I. Introduction: Gender and Sexuality

1. The word *sex* refers to the biological aspects of being male or female, or to sexual intercourse.
2. The word *gender* refers to the psychological, social, and cultural aspects of masculinity and femininity.
3. *Gender roles* consist of the behaviors, attitudes, and personality traits that a given culture designates as either masculine or feminine.
4. *Gender identity* refers to a person’s psychological sense of being male or female.
5. *Sexual orientation* refers to the *direction* of a person’s emotional and erotic attraction, whether toward members of the opposite sex, the same sex, or both sexes.
6. By the time most people reach adulthood, both gender identity and sexual orientation are well established.

II. Gender Stereotypes and Gender Roles

Gender-role stereotypes are the beliefs and expectations people hold about the characteristics and behaviors of each sex.

A. Gender-Related Differences: The *Opposite* Sex?

1. Two important qualifications of male–female differences:
   a. The differences between men and women are *average*, not absolute differences.
   b. Knowing that a gender difference exists in no way explains what *caused* that difference.

2. Personality Differences
   a. For *most* personality characteristics, there are *no* significant average differences between men and women.
   b. However, men and women consistently differ on two personality dimensions:
      (1) Women tend to be more *nurturant* than men.
      (2) Men tend to be more *assertive* than women.

   a. Research findings suggest that men and women differ little in their *experience* of emotions.
   b. However, women more easily *express* their emotions and display more emotional awareness.
   c. Psychologists have consistently found differences in the types of emotions expressed by men and women.
      (1) A recent cross-cultural study found a consistent pattern: Women report experiencing and expressing more sadness, fear, and guilt, while men report experiencing and expressing more anger and hostility.
      (2) The researchers argue that the male role encourages the expression of these powerful emotions—emotions that confirm the person’s autonomy and status. In contrast, the female role encourages the expression of powerless emotions—emotions that help maintain social harmony by minimizing conflict and hostility.
d. The expression of emotions is strongly determined by culturally determined display rules; in the United States and many other cultures, women are allowed a wider range of emotional expressiveness and responsiveness than men.

4. Cognitive differences
   a. For most cognitive abilities, there are no significant differences between males and females.
   b. Verbal, reading, and writing skills: Females consistently score much higher than males on tests of verbal fluency, reading comprehension, spelling, and, especially, basic writing skills.
   c. Spatial skills: Males outscore females on some, but not all, tests of spatial skills.
   d. Math skills: On average, males do slightly better than females on tests of advanced mathematical ability.

5. Sexual attitudes and behaviors: A meta-analysis of 170 previous studies found that
   a. Men and women were very similar on many dimensions.
   b. Some differences did emerge. Compared to women, men
      (1) had more permissive sexual attitudes, including much greater acceptance of casual sex.
      (2) tended to have more sexual partners and experienced their first intercourse at an earlier average age.
      (3) reported a higher incidence of masturbation.
   c. Researchers have found that both men and women tend to distort their responses to questions about their sexual behaviors and attitudes to better match gender norms and expectations. Women tend to downplay or minimize their sexual experiences; men tend to exaggerate theirs.
   d. In sum, men and women are not dramatically different.

III. Gender-Role Development: Blue Bears and Pink Bunnies

Gender plays an important role in most cultures; girls and boys are treated differently at birth.

A. Gender Differences in Childhood Behavior: Batman Versus Barbie
   1. From about 18 months to the age of 2 years, sex differences in behavior begin to emerge. Toddler girls play more with soft toys and dolls and ask for help from adults more; toddler boys play more with blocks and transportation toys (trucks and wagons) and play more actively.
   2. Between the ages of 2 and 3, preschoolers start acquiring gender-role stereotypes for toys, clothing, household objects, games, and work. From age 3 on, there are consistent differences in preferred toys and play activities. Boys play more with balls, blocks, and toy vehicles. Girls play more with dolls, domestic toys, dressing up, and art activities.
   3. Throughout the remainder of childhood, boys and girls play primarily with members of their own sex. Also, boys play in larger groups and play more roughly than girls.
4. Children are far more rigid than adults in their beliefs in genderrole stereotypes.
5. Girls’ more flexible attitude toward gender roles may reflect society’s greater tolerance of girls who cross gender lines in attire and behavior.

B. Explaining Gender Roles: Two Contemporary Theories

Gender theories have included findings and opinions from anthropology, sociology, neuroscience, medicine, philosophy, political science, economics, and religion.

1. Social learning theory: Learning gender roles
   **Social learning theory** contends that gender roles are learned through reinforcement, punishment, and modeling.

2. Gender schema theory: Constructing gender categories
   a. **Sandra Bem** incorporates some aspects of social learning theory but approaches gender-role development from a more strongly cognitive perspective.
   b. **Gender schema theory** contends that children actively develop mental categories (or schemas) for masculinity and femininity.

   Gender schemas
   (1) influence how people pay attention to, perceive, interpret, and remember gender-relevant behavior;
   (2) seem to lead children to perceive members of their own sex more favorably than members of the opposite sex; and
   (3) include a broad range of qualities and attributes that are less concrete, such as associating “gentleness” with females and “toughness” with males.

3. In Focus: Beyond Male and Female: Variations in Gender Identity
   a. An **intersexed** individual is someone whose biological gender is ambiguous.
   b. **Transgendered** individuals (also called **transsexuals**) are biologically male or female; however, their gender identity is in conflict with their biological sex.
   c. **Gender identity disorder** may be diagnosed when extreme discomfort with one’s assigned gender causes significant psychological dysfunction. However, many professionals disagree with the classification of gender-variant behaviors, attitudes, and feelings as constituting a “disorder.”

IV. Human Sexuality

The scientific study of sexuality is multidimensional—biological, psychological, social, and cultural factors must all be taken into account.

A. First Things First: The Stages of Human Sexual Response

The human sexual response cycle was first mapped by sex research pioneers **William Masters** and **Virginia Johnson** during the 1950s and 1960s. Their findings indicated that the human sexual response can be described as a cycle with four stages.

1. Stage 1: **Excitement**—the beginning of sexual arousal is accompanied by a variety of bodily changes.
2. Stage 2: *Plateau*—physical arousal builds as pulse and breathing rates continue to increase.

3. Stage 3: *Orgasm*—the third and shortest phase of the sexual response cycle; blood pressure and heart rate reach their peak; muscles contract rhythmically.

4. Stage 4: *Resolution*—arousal slowly subsides and returns to normal levels. The male experiences a *refractory period*, during which he is incapable of having another erection or orgasm.

**B. What Motivates Sexual Behavior?**

1. In most animals, sexual behavior is biologically determined and triggered by hormonal changes in the female. During the cyclical period known as *estrus*, a female animal is fertile and receptive to male sexual advances.

2. As you go up the evolutionary scale, sexual behavior becomes less biologically determined and more subject to learning and environmental influences.

3. A woman’s fertility is regulated by monthly hormonal cycles. Some, but not all, women also experience monthly fluctuations in sexual interest and motivation. However, these changes are highly influenced by social and psychological factors, such as relationship quality.

4. When human males experience lowered levels of *testosterone* because of illness or castration (removal of the testes), a drop in sexual interest tends to occur, although the effects vary among individuals.

5. In *both* men and women, sexual motivation is biologically influenced by levels of testosterone in the body.

6. Culture and Human Behavior: Evolution and Mate Preferences
   a. David Buss coordinated a large-scale survey of more than 10,000 people in 37 different cultures.
   b. Men and women across all 37 cultures generally agreed that they wanted a mate who was kind and understanding, intelligent, emotionally stable, and healthy, and who had a pleasing personality.
   c. Men were more likely to value youth and physical attractiveness; women valued financial security, access to material resources, high status and education, and good financial prospects.

   d. *Evolutionary psychology*’s explanation for these gender differences is that mating behavior is adaptive to the degree that it furthers the reproductive success of transmitting one’s genes to the next generation and beyond.

**C. Sexual Orientation: The Elusive Search for an Explanation**

1. **Sexual orientation** refers to the direction of a person’s emotional and erotic attraction. A *heterosexual* person is sexually attracted to individuals of the other sex, a *homosexual* person to individuals of the same sex, and a *bisexual* person to individuals of both sexes. The term *homosexual* can be applied to either males or females. Female
homosexuals are usually called **lesbians**. Male homosexuals typically use the term **gay**.

2. There is not always a perfect correspondence between a person’s sexual identity, sexual desires, and sexual behavior.

3. Determining the number of people who are homosexual or heterosexual is problematic for two reasons.
   a. Survey results vary depending on how the researchers define the terms homosexual, heterosexual, and bisexual.
   b. Gays and lesbians are not distributed evenly throughout the population.

4. Depending on how sexual orientation is defined, estimates of the prevalence rate of homosexuality in the general population range from 1 percent to 21 percent.

5. An estimated 7 to 15 million American men and women are gay or lesbian.

6. What determines sexual orientation?
   a. Despite considerable research, psychologists and other researchers are not certain why people become homosexual or bisexual.
   b. Still, evidence from twin studies suggests that genetics play a role.

   (1) Psychologists Michael Baily and Richard Pillard (1991) compared the incidence of male homosexuality among pairs of identical twins, fraternal twins, and adoptive brothers and found that the closer the degree of genetic relationship, the more likely it was that when one brother was homosexual, the other brother would also be homosexual.

   (2) More recently, Swedish researchers (Längström et al., 2008) showed that both genetic and nonshared environmental factors (influences experienced by one, but not both, twins) were involved in sexual orientation.

   (3) Genetic influence is likely to be complex, involving the interactions of multiple genes, not a single “gay gene.”

   c. Differences in brain structure between heterosexuals and homosexuals may play a role.

   (1) Differences have been discovered in brain function or structure among gay, lesbian, and heterosexual men and women (e.g., Le Vay, 2007)

   (2) However, most of these studies have been small or inconclusive.

   (3) Also, there is no way of knowing whether brain differences are the cause or the effect of different patterns of sexual behavior.

   (4) Thus, these studies show that some biological factors are correlated with a homosexual orientation, but, as
indicated, correlation does not necessarily indicate causality.

d. According to the results of Bell et al.’s comprehensive 1981 study

(1) Homosexuality is not due to unpleasant early heterosexual experiences.
(2) Homosexuality is not the result of an abnormal relationship between the parents and the child.

7. Several researchers now believe that sexual orientation is established as early as age 6.
8. Male and female homosexuals are less likely than heterosexuals to have followed the typical pattern of gender-specific behaviors in childhood.
9. Once sexual orientation is established, whether heterosexual or homosexual, it is highly resistant to change.
10. It seems clear that no single factor determines whether people identify themselves as homosexual, heterosexual, or bisexual; psychological, biological, social, and cultural factors are undoubtedly involved in determining sexual orientation.
11. Homosexuality is no longer considered a sexual disorder by clinical psychologists or psychiatrists.
   a. Gays and lesbians can be found in every occupation and every socioeconomic level in our society.
   b. Children who are raised by gay or lesbian parents are as well adjusted as children who are raised by heterosexual parents. They are no more likely to be gay or lesbian in adulthood.

V. Sexual Behavior

The National Health and Social Life Survey (NHSLS), a scientifically constructed national survey, provides information about different aspects of adult sexual behavior in the United States. Some NHSLS findings (data collected in 1992), and also more recent ones (data collected in 2002) from the National Survey of Family Growth (NSFG) on the sexual practices of American adults. The NHSLS targeted the sexual practices of Americans between the ages of 18 and 59; the NSFG targeted a younger group, males and females between the ages of 15 and 44. The findings of both surveys follow.

A. How Many Sex Partners Do People Have?

1. People today, especially young people, have more sex partners than did previous generations.
   a. However, the differences between the behavior of today’s young adults and that of their parents’ generation are not as great as you may first think.
   b. Differences are more pronounced with each additional generation you go back.
(1) For example, the 2002 NSFG found males reported more sexual partners than females; with 53 percent of males aged 25 to 44 reporting having had seven or more sexual partners, while for females in the same age range, 31 percent reported having seven or more sexual partners. But a decade earlier, the NHSLS produced very similar findings, with 56 percent of the males between the ages of 18 to 59 reporting having had five or more sexual partners, while 29 percent of the females in the same age range reporting five or more sexual partners.

c. Another example: The 1992 NHSLS found that 80 percent of males and females had either one or no sexual partner in the previous year, while the 2002 NSFG found almost exactly the same figure.

d. These findings contradict many hypersexualized media portrayals of adult sexuality.

e. Why do most people report having just one sexual partner in the past year? For most Americans, the onset of adulthood marks a commitment to the task of establishing long-term, intimate relationships.

(1) Among people age 30 to 50, about half have had five or more sexual partners. In contrast, only about a third of those over age 50 have had five or more sexual partners.
(2) Young adults today tend to become sexually active at an earlier age, marry at a later age, and have more sexual partners than members of older generations.
(3) The majority of people—about 80 percent—had either one sexual partner or none in the preceding year.
(4) By age 30, most Americans are part of a couple—either married or cohabiting.

2. In 1960, the average age of first marriage for males was 23 versus 20 for females. Today, the average is 28 for males and 26 for females.

3. Focus on Neuroscience: Romantic Love and the Brain

a. Research results suggest that love activates brain areas that are involved in other positive emotions, such as happiness, but in a way that represents a unique pattern.

b. Looking at a photo of one’s romantic partner produced heightened activity in four brain areas associated with emotion: the anterior cingulate cortex, caudate nucleus, putamen, and insula.

c. These are the same brain areas that are activated by euphoria producing drugs, such as opiates and cocaine.

B. How Often Do People Have Sex?

1. One-third of American adults have sex with a partner two or more times per week; one-third have sex a few times per month; and one third have sex a few times a year or not at all.

2. Married or cohabiting couples have the most active sex lives.
3. About 85 percent of the NHSLS respondents reported that they were physically and emotionally satisfied with their sexual relationships.

C. What Do People Actually Do When They Have Sex?
1. The NHSLS and the NSFG produced very similar results: In terms of actual practices, vaginal intercourse is nearly universal as the most practiced sexual activity among heterosexual couples.
2. The figures for oral sex increased between the 1992 NHSLS and the 2002 NSFG. In the NHSLS, about 77 percent of men and 68 percent of women reported that they had oral sex, while in the NSFG, 90 percent of men and 88 percent of women engaged in it.
3. A similar upward trend was evident for anal sex with the opposite sex. In the NHSLS, 26 percent of males and 20 percent of females indicated they had engaged in anal sex. Ten years later, 40 percent of males and 35 percent of female respondents had had anal sex with a member of the opposite sex.

D. What Would People Like to Do Sexually?
1. The NHSLS found that most people prefer the tried and true. For both sexes, the most preferred sexual activities were as follows:
   a. having sexual intercourse
   b. watching their partner undress
   c. receiving oral sex
   d. giving oral sex
2. With one exception, at least 90 percent of men and women found no appeal in the following:
   a. being forced to do something sexual
   b. forcing someone to do something sexual
   c. receiving anal intercourse
   d. having a same-gender sex partner
   e. having sex with a stranger (90 percent of women found this unappealing).
3. In Focus: Everything You Wanted to Know About Sexual Fantasies
   a. Sexual fantasies are a nearly universal human phenomenon.
   b. Compared to women, men report a higher incidence of sexual fantasies.
   c. Men tend to fantasize themselves in active roles, whereas women tend to imagine themselves in sexually passive roles.
   d. Men tend to have sexual fantasies with more explicit imagery, whereas women are more likely to imagine romantic themes.
   e. Men are more likely than women to imagine having sex with multiple partners.
   f. People who engage in sexual fantasies tend to exhibit the least number of sexual problems and the lowest level of sexual dissatisfaction.

E. Sexuality after Sixty? Seventy?! Eighty??!
1. The myth is: Sexual interest and potency evaporate during late adulthood.
2. The reality is: Most older adults are sexually active.
3. Physical health and having an intimate partner are stronger influences on the likelihood and frequency of sexual activity among senior adults than is age.
   a. Sixty-five percent of people in the 65–74 age range with no serious health problems and an intimate partner had sex more than 2–3 times per month. Among those in the 75–85 range with no serious health issues and an intimate companion, 54 percent had sex more than 2–3 times per month (Lindau et al., 2007).
4. Aging can affect the sexual friskiness of seniors.
   a. About half of all sexually active seniors report one or more bothersome sexual problem.
   b. Older men and women take longer to become sexually aroused and achieve orgasm.
   c. Older women achieve vaginal orgasm more slowly.
   d. Older men are likely to have difficulty achieving or maintaining erection.
5. Still, despite the inevitable physical changes accompanying aging, love and affection can continue to thrive and grow in the twilight years.

VI. Sexual Disorders and Problems

Sexual dysfunctions are consistent disturbances in sexual desire, arousal, or orgasm that cause psychological distress and interpersonal difficulties.

A. How Common Are Sexual Problems?
The National Health and Social Life Survey found the following:
1. The incidence of sexual dysfunction among adult Americans was much higher than previously believed: 43 percent of women and 31 percent of men suffered from sexual problems.
2. For women, the most common sexual problems were low sexual desire and arousal problems, including the inability to achieve orgasm; for men, the most common sexual problems were premature ejaculation and problems achieving or maintaining an erection.
3. Sexual problems were most common among young women and men older than age 50.

B. Categories of Sexual Dysfunctions
1. **Hypocactive sexual desire disorder** is characterized by little or no sexual desire.
2. **Sexual aversion disorder** is characterized by active avoidance of genital sexual contact because of extreme anxiety, fear, or disgust.
3. **Dyspareunia** is characterized by genital pain before, during, or after intercourse.
4. **Erectile dysfunction** is characterized by a recurring inability to achieve or maintain an erection.
5. **Male orgasmic disorder** is characterized by recurring delays or a complete absence of the ability to achieve orgasm through intercourse.
6. **Premature ejaculation** is characterized by orgasm occurring
before it is desired, often immediately or shortly after sexual stimulation or penetration.
7. **Female orgasmic disorder** is characterized by consistent delays in achieving orgasm or the complete inability to achieve orgasm.
8. **Vaginismus** is characterized by the persistent, involuntary contractions or spasms of the vaginal muscles, which result in uncomfortable or painful intercourse.
9. Sexual dysfunctions may be caused by physical or medical conditions or by psychological factors; ED, for example, often results from impaired blood flow, whereas premature ejaculation may involve psychological factors, such as anxiety about sex or sexual performance.
10. Many sexual dysfunctions can be successfully treated by psychologists and physicians who have received specialized training in sex therapy.

C. The Paraphilies: Unusual Sexual Fantasies, Urges, or Behaviors

A **paraphilia** is a nontraditional sexual behavior in which a person’s sexual gratification depends on an unusual sexual experience, object, or fantasy. Generally, men are more likely than women to exhibit a paraphilia.

1. **Exhibitionism**—sexual arousal achieved by publicly exposing one’s genitals to shocked strangers.
2. **Frotteurism**—sexual arousal from touching and rubbing against a nonconsenting person, usually in a crowded public situation, such as a crowded bus or subway car.
3. **Fetishism**—sexual arousal in response to inanimate objects or body parts not typically associated with sexual arousal.
4. **Transvestic fetishism**—in heterosexual males, sexual arousal from cross-dressing in women’s clothes.
5. **Pedophilia**—sexual fantasies, urges, or behavior involving sexual activity with a prepubescent child.
6. **Voyeurism**—sexual arousal from observing an unsuspecting person who is disrobing, naked, or engaged in sexual activity.
7. **Sexual sadism**—sexual arousal achieved through intentionally inflicting psychological or physical suffering on another person.
8. **Sexual masochism**—sexual arousal in response to actually being humiliated, beaten, bound, or otherwise made to suffer.
9. The exact causes of paraphilias remain obscure.

D. Sexually Transmitted Diseases

1. **Sexually transmitted diseases (STDs)** are infectious diseases that are transmitted primarily through sexual intercourse or other intimate sexual contact.
2. STDs include bacterial, viral, and parasitic infections.
   a. Bacterial STDs include gonorrhea, syphilis, and chlamydia.
   b. **Pubic lice** is an example of a parasitic STD.
   c. Viral STDs include herpes and AIDS.
d. Both bacterial and parasitic STDs can be cured.
e. Viral STDs cannot be cured.

3. Genital herpes
   a. Genital herpes is one of the most common sexually transmitted
diseases in the United States, with more than 45 million people
age 12 years or older having had a genital herpes infection. It is
caused by both herpes simplex virus type 1 (HSV-1) and herpes
simplex virus type 2 (HSV-2).
b. Most people with herpes have no symptoms and are unaware
that they are infected.
c. Symptoms first appear within two weeks of infection, and can
include flulike symptoms, low-grade fever, and swollen glands.
Blisters may appear on or around the genitals or rectum, which
eventually break and leave sores.
d. Subsequent outbreaks are usually less severe. Three to five
outbreaks a year is typical, although age and other factors can
affect the recurrence.
e. Stress, depression, and poor coping strategies are among the
psychological factors associated with recurring outbreaks.
f. Transmission can occur from an infected partner who does not
have visible sores and may not even know that he or she is
infected.
g. There is no cure for genital herpes; however, antiviral
medications can shorten and prevent outbreaks.

4. HIV and the AIDS Epidemic
   a. AIDS, or acquired immune deficiency syndrome, is a disease
that gradually depletes and weakens the human immune
system. It is caused by the human immunodeficiency virus
(HIV), which enters the bloodstream through the exchange of
infected body fluids, primarily semen, vaginal fluids, and blood.
b. HIV can be transmitted by having unprotected sexual
intercourse; by sharing needles or syringes with an infected person;
by an infected mother to her infant during pregnancy, birth, or
breast-feeding; and, less commonly, through receiving a
transfusion of infected blood.
c. Once a person is infected, the HIV virus can exist in his or her
body for a decade or longer without causing any apparent
symptoms; nonetheless, the person is an HIV carrier and can still
infect others. Only blood tests can determine the presence of HIV
in a person’s body.
d. In 2008, an estimated 1.2 million people in the United States
were infected with HIV.
e. When the virus becomes active, it selectively attacks a key
component of the body’s immune system: the helper T cells. The
person becomes greatly susceptible to other diseases, including
cancer, pneumonia, and encephalitis; eventually, the person succumbs to some opportunistic infection.

f. Gay men, intravenous drug users who share contaminated needles, and people with multiple sex partners are the groups most at risk of becoming infected by HIV. However, heterosexual transmission is the fastest growing category, accounting for about one out of three new cases of AIDS in the United States.

g. But no one is immune to HIV.

(1) Heterosexual transmissions account for about one-third of new infections each year in the United States.
(2) Most women are infected through sexual contact with HIV infected men.
(3) Most infections occur among adolescents and young adults under the age of 30.

h. The annual rate of new HIV infections has been stable in the United States for more than a decade.

i. Race alone is not a risk factor. But blacks are more severely affected by HIV than other U.S. racial and ethnic groups.

(1) Factors contributing to the disproportionate HIV risk for U.S. blacks include poverty, higher rates of other STDs, and drug use.

j. HIV is classified as a **retrovirus**. Although there is no cure for AIDS yet, its progression can be slowed using a combination of **antiretroviral drugs**. Because they can suppress the virus, but not kill it, these drugs cannot eliminate HIV from the body and so must be taken continuously. And, because HIV reproduces itself, variants emerge in the person’s body, some of which can be resistant to a particular antiretroviral drug.

k. Thus, a combination of different kinds (typically, three) of antiretroviral drugs are used to suppress the virus.

l. Although combination drug treatments often have many side effects, are expensive, and are complicated to administer, because of them the death rate from AIDS has sharply decreased and stabilized in the United States and other industrialized countries.

m. Infection rates are extremely high in developing nations, where drug treatment programs are often unavailable or very limited.

5. The ABCs of Preventing STDs

a. A = Abstinence
b. B = Be Faithful
c. C = Condoms

VII. Application: Men, Women, and Conflict: Bridging the Gender Gap

A. Researchers have found that men and women communicate differently when dealing with problems, emotional issues, and interpersonal conflict.

1. Women often become the “emotion managers” and “care-takers of
intimacy” in close relationships.
2. During emotional conflicts, men are more likely than women to experience flooding—feeling overwhelmed by their own emotions.
3. When men experience flooding, they typically go into the stonewalling mode—which frustrates and angers women, who react by flooding.
B. John Gottman has written or co-written several books to help couples improve their relationships. The following are five of his suggestions for handling conflicts constructively:
1. Be aware of gender differences.
2. Call a time-out if you are feeling overwhelmed.
3. Focus on constructive thoughts during the time-out.
4. Resolve the problem together.
5. Keep the focus on maintaining the relationship.