By suppressing the expression of female sexual desire, and often the sensation of desire itself, our society has created a mechanism which practically guarantees the "battle of the sexes." As Albert Ellis describes the process:

Many males in our culture are so thwarted by our sex codes and become so sex-hungry that they begin to see females only as sex objects and to depreciate any nonsexual attributes they may have. In their turn, millions of our women become so resentful of the

fact that the men's interest in them is almost primarily sexual that they become misanthropic and after a while find it almost impossible to love any man.<sup>6</sup>

Other cultures have restricted female sexual expression more than we have. But this restriction has been enforced largely through external restraints (such as chaperonage) rather than through internal inhibition. In Latin and Muslim countries, for example, it has been acknowledged that young men and women have sexual desires and that if they are together alone they will act upon them. In the United States, we permit the young couple to be together in relative privacy, but tell them they should not act on their desires, even that they should not feel those desires.<sup>7</sup>

Such internal restraints, reinforced principally through guilt and anxiety, may be much more damaging to psychic well-being as well as more productive of bad feeling between males and females. To the girl, the boy is someone who is always trying to get something from her. To the boy, the girl is someone who leads him on and then stops, who tells him that he is not to act on or even acknowledge feelings that are frequently the strongest he has ever experienced.

The double standard is frequently attacked as being the instrument and ideology for the inferior treatment of women. While it undoubtedly functions in this regard, the debate often loses sight of the fact that at least in the sexual realm, men are not necessarily better off for it. After all, if a man believes that women are supposed to avoid sex outside of marriage, he may not escape (though he may distort its expression) the feeling of guilt from being the agent of her wrongdoing. James McCary writes:

Clinicians have presented convincing arguments that many men are beset with considerably more guilt over sexual matters than women are. . . . A man . . . feels that as the instigator of the sex act, he is the "seducer," and that the responsibility for the girl's participation rests squarely upon his shoulders. To placate his own guilt or anxiety, therefore, he must feel either that there is love in the relationship, or that the girl is "bad." Furthermore, since he feels guilty about his "seduction" of the girl, he comes to regard her as the instigator of his guilt. He is then impelled to express his hostility and anger by quarreling or fighting with her, speaking to her in a degrading manner, or otherwise manifesting his rejection of her--the very girl who thought enough of him to share with him the most intimate of human experiences.<sup>8</sup>

Double standard sex is not a zero sum game where the woman loses what the man wins. It is a negative sum game where both lose what neither gains.

But a single restrictive standard also poses a problem. Sexual impulses prevented from direct expression tend to have a distorted expression. Albert Ellis illustrates one consequence:

. . . there is some evidence that sexual blocking--even when it causes considerable hostility between the sexes . . . --also may foment a particular kind of romantic or obsessive-compulsive love. Romantic love . . . has its clearcut disadvantages, and is not necessarily a particularly good harbinger of mature, marital love.<sup>9</sup>

Moreover, romantic love is often jealous love:

The kind of monogamous, monopolistic sex relations that we value in our society encourages members of both sexes to become insecure about winning and retaining the exclusive affections and sex favors of the individuals in whom they are interested. Consequently, lovers and married partners tend to become exceptionally jealous of their loved ones for presumably causing them to be so jealous and insecure.<sup>10</sup>

With this background of reciprocal hurt, that males and females ever succeed in establishing intimate relationships is an impressive tribute to our capacity to forgive or to forget. But even the couple who attempt to ignore restrictive morality are not necessarily freed from its pressures. As Edward Tyler explains:

A young man, repeatedly warned not to risk catching V.D. or impregnating a girl gains little useful sexual knowledge. Simultaneously he gets the implied message that he must be a homosexual if he doesn't show sexual interest in females. Usually, he is expected to be the informed member of the sexually ready couple. He can't admit his naivete without losing masculine status. He must perform well instantly. To avoid the anxiety of questioning his own ability to perform, he is frequently so focused on his behavior that he is not aware of or responsive to the needs and cues of his partner.

The novice female can't offer her partner suggestions without implying she has had previous experience or is oversexed. She can't even ask questions without risking embarrassing him since he is ashamed to admit he needs her help. So what should be a learning experience for both is shut off by a conspiracy of silence. [*Italics in original.*]<sup>11</sup>

Linked with prohibitions on premarital sex is the cultural demand for marriage. For a variety of reasons, this cultural demand now contributes to the difficulty of forming intimate relationships. George Bach writes:

For many singles, each contact with the opposite sex is a threat. They become extremely cautious about statements or actions that might be construed as commitments. They fear being exploited as marriage partners. They keep their sexual relationships cool and distant (in the broad sense) and so deny themselves intimate rewards, for fear that genuine intimacy will force or entice them into marrying.<sup>12</sup>

The search for intimacy under the conflicting demands of sexual frustration and social pressures is for many wrought with disappointment, tension, and anxiety. John Cassel has said:

All diseases seem to occur more frequently to people who are in a situation where they can't get the feedback about their actions. People are denied feedback, or actions are fruitless, or people have never had an opportunity to learn what behavior is effective.<sup>13</sup>

To a considerable extent, contradictory social demands and the lack of generally accepted social standards in the sexual realm have created such a situation for teenagers and young adults in America.

We have already seen that the state of sexual relations in marriage

is not very good even with relative legal and social sanction, availability of contraception and other assistance. One can imagine in what state marital sex relations and marital relationships in general would be if like many of their unmarried counterparts, husband and wife were required to live apart at their parents' houses or in dormitories, having to conceal their sexual relationship, in continual fear of pregnancy from a torn condom or mistimed withdrawal, and plagued with a nagging guilt that they were doing something "wrong."

The high rate of marital break-up reflects social pressures that make intimate relationships difficult. Yet marital relationships are in a relatively privileged position compared to non-marital relationships. The latter serve many of the same needs for the people involved, yet besides receiving little societal recognition and support, they are often actively interfered with by parents and other authorities.<sup>14</sup>

The net effect of all these obstacles is to deprive many young people of the support that intimate relationships, genital or not, can afford. This is doubly unfortunate in view of the importance of intimate relationships for emotional growth. Referring to the young as "their own best therapists," Madison asserts that a boy-girl relationship can often foster or permit growth faster than a relationship with a professional therapist.<sup>15</sup> Yet the conflict between sexual feelings and their lack of social acceptance and support interferes with male-female relationships particularly during adolescence and early adulthood.

It is not only intimacy with peers that suffers. Relationships with adult authorities, particularly with parents, suffer from the conflict between sexual desires and traditional morality. When the child

reaches puberty, he or she may suddenly find that the adults who had offered protection, advice, assistance, counsel, and love are now often the chief antagonists to his or her newly developed needs and desires. Since these desires have arisen quite spontaneously and autonomously from within the young person, it is extremely difficult to renounce or separate them from the awareness without some corresponding rejection of the self. It is quite likely that this process contributes in no small measure to the self doubt and criticism viewed as a "natural" part of growing up.<sup>16</sup>

Parents, teachers, and administrators of educational institutions claim that they seek to help the adolescent, pass on knowledge, and assist in the maturing process. But they feel obliged to "protect" the adolescent against his or her maturing sexual desires in a way that sometimes seems to reflect a need to protect themselves against their own suppressed sexual desires.<sup>17</sup> The Reverend Thomas Brown writes:

It is sometimes surprising to notice how often parents develop exaggerated fears about the sexual experiences of their adolescents. It is as though they expect their children to fulfill the wildest fantasies they themselves had during their own adolescence.<sup>18</sup>

Another motivation is suggested by Richard Hettlinger:

The adult generation exhibits what a British writer has called "an almost obscene obsession with the sexuality of the young" . . . prompted by envious rancour and a bullying intention to interfere. Of course, we weren't nearly as chaste as we like to imagine; Kinsey discovered long ago that the real breakdown of Victorian sexual standards came with the men and women who were in college in the 1920's. But it suits us to impose official restrictions on our students since we can then pretend a moral superiority, and punish them for the open enjoyment of sexuality which we were denied at their age. [*Italics in original.*]<sup>19</sup>

Whatever unconscious factors may be present, empirical evidence points to role and responsibility as important factors in parental

attitude toward premarital sex. In the course of his surveys, Ira Reiss found that

. . . parents tend to be less sexually permissive, the more responsibility they have for young people . . . it would seem that the primary cause of parent-child divergence over sex is role and responsibility . . . [Italics in original.]<sup>20</sup>

He notes further that childless couples are more permissive than parents of the same age, while:

Being responsible for others, incidentally, inhibits permissiveness even when the dependents are siblings. The first born are far less likely to approve of premarital intercourse than are the youngest children.<sup>21</sup>

There is thus a type of class antagonism as rising teenage permissiveness (which rises with age) comes directly into conflict with falling parental permissiveness (which falls as teenagers' age rises).<sup>22</sup>

It is accordingly not surprising to read the results of a study by Roger Libby and Gilbert Nass of likely parental reactions to premarital sexual relations on the part of an eighteen-year old daughter. Forty-three percent of the parents indicated that they would try to change the daughter's behavior by showing their disapproval and using discussion to convince her that such behavior is wrong; a further 17 percent would approach it situationally and say it "depends on the circumstances"; 10 percent would try to understand and would provide support (but would "find out why"); while only 5 percent reported they would give contraceptive advice.<sup>23</sup> These parental reactions mean that a very large number of adolescents and young adults are either in open conflict with their parents or must keep secret an important aspect of their lives, an aspect in which they might otherwise value greatly the counsel and experience of members of their parents' generation.<sup>24</sup>

The adolescent or young adult who acknowledges and attempts to act on the desire for sexual intercourse finds that this spontaneous, natural, and very powerful desire can lead to a great deal of conflict with the opposite sex and older generation. Not surprisingly, many young people attempt the alternative course of suppressing their awareness of sexual desires or try not to act on them. But though it may spare them open conflict with adult authorities, this course may contribute to inner emotional conflict, neurotic symptoms, and possible subsequent difficulty in marital sexual adjustment. All of this has very important implications for public mental health, which we shall now consider specifically.

## PSYCHIC HEALTH

In previous chapters we have discussed stress, anxiety, guilt, relationships, and other matters which either fall under the heading of mental health or have strong implications for it. There remains the question of a more direct relation between existing sexual morality and impairment of psychic health.

The existence of a direct relation between sexual morality and psychic health was asserted by Freud and other founders of the psychoanalytic movement. According to Freud, sexual prohibitions internalized in the superego and enforced in external reality create a conflict between the ego and the sexual instincts. This conflict is the principal basis for the development of neuroses.<sup>1</sup> Blocked from discharge through heterosexual genital coitus, libido energizes alternate impulses such as other types of sexual impulses, sadism, neurotic symptoms, and neurotic character structure. Some people are able to sublimate a substantial portion of their libido into artistic, scientific, or other creative endeavors. But sublimation involves predominantly the "pregenital" sexual drives--oral and anal sexuality, and sadism.<sup>2</sup>

Freud's theory of sexuality "from the first provided the strongest motives for the resistance against psycho-analysis"<sup>3</sup> and remained a hard bone to swallow even after many other parts of psychoanalytic theory had come to enjoy increasing recognition. Freud himself substantially

modified his views when he later theorized the existence of a death instinct as a primary force in opposition to the sexual instinct (termed Eros), a modification which in turn was not accepted by many analysts.

Freud's thinking has never been fully accepted by the various psychological professions. In particular, his singling out of sexuality as the primary cause of neuroses has not been retained even among psychoanalytic writers. The Committee on Adolescence of the Group for the Advancement of Psychiatry, for example, notes: "If the function of eating, instead of sexual functioning, were the focus of massive cultural repressions and prohibitions, then eating might become a greater focus than sex for the development of emotional disturbance."<sup>4</sup> Alexander Leighton, in his distillation of theories of dynamic psychiatry, has expressed what is probably the most widely held view when he lists sexual satisfaction as one essential striving sentiment among many, interference with which has consequences which often lead to psychiatric disorder.<sup>5</sup>

But though interference with sexual expression remains an important source of emotional disturbance, at least in the conceptual framework of clinicians ascribing to the above views, the demotion of sexual suppression from the cause of neuroses to a cause has reinforced the tendency to ignore the role of sex entirely in public education and institutional policy. The typically widespread difficulty encountered in growing up sexually also makes us want to forget about it. The result, though, is a confused situation in which sexual conflicts and the symptoms they give rise to figure prominently in the daily practice of psychotherapy, while sexual matters are not assigned corresponding importance

in the training of psychotherapists and in public mental health education.

This concentration on clinical practice rather than on public mental health education is consistent with the prevailing orientation of the mental health professions in other areas as well. While there are many reasons for this orientation, in some respects the concentration on clinical work represents a retreat to the sanctuary of the physician-patient relationship from the embattled arena occupied by Freud, Reich, and others.<sup>6</sup> This retreat is itself part of a larger transformation in the character of psychoanalysis, described by Erich Fromm:

Psychoanalysis was originally a radical, penetrating, liberating theory. It slowly lost this character and stagnated, failing to develop its theory in response to the changed human situation after the First World War, instead it retreated into conformism and the search for respectability.<sup>7</sup>

The public stance of the mental health professions, however, may result in added confusion and conflict for individuals who undergo therapy. On the one hand their therapist encourages them to accept their sexual selves more; on the other, neither their therapist nor his or her colleagues speak out against the daily social rejection of sex. A similar confusion would be inspired if the medical profession treated illnesses caused by drinking contaminated water, explained the source of infection to the patient, but made no effort to inform the community or improve the water supply.

Further, the lack of an understanding and articulation of the social influences on lack of acceptance of sexuality prevent the conflicted individual from enlisting his or her intellect in support of a healthier

sexual orientation. People feel uncomfortable, guilty, anxious. Not understanding the external influences that give rise to the feelings, they assume that their origin is internal. They blame themselves ("why do I feel so guilty about everything"), instead of assigning the feeling to the (external) cause ("no wonder I feel so guilty, with all this negative input about sex").<sup>8</sup>

The lack of a clear, consistent, and generally accepted cultural understanding of sexuality is especially hard on adolescents:

For better or worse the "official" standards always change more slowly than actual behavior. Whereas attitudes favoring greater sexual freedom can be discerned among some of the clergy as well as others who seriously appraise the morality of our culture, the long-established, prohibitive standards continue to be vigorously defended. . . .

One result of this kind of morality is that the adolescent has both the tremendous task of controlling his sexual feelings and urges, and the heavy burden of guilt arising from the almost inevitable failure to do so. . . .

Adolescents find it very difficult to live by the culturally prescribed sexual morality, and they often pay a high price emotionally in attempting to do so. . . . The nature of the dilemma determines the standard variations of adolescent efforts at solution of the problem: rebellion against sexual ethics and denial of conscience; early dependent marriage; early marriage with withdrawal from the socio-economic struggle; repudiation of sexual prohibitions in good faith and sincerity but with unavoidable unconscious guilt; subordination of sex to, and contamination of sex with, competitive goals; or strong repression of sexuality, with the likelihood of subsequent mental or emotional disorder.<sup>9</sup>

Whether or not it results in a condition specifically amenable to diagnosis, there is little doubt that sexual loneliness and frustration is a major cause for unhappiness, even misery, among adolescents and those who by bachelorhood, separation, divorce, widowhood or some other reason do not have regular access to a sexual partner.

So great is the importance of the sexual factor in many persons, that there is practically a class division between persons of strong

sexual feelings who do not have a satisfactory sexual partner and those who either lack the feelings or have a partner. Sexual hunger is on the same order as a constantly unfulfilled need for food; it keeps entering the awareness despite attempts to push it out, it affects one's interaction with others, and just as a genuinely hungry person would be unwelcome at a dinner party, a sexually hungry person is frequently unwelcome in socio-sexual interaction.

Sexual morality is not the only factor interfering with the formation of satisfactory relationships, and perhaps not even a primary one. But it nevertheless is the major factor in sexual deprivation. While a relationship that provides sexual gratification without having the potential to provide more of the rewards of intimacy may be quite unsatisfactory for an extended period, for many people it nevertheless represents an alternative considerably preferable to no sexual relationship at all.<sup>10</sup>

For men, though not for women, the traditional double standard provided some acceptance of sexual needs. Prostitutes and "bad" women were recognized if not entirely legitimate outlets for male sexual expression. But in the progress toward a single standard that has taken place during the present century, the opportunities previously available to men have on the whole not been extended to women. To some extent, they have decreased for men.

Though women do enjoy much greater freedom today to enter sexual relationships, including casual sexual relationships, it is often complicated by social and socially-induced emotional concerns. Masters and Johnson report the situation with respect to one of their research subjects:

Since sexual activity had become a major factor in the girl's life, termination of the marriage placed her in a difficult socio-sexual position. Although there were several sexual partners during the separation year and an increased masturbatory frequency, Subject A was well aware that she could not return to her high-school pattern of indiscriminate acceptance of multiple sexual partners without the strong possibility of jeopardizing socially her chances of a successful second marriage. Obviously, the research program has provided the opportunity for some regularity of tension release and, of extreme importance to Subject A, the social protection of anonymity.<sup>11</sup>

Similarly, changes in sex roles and attitudes have introduced inhibiting factors into many males' readiness to enter into casual sexual relationships.

Since in most places there is an abundance of males and females, sexual scarcity is a function of social factors. One obvious source of scarcity is the social teaching of premarital chastity. Philip Slater has pointed out another: "by the time an American boy or girl reaches maturity he or she has so much symbolic baggage attached to the sexual impulse that the mere mutual stimulation of two human bodies seems almost meaningless."<sup>12</sup> Restrictions on extramarital relations also play an important role in restricting sexual opportunities. Cultural emphasis on exclusive monogamy operates with particular harshness on the woman who is divorced or widowed. Frequently her sexual availability means exclusion from her previous social circles, as other women fear her as a potential rival. Beyond age sixty, as differential mortality increases the female/male ratio, the cultural demand for exclusive monogamy is a tremendous barrier to heterosexual intercourse.

For those who retain awareness of their unsatisfied sexual desires, sexual deprivation can be a focal point for unhappiness and frustration. More frequently, it is kept from awareness, by both the individual

and the society, often finding its expression in symptomatology or difficulties in living. Regarding the former, Barry Berkey has written that:

Autonomic nervous system concomitants of unrelieved sexual tension may involve almost any organ system of the body. Some symptoms are more clearly sexual in nature, such as anal or vulvar pruritus, frequent erections, nocturnal emissions, bizarre pelvic sensations, or pseudocyesis. Less obvious but perhaps even more frequent are nonspecific gastrointestinal complaints, tension headaches, or dizziness.<sup>13</sup>

He adds that "feelings of anxiety, tension, irritability, and alternating levels of anger or frustration often result from sexual deprivation." Other writers have also noted sexual dissatisfaction or concerns as underlying physical and emotional symptoms.<sup>14</sup>

Sexual deprivation may, in turn, interfere with attempts at developing interpersonal relationships. A high degree of sexual deprivation coupled with insecurity about prospects for obtaining sexual gratification lead to preoccupation with sexual possibilities and reduced ability to interact spontaneously. Equally important, sexual scarcity may impel people into marital relationships without adequate consideration. Regarding the research subject referred to earlier, Masters and Johnson report:

She has explored the possibility of remarriage on two occasions during the past three years while cooperating with the program, but has felt that neither of the two opportunities would satisfy her primary interest in the potential security of a home and family. On both occasions she has voluntarily emphasized her relief that she did not have to evaluate the marital opportunities in a prejudiced state of sexual need.<sup>15</sup>

Someone who has never experienced severe sexual deprivation, or who has put painful memories away in the hope of never having to re-live the feelings, may have difficulty appreciating its importance to the

individuals concerned.<sup>16</sup> Still another obstacle to recognition of sexual desperation as a social problem is the fact that so many of us have had to deal with it as a personal problem that our perspective is shaped by that experience.

Typically, success in finding sexual satisfaction becomes a measure of individual competence and self-worth. In trying to build up their confidence, individuals tend to deny their own insecurities, anxieties, and failures and to look down upon those who are more open about the difficulties. One student who is very outgoing may criticize her roommate for not going to mixers. Another may exhort his friend to be more aggressive in dating, to use a line, get her drunk, etc. But as with the unemployed during a recession, while there may be strategies that are more or less successful for finding a job, the process is a good deal more difficult than it need be and there are not enough opportunities to go around. This assessment applies equally well to the sexual area.<sup>17</sup>

If it is accepted that the emotional well-being of many people is hampered by sexual frustration, loneliness, anxiety, and guilt, it should also be apparent that a correspondingly large amount of their behavior reflects these frustrations, fears, and guilts. We can expect behavior to be affected in several ways. First, unresolved sexual longings and conflicts contribute an emotional charge to behavior involving sexual matters. Dating behavior, setting of restrictions on adolescents, considerations of sex laws, and marital interaction accordingly reflect a loss of rationality and spontaneity. Second, sexual conflicts introduce a significant sexual element into situations where it was otherwise

absent or insignificant. Opportunities for this effect are multiplying with the recent opening up of previously all-male occupations to women. The concepts of mixed male-female police patrol cars and of male-female tractor-trailer overnight driving teams, for example, have both prompted the objection of adultery and sanctioned "immorality." Finally, by interfering with rather than facilitating pleasurable sexual functioning, our society deprives many individuals of a readily available source of emotional gratification, feelings of competence, and other ego benefits to add to the positive side of psychic balance. There is that much less to set against frustrations in other spheres of activity, so that behavior in all areas reflects less personal security, lower frustration tolerance, and greater overall dissatisfaction.

Where negative emotional states are present in large numbers of people, the behavioral impact becomes important in social terms as well. In our final chapter on health consequences of restrictive sexual morality, we will consider several instances where feelings and emotions that derive from sex-negative morality contribute to social behavior with negative health potential.

## XI

### SOCIAL BEHAVIOR

Urbanization has multiplied the ways in which our behavior affects one another. Whereas fate in an agricultural society of earlier centuries was bound up primarily with the weather, infectious disease, and wild animals, in our modern industrial society "fate" is increasingly a matter of our ability to live and work together harmoniously. In this chapter we will consider some examples of the social behavioral impact of sexual and psychic conflict discussed in the previous chapter.

One example of an activity where emotional well-being has a sizeable health impact is automobile driving. In this activity, general dissatisfaction as well as misplaced sexual feelings can have negative consequences for both the driver and other individuals. Joseph Noshpitz, Director of the Clinical Institute at the Hillcrest Children's Center, observes:

Boys escape their tensions and frustrations by grabbing a six-pack of beer and cruising. Nervous energy and a desire to escape the juvenile bonds of dependence are expressed in drag racing and "peeling out" . . .

The untested sexuality and fears of sexual inadequacy of young men are compensated for by owning powerful autos and driving them daringly and often recklessly.<sup>1</sup>

Reckless driving behavior poses obvious health risks. What is often less appreciated are the not easily quantifiable but more pervasive implications for environmental health, resource use, land-use, noise, and transportation policy of the dependence on the automobile as

a mode of deriving feelings of competence and of working out inner conflicts, among all strata of the driving population. Certainly sexual relationships in a supportive atmosphere would be a more effective remedy for untested sexuality and fears of sexual inadequacy. Similarly, sexual relationships would provide a more economical and ecological outlet for the sexual feelings expressed in the ownership of luxury automobiles.<sup>2</sup>

The tendency of people to purchase commodities as substitute gratification for sexual and other unfulfilled psychic urges has been of utmost importance for maintaining our mass-consumption economy. From a marketing standpoint, the beauty of psychic urges is that they motivate consumption without being satisfied by the products consumed. Unlike material needs--food, shelter, transportation--the potential of psychic needs to motivate consumption is unlimited.

The use of sexual stimuli in advertising has increased dramatically since the Second World War, reflecting the greater proportion of production and consumption that is not oriented toward fulfilling direct material needs.<sup>3</sup> Sexual stimuli have played the dual role of drawing consumer attention to particular products or services, while helping to maintain an overall level of sexual tension. Sexually motivated consumption has benefited our society by maintaining economic activity and employment, and is presumably no more wasteful in this regard than are military expenditures. But from a public health viewpoint, production and consumption that contribute relatively ineffectively to satisfying existing material, psychic, and social needs constitute a drain on energy and other resources and an unnecessary contributor to

environmental pollution. Furthermore, as the parameters of the world economy have changed from perceived abundance of resources to scarcity, the stimulation of artificial demand appears increasingly inappropriate.

Frustration and anxiety about the satisfaction of needs may also find expression in social movements. One of the earlier writers to investigate the social-psychological bases for social movements, Wilhelm Reich, contended that the powerful and unconscious longing for sexual pleasure in people who have been raised in a sex suppressive environment coupled with their fear of freedom constitutes fertile soil for the promises of authoritarian ideology. In Reich's words:

The moral inhibition of the child's natural sexuality, the last stage of which is the severe impairment of the child's genital sexuality, makes the child afraid, shy, fearful of authority, obedient, "good," and "docile" in the authoritarian sense of the words. It has a crippling effect on man's rebellious forces because every vital life-impulse is now burdened with severe fear; and since sex is a forbidden subject, thought in general and man's critical faculty also become inhibited. In short, morality's aim is to produce acquiescent subjects who, despite distress and humiliation, are adjusted to the authoritarian order. Thus, the family is the authoritarian state in miniature, to which the child must learn to adapt himself as a preparation for the general social adjustment required of him later. Man's authoritarian structure--this must be clearly established--is basically produced by the embedding of sexual inhibitions and fear in the living substance of sexual impulses. (Italics in original.)<sup>4</sup>

An alternate formulation of the relationship comes from the Group for the Advancement of Psychiatry report on adolescence:

With the pubertal surge of the sexual drives, the urge to love expresses itself in many ways. Some of the love feelings are directed to the self, some to people, some to other objects such as pets, automobiles, books, and scientific projects; and finally, some of these feelings can seize onto ideas or causes--which then become ideals.

It is not necessarily the universality of the social value of an idea that determines its appeal for youth. The Hitler "ideal," for example, of building a new, thousand-year "Aryan" empire, regardless of the cost to other peoples, was seized upon by German

teenagers in the 1930s with no less zeal and probably in far greater numbers than civil rights and the Negro's cause has been seized upon by young Americans in the mid-1960s.

For the individual young person, the commitment to an ideal also may help to fill the void resulting from increased independence from the parents. . . . Here is a substitute to fill this void, a non-material substitute which is uncontaminated by sexual elements and does not tempt toward forbidden action.

Important for many--although by no means for all--young idealists is the fact that there are other young people who share one's outlook, a group to which one can belong not so much because of a personal interest in each other, but because of a mutual and "pure" interest in the ideal; love for each other is subordinated to love for "the Cause." Psychologically, this helps the youth to master the still threatening sexual and aggressive feelings and also the problems resulting from the search for identity.<sup>5</sup>

Sexual conflict has also been cited by other writers as an element in authoritarian social movements<sup>6</sup> and in the moral absolutism of the radical youth movements in the last decade.<sup>7</sup>

It is important to remember that suppression of sexual impulses takes place in the context of the relationship of an individual with other individuals and with society. When an individual's impulses, particularly very strongly felt longings, can find no legitimate and effective outlet, the impact is felt by the total personality. Sexual strivings spring from hormonal action but also from the impulses to grow and to reach out. We do not need to demonstrate a mechanistic relation between denial of sexual satisfaction and destructive behavior to appreciate that overt and subtle rejection of sexual strivings is one way in which our society stunts the emotional growth of its adolescents, with all that implies for fostering destructive aggression, drug abuse, and chronic depression.<sup>8</sup>

Finally, while racism, like authoritarian and destructive behavior, is a product of many factors, sexual feelings do appear to be important in the emotional underpinnings for racial fear and hatred. In a culture

where most sexual feelings are unacceptable, individuals must employ various psychological mechanisms for dealing with them. The most basic mechanism is unconsciously to deny or repress awareness of even the existence of the unacceptable feelings. But the repressed feelings continue to seek discharge, and may be dealt with in several ways. One way is for the feelings to be "projected" onto another individual or individuals, so that what was originally one's own feeling is now perceived as someone else's. The impulse to condemn the feelings may now be satisfied by directing disdain, hostility, or punishment toward the other individual.

Though anyone can be the recipient of projected feelings, people who can be viewed as alien are most often chosen. In Europe, the Jews have been primary recipients. In the United States (and in recent years Britain as well), principal recipients have been black people, and for a brief period, "hippies," "peaceniks," "radicals," and youth in general.

In the American South, the impact of unconscious sexual conflict on racism is greater as a result of the sexual situation under slavery. While Victorian standards protected the "purity" of white women, the slavery system made black women sexually available to white males on or about the plantations, with a consequent exacerbation of sexual guilt and distortion. As W. J. Cash explains;

In the isolation of the plantation world, the home was necessarily the center of everything; family ties acquired a strength and validity unknown in more closely settled communities; and, above all, there grew up an unusually intense affection and respect for the women of the family--for the wife and mother upon whose activities the comfort and well-being of everybody greatly depended . . .

Yet if such a woman knew that the maid in her kitchen was in reality half-sister to her own daughter, if she suspected that her husband sometimes slipped away from her bed to the arms of a mulatto wench, or even if she only knew or suspected these things of her

sons or some other male of her family, why, of course she was being cruelly wounded in the sentiments she held most sacred. And even though she feigned blindness, as her convention demanded she should-- even if she actually knew or suspected nothing--the guilty man, supposing he possessed any shadow of decency, must inexorably writhe in shame and an intolerable sense of impurity under her eyes.

Join to this the fact that the Yankee's hate (and maybe his envy) had not been slow to discover the opening in the Southern armor, that his favorite journals were filled with "screamers" depicting every Southerner as a Turk wallowing in lechery, and it is plain that here was a situation which was not to be tolerated.

And the only really satisfactory escape here, as in so many other instances, would be fiction. On the one hand, the convention must be set up that the thing simply did not exist, . . . ; and on the other, the woman must be compensated, the revolting suspicion in the male that he might be slipping into bestiality got rid of, by glorifying her; the Yankee must be answered by proclaiming from the housetops that Southern Virtue, so far from being inferior, was superior, not alone to the North's but to any on earth, and adducing Southern Womanhood in proof.<sup>9</sup>

Idealization of the white woman and her "purity" in turn reinforced anti-sexual ideology and the double standard. It also laid the basis for the "Southern rape complex," which emerged as a principal justification for the violence toward the Negro during Reconstruction.<sup>10</sup> Rape of a white woman by a black man, attempted rape, and rumors of rape have precipitated race riots during the first decades of the present century.<sup>11</sup> It remains a very emotional issue, much more so than when the victim is a black woman or the rapist a white man, and has accounted for both lynchings and a significant proportion of executions in the Southern states.

In the contemporary context, interracial sexual feelings are characterized by myths, heightened interest in the "exotic," and social condemnation. William Greer and Price Cobbs describe the situation;

The culture seems to require that white people find sexual contact with blacks too horrible to contemplate--and white people comply with that requirement in their public behavior.

Their private attitudes are another matter. They find black people attractive sexually and subscribe to the almost universal myth

of their sexual superiority.

Here again the impress of the culture is important in determining the quality and quantity of the individual response. The culture designates Negroes as sexually superior and uninhibited in their behavior. It further requires that whites view them with contempt and sexual congress with them with horror.

The effect is a weak rather than a strong barrier, since the same culture has defined all sexual acts as debased and forbidden. To describe intercourse with blacks in the same but only stronger terms imposes little restraint. As a result, sexual contact between the races is barred primarily by a superficial public disapproval.

But behind the curtain of public disapproval there remains the intense sexual interest in exotic partners and the individual psychological reaction to a person of a different color and a different class. Public opposition has thus served to heighten the sexual interest black people have for whites.<sup>12</sup>

Calvin Hernton reports that black women working in white homes "are awed by the obsessive questioning by white women regarding the sexual behavior of Negroes."<sup>13</sup> Similarly, John Griffin, a white reporter who travelled through the South posing as Negro, writes that repeatedly the white men who gave him rides would question him about Negro sexuality, the size of Negro genitalia, and Negro interest in white women.<sup>14</sup>

But in the context of white sexual insecurity and conflict, their heightened sexual interest in blacks is a liability. Envy over the supposed sexual superiority of black males as well as sexual feelings projected onto them motivate anxiety, violence, and opposition to black people's strivings for greater economic, political, and social equality. Thus, castration and mutilation of the genitalia has been a frequent accompaniment of lynchings.<sup>15</sup> In his 1940's survey, Gunnar Myrdal asked Southern whites to list in order of importance the things they thought Negroes wanted most. Intermarriage and sexual intercourse with whites was ranked first, while economic opportunities was ranked sixth, precisely the reverse of the results from a survey of blacks.<sup>16</sup> Without denying the economic and political advantages to whites that racial

discrimination has often buttressed, nor the rational and irrational fears about crime, property values, and children's education, it nevertheless appears that conflicted sexual feelings of whites add to the emotionality and irrationality of race relations.

Sexual deprivation, along with guilt, anxiety, impaired relationships, frustration, and the lack of ego support from sexual satisfaction all affect social behavior. But psychic conflict that affects so many individuals itself springs from cultural conflict. As Louisa Howe has so aptly stated, ". . . mental or emotional disorder signifies not only an 'illness' to be treated by a physician; it also expresses a lack of order in the community."<sup>17</sup> It is just such a lack of order that we have been investigating in this study. We will now consider sexual morality in the context of cultural change and public mental health education strategies for improving sexual mental health.

## CULTURAL CHANGE, SEXUAL MORES, AND PUBLIC MENTAL HEALTH EDUCATION

Cultural phenomena, including sexual attitudes and behaviors, do not exist independently of the rest of a culture. Tradition, contact with other cultural groups, economic, demographic, geographic, and technological factors all contribute to the evolution of sexual mores.

Cultural change, moreover, occurs neither instantaneously nor automatically. A technological advance or other change in one sphere alters existing relationships in the culture. The change may produce an opportunity as the advent of effective contraception created the opportunity to relax restrictions on sexual intercourse without a commensurate increase in fertility. It may produce a compulsion, as an epidemic of syphilis such as occurred in Medieval Europe compelled drastic measures to curtail infection.

In either case there results a tension between existing social conditions and new ones that are possible or necessary. Forces and desires that were kept in check by previous restrictions now clamor for expression. Previously successful patterns of behavior lose their meaning and effectiveness. Fortunate is a society, that can adapt smoothly and rapidly to changed conditions while cushioning the impact of that adaptation for its members.

The link between cultural change and psychic impairment has been noted by, among others, Franz Alexander:

Changed cultural conditions require new, or at least modified, emotional patterns. Only if educational standards and ideals are appropriate to the existing conditions can the spread of neuroses be prevented. Education which belongs to the conditions of the past leads to emotional disturbances. For example, stress upon individual accomplishments was more important in pioneer days than it is now in our highly industrialized civilization.<sup>1</sup>

It is possible that suppression of sexual expression in one cultural setting may not be productive of neurotic and relationship disturbance, while in other circumstances it may. The harmful effects of traditional sexual morality in the United States today primarily reflect a failure to adapt. As Ira Reiss has written concerning sexual standards:

Many of our problems in America today are due to the fact that we are operating, in certain respects, with our ancient rural customs in an urban-industrialized society. There is nothing wrong with these customs as such, but many of them do not fit our present-day society.<sup>2</sup>

We cannot present a proper treatment of the cultural changes that have rendered obsolete many aspects of traditional sexual morality, but a list would include effective means of contraception, diagnostic and therapeutic procedures for venereal disease, medically safe abortion procedures, an economy capable of providing these services, mass education, geographical mobility, equalization of economic opportunities for women, urbanization, and mass communications media. It is conceivable that at some future time changed conditions will again support a restrictive sexual morality. But that is not the case at present.

It would not be correct, however, to view sexual mores simply as the product of material conditions. People and societies can react differently to similar situations. Some responses permit greater fulfillment, others less. Each must be effective at least at some minimal level

in order to continue. But above that level, the range is great. Just as an individual's problem-solving behavior and ability to take effective action can be impaired under conditions of stress, so, too, can a society's adaptability be impaired. Certain aspects of the history of sexual morality constitute sub-optimal responses to existing circumstances even as behavior and attitudes today often yield a significantly lesser degree of fulfillment than is possible.

This discrepancy, between actual and potential fulfillment under existing material conditions, invites the attention of public mental health workers. Indeed, the movement for sex education and the acceptance of sexuality as a healthy entity, as pursued by SIECUS for example, fits basic principles of community mental health and is a prime example of their application. Despite this concordance, the community mental health movement has not become a major force in this area.

Some reasons for the lack of leadership from the community mental health movement would include the lack of training in human sexuality among health professionals noted earlier and the influence of personal feelings, often unconscious, about sexuality. Even Mary Calderone, a founder of SIECUS and the "first lady of sex education" has admitted to having a "puritan conscience."<sup>3</sup>

Still more compelling reasons lie in the sexual ignorance and anxieties of the overall population and their expression in the behavior of elected officials. Public funding of sex research has been minimal, while private funding has been intermittent. The Rockefeller Foundation's support of the Kinsey research was discontinued following the establishment in 1953 of a House Committee to Investigate Tax-Exempt

Foundations; "The Congress," announced Representative B. Carroll Reece, "has been asked to investigate the financial backers of the institute that turned out the Kinsey sex report last August."<sup>4</sup> Though efforts such as Reece's are generally the work of incensed minorities, their influence would be minimal if they did not strike responsive chords among both professionals and the lay public.<sup>5</sup>

The widespread anxiety and negative feelings that we have discussed earlier thus have political effects that interfere with efforts to remove them. This is not unusual in public health education practice, as we are quick to note in dealing with other cultures. Nor is it unusual for powerful social institutions to oppose scientific or public health progress either to protect their own particular interests or as an expression of the anxiety they serve to bind. Thus the Roman Catholic Archdiocese of New York was one of the most vocal opponents to a New York City gay civil rights bill.<sup>6</sup> The Catholic Church has also spearheaded opposition to legalizing abortion and contraception. With respect to the latter, the following excerpts from the Minority Report of the Papal Commission on Birth Control illustrate the influence of institutional considerations:

If the Church should now admit that the teaching passed on is no longer of value, teaching which has been preached and stated with ever more insistent solemnity until very recent years, it must be feared greatly that its authority in almost all moral and dogmatic matters will seriously be harmed . . . Is it nevertheless now to be admitted that the Church erred in this her work, and that the Holy Spirit rather assists the Anglican Church?<sup>7</sup>

Radical psychoanalysis has pointed to an even more fundamental interest in restrictive morality:

Sexuality offers one of the most elementary and powerful opportunities for satisfaction and happiness. If it were permitted to

the full extent required for the productive development of the human personality, rather than limited by the need to maintain control over the masses, the fulfillment of this important opportunity for happiness would necessarily lead to intensified demands for satisfaction and happiness in other areas of life. Since the satisfaction of these further demands would have to be achieved through material means, these demands of themselves would lead to the breakup of the existing social order. Closely allied to this is another social function of restrictions on sexual satisfaction. Insofar as sexual pleasure as such is declared to be something sinful, while sexual desires remain perpetually operative in every human being, moral prohibitions always become a source of production for guilt feelings, which are often unconscious, or transferred to different matters.

These guilt feelings are of great social importance. They account for the fact that suffering is experienced as just punishment for one's own guilt, rather than blamed on the defects of social organization. They eventually cause emotional intimidation, limiting people's intellectual--and especially their critical--capacities, while developing an emotional attachment to the representatives of social morality.<sup>8</sup>

Nevertheless, since the above was written, social changes have greatly eroded the power and authority of the representatives of restrictive sexual morality. During the present decade, this erosion has accelerated with a majority of young people refusing to obey, if not necessarily escaping the effects of, the traditional sexual prohibitions. Perhaps it will now be possible to deal with the situation described in this study along the lines of rational humanism.

Erich Fromm writes that

. . . mental health cannot be defined in terms of the "adjustment" of the individual to his society, but, on the contrary, . . . must be defined in terms of the adjustment of society to the needs of man, of its role in furthering or hindering the development of mental health. Whether or not an individual is healthy, is primarily not an individual matter, but depends on the structure of his society. A healthy society furthers man's capacity to love his fellow men, to work creatively, to develop his reason and objectivity, to have a sense of self which is based on the experience of his own productive powers.<sup>9</sup> [Italics in original.]

Similarly, the Group for the Advancement of Psychiatry notes:

Our perspective brings home to us the possibility not only of

disturbances in adolescent development but also of consistent pathogenic social norms in our own culture. . . . To a degree, every society manufactures its own problems and, in ours, an example may be the "problem" of adolescence. Preventive psychiatry looks beyond a knowledge of causes to effecting a change in epidemiological conditions. Therapy of cultural institutions would appear to be as much of a possibility and a need as is the therapy of individuals.<sup>10</sup>

The preceding chapters have reviewed the importance of our sex-negative legacy as a source of negative health consequences. In the earlier part of this chapter we suggested the existence of social conditions that may now permit a reversal of that legacy. In the spirit of changing epidemiological conditions and designing therapy for cultural institutions, we will now consider the requirements for a public health effort to effect such a transformation.

A public mental health program includes the following components:

--the establishment of clinics to facilitate access to individual and group therapy; this has been the chief component of existing community mental health programs. In the area of sexual health, sex and relationship therapy (also referred to as marital therapy or marriage counseling) can be offered in a similar manner either in specialized clinics or through an existing mental health center. While the latter method may be preferable in many regards, it currently suffers from the following (remediable) deficiencies: most mental health personnel have received little or no specific training in sexuality and sex therapy, and often very little in relationship therapy; a sex clinic is identified as dealing with sexual problems--in the absence of effective publicity, many potential clients may be unaware that their mental health center welcomes people with sexual complaints.

--institutional changes to reduce stressful situations and barriers to satisfaction of needs--i.e., to make living easier. As Franz Alexander has written, "a patient is not neurotic per se but because he is involved in a certain situation with which he is unable to cope."<sup>11</sup> Everyone's capacity to coordinate needs harmoniously with each other and with external conditions is limited, though there are wide differences among individuals. Where physical barriers are concerned, we install staircases, elevators, and for the handicapped, ramps. Similarly, in the emotional area we can provide ramps for the many who could cope more effectively in an easier situation. And in the sexual area an encouraging, supportive approach instead of myriad institutional barriers would improve the ability of the shy and insecure as well as the outgoing to engage in satisfying relationships. It is only in recent years that we have begun to move away from the pioneer-frontier ethic against "coddling" people physically. It will take some time and effort before it will be acceptable to "coddle" them emotionally.

--educational programs to increase ego strength and resistance to emotional insult. One major component in both psychotherapy and sex therapy is education. Education can help people to accept their "unacceptable" feelings, to perceive anxiety and defensive behavior, to perceive how external factors are often responsible for negative views of sex and self, and to relate more effectively. Sex education in particular could reduce the burden of worries about masturbation, homosexuality, impotence, etc.

Educational programs can also provide permission to be interested in learning about sex, an important ingredient to counter existing conditioning.<sup>12</sup>

—programs to improve the emotional resilience of both children and adults, in the manner that proper nutrition improves both physical health and resistance to infection. Besides education already referred to, and improved "emotional nutrition" from interaction in a society where barriers to fulfillment have been reduced, there is also the possibility that some means will be found to discharge stress and build emotional strength on a mass scale.<sup>13</sup>

In dealing with sexual, emotional, and relationship health, we can expect considerable interaction among these components. Sex therapy and sex education for parents will improve the emotional environment for their children and thus constitute a form of primary prevention. Sex education can also help to provide permission to be sexual, an important concept in the approach of Masters and Johnson and other sex therapists.<sup>14</sup>

Moreover, institutional change that helps people to cope can also be therapeutic. As Bellak points out;

. . . the success of treatment of the mentally ill will depend on our ability to design and expose the patient to psychodynamically well conceptualized new experiences which will reverse earlier ill effects, and thereby enable the restructuring of his personality.<sup>15</sup>

Emotionally positive experiences can help reduce the impact of earlier negative ones. Sexual competence is an important source of ego strength.

Finally, emotional and sexual health, like emotional illness, are

"contagious." Interaction with healthy individuals has a positive effect, while interaction with anxious, guilty, and inhibited individuals has a negative effect. If, through sex education and therapy programs, we can increase the proportion of sexually healthy individuals beyond a certain point, the influence of these individuals will accomplish the transformation to a sex-affirmative society.

Such a process of transformation has been at work throughout the century and most indications are that it is likely to continue. What makes the situation so ripe for public health intervention is that a relatively modest program can reap considerable rewards in the many areas we have discussed. If we can hasten, even by only a decade, the full acceptance of sexuality, it is an opportunity not to be missed.

## XIII

### CONCLUSION

We have now completed our review of negative consequences of traditional sexual morality for public health and have explored some of the broader implications. Despite the scarcity of controlled studies and "hard" evidence, it is apparent that our sex-negative heritage constitutes a significant noxious influence and an obstacle to improvement in a variety of areas of physical and emotional health. There is also evidence that sex-negative morality interferes with our ability to improve interracial understanding, promote environmentally sound economic behavior, and promote greater cooperation and socially positive behavior.

These associations would appear to qualify sex-negative morality for "official" designation as a public health hazard. For various reasons such a designation has not occurred. The premise on which this study is based is that the lack of a wider recognition of the harmful effects of traditional sexual morality partly results from the absence of a wider appreciation of the full range of health effects. Restrictive sexual morality must be regularly contended with by sex educators, clinicians, counselors, family planning agencies, enlightened parents, and individuals in their personal lives. But rarely has the common element been isolated and held up for investigative scrutiny.

By focusing on sex-negative morality as an etiological factor in

itself, this study seeks to foster a wider recognition among members of the health professions as well as the public of the value of embodying the principle of sex-affirmation, instead of sex-denial, as the basic theme for social attitudes and institutional policies. Indeed, the shift from sex-denial to sex-affirmation has been underway for the better part of a century. The task at this stage is to complete the dismantling of the Victorian edifice and install a firmer foundation for a sex-affirmative value system.

Notes to Chapter I

<sup>1</sup>C. David Jenkins, "Components of the Coronary-Prone Behavior Pattern," Journal of Chronic Disease 19 (1966):599-609; see also C. David Jenkins, "Psychologic and Social Precursors of Coronary Disease," New England Journal of Medicine 284 (4 February and 11 February 1971): 244-55, 307-17.

<sup>2</sup>Sigmund Freud, Wilhelm Reich, Alfred Kinsey and associates, Albert Ellis, Lester Kirkendall, Alexander Lowen, William Masters and Virginia Johnson, Warren Johnson, and James McCary. For full references, see the bibliography.

<sup>3</sup>Edward M. Brecher, The Sex Researchers, with a Foreword by William H. Masters and Virginia E. Johnson (Boston: Little, Brown & Co., 1969; New York: New American Library, 1971), pp. 321-22.

<sup>4</sup>William H. Masters and Virginia E. Johnson, interview with Playboy Magazine, St. Louis, Mo., January 1968, published in the May 1968 issue and reprinted in Masters and Johnson Explained, ed. Nat Lehrman (Chicago: Playboy Press, 1970), p. 134.

<sup>5</sup>During the first fifteen years of their research, Masters and Johnson received one federal grant of \$25,000 a year for the four years ending in 1962. A 1963 application to the National Institute of Mental Health was turned down, while application to the Institute of Child Health and Human Development was discouraged after initial inquiries. William H. Masters and Virginia E. Johnson, press conference, Boston, April 20-22, 1970, in Lehrman, Masters and Johnson Explained, pp. 88-89.

<sup>6</sup>Wardell B. Pomeroy, Dr. Kinsey and the Institute for Sex Research (New York: Harper & Row, 1972; New American Library, 1973), pp. 374-401. The private foundations that provide a large measure of Masters and Johnson's funding have, except for the Playboy Foundation, declined to make public their supporting role. Masters and Johnson, press conference, pp. 88-89.

<sup>7</sup>The interaction between professional behavior and personal sexual experience has been noted by Kinsey, Pomeroy and Martin. The researchers, who had the unique perspective from having the sex histories of many professionals, comment:

Meetings of educators who are discussing sex instruction and policies to be followed in the administration of educational institutions, may bring out extreme differences of opinion which range from recommendations for the teaching of complete abstinence to recommendations for frank acceptance of almost any type of sexual activity. No other subject will start

Notes to Chapter I, continued

such open dissension in a group, and it is difficult for an observer to comprehend how objective reasoning can lead to such different conclusions among intelligent men and women. If, however, one has the histories of the educators involved, it may be found that there are persons in the group who are not ejaculating more than once or twice a year, while there may be others in the same group who are experiencing orgasm as often as ten or twenty times per week, and regularly. There is, inevitably, some correlation between these rates and the positions which these persons take in a public debate. . . . In the same fashion, we have listened to discussions of juvenile delinquency, of law enforcement, and of recommendations for legislative action on the sex laws, knowing that the policies that ultimately come out of such meetings would reflect the attitudes and sexual experiences of the most vocal members of the group, rather than an intelligently thought-out program established on objectively accumulated data. Alfred C. Kinsey, Wardell B. Pomeroy, and Clyde E. Martin, Sexual Behavior in the Human Male (Philadelphia: W. B. Saunders Co., 1948), p. 199.

Notes to Chapter II

<sup>1</sup>It was the generation born during the first decade of the present century who carried out America's first sexual revolution. Ira L. Reiss, Premarital Sexual Standards in America (New York: The Free Press, 1960; paperback edition, 1964), p. 228. For comparative data on sexual experience by decade of birth, see Alfred C. Kinsey et al., Sexual Behavior in the Human Female (Philadelphia: W. B. Saunders Co., 1953; New York: Simon & Schuster, 1965), pp. 242-46, 252-58, 298-302, 356-59, 422-24, and tables.

<sup>2</sup>Reiss, Premarital Sexual Standards in America.

<sup>3</sup>It may be objected that what is justified or legitimized is not the feelings but the behavior. A negative valuation of the behavior, however, tends to become attached to the feelings. An example is the situation of a man who finds himself sexually attracted to a new acquaintance and concludes therefrom that he no longer loves his wife. It should be noted that the text is not meant as a criticism of Reiss' classification, which has deliberately been framed according to existing attitudes.

<sup>4</sup>The survey was conducted by Robert Wilson, then Director of the student-run Human Sexuality Information and Counseling Service, using a random sample of undergraduates enrolled in the spring of 1972. The study method and some of its findings are described in Karl E. Bauman and Robert R. Wilson, "Contraceptive Practices of White Unmarried University Students: The Significance of Four Years at One University," American Journal of Obstetrics and Gynecology 118 (15 January 1974): 190-94. I am grateful to Robert Wilson for making these unpublished data available to me.

<sup>5</sup>Alexander Lowen, Love and Orgasm (New York: Macmillan Co., 1965).

<sup>6</sup>Ibid., p. 6.

<sup>7</sup>William H. Masters and Virginia E. Johnson, Human Sexual Inadequacy (Boston: Little, Brown & Co., 1970), pp. 10-14 *passim*.

<sup>8</sup>Albert Ellis, Sex Without Guilt (New York: Lyle Stuart, 1958; Lancer Books, 1966), p. 21. One reason that the concomitant point is rarely stated may be that it has been difficult to get it into print. Ellis recounts his own experience:

Censorship of outspoken articles on the subject [of masturbation] is especially rife; so much so in fact that the original version of this article was refused admittance in a book which I

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edited and a scientific journal of which I was associate editor; and when it was given as part of an important symposium on religion and sex, the entire symposium was never published. Ibid., pp. 21-22.

<sup>9</sup>Ibid., pp. 23-24.

<sup>10</sup>Sherwyn M. Woods, "Sexual Problems of Medical Students," Medical Aspects of Human Sexuality 4 (February 1972):72-73.

<sup>11</sup>Benjamin F. Miller and John J. Burt, Good Health, 3d ed. (Philadelphia: W. B. Saunders Co., 1972), pp. 248-49.

<sup>12</sup>Wilhelm Reich, The Sexual Revolution, trans. Theodore P. Wolfe, 4th ed. (New York: Farrar, Straus & Giroux, 1945; Noonday Press, 1969), pp. 110-11.

<sup>13</sup>James Leslie McCary, Human Sexuality (New York: Van Nostrand Reinhold Co., 1967), p. 21.

<sup>14</sup>Ibid., pp. 21-22.

<sup>15</sup>Lee Salk, What Every Child Would Like His Parents to Know (New York: David McKay Co., Warner Books, 1973), p. 102.

<sup>16</sup>Ibid., pp. 102-103.

<sup>17</sup>Clark Vincent writes: "One of the most helpful things the physician can do for the young married couple is simply to provide the kind of atmosphere in which they can talk openly in front of him about their attitudes toward sex. Frequently the physician will discover that he is making it possible for a husband and wife to talk to each other for the first time about their feelings, desires, and hangups in this area." Clark Vincent, "Sex and the Young Married," Medical Aspects of Human Sexuality 3 (March 1969):20.

<sup>18</sup>John Gagnon writes:

The privatization of sexual consensus means that no one can be sure of the behavior of others, and this insecurity is accompanied by a belief that statements that differ from the conventional norms will be taken as evidence of sexual deviation. The only system of values that can be invoked in a time of sexual controversy is the most conservative, and this often results in the most puritan of the community defining the content of public sex education for children. This lack of consensus makes it very difficult for a body of disinterested opinion about sexuality to

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exist. Any statement by an individual about sexuality is commonly presumed to be related to the sexual preferences and desires of that individual. . . . Another consequence of this lack of knowledge and consensus is the degree to which fantasy may be projected into and then shape the sexual situation. In most areas of social activity, a reality check upon individual fantasies is provided either by interaction with other persons or by contact with the mass media; but the sexual area lacks such checks, and the proportion of fantasy probably outweighs the proportion of reality. With these conditions prevalent in the adult sexual community, it is not difficult to see some of the difficulties inherent in parent-child interaction, out of which come the primary experiences that shape character structure and sexual behavior. John H. Gagnon, "Sexuality and Sexual Learning in the Child," Psychiatry 28 (August 1956):214-15; reprint #017, Sex Information and Education Council of the U.S. (hereafter SIECUS), Suite 922, 122 E. 42 St., New York, N.Y. 10017.

<sup>19</sup> Bronislaw Malinowski, The Sexual Life of Savages in North-Western Melanesia, with a Preface by Havelock Ellis (New York: Harcourt, Brace & World, Harvest Book edition, 1929), p. 441. In further juxtaposition to our own customs, the acceptance of sex for children and adolescents in the Trobriand Islands is accompanied by a strict etiquette barring any reference to the sexual past or present relation between husband and wife. *Ibid.*, pp. 110-11.

<sup>20</sup> Warren R. Johnson, Human Sexual Behavior and Sex Education, 2d ed. (Philadelphia: Lea & Febiger, 1968), p. 66.

<sup>21</sup> It is not uncommon in college dormitories that have liberalized their visitation policies for difficulties to arise concerning privacy and sexual relations. In some cases students go without sexual opportunity because of the presence of roommates, while in others students spend most nights in the television lounge because their roommates have regular sleeping companions. In the absence of single rooms or other provisions for privacy, perhaps the most satisfactory arrangement would be the Trobriand one, where the two, three, or four unmarried couples sharing a bachelor's hut "undertake to pay no attention to the rest"; it is considered "bad form to watch another couple during their lovemaking." Malinowski, Sexual Life of Savages, p. 73.

It should be added that feelings of vulnerability and shame are not the only motives for privacy, and that individuals who prefer not to discuss their sexual or other intimate relationships do not thereby confess to being inhibited. Compulsory openness would not represent a

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significant improvement over compulsory closedness.

<sup>22</sup>Warren Johnson reports: "In Indiana and Wyoming, 'heavy petting' with a girl under twenty-one years of age is 'sodomy' and calls for a prison sentence of ten or more years. In New Jersey, 'heavy petting' is lewdness or carnal indecency and can bring a penalty of three years in prison. In Michigan the penalty is five years." Johnson, Human Sexual Behavior and Sex Education, p. 128. Most states have laws prohibiting oral-genital and anal intercourse, frequently employing such colorful language as "unnatural acts" or the "abominable crime against nature."

<sup>23</sup>In 1960 a professor of biology at the University of Illinois was dismissed for having expressed, in a letter to the student newspaper, the view that premarital sexual relations should be condoned. The dismissal of Leo F. Koch, who had been a member of the faculty since 1955, was approved by President David D. Henry after a recommendation by the Executive Committee of the College of Liberal Arts and Sciences. An appeal to the courts was unsuccessful. "Professor Ousted for His Views on Sex," New York Times, 8 April 1960, p. 34 and "Ex-Professor's Plea Fails," New York Times, 28 June 1961, p. 13.

<sup>24</sup>In Merrick, Long Island, the school board excised two chapters on sex from a new health textbook, obliterating in black ink references in the table of contents. "L.I. Parents Protest Deletion of Section on Sex from Health Text," New York Times, 17 October 1970, p. 31. The senior high school biology textbook in the Los Angeles public schools suffered the same fate. Mary Breasted, Oh! Sex Education! (New York: Praeger Publishers, 1970; New American Library, 1971), p. 248.

Writing in 1968, Ira Reiss reports:

The chief impressions that I have been left with are that the key characteristics of the sex education programs that exist in most of our public schools today are: 1) the courses have strong moralistic and propagandistic elements, 2) the courses stress physiological aspects of sexuality, 3) the courses are isolated and sexual materials are not integrated into other relevant courses in the school systems, 4) the teachers of these courses are inadequately trained for an inadequately defined task. Ira L. Reiss, "Sex Education in the Public Schools: Problem or Solution?" Phi Delta Kappan, September 1968, p. 52.

<sup>25</sup>The Reverend Thomas Brown writes: "Many parents feel guilty and embarrassed at the thought of their own children knowing that they engage in sexual activity. Such feelings often parallel those the parents had toward their own parents. The parents feel compelled to hide acknowledgment of their sexual interests and activities from their children, just as they once felt a need to hide these from their

Notes to Chapter II, continued

own parents." Thomas Edwards Brown, Concerns of Parents about Sex Education, SIECUS Study Guide No. 13 (New York: Sex Information and Education Council of the U.S., 1971), p. 7.

<sup>26</sup>An encouraging, affirmative attitude toward sexual pleasure is, of course, not equivalent to an injunction to participate any more than the celebration of art, music, literature or swimming is equivalent to required courses in these subjects.

Notes to Chapter III

<sup>1</sup>For references and a discussion of the association of social factors and illness, see John Cassel, "Physical Illness in Response to Stress," in Social Stress, eds. Sol Levine and Norman A. Scotch (Chicago: Aldine Publishing Co., 1970), pp. 189-209.

<sup>2</sup>Walter H. Smartt and Andrew G. Lighter, "The Gonorrhea Epidemic and its Control," Medical Aspects of Human Sexuality 5 (January 1971): 100.

<sup>3</sup>Ralph Chester Williams, The United States Public Health Service 1798-1950 (Washington, D.C.: Commissioned Officers Association of the U.S. Public Health Service, 1951), p. 592.

<sup>4</sup>American Social Health Association, Today's VD Control Problem (New York: American Social Health Association, 1973), p. 27. Martin Weinberg of the Institute for Sex Research at Indiana University recalls that in California several years ago, a teacher was dismissed for talking about venereal disease in a health education class. Though a bill was subsequently passed to prevent a recurrence of such a dismissal, the legislature was unwilling to fund research aimed at developing a vaccine against gonorrhea. In the words of one lawmaker, "This would give my children a green light." Martin Weinberg, lecture delivered for the course "Topics in Human Sexuality," School of Public Health, University of North Carolina, Chapel Hill, North Carolina, November 28, 1972.

<sup>5</sup>Robert C. Sorenson, Adolescent Sexuality in Contemporary America (New York: World Publishing, 1973), table 158, p. 404.

<sup>6</sup>This fear acquires additional strength from anxiety about "sexual scarcity," to be discussed in chapter ten.

Notes to Chapter IV

<sup>1</sup>Leo Morris, "Estimating the Need for Family Planning Services Among Unwed Teenagers," Family Planning Perspectives 6 (Spring 1974): 92-93.

<sup>2</sup>Group for the Advancement of Psychiatry, Committee on Preventive Psychiatry, Humane Reproduction, Report #86 (August 1973), p. 395.

<sup>3</sup>A new law enacted at the same time prohibits the mailing of "unsolicited advertisement of matter which is designed, adapted or intended for preventing conception." Although the 1971 law excepts mailings to dealers, physicians, pharmacists and other persons who might have a professional concern, it nevertheless interferes with efforts to develop direct mail solicitations as an additional avenue for marketing contraceptives to groups not well served by other means. Harriet F. Pilpel and Peter Ames, "Legal Obstacles to Freedom of Choice in the Areas of Contraception, Abortion and Voluntary Sterilization in the United States," in Aspects of Population Growth Policy, Commission Research Reports, Commission on Population Growth and the American Future, vol. 6, eds. Robert Parke, Jr. and Charles F. Westoff (Washington, D.C.: Government Printing Office, 1972), p. 60.

<sup>4</sup>Norman E. Himes, Medical History of Contraception, with an Introduction by Alan F. Guttmacher (New York: Gamut Press, 1963), p. 315.

<sup>5</sup>Alan F. Guttmacher, Introduction to *ibid.*, p. x.

<sup>6</sup>"Birth-Curb Backer Seized; Child, 3, Attended His Talk," New York Times, 7 August 1971, p. 13; "Mother and Birth-Control Crusader Are Arrested at L.I. Lecture," New York Times, 8 August 1971, p. 43. Baird and the baby's mother were brought to court, handcuffed, after spending the night in the county jail.

<sup>7</sup>"Barrier Methods," Population Report, issued by the Department of Medical and Public Affairs, Science Communication Division, George Washington University Medical Center, Series H, No. 1 (December 1973): 12-13. In 1974 the New York State Legislature voted down a bill to allow open display of non-prescription contraceptive materials in drug stores: in the words of one legislator, "The New York State Legislature would be telling our young people to have a good time, and I strongly disapprove." Quoted in "Sex and the New York State Legislature," SIECUS Report 2 (July 1974): 3.

<sup>8</sup>John F. Kantner and Melvin Zelnik, "Contraception and Pregnancy: Experience of Young Unmarried Women in the United States," Family Planning Perspectives 5 (1973):21-22.

Notes to Chapter IV, continued

<sup>9</sup>Sorenson reports that, as with venereal disease information, more than one quarter of teenagers would like to ask their parents for information about birth control but are afraid of being questioned about their sexual activities. Sorenson, Adolescent Sexuality in Contemporary America, table 166, p. 405.

<sup>10</sup>John F. Kantner and Melvin Zelnik, "Sexual Experience of Young Unmarried Women in the United States," Family Planning Perspectives 4 (October 1972):16.

<sup>11</sup>Michael Schofield, The Sexual Behaviour of Young People (London: Longmans, Green & Co., 1965), p. 251.

<sup>12</sup>Karl E. Bauman, "Selected Aspects of the Contraceptive Practices of Unmarried University Students," American Journal of Obstetrics and Gynecology 108 (15 September 1970):208.

<sup>13</sup>Ira L. Reiss, Premarital Sexual Standards, SIECUS Study Guide No. 5 (New York: Sex Information and Education Council of the U.S., 1967), pp. 14-15.

<sup>14</sup>Additional influences are also present. One or both partners may reject the condom because it interferes with their pleasure. Various objections may be raised to other methods, and for some, running the risk of pregnancy may be viewed as an expression of love on the part of the female. Godfrey Hochbaum, Ph.D., of the University of North Carolina at Chapel Hill Department of Health Education, has called to my attention yet another factor which operates in many health behavior situations in addition to contraceptive behavior--a faith in one's own safety. In fact, nearly all of the reasons cited for not using automobile seat belts would have their contraception counterparts.

<sup>15</sup>Morris, p. 93.

<sup>16</sup>These figures would result from a mortality rate of 100 per 100,000 illegal abortions and a major complication rate of 5 percent applied to a base of one million abortions per year. Of the prevalence of illegal abortions, Christopher Tietze and Deborah A. Dawson write: ". . . a round figure of 1,000,000 abortions per year gained wide acceptance during the late 1960s. The results of a later survey in North Carolina, using the randomized response technique, and of a retrospective estimate based on the number of legal abortions and of births in New York City during the period 1970-1972, are compatible with this estimate." Christopher Tietze and Deborah A. Dawson, "Induced Abortion: A Factbook," Reports on Population/Family Planning, No. 14 (December 1973):10.

Notes to Chapter IV, continued

Similarly, applying a fertility/population model to the developed countries in the post-World War II period and assuming universal practice of contraception having a 95 percent effectiveness and reasonable reproductive health, Tietze and Dawson conclude that the population growth experienced would require abortion ratios on the order of 300 to 600 per 1,000 live births. *Ibid.*, p. 6.

The one million figure is also compatible with the Institute for Sex Research findings of 999 illegal abortions in their sample of women who had experienced 4,248 conceptions resulting in 2,434 live births. Paul H. Gebhard et al., Pregnancy, Birth and Abortion (New York: Harper & Row, 1958; Science Editions, John Wiley & Sons, 1966), p. 29.

Regarding the rate for major medical complications, Gebhard et al. received reports of severe physical consequences (septicemia, peritonitis, other serious infection, long hospital stay, invalidism, or a record of almost dying) in connection with 6.6 percent of 442 abortions where the consequences were known to the researchers. Mild (bleeding, cramps, temporary menstrual difficulties, or hospital stay of a day or so) and moderate (severer bleeding or cramping for a longer period of time, some infection, more than temporary menstrual difficulty, hospitalization for several days) physical consequences were reported in connection with 3.2 percent and 6.8 percent, respectively. All figures are for white females. *Ibid.*, p. 206.

The mortality rate of 100 per 100,000 is Alan F. Guttmacher's. Alan F. Guttmacher, Pregnancy, Birth and Family Planning (New York: Viking Press, New American Library, 1973), p. 170.

<sup>17</sup> Liberal abortion policies adopted in the 1950s were associated with declines in reported mortality from abortion by one-half (in Hungary) and three-fourths (in Czechoslovakia) in the course of a few years. These figures include mortality from illegal and/or self-induced abortions that have continued in Hungary. The enactment in Romania of a restrictive abortion law was followed by almost a fivefold increase in deaths due to abortion. Mortality rates in New York City and California where legal abortion has been widely available for several years are 5 per 100,000. The Joint Program for the Study of Abortion found a "major" complication rate of 1 percent of all legal abortion patients in 1970-71. For a discussion and references, see Tietze and Dawson, "Induced Abortion," pp. 48-50.

Notes to Chapter V

<sup>1</sup>Harold I. Lief, "Sexual Attitudes and Behavior of Medical Students: Implications for Medical Practice," in Marriage Counseling in Medical Practice, eds. Ethel M. Nash et al. (Chapel Hill: University of North Carolina Press, 1964), p. 303. This article also discusses medical students' sexual inhibition, role expectations, sexual anxiety and general lack of attitudinal preparation for dealing with patients' sexual concerns.

<sup>2</sup>R. K. Greenbank, "Are Medical Students Learning Psychiatry?" Pennsylvania Medical Journal 64 (1961):991. A decade later, results from a survey of 500 medical students in six medical schools found that 22 percent believed that masturbation is etiologically related to mental illness; 54 percent believed that there are two kinds of physiological orgasmic responses in women, one clitoral, the other vaginal; 15 percent believed that the condom is the most reliable of the various contraceptive devices; 20 percent believed that pornography is responsible for much of today's aberrant sexual behavior. Harold I. Lief, "Obstacles to the Ideal and Complete Sex Education of the Medical Student and the Physician," in Contemporary Sexual Behavior: Critical Issues in the 1970s, eds. Joseph Zubin and John Money (Baltimore: Johns Hopkins University Press, 1973), p. 447.

<sup>3</sup>Woods, "Sexual Problems of Medical Students," pp. 73 and 78.

<sup>4</sup>Ibid., pp. 80 and 83.

<sup>5</sup>Donald W. Burnap and Joshua S. Golden, "Sexual Problems in Medical Practice," in Human Sexuality in Medical Education and Practice, ed. Clark Vincent (Springfield, Ill.: Charles C. Thomas, 1968), p. 52. The original sample consisted of 110 physicians randomly selected from the membership of a local county medical association. Sixty physicians were interviewed.

<sup>6</sup>Ibid. The difference was statistically significant at the .001 level.

<sup>7</sup>Ibid., table 4-II, p. 50.

<sup>8</sup>Ibid. The difference was statistically significant at the .05 level.

<sup>9</sup>C. Nash Herndon and Ethel M. Nash, "Premarriage and Marriage Counseling. A Study of Practices by North Carolina Physicians," Journal of the American Medical Association 180 (1962, No. 5):398.

Notes to Chapter V, continued

<sup>10</sup>James L. Mathis, "Iatrogenic Sexual Disturbances," Medical Aspects of Human Sexuality 1 (September 1967, No. 1):49-50.

<sup>11</sup>Philip Sarrel, M.D., lecture as part of the Medical Sex Education Workshop, Summer Program in Human Sexuality, Institute for Sex Research, Indiana University, Bloomington, Indiana, 21 July 1972.

<sup>12</sup>Masters and Johnson, Human Sexual Inadequacy, p. 188.

<sup>13</sup>The latter couple "was assured that the symptoms of impotence would disappear if there were regularity in church attendance for at least one year. Two years later, despite fanatical attendance at all church functions, the symptoms of impotence continued unabated." *Ibid.*, p. 189.

<sup>14</sup>*Ibid.*, pp. 190-91.

<sup>15</sup>*Ibid.*, p. 189.

<sup>16</sup>*Ibid.*, p. 202.

<sup>17</sup>John Peel and Malcolm Potts, A Textbook of Contraceptive Practice (Cambridge: The University Press, 1969), chapter 1; Alex Comfort, The Anxiety Makers (London: Nelson, 1967), pp. 154-73.

<sup>18</sup>A dissenting voice from the fifteenth century held that though women might lack the capacity for sexual gratification, they certainly did not lack the desire: "A woman is more carnal than a man. . . . All witchcraft comes from carnal lust, which is in women insatiable." Sprenger and Kramer; Malleus Maleficarum, Part I, Question 6, quoted in Morton M. Hunt, The Natural History of Love (New York: Alfred A. Knopf, 1959; Minerva Press, 1967), p. 177.

<sup>19</sup>Daniel G. Brown, "Female Orgasm and Sexual Inadequacy," in An Analysis of Human Sexual Response, eds. Ruth and Edward Brecher (New York: New American Library, 1966), pp. 128-29. Italics in original.

<sup>20</sup>Johnson, Human Sexual Behavior and Sex Education, p. 54.

<sup>21</sup>*Ibid.*, p. 29.

Notes to Chapter VI

<sup>1</sup>Robert O. Pasnau, in "Psychosomatic Aspects of Menstrual Disorders," Clinical Obstetrics and Gynecology 12 (September 1969):724-40, cites figures of 21-32 percent for premenstrual tension and 32-84 percent for dysmenorrhea, depending upon the study and the criterion used.

<sup>2</sup>Ibid.

<sup>3</sup>Morris Paulson, "Psychological Concomitants of Premenstrual Tension," American Journal of Obstetrics and Gynecology 81 (April 1961): 733-38. Paulson also notes:

Whereas 78 per cent of the high premenstrual tension group indicated increased sexual drives at specific periods throughout the month, only 37 per cent of the low premenstrual tension group indicated such increased drives. The question arises as to the expression of these sexual needs in those women with high premenstrual tension. Are these sexual drives generally satisfied or, if left unsatisfied, is the frustration of such drives expressing itself through psychic manifestations in the premenstrual disorder? Ibid., p. 737.

<sup>4</sup>For example, in 1968 William Masters characterized Playboy Magazine as the "best available medium for sex education in America today. Interview with Playboy magazine in Lehrman, Masters and Johnson Explained, p. 168.

<sup>5</sup>Johnson, Human Sexual Behavior and Sex Education, p. 67. A notable victim of concern about nocturnal seminal emissions was Havelock Ellis, the great-grandfather of contemporary sex researchers. He writes that his "copious seminal emissions during sleep, once or twice a week . . . [were] a source of nervous apprehension, for I vaguely felt that they were something to be ashamed of; I constantly dreaded their occurrence and feared their detection." Quoted in Brecher, Sex Researchers, p. 40. Unfortunately for Ellis, he came under the influence of Dr. Charles Drysdale's Elements of Social Science. Though a believer in the benefits of sexual intercourse, Drysdale was convinced of the harmfulness of nocturnal emissions (which he labelled "spermatorrhoea" on analogy with diarrhoea and gonorrhoea), asserting that they led to atrophy of the sexual apparatus, general weakness and debilitation, insanity and even death. Brecher, Sex Researchers, pp. 40-42.

<sup>6</sup>Kinsey, Pomeroy, and Martin, Sexual Behavior in the Human Male, p. 527.

Notes to Chapter VI, continued

<sup>7</sup>Ibid., p. 530.

<sup>8</sup>Masters and Johnson report the history of one of their male patients: "At age 13, the first occasion of nocturnal emission was soon identified by his mother. His father whipped him for this 'sin of the flesh,' and thereafter his sheets were checked daily to be sure that he did not repeat this offense." Masters and Johnson, Human Sexual Inadequacy, p. 119.

<sup>9</sup>Comfort, Anxiety Makers, p. 74; Brecher, Sex Researchers, p. 39.

<sup>10</sup>Kinsey, Pomeroy, and Martin write that Talmudic references and early Christian writers viewed masturbation as a greater sin than non-marital sexual intercourse. See Kinsey, Pomeroy, and Martin, Sexual Behavior in the Human Male, pp. 473, 476.

<sup>11</sup>The list of references includes publications by the U.S. Public Health Service and all editions of the Boy Scout Manual from 1911 through 1945.

<sup>12</sup>Kinsey, Pomeroy, and Martin, Sexual Behavior in the Human Male, pp. 513-14.

<sup>13</sup>See, for example, Walter R. Stokes, "An Appraisal of Erotic Emotion and Auto-Erotic Behavior," in The New Sexual Revolution, eds. Lester A. Kirkendall and Robert N. Whitehurst, with a Preface by Paul Kurtz (New York: Donald W. Brown, Inc., in association with Prometheus Books, 1971), p. 78. Norman Tabachnick, Associate Chief Psychiatrist of Los Angeles Suicide Prevention Center, reports that guilt, shame and the imagined consequences of masturbation occasionally lead to suicide attempts and completed suicides. Norman Tabachnick, "Sex and Suicide," Medical Aspects of Human Sexuality 4 (May 1970):63.

<sup>14</sup>William H. Masters and Virginia E. Johnson, Human Sexual Response (Boston: Little, Brown & Co., 1966), p. 201. There were 654 males among the study subject applicants.

In the more than 20,000 telephone calls to a sex information service in New York City during an eighteen-month period, masturbation was the second most frequent topic discussed by male callers. A typical question was, "Is it normal for a married man to masturbate sometimes?" Susan Sarlin, "A Study of Callers to Community Sex Information, Inc.," SIECUS Report 3 (September 1974):4.

<sup>15</sup>Stokes, "Appraisal of Erotic Emotion and Auto-Erotic Behavior," p. 84.

Notes to Chapter VI, continued

<sup>16</sup>Papal Commission on Birth Control, Report of the Minority, in The Catholic Case for Contraception, ed. Daniel Callahan (New York: Macmillan Co., 1969), p. 208; reprinted from the National Catholic Reporter, 19 April 1967.

<sup>17</sup>David R. Mace, "The Sexual Revolution: Its Impact on Pastoral Care and Counseling," The Journal of Pastoral Care 25 (December 1971); reprinted by SIECUS, no pagination.

<sup>18</sup>Stokes, "Appraisal of Erotic Emotion and Auto-Erotic Behavior," p. 82.

<sup>19</sup>Robert L. Arnstein, "Homosexual Concerns of College Students," Sexual Behavior (December 1971); reprinted by SIECUS, citing a study by C. C. Fry and E. G. Rostow, no pagination.

<sup>20</sup>Quoted in *ibid.* Arnstein also cites a 1965 study of Cornell University students, which indicated that only a small proportion of those who admitted having concern about homosexuality had sought help at the Mental Health Clinic.

<sup>21</sup>Kinsey, Pomeroy, and Martin, Sexual Behavior in the Human Male, p. 650. The sample was limited to white males.

<sup>22</sup>Loneliness and difficulty in forming stable intimate relationships are also consequences of societal attitudes toward homosexuality. Martin S. Weinberg and Colin J. Williams, Male Homosexuals: Their Problems and Adaptations (New York: Oxford University Press, 1974), pp. 87-88, 157-58 *passim*.

<sup>23</sup>Evalyn S. Gendel, M.D., quoted in Barbara Goodheart, "Sex in the Schools: Education or Titillation?" Today's Health 48 (No. 2); reprinted by SIECUS, no pagination.

<sup>24</sup>"Playboy Interview: Dr. Mary Calderone," Playboy (April 1970); SIECUS reprint #072, no pagination.

<sup>25</sup>Woods, "Sexual Problems of Medical Students," p. 73. In this connection it is interesting that when children undress and touch each other they often pretend they are "playing doctor." Perhaps "playing doctor" is a valuable preparation for medical training after all.

<sup>26</sup>Harvey W. Caplan and Rebecca A. Black, "Unrealistic Sexual Expectations," Medical Aspects of Human Sexuality 8 (August 1974):22.

<sup>27</sup>Masters and Johnson, Human Sexual Response, p. 162.

Notes to Chapter VI, continued

<sup>28</sup> Six women in the study group rejected nursing from fear "of the high levels of eroticism stimulated by the suckling process." These six women had attempted nursing with previous pregnancies. Ibid., p. 162.

<sup>29</sup> Niles Newton, "Interrelationships Between Sexual Responsiveness, Birth, and Breast Feeding," in Zubin and Money, Contemporary Sexual Behavior, pp. 77-98.

<sup>30</sup> Ibid., p. 78. Twelve of Masters and Johnson's study subjects also reported sensations akin to those of orgasm during the second stage of labor. Masters and Johnson, Human Sexual Response, p. 136.

<sup>31</sup> Masters and Johnson, Human Sexual Response, p. 246.

Notes to Chapter VII

<sup>1</sup>Masters and Johnson's clinical series included fifteen women in their fifties who had never experienced orgasm, by any means of sexual stimulation. More than half of these women became orgasmic during the Masters and Johnson treatment program. Masters and Johnson, Human Sexual Inadequacy, p. 333.

<sup>2</sup>Ira L. Reiss, The Social Context of Premarital Sexual Permissiveness (New York: Holt, Reinhart & Winston, 1967), pp. 111 and 115. The sample was a 1963 sociology class at the University of Iowa.

<sup>3</sup>Kinsey et al., Sexual Behavior in the Human Female, pp. 431 and 437.

<sup>4</sup>Kinsey, Pomeroy, and Martin, Sexual Behavior in the Human Male, p. 392.

<sup>5</sup>The film was exhibited at the Institute for Sex Research Summer Program in Human Sexuality, Bloomington, Indiana, 23 July 1972. Weinberg and Williams report that the major means of enforcement of anti-homosexual laws include police decoys, clandestine observation, routine patrol of places where homosexuals are known to congregate, and harassment of homosexual bars, baths, private clubs, etc., and their patrons. Weinberg and Williams, Male Homosexuals, pp. 24-26.

<sup>6</sup>"The Consenting Adult Homosexual and the Law: An Empirical Study of Enforcement and Administration in Los Angeles County," U.C.L.A. Law Review (March 1966), p. 663, cited by Weinberg and Williams, Male Homosexuals, p. 23.

<sup>7</sup>The New Mexico Civil Liberties Union recently secured the release of a man who had served ten years of a life sentence. He had pleaded guilty to sodomy after the trial court had told him that the penalty would be "not less than one year in prison." "Over a Year," Civil Liberties, published by the American Civil Liberties Union, May 1974, p. 8. In one state, the minimum penalty for oral-genital contact is life at hard labor--in contrast, male contact with a cow is punished by "only" five years or less. Robert Veit Sherwin, "Sexual Problems and Marital Dissolution," Medical Aspects of Human Sexuality 4 (April 1970):16.

<sup>8</sup>Quoted in Donald J. Cantnor, "The Homosexual Revolution--A Status Report," in The New Sexual Revolution, eds. Kirkendall and Whitehurst (New York: Donald W. Brown, Inc., in association with Prometheus Books, 1971), p. 94. In another demonstration of legislative emotions, the California legislature several years ago passed a law prohibiting sexual contact between animals within 500 yards of a school. Paul H.

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Gebhard, Ph.D., lecture on "Sex Law and Sex Offenders," Institute for Sex Research Summer Program, 23 July 1972.

<sup>9</sup>Weinberg and Williams, Male Homosexuals, p. 23. In some jurisdictions, such as San Francisco, a person convicted of a sex offense (felony or misdemeanor) is required to report to the chief of police or sheriff where he resides and undergo a registration procedure involving fingerprinting, photographs, and notifications of any change of address. Ibid., p. 48. Convicted, accused, or even suspected homosexuals may also be liable to incarceration under "sexual psychopath" laws. See n. 20 of this chapter.

<sup>10</sup>Ibid., p. 19.

<sup>11</sup>Ibid., p. 83.

<sup>12</sup>Ralph Slovenko reports that approximately 80 percent of rape convictions are for statutory rape. During a ten-year period in New York City, 59 percent of all convicted sex offenders were charged with statutory rape. Ralph Slovenko, "Statutory Rape," Medical Aspects of Human Sexuality 5 (March 1971): 155.

<sup>13</sup>Ralph Slovenko, "A Panoramic View: Sexual Behavior and the Law," in Sexual Behavior and the Law, ed. Ralph Slovenko (Springfield, Ill.: Charles C. Thomas, 1965), p. 10. The "safe" states are Louisiana, Michigan, Missouri, New Mexico, New York, Oklahoma, South Dakota, Tennessee, Vermont, and Washington.

<sup>14</sup>George Becker, United Press International, "Sex Illegal," Daily Tar Heel (Chapel Hill, North Carolina), 2 October 1974; Ronald Sullivan, "Unwed Parents Win Legal Point," New York Times, 23 March 1971, p. 21. While upholding the statute, the court ruled that the law against fornication could not be used to prosecute unwed parents seeking welfare assistance for their illegitimate children since to do so would violate the Fifth Amendment protection against self-incrimination and would also deter parents from seeking assistance for their children, thus punishing the child. Both defendants had received prison sentences, one of which had been suspended.

<sup>15</sup>Paul H. Gebhard et al., Sex Offenders, 1st ed. (New York: Harper & Row and Paul B. Hoeber, Inc., 1965), p. 130. The authors chose age sixteen as the demarcation of adulthood. For their reasons, see pp. 106-107.

<sup>16</sup>Ibid., p. 130.

<sup>17</sup>Recounted by Martin S. Weinberg, Ph.D., speaking on "Variations of Sexual Behavior" at the University of North Carolina at Chapel Hill, 17 April 1972, as part of the course "Topics in Human Sexuality." Even

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when those arrested are eventually acquitted by the courts, they have often suffered considerably from the embarrassment, publicity, stress, and expense of legal defense. The expense to society is also substantial, including the cost of law enforcement personnel and the courts. In this connection, the occasional sodomy prosecution is less important than the much more frequent attempts to suppress prostitution, massage parlors, and "adult" books and films. The Institute for Sex Research was forced to fight a seven-year legal battle with the U.S. Customs Department in order to obtain materials from abroad for its library.

<sup>18</sup>Sherwin, "Sexual Problems and Marital Dissolution," p. 26.

<sup>19</sup>Ibid., p. 25.

<sup>20</sup>"Conviction of a Mother for Lewdness Upheld," New York Times, 9 December 1971, p. 48. "Sexual psychopath" laws, introduced in the 1930s and in force in a majority of states, provide for a civil commitment procedure for persons judged "sexual psychopaths":

On the basis of suspicion alone, without any proof or direct evidence that an offense has actually taken place, a person may be taken into custody, denied his freedom indefinitely, and put through a rigorous psychiatric investigation. If he is adjudged a "sexual psychopath," he need not be released until several psychiatric authorities are able and willing to attest that he has been "cured." Wainwright Churchill, Homosexual Behavior Among Males: A Cross-Cultural and Cross-Species Investigation (New York: Hawthorn Books, 1967), p. 221, quoted in Weinberg and Williams, Male Homosexuals, p. 24.

For references concerning these laws, see Weinberg and Williams, Male Homosexuals, p. 23, n. 24.

<sup>21</sup>Martha L. Stein, Lovers, Friends, Slaves: The Nine Male Sexual Types (New York: G. P. Putnam's Sons, 1974). This passage quoted from the review by Michael Phillips in SIECUS Report 3 (September 1974):9.

<sup>22</sup>Masters and Johnson, Human Sexual Response, p. 10.

Notes to Chapter VIII

<sup>1</sup>K. Jean Lennane and R. John Lennane, in a recent article, "Alleged Psychogenic Disorders in Women--A Possible Manifestation of Sexual Prejudice," New England Journal of Medicine 288 (8 February 1973):291, note "the most remarkable persistence . . . of the Biblical attitude<sup>37</sup> to pain in labor, for which the woman is still held morally responsible,<sup>16</sup> allowing irrational and ineffective treatment of prolonged and severe pain to continue in the otherwise analgesia-oriented 20th century."

16. Read GD: The influence of the emotions on pregnancy and the parturition, Antenatal and Postnatal Care, Seventh ed., Ed. by F.J. Brownes. London, J&A Churchill, 1951, pp. 88-113.

37. The Bible (revised version) Genesis 3:1-16.

<sup>2</sup>G. Rattray Taylor, Sex in History (New York: Vanguard Press, 1954; Harper & Row, 1973), p. 176.

<sup>3</sup>Though the Kinsey researchers had preceded Masters and Johnson in filming human sexual behavior, they deemed it wise to limit public disclosure of this source of their information to a single cryptic reference in Sexual Behavior in the Human Female. Pomeroy, Dr. Kinsey and the Institute for Sex Research, p. 191. Pomeroy credits the emotional reaction to the volume on the human female, a much more sensitive subject than the human male, with the loss of Kinsey's foundation support. The Journal of the American Medical Association for many years refused to publish any of Masters and Johnson's research. Wilhelm Reich's books and writings were burned by the U.S. Food and Drug Administration in 1956, an action that is hard to dissociate completely from his outspokenness about the sexual rights of adolescents.

<sup>4</sup>This has not always been the case. Walter Stokes relates the following story told him early in his practice by a cultured, elderly woman of one of the First Families of Virginia:

She commented that up to the time of her marriage her mother had never directly mentioned sex in any way. But as her wedding approached, the mother took her aside and grimly instructed, "You are about to be married and must be thinking of having children. To do this a woman must submit to revolting physical contact with her husband. She must summon all her courage and endure this, as she does childbirth. It is said that there are women who enjoy sexual contact with a man, but this has never been known in the history of our family. I am sure you will not enjoy the sex act but if you should, never let your husband know, for no decent man can respect a woman who does." Walter R. Stokes, "Inadequacy of Female Orgasm as a Problem in Marriage Counseling," in Handbook of

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Marriage Counseling, eds. Ben N. Ard, Jr. and Constance C. Ard (Palo Alto, California: Science and Behavior Books, Inc., 1969), p. 361.

<sup>5</sup>Some have lamented rising expectations and the dissatisfaction they have unearthed. But this is a process that goes on in many areas of living and is probably responsible for a great deal of fuller attainment. On the other hand, cultural expectations that are unreasonably demanding may contribute to sexual dysfunction. The question is what are realistic expectations.

<sup>6</sup>For a study that investigated feeling dimensions of female sexual response as well as orgasm, see Seymour Fisher, The Female Orgasm (New York: Basic Books, 1973).

<sup>7</sup>Even medical writers have not yet accepted the lack of orgasm in marital intercourse as an indication of sexual dysfunction: "Lessening of frigidity is a slow process, but by careful attention to the particular problems of each case, a good result can frequently be achieved. It is important to remember that it is not necessary for a woman to achieve an orgasm but only that she find intercourse a pleasurable experience." George W. Thorn, "Disturbances of Sexual Function," in Harrison's Principles of Internal Medicine, 7th ed., edited by Maxwell M. Wintrobe et al. (New York: McGraw-Hill, 1974), p. 248.

<sup>8</sup>Kinsey, Pomeroy, and Martin, Sexual Behavior in the Human Male, p. 580. The Kinsey researchers were probably reacting to the prevailing theory of the time, that premature ejaculation necessarily indicated underlying neurosis or character disorder.

<sup>9</sup>Masters and Johnson have suggested the existence of a level of impairment even more far-reaching than current clinical categories imply:

Johnson: If I may be permitted to comment on the larger issue implicit in your question--the fact that so many people of both sexes feel sexual pleasure only in the sex organs themselves--this is a manifestation of their rejection of their total sexuality. For example, a lot of women do not respond to breast stimulation because of its implied impropriety. A young person exposed to this type of negation will frequently reject the concept of breast stimulation and/or response. An anesthesia comparable with self-hypnosis is induced. I mention the breasts particularly because this type of negation comes out so dramatically when women reject nursing.

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Masters: Yes, and this negation may extend even to the genitals--as with the unresponsive woman who claims she never feels a thing during intercourse, no stimulation whatsoever. She has a certain amount of vaginal anesthesia that we're convinced--as are many others--is psychogenically induced and relates to attitude, circumstance and environment. I do want to stress, however, that we lack definitive data concerning the psychological deterrents to sexual response and sexual tension. Interview with Playboy Magazine, in Lehrman, Masters and Johnson Explained, p. 150.

The concept of unimpaired sexuality as involving a whole-body response has also been advanced by Wilhelm Reich in The Discovery of the Orgone, trans. Theodore P. Wolfe (New York: Farrar, Straus & Giroux, 1942; Noonday Press, 1961), vol. 1: The Function of the Orgasm, and other works, Lowen in Love and Orgasm, and others.

<sup>10</sup>Masters and Johnson, Human Sexual Inadequacy, especially chapters 1, 6, and 8; McCary, Human Sexuality, chapter 1.

<sup>11</sup>For reference and discussion, see Fisher, Female Orgasm, pp. 22-34 and chapter 2.

<sup>12</sup>Kinsey et al., Sexual Behavior in the Human Female, table 106, p. 404.

<sup>13</sup>Fisher, Female Orgasm, chapter 8.

<sup>14</sup>Press conference, 20-22 April 1970, Boston, in Lehrman, Masters and Johnson Explained, p. 79.

<sup>15</sup>Physical and medical causes are most likely to be associated with complaints of dyspareunia or impotence. For medical conditions such as disease states or drugs known to cause these, see Masters and Johnson, Human Sexual Inadequacy, chapters 6 and 10.

<sup>16</sup>Kinsey, Pomeroy, and Martin, Sexual Behavior in the Human Male, pp. 236-37.

<sup>17</sup>Masters and Johnson, Human Sexual Inadequacy, p. 157.

<sup>18</sup>Kinsey, Pomeroy, and Martin, Sexual Behavior in the Human Male, table 50, p. 236.

<sup>19</sup>Masters and Johnson, Human Sexual Inadequacy, chapter 12.

<sup>20</sup>Kinsey et al., Sexual Behavior in the Human Female, p. 352.

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<sup>21</sup>Ibid., table 104, p. 403.

<sup>22</sup>Many other studies have found similarly large percentages of women experiencing orgasm in a minority of coitus. A questionnaire survey of readers of Psychology Today and of its French sister magazine Psychologie reported that 30 percent of the American females and 26 percent of the French females reached orgasm one fourth of the time or less during sexual intercourse. Psychology Today, July 1972. A questionnaire survey of 2,372 American wives most of whom had attended college and were employed reported that 8 percent "never" had orgasm while an additional 32 percent experienced orgasm "some of the time" or "once in a while" during marital coitus. Robert R. Bell and Phyllis L. Bell, "Sexual Satisfaction Among Married Women," Medical Aspects of Human Sexuality 6 (December 1972):142. Neither of these samples was statistically representative. A study which attempted to secure a representative sample, with moderate success, reported that of non-virgin unmarried teenage females, 57 percent experienced orgasm rarely or never. Sorenson, Adolescent Sexuality in Contemporary America, table 336, p. 432. Additional references may be found in Brown, "Female Orgasm and Sexual Inadequacy" and Fisher, Female Orgasm.

<sup>23</sup>The Kinsey criterion was explained in a letter to me from Ms. Joan Brewer, reference librarian at the Institute for Sex Research, Bloomington, Indiana, 5 December 1973.

<sup>24</sup>Of 106 women who experienced orgasm only with direct clitoral stimulation, 80 percent developed the ability to respond orgasmically from coital stimulation. Masters and Johnson had only moderate success with another category, random orgasmic dysfunction. Women in this category have experienced orgasm at least once from both manipulative and coital stimulation, but "are rarely orgasmic and usually are aware of little or no physical need for sexual expression." Of 32 women in this category, 20 became orgasmic during the two-week treatment program, a figure that declined slightly during the five-year follow-up period. See Masters and Johnson, Human Sexual Inadequacy, chapters 8 and 14.

<sup>25</sup>Helen Singer Kaplan, The New Sex Therapy (New York: Brunner/Mazel, 1974), pp. 379-81. The method of achieving female orgasm should not be confused with the Freudian distinction between "clitoral" and "vaginal" orgasms. Masters and Johnson found the same physiological responses in orgasms produced by direct clitoral stimulation, penile stimulation (which they regard as including indirect clitoral stimulation via the labia minora and clitoral hood), and by breast stimulation alone (a relatively rare ability). The more physiologically intense orgasms, in fact, resulted from masturbation, though subjective ratings of intensity were frequently not correlated with physiological measurements. See Masters and Johnson, Human Sexual Response.

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For a critical view of the Freudian concept based on a rather intensive psychological investigation and a thorough review of the literature, see Fisher, Female Orgasm.

<sup>26</sup>Kinsey, Pomeroy, and Martin, Sexual Behavior in the Human Male, p. 580.

<sup>27</sup>Many females, even though they take longer to respond to orgasm in coitus may masturbate to orgasm in a matter of a minute or two. The median female who masturbates ordinarily takes less than four minutes to reach orgasm by this method, while she may require ten or twenty minutes to reach orgasm through coitus. The average male seems to require two to four minutes to reach orgasm during masturbation. Kinsey et al., Sexual Behavior in the Human Female, p. 626.

<sup>28</sup>Kinsey, Pomeroy, and Martin, Sexual Behavior in the Human Male, p. 580.

<sup>29</sup>Such intimacy, while valuable in public health terms, may not be congruent with other values and solidarities important to the system of social relationships. See Lee Rainwater, "Marital Sexuality in Four Cultures of Poverty," Journal of Marriage and the Family 26 (November 1964):457-66.

<sup>30</sup>The quality of the interaction is appropriately the focus of Masters and Johnson's clinical criterion, according to which a man is a premature ejaculator if despite the couple's desires he climaxes before his partner more than half of the time. Masters and Johnson, Human Sexual Inadequacy, p. 92. The definition has validity only if the female is not orgasmically dysfunctional for reasons other than rapid ejaculation by her partner.

Kinsey has called attention to another dimension of sexual communication:

Mutual responses in a socio-sexual relationship are also significant because the one partner may respond sympathetically to the reactions of the other partner. The male may become emotionally aroused when he observes that his wife is aroused, and he is particularly liable to be aroused when he is in physical contact with her and can feel her responding. It is this interplay of physical, psychologic, and emotional responses which makes coitus one of the most completely mutual activities in which two individuals may engage.

Simultaneous orgasm for the two partners in a coital relationship derives its significance chiefly from the fact that the intense responses which the one partner makes at the moment of orgasm may stimulate the other partner to similarly intense

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response. Consequently simultaneous orgasm represents, for many persons, the maximum achievement which is possible in a sexual relationship.

The failure of an unresponding sexual partner to provide these physical or emotional stimuli may, on the other hand, do considerable damage to the effectiveness of the relationship. The responding male, especially if he has had previous experience and understands what effective coitus may be, will sense the lack of cooperation, and his responses may be inhibited or stopped. Such failures lead not only to disappointment, frustration, and a sense of defeat, but sometimes to contrary emotional responses which become anger and rage. Kinsey et al., Sexual Behavior in the Human Female, p. 372.

<sup>31</sup>Masters and Johnson, Human Sexual Inadequacy, pp. 14-15.

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<sup>1</sup>Quoted in Linda Wolfe, "The Masterses' Disciples: Sex Therapy in New York," New York Magazine, 17 April 1972, p. 70.

<sup>2</sup>Robert C. Long, "Sexual Health Care," SIECUS Report 3 (September 1974):14.

Further support for this proposition comes from the Kinsey studies:

. . . our data confirms what many clinicians have regularly seen, that the persistent failure of the female to reach orgasm in her marital coitus, or even to respond with fair frequency, may do considerable damage to a marriage. If the coitus fails to bring the satisfaction and physiologic release which the female might obtain from completed activity, and if the female is disappointed because of her inability to accomplish what she thinks she should, she may develop a sense of inferiority which further reduces the possibilities of her ever having satisfactory relationships.

The failure of the female to reach orgasm may also be a source of considerable disappointment to the male. Today most males, especially among better educated groups, feel under some obligation to see that the female secures gratification comparable to their own in coitus. To such a male, the failure of the wife may seem an indication of some incapacity on his part, and he, in consequence, may develop a sense of inferiority which, again, may compound the difficulties. Far from contributing to the solidarity of the marriage, the coitus may then become a source of disappointment, friction, and more serious discord. Kinsey et al., Sexual Behavior in the Human Female, pp. 371-72.

<sup>3</sup>George Levinger, "Sources of Marital Dissatisfaction Among Applicants for Divorce," American Journal of Orthopsychiatry 36 (5 October 1966):803-807. Looking at the other side of the coin, "Clifford Kirkpatrick's analysis of the components of successful marital adjustment . . . ranked 'adequate sex information in childhood' third in importance among the leading ten factors considered fundamental to a successful marriage." Clifford Kirkpatrick, The Family As Process and Institution (New York: Ronald Press, 1959), quoted in McCary, Human Sexuality, p. 7.

<sup>4</sup>Virginia Johnson, interview with Playboy Magazine in Lehrman, Masters and Johnson Explained, pp. 108-109.

<sup>5</sup>Delay in seeking therapeutic assistance is not uncommon. In a series of 100 unconsummated marriages seen at the Tavistock Clinic in

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London, 65 couples had been married without having sexual intercourse for more than a year, including 27 couples who had waited more than five years (the longest waited 17 years). With treatment, 81 percent of the sample consummated their marriages. Leonard J. Friedman, "Unconsummated Marriages," Medical Aspects of Human Sexuality 4 (May 1970):17. The study is described in Leonard J. Friedman, Virgin Wives: A Study of Unconsummated Marriages (London: Tavistock Publications Ltd., New York: Lippincott, 1962).

<sup>6</sup>Albert Ellis, If This Be Sexual Heresy (New York: Lyle Stuart, 1963), p. 208, quoted in Ben N. Ard, Jr., "Love and Agression: The Perils of Loving," in Handbook of Marriage Counseling, eds. Benjamin N. Ard, Jr. and Constance C. Ard (Palo Alto, California: Science and Behavior Books, Inc., 1969), p. 51.

<sup>7</sup>Paul Gebhard et al. write:

On the one hand we stress and encourage the development of heterosexual behavior--the literature, the advertisements, the movies, everything relentlessly dins in the order: be sexually attractive, find romance, get a mate! On the other hand we strive to prevent heterosexual coitus, the logical end product of the social campaign for heterosexuality, in any situation other than legal marriage. We tread on the accelerator and brake simultaneously; this may result in the desired speed, but it is rough on the mechanism. Gebhard, Sex Offenders, p. 108.

<sup>8</sup>McCary, Human Sexuality, p. 209.

<sup>9</sup>Ellis, If This Be Sexual Heresy, p. 207, quoted in Ard, "Love and Aggression," p. 54.

<sup>10</sup>Ellis, If This Be Sexual Heresy, p. 209, quoted in Ard, "Love and Aggression," pp. 57-58.

<sup>11</sup>Edward A. Tyler, "A Tolerant Attitude about Human Sexual Behavior," Bloomington, Indiana, April 1971 (Mimeographed), p. 4. Commenting on the reaction of the uninformed male to a multi-orgasmic female partner, McCary notes: "Men who do not understand this normal sexual need of many women, are likely to believe they are involved with a sensual freak who refuses to recognize the end of a good thing when she arrives there. Since they do not understand female sexuality, men often stigmatize a perfectly normal woman as being a nymphomaniac simply because she happens to have a healthy sexual appetite." McCary, Human Sexuality, pp. 302-303.

<sup>12</sup>George R. Bach and Ronald M. Deutsch, Pairing (New York: Peter H. Wyden, 1970; Avon Books, 1971), p. x.

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<sup>13</sup>John Cassel, Professor and Chairman of the Department of Epidemiology, lecture at the University of North Carolina, School of Public Health, Chapel Hill, 15 November 1972, as part of the course "Principles of Epidemiology." The idea is developed in his "The Relation of the Urban Environment to Health: Implications for Prevention," Mount Sinai Journal of Medicine 40 (July/August 1973):539-50.

<sup>14</sup>Kinsey et al. write:

As another instance of the everyday need for a wider general understanding of human sexual behavior, there are the sexual problems of unmarried individuals in our social organization, and particularly of unmarried youth. The problems are products of the fact that the human female and male become biologically adults some years before our social custom and the statute law recognize them as such, and of the fact that our culture has increasingly insisted that sexual functions should be confined to persons who are legally recognized as adults, and particularly to married adults.

This failure to recognize the mature capacities of teen-age youth is relatively recent. Prior to the last century or so, it was well understood that they were the ones who had the maximum sexual capacity, and the great romances of literature turned around the love affairs of teen-age boys and girls. Achilles' intrigue with Deidamia, by whom a son was born, had occurred some time before he was fifteen. Acis had just passed sixteen at the time of his love affair with Galatea. Chione was reputed to have had "a thousand suitors when she reached the marriageable age of fourteen." Narcissus had reached his sixteenth year when "many youths and many maidens sought his love." Helen was twelve years old when Paris carried her off from Sparta. In one of the greatest of pastoral romances, Daphnis was fifteen and Chloe was thirteen. Heloise was eighteen when she fell in love with Abelard. Tristram was nineteen when he first met Isolde. Juliet was less than fourteen when Romeo made love to her. All of these youth, the great lovers of history, would be looked upon as immature adolescents and identified as juvenile delinquents if they were living today. Kinsey et al., Sexual Behavior in the Human Female, pp. 13-14.

<sup>15</sup>Peter Madison, "The Campus: Coming of Age at College," Psychology Today, October 1971, p. 110.

<sup>16</sup>A negative attitude toward themselves and their desires on the part of adolescents may also reflect the changed attitude of their parents toward them: "Often parents seem to consider their adolescent

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children as sexually dangerous once they acquire the biological capacity to reproduce. Unconsciously they seem to see their sons and daughters as a mass of powerful sexual impulses which threaten to become overwhelming at a moment's notice." Brown, Concerns of Parents about Sex Education, p. 17.

<sup>17</sup>Richard Hettlinger reports: "I once heard a college official say, in all seriousness, that he had opposed the building of double carrels in a new library because 'to include them would be tantamount to inviting their use for intercourse'--presumably in the vertical position!" Richard F. Hettlinger, "Sex and the College Student," Sexual Behavior (November 1972); reprinted by the College Program, Planned Parenthood Federation of America, Inc., no pagination.

<sup>18</sup>Brown, Concerns of Parents about Sex Education, p. 18.

<sup>19</sup>Hettlinger, "Sex and the College Student."

<sup>20</sup>Ira L. Reiss, "How and Why America's Sex Standards Are Changing," in Ard and Ard, Handbook of Marriage Counseling, pp. 255-63.

<sup>21</sup>Ibid., p. 258.

<sup>22</sup>Reiss, Social Context of Premarital Sexual Permissiveness, p. 143.

<sup>23</sup>Roger W. Libby and Gilbert D. Nass, "Parental Views on Teenage Sexual Behavior," Journal of Sex Research 7 (August 1971):229.

<sup>24</sup>Robert Sorenson reports that 37 percent of his teenage sample agreed that "the fact that I have to conceal my sexual activities from my parents makes it hard for me to be close to them." Sorenson, Adolescent Sexuality in Contemporary America, p. 68. Advise and counsel of adults may also be undermined by the discrepancy between professed sexual standards and perceived sex-related behavior--a father punishes nudity or references to sexual topics, yet he enjoys looking at Playboy centerfolds; young people are told that sex and marriage are sacred, yet hear adults snicker about a man having an extramarital affair.

Notes to Chapter X

<sup>1</sup>Sigmund Freud, A General Introduction to Psychoanalysis, 17th ed., authorized translation with a Preface by G. Stanley Hall (New York: Boni and Liveright, 1927), lectures 22-25.

<sup>2</sup>Erich Fromm, "Psychoanalytic Characterology and Its Relevance for Social Psychology," in Erich Fromm, The Crisis of Psychoanalysis (New York: Holt, Rinehart & Winston, 1970; Greenwich, Connecticut: Fawcett Publications, 1971), p. 165.

<sup>3</sup>Sigmund Freud, Preface to the Fourth Edition, Three Essays on the Theory of Sexuality, trans. and ed. James Strachy (New York: Basic Books, 1962; Avon Books, Discus Edition, 1971), p. xix. See also p. xviii.

<sup>4</sup>Group for the Advancement of Psychiatry, Committee on Adolescence, Normal Adolescence: Its Dynamics and Impact, Report No. 68, 1968, p. 772.

<sup>5</sup>Alexander H. Leighton, "Psychiatric Disorder and Social Environment," in Issues and Problems in Social Psychiatry, eds. Bernard J. Bergen and Claudewell F. Thomas (Springfield, Illinois: Charles C. Thomas, 1967). The other essential striving sentiments are: physical security, the expression of hostility, the expression of love, the securing of love, the securing of recognition, the expression of spontaneity, orientation in terms of one's place in society and the places of others, the securing and maintaining of membership in a definite human group, and a sense of belonging to a moral order and being right in what one does. It is important to note that negative sexual morality also creates a conflict between the last of these striving sentiments and sexual desires.

<sup>6</sup>Ola Raknes writes:

When I first heard of Reich, it was during my psychoanalytic training in Berlin in 1928, Reich was spoken of as an outstanding clinician and an able theorist. But I was warned against his mixing up psychiatry and psychotherapy with politics and his claim that every therapist should point out the social and ideational causes of mental disturbances, and also help to find general prophylactic measures against them. Such claims, I was told, were apt to disturb the therapeutic work and to provoke enmity against it both in the general public and in the medical profession. As I myself did not share such fears--partly, it is true, out of ignorance--I thought that my warners exaggerated. Much later, in New York in 1946, I was to learn how general such an attitude was in the medical profession. Ola Raknes, Wilhelm

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Reich and Orgonomy (London: St. Martin's Press, 1970; Baltimore: Penguin Books, 1971), pp. 53-54.

Probably the organization that has been foremost in conducting public mental health education in sexuality during the last decade is the Sex Information and Education Council of the U.S. (SIECUS), 1855 Broadway, New York, N.Y. 10023. SIECUS, and its executive director Mary S. Calderone in particular, were the targets of a vicious anti-sex-education campaign waged by the John Birch Society, the Christian Crusade, and other militant right-wing organizations, several years ago.

<sup>7</sup>Erich Fromm, "The Crisis of Psychoanalysis," in Fromm, Crisis of Psychoanalysis, p. 16.

<sup>8</sup>Since negative attitudes and practices concerning sexuality will no doubt persist for many years, an intellectual understanding and awareness of their persistence and impact is an important mental health "vaccine" in the sex education of young people as well as a component of treatment for those already afflicted. Such understanding, for example, can help a child to weather criticism from other children or adults who have "caught" him masturbating, examining his genitals or a friend's, or engaging in other anxiety-provoking behavior. Albert Ellis, founder of rational-emotive psychotherapy, has emphasized the importance of rational counter-beliefs in weakening the impact of irrational beliefs on mental health.

<sup>9</sup>Group for the Advancement of Psychiatry, Committee on Adolescence, Normal Adolescence, pp. 778-79.

<sup>10</sup>Freud notes that: "The most striking distinction between the erotic life of antiquity and our own no doubt lies in the fact that the ancients laid the stress upon the instinct itself, whereas we emphasize its object. The ancients glorified the instinct and were prepared on its account to honour even an inferior object; while we despise the instinctual activity in itself, and find excuses for it only in the merits of the object." Freud, Three Essays on the Theory of Sexuality, p. 38, n. 1.

<sup>11</sup>Masters and Johnson, Human Sexual Response, pp. 304-305.

<sup>12</sup>Philip Slater, The Pursuit of Loneliness (Boston: Beacon Press, 1971), p. 85.

<sup>13</sup>Barry Berkey, "Psychiatric Sequelae of Sexual Deprivation," Medical Aspects of Human Sexuality 5 (October 1971):184.

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<sup>14</sup>Pietro Castelnuovo-Tedesco, "Talking with Patients About Their Sexual Problems," Medical Aspects of Human Sexuality 2 (June 1968):21-25, 28; Daniels D. Hansen, "Physical Manifestations of Sexual Conflict," Medical Aspects of Human Sexuality 1 (September 1967):31-34; Rosalind D. Cartwright, "Insomnia Caused by Sex," Medical Aspects of Human Sexuality 5 (July 1971):122-36.

<sup>15</sup>Masters and Johnson, Human Sexual Response, p. 305.

<sup>16</sup>Kinsey's observation about variation in personal sexual experience (see Chapter I, n. 4) is relevant here.

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<sup>1</sup>Joseph D. Noshpitz, commentary to Norman Tabachnick, "Sexual Aspects of the Automobile," Medical Aspects of Human Sexuality 7 (September 1973):166.

<sup>2</sup>Reported by I. White, "Implications of a Holistic Theory of Attitude Formations," Proceedings of the International Conference on Attitude Research (Madrid, 1973), cited in *ibid.*, p. 157.

<sup>3</sup>For a discussion of the role and significance of advertising and other marketing functions in the light of the reorientation of consumption, see John Kenneth Galbraith, The New Industrial State (Boston: Houghton Mifflin, 1967) and The Affluent Society, 2d rev. ed. (Boston: Houghton Mifflin, 1969).

<sup>4</sup>Wilhelm Reich, The Mass-Psychology of Fascism, 3d ed., rev. and enl., translated by Vincent R. Carfagno (New York: Farrar, Straus & Giroux, Simon & Schuster, 1970), p. 30. A recent study of the Protestant Ethic found a positive and significant correlation between a Protestant Ethic Scale and the Mosher scales for Sex Guilt and Morality Conscience Guilt. Endorsement of the Protestant Ethic was also substantially correlated with measures of authoritarianism. Herbert L. Mirels and James B. Garrett, "The Protestant Ethic as a Personality Variable," Journal of Consulting and Clinical Psychology 36 (February 1971):40-44.

<sup>5</sup>Group for the Advancement of Psychiatry, Committee on Adolescence, Normal Adolescence, pp. 825-26.

<sup>6</sup>Hadley Cantril, The Psychology of Social Movements (New York: John Wiley & Sons, 1941), p. 267; Barrington Moore, Jr., Social Origins of Dictatorship and Democracy (Boston: Beacon Press, 1966), p. 493.

<sup>7</sup>Slater, Pursuit of Loneliness, p. 80.

<sup>8</sup>In his new work on destructiveness, Erich Fromm draws a distinction between benign aggression and malignant aggression in which the latter

. . . necessarily emerges as the result of stunted growth, of psychological "crippledness." . . . If man cannot create anything or move anybody, if he cannot break out of the prison of his total narcissism and isolation, he can escape the unbearable sense of vital impotence and nothingness only by affirming himself in the act of destruction of the life that he is unable to create. Erich Fromm, The Anatomy of Human Destructiveness (New York: Holt, Rinehart & Winston, 1973; Greenwich, Connecticut: Fawcett Publications, 1975), pp. 406-407.

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Stunted growth and blocked creativity are by no means restricted to sexual life. It is beyond the scope of this work to consider the impact on psychic needs of the present organization and operation of our educational, industrial, governmental, and familial structures except to agree that their impact is of the same order as that of our sexual morality. An improvement in the sexual sphere can nevertheless be expected to have a positive impact on the functioning of other spheres.

<sup>9</sup>W. J. Cash, The Mind of the South (New York: Alfred A. Knopf, Inc., and Random House, Inc., 1941; Vintage Books), pp. 88-89.

<sup>10</sup>Ibid., pp. 118-19.

<sup>11</sup>Willis D. Weatherford and Charles S. Johnson, Race Relations: Adjustment of Whites and Negroes in the United States (New York: Negro Universities Press, 1934; reprinted 1969), pp. 59 and 231.

<sup>12</sup>William H. Grier and Price M. Cobbs, Black Rage, with a Foreword by Fred R. Harris (New York: Basic Books, [1968]), p. 190.

<sup>13</sup>Calvin C. Hernton, Sex and Racism in America (New York: Grove Press, Inc., 1965; 1st Evergreen Black Cat Ed., 1966), p. 25.

<sup>14</sup>John Howard Griffin, Black Like Me (Boston: Houghton Mifflin Co.; Cambridge: Riverside Press, 1960, 1961), pp. 91-94 and 108-109.

<sup>15</sup>Beth Day, Sexual Life Between Blacks and Whites, with an Introduction by Margaret Mead (New York: New World Publishing, 1972), pp. 69 and 73.

<sup>16</sup>Gunnar Myrdal, An American Dilemma, 7th ed. (New York, London: Harper & Brothers, 1944), vol. 1, pp. 60-61, cited in Hernton, Sex and Racism, p. 3. The white's list was:

1. Intermarriage and sexual intercourse with whites
2. Social equality and etiquette
3. Desegregation of public facilities, buses, churches, etc.
4. Political enfranchisement
5. Fair treatment in the law courts
6. Economic opportunity.

<sup>17</sup>Louisa P. Howe, "The Concept of the Community: Some Implications for the Development of Community Psychiatry," in Handbook of Community Psychiatry and Community Mental Health, ed. Leopold Bellak (New York: Grune & Stratton, 1964), p. 39.

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<sup>1</sup>Franz Alexander and Thomas Morton French, An Approach to the Cause and Treatment of Vegetative Disturbances, Studies in Psychomatic Medicine, vol. 1 (New York: Ronald Press, 1948), p. 32.

<sup>2</sup>Reiss, Premarital Sexual Standards in America, pp. 218-19. Other writers would contend that sexual restriction is necessarily productive of psychological and social disturbance.

<sup>3</sup>"Playboy Interview: Dr. Mary Calderone." She added that personally she did not believe in teenage premarital sexual intercourse, perhaps due to a "generational hang-up."

<sup>4</sup>Quoted in Pomeroy, Dr. Kinsey and the Institute for Sex Research, p. 376.

<sup>5</sup>It was in the hope of forestalling an emotional response that Masters and Johnson employed a turgid style in their two books:

Johnson: After working in this field for many years, we knew the emotional impact--a reaction we call the "visceral clutch"--that this research would produce, and we felt if we could soften the impact, at least until the material could be absorbed and evaluated, it would be ultimately treated more objectively.

Masters: Exactly. We know that in sexual matters, regardless of one's discipline or lack of it, one evaluates the material first emotionally and then intellectually--if the second evaluation ever has an opportunity to develop. If we've made the book pedantic, obtuse, and difficult to read, we did it deliberately. Masters and Johnson, Interview with Playboy Magazine in Lehrman, Masters and Johnson Explained, p. 134.

<sup>6</sup>"City Governments Accept/Reject Gay Civil Rights Proposal," SIECUS Report 3 (September 1974):3. The Episcopal Diocese was one of the strongest proponents.

<sup>7</sup>Report of the Minority in The Catholic Case for Contraception, ed. Daniel Callahan (London: Macmillan Co., 1969), pp. 209-10.

<sup>8</sup>Erich Fromm, "The Theory of Mother Right and Its Relevance for Social Psychology," in Fromm, Crisis of Psychoanalysis, p. 126. Since writing the above, Fromm has modified his views:

In the middle of the twentieth century the problem is no longer that of sexual repression, since with the growth of a consumer society sex itself has become an article of consumption,

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and the trend in the direction of instant sexual gratification is part of the pattern of consumption that fits the economic needs of a cybernated society. In present-day society it is other impulses that are repressed; to be fully alive, to be free, and to love. Fromm, "Crisis of Psychoanalysis," p. 37.

Without disagreeing with Fromm about the importance of these other strivings, I would have to object that "instant sexual gratification" is not the experience of the overwhelming majority of young people in our society. Moreover, the overt and subtle restrictions on sexual expression are very much tied up with the repression of impulses to be fully alive, to be free, and to love.

<sup>9</sup>Erich Fromm, The Sane Society (New York: Holt, Rinehart & Winston, 1955; Greenwich, Connecticut: Fawcett Publications, Fawcett World Library, 1969), p. 71.

<sup>10</sup>Group for the Advancement of Psychiatry, Committee on Adolescence, Normal Adolescence, p. 838.

<sup>11</sup>Franz Alexander, Fundamentals of Psychoanalysis (New York: Norton, 1948), p. 201.

<sup>12</sup>Many existing programs, out of their concern not to give a "green light," do not convey this permission. A sex counseling therapy team at the State University of New York report:

So many otherwise bright and inquisitive college students surprise us by their lack of reading in the area of sexual functioning, especially when such reading materials are readily available. Our impression is that the same embarrassment and unconscious resistance to being overtly sexual, which partly underlies their dysfunction in the first place, also accounts for their hesitancy about seeking out reading materials in bookstores or libraries. Our suggestion that the student read certain books usually provides the motivation and permission that he isn't able to supply on his own. Roger Bauer and Joan Stein, "Sex Counseling on Campus: Short-Term Treatment Techniques," American Journal of Orthopsychiatry 43 (October 1973):828.

<sup>13</sup>Transcendental Meditation, a technique which induces a physiological state of apparent deep rest and integration of brain function, appears to have some promise in this regard. Studies conducted by various investigators have found meditators to have lower heart and breath rates, fewer spontaneous galvanic skin responses, more rapid habituation of galvanic skin response to a stressful stimulus, and faster recovery from sleep deprivation than non-meditators. Hypertensive patients practicing TM experienced decreases in blood pressure. Meditators also reported decreased use of alcohol, cigarettes, and non-

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prescription drugs. For references, see Fundamentals of Progress: Scientific Research on Transcendental Meditation, World Plan Executive Council, National Center, 1015 Gayley Avenue, Los Angeles, California 90024.

Transcendental Meditation (TM) was introduced into this country in the late 1950's by Maharishi Mahesh Yogi and is taught by teachers working through the International Meditation Society and the American Foundation for the Science of Creative Intelligence. Courses in the Science of Creative Intelligence are granted academic credit at a number of major American universities. If the claims that have been made for this practice and have been supported by preliminary investigation are confirmed by further study, we can expect TM to have a profound positive impact in all of the areas that have been discussed in this study.

<sup>14</sup>Masters and Johnson, Human Sexual Inadequacy, pp. 298-99.

<sup>15</sup>Leopold Bellak, "Community Psychiatry is the Third Psychiatric Revolution," in Bellak, Handbook of Community Psychiatry and Community Mental Health, p. 9.

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