Human Sexuality

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Chapter 1: Human Sexuality

Retrieved from: https://courses.lumenlearning.com/boundless-psychology/chapter/sexuality/

The Psychology of Human Sexuality

Retrieved from: https://nobaproject.com/modules/the-psychology-of-human-sexuality

Introduction

What is human sexuality? The dictionary defines **human sexuality as an area of research and study that focuses on all aspects of humans as sexual beings. Basically, human sexuality involves much more than anatomy and sexual responses, but incorporates how we engage in**

relationships and behaviors that determine our desires and sexual identity as well as our overall sexual health, well-being, and our perceptions and expressions.

Understanding and experiencing sexual issues, behaviors, and how they are involved in our daily lives and environments determine how we react to certain situations, other people, and most importantly, relationships. Human sexuality has as much to do with emotional reactions as values, morals, and responsibilities.

No course on human sexuality would be complete without exploring myths and misconceptions regarding the subject. Understanding human sexuality also means understanding, developing tolerance for, and respecting others, regardless of their sexual diversity, or what we consider to be normal or abnormal behaviors.

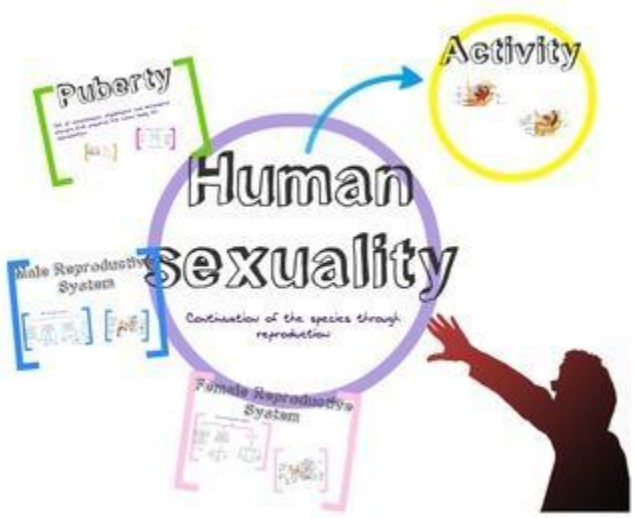
Everyone Listens When "Sex" Is Mentioned

Sex is not merely a physical act between two people, but incorporates many meanings, including the act itself, the process of reproduction, lovemaking, as well as defining every individual's concept of sexual identity and gender. Sex also determines whether an individual is male or female. Most of us think of sex as being a defining factor into who we are.

After all, we’re male or female, masculine or feminine. Unfortunately, it's not so simple, and biological sex has many sides, aspects, and dimensions.

We've already briefly touched on issues regarding the development of sexual identity and gender. Actually, many of you may already think you know all there is to know about sex, relationships, and gender identity issues, but many don't realize the enormous and forceful impact that ideas of sex, gender identity, attitudes, and religious beliefs have on relationships as well as concepts of personal identity and yes, even our psychological and physical health.

B. Studying Human Sexuality



Understanding and studying human sexuality goes way beyond the physical aspect of sex. The study of human sexuality includes understanding and enriching our emotional expectations as well as enhancing self-knowledge, identity, and developing values and morals. Regardless of your upbringing, culture, heritage, or faith, human sexuality plays an important role in our lives from childhood to old age.

Because sex is an emotional as well as physical act, our study of human sexuality will often create unexpected reactions from students. Some topics will make students uncomfortable, while others may be amused, confused, or

offended. That is not the intent of this course; on the contrary, it is important for individuals to focus on their own feelings and rely on their own upbringing, cultural beliefs, and faith when it comes to incorporating human sexuality basics into everyday life experiences.

One of the most important aspects of any course on human sexuality is to encourage students to make responsible choices. While our sexual values and morals contribute to making responsible sexual choices throughout our lifetime, individuals today need to learn about the dangers as well as the pleasures involved in human sexuality.

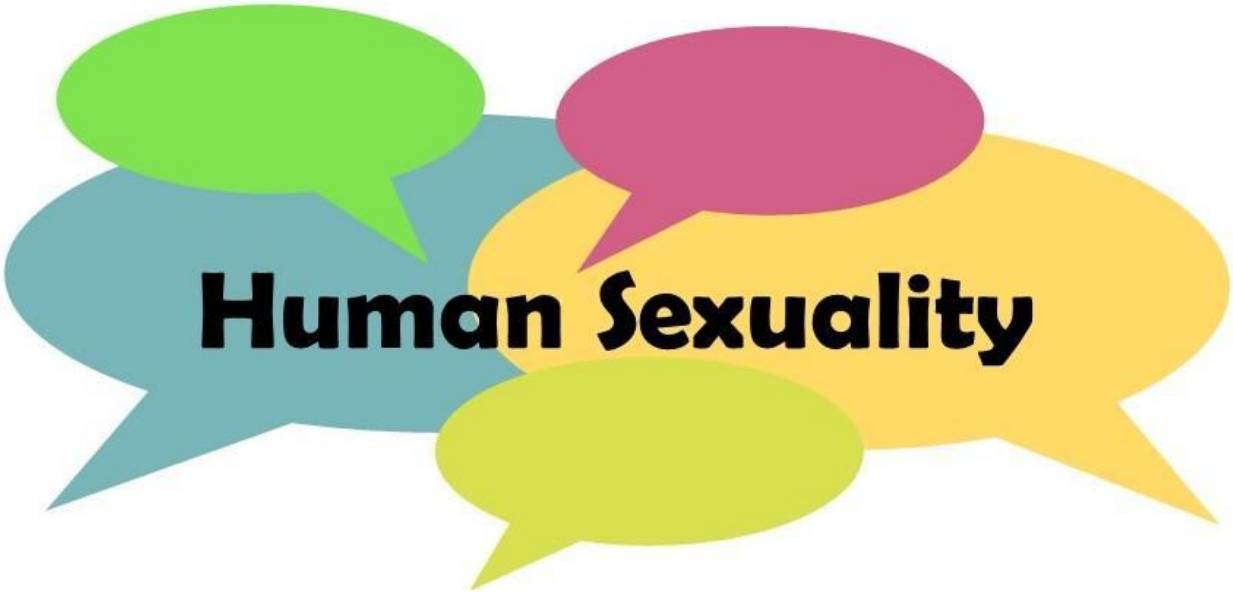
Do you know the difference between HIV and AIDS? Do you know how to protect yourself, or your partner from HIV or other sexually transmitted diseases? If you're a woman, do you know how to protect yourself against pregnancy? Better yet, do you know how to protect yourself from abuse, sexual violence, or peer pressure? Whether you're a man or a woman, you certainly have expectations of relationships and dating. How do you communicate your needs, desires, or expectations to your boyfriend, your spouse, or anyone else involved in your life? It's easy to make snap decisions in the blink of an eye, but remember that information is power. Knowledge, information, knowing how to use good judgment, as well as accepting and recognizing consequences for poor decisions can literally affect the rest of your life.

Human sexuality courses are designed to inform, and provoke thought and reflection. Students who understand the risks of contracting AIDS, HIV, or sexually transmitted diseases (STDs) are less likely to become the victims of such diseases. Information regarding birth control and contraception are less likely to become pregnant.

Students who understand basic human behaviors, relationships, and sexual dysfunctions, attitudes and behavior may be able to protect themselves against abuse, date rape, and domestic violence.

C. Understanding Human Sexuality

Human sexuality goes way beyond sexual relationships, acts, and behaviors. In order to understand human sexuality, it is essential to understand basic anatomy and physiology. These concepts will be explored in this course, as will the lifecycles of sexuality, our concepts of self, how relationships are formed, as well as the difference between male and female expectations when it comes to relationships and sexual relations.



The concept of sexuality in power, sexual dysfunctions, and attitudes and behaviors regarding sex will also be fully explored throughout this course. Because sexual relationships and human sexuality involved more than a physical act, students will also learn about and understand psychosocial relationships, behaviors, and interactions.

Did you know that many people think they know a lot about sex, and they really don't? Who do you get your information from? Television? Magazines, books or movies? Your friends? The Internet? Some of you may have already been involved in sexual relationships, or completed sex education classes in high school, but more than likely, much of your information is from observing unscientific behaviors of friends or family.

Personal experience doesn't make you an expert in human sexuality. Neither do talks with your parent or friends. Many of us develop our concepts regarding sex from early experiences, which can hardly be used as a basis for lifetime relationships, but unfortunately, they often are.

The study of human sexuality is complex and involves various levels of love, intimacy, and normal human sexual responses. It involves a difference to become pregnant or efforts to prevent pregnancies. Human sexuality means understanding expectations, stereotypes, and different sexual development that is experienced through life. It also involves information regarding sexual aggression and violence, sexual orientation, and the problems, therapies, and solutions.

Normal or Not?

Many people are terrified of being "abnormal." But who defines what is normal and abnormal in relationships, sexual preferences, responses, and problems? Who determines the "normal frequency" of sexual relations between couples? In many cases, the concept of normalcy is determined by where were brought

up, our cultural heritage, our faith, and our belief in what comprises a normal relationship. How is normal determined?

Sexual relationships and human sexuality differ depending on geography. For example, the sexual relationships or habits of a couple from the Bronx may be considered taboo in portions of Africa, South America, or Asia. The practices of the Polynesian couple might seem strange to a couple living in France. Geography and cultural heritage play large part in what is considered normal or taboo when it comes to sex or sexual relationships.

Human sexuality is also determined in great extent to how our parents discussed issues of sex and sexuality with us. For example, did your parents use nicknames or anatomically correct names for male and female genitals? Did they discuss with you what could be considered appropriate or inappropriate touching? Did they discuss certain sexual behaviors such as menstruation, masturbation, intercourse, birth control, homosexuality, or sexual abuse with you? For Americans, the answer is no most of those.

D. Sexual Health

Sexual health also plays an important role in determining what is considered normal or abnormal. Do you engage in healthy sex? What is healthy sex? Sexual research has been going on for decades in order to determine the answers to such questions. Every

day we open magazines and watch television to be deluged with visual and audio messages that encourage and intensify attraction, beauty, allure and more. The advent of the electronic age and most especially the Internet will play a great role in how today's generation perceives sex, sexual behavior and sexual health.

Sexual health is a part of our overall health, but one that is often neglected because of embarrassment, shame, or attitudes that our sexual preferences, questions, and concerns should not be discussed openly. Sexual health is not only physical, but may be emotional and psychological as well. Psychological and emotional sexual health issues may include but are not limited to controlling relationships, guilt about sex, fear about sex, violence, or how we perceive sex.

There are several misconceptions as well as truths involved in understanding human sexuality. Some people believe that anyone who takes a course or who is interested in human sexuality will make more informed choices about behaviors and relationships. Some believe that understanding human sexuality encourages a satisfying sex life or a sense of identity. Many believe that understanding sexuality encourages the rejection of wives' tales or misconceptions and encourages stronger emotional and physical relationships.

Regardless of your conceptions regarding human sexuality at the beginning of this course, you are encouraged to think about the topics broached in this course and utilize the information provided in order to make better and more informed choices and responses in the future, not only regarding sexual relationships, but relationships and expectations as a whole.

This is not to say that any or every future episode or event in your life can be anticipated ahead of time, but that armed with knowledge, you will be able to separate fact from fiction, make rational and informed decisions and most importantly, learn to accept and understand how you feel about human sexuality.

Sexuality through the Ages

It's obvious that sexual relationships have been engaged since the beginning of man, though our historical perspective of sexual relationships as well as beliefs and customs regarding human sexuality are based on historical records that date back over 20,000 years. Did you know that Stone Age cave drawings have been shown to include depictions of sexual behavior, pregnancy, and childbirth?

A large number of ancient civilizations worshipped females as creators of the world as they knew it. We all understand the concept of "Mother Nature". Many cultures, including Native American, Egyptian, Japanese, and Babylonian beliefs that females created the world in ancient times.

Ancient Greek culture is still studied today through their mythology and art. As a patriarchal or male dominated society, the Greeks were known to be relatively tolerant regarding sexual habits and behaviors. Indeed, Greek mythology is filled with male bisexuality. The Greeks are well known for respecting and prizing beauty of both men and women. Prostitutes, from

brothels to courtesans, were common and indeed socially acceptable in all social circles in the Greek culture.

Ancient Rome is known by many historians to be one of the most decadent in the history of mankind and is blamed for the fall of the Roman Empire. As in Greece, ancient Roman citizens didn't much differentiate between heterosexual or homosexual relationships. As a matter of fact, large numbers of Roman citizenry were devoted to Bacchus, the god of ecstasy and wine. Many Roman rulers were bisexual and even Caligula is rumored to have engaged in orgies that included sadomasochism and bestiality.

As Christianity developed throughout the European continent, intellect, religion, and Western political cultures played a great role and influence over attitudes regarding sexual behavior.

From the end of the Roman Empire until about the 16th century, Catholicism was a dominant force in Western Europe. The Church established morality and behaviors such as homosexual relationships, adultery, and lust was frowned upon. Marriage was expected to be monogamous and adultery was severely punished. Adulterers were publicly humiliated and sometimes beaten or stoned and shunned.

Sexuality ideas within the Catholic realm as well as attitudes regarding sex and sexuality were more fully developed when Augustine, a fourth century bishop, denounced sexuality as an inherent threat to spiritual growth. However, Augustine was unable to argue against the Bible's justification of sex in marriage and stated that, "it was only through procreation that the evil act became good."

At this point in time, guilt played an immense role in how sexual behavior and relationships were formed during the Middle Ages. Anything other than "normal" sexual practices, meaning "normal intercourse" in the typical “missionary” or man-on-top position was considered abnormal and decadent.

By the early 1800s, sexual health and development became increasingly stifled. While the role of churches in religion and their impact decreased somewhat in family life, society became increasingly prudish. Women were covered from neck to toe. It was considered improper for any part of a woman's body, including her arms, to show in public. It was believed at that time that indulging in sexual relationships was actually detrimental to physical and emotional health. It wasn't until the end of the 19th century that attitudes about the human body and sexual behavior began to change.

The 20th Century and Beyond

Perhaps due to the growing abilities of travel, communication and understanding of human anatomy and development, attitudes regarding human sexuality went through a transition during the late 1800s and into the early 1900s. For example, the Victorian era still held a severe grasp on many attitudes regarding birth control and sexual behavior outside of marriage.

While prostitution has always been a part of society since the beginning of man, the late 1800s and early 1900 saw a growth in the openness of the practice of prostitution and promoted what was known as "social diseases". It was during this time that sexually transmitted diseases and infections were first understood by the medical community. **The snowball effect of the growing desire of young people to experience sexual freedom common in the 1960s culminated during what was known as the "sexual revolution".**

In the 1960s, youth around the world experimented with open and free sex among their peers. This is not to say that all members of the younger generation were involved with such inhibition when it came to sexual activity, but due to the popularity of advanced birth control methods developed following the Second World War gave individuals accessibility as well as reinforced the aspect of "sex for fun" rather than sex as an activity that was engaged primarily for procreation.

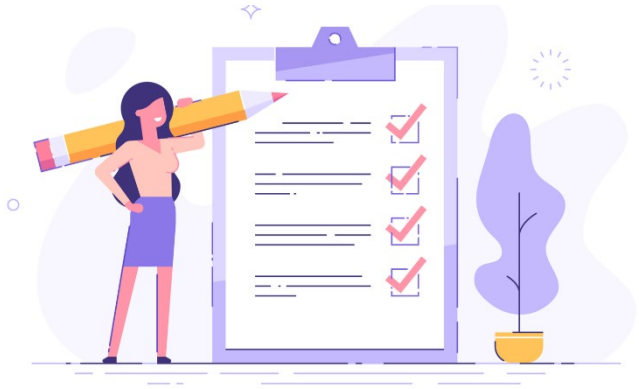
While many individuals may forever view the 1960s as the "hippie", or "flower power" mentality, many other developments, including greater independence and freedom for women, improved economies, and cheaper and readily available methods of transportation played a role in the development of sexual understanding in human development.

In the late 1950s, popularity of "girlie magazines" entered a boom. That didn't end until the mid-1970s. College students rallied for availability of contraceptives and promoted coed dormitories. It is also the time when old-fashioned double standards (it's okay for the man but not for the women to engage in sexual activity) tilted more toward equality, which led to a change in sexual standards still present today.

Unfortunately, the sexual revolution of the 60s also brought with it an increase in the number of individuals suffering from sexually transmitted infections and diseases, the most common of which was genital herpes, which reached almost epidemic proportions.

The sudden rise in individuals suffering from HIV and AIDS served as a wake-up call to many around the world and brought about information and marketing they cautioned safe sex and the benefits of limited sexual partners.

E. The Study of Human Sexuality



How is human sexuality studied? Remember that sexuality is a part of every individual's personality, whether he or she is aware of that fact or not. There are multitudes of factors that encourage and lead humans to engage in sexual activity. **The multitude of methods commonly used today to survey and study sexual behavior in humans** include but are not limited to:

- **Observational Method** - direct observation of sexual behavior in laboratories or in the field is one of the most common methods of studying human sexuality and behavior. For example, the study of body language and nonverbal communication has always been of great interest to psychologists and researchers. However, the most positive studies consist of those where participants are unaware that

he or she is being observed, in order to prevent the "observer effect", which changes the behavior of participants due to the presence of an observer.

- **Survey method** - this type of methodology utilizes information that is collected through interviews, surveys or questionnaires of participants. This method is basically used to generate information on sexual behavior and attitudes within certain groups of individuals or population demographics to gain more detailed perceptions, feelings and attitudes regarding sexual behavior. However, this method is not always accurate, as many individuals may answer untruthfully in order to maintain the idea of socially acceptable responses to certain questions.
- **Correlational method** - this method enables psychologists or researchers to view and examine relationships and correlation between communication, couple longevity, compatibility, and sexual satisfaction.
- **Experimental method** - this methodology enables psychologists and researchers to attempt conclusions between independent and dependent variables. For example, researchers often used this method to observe and study the response and attitudes of participants to mentally or sexually arousing materials while physiological responses are being measured through instruments that measure blood pressure, oxygen, heart rate, and so forth.

Human sexuality is also studied from a biological perspective and involves the study of hormones such as those produced by the pituitary gland, hypothalamus, and hormones produced by the ovaries and testes as well as the adrenal cortex. This field of study also involves research into both male

and female hormones such as estrogens, progestin, testosterone, androgens, and so forth.

Organic, neurological, and physical aspects of the human body offer researchers nearly never-ending opportunities to research human sexuality behavior and development in a wide range of scenarios. Human sexuality encompasses sociological as well as philosophical and religious aspects of any individuals given environment. Physiological, moral, ethical, cultural, and political aspects determine what type of sexual behavior is acceptable or unacceptable in certain cultures.

Researchers are also studying what is called the "learning perspective" which seeks to understand how sexual behaviors may also reflect our experiences. For example, why do some cultures hold some sexual behaviors as acceptable and others as taboo? Why is it that some individuals within a certain culture find nothing wrong with certain sexual acts, while others may consider them abhorrent?

Understanding human behavior, growth and development, heritage, culture, and a multitude of other factors when it comes to sexual growth and development is believed to play a large role in shaping the sexual behavior of certain individuals.

The study of human sexuality is very complex and involves many different aspects of our daily environment and lives including learning, physiology, and understanding. History, culture, and personality also play a large role in the development of any individual. In addition, religious beliefs, traditions and background also have a huge impact on whether or not certain sexual activities are considered "acceptable" or not in today's society.

F. Conclusion

The acceptance or unacceptance of certain types of sexual behavior in different societies also holds the ability to offer greater understanding to socio-cultural aspects of human sexuality and development. In social norms involving politics, mass media also plays a large role in the development of sexual behavior and acceptance in society. The impact of the sexual revolution and growth of feminism in society has also offered today's men and women a new outlook on sexual behavior and expectations in the 21st century.

Sexuality is known to occur in life cycles that incorporate much of our growth and development from early childhood until old age. Concepts of "self" also determine many individual concepts and beliefs regarding sexual behavior. Such concepts of self and an understanding of the life cycles of sexuality will be explored more fully in the next lesson.

Chapter 2: Sexuality and Lifecycles

Sexuality Across the Lifespan

Retrieved from: https://www.jogc.com/article/S1701-2163(16)35354-3/pdf

Sexual development begins the moment we’re born and doesn't end until we die. Every stage of development, from childhood to adolescence, adulthood, and old age is a never-ending journey of knowledge, experience, and development. Many researchers today don't fully understand childhood sexuality because its research is often difficult composed of shaky morals and taboos regarding it.

Despite today's more open attitudes toward sexual development, some topics are nevertheless difficult for many to discuss, and one of those is the idea of sexuality in children. While many aspects of childhood sexual development focus on sexual abuse, there have been little research and study of otherwise normal childhood sexual development.

The study of sexuality in adolescence is more acceptable, and there have been multiple studies published regarding the sexual attitudes and behaviors of individuals between 12 and 18 years of age.

Because adolescents are typically known to be fraught with difficulties, emotional minefields, unplanned pregnancies, and STDs (sexually transmitted diseases), researchers and psychologists have long studied aspects of adolescent sexuality in this developmental stage. Studies in sexual development incorporate behavioral, social and biological changes that take place in the human form from birth through old age. Several theories abound regarding the basics of sexual develop in adolescents as well as behaviors that continue into adulthood and old age. Adolescence is defined as extending from the late teens, but generally covers the advent of puberty, which usually takes place at 12 or 13 years of age, to 18 years old, or the end of high school.

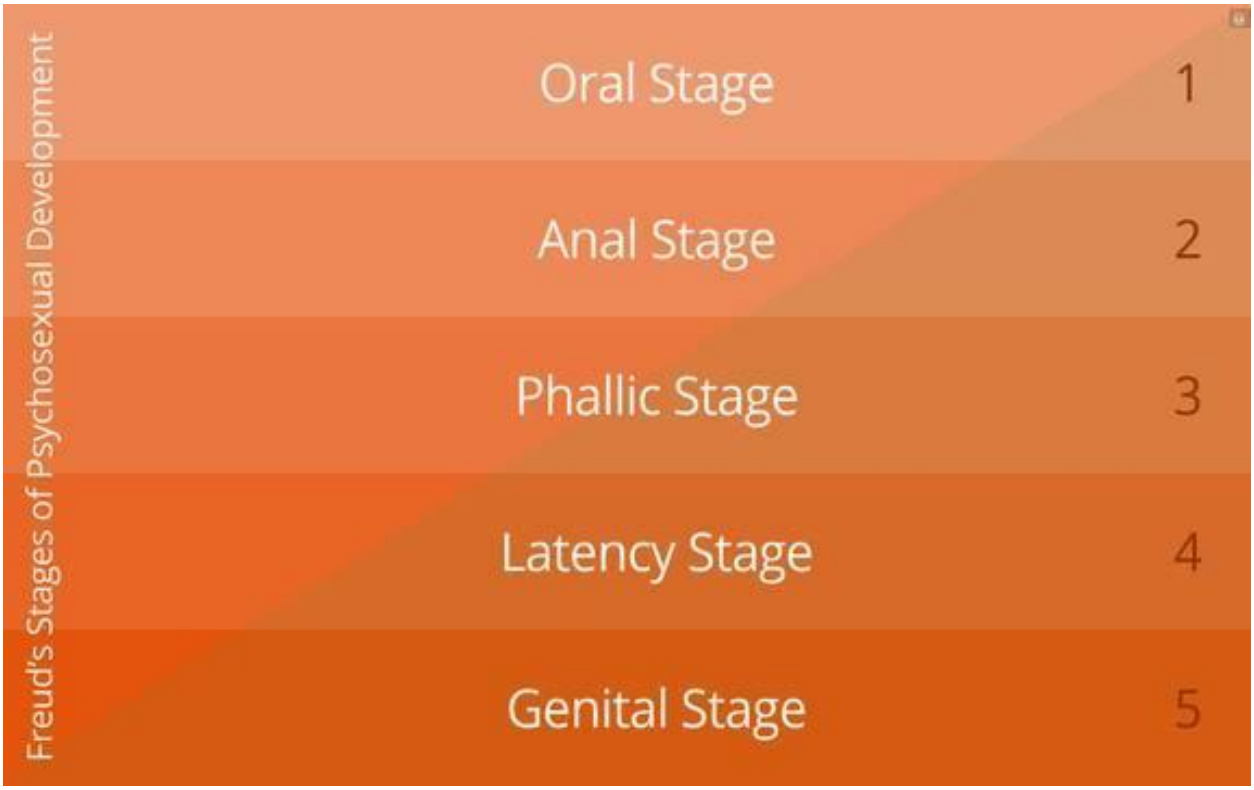
A. Sexual Development Theories

Human sexual development has been studied for decades. Most of us are familiar with Sigmund Freud and his psychoanalytic theories, which emphasize sexuality in nearly every aspect of our psychological development. However, other common approaches for the study of sexual development include what are known as psychosocial theory and social cognitive theories, which strive to define and explain the parameters of human growth and development that are not connected with sexuality or sexual behaviors.

Freud's Psychosocial Theory

Freud's Psychosexual Stages of Development

Retrieved from: https://www.simplypsychology.org/psychosexual.html



There is a fine balance between over emphasizing sexual behavior or removing aspects of sexual development from human behavior and development. Freud believed that the driving force for most behaviors in humans was emphasized by the sex drive. Freud's psychoanalytic theory has influenced cultures in the West for decades. As when it was introduced, Freud's psychoanalytic theory is still considered controversial. According to Freud, everything that a human does is related to struggles to fulfill needs and desires that may or may not be opposed by societal constraints or conflicts.

According to Freud, the sex drive, or libido as he called it, is the main force behind personality development that begins to occur in children.

According to Freud, every human being takes a journey along "psychosexual stages":

- Oral stage
- Anal stage
- Phallic stage
- Latency period
- Genital stage

For example, the **oral stage**, which Freud defined as lasting from birth through the first year, focuses on an infant's ability to explore his or her world through the mouth. Infants require a balance of stimulation that explores his or her ability to chew, suck, and bite. Freud believed that if infants were not adequately stimulated during this stage, they would not enter the next stage, known as the anal stage.

Lasting from one to three years, the anal stage was the period of time in which a child masters toilet training. During this time frame, toddlers develop control over urinating and elimination. Toddlers in this age group recognize that parents or other adults placed limits and expectations on his or her behavior. Again, according to Freud, if toilet training techniques or methods are either too permissive or too harsh, a child may develop lasting believes that may affect his or her behavior throughout life.

The period of three to six years is known as the phallic stage and focuses on a child's excessive and never-ending curiosity, both of his or her body and surrounding environment. Freud believed that this stage provides children the opportunity to identify with opposite sex parents. This phallic stage is also one of Freud's most controversial because he professed

that boys develop attractions to their mother while experiencing jealousy or fear of what may be considered their chief rival for that affection, the father. Freud believed that a boy who suppresses such desires and identify with a father is what lies behind male attitudes, appearance, sex roles, and behaviors.

The "Oedipus complex" in males is relatively comparative to the "Electra complex" that is experienced by females who naturally show affection for fathers and secretly blame their mothers for a lack of male genital organs. However, these small children eventually accept they will never belong to their fathers, and therefore identify with their mothers.

The fourth stage of sexual development is called the latency period, and ranges from six to 12 years for both boys and girls. This period is known as a relatively asexual stage of development and one in which children are more focused and attentive on social activities and personal achievements. During this stage, Freud believed that the ego and super ego of each individual is strengthened and offers a great influence on the next stage of development.

The last stage of sexual development, according to Freud, is the **genital stage**, which incorporates those 12 years of age and older. Freud believed that this stage focuses the libido on sexual pleasure with partners growing interest in dating and those of this age group express sexual behavior.

Again, many of the aspects of Freud's theories of sexual development offer little scientific support. While toddlers may often express curiosity regarding genitalia of males and females, it certainly doesn't suggest incestuous feelings. While it is understood in the knowledge that sexuality is a part of

the human psyche, today's theories of human development do not rely solely on the human sex drive.

Erikson's Psychosocial Theory

Erik Erikson's Stages of Psychosocial Development

Retrieved from: https://www.simplypsychology.org/Erik-Erikson.html

These days, such views of male and female development, attitudes, and beliefs are often scoffed at by researchers, and have brought forth alternative psychosocial theories, among those presented by Erik Erikson. Erikson believed that social and cultural motives were more prevalent in the development of human behavior than the sex drive. Basically, he believed that social environments shape children. During various developmental stages, Erikson believes that children are offered and face various challenges for emotional growth and development.

Erikson developed eight major psychosocial challenges or stages of development that may be compared to Freud's corresponding development. As with Freud's psychosocial theory, Erikson's psychosocial theory also believed that individuals must master each stage of development in order to adjust successfully to life's challenges. Erikson did believe that sexual development plays a role in shaping sexual behavior, but that it is not the driving factor for success.

Erikson's stages of development, like those of Freud, have been criticized because it does not offer why such challenges or stages of development occur in the first place. However, it may be forever impossible to determine answers to those questions. Nevertheless, many Western and Eastern cultures experience similar social challenges, and the development of such psychosocial theories provides somewhat of an understanding of human nature.

For example, take a look at Erikson's various stages of development. According to Erikson, psychosocial development occurs with special challenges. For example, Erikson believes such challenges may be classified as follows:

- Birth to one year - basic trust versus mistrust
- One to three years - autonomy versus shame in doubt
- Three to six years - initiative versus guilt
- Six to 12 years - industry versus inferiority
- 12 to 20 years - identity versus role confusion

These classifications are broken down into a variety of influences and events. For example, basic trust in mistrust is the point in time when infants learn to trust others and rely on others to care for their needs. Parents or other caregivers who are inconsistent or reject such responsibilities of care encourage infants to become wary or mistrusting of people. At this stage, the primary caregiver parent is the key to attachment and social development.

The development of one to three-year-old incorporates economy versus shame in doubt. At this stage, Erikson believed the children need to learn to be autonomous, such as feeding and dressing themselves, taking care of toileting habits brushing their teeth, and so forth. Erikson firmly believed that children who fail to gain this type of independence encourage children to doubt their abilities, which generates shame and embarrassment. As with the first stage of development, parents or a primary caregiver plays a major part of the toddler's ability to learn to socialize.

During third to sixth year of life, Erikson believed that children begin to accept responsibilities, many of which are beyond their capacity to manage. Children enjoy acting and playing grown-up, and also experience a certain degree of independence that produces conflicts with parents as well as siblings or other family members. Such conflicts initiate guilt. It's at this stage Erikson believes that children learn how to balance their curiosity with their privileges, as well as the rights and wishes of others. At this stage, social development spreads to other family members and not just the parents.

Six to 12-year-old children are learning how to socialize in outside environments as well as learned skills and knowledge at school. During this stage, children are continually comparing themselves with their peers as well as other members of society. Children at this stage typically develop self-

assurance and confidence in themselves, but feelings of inferiority are often common. At this stage, a child's reliance on social development ventures beyond parental or family boundaries and also incorporates friends, peers, and teachers.

The growth of an individual between 12 and 20 years old is a constant journey toward maturity and self-awareness. During this stage, most adolescents have established their identities within social groups and school situations, but often remain uncertain or confused about how they should behave on an adult level, as well as what to achieve as adults. Their peers have a major influence on behaviors as well as attitudes, with less emphasis placed on family and parental guidance.

The Importance of Observational Learning

Observational learning is defined as patterns of behavior that are learned by imitation. In the field of psychology, observational learning is one of the most important forms or methods of learning engaged by others. Life experiences serve to shape and develop human behavior in a multitude of situations and circumstances and experiences among families, friends, neighborhoods, and cultures play a large role in how beliefs and attitudes developed.

Sexual development relies a great deal on how various individuals perceive role models in his or her environment. Role models can include parents, peers, celebrities, siblings, and other acquaintances. Listening to and watching friends, television, books and movies generally develop sexual skills. Different cultures view the sexual development of adolescents in different ways. In some South American societies, sexual experimentation and curiosity is encouraged to promote close-knit communities. In the United States, sexual experimentation among teens is generally discouraged.

Attitudes, values and beliefs also have a great impact on how sexuality is developed. Many psychologists believe that values and morals influence reactions to the development of sexual relationships. Attitude also plays a great deal in the success or failure of dating relationships and decisions that individuals make about their own sexuality. It is during the adolescent stage that most individuals develop tolerances and intolerances of certain behaviors, and that includes human sexuality.

Erikson's Adult Stages of Development

Orenstein GA, Lewis L. Eriksons Stages of Psychosocial Development
Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK556096/

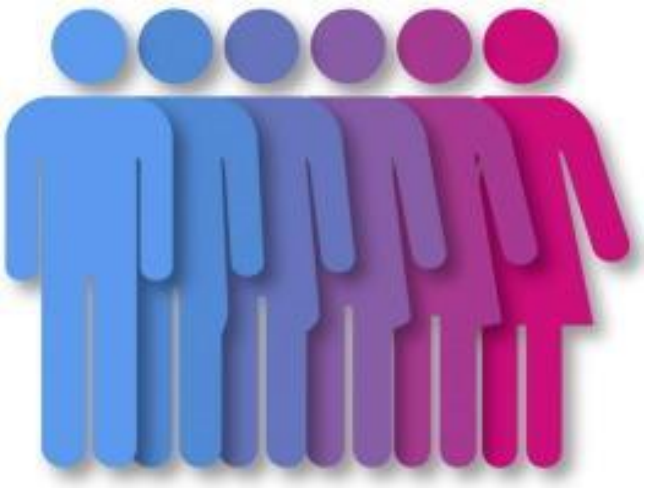
Human sexual development doesn't end at young adulthood. Erikson believed that adult stages of development reached from the age of 20 to old age. For example, Erikson believed the young adulthood (20 to 40 years of age) provided the psychosocial challenge of intimacy versus isolation. He also believed that this stage of human development provided the foundation for

developing friendships and achieving companionship and love with others. Those unable to develop and maintain such relationships are prone to feeling lonely or isolated. Primary social attention is placed on close friends, spouses, and lovers rather than parents, siblings, or acquaintances.

Erikson believed that individuals 40 to 65 years of age (middle adulthood) reached a stage called generativity versus stagnation. During this stage, he believed that adults face challenges of raising families and pursuing careers. At this stage, adults are basically charged with responding and addressing the needs of younger people, including children, family members, and young members of society. Those who are unable to share such responsibilities may become self-centered and may literally be considered as general stagnation.

Old age is considered an adult stage of development that creates a challenge between ego integrity and despair. Erikson believed that older adults tend to view life as either having been happy, productive or meaningful or one filled with disappointments, empty promises, or unrealized life goals. Older people rely on social experiences as well as one's own life experience to determine whether or not he or she feels their life has been successful and fulfilling.

B. Establishing Sexual Identity



Sexual identity is defined as an individual's perception of sexuality, orientation, sexual preferences engender. The concept of sexual identity typically begins in early adolescence and continues into

adulthood. It is a continual stage that takes years to develop. It is at this stage of development at the concept of self, such as self-views or self-concept is realized.

Individuals who develop healthy sexual viewpoints generally enjoy positive relationships and have fewer inhibitions than those who have been taught to believe that sex is bad or "dirty" or that certain behaviors are unacceptable. However, the concept of unacceptable behaviors or taboos often changes within cultures.

At this stage of development, an individual enjoys additional clarification of the type of people he or she finds sexually attractive. The formation of a sexual identity not only incorporates personal beliefs and views, but it's also based on attitudes, "messages," and passed as well as current sexual partners that have developed over time.

In some ways, sexual identity is often defined as a process of acquiring sexual meaning or an individual's interpretation or feeling regarding sexual experiences and cultural norms. In many cases, sexual development and meaning is generated through interactions within a person’s environment. Basically, a personal experience plays a great role in sexual meanings and identity of any given individual but is also dependent on the laws, values, morals, and expectations in one's own culture or society.

For example, different cultures believe or tolerate different attitudes regarding sex education, premarital sex, homosexuality, as well as the viewing of nudity in the media. For example:

- Do you believe it's wrong for men and women to engage in premarital sex?
- Do you believe it's wrong for men or women to commit adultery?
- Do you believe it's wrong for men or women to engage in same-sex relationships?
- Do you believe it's wrong for adolescents less than 16 years of age to engage in sexual relationships?

Many individuals ask these questions will invariably answer in different ways. For example, in many cultures, sex before marriage is acceptable, while many believe that sex between individuals less than 16 years of age is wrong. In many cultures, extramarital affairs or sex was considered wrong.

However, concepts such as homosexuality are not considered particularly disturbing in countries that are permissive in nature, such as Canada, Spain, Norway, or the Netherlands. In the Philippines, any sexual activity outside of marriage is considered unacceptable. Teen sex and extramarital affairs are also disapproved of in the Japanese culture, while homosexuality is extremely frowned upon.

Individuals in the United States show an almost equal division in attitudes regarding premarital sex, homosexuality, and teenage sex. Studies have shown that cultures in Asia and the Middle East place a great deal of importance on virginity among females and in some countries such as Egypt, Lebanon, Syria or Jordan, family on a relies on female chastity. In some cultures, such as these, women who engage in premarital sex have literally "dishonored family" and may be stoned or murdered. As a matter of fact, among such cultures, men who murder female relatives who'd been caught

having sex before marriage or engaging in adulterous affairs are not punished in any way.

Phases of Sexual Development

The driving factor behind most adult's sexual development is the seeking of intimacy, companionship, and long-term relationships. However, the phases of adult sexual development can be divided into several categories that include:

- **Early adulthood**
- **Midlife**
- **Late adulthood**

For example, one of the largest psychosocial challenges that faces young adults is their desire to achieve meaningful relationships. At this stage, most people have developed concepts of self that have enabled them to distance themselves from seeking approval from parents or teachers and develop their own sense of identity, values, goals and desires. In most cases, such individuals look for a partner who echoes or mirrors their own goals.

Establishing trust is a basic foundation of reaching such intimacy, and identifying likes and dislikes, values, morals and goals are often the result of what we know as the "couple". However, intimacy also requires that an individual knows and feels comfortable with his or her own thoughts and feelings, a willingness to share such feelings, and the ability to use such skills

such as communication and awareness to effectively communicate with partners.

As individuals reached their 20s, the search for clarification of sexual behavior and values, the desire for intimate relationships, and concepts of self-assurance and confidence helped to establish relationships that often prove satisfying on both emotional and sexual levels. During our 20s, we learned how to become partners, wives, husbands, parents, and working members of society. At this stage of development, both men and women are learning to adapt to new roles and next occasions as well in meeting challenges in developing relationships.

This stage also requires that women especially cope with the changes in appearance brought about by adulthood, pregnancy, or childbirth and a perpetual search for youthful appearances. In many cultures, adults in their 20s are considered to being in their sexual prime.

C. The Midlife Stage of Sexual Development

As we enter indoor 40s and 50s, most adults have settled into responsible jobs, careers, and are comfortable with their role in the family unit. In addition, the midlife stage also encourages us to adjust and except changes in physical appearance, such as receding hairline, weight gain, slowed metabolisms, decreased endurance, loss of muscle tone, and an enhanced vulnerability to illnesses.

Most women experience an end to their reproductive years in their 50s, though some reached this stage more commonly known as menopause sooner and

sometimes later. In many situations, women who have identified their concept of self-worth in their ability to bear children are tormented by this change and often base their sexual desirability on this factor.

Men and women feel differently about aging. For women, getting old means less sexual attractiveness and changes in the body that often bring about feelings of self-consciousness and frustration. Men are generally considered to be more vulnerable to a slowing of their sexual functions and abilities, which often plays a great role in how they feel about themselves.

However, for many, the aging process is a normal part of human growth and development, and approaching middle age with a healthy and positive attitude often makes up for changes in body shape and capabilities. Many adults in this age group are happy to discover that their sex lives actually improve.

Many changes in sexual activity is often related to outside factors such as where they're not partners or emotionally supportive, healthy, or who are suffering from alcoholism or a depression. Nearly one third of divorces occur during these years.

D. Sexual Development during Late Adulthood

It is generally believed by the "younger generation" that individuals in their 60s or older should not engage in sexual behavior because it's "gross" or unacceptable. However, adults 60 years of age and older are not only dealing with a decrease in sexual function in many stages, but are also grappling with

retirement, finances, and feelings of mortality. While many seniors find such changes threatening overwhelming, many are comfortable with the adjustments.

While health problems are more common in older adults, including disabilities, the majority of older adults continue to gain just as much enjoyment from their sexual activities as they did when they were younger. Older couples are often able to achieve higher levels of marital satisfaction, emotional closeness, and companionship than couples half their age.

Many older couples enjoy maintaining a certain amount of separation in their daily environments in order to avoid "emotional crowding". There is no reason why older adults can enjoy sexual relationships, and those who are physically healthy can enjoy sexual activities well into their 70s, 80s, and 90s.

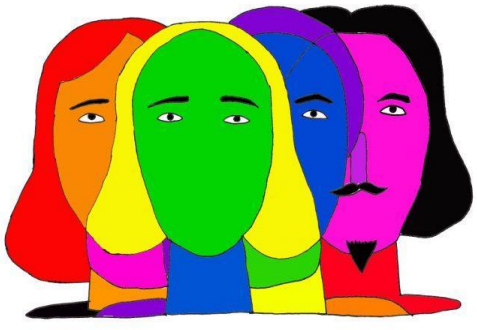
Sexual responses and expectations will necessarily change as each of us age, but research has proven that older individuals may enjoy satisfying sexual interactions and relationships as well as an enhanced intimacy. Sexuality is part of human nature, and though it changes as we age, it doesn't ever really disappear. Knowing what to expect, understanding and preparing for such changes, as well as understanding what is considered normal or abnormal allows many of us to maintain healthy and happy sexual relationships throughout every phase of our life.

E. Conclusion

As you can see, sexuality is present during every lifecycle, from birth until death. While it is generally accepted that the height of our sexual awareness occurs during adolescence and our 20s and 30s, this in no way is meant to imply that your sex life or your desirability or your enjoyment of sex will end at any given stage or phase of development.

Many sexual relationships are based on more than physical closeness, and incorporate concepts of sexuality that include behavior, intimacy, a great sense of identity and self-awareness, as well as the ability to reproduce. Such concepts as sexuality and sexual development will be explored in greater detail in the next lesson.

Chapter 3: Concepts of Sexuality



Human sexuality is more than a completion of a sexual act. Sexuality also involves, to varying degrees, concepts of intimacy, behavior, identity, and reproduction. The majority of sexual relationships between

couples today involve varying degrees of expectations regarding intimacy, what makes intimacy, and how it plays a role in any relationship. Likewise, behavior, attitudes, and expectations regarding relationships and sexual activities and preferences also play a large role in how individuals behave in a particular relationship.

Concepts of identity as well as what is considered to be normal and abnormal is a personal decision among every individual that also has a large impact on how a person feels initiating, engaging in, and maintaining a sexual relationship that also meets the needs of every individual, including self-confidence, assurance, self-worth, emotions, and feelings. At the bottom of every sexual relationship, each individual engaged in sexual activities must also determine whether pregnancy is desired or not. Fear of becoming pregnant is an inhibitor to the enjoyment of sexual relationships for many women. At the other end of the spectrum, men who are fearful of getting a female partner pregnant may also feel inhibited and therefore gain less pleasure out of sexual relationships.

Intimacy is considered a prerequisite to any type of lasting relationship. However, our perceptions of intimacy differ between individuals. What, exactly, is intimacy? Is it holding hands, hugging, and kissing? Or is it merely a physical presence in a time of need? Is intimacy physical or emotional in nature, or both? Different people consider intimacy to be a knowing glance of the eye, a squeeze on the back, a hug, or an assurance that a partner will stand by you no matter what.

This lesson will focus on various concepts of these different aspects of human sexual development and how they play a major role in the development of relationships and expectations.

A. The Impact of Feelings on Sexual Relationships

Many people believe that a sexual relationship without feelings or emotions is an empty and meaningless activity. Others seek out these kinds of relationships. The impact of feelings and emotion on sexual arousal is at the basis of the less thought about concepts of sexuality that include beliefs regarding behavior, intimacy, and sense of self or identity. If you have experienced an intimate relationship, you more than likely remember feelings that evoke happiness, joy, pleasure, disappointment, anger, and grief.

Many of us automatically put ourselves in a variety of circumstances and situations, some based on past relationships and experiences, and others where we have used such experiences to improve our concepts and beliefs regarding what each of us wants out of a relationship. Some of us have been involved in relationships that were unhealthy, mismatched, and sometimes abusive. Many such relationships initiate pain, disappointment, sadness and frustration.

It is important for any individual who has experienced a disappointing, unhealthy, or abusive relationship to identify negative emotions related to that relationship and address and examines the failed relationship in order to

improve the potential for enjoying a normal and balanced relationship in the future. It is perfectly natural for people who have experienced abusive or unhealthy relationships to be suspicious or wary of developing any new relationships, or to stop comparing current partners with past partners. Finding a strong and healthy relationship requires an individual to do some sometimes-heavy soul-searching, but enables an individual to determine where he or she draws the line in expectations and demands.

Most relationships are not easy, and are filled with ups and downs. Love is a mysterious, complex, and often confusing and frustrating condition. However, understanding yourself, your expectations, and the reasons why you feel about certain things will help generate a basic awareness, as well as insight and sensitivity and understanding regarding yourself, and your partner to create rewarding and healthy relationships.

Most people, regardless of age, closely linked love, intimacy, and sex. Research has shown that the healthiest romantic relationships are both physically as well as emotionally satisfying. While many couples seem to be content with sexual relationships without deep emotions involved seem common, they are actually the exception to the rule. Even in the 21st century, the majority of individuals asked a question of whether or not they would have sex with someone they were not in love with responded to the negative.

It may seem that casual sex in the 21st century is pervasive, but even individuals who have engaged in casual sex in college have stated that they desire a meaningful and emotional connection with sexual partners in their future. Emotions therefore play a great role in the development of human sexual behavior, but focus more on environments than initiate sexual behaviors, rather on the sexual act itself.

Understanding how intimacy and emotional commitment and connections between partners develops and grows over a period of time and how enhanced intimacy and sexual behavior are interconnected is the focus of this lesson. A great majority of single as well as married and dating couples have stated that one of the most important components of any relationship is communication.

However, some relationships that start out well don't end well. In many cases, issues of control, abuse, and violence develop within relationships, and finding or determining reasons for such behaviors and understanding what causes them will help many individuals to learn to spot trouble signs early on in a relationship before things get out of hand and individuals are harmed by verbal, emotional, sexual, or physical abuse.

So, ask yourself this - are love and romance part of human nature or are they influenced by culture or time? Did people in the Victorian era feel differently about love and romance than we do today? Have attitudes regarding relationships and sexual behavior changed over the decades? Most of you will answer a definitive yes. For example, in the old days, parents often arranged marriages for their children long before they met or were even of marriageable age. Matches between children of families were designed to strengthen family power and wealth. In most cases, a woman was considered exceedingly attractive if she came with a wealthy dowry that included money, land, or homes.

Of course, we must remember that the life age expectancy, for example, in the 1700s was on average 40 years of age, so couples married young. In those days, a woman was considered an "old maid" anywhere between 22 and 26 years of age.

In many cases, men and women in the "old days" were married very quickly after meeting. In many situations, marriages were a matter of convenience, propagating the family line to reproduction, and to avoid the stigma of being considered unmarriageable.

Today, most marriages are entered into because of love and feelings of intimacy between individuals, and not because of the pressures placed on them to parents, culture, or tradition, although it is still remain true in some cultures.

B. The Eligibility Factor

How do we approach relationships? The criteria we use to determine what we may hope are suitable partners differs among individuals. Many of us try to get to know potential partners before we even meet them. For example, a certain number of criteria may enable individuals to narrow down a field of "eligible" for those looking for that perfect partner. Asking ourselves various questions may help with such considerations, including:

- Is an individual of the same ethnic or racial background?
- Does ethnicity matter?
- In regard to relationships, does it matter whether the other person is male or female?

- Does the person’s age matter? For example, do you care if a potential partner is older or younger than yourself?
- Do physical attributes matter? Is the person you're interested in tall enough, short enough, thin enough, pretty enough, handsome enough or muscular enough?
- What if the person's religion? Does it matter?
- What is the person’s socio-economic status? Does it even matter how much or how money or potential earnings this person makes?
- Does this person have a job? What are his or her hopes for a career?
- Do I like this person's personality?

Consciously or subconsciously, we all mentally compare attributes and desirability when meeting someone for the first time. In most cases, we also have a positive, mediocre, or negative reaction to meeting individuals, which of course may change over time, though gut instinct usually prevails.

In many cases, an individual on the lookout for a sexual or lifelong partner is able to initially determine whether or not that individual can be more than merely a friend upon the first few contacts. Ideas and considerations of attraction and potential romance factor also is a very individual and personal emotion.

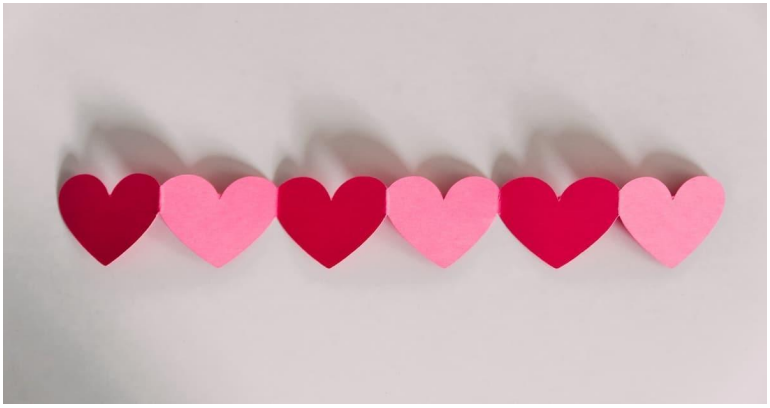
While physical attractiveness plays a great deal in physical attraction between couples, society and the media today seem to be inordinately focused on attractiveness, physical appearance, ideal body weight, shape, and so forth. Studies have shown that society does have a bias toward those who are beautiful and attractive. For example, it is long been accepted that attractive individuals applying for jobs typically win out over those who are overweight or unattractive. We will address how the media affects attitudes and behavior

in a later lesson, but suffice it to say that for generations, physical attraction is the key factor when it comes to looking for a sexual partner.

However, ideas of physical attraction have changed over the years. For example, in the Victorian age, ideal female body types ranged just under 5'5" tall and weighed roughly 140 pounds. Today, women are considered especially attractive if they are around 5 foot eight or 9 inches tall and weigh roughly 120 pounds, or less.

C. Different Types of Love

Marzec, Magdalena & Lukasik, Andrzej. (2017). Love Styles in the Context of Life History Theory. Polish Psychological Bulletin. 48. 10.1515/ppb-2017-0027.
Retrieved from:
https://www.researchgate.net/publication/318187921_Love_Styles_in_the_Context_of_Life_History_Theory



Yes, there are different types of love. A Canadian sociologist named John Alan Lee broached a theory in the 1970s that suggested that people adhere to specific psychological motives regarding relationships. These six categories were called styles of love and have continued to serve as a foundation for research on intimacy and

relationships. Lee named the six "styles" of love after figures from Greek mythology.

Take the following survey (*adaptation of Hendrick and Hendrick 1986*) and provide a true or false to each statement according to your own beliefs and perceptions. Then check your answers as defined by Lee. Below the survey, we will provide detailed explanations that incorporate the various styles of love as proposed by Lee.

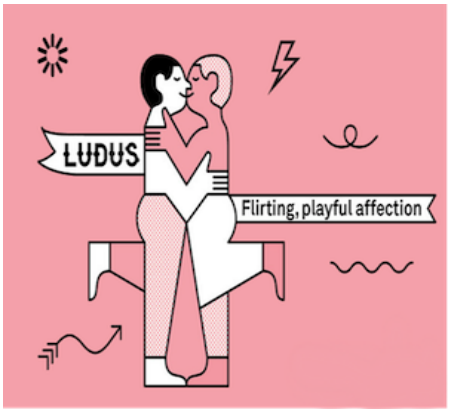
1. My partner and I were attracted to each other immediately when we first met.
2. My partner and I have great physical chemistry between us.
3. I feel that my partner and I were meant to be together.
4. I have sometimes had to prevent two of my partners from finding out about each other.
5. Sometimes, I enjoy playing "love games" with several partners at once.
6. I believe it's a good idea to keep my partner a little uncertain about my commitment to him or her.
7. I find it difficult to pinpoint exactly when my partner and I fell in love.
8. The most fulfilling love relationship grows out of a close friendship.
9. It is necessary to care deeply for someone for a while before you can truly fall in love.
10. When I am in love, I am sometimes so excited about it that I can't sleep.
11. I am constantly worried that my partner may be with someone else.
12. When my partner is busy or seems distant, I feel anxious and sick all over.
13. It is best to find a partner who has similar interests to your own.

14. I try to make sure my life is in order before I choose a partner.
15. A person's goals, plans, and status in life are very important to me in choosing a partner.
16. I would rather suffer myself than allow my partner to suffer.
17. I cannot be happy unless my partner's happiness needs are met first.
18. I am usually willing to sacrifice my own needs and desires to allow my partner to achieve his or hers.

Statements 1, 2 and 3 define **Eros** love
Statements 4, 5 and 6 define **Ludus** love
Statements 7, 8 and 9 reflect **Storge** love
Mania love is reflected in statements 10, 11 and 12
Statements 13, 14 and 15 define Pragma love
Agape love is reflected in statements 16, 17, and 18

Eros love is considered to be passionate and erotic nudist common with short-term relationships. Individuals involved in this type of relationship place emphasis and focus on romance and strong physical attraction to potential partners. Many such individuals believe in love at first sight and enjoy touching, kissing and hugging.

Ludus love focuses on the initial excitement involved in the formation of her relationship, more than on the development of the relationship. Such individuals typically move from one relationship to another. Many individuals who claim this type of style enjoy



"playing the field" and enjoy the game of pursuit and conquest.

Storge love is defined as being characterized by emotional caring and friendship. This type of relationship is based on friendship and is most often the result of close friendships that develop over a long period of time into love. The emphasis on this type of relationship is friendship, stability, and security.

Pragma love is as the word implies, pragmatic. It involves relationships that are selected according to rational as well as practical criteria almost in a businesslike manner. Mania love is often associated with controlling, and possessive relationships. Such individuals often cling to his or her partner. The receiving partner often feels stifled or smothered by a partner. In some severe cases, this type of love also precipitates stalking, physical violence, threats of violence, and in some cases, suicide.

Agape love is focused and pays particular attention to the concept of giving or offering to another a partner when he or she particularly needs without expectation or receiving something in return. This type of relationship is often self-sacrificing and altruistic. In many situations, these relationships are one-sided, and are also non-demanding and patient. While this type of relationship is often held up as an example, any relationship should be a balance of giving and receiving, and not the continual giving or receiving of only one partner within the relationship.

Of course, if you answered two or three within any given set of styles doesn't necessarily mean that your expectations, emotions, or attitude regarding relationships won't change in the future. Many individuals find that he or she agrees with more than one style, which implies a multitude of possibilities. In addition, after experience, expectations change and relationships can also change as well as grow over length of time. Your expectations regarding relationships may differ between your teens, your 20s, your 40s, and your 60s.

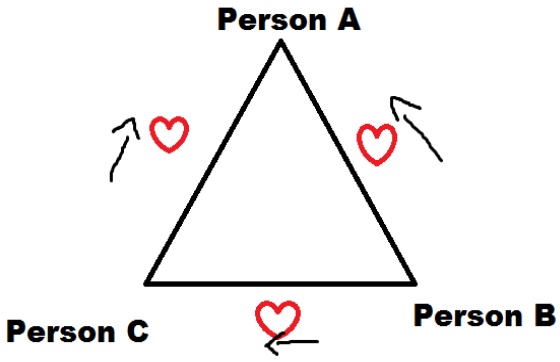
Many individuals have no idea what type of style of love they would prefer, as they may never have been in love or thought very much about the rationale involved in such styles.

D. The Love Triangle Theory

Robert J. Sternberg: Duplex Theory of Love: Triangular Theory of Love and Theory of Love as a Story

Retrieved from: http://www.robertjsternberg.com/love

We're not talking about a sexual love triangle here, but what psychologist Robert Sternberg called the **Triangular Theory of Love**. According to Sternberg, love involves three major fundamental components of passion, intimacy, and commitment (*The Triangle of Love*, Robert J. Sternberg, 1998).



According to Sternberg, relationships can consist of any of the three listed components, any combination of two, or even all three. In this context, intimacy is not meant to imply sexual intimacy, but emotional closeness between two people. Passion on the other hand it is the physical side of a relationship, while commitment is the rational aspect of a love relationship. According to Sternberg, these components may appear in combinations, which range from "liking" to infatuation, commitment only, or a combination of intimacy and passion, which equates to romantic love.

In most relationships, purely sexual or otherwise, individuals often feel unhappy if any of the three components are missing from a relationship. Individuals who are committed to relationships can at the same time feel lonely and disconnected if they lack intimacy with a partner. Relationships that let commitment often led to feelings of frustration, anger and betrayal. Many couples that lack passion often express a longing for physical closeness.

In addition to intimacy, passion and commitment, one overriding factor has a great influence over all three. That's communication. Communication is considered by many to be an integral component of any relationship and is the driving force of the three components listed by Sternberg; passion, intimacy and commitment.

E. Behavior and Communication

In many cases, our behavior is determined by our ability or inability to communicate our feelings and emotions to sexual partners throughout the relationship. Communication has long been understood as one of the most meaningful methods of maintaining happiness as well a success in a romantic

relationship. Adequate communication skills enable couples to express different aspects of the relationship with each other and help to deal with problems or negative emotions.

In some cases, our behavior is related to her inability or has a chance to expose everything about ourselves to a potential partner. Our ability to confide in our partner may increase as the love relationship develops and matures, but self-disclosure is often a step-by-step process that ranges from basic biographical information to very personal perceptions of identity and self-worth.

For example, studies on social development of relationships have determined that our ability to communicate emotions and feelings in relationships follows a particularly hierarchy. For example, most of us are fairly comfortable with revealing biographical background information about ourselves including family, hometown, siblings, what we did in college, and so forth. From there, we move on to what are called superficial preferences that include the types of food, music and close we like. From there, most of us are willing to discuss our goals and aspirations including desires for family, marriage, careers, and lifestyles.

As our relationships deepen, we are able to express spiritual, philosophical, and religious beliefs, expectations, and convictions. From there, we tentatively move on to expressing our private fears, fantasies, or past experiences with our partners. The last level of personal information that is

usually expressed is our concepts of our inner selves, which defined who we are as a person or individual.

F. Relationship Behavior and Attitude

An individual's behavior in its relationship or marriage is often attributed to positive as well as negative actions and reactions of a partner. It is understood that happy and well-adjusted couples are able to engage in what are known as **relationship-enhancing attributions**. Couples who are unable to communicate, or those who are generally unhappy tend to engage in **distress-maintaining attributions**.

For example, let's say you know a couple that generally personifies a healthy relationship. One day, one of the partners does something that makes the other upset, inconvenienced, sad or angry. How do you think this partner is likely to feel about such an attitude or behavior?

An individual in a healthy and positive relationship typically assumes that the negative reaction or behavior is due to outside or external influences. He or she may also realize that the negative behavior is uncharacteristic or unusual. The partner may also place little importance on the negative reaction and choose instead to focus on the positive aspects of the relationship.

However, the person involved in a distressed maintaining or unhappy relationship may assume that the negative behavior is due or caused by the individual, and that such reactions are typical in the partner. In addition, the negative reaction is also considered to be consistent with another occurrence.

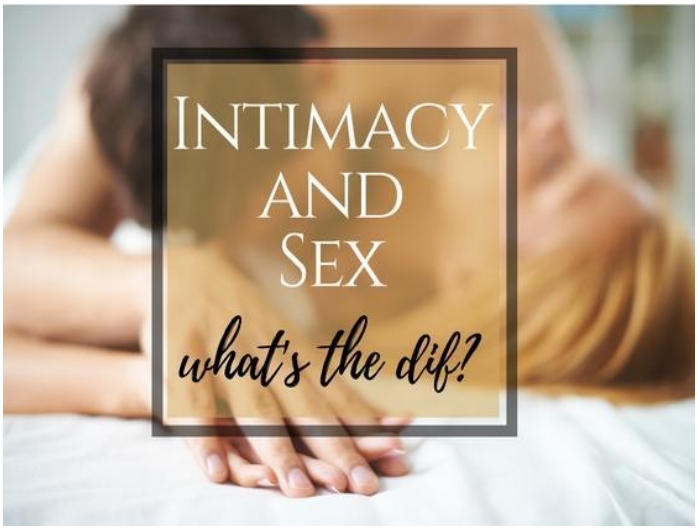
While the relationship is completely black or white, relationship attributes generally either provoke pleasure or distress on partners. For example, in a healthy relationship even a partner who forgets an anniversary date is a typical situation. Let's say the man forgot the woman's anniversary date. In a healthy relationship, the woman may understand that a man is concerned or stressed overworked, that he usually remembers the anniversary date, and it is a great guy, and this is not really so much of a big deal.

However, in an unhealthy relationship, suspicion and frustration often rule. For example, in this type of relationship, the man may offer a card celebrating the anniversary, which prompts the woman to believe that he's feeling guilty about something, but he never sends or offers cards or flowers, or that he is "after something". In addition, if the man forgets the anniversary, she may believe that the man doesn't care about her, that he does this all the time, and that her feelings just don't matter to him.

Intimacy, Love, Sex and Communication

For many couples, a sexual happiness revolves around how the couple communicates in all types of situations and environments. In many situations, one, or both partners in a relationship are hesitant or unwilling to discuss fears, problems, or difficulties. In many cases, healthy and vigorous sexual relationships often suffer due to a lack of one or both partners' ability to

communicate not only sexual needs and expectations, but expectations and desires for intimacy, consideration, and respect.



Criticism, feelings of contempt and defensiveness often lead to decreased sexual attraction between partners. Individuals who are continually treated with contempt or criticisms experience a decrease in sexual attraction toward a partner. We will discuss such concepts of sexuality and power in a later lesson, but suffice it to say that if you feel unequal to your partner, or unable to communicate your innermost feelings, attitudes or beliefs with a partner, the sexual relationship between such couples will ultimately suffer.

Falling in love is a highly emotional event in our lives. The more you know how you feel about yourself and your expectations, the more you will enhance your ability to choose a partner who will be able to not only meet your needs, but enable you to meet those of your partner.

Focusing on feelings is one of the best things any individual can do when entering a relationship. Your ability to communicate expectations, wants and desires is an important aspect of the dating processes, from your teens through your Golden Years.

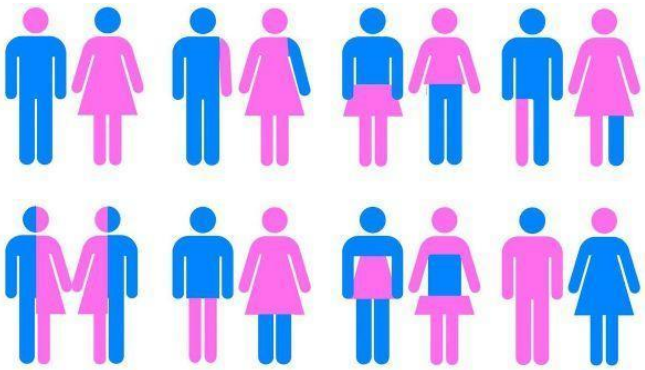
Understanding what you want in a partner is the basis for how you choose your partners. While we don’t always know how things are going to work out

in any relationship, understanding your concepts of sexuality and relationships and those of your potential partner will help nurture positive and enhanced relationships that have a strong chance of survival.

Understanding who you are and what you want also means understanding what and whom you are attracted to, as well as sexual orientation in regard to your attitudes, beliefs and perception of heterosexuality and homosexuality.

Chapter 4: Sexual Orientation

Bowins, Brad. (2015). What Is Sexual Orientation All About? Explaining an Evolutionary Paradox. International Journal of Social Science Studies. 3. 10.11114/ijsss.v3i2.698.
Retrieved from: https://www.researchgate.net/publication/276395674_What_Is_Sexual_Orientation_All_About_Explaining_an_Evolutionary_Paradox



Sexual orientation is merely a name that defines a person's concept or beliefs toward or regarding romantic or sexual relationships. For example, most Americans recognize three specific definitions of sexual orientation that include heterosexuality, bisexuality, and homosexuality. However, there is an additional definition of sexuality, commonly attached to those who generally show little or no interest in sexual relationships. Such a person is labeled with the term "asexual." However, for the purpose of this course, we will not pursue

a discussion of an asexual individual, but rather limit our discussions to the generalized categories of sexuality that involves reactions, emotions, and romantic feelings for individuals of the same or opposite sex.

A. Defining Sexual Orientation

Sexual orientation, as mentioned above, may be defined as an individual's romantic or sexual attraction to one or both genders. A **heterosexual** is defined as an individual who experiences romantic or sexual feelings for someone of the opposite sex. A **bisexual** individual may feel such attractions for both genders, while a **homosexual** generally has romantic or sexual feelings for members of the same sex.

In many situations, bisexuals generally prefer one sex to the other, and is often a confusing concept for individuals in Western cultures to understand, because in most cases, believes prevail that someone is either heterosexual or homosexual in nature. Alfred Kinsey, of the Kinsey report, created a scale of sexual behavior that seeks to define sexual experiences and the sexual behavior of people involved in a survey and interviews regarding sexual behavior and orientation.

The model of Kinsey scale rates online and offers a seven-point scale of behavior ranging from zero to seven. Kinsey believed that sexual orientation could comprise of a variety of either same-sex or opposite sex activity that

may often change during a person's lifetime. While many individuals, at the time and today leave the Kinsey scale is simplistic, it was one of the first of its kind to try to understand the basics and the foundations and origination of sexual orientation among individuals.

What Does the Kinsey Scale Have to Do with Your Sexuality?

Retrieved from: https://www.healthline.com/health/kinsey-scale

Kinsey's scale of sexual behavior is defined as follows:

- 0 - exclusively heterosexual with no homosexual
- 1 - predominantly heterosexual, only incidentally homosexual
- 2 - predominantly heterosexual but more than incidentally homosexual
- 3 - equally homosexual and heterosexual
- 4 - predominantly homosexual but more than incidentally heterosexual
- 5 - predominantly homosexual but incidentally heterosexual
- 6 - exclusively homosexual with no heterosexual

Many researchers at the time and as the years passed realized that this scale fails to answer particular questions or scenarios. For example, where does someone who fantasizes about members of the same gender along in this scale? What about individuals with no sexual experience? Basically, Kinsey scale is rated on behavior, and not on any other considerations that must be explored when it comes to sexual orientation.

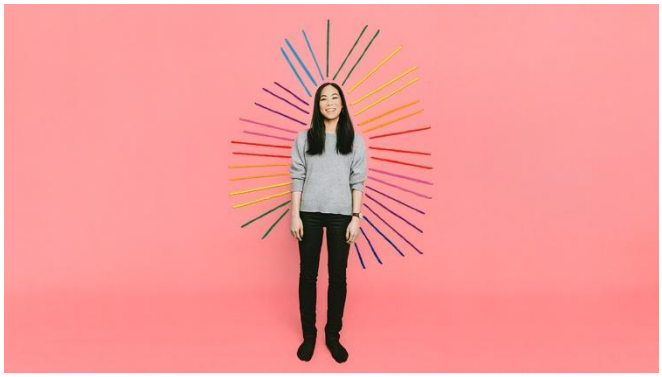
Where do individuals get their sexual identity information? How much impact this family environment, culture, religion, or experience play in the creation and development of sexual orientation? **Sexual identity** is defined as an individual who has eventually identified him or herself as homosexual, bisexual, or heterosexual. In many cultures, homosexuality and bisexuality is considered abhorrent, while other cultures are more permissive in nature.

Remember that we earlier mentioned Sigmund Freud's classification of psychosocial development, where he believed that infants are capable of sexual or erotic attraction to mothers and fathers. Freud also believed that bisexuality is inherent in every individual but believed that the practice of heterosexuality was the result of normal psychosocial growth and development. However, Freud's concepts and theories are also severely limited and constrained due to values, concepts, and beliefs of his time.

Regardless of how any individual perceives him or herself as a sexual being, conflicts over such sexual identity often develop into forms of sexual dysfunctions, poor relationships, injured self-esteem, and often develop into chronic state of anxiety or depression.

B. Homosexuality and American Culture

In the late 1960s, homosexuality was still against the law. As a matter of fact, it used to be illegal to serve alcohol to homosexuals and police raids and arrests were common in places where homosexuals gathered.



In early 1970, the gay rights movement was under way. However, decades later, many Americans still don't understand sexual orientation - homosexuality, bisexuality, or heterosexuality. In 2004, the *American Psychological Association* defined sexual orientation in this way:

"Sexual orientation is an enduring emotional, romantic, sexual or affectional attraction to another person. It is easily distinguished from other components of sexuality including biological sex, gender identity (the psychological sense of being male or female) and the social gender role (adherence to cultural norms for feminine and masculine behavior). Sexual orientation exists along a continuum that ranges from exclusive homosexuality to exclusive heterosexuality and includes various forms of bisexuality. Bisexual persons can experience sexual, emotional and affectional attraction to both their own sex and the opposite sex. Persons with a homosexual orientation are sometimes referred to as gay (old men and women) or as a lesbian (women only). Sexual orientation is different from sexual behavior because it refers to feelings and self-concept. Persons may or may not express their sexual orientation in their behaviors."

C. Homosexuality

Retrieved from: https://www.britannica.com/topic/homosexuality

Many researchers, psychologists, and scientists have neglected to focus attention on heterosexual relationship growth and development because it is

considered "normal". However, more attention and studies have been placed on homosexuality and identity formation among gays and lesbians because of the controversy that has always embraced such preferences. While the 21st century is seeing more acceptances of such lifestyles, such has not always been the case.

Many individuals are raised in cultures, families, and faiths that believe it is wrong or even sinful to encourage or accept same-sex feelings. Such attitudes increase the burden on individuals who feel such meanings, and many end up displaying symptoms of intense psychological burdens and stress.

Vivian Cass developed a model of identity formation of gays and lesbians in the late 1970s that introduced a six-stage model of development. Her six-stage model included:

- **Identity confusion**
- Identity comparison
- **Identity tolerance**
- Identity acceptance
- Identity pride
- **Identity synthesis**

According to Cass, the first stage of homosexuality identity formation involves awareness of certain same-sex feelings that often present themselves in childhood. This confusion reaffirms that a child may feel differently or be perceived differently than others. By

the time an individual reaches adolescence, he or she will begin comparing his or her beliefs with peers, which often results in a cell statement, "I must be gay."

It is at this time that most adolescents realize that their feelings for those of the opposite sex are indeed different. Often, adolescents feel a great sense of confusion, shame, anger, and worry over their feelings of those of the opposite sex. Eventually, identity tolerance is reached, when an individual accepts the fact that he or she is probably homosexual. However, this stage often is not reached until late adolescence or early adulthood. Isolation, alienation, and shame will often continue to be major psychological hurdles to such individuals to face and overcome without the support of family, friends, or peers who may be experiencing the same thing.

During early adulthood, most homosexuals decide to either be open about their sexual feelings and orientation or seek to keep such dealings secret and hidden. In many situations, revealing one's homosexuality can endanger family relationships, friendships, jobs, and even careers. In many situations, a homosexual may spend years or decades "in the closet", which may lead to ongoing anxiety and lead to anxiety or stress related disorders and depression.

In the "old days", it was essential for many individuals to hide their sexual orientation when it came to homosexuality. Famous movie stars, politicians, and sports figures protected their public reputations at all costs. Today however, more individuals feel comfortable expressing their homosexuality.

This is not to say that majorities of cultures and communities accept the concept of homosexuality. Society today can be extremely hostile, intolerant, and unsupportive of homosexuals. However, changing attitudes, the wealth of

information and the media have played a great role in bringing homosexuality in the open.

In an effort to reduce the rate of suicide attempts and "successful" suicide among gay or lesbian youths (nearly 2 to seven times higher than the rate of heterosexuals), education and awareness is promoted on most high school and college campuses within the United States. Western Michigan University developed a handout that was encouraged to help not only homosexuals come to terms with their environment, but also to help fellow students, friends and family members to offer support to their peers. The hand-out includes tips and suggestions that include but are not limited to:

- Acknowledge your own feelings, values, beliefs, and thinking about homosexuality, lesbians, and gay men.
- Educate yourself about homosexuality.
- Talk with lesbians and gay men you know and those who support them.
- Provide an open and supportive atmosphere for your friends who think they might be homosexual. Be an impartial and supportive listener.
- Remember that friends and acquaintances you associate with might be gay or lesbian.

- Remember that societal oppression and discrimination create much of the unhappiness of many lesbians and gay men.
- Remember that stereotypical "gay" behavior or appearance does not mean that the person evidencing this behavior or appearance isn't necessarily gay or that gay men necessarily exhibit these traits.
- Help people to help themselves by reinforcing their own expressions of self-worth, self-acceptance, and self-reliance so they can take charge of their own lives and integrate their feelings, thinking, and behavior in a positive way. Do not pity them.
- Know when your knowledge has reached its limit. If you are not gay or lesbian, do not presume to know everything about it, no matter how well educated you are.
- Know when your prejudices are negative feelings are interfering in your interactions with gay men or lesbians.
- Consider working for civil rights for lesbians and gay men in order to create a more positive environment for everyone.

D. Homosexuality in Other Cultures

The Global Divide on Homosexuality
Retrieved from: https://www.pewresearch.org/global/2013/06/04/the-global-divide-on-homosexuality/

In different cultures and geographic locations around the world, homosexuality is often considered either accepted or taboo. For example, in Oriental cultures, such as those coming from Thailand, China or Japan, a person's sexual identity, expression, or preferences are private. In such

cultures, people don't particularly care what orientation and individual follows, as long as he or she produces offspring or a family.

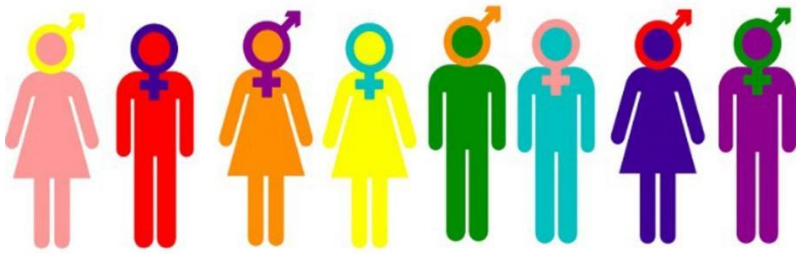
Homosexuality is present in nearly every culture around the world, whether it's recognized or not. In the early 1950s, 76 societies from around the world were surveyed, and over 60% of them responded to same-sex relationships among various members of communities may be considered appropriate and normal. In many cultures, same-sex behaviors are expected, as among many South Pacific and Pacific Island cultures. In many Pacific cultures, including those found in New Guinea, male boys are generally considered to be both on masculine and infertile and were often encouraged to engage in same-sex activities in order to strengthen their fertility. However, these same individuals become exclusively heterosexual after marriage.

Some South African cultures actually encourage same-sex relationships between young girls in older women, which do not carry a stigma for either individual as long as the younger participant fulfills social expectations and obligations of marriage and childbearing. Many younger and older women in aboriginal Australian tribes were also common, as well as among other cultures they were segregated by gender and household expectations. In many other cultures, including those found in North Africa, Central and South America, and Mediterranean countries, gender roles and expectations are distinct, and while those who are engaged in same-sex relationships may both participate, only the effeminate partners are stigmatized.

In many of these cultures, such relationships between men may be tolerated and accepted, but not so with relationships among women. In many cultures, such relationships are considered as detrimental to family growth and development.

Cross gender behaviors have also been noted in societies throughout time. In many cultures, individuals who express both male and female gender behaviors are not considered gay and in many cultures were even considered to be spiritually gifted, wise, and highly prized as well as protected by communities.

E. Determining Sexual Orientation



Is sexual orientation truly a personal choice or preference or is it based on sexual orientation depending on the vagaries of nature or on how a boy or girl is nurtured in childhood? Such questions continue to be controversial and promote continuous discussion and argumentation regarding such concepts.

For example, are we genetically programmed at birth to be male or female? Is a human being biologically predisposed to be homosexual, bisexual, heterosexual, or asexual? What impact does learning experiences and predispositions have in the development of sexual orientation and sexual identity?

Over the years, many theories have been developed that attempt to answer such questions. Such theories include but are not limited to:

- Learning theory
- Psychoanalytic theory
- Biological theories

For example, those who believe in the **learning theory** generally believe that behavior is learned. Such individuals also believe that conditioning also plays a large role in gender identity and behavior patterns. This theory relies on the belief that each individual learns to be straight, bisexual, or gay through a variety of learned experiences. According to this theory, homosexuals may have been oriented to such patterns of behavior through such considerations as:

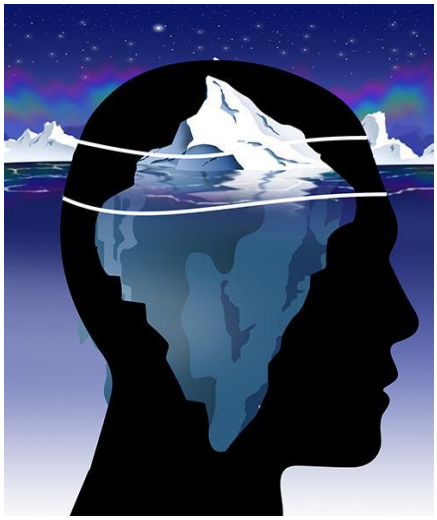
- Accidental stimulation by same-sex caregivers of genitalia
- Absence of an opposite sex partner during periods of sexual arousal
- A lack of heterosexuals skills
- Excessive attention by same-sex persons

However, such considerations may also be balanced by the fact that theorists also believe that one single experience isn't enough to reinforce same-sex attraction. Others believe that male-dominant societies and prevalence of same-sex behavior among one gender or another or a lack of influence of opposite sex family members and caregivers may lead individuals to lean toward homosexuality rather than heterosexuality during important growth and developmental phases.

However, this theory also doesn't take into consideration how individuals from strong heterosexual societies develop such sexual orientation when such behavior is not encouraged but frowned upon. Indeed, in America, heterosexual behaviors in relationships are the norm in all forms of media and social behavior expectation.

Psychoanalysis, McLeod 2007, updated 2019

Retrieved from: https://www.simplypsychology.org/psychoanalysis.html



The **psychoanalytic theory** is based on Freud's early writings regarding psychosocial development and that homosexuality is the result of over identification with opposite sex parents. Even though such theories were later rejected, the years later attempted to define men who prefer men as having been separated from their mothers at an early age and are the result of dysfunctional family dynamics. In addition, many theorists believe that homosexual behavior was also the result of dominant or overprotective mothers or passive or literally invisible father figures.

Studies in such psychoanalytic theories have recognized and now understand that homosexuality is not generated from dysfunctional family units. It can be said that good or bad parenting has little to play in the development of homosexual orientation in any individual. In addition, studies have also shown that homosexuals don't experience any increase in psychiatric disorders than heterosexuals, or that he or she is suffering from psychological distress or

poor social adjustments. In the early 1970s, the American psychiatric Association, under pressure from gay rights activists as well as the results of previous studies removed homosexuality from their list of disorders found in their *Diagnostic and Statistical Manual of Mental Disorders*.

Biological theories of sexual orientation believed that hormones, genetics, and the development of the brain play a large role in the sexual orientation of any given of individual. Indeed, hormones play a large role in how our bodies rolling developed. In many cases, many scientists today believe that exposure to antigens during fetal development plays a large role in the development of male heterosexuality or female homosexuality. For example, absence of androgens or insensitivity to such androgen hormones will more likely produce a male homosexual or a female heterosexual. However, studies throughout the 1980s and 1990s found little supporting evidence to the role of hormonal abnormalities in the development of homosexuality in males and females.

Hormonal studies then explored the potential of prenatal exposure to estrogens, but such studies involving estrogens and progestin compounds do not support such theories. Scientists then ventured into the study of how hormones may influence sexual orientation based on such hormones influence on brain structures. Research during the early 1990s determined that areas of the brain that are believed to influence sexual functions differ between homosexuals and heterosexuals, but such studies are controversial and based on assumptions related to animal studies and not humans. In addition, other biological factors such as nutrition, brain structure, physiology, and overall health also play a great deal of importance in the growth and development of the brain.

Can homosexuality be inherited? Such is the question for many who engage in genetic studies of homosexuality. In the early 1990s, genetic studies were performed on gay men who had gay brothers as well as sibling pairs and twins. However, the results of such studies are ambiguous at best. While studies produced results a high relationship of homosexuality between identical twins, evidence is lacking that make definitively state the genetic heredity plays an overriding factor in homosexual sexual orientation.

Bisexuality

Many of us may wonder how an individual may be sexually attracted to both males and females. However, bisexuality is defined as "sexual orientation in which a person may be emotionally, psychologically, and physically attracted to members of either sex." The field of bisexuality has not received much attention in regards to scientific research because more emphasis is placed on "non-normal" sexual orientation such as that considered to be expressed through homosexuality.

Many bisexuals face prejudice as well as discrimination by both heterosexual and homosexual groups. In many situations, those who express bisexual feelings and emotions are erroneously considered to be promiscuous. Sexual behavior in heterosexuals, homosexuals, or bisexuals is not defined simply by

sexual behavior but also includes and involves romantic relationships, emotions, and feelings.

Is Sexual Orientation a Choice?

The debate also continues on whether or not sexual orientation is a choice. It is understood that sexual orientation is developed through various environmental factors as well as biological, and emotional factors. Sexual relationships are hard enough to define in heterosexual societies let alone those that involve its homosexuality. Everyone experiences sexual orientation and development in a different way, with different feelings, emotions, and cultural, religious, and moral and ethical considerations.

Many members of society consider sexual orientation to be a choice, and therefore a person consciously decides whether or not to be heterosexual or homosexual. Many of these very same individuals believed that such a good or bad choice reflect on morals, upbringing, and attitude. Many believe that a poor choice, i.e., one that leans toward homosexuality, is irresponsible. These same individuals believed that since homosexuality is a choice that a person who is homosexual can just as easily become heterosexual.

However, individuals must always consider that babies do not choose the environment in which they are raised. They don't choose to be rich or poor; they don't choose what color, culture, or religion they are brought up in. In

many instances, such influences play a large role in how we view ourselves. This concept of sexual orientation places a good deal of importance on environmental situations and scenarios, and not the ideas that sexuality can be biological in nature. However, biological considerations or inborn characteristics that lean toward homosexuality are generally unacceptable by major portions of society.

Indeed, many refute comparison between biological or pathological conditions that result in cerebral palsy, cleft palettes, and varying degrees of retardation with those of homosexuality or sexual orientation. In society and cultures around the world, ideas and perceptions of sexual orientation are based on cultural as well as political values.

We will explore the concept of sexual behavior and religion in a later lesson, but for now, realize that religion and the concept of homosexuality vary around the world. Some religions have become more tolerant of the concept of homosexuality, while others continue to consider homosexuality as abnormal, immoral, and unacceptable.

Because in most religious cultures, procreation is the goal of sexual activities and anything that does not follow such goals is considered amoral. Religions such as Islam, Christianity, and Buddhism are examples of such beliefs that frown upon such relationships and behaviors. However, other religions consider various sexual activities within heterosexual relationships to be acceptable, including Judaism, some Islam sects, and some Christians, including Roman Catholics, Methodist, and Baptist, which don't necessarily accept homosexuality per se, but do not necessarily condemn individuals engaged in such behaviors.

In most religions, adultery is considered a sin, while divorce or second marriages are not. Same-sex behavior is often accepted in more liberal Christian cultures and some nondenominational churches. In some religions, gay Christians are again as ministers and some same-sex unions often receive a church's blessings.

Put it this way - how often do you hear a heterosexual being asked whether or not their sexual orientation was a choice? For example, how would you feel if you had to answer these questions?

- When did you decide to become a heterosexual?
- Why did you choose to become a heterosexual?
- At what age did you realize you were heterosexual?

A homosexual being asked the same questions will more than likely feel just the way you do when asked to respond to such types of questions. For example, you can even take it a step further. What about these questions:

- Do you think your heterosexuality is just a phase that you'll probably grow out of?
- How do you know you wouldn't prefer sleeping with someone of the same sex if you've never slept with someone of the same sex?
- Why do you engage in obvious and public displays of affection?
- Why are heterosexuals promiscuous?

Do Origins Matter?

The controversy over sexual orientation is likely to continue. Some researchers today believe that prejudice and attitudes as well as hostility targeted against homosexuals in many Western cultures may be alleviated through a greater understanding of sexual orientation. In many cases, such negativity is based on false information as well as online information regarding homosexuality.

Some researchers and analysts believe that sexual orientation is determined in a great extent by biological and genetic considerations, much like sex, race, and hair color. However, are such studies truly necessary and relevant? Does it truly matter what causes one individual to choose one gender over another when it comes to sexual preferences?

Regardless, discrimination follows many homosexual relationships into the 21st century. Nondiscrimination and antidiscrimination laws involving sexual orientation are present in less than 10% of countries around the world. Few laws in the United States protect people from discrimination dependent on their sexual orientation.

The American Civil Liberties Union offers their official policy statement (2002) that imparts states:

"The struggle of lesbian, gay, bisexual and transgender (LGBT) people for full equality are one of this generation's most important and galvanizing civil rights movements. Despite the many advances that have been made,

however, LGBT people continue to face discrimination in many areas of life. No federal law prevents a person from being fired or refused a job on the basis of sexual orientation. The nation's largest employer - the United States military - openly discriminates against gays and lesbians. Mothers and fathers still lose child custody simply because they are gay or lesbian.

Discrimination based on sexual orientation still permeates many areas of American life. Businesses openly fire LGBT employees, and every year, lesbians and gay men are denied jobs and access to housing, hotels and other public accommodations. Many more are forced to hide their lives, deny their families and lie about their loved ones just to get by. The 14th Amendment forbids discrimination of any group of individuals, and should include people of any sexual orientation. Homophobia or extreme fear or hatred of gay and lesbian individuals has led to hate crimes and abuses in the United States and around the world."

In many cultures around the world, same-sex behavior in a variety of countries carries with it a variety of punishments. For example, gay males in Kenya may be sentenced to 14 years of imprisonment, while a gay male in Nigeria or the Sudan may face death. In Jamaica, a gay male may face 10 years of hard labor while in Afghanistan, both lesbians and gay males may face death. In Bombay, gay males and lesbians may face life in prison, with equal penalties in India and Nepal. In Pakistan, gay males and lesbians may face death, while in the Middle East, countries such as Iran and Saudi Arabia also sentence practitioners to death.

Conclusion

America is a predominantly heterosexual society, though most heterosexuals have a least one acquaintance, friend, or family member who is a lesbian, gay, or bisexual, whether that knowledge is known within the family unit or not. Sexual orientation is a private and personal decision. Understanding gender roles, the differences between masculine and feminine behaviors and attitudes often influences sexual orientation. Our next lesson will focus on gender roles and viewpoints and explore the differences between masculine and feminine behaviors and attitudes as well as the impact that male and female gender roles place on our sexual growth and development.

Chapter 5: Viewpoints

Viewpoints in regard to gender roles vary according to upbringing, behavior, and attitude. We all know that men and women have different attitudes, and as a matter of fact, think differently. However, what develops distinctions between male and female behaviors or masculinity and femininity? What is it that makes us a man or a woman? Is that determination based primarily on physical makeup or sexual organs we're born with? If so, why are some men more masculine than others? Why do some girls grow up being tomboys? This lesson will seek to explain the difference in viewpoints between male and female, and masculine versus feminine.

Actually, gender roles have been stereotyped for hundreds of years, although most are oversimplified concepts of what a man or a woman should look or behave like. In many situations, such stereotypes have prevented men and

women from achieving their goals, dreams, and desires. In many cultures, gender role stereotypes have actually succeeded in defining behaviors and attitudes, which often unfortunately morph into false beliefs and conceptions about what women and men should or shouldn't do, as well as can or can't do.

For example, many believe that women cannot be successful in typical male roles or careers such as airline pilots, military personnel, sports figures, or even corporate presidents because they lack in domination, aggression, or mechanical abilities that are required for such a roles. However, women today have shown that they can and often are fully capable of performing in such rules. Regardless of the success of many women to break sex gender boundaries, stereotypes continue to persist.

Gender role stereotypes continue to be major career obstacles, for both men and women. In many situations, your gender may directly affect whether or not you are eligible for certain jobs. An equal pay is still a major problem in many career fields not only in the United States but around the world. Even today, in the 21st century, many women earn less than men for the same type of work.

Human sexuality defines all types of individuals in many aspects of gender that are not understood by many. Men and women are both equally capable of excelling in academics, medicine, politics, business, and sports, and yet we continue to see many women literally chained in place by continued stereotyping.

Gender role identification also incorporates attitudes regarding what women should or should not do. In many cultures around the world, men continue to

define the boundaries for women's work in man's work. Some behaviors that are considered fairly typical as well as appropriate for each sex differ among societies. For example, in the Middle East, it's perfectly difficult to find men engaged in occupations that are generally relegated to women in the United States.

Ask yourself this question: your friend tells you that she is expecting a child. Tests have determined the child will be a girl. Will you go out and buy that child something pink and frilly, or will you buy the girl a toy toolkit? As you can see, our concepts of gender have been ingrained in us for decades, and aren't easy to break!

Gender role stereotypes can be defined as an oversimplification or widely held belief regarding characteristics that define men and women. Despite efforts to overcome such habits and attitudes, individuals today continue to perceive gender as a specifically defined concept of identity, which can't be further from the truth.

A. Emotions and Gender Identity

Are emotions involved in gender identity? Studies seem to think so. The human population is divided into two genders: male and female. However, many men are more effeminate than others, while many women are more masculine than their peers. Have you ever tried to imagine what your girlfriend might be like if she was a man? In many cases, viewing a member of the

opposite sex in such a way is impossible, which goes to show how firmly implanted our ideas of gender roles and identity in society today appear to be.

However, gender isn't just a matter of dividing groups into male or female. Gender identity involves more than a spectrum that starts with black and ends in white. There are many shades of gray, and combinations that may be present in every given individual and every one of them can be considered normal. Sexual diversity involves many concepts of female or male identity, as what makes a man different from a woman, or the difference between masculinity and femininity.

Are you a man? Are you a woman? Do you consider yourself to be masculine or feminine? Can you be some of both? Some of these questions aren't so easily answered by many individuals. Many women have male traits, and many men also carry effeminate traits. What makes one woman want to be a firefighter and another a fashion designer? What makes a man want to be a combat soldier or a nurse? These questions aren't always easily answered, but they have to do with our concepts of gender identity. Gender identity may be defined as which particular sex in individual perceives him or herself to be.

According to research, gender identity begins around the age of four. The idea of gender is used to define feminine and masculine dimensions of human nature. Gender identity goes way beyond a sex definition of male or female. How much of your conscious thought determines masculinity or femininity? Imagine someone waking up from a coma, not knowing whether he or she

was a male or female? What if he or she were under a sheet and couldn't see their body? How would that feel? What would determine the answer, beyond physical attributes?

Every one of us is an individual and each one of us carries distant perceptions as to masculine or feminine behavior, as well as what comprises a male or female identity. Does a woman who wears men's jeans, overlarge T-shirts, and a pixie haircut make her any less feminine than a woman who enjoys wearing high heels and silk dresses?

In many cases, or individual personalities, actions, and attitudes offer a challenge to preconceptions of what is considered male or female behavior, and also expresses differing aspects of masculinity and femininity.

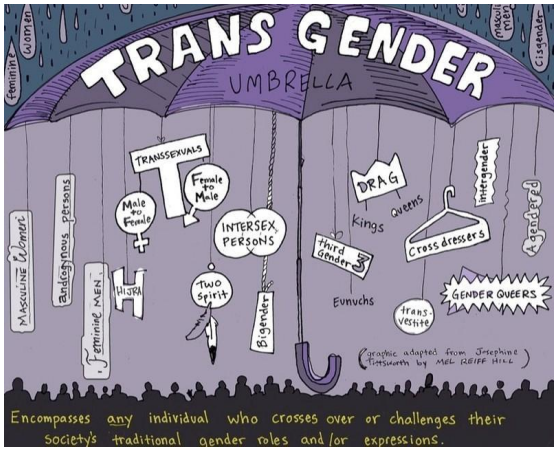
Gender roles in viewpoints are an often confusing subject within the field of human sexuality and how sexual identity as a man or woman develops in childhood, as well as how that person feels about sex and gender differences helps each of us to distinguish sexual orientations, understand stereotypes, and understand how gender influences every aspect of our lives, from our relationships to her inability to communicate with others.

B. Distinguishing Gender Identity and Sex

Retrieved from: https://www.healthline.com/health/sex-vs-gender#sexual-orientation

Today, the term gender is often confused for sexual orientation. As a matter of fact, gender personifies a specific aspect of the human condition. Our sex is determined by our biology, while gender identity is something we learned

during the course of our upbringing, as well as experiences not only in childhood but also throughout our life. Experiences in the home and our family environment influence our attitudes regarding gender identity.



Therefore, gender identity and sex are separate, but both play an important role in how we perceive ourselves. In many cases, an individual's gender identity may be opposite of their biological sex. Many men, born with male genitalia, lean strongly toward a female gender or gender identity, and the same can be said for many women who lean more toward 'manly' feelings. In many cases, men and women may dress and behave as members of the opposite sex, which is called **transgender** or **transsexual** behavior.

Psychologists have determined that personality may involve genetic and biological leanings, but gender identity is strongly influenced by attitude and experience gender is not merely male or female, but incorporates many different aspects in viewpoints. A person wouldn't necessarily identify a friend as being merely aggressive, shy, or outspoken. Individuals are not identified by such means, and the same thing goes for gender identity.

We all know that the difference between males and females is a matter of a chromosome. Females have two X chromosomes while males have an XY combination. Why chromosomes encourage male hormones to be secreted, which is why male genitalia develop on fetuses. These hormones are called **androgens**. However, the difference between male and female fetuses cannot be determined until about 12 weeks of age.

However, there are cases when fetuses develop with extra chromosomes, and some babies are born with both male and female genitalia. For example, Klinefelter syndrome and Turner syndrome produce fetuses with variations in chromosomes. In some cases, genitalia are not easily identified as being either male or female.

Klinefelter syndrome occurs occasionally in males born with an additional ex-sex chromosome. Because of this, they carry an XXY-chromosome combination, which is called Klinefelter syndrome, after the physician who studied it in the early 1940s. However, this is not to say that XXY males are aware of the extra X-chromosome. In some cases, males lived their entire life without realizing they have an extra X-chromosome, which may only be noted if the syndrome becomes active. Such individuals may experience a lack of facial hair, smaller sex organs, a more round body shape and some breast enlargement during the puberty stage.

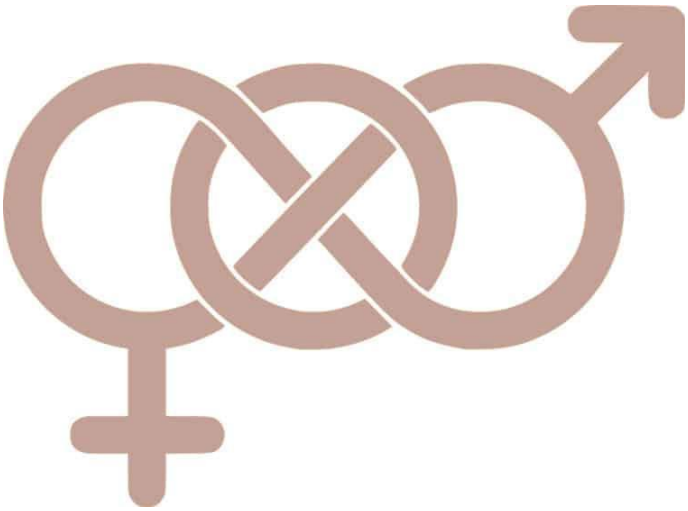
Research has shown that XXY males are typically sterile and have a higher rate of autoimmune illnesses and diseases than those who don't. In addition, males diagnosed with Klinefelter syndrome often exhibit learning difficulties and slower language development skills.

Turner syndrome is a condition that was studied in the late 1930s among female infants, which involves the result of damage to one of the pair of X-chromosomes during fetal development. In nearly all cases, female fetuses with such damage are miscarried during the first two trimesters of pregnancy. However, for those infants who survive, Turner syndrome produces kidney damage, heart abnormalities, and short in stature, arrested or absent sexual development, among others. Women diagnosed with Turner syndrome are

sterile and as they age, become increasingly at risk for osteoporosis and kidney failure.

Androgyny

Retrieved from: http://psychology.iresearchnet.com/social-psychology/personality/androgyny/



Androgyny, also known as **complete androgen insensitivity syndrome** (see AIS) is extremely rare and caused by hormonal disorder that result in genetically formed males who possess female genitals. This condition is caused by insensitivity to androgens that initiate development of male genitalia during early pregnancy. In such cases, such babies are born with female appearances, although internal testicles are present. Because of this, the child produces male testosterone, although most babies in such cases are raised as girls. As the girls grow and develop, the insensitivity to the antigens is continuous and is eventually converted to estrogen, which encourages female breast development during puberty.

Partial androgen insensitivity syndrome (PAIS) is similar to complete androgen insensitivity syndrome, but results in fetal development with lower responses to androgens within the uterus. In such cases, a baby born with

ambiguous appearing genitalia (not readily identifiable as male or female) is also known as "intersex baby".

A very small percentage of humans are born with intersex characteristics. Intersex babies are generally born with one of several conditions, which include:

- XY chromosomes, meaning genetically male, but with external female genitalia
- Genetically female (XX chromosomes) but with external male genitalia
- Genetically female, but with ambiguous external genitalia

If no genetic testing is performed, children, parents, and positions are often unaware of the condition until the child reaches the puberty stage and sexual characteristics begin to develop or not. In cases of ambiguous external genitalia, physicians may opt to alter sexual anatomy through surgical procedures to create a more normal female or male appearance. In those cases, the child is raised as the sex that has been created to such surgical procedures.

However, in recent years surgical procedures involving intersex babies have created extreme controversy. Intersex does not mean an individual is born with both female and male genitalia, but refers to an individual born with ambiguous genitalia. Why are such surgeries performed in the first place? It seems that society must have a determination of whether or not an individual is male or female in order for that individual to fit into society. Many parents question how their child will grow up in a society that does not understand such conditions. Will the child be raised as a male or female? Will the child use

a man's or a woman's restroom? How will the child eventually date and marry without a clear indication of a definite sexual identity?

C. Gender Identity Development

How is gender identity developed? While our biological sex is predetermined at conception, gender identity, meaning masculinity or femininity, maleness versus femaleness, develops in infancy and early childhood. This debate of "nature versus nurture" still continues today in determining whether or not nature or environment plays a role in the development of gender identity.

Research has determined that hormones may have some sort of impact on individual's sexual identity or orientation but such studies are difficult to quantify because everyone behaves differently, both emotionally and by attitude, to experiences and surrounding environments, as well as upbringing.

Research has relied mostly on observation of individuals who have been diagnosed with hormonal disorders, or children who have not yet developed specific gender identity during infancy or as toddlers. Hormones do play an important role on the development of gender-based behaviors. However, childhood development also played a large role in the preferences of a child's play preferences as well as playmates.

By the age of three or four, sexual identity is defined. This period will last through puberty. By this time, children are exposed to others, parents, brothers and sisters, and other family members have influenced them.

Studies have shown that infants and toddlers seem to have a preference for same-sex friends. In most situations, boys and girls seem to automatically gravitate toward separate groups, place settings, and activities. In most cases at this stage in life, boys do not like girls playing with them and vice versa. By the time they're six years old, children spend more time when same-sex friends and family members than those of the opposite sex.

Cultures around the world encourage same-sex play. In addition, such behavior is seen in the animal kingdom, most especially among primates like chimpanzees and monkeys. Therefore, it can be said that sexual biology has a strong influence on gender development, but social influence cannot be ignored. Humans are social creatures and we begin to interact with others from the moment we're born. In many cases, expectations as to gender role and identity developed the moment we are born.

For example, a parent may learn that the baby she is carrying is male or female and decorate the child's nursery in specific color schemes as well as purchasing gender appropriate clothing and toys. Have you ever been invited to the home of an acquaintance that has had a baby? Surely you have. However, what do you do when you don't know the sex of the baby and you want to purchase a baby gift? Do you buy a doll or a football? Would you buy a football for an infant girl or a doll for a baby boy? In most cases, the answer to that question is no. Why not?

Society has defined clear boundaries between male and female. If we know someone's gender, we think we have a greater understanding into how he or she behaves, and we base our expectations on such knowledge. Parents,

friends, teachers, and the media have an unbelievable impact on the development of gender role identity in today's society.

Male versus Female

A study performed by Johnson and Young in 2002 studied the media, most specifically television, and behaviors regarding gender identity. The studies determined the following:

- Men are usually more dominant than women in male-female interactions.
- Men are often portrayed as rational, ambitious, smart, competitive, powerful, stable, violent, and intolerant; women are portrayed as sensitive, romantic, attractive, happy, warm, sociable, peaceful, submissive, and timid.

- Television programming emphasizes male characters strength, performance and skill; for women, it focuses on attractiveness and desirability.
- Marriage and family are not as important to men as to women in television programs. One study of TV programming found it for nearly half the men, it was impossible to tell if they were married, a fact that was true for only 11% of the women.
- Television ads for boy oriented products focus on action, competition, and destruction, and control; television ads for girl-oriented products focus on limited activity, feelings, and nurturing.
- Approximately 65% of the characters in television programs are male (even most of the Muppets have male names and voices).
- Men are twice as likely as women to come up with solutions to problems.
- Women are depicted as sex objects more frequently than men.
- Men are shown to be clumsy and inept in dealing with infants and children.
- Saturday morning children's programs typically feature males in dominant roles with females in supporting or peripheral roles.

Turn on the television and see for yourself. Open a magazine and you'll also see a similarity in focus when it comes to ads. While we are often warned against allowing children to watch much television, studies have shown that children who are less exposed to television than others express less stereotypical behaviors and attitudes.

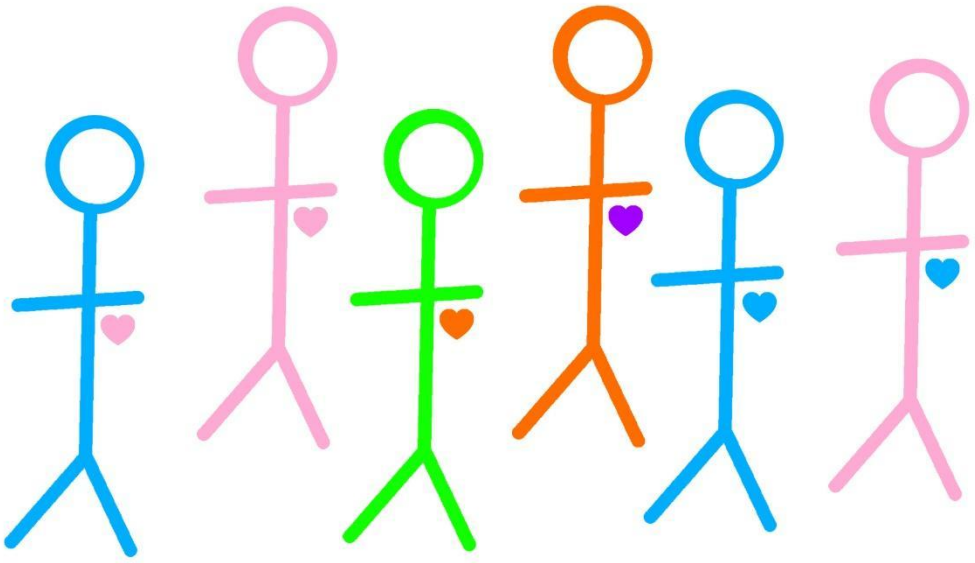
Studies have also shown that children who watch television shows where such stereotypes are broken, such as women and strong detective or police roles,

or men are portrayed as nurses, teachers, or stay at home dad, are less likely to be impacted by such gender separation lines.

However, some individuals clearly understand the difference between their gender identity and their biological sex, a condition termed as a **transgendered** individual. There is a difference between a transgender individual and a transsexual. Transgender individuals often strive to identify with concepts of identity that defy their sexual identity. For example, a biological male may believe he is somewhat or fully female in that male sexual organs are unnatural. Such an individual is called a male-to-female or MTF. A biological female who believes "he" has been born with female genitalia by mistake is known as a female-to-male or FTM individual.

Such individuals who make the decision to transition from a biological sex gender to gender identities through hormone therapies, surgeries, or dress are known as **transsexuals**. For some individuals, cross-dressing is an occasional or continuous endeavor to find comfort or stability with one's gender identity. In many cases, sexual reassignment surgery is the only hope for such individuals to feel comfortable in their own bodies.

D. Sexual Orientation and Gender Identity



Being born with male or female genitalia is not always an indication of sexual orientation. Genitalia are not what influence emotions, attraction, and behaviors. While a person may exhibit male gender identity, he may also be bisexual, heterosexual, or homosexual. The same thing goes for women. Human sexuality involves both gender as well as sexual orientation. A person's identity as well as life experiences and behaviors may rely on a single or a variety of combinations determined by biological sex, sexual orientation, and gender. For example, most biological males exhibit male gender identity and heterosexual behavior.

Stereotypes often occur when it comes to gender identity. Gender stereotypes are beliefs or solutions that people who belong to a certain sex or group are easily identifiable by various characteristics. Unfortunately, stereotypes fail to take into consideration how unique and individual people are. For example,

it's a mistake to assume that just because a child is a girl, she will automatically like playing with dolls, or that a young boy will automatically want to play with a fire truck.

In many cases, we make assumptions on how we expect people to behave in various roles. Women have long lived under the stereotype that she must be a natural housekeeper, maternal, and enjoy cooking, cleaning, and serving others. Men have long lived under the stereotype that they must be the head of a family, the main breadwinner, the strong leader of a family unit. However, there are many variations between one extreme and another. How a person learns to behave and who a person is not only based on biological sex, but on attitudes, upbringing, and desires.

Just because we expect people to behave a certain way doesn't necessarily mean that we should agree or disagree. Stereotypes do exist and will continue to exist. However, understanding how we in the West often stereotyped individuals is personified in our attitudes, expectations and behaviors within society.

Gender stereotypes limit an individual’s freedom of expression and identity. For example, certain characteristics are commonly defined as male or female. It's considered desirable in today's society for a man to exhibit characteristics such as decisiveness, confidence, strength, and independence. Women are expected to be emotional, fearful, talkative, and passive. However, such traits are considered to be undesirable by many. Women also want to be seen as strong, independent, and assertive. Unfortunately, men who appear submissive, passive or emotional produce undesirable results in society.

The stereotypes listed above that are considered feminine are also typically considered to be undesirable characteristics in both males and females. Such stereotypical attitudes are often discriminating and prejudicial against both males and females. Because each one of us is unique, each one of us should also be able to express our individuality without being stereotyped or classified by a certain name or term that defines our identity.

Gender stereotypes develop in the same pace as gender identity, and by the time children are five years old, most understand the difference between male and female behavior as well as desirable traits of masculinity and femininity.

As children venture through elementary school in junior high school, gender stereotypes and expectations grow. Many skills such as sports, mechanics, and math are defined as specifically masculine, while skills in music, art, and reading are considered to be more feminine. By the time children reached high school, gender stereotypes are firmly implanted in our brains. After school activities, jobs, and choices for recreation are generally determined according to social expectations.

Hopefully, the 21st century will see a decrease in personal as well as gender stereotypes and stereotypical behaviors. While great strides have been made toward equality not only for women but men wishing to enter traditionally female roles, stereotypes in occupational careers are still prevalent. For example, a great majority of airline pilots, architects, lawyers and doctors continue to be male, while fields of education, nursing and service-oriented careers continued to be almost exclusively female. We must always remember that gender stereotypes are influenced by life experience and may change over time, but individuals today still make the mistake of identifying men and women along gender roles and identity.

Gender and Emotions

Listed below are common beliefs are attitudes that have been divided into typically male or female stereotypes. See if you agree or disagree.

Male oriented goals:

- Demonstrating authority
- Gathering information
- Avoid asking questions
- Avoid talking about feelings
- Seek respect
- Avoid personal discussions with friends
- Seeking personal independence

Female oriented goals:

- Empathize and offer emotional support
- Continually seek harmony
- Attempt to cooperate
- Ask questions
- Seek to talk about feelings
- Seek acceptance
- Discuss personal issues with friends
- Seek a sense of shared community

As you can see, many women often exhibit male oriented goals, and vice versa. It can be said that our viewpoints regarding masculine or feminine behavior in regard to gender is greatly influenced I individual upbringing. When it comes to the nurture-nature debate, controversy over gender differences is bound to continue, but hopefully, individuals will see more overlapping between genders than a clear delineation of expected behaviors for each gender.

E. Conclusion

Most people don't spend an awful lot of time considering their gender identity. In most cases, an individual is male or female, feminine or masculine, man or woman. However,

this concept of gender is complicated and often clouded by stereotypes, upbringing, and attitudes. Becoming aware of gender issues is important in understanding human behavior, both emotionally and sexually. No one likes to be stereotyped into a certain group or classification.

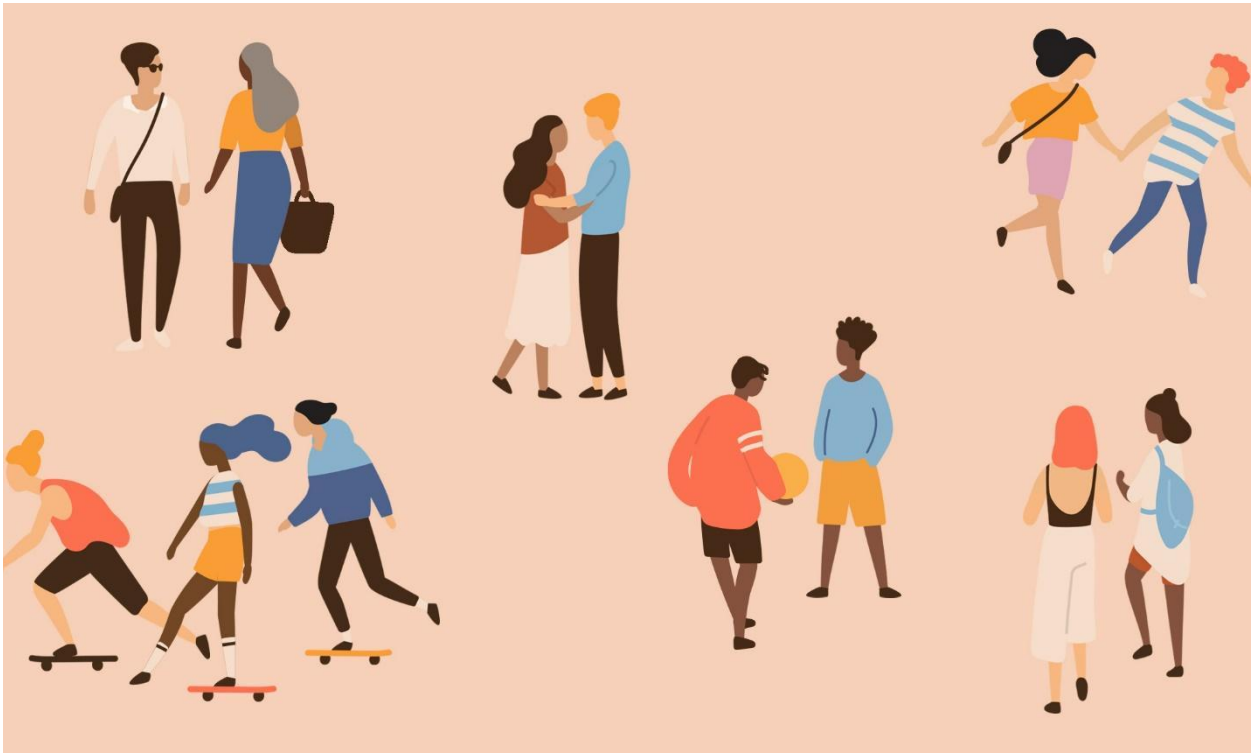
Masculinity or femininity incorporates various characteristics that may blend between genders. Being aware and accepting the diversity of genders in society today is a basic facet of human sexuality and behavior. Understanding who we are, what we want out of life and seeking pleasure, happiness and satisfaction is part of our human nature and goes much deeper than the appearance of external genitalia.

Our expectations, behaviors, and chosen roles in life are often independently decided upon regardless of stereotypes, expectations, or attitudes expressed individuals in all facets of society. Some men are effeminate, while some women are masculine. This blending of expectations and attitudes does not make them any less male or female, but enables many of us to address and understand a greater understanding of humanity.

Because of the variety of attitudes and viewpoints regarding gender, there are also many different types of relationships. Values and expectations in regard to relationships and our response to them in a variety of situations will be explored in the next lesson.

Chapter 6: All about Relationships

Retrieved from: https://www.happy-relationships.com/types-of-relationships.html



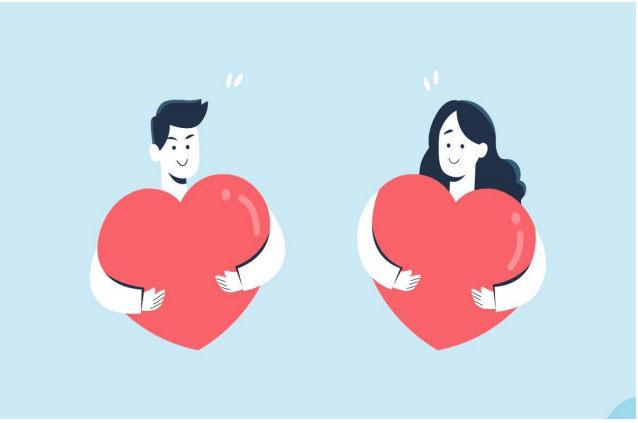
Relationships are a basic aspect of human interaction and as such, comprise many different types. Cultures around the world have different ideas, customs and beliefs regarding relationships, and different relationships also incorporate a wide variety of attitudes, traditions and expectations.

For example, in some cultures around the world, romantic love is discouraged within family relationships because it is believed that romance and love can actually damage a family unit. This damage is created when an individual places more importance on his or her own feelings within a relationship than on the needs of the family unit. Such an attitude regarding marriage and family may seem odd to individuals living in the Western Hemisphere.

In the West, romantic relationships are the reason for dating, marrying, and creating a family. They are encouraged and expected. While the search for love, companionship, and intimacy gradually develop within any relationship,

the wide disparity of attitudes regarding romantic relationships just go to show that there are many different types of relationships sought after around the world.

A. Looking for Romance?



What do you look for in a romantic relationship? Ask ten different people, and you're likely to get ten different answers. Every individual may define romance in a different way. Men and women also look at romance from different perspectives.

In addition, men and women often exhibit different behaviors and expectations when it comes to developing relationships. Invariably, most women would like to see their male partners exhibit more emotion and expression, while many men would appreciate it if women took more initiative when it came to love making and experimentation.

This is not to imply such stereotypical attitudes to every man or woman, but merely to introduce the concept of totally different attitudes when it comes to romance, relationships, and expectations among young, middle-aged, and older individuals. Indeed, such expectations may become even broader in cross-cultural relationships. Thanks to the Internet, online dating has served to introduce the blending of Western and Eastern cultures when it comes to relationship expectations, traditions and customs.

Individuals in Western countries are only now truly beginning to appreciate the difference between cultural definitions of marriage as well as what is expected of each partner in such cross-cultural situations.

B. Relationships

As individuals are unique, so too are relationships. However, common relationship patterns are often observable in any social community, and that goes for heterosexual relationships, as well as those among homosexual and bisexual individuals. Different types of relationships can be categorized as:

- Romantic/courting/dating
- Marriage
- Relationships between adult family members
- Relationships between parents and children
- Friendship

Every individual's attitudes or feelings regarding relationships will influence how he or she approaches each type of relationship. For example, gender roles and gender identity play a large role in how any given individual will approach dating, engagements, marriage, and parenting. Recent studies have shown that over 75% of Americans get married and enjoy heterosexual relationships,

although nearly 50% of relationships belong to same-sex couples with a history of monogamous behavior.

The only difference between the attitudes of such couples is a legal one. In many states, it is still illegal for gay couples to marry, although the attitudes and behaviors of such couples closely mirror those of heterosexual relationships. While such couples often designate themselves as "domestic partners" many government entities still do not recognize permanency of such relationships when it comes to paying taxes, sharing property or raising children.

Attitudes regarding same-sex relationships and marriage differ around the world. For example, same-sex couples are allowed to legally marry in Denmark and Norway, and both Sweden and Iceland recognize civil weddings and ceremonies between same-sex couples. In Hungary, while same-sex marriages are not permitted, same-sex partners are allowed to inherit pensions or property from a deceased partner.

In most cultures, men have been seen as the major heads of family and "protectors" as well as main providers for thousands of years. In most cases, this definition and division of power is often seen more in heterosexual relationships than those among same-sex couples. As a matter of fact, the relationship between same-sex couples is often founded on what can be called a very close friendship, and is more equal than many found in heterosexual relationships.

While many heterosexual couples do equally divide expectations, responsibilities and financial obligations, the division of power is often one-

sided or at least encourages the leading of “power” toward one partner over another within the relationship.

It can be said however, that heterosexual as well as same-sex couples often engage in the same type of progress of growth development and sharing. Well-adjusted couples, whether heterosexual or homosexual, often go through the same "growing pains" typically found in most heterosexual relationships. Each partner must learn how to live together with another, to give and take, to compromise, and to grow in experience and expectations.

Family Relationships

Family relationships are difficult to fit into one specific concept. Every family is different and diverse. In most cultures, the term family relates to blood relatives or legal relatives. In other cultures, as well as sexual orientation, a family may be a group of two or more individuals who are committed to each other, a family unit, or a community.

The relationship between couples in a marriage and that produced within a family unit are different. For example, the concept of love within a family unit incorporates the love we feel for a spouse or partner, and the love we feel for sons and daughters. In many cases, the relationships between parents and children are often strained, as are relationships among extended family

members. Each relationship brings with it the attitudes and expectations of each individual.

Homosexuals, bisexuals, and heterosexuals approach relationships, sexual behavior, and gender identity differently. Heterosexual relationships most often structure themselves following traditional and expected general roles, and these rules are often displayed and expected within the overall family unit. It's easy to see how upbringing, experience, and the environment can heavily influenced attitudes and beliefs when it comes to defining a relationship or a family unit.

Love and Relationships

Many of us might find it extremely difficult to envision a relationship without love and intimacy. However, keep in mind that every individual may see love as something different than yourself. Love has been written about, talked about, and expressed since the dawn of man, and fills our books, our music, and our philosophy. Love is an aspect of humanity and human sexuality that plays a very important role in our growth and development.

Have you ever met anyone who doesn't have a desire to be loved? Have you ever met anyone who claims to be perfectly content without the love or interest of another individual? Many of us automatically assume that every individual has an inborn desire to be loved, an issue that is as important as sleep, water, and sustenance.

But what, exactly is love? Again, ask ten different people and you may receive ten different answers. Even the terms “loving someone” and “being in love”

may mean different things to different individuals. Love can change over time and develop from lustful infatuation to a deep and endearing companionship with another human being.

As mentioned earlier, are expressions or beliefs regarding love for our parents are different than the love we feel for a partner or spouse. According to detailed psychologist Robert Sternberg, love involves several values or considerations that include:

- Intimacy
- Commitment
- Passion
- "Empty love"

Intimacy is defined as the greatest emotional aspect of love, which creates feelings of closeness and emotional connections and sharing. Passion is often equated with sexual arousal, while commitment is defined as in individual's conscious decision to stay within a relationship. An empty love relationship is defined as one that exists despite a lack of both passion and intimacy.

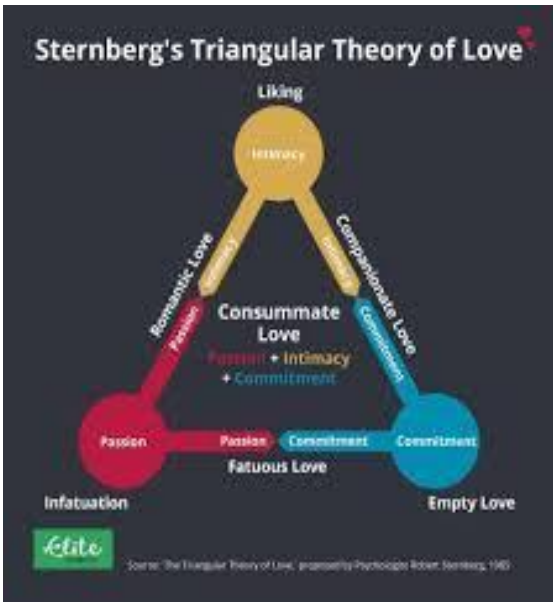
C. Sternberg's Triangular Theory of Love

Retrieved from: http://www.robertjsternberg.com/love

In the mid-1980s, a psychologist by the name of Robert Sternberg introduced his Triangular Theory of Love. Sternberg proposed that love develops when three similar yet distinct components are present in any relationship. According to him, the strength of each of those values will determine the type

of love a person will experience. If all three components are present and strong, "ideal love" will be achieved.

Sternberg believed that when a person feels intimate with someone, they share an emotional connection and an automatic desire to express feelings with one another. Passion is the force that drives one person to another and brings with it not only intense emotional feelings, but strong sexual urges as well. Basically, passion is the driving force of sexual energy found within such a relationship.

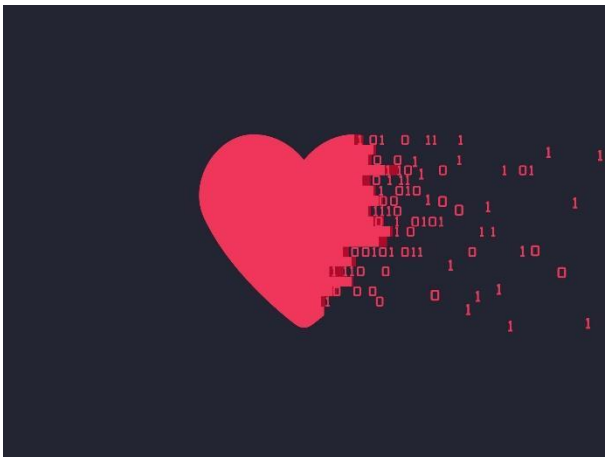


Commitment, according to Sternberg, is the mental aspect of a love relationship that is conscious and aware of choices as well as motivations. When combined, Sternberg believed that intimacy, commitment, and passion create specific types of love.

For example, according to Sternberg's Triangular Theory of Love, intimacy plus passion equals **romantic love**. Romantic love is defined by Sternberg as emotional and physical attraction to another individual without a long-term commitment. However, intimacy plus commitment equals **companionate love**. **Companionate love** is defined as a long-term relationship, almost a friendship that develops in a marriage after passion ebbs. On the other hand, passion plus commitment equals **fatuous love**. **Fatuous love** is defined as a relationship that is initially quite passionate, but lacks the intimacy that creates a long-lasting relationship. It is only when intimacy, commitment and passion joined together in equal relationships bit the ultimate, or

consummate love is achieved. This type of love is exceedingly difficult to reach.

Love Colors



Sternberg isn't the only one to introduce a love theory. In the early 1970s, psychologist John Allen Lee broached his theories on love that involved six different types of love, but while similar to Sternberg's, divided love into categories, much like primary colors. Lee's theory was introduced in an earlier lesson and included the terms Eros, Ludus, Storge, Pragma, Mania, and Agape type love.

According to Lee, the term Eros was used to define passionate love based on strong physical attraction or arousal toward another individual. Ludus is defined characteristics of individuals enjoy "the chase" of love, as well as being "in love" and "falling in love" with another. In this relationship, we believed that sexual attraction and bonds of love began as close friendships, but did not enjoy long-term results.

This theory of Lee's also proposed secondary love types; among which Pragma, Mania, and Agape were numbered. As mentioned earlier, **Pragma type love** suggested a practical love relationship that was based on logic and the advantages of being engaged in a specific relationship. **Manic love**, known as mania, is one of the processes of types of a love relationship, which often

results in possessiveness or obsession with another individual and often leads people in trouble. Agape type love, as defined by Lee, is the display of selfless love traits and characteristics that enable one person to place the needs of a partner consistently ahead of his or her own.

D. The Two-Component Theory of Love

Burscheid and Walster broached another theory on love in the early 1970s. Their theory followed that the concept of love was based on c and passion. For example, companionate love is a type of relationship that enjoys security and trust, and is similar to that introduced by Sternberg that involves commitment and intimacy. This companionate love is also similar to the storge type of love that is described by Lee's theory.

Passionate love, according to Burscheid and Walster, defines a relationship that is built on physical and sexual arousal as well as extreme emotion. According to this theory, the feeling of needing to be "in love" is the main component of passionate love.

Burscheid and Walster were not the first to introduce the two-component theory of love. Back in the early 1960s, Schachter's Two Factor Theory of Emotion defined companionate love as the direct result of equal communication within a relationship, as well as mutual liking and respect.

Regardless of who broaches theories regarding love, one thing is often agreed upon by all individuals, and that is that in order for any type of relationship or love to last, couples must be able to trust and respect each other, as well as engage in complete honesty with one another. Concepts of loyalty and support and care or concern for partners are also essential to a successful and loving relationship.

Why Do We Love?

Why are some of us attracted to certain individuals? Why do we feel such a strong desire to love and be loved? Research into human dynamics has realized the need to belong is a fundamental human desire. Humans are social, and on some level, each and every one of us want to feel included in relationships, groups, and society. In many situations, our self-esteem and confidence in ourselves is enhanced or limited by our ability to feel connected to others in a variety of situations and relationships.

But why do we love a specific person? How is it that we ultimately choose a specific individual with which to develop a loving and hopefully lasting bond? What is it that we look for in a companion, partner, or spouse? Of course, every individual is going to desire, want, or need different things in his or her life, but what are the characteristics and traits involved in finding satisfying and loving relationship the same in all humans?

Because of the growth of the Internet and the growing popularity of online dating, choosing sexual partners and potential lifelong partners is no longer limited to their **proximity**. While most of us frequently become attracted to

and fall in love with individuals we see every day at school, at church, or at work, this is not necessarily the case for everyone.

Of course, constant social interaction with specific groups or people often encourages individuals within such groups to date. Studies have shown that the chances of meeting "your one and only" are quite good that he or she may live within walking distance of your home, school or workplace.

Similarity or "sameness" is also an important factor in engaging in potentially romantic relationships. We naturally gravitate toward people who share values, cultural interests and traditions, and attitudes. As a matter of fact, the more we have in common with a potential mate, the more chances of developing a strong relationship with that individual. While there is a common saying that opposites attract, there is no conclusive research that has determined that those with dissimilar attitudes evolve into a closer relationship than those with similar attitudes.

Another important factor in deciding or choosing romantic partners is reciprocity. If we know someone likes us, studies have shown that we more likely to gravitate toward that person whose feelings we are in certain about. Knowing that another person likes or respects you helps generate an initial sense of belonging as well as helping boost self-esteem and confidence to pursue such a relationship.

What about "love at first sight?" Many people consider such a concept to be a fairy tale or a cliché. However, studies have shown that in many individuals are attracted to people we find exceedingly handsome or beautiful, and while beauty is in the eye of the beholder, today's society expresses prevalence for those who are attractive; people who have the perfect body, perfect weight, and features that cultures deem physically appealing.

Our concepts of desirability differ around the world. Regardless of culture, most men and women around the world who seek partners want to be "in love". Nearly 90% of cultures around the world follow some concept of romantic love, but that is not the only criteria for successful and long-lasting relationships. In most cultures around the world, other factors that lead to successful relationships include:

- Stability
- Dependability
- Sincerity
- Kindness
- Financial stability
- Social status
- Age

As you can see, relationships comprise a wide variety of considerations that are not limited to merely overwhelming passion or emotions. As every individual may feel different aspects such as those listed above are important in the development of any relationship, so too do cultures that express different standards of what is considered beautiful.

Preferences and physical attributes and build are often varied in different cultures and areas around the globe. For example, Western cultures such as that in the United States prefer thin women to plump women, while in Australia, aboriginal tribesmen find plump partners more attractive. Some cultures prefer women with sagging breasts, as opposed to those with firm breasts. In cultures such as India, Indonesia, and China, a bride's virginity is not only highly valued, but expected by men. However, men from Nordic countries such as Norway and the Netherlands and Sweden find virginity irrelevant.

It can be said that most cultures around the world view love as one of the most basic requirements for entering into the state of marriage. However, in some cultures such as those found in Pakistan and India, love is not an automatic prerequisite to entering into this state. In many other cultures, including those found in Thailand and Mexico, the concept of romantic love is considered to be "icing on the cake".

Some of the most desirable characteristics and traits among cultures around the world place a high importance on are dependability and emotional stability, and while most people would love to have in a physically attractive partner, standards of beauty and attractiveness differ and should be accepted and understood by anyone entering into a relationship that crosses cultural boundaries and traditions.

E. The Concept of Love Schemas

Retrieved from:
http://www.elainehatfield.com/uploads/3/4/5/2/34523593/57._hatfield__rapson_1996.pdf

Many of us continue to look for love while others seem to care less. What causes such a difference in individuals? In the mid-1990s, Hatfield and Rapson theorized that love schemas (different views or expectations regarding individuals in partners in a love relationship) are most often based or determined on comfort levels, as well as independence and degrees of closeness and desire within any given relationship.

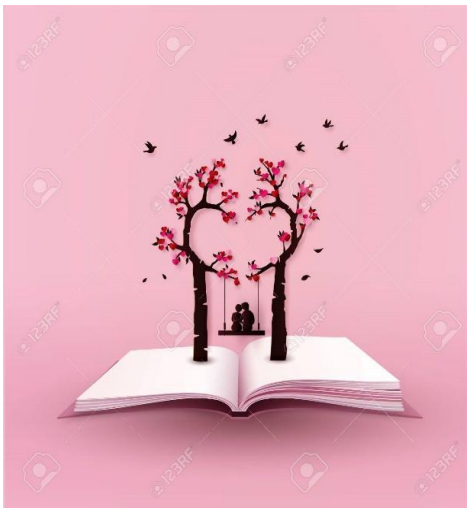
Researchers Hatfield and Rapson defined a person who seemed uninterested in any type of a romantic relationship as being totally uninterested, or only interested in casual relationships that require low maintenance. However, they described any person interested in a love relationship as being categorized into one of four groups:

- Clingy
- Skittish
- Fickle
- Secure

Secure individuals personify characteristics such as self-confidence as well as a comfort level that involves independence and intimacy. Skittish individuals are seen to be uncomfortable with intimacy, although comfortable with their "State of Independence". A fickle individual wants a loving relationship, but is uncomfortable with independence and intimacy. However, the secure individual is comfortable *and* self-confident.

Regardless of scientific methodologies that purport to define relationships into certain categories, most of us consider love to be an emotional and intensely personal journey of self-discovery that involves physical attraction, proximity, similarity, reciprocity and communication.

F. Behavior, Relationships, And Intimacy



Personal attitudes and behavior offer all of us clues as to how someone else might be feeling. There are times when many of us just want to be left alone to think, to relax, or to rest. However, voicing such requests or demands when someone is angry with you or vice versa carries with it completely different connotations. Why is that?

Many of us attribute our own perceptions and beliefs into seemingly innocuous comments or requests within social groups or relationships. In some cases, many of us tend to feel hurt or offended if a partner in some way, shape or form says or does something that seems to imply a lack of concern, feelings, or attitudes toward our own feelings or behavior.

Many of us are looking for validation with our partners, and are overly sensitive to criticism. Many of us respond to such criticism with defensiveness. However, when it comes to developing an open and well-developed physical

or sexual relationship with another individual, we must always remember to improve and enhance communication.

Think of it this way. Your partner or spouse may have done ten considerate or thoughtful things for you in the past week, but one slip of the tongue, misstep, or action can literally erase all those gestures in the blink of an eye. Because of this, couples need to learn how to control emotions in such situations in order to prevent a breakdown of communication.

Also consider that throughout any developing relationship, people can change their minds, attitudes, and behaviors. When met with disagreements between couples, many are compelled to try to fix the problem, feeling that not doing

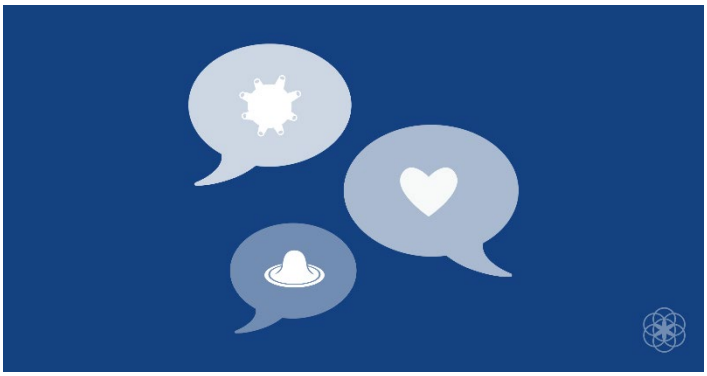
so will irreparably damage the relationship. However, couples that invariably agree to disagree often find themselves growing closer because each is able to retain their beliefs, attitudes and identity without endangering the relationship.

Men and women argue and fight differently. However, it can be said that both men and women are ultimately seeking support, affection, and acceptance. While the strategies to reach their goals may be different, both understand the end result. It's generally understood in social circles that men strive to avoid conflict, while women have a hard time accepting and understanding emotional distance from their male partners. In many cases, women perceive such emotional distance as lack of interest, care, or concern. Men generally don't tend to like to discuss problems within relationships, while women strive to discuss problems in order to repair relationships.

So how do problems get resolved? Basically, by following this five-step approach to improving communication, couples with differing attitudes regarding avenues of discussion or dialog to discuss problems may prove beneficial:

- Choose a time and place for discussions
- Focus on a specific problem and don't stray onto other subjects or disagreements
- Give each other equal time to speak. (Some Native American tribes utilized on what was called a "talking stick". Whoever held the stick spoke without interruption. When he or she finished, the stick was passed on to the next individual). Common respect for each participant in any discussion encourages open communication.
- Refrain from blame or attacks and focus on solving problems

- Agree to disagree. Agree to take breaks if necessary, before a solution has been reached. Lay the ground rules prior to such discussions and stick to them.



Sexual problems within relationships can be resolved in the same manner. Effective communication regarding sex and sexual behavior within any relationship enhances the foundation upon which successful relationships are built. **Sexual self-disclosure** is defined as *the extent to which the partners in a love relationship are comfortable with and willing to reveal their sexual desires, backgrounds, fears, fantasies, and preferences*.

Sexual self-disclosure enables both partners to express or discuss their sexual needs and desires, their fears and concerns, their questions were fears regarding sexually transmitted diseases or infections, as well as what each individual may like or dislike when it comes to sex or sexual behavior. Couples who enjoy open communication should also be able to safely express both positive and negative sexual experiences of their past, as well as sharing sexual morals and values.

While many individuals may feel uncomfortable about exposing their deepest most personal feelings, thoughts and desires regarding sexual behavior, attitudes or beliefs in relationships, doing so enhances communication and helps build the bonds that create strong and lasting relationships.

Why Relationships End

Many types of relationships encourage and stimulate both verbal, physical as well as sexual communication, but in many cases, relationships end and communication either breaks down or falters. Some of the most common reasons why relationships fail include but are not limited to:

- Low self-confidence, self-esteem, or insecurity
- Excessive jealousy
- Lying or cheating
- Isolation
- Faulty or ineffective communication
- Decision-making imbalances or power imbalances
- Control issues
- Violence

Our next lesson will focus on the sexual aspects of relationships and balances of power, and will explore the reasons that initiate or propagate a failing relationship as well as different types of abusive relationship, and the aspect of physical, emotional, or sexual assault and its aftermath in a variety of social or sexual relationships.

Understanding what a healthy and non-abusive relationship is, is often based on your sexual philosophy, as well as your ability to recognize cycles of abuse or violence. There are many different types of relationship abuse, and understanding your own sexual health and the signs of a potentially abusive relationship will be explored in detail.

Chapter 7: Sexuality and Power

Retrieved from:
https://www.researchgate.net/publication/305214179_Power_Relations_in_Sexuality

Many of us, despite our best intentions, hopes and dreams, end up in relationships that are not quite what we expect. They are a multitude of abusive relationships that involve everything from physical and sexual abuse to emotional and verbal abuse. The lines dividing such abuse are often vague. Any individual who has never experienced a violent or abusive relationship may fail to understand how something that begins with love and happiness may very well disintegrate into a never-ending cycle of despair.

Most types of abusive relationships have one thing in common: a desire to control a partner. In many cases, such control is the result of jealousy, envy, and selfishness. In many situations, more often than we think, it is often

impossible to know everything about a potential partner or spouse before you spend day after day, week after week, or even year after year getting to know them.

A. Control

Many issues of control within a relationship start off innocuously enough. For example, a spouse may question where partner has been, whether or not money was spent, or whom he or she was with. Many partners in a relationship or even a marriage may consider it typical or expected for a husband or wife to ask to see receipts, to note the dominant mileage, or to call word "check-in" every so often while not at home.

However, such issues of control are not normal and suggest suspicion, mistrust, and jealousy. It can basically be said that anyone who keeps such a close eye on someone whom they profess to love are prime examples of controlling behavior that may lead to dangerous and potentially abusive relationships.

Studies have shown that relationships that involve one partner who strives to maintain control over the other is a weak relationship that may spiral downward as it disintegrates. Such desire of control may stem from low self-esteem, jealousy, poor communication as well as ideas regarding gender and a man or woman's place within the family unit.

It should be stressed that relationships generally maintain a healthy and happy path when both partners are treated equally and are given the space to express themselves with friends, family members, or other social activities within and outside of the immediate relationship.

Control becomes a major issue when a partner's freedom or sense of freedom is decreased by the controlling behavior of another. For example, a husband may specify when, where, or who their partner may go out with. This type of personality may also demand that the partner relate every detail of what occurred, what was said, and what was done while that partner is a way from the home.

Such examples of control may also be expressed by one partner not allowing the other to stray from expected schedules, or one who is expected to be home at a specific time every day. In many such cases, such individuals also threaten reprisal for "disobedience".

Constantly checking up on a partner or spouse during class, on a college campus, or at work are prime examples of controlling behavior that is spiraling out of control. Maintaining complete control over bank accounts and paychecks is another aspect of such controlling behavior as is threatening intimidation or physical abuse if the partner threatens to leave the relationship.

Another type of controlling behavior is verbal or emotional abuse. Such abuse can take form of constant criticism, putting the other partner down, and name-calling. In most relationships, while the controlling partner seems to be in

charge, in most cases, they are individuals with low self-esteem, confidence and may be considered the weaker of the two.

No one wants anyone to have such control over his or her life. Controlling partners generally instill a sense of unhappiness that continues to grow until the relationship may eventually fall apart. It's a vicious cycle of insecurity and control that continuously repeats itself until a person may literally feel as if he or she is living in a prison.

In many cases, the line between control and physical abuse is a fine one. Controlling partners in a relationship almost always invariably cross the line into physical violence that includes but is not limited to throwing objects at the person, threatening violence, pushing, slapping, and more. While not all such types of relationships that involve control issues become violent, the vast majority of them do.

B. Domestic Violence

Retrieved from: https://courses.lumenlearning.com/wm-introductiontosociology/chapter/violence-and-abuse/

Domestic violence is defined as any type of violence within the relationship that involves two people or family, whether or not those people live in a dorm room, an apartment, or a home. Domestic violence is not limited to married couples, but occurs within

all types of relationships. In many cases, domestic violence is accompanied by sexual aggression.

A person's ability to recognize and understand the signs of potentially violent or abusive relationships will help individuals stay away from destructive and dangerous situations. The ability to recognize such situations as soon as possible may help to prevent harm and abuse. While many women, and some men, continually hope for improvements within such a relationship, finding the strength and determination to walk away is often one of the only ways to escape physical harm, continued abuse, and in some cases, even death.

No one plans on entering a violent relationship. In many cases, an individual may not realize that he or she has been dating someone with violent propensities. In such situations, the courting process has gone smoothly and partners have expressed nothing but love, gentleness, and affection with one another. Often however, after the marriage vows have been declared, many women often find the men of their dreams have suddenly morphed from knights in shining armor to monsters and ogres.

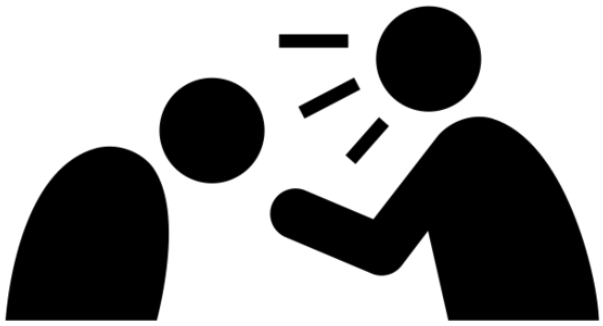
Before we get any further in this lesson, be assured that help is out there for victims of domestic violence. One such organization, called the National Domestic Violence Hotline, is available 24 hours a day and offers information and crisis assistance to help any individual find a local, safe shelter, health care resources, counseling and even legal assistance. This resource can be accessed at 800-799-SAFE (799-7233), or by visiting the Internet website at www.ndvh.org

C. Abusive Relationships

Abusive relationships come in many different shapes and forms. In some cases, abusive relationships can take years or decades to develop. Because the degree and type of abuse in such a relationship often depends on the individual, situations, and location, it's difficult to come up with a definitive description of relationship abuse.

Each person's experience of abuse would differ from another's. Relationship abuse is often categories into three types:

- Verbal
- Emotional
- Physical



Verbal abuse is defined as attacks with words. In many cases, verbal abuse has been shown to initiate extreme psychological and emotional damage to those on the receiving end. Most expressions of verbal abuse come in the form of humiliating comments, accusations, and belittling comments. Even though verbal abuse is not considered physical in nature, the effects are long lasting. Many children who have been verbally abused carry the effects of such abuse with them well into adulthood. Verbally abused spouses often exhibit low self-esteem, low self-image, and an overwhelming sense of powerlessness or fear.

Verbal abuse is defined as any type of verbal interaction that includes mocking, trivializing, name-calling, intimidating, ridiculing, yelling, threatening, insulting, and so forth.

Emotional abuse takes a massive psychological toll on an individual and differs from verbal abuse because it focuses on the victim's feelings and emotions. Emotional abuse is often times considered more difficult to recover from then verbal or physical abuse. It has been said by experts that broken bones and cuts and bruises mend faster than deeply inflicted wounds caused by emotional abuse that initiates feelings in a victim of unworthiness, blame, unattractiveness, and undesirability.

In many cases of emotional abuse, the abuser takes advantage of his or her ability to manipulate and control a partner's emotions and feelings. Intimidation may include and is not limited to threatening with physical harm, destroying personal property, or threatening or actually injuring friends, family members, or even pets of the individual.

Some of the most common forms of emotional abuse are expressed in the following types of communication:

- Why would I want to touch you?
- Why should I tell you what I'm thinking?
- You better do what I say.
- You're not worth my time.

- Stop complaining, you're not hurt.

Such communications also often imply threats if directions, commands, or demands are not met or followed.

Any type of abuse that takes on physical form characterizes **physical abuse**. However, it should be understood that not all types of physical abuse in a relationship necessarily imply slapping, hating, broken bones, bruises, bleeding, or trips to the emergency room. In many violent relationships and domestic violence scenarios, man, and sometimes women, cause invisible damage to others.

Many instances of violence and domestic abuse involve spouses or partners that do hit and cause bruises, cuts, scrapes, and bleeding, but on body parts that are not necessarily exposed to others. In some cases, a violent partner may twist or grab a limb, which causes pain without leaving noticeable injuries or bruising. In many cases of domestic abuse, victims don't show outward signs of physical damage.

Physical abuse is considered to be anything that involves contact, such as choking, punching, biting, changing, holding someone down against their will, sexual abuse, rape, physical intimidation, raising fists, or blocking a victim's ability to escape from any situation.

Common Signs of Relationship Abuse

A publication released by Project Sanctuary offers a brochure and asks questions that may lead any individual to recognize whether or not he or she may be involved in an abusive relationship.

Signs you may have an abusive partner - if you think you may be the victim of a violent relationship, ask yourself the following questions:

Are you...

- Frightened at times by your partner's behavior?
- Afraid to disagree with your partner?
- Often apologizing to others for your partner's behavior toward you?
- Verbally degraded by your partner?
- Unable to see family or friends do to your partner's jealousy or control over you?
- Afraid to leave your partner because of threats to harm you or to commit suicide if you do?

Do you...

- Feel as if you sometimes have to make up excuses to justify your behavior to avoid your partner's anger?
- Avoid family and social functions because you're afraid of how your partner will behave?

Have you been...

- Shoved, hit, pushed, choked, grabbed, physically restrained, intimidated, humiliated, put down, threatened, ridiculed, or attacked by your partner or thrown objects?
- Forced by your partner to engage in sexual acts against your will?

While the above are the most common signs of potential abuse or ongoing abuse within a relationship, some relationships may be headed down such a path before a partner can recognize the signs of a developing cycle of abuse or violence.

D. Violence and Abuse Cycles

A **cycle of violence** is defined as *a repetitive pattern of stages that define most abusive and violent relationships, cycling through the honeymoon stage, the tension-building phase, and the explosion of violence, followed by a return to the honeymoon stage, and the beginning of a new cycle.*

Break the Cycle
Because Everyone Deserves a Healthy Relationship

Cycles of violence generally develop over long periods of time. In many cases, the victims of domestic violence are typically unsure of when the pattern of behavior began, because it begins so gradually. In many cases, victims of emotional and verbal or psychological abuse don't recognize that he or she is in the grip of such a cycle until things become more heated or violent.

Most abusive relationships follow a certain pattern that includes:

- the honeymoon phase
- the tension building phase
- period of violence
- return to honeymoon phase

However, most abusive relationships follow basic cycles that are often predictable, and will continue unless someone intervenes. Most relationships start off exciting and full of hope and happiness. This is generally considered to be the **honeymoon phase** of intimate relationships.

In many relationships, situations and events arise that inevitably cause tension between partners, and this is to be expected, but the difference between a healthy and an unhealthy relationship is that a healthy bond between two individuals who enjoy open communication is able to resolve such situations or offense through rational discussions. Unfortunately, this type of approach to solving problems and crises fails in abusive type relationships. In many cases, unresolved disagreements build tension (**tension-building phase**) that increases over time. Whether disagreements are over sexual relationships, finances, or work, one partner soon finds him or herself continually giving in to the other partner in order to maintain peace.

In many cases, this continued scenario of "surrender" on one half of the partnership might keep the peace, but only for a while. In some cases, one person in a relationship may need to endure this tension-building phase of the

abuse of cycle for weeks, months, or even years. In many situations, if the "submissive" partner doesn't give in, insults, criticisms, and verbal abuse typically follow. This aspect of intimidation and bullying by an abusive partner often encourages the other to submit to his or her wishes for fear of ongoing anger, verbal or emotional abuse, and in some cases, physical abuse.

Studies have shown that relationships that often include threats and insults personified by the tension-building phase nearly always erupt into **physical violence**. After the first display of physical intimidation, threats or violence, abusers most often express their sorrow, promises that it will never occur again, and beg forgiveness. For a while, the abuser is generally sorry for his or her behavior, and often buys gifts for the abused partner as well as bends over backwards to make sure life at home "returns to normal". In such a manner, the relationship reenters the honeymoon phase and the cycle starts all over again.

Unfortunately, for most partners on the receiving end of such violence, the honeymoon phase is a mere façade. Many victims of such abuse live in fear every day and literally "walk on eggshells" waiting for the other shoe to drop. He or she may be continuously afraid of what may set the partner off in the future, and avoid situations or activities that may trigger and increase tension that leads to violent explosions.

Often, signs of a potential abuser are obvious, while others are less so. Some of the most obvious warning signs of a potentially abusive individual include the following characteristics. An abuser:

- commonly uses threats of violence with others
- displays controlling behavior

- isolates partners from friends and family members
- continually blames others for failures or problems
- displays signs of excessive jealousy
- breaks, hits, or throws objects when angry
- displays anger or criticism when criticized him or herself
- experiences extreme "Jekyll and Hyde" moods or reactions
- often displays force or power in sex that is disguised as "play"

E. Assault and Its Aftermath

One of the most common forms of physical abuse in any relationship is a sexual assault. In many scenarios and situations, stronger partners often coerce or force weaker partners into sexual behavior or acts and use threats of violence, violence, or outright force to get his or her own way.

Sexual assault is defined as coercive sexual content that doesn't necessarily involve intercourse. Sexual assault is commonly known as rape, acquaintance rape, and statutory rape. **Rape** is defined as *the occurrence of sexual intercourse by force or threat of force without the consent of the person against whom it is perpetrated*.

Yes, a partner or spouse who takes advantage by force or threat has committed sexual assault or rape upon the partner. While many cultures and societies around the world frown upon the concept

of a husband raping a wife, the truth is that any unwanted or undesired sexual activity between two individuals is considered sexual assault.

The concepts of acquaintance or date rape are difficult for many people to grasp, and is one of the most well-known forms of rape that defines non-consensual sex between two individuals. Unfortunately, date rape and acquaintance rape is also a type of rape that is least likely to be reported to authorities, most often because the victim herself is hesitant to define the act as rape.

Marital rape is also considered to be a form of acquaintance rape and involves any husband who forces of sexual intercourse on his wife. In most societies, and even in America up until the 20th century, women were considered to be the property of husbands and fathers, who had the right to do what they wanted with such property. Indeed, women had very few rights, and until recently (the late 1980s), couldn't prosecute a husband for rape.

Today, 48 states have laws covering marital rape, although a majority of them carry exemptions such as that a wife and husband must be legally separated, or have filed for divorce, or living separately at the time the rape occurred in order for the husband to be charged and tried for the act. Unfortunately, marital rape is not considered to be a very serious problem, and many make the mistake of believing that the emotional, psychological and physical results of such activities that take place in the marital bed are somehow less severe

than the experience or reactions of an individuals who experiences 'stranger' rape.

Sexual Abuse Patterns

Sobsey, D., Doe, T. Patterns of sexual abuse and assault. *Sex Disabil* **9,** 243–259 (1991). https://doi.org/10.1007/BF01102395

Sexual abuse often follows specific patterns. In some cases, victims of sexual abuse become abusers themselves. In the 1970s, social services departments including child welfare workers and mental health workers and providers became aware of a growing need to aid and support victims of childhood sexual abuse and incest. **Childhood sexual abuse** is defined, very broadly, as any sexual interaction between a child or adolescent and adult or a more knowledgeable child that can but does not always involve physical contact.

Incest is defined as a sexual activity between a child or adolescent and a relative, most commonly parents, foster parents, stepparents, a parent's live-in partner or lover, as well as extended family members.

Sexual abusers, whether they are children or adults, come from all socioeconomic backgrounds, ages, and races. However, studies have also shown that roughly 80% of sex abusers of children are known by the child or are family members of the abused child. In fact, most child molesters are

friends, teachers, neighbors, or other community members known to a child. While nearly 90% of child abusers are male, women also initiate sexual abuse upon children, though such instances are rare.

Girls are traditionally considered to be a greater risk for sexual abuse than boys, and studies released in the late 1990s reveal that nearly three times as many girls as boys are sexually abused, most probably because girls betray a greater risk for victimization than males. For example, such risks can include but are not limited to a mother or father's inability to constantly monitor a child because of disability, employment, or illness, or those living in homes where marital conflict exists between parents, as well as relationships between children and parents that are not ideal. Individuals exposed to excessively strict or abusive parents, as well as those having stepparents in the home are also risk factors.

Sexual Abuse and Its Psychological Impact

Victims of sexual abuse, regardless of age, often experience anxiety and anxiety disorders such as depression, and posttraumatic stress disorders. Such individuals often also experience decreased self-esteem, aggressive behaviors, overall behavior problems and anger. Children especially develop such behaviors, including sexually inappropriate behavior among peers.

The long-term and psychological impact of sexual abuse cannot be over emphasized. Any individual with a history of abuse may experience

psychological problems, poor self-esteem, inability to maintain healthy relationships and are often more likely to become victims of sexual abuse in their future, as well as sexual maladjustments, self-destructive behavior, eating disorders and substance abuse.

Sexual harassment is also considered an abuse of power of spouses, employers, and peers. Sexual harassment is defined as *any deliberate or repeated pattern of sexual advances that are unwelcome and/or other sexually related behaviors that are hostile, offensive, or degrading to the recipient.*

Sexual harassment can take the form of touching, cornering, suggestive comments or gestures, letters, telephone calls, teasing, remarks and jokes. The United States Equal Employment Opportunity Commission (EEOC) has defined clear guidelines that describe unwelcome physical conduct of sexual natures or unwelcome verbal comments as sexual harassment when:

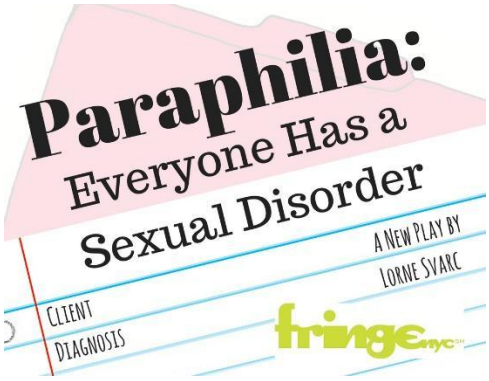
- an individual's rejection of such conduct, or submission to such conduct, is used as a basis for employment decisions
- the unwelcome conduct interferes with an employee's work performance or creates an intimidating, hostile, or offensive working environment.

Because men and women view sexual harassment differently, guidelines in place by various employers in the workplace must be clearly defined. However, most men and women do agree that pressuring others for sexual favors or deliberate touching or "invading another person’s space" can be considered sexual harassment when such behaviors are obvious and overt, but lines are still blurry regarding more subtle forms of sexual harassment that can be construed by many as mere friendliness or camaraderie.

Atypical Sexual Behavior

No study into the basics of human sexuality would be complete without at least briefly touching upon the subject of atypical sexual behavior. **Atypical sexual** behavior is generally defined as "not normal" or "deviant". However, like other aspects of sexual development and behavior, public standards and cultural beliefs cannot often specifically determine whether or not such behavior is considered normal or abnormal.

Because most individuals define normal sexual behavior according to their own beliefs, it's often difficult to state whether or not such behavior is atypical. As a matter of fact, some states actually define what types of sexual activity is atypical or deviant, which are most often described as what is publicly or culturally acceptable in modern society and what is not.



Sexual deviations are also known as **paraphilia**. For people suffering from such deviations, discomfort, anxiety and guilt are common psychological side effects. Actually, paraphilia incorporates a multitude of sexual deviant behaviors, which may be categorized as:

- **Fetishism** - sexual arousal often associated with inanimate objects
- **Pedophilia** - more commonly known as child molestation, or having sex with children

- **Voyeurism** - often known as a "peeping Tom"
- **Exhibitionism** - most commonly defined as flashing or inappropriately displaying genitals to unsuspecting and unwilling individuals

Of course, there are more, including **sexual masochism** and **sadism**, which is the desire to experience or inflict pain upon a sexual partner, and transvestite fetishism, which is defined as achieving sexual arousal by wearing the clothing of the opposite sex.

Child molestation is a severe and serious crime committed in any culture. Studies have shown that child molesters are typically male and are often married. Many child molesters are actually fathers, and many express religious, rigid, or passive character traits. Studies have also shown that nearly two thirds of all cases of pedophilia occur through an acquaintance, relative, or friend of the child. In many cases, child molesters are considered to be rapists, although the general term of molestation rarely exceeds fondling activities.

Recognizing the signs of child molestation is important for social workers, service providers, teachers, parents, and neighbors. The most basic signs of child molestation include:

- A child is especially hesitant to be seen nude when such hesitancy or fear was previously absent.

- The child expresses physical complaints like stomachaches, headaches and other symptoms typically associated with stress.
- The child begins to express signs of anxiety, fear, shame, discomfort or other signs of discomfort or embarrassment when hearing references to sex or sexual behavior.
- The child begins to express comments of self-deprecation or self-blame, suicide or self-destructive actions or attitudes.
- The child becomes irritable or emotionally unstable, when such behaviors were non-existent in the past.
- The child begins to engage in risk-taking behaviors or activities.
- The child begins to express or exhibit obvious signs of loss of self-esteem and self-worth or self-confidence.

How do Most Child Molestations Occur?

In most cases, a child molester looks for specific children or scenarios that will enhance his ability to nab a child or to engage in atypical behaviors. Such situations include but are not limited to the fact that:

- The majority of child molesters act alone
- Many child molesters are actually child care providers
- Most molestations take place in the abuser's home
- Child molesters try to encourage children to engage in such behaviors through persuasion, touching and even talking about sex with older children through Internet contact

- Child molesters often use threats of abuse or force or punishment to compel children to comply with their wishes
- Many child molesters bribe children with promises of gifts or money

The long-term results of child molestation often follow children into adulthood and leave emotional scars that inhibit such an individual's engaging in "normal" sexual relationships with others. Such emotional scars also involve hesitance or inability to trust, to get close to someone, or to enjoy sexual relationships.

Some types of atypical sexual behavior don't hurt anyone. Others do. What goes on behind the closed doors of many adults is their own business as long as each partner willingly engages in such behavior, while others promote harm, both physically and emotionally. However, pedophilia, voyeurism, exhibitionism and child molestation do cause permanent and lasting harm in many and victimizes unwilling participants.

F. Conclusion

Distributions of power within home environments, schools, college campuses, and workplace environments are not always clearly defined. In many scenarios throughout the United States and the globe, sexuality and power are closely linked. Regardless of location, demographic, race, or age, individuals who understand the dynamics of

healthy sexual relationships may help to avoid entering into potentially abusive relationships by understanding behaviors and attitudes of potential partners.

Sexual assault, regardless of form, as well as abuse, regardless of whether it's physical, emotional, psychological, or verbal, leaves a lasting impression and impact on its victims. Breaking the cycle of violence in many relationships requires individuals to educate themselves and to rely on family, friends, and social services offered in communities to break away before such abuse results in irreparable damage and in some cases, death.

In many cases, the cycle of violence can be broken when a person takes a stand against such power plays and abuse, but regardless of the situation anyone finds himself in, it's important to remember that help is out there.

In many cultures and traditions around the world, concepts of sexuality are tied closely with religious faith and beliefs. Our next lesson will explore the sometimes-uneasy relationship between religion and sexuality in American culture as well as those found around the world. Diversity in faith, religion, and beliefs regarding sexuality and sexual development plays a large role in how couples in different societies date and marry.

In addition, concepts involving conception, pregnancy, and birth play an important role in the growth and development of healthy sexual relationships. Religious beliefs regarding conception, pregnancy, abortion, and birth control will also be explored in the next lesson.

Chapter 8: Religion and Sexuality

Religion plays an enormous role in the sexual growth and development and attitudes of many people. Whether that religion is founded in Christianity, Hinduism, or Islam, religious beliefs, concepts, and attitudes have a definitive role in the development of attitudes and perceptions within the field of human sexuality.

This lesson will briefly describe various concepts involved in the world's most popular religions. From Catholic and Unitarian attitudes and perceptions regarding sexual growth, relationships, and those espoused by Islam or Hinduism, it is easy to understand why traditions, culture, and heritage can have such a large impact on how any given individual views sexuality, gender roles, taboos, and more.

A. Human Sexuality and Christian Beliefs

Christianity incorporates a multitude of faiths and beliefs. From Catholicism to Lutheranism, Protestantism, Unitarianism, the Christian Fellowship in the United States and around the world offers blends of liberalism, conservatism, and everything in-between when it comes to ideas regarding sexual behaviors and faith.

The Bible commands reaches of the Earth's to "be fruitful and multiply". Indeed, throughout history, and in Biblical writings, God appears to approve regarding human sexuality and reproduction.

For example, Biblical verses encouraging reproduction are found throughout the Old Testament, most frequently in the book of Genesis:

Bring forth with thee every living thing that is with thee, of all flesh, both the fowl, and of cattle, and of every creeping thing that creep up upon the earth; that they may breed abundantly in the earth, and be fruitful, and multiply upon the earth. And God blessed Noah and his sons, and said unto them, be fruitful, and multiply, and replenish the earth (Genesis 8:17; 9:1).

I am God Almighty: be fruitful and multiply; a nation and a company of nations shall be a fee, and kings shall come out of thy loins (Genesis 35:11).

It can be said that many passages found within the Holy Bible exude romance and the intimacy of human relationships, including the Song of Solomon. The Holy Bible is also one that makes its point regarding human sexuality and behavior clear to readers. Sexual terms, stories, and expectations when it comes to sex and sexual behaviors and relationships have made it clear that sexual interaction is part of the human condition.

Many passages within the Bible are commentaries on the hypocrisy of humanity through the ages. According to Christian belief, God created the earth and everything on it, including humans, and every aspect of human growth and development, including human sexuality.

Sexual attitudes and behavior have changed over the centuries, but one aspect of humanity cannot be denied, and that is that the world's oldest profession (prostitution) has been around since the dawn of man. During the Middle Ages and well into the Victorian era, sexual behavior was considered sinful for many Christians. As a matter of fact, by the eighth century, inhabitants throughout Europe were severely penalized and punished for anything that was considered immoral sexual behavior.

Martin Luther, a major force in the Reformation, attacked such beliefs and attitudes by proclaiming that God did not save by the works of man, but through grace. Martin Luther, a former monk, eventually married and had children. Luther, like others of his time, believed that human works and efforts such as fasting, good works, depriving the body, sexual abstinence, self-effort, and church donations (for the express purpose of gaining favors from God) did not contribute toward man's salvation, but that such salvation was gained from the grace of God. *Not by works of righteousness which we had done, but according to his mercy he saved us, by the washing of regeneration, and renewing of the Holy Ghost*" (Titus 3:5).

"*For by grace are ye saved through faith; and that not of yourselves: it is the gift of God: not of works, lest any man should boast*" (Ephesians 2:8, 9). The mass of Christians today believe that man can be saved only through faith in Jesus Christ and that salvation is a free gift from God.

Today, beliefs within the Christian faith as well as Roman Catholic Church doctrine has ever so slowly begun to turn away from anti-sexual teachings. Many Christians today accept their human sexuality as a natural gift of God as well as one that has been God ordained. In 1981, Rachel Moss edited a

documentary report created by the British Council of Churches, which says in part:

Sex is created and instituted by God in the very beginning! God is the author of genuine pleasure, genuine happiness, genuine fleshly satisfaction, even sex!" All things were made by Him, and without Him was not anything made that was made" (John 1:3). Including your sexual organs, your body, and every part of you. If sex is a sin, then God is a sinner, because He made it and He created us to have it and enjoy it!

God is the God of the body, the God of sex - He made your flesh in His image! "God created man in His Own image, in the image of God created He him; male and female created He them" (Genesis 1:27). Praise God for sex! He created it!

Over the centuries, church board members and policymakers have begun to either reject or accept sexual teachings and practices that have developed over centuries of tradition and beliefs. In many instances, it is believed that negative teachings regarding sex were to blame for literally driving many individuals away from Christian churches and fellowships because of the over-emphasis on guilt, shame, confusion and frustration.

One particularly outspoken individual, Matthew Fox, a former Dominican priest, believed that the Catholic church’s obsession and focus on sin, sex, and celibacy was an early driving force behind the attitudes of early traditional church teachings that generated and stoked many of today's attitudes

regarding women and sex. Indeed, in early Catholic teachings, women and sex were often the focal point of blame for immorality, diseases, and unfaithful or unclean leanings, as well as leading individuals away from God.

Today, attitudes continue to change. Indeed, concepts of intimacy, love and affection are often used in therapeutic psychological and physical treatments for many. Christine E. Gudorf, author of *Body, Sex, and Pleasure: Reconstructing Christian Sexual Ethics* writes, "Sex is pleasurable in many different ways. Mere body touch is pleasurable. Another person's touch on our skin normally releases chemical compounds called endorphins, which function as painkilling anesthetics. We actually seem to need the pleasure of touch. Infants denied physical touch do not thrive. They do not grow, do not eat or sleep well. They do not develop normally intellectually and emotionally... elderly persons who are touched affectionately often retain their health and their alertness much longer, and complained of pain less than those deprived of touch. The therapeutic aspect of touch is one reason for the popularity of massage."

Religious concepts involving sexual behaviors, attitudes, and beliefs, as well as what is generally considered acceptable or unacceptable is defined by religious doctrine, tradition, and each individual's personal faith. For example, in many religions, extramarital sex is frowned upon. So to are same-sex relationships, bestiality, and prostitution, just to name a few. Concepts of adultery and promiscuity are often at the base of morality lessons found both in the Holy Bible as well as in many church doctrines.

As with many other religions and faiths, the concept of human sexuality doesn't often coincide with religious teachings and expectations. However, according to David Brent Berg:

"The measure of a sexuality that accords with the New Testament is simply this: the degree to which he rejoices in the whole creation, in what is given to others as well is to each of us, while enabling us always to be the final word to God, who is the beginning and end of all things.

Sex is created and commanded by God for your enjoyment, unity, fellowship, procreation, and a type of his own relationship with us in the spirit. God uses sex as a tool to keep men and women together in beautiful harmony and having children and families and a happy, loving home. He wants you to have sex not only for your own physical enjoyment and satisfaction, but also to produce human beings, immortal souls for the kingdom of God!"

B. Buddhism and Sex

Retrieved from: https://www.learnreligions.com/sex-and-buddhism-449730

Buddhism is a religious belief practiced around the world, with originations in the Orient. Buddhism is a faith that doesn't advocate extreme permissiveness or Puritanism, but teachings within this faith believe that Buddha understood human nature and knew that humans were sexual in nature. Therefore, the Buddhist attitude and outlook generally encourages the following behavior pattern for young men:

He avoids unlawful sexual intercourse, and abstains from it. He has no intercourse with girls still under the protection of father or mother, brother,

sister, or relative; nor with married women, nor female convicts; nor lastly with betrothed girls.

For many Buddhists, sexual feelings or offenses aren't necessarily considered wicked, and that failures to live up to expectations regarding sexual behavior are no more or less serious than failures to live up to other guidelines and expectations of the Buddhist concepts of existence.

Unlike Christianity, Buddhism does not create commandments for men to follow. On the contrary, "it is an undertaking by you to yourself, to do your best to observe a certain type of restraint, because you understand that it is a good thing to do. This must be clearly understood. If you don't think it is a good thing to do, you should not undertake it. If you do think it is a good thing to do, but doubt your ability to keep it, you should do your best, and probably, you can get some help and instruction to make it easier. If you feel it is a good thing to attempt to tread the Buddhist path, you may undertake this and other precepts, with sincerity, in this period."

For example, there is a similarity between Christianity, Judaism and Buddhism when it comes to adultery. Traditional Christian attitudes regarding sexual intercourse are that it is permissible within a marital bond and relationship. Other than that, sexual behavior for other means than procreation grows complicated in regard to homosexual behavior and the desire for contraception.

Buddhist attitudes regarding sexual pleasure as sinful are not as clear as those found in other faiths. The concept of sin is not particularly applicable in Buddhism, which believes and relies on the Five Precepts rather than say, the structure of the Ten Commandments. On the contrary, Buddhist attitudes rely

more on concepts that "sexual indulgence is not wicked, but it may be in some degree inadvisable." In all things, moderation is advised.

The Buddhist religion, like others found throughout the world, has developed basic ideas regarding marriage. However, while Christianity considers marriage as a "sacrament", Buddhism generally "blesses" a couple after a civil wedding ceremony. Basically, Buddhists believe that a couple's desire to practice contraception is their own business, but there is no Buddhist teaching that either bans or approves it. However, abortion is not condoned, as it is contrary to the First Precept. Only in cases of serious health hazards is abortion condoned.

Like Christianity, adultery is frowned upon in the Buddhist religion. While some Buddhists do not consider adultery to be specifically wicked, Buddhists are encouraged to "behave themselves sexually" as in other respects and aspects of their environment and to display and exercise charity when it comes to the faults or lapses of others.

In many cultures around the world, it has been acceptable for boys, but not girls, to engage in sexual behavior before marriage. Buddhism teaches that most human beings make mistakes. Self-restraint is advised!

Sex and religion within the Buddhist, Christian and Roman Catholic Church, as well as Islam, Judaism and other religions around the world are often different, although at times, attitudes and religious laws regarding sexual behaviors are quite similar.

In the Buddhist faith, sex is an expression, though sexual restraint is encouraged to avoid cravings and lustful thoughts. Irresponsible sexual

behavior, in the Buddhist religion, may cause harm to others, bring unwanted children into the world, and affect other people's emotional and psychological peace and security.

According to the Tibetan Book of the Dead, individuals "whose karmic predispositions destined them for rebirth in human form see couples in sexual union and experience desire for an attractive member of the opposite sex among those couples. By this desire they thereupon find themselves drawn into the womb and reborn - which was not at all what they wanted!"

According to Buddhist teachings, four stages are involved in the path to Full Enlightenment. Within Buddhism, control of any temptation is gained by concentrative meditation practices that still the mind. The true Buddhist way helps believers achieve their goals, and there is no forcing involved.

In the Buddhist religion, sex in and of itself is neither good nor bad but can create difficulties. Within ideals of sex in many faiths, from Christianity to Buddhism monogamous marriage and positive and beneficial behaviors regarding human sexuality are encouraged.

C. Hinduism and Sexuality

Retrieved from: http://www.mahavidya.ca/2016/04/26/sexuality-in-hinduism/

Hinduism is an ancient religion that offers different views regarding sexual morality that differs according to geographic regions and sects. Sexual imagery in Hinduism is prominent, although sexual self-restraint is

encouraged in order for an individual to spiritually advance him or herself toward developing their *karma* (positive earthly action), *dharma* (social duties and obligations), and *kama* (physical pleasure) and *artha* (material prosperity or achievement).

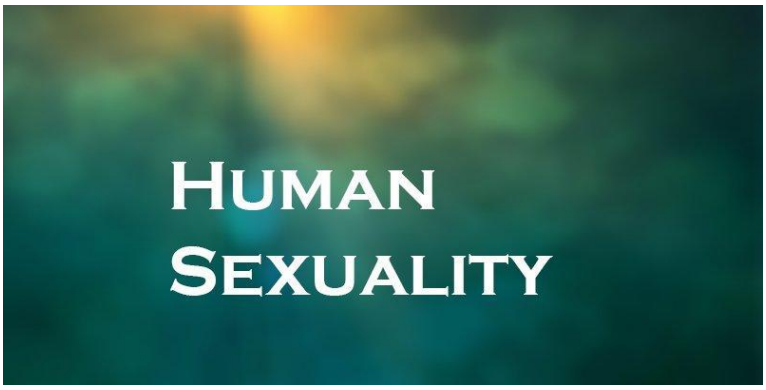
In many geographic locations, Hindus view premarital as well as extramarital sex to be immoral. Similar to the Buddhist view of enlightenment, such behaviors outside of marriage are damaging to the life stages that Hindus are compelled to follow in order to attain *Moksha*, which is similar to the *Nirvana* of Buddhist beliefs.

Among Hindus, heterosexual monogamy as well as live-in relationships are considered legal, though the state of India continues to fail to recognize same-sex unions. However, even though there are no specific restrictions regarding sexual behaviors, sexuality is considered to be intensely private among Hindus.

One of the most popular and well-known documents regarding Hinduism is the *Kama Sutra*, by Vatsayana, which many believe to be a mere sexual "how-to", but actually is a study of society, ethical, and sexual morals they were practiced at the time the book was written.

D. Judaism And Human Sexuality

Judaism is an ancient and respected religion that is based on the teachings of the Torah. The Jewish Hebrew Bible not only sanctions monogamous relationships, but also prohibits adultery as well as certain behaviors within the Jewish faith. Judaism offers traditional views against homosexuality,



incest, and adultery. The differences between Orthodox and Conservative Judaism also offer different views regarding sexual relationships, sexual activities within a marriage unit, as well as those that guide divorce.

Traditional beliefs according to Judaism understand that reproduction and sex are among holy acts that follow and maintain biblical teachings regarding relationships within marriage.

Orthodox Judaism prohibits immoral thoughts, as well as an individual from staring at someone of the opposite sex. Orthodox Judaism also requires that the body be clothed respectably, and generally require everyone to avoid pictures or images that may be potentially sexually arousing. Orthodox Judaism prohibits an individual from wearing the clothing of members of the opposite sex, as well as hugging or kissing a spouse in public.

On the contrary, conservative Judaism has eased prohibitions observed by their more Orthodox brothers, in particular restrictions regarding lesbian and gay relationships and marriages. Conservative Judaism can be considered to be literally sitting on the fence between liberal as well as traditional views regarding many sexual behavior and matters.

Indeed, Reconstructionist and Reformed Judaism followers don't necessarily observe traditional sexuality expectations and have been known to welcome

homosexual couples as well as non-married couples into their congregations, even endorsing homosexual commitment ceremonies and marriages.

E. Sex and Islam

Like other religions around the world, concepts of sexuality within Islam are quite different than those perceived by Christians, or Buddhists. In many cultures, it's important for everyone to understand the variety of beliefs and teachings of any faith in order to understand their own. Muslims are different than non-Muslims in their way of life as well as their belief and value systems. Like many other cultures around the world, Muslim children are told to avoid alcohol, not to eat pork, not to take drugs, and not to engage in premarital sex.

Islam basically discourages the concept of celibacy as a religious practice because it believes that marriage regulates sexual temptations, desires, and relationships of the human race.

While Islam recognizes sexual needs, and the power of such needs, and the subject of sexuality is discussed in the Quran as well as in the sayings of Prophet Mohammed, such discussions are limited to marital and family life experiences. The Islam faith doesn't consider either men or women as objects of sexual pleasure. Sex outside of marriage in the Islamic faith is punishable, while sex with a spouse is considered to be an act of worship. In the Islamic world, virginity is a virtue.

The Quran, the Holy writings of the Islamic faith, mentions aspects regarding reproduction, sex, and creation. For example:

- "Did We not create you from a sticky fluid? Which We laid up in a safe abode, for a known term. Thus, we arranged, how excellent is Our arrangement".
- "So, let men consider from what he has created. From a gushing fluid the issues between the lion and the ribs."
- "Verily We created man from a product of wet earth, then placed him in a drop in a safe lodging, then We fashioned the clot into a little lump, then We fashioned the lump into bonds, then We clothed the bones with flesh, and then produced it as another creation. So, blessed to be Allah, the best of creators".
- "Your women are a tilth for you, so enjoy your tilth the way you wish, and make an introduction to yourself."

The Prophet Mohammed (PBUH) said:

- When one of you have sex with your wife it is a reward will act of charity". The companions were surprised and asked, "but we do it out of our desire, how can it be counted as a charity?". The Prophet replied "if you had done with the forbidden woman, it would have been counted as a sin, but if you do it in legitimacy it is counted as a charity?".
- "Let not the one of you fall upon his wife like a beast falls. It is more appropriate to send a message before the act".
- "Do not do both secrets of your sex with your wife to another person, nor describe her physical feature to anyone".

When it comes to adultery, Allah states in the Quran:

- "Do not come near to adultery. Surely it is a shameful deed and Evil, opening roads to another evils".
- "Say: Verily, my Lord has prohibited the shameful deeds, be it open or secret, sins and trespasses against the truth and reasons".
- "Women impure are for men impure, and men impure are for women impure and women of purity are for men of purity, and men of purity are for women of purity".

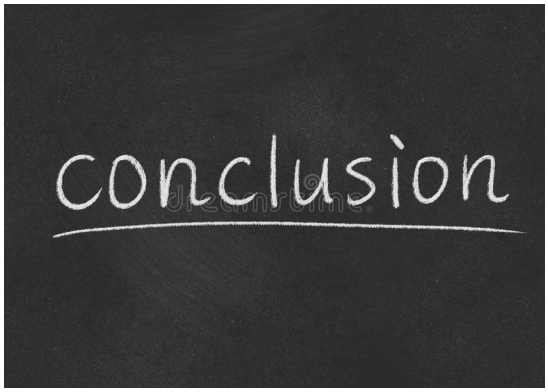
In the Islamic world, adultery is a crime against society. Illegal sex is prohibited, as is anything that leads to illegal sex. These concepts include provocative clothing, dating, nudity, pornography, obscenity, and free mixing of the sexes. Dress codes in Islamic societies are designed to protect men and women from temptation and to prevent them from losing self-control and engaging in sinful behavior.

Islam encourages marriage and considers it a contract witnessed by Allah. Says the Prophet Mohammed:

- "Marriage is my tradition. He who rejects my tradition is not of me".
- "Marriage is half of the religion, the other half is being God-fearing".

Homosexuality is forbidden in the Islamic faith, while acts of sodomy are punishable by death.

F. Conclusion



It can be seen that views regarding human sexuality, sexual conduct, and standards of morality between religions and religious faiths differ widely. Psychologists, counselors, psychiatrist, and teachers as well as laypeople should be familiar with the different aspects of the attitudes and behaviors that are based on religious teachings and beliefs.

This lesson has not intended to offer an in-depth study of various religious beliefs regarding human sexuality or sexual behavior, but merely as a starting point for individuals to understand the differences in concept, morals, virtues, and guidelines of different religions when it comes to relationships, viewpoints, concepts of sexuality, as well as sexual behavior and attitudes.

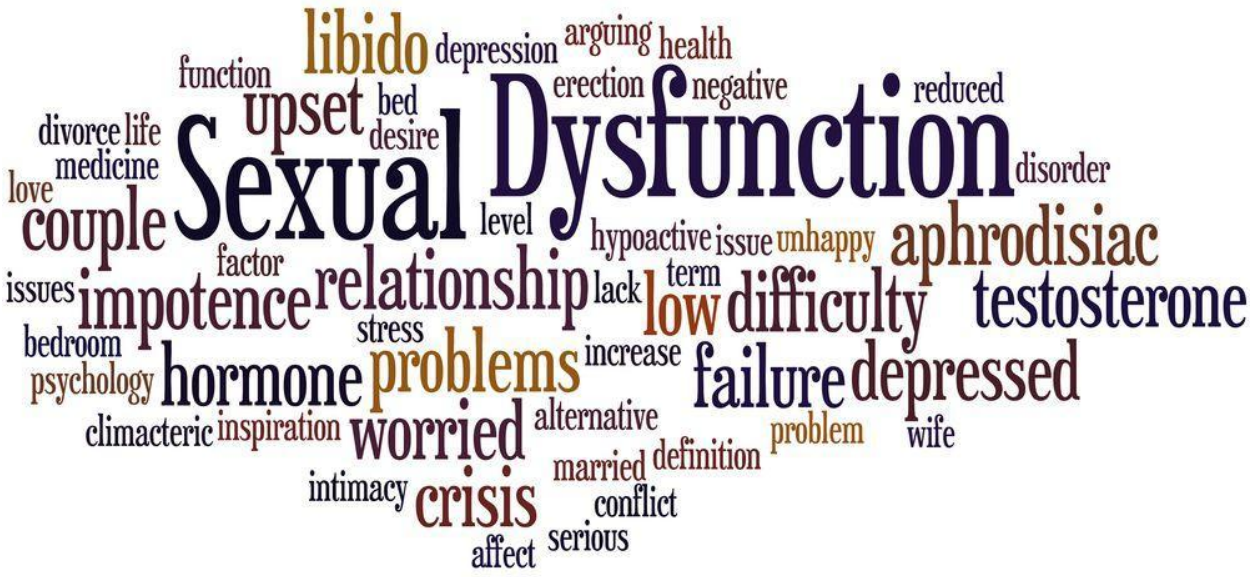
Every individual perceives his or her sexual behavior within the concept of religion in a different light, and as such, should be discussed and understood by individuals entering relationships, as well as communications between individuals in and of different social environments and psychosocial environments.

Since the birth of television and cinema, attitudes and behaviors regarding sex, human sexuality, and sexual behavior has changed. Sexual behaviors in the workplace as well as concepts of beauty have become prevalent and prominent in social media, which plays a powerful role in the development of attitudes and behaviors. Such influences will be explored in the next lesson

and will help individuals to understand as well as recognize such concepts as sexual harassment, expectations and morals within the workplace.

Chapter 9: Sexual Dysfunction

Retrieved from: https://familydoctor.org/condition/sexual-dysfunction/



Sexual dysfunctions and disorders are much more common than many people think. As a matter of fact, many people who believe that they may have problems instigate sexual counseling that may involve but is not limited to arousal, desire, or sexual pain. In many situations, individuals don't share sexually related problems with friends, spouses or close family members, and

even counselors, despite the fact that effective treatment and counseling is available for a multitude of major complaints.

It can be said that healthy sexual interaction involves aspects of trust, communication, similar expectations, respect, and love in order to enjoy longevity and pleasure for both individuals involved in any relationship. Relationship issues and lack of intimacy cause one of the major factors that contribute to sexual dysfunction and problems.

The psychological causes of sexual dysfunction cannot be over emphasized. Emotions like stress, depression, anxiety and guilt, and even fear are known to trigger various responses within the endocrine and nervous system that conflict with sexual arousal.

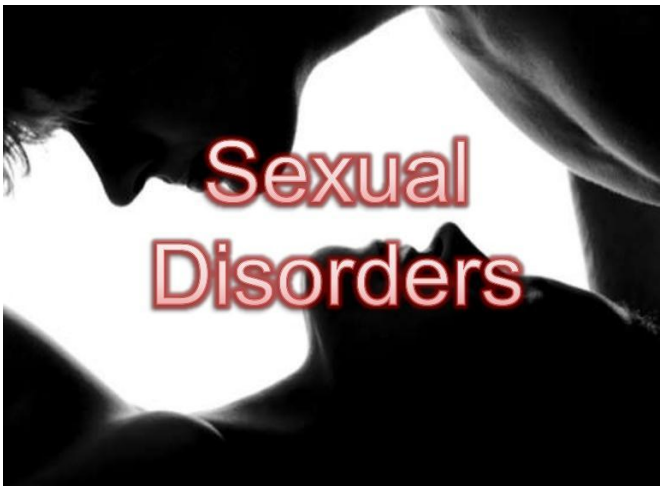
Some of the most common psychological causes of sexual problems are caused by stress related to work, money, family problems, grief, children, and family responsibilities. In addition, partners may feel guilty over past behaviors, lying, deceptions, or betrayal of partners. Anxiety over relationships, the desire to please a partner, as well as lack of sexual experience is common factors in the development of some disorders. Fear of infertility, pregnancy, pain, as well as transmitting or receiving a sexually transmitted disease are also important and common factors in the development of sexual dysfunctions.

Most relationship issues rely on trust and open communication to thrive. Poor communication inhibits sexual desire and stimulation. Loss of trust commonly affects desire and arousal. In addition, anger and resentment create barriers to sexual intimacy that may develop into inability to achieve any joy or pleasure from sexual activities.

Different expectations when it comes to sex and sexual activities among partners, whether it's based on religious, comfort levels or cultural beliefs that also create barriers that couples must overcome.

Lack of self-esteem, self-respect, and confidence are also important factors in the development of sexual problems. Lack of respect of a partner will eventually undermine desire, feelings, and responses to any sort of intimacy. Mutual respect is highly desirable in any relationship, and each partner in a relationship expects enjoying a sense of value, honor, and courtesy. Without mutual respect, trust, communication, love inevitably suffers.

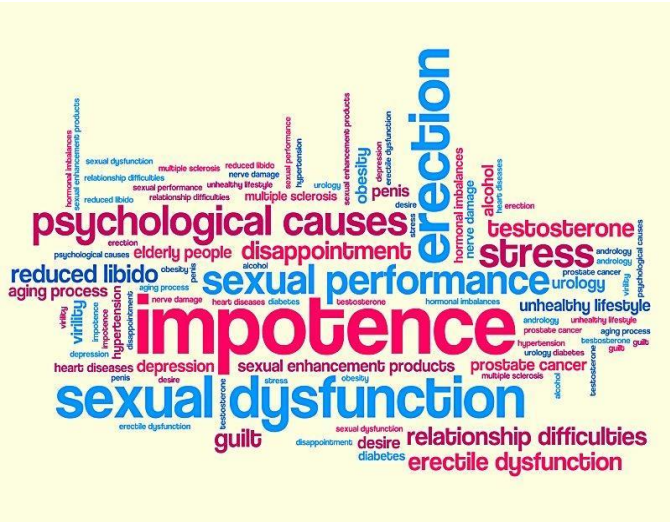
A. Types of Sexual Disorders



Many types of sexual disorders develop within certain relationships fraught with abuse and inequality. Others develop from childhood and may be the result of childhood abuse or incidents that have long-lasting effects on a given individual. In others, sex or sexual relationships are just not that important. Some of the most common types of sexual disorders include the following.

Desire disorders, which are defined according to a person's expectations, history, age, sex, and the type of relationship he or she is engaged in. In many

relationships, sexual desire is not at the top of the list, which is perfectly normal. In other relationships, sexual feelings or attraction can fade or disappear altogether, often caused by relationship problems, illness, or fatigue.



Sexual dysfunction is the definition of a loss of desire that is persistent, and causes a person concern or worry. Diminished desire can affect both sexes, but is more common among women. As a matter of fact, some people are repelled by the thought of sex, and avoid it at all costs. The condition, known as **sexual aversion**, lies somewhere between a depressed or decreased sexual desire and one that is repelled by the thought of having sex with another individual.

Some of those most common causes of sexual desire disorders are physical in nature, and may include hormonal difficulties, side effects of medications, chronic fatigue, and illness. Psychological factors may include religious beliefs, a fear of pregnancy, depression, marital difficulties, or even a lack of attraction to one's partner.

Desire disorders aren't easy to treat because they incorporate a multitude of problems and issues that are highly personal and range in importance according to each individual. In many cases, unless desire disorders are determined to be physical in nature, they're very difficult to treat because they

involve aspects of personality, sexual history, relationship attitudes, as well as how that person was treated or raised during childhood.

Sexual pain disorders are caused by pain in the genital areas, experienced by both men and women. This condition is called **dyspareunia**, and while it is rare in males, women experiencing the condition often experience intense levels of anxiety prior to sexual intercourse, which more often than not contributes to fear of men and most sexual behaviors. It can be said that dyspareunia may very well be considered a phobia and should be treated as such. Treatment of sexual pain disorders are generally induced by progressive relaxation techniques, desensitization methods to reduce fear and physical reactions to it such as anxiety and muscle tension, and a great deal of understanding by sexual partners.

Arousal disorders affect both men and women and include but are not limited to male erectile disorder as well as female sexual arousal disorder, where men and women are unable to respond in what are considered to be "normal" manners to sexual situations. For many individuals, factors such as anxiety, anger, drinking, drug use, and fatigue lead to arousal disorders. For some, an overreaction to a temporary loss of arousal feelings and sensations often causes individuals to develop a never-ending cycle that contributes to further inhibition and difficulties.

Men and women should realize that isolated incidents of sexual performance should not be defined as a sexual dysfunction. Temporary changes or alterations in arousal, sex drive, and psychological considerations involving intimate relationships change over time, and only when performance difficulties become recurrent, persistent, or distressing should a person consider such difficulties of the sexual dysfunction.

The American Psychiatric Association efficiently defines nine basic sexual dysfunctions, described in detail in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5).

Classification and Description of Recognized Sexual Dysfunctions

According to the American Psychiatric Association, the following provides a list of sexual dysfunctions in their description:

- **Hypoactive Sexual Desire Disorder** - recurrently or persistently deficient (or absent) sexual fantasies and desire for sexual activity.
- **Sexual Aversion Disorder** - recurrent or persistent extreme aversion to, and avoidance of, all (or almost all) genital sexual contact with a sexual partner.
- **Female Sexual Arousal Disorder** - persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, and adequate lubrication- swelling response of sexual excitement.

- **Male Erectile Disorder** - persistent or recurrent inability to obtain or maintain until completion of the sexual activity and adequate erection.
- **Female Orgasmic Disorder** - persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase.
- **Male Orgasmic Disorder** - persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase during sexual activity.
- **Premature Ejaculation** - persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it.
- **Dyspareunia** - recurrent or persistent genital pain associated with sexual intercourse in either a male or female.
- **Vaginismus** - recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse.

In some cases of sexual dysfunctions, medical causes are responsible for male erectile disorders. Such medical causes may include aging, drug abuse, infections, prescribed medications, vascular disease, and neurogenic and urological concerns.

In most cases of sexual dysfunctions, the emotional state of the individual often serves as a trigger. Such emotions may be external or internal. External triggers include but are not limited to attraction, location, and physical

stimulation or lack thereof, while internal triggers may include but are not limited to fantasies, memories, or previous experiences.

Sexual attitudes and behaviors are also influenced by cultural attitudes and expectations. For example, in the Victorian era, women were considered ideal as wives and mothers who are pure in thought, deed, and behavior. During those times, the expression of sexual urges were considered improper, and women were discouraged about discussing sex or intimate issues not only among each other, but with their husbands as well.

In many situations even today, women are hesitant to express or discuss sexual preferences or concerns with boyfriends, spouses, and even among friends. What people desire or fantasize about are intensely personal and private for many. What can be considered "hypoactive" sexual desire is subjective, and it's hard to define, again based on people's cultural backgrounds, traditions, situations, and age.

In many relationships, women, and sometimes men, engage in sexual relationships only because it is desired by the other, and he or she wants to avoid conflict and please their partner.

B. Sexual Addictions

Giugliano, John. (2009). Sexual Addiction: Diagnostic Problems. International Journal of Mental Health and Addiction. 7. 283-294. 10.1007/s11469-009-9195-3.

At the opposite end of the spectrum of hypo-sexuality is hyper-sexuality, also known as a sexual addiction, or nymphomania. Such terms describe excessive sexual desire, though as with hyposexual desires, what determines "excessive" desires are not specifically classified or defined. Many people consider sexual addiction to be similar to addictions experienced a drug addicts and alcoholics. According to Patrick Carnes in his 1983 writings, sexual addiction comprises four specific symptoms:

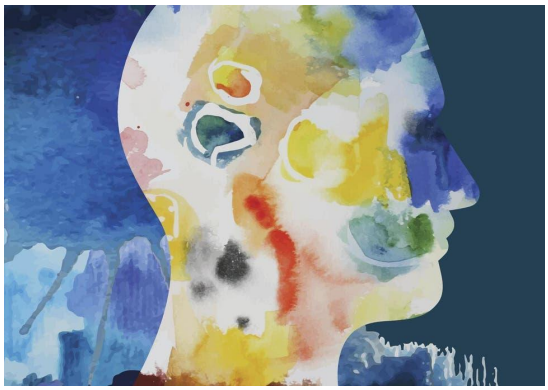
- Preoccupation with sex
- Ritualized sexual behaviors (seeking prostitutes or anonymous sexual partners)
- Compulsive sexual feelings and behaviors
- Intense emotion (such as shame or guilt) over such behavior

However, such definitions have not been supported by medically viable research. In addition, many studies engaged by individuals purport that many sexual addicts are also involved in heavily preoccupied in pornography, prostitution, and in some cases, child molestation. In many cultures, hypersexuality or nymphomania is considered to be a perversion or disease that has also been linked with compulsive sexual behaviors in individuals with exaggerated sex drives.

However, much like the situations involving decreased or hyposexual behaviors and attitudes, hypersexuality is also difficult to define as every given individual's situation, circumstances, beliefs and behaviors are different.

Because scientific research has not gained a good understanding of sexual desire, labeling individuals as nymphomaniacs, hypersexual, in conditions such as sexual addiction or disorders creates increased anxiety, stigmatism, and suggest abnormal sexual pathology and behavior in many individuals.

C. Sex in the United States



Attitudes and expectations promoted by the media as well as gossip play important role in common conceptions of sexual dysfunctions and disorders. Watch the TV for an evening and viewers are more than likely to view at least one television commercial regarding the next, and greatest pill to enhance male sexual capabilities.

For example, take a look at the comment perceptions regarding sex and sexuality commonly dispensed during TV shows and in magazines, books, and movies. Such concepts have created what are known as "fantasy models of sex" that exhibit and encourage how people should relate, look, and have sex. Sexual pressures and attitudes caused by the media will be explored in a later lesson, but suffice it to say that the following conceptions are the most common:

- The best sex or sexual experience always ends with an orgasm
- Sex generally means sexual intercourse
- Women shouldn't have sex if their man straining

- Most people are open-minded and comfortable when discussing or engaging in sex
- Most "real" men are not interested in communications or feelings
- Man are consistently ready, willing, and able to engage in sex
- Making love should always be spontaneous and natural, but never planned
- Sex is not possible without a male erection

The above conceptions are false. As a matter of fact, sexual performance and sexual adequacy is not always judged by its outcome. Sexual behavior does not always need to include orgasm in order to be considered optimal, because other aspects of sexual behavior, including intimacy, sharing, a sense of closeness, and pleasure are often typically experienced. As a matter of fact, many men and women have stated that personal satisfaction and pleasure is often achieved by mere acts of hugging, cuddling, and kissing.

Likewise, sex implies a multitude of sexual activities apart from sexual intercourse. Kissing and caressing, most commonly known as foreplay, are a large part of the sexual act. In addition, sexual experiences do not always require a male to achieve an erection, although many men as well as their partners are unfortunately affected by such comments and beliefs, which sometimes lead to dysfunctions caused by feelings of inadequacy or failure.

One of the most prevalent myths regarding men and sex is that men aren't concerned about communicating or feeling. Men who engage in such expressions are often considered to be weak, while men who are stoic are referred to as macho. Unfortunately, attitudes negatively affect behaviors, attitudes, and relationships. Most men feel that their emotions, feelings and

ability to communicate are essential for enhancing and maintaining positive relationships with others.

Another common myth is that men are continuously prepared to engage in sexual behaviors. Such attitudes place enormous pressure on both men and women and often lead to misunderstandings, misconceptions, and miscommunication between couples and sexual partners.

In all of the above examples, such misconceptions regarding sex serve to overemphasize a man or woman's ability to perform sexually and sometimes offer fantastical goals that no man or woman can achieve on a regular basis. Indeed, such attitudes and expectations serve to restrict the ability of men and women to engage in comfortable and relaxing sexual activity. Such attitudes or unrealistic and serve to detract from the enjoyment a man or woman may gain from a sexual experience.

D. What Causes Sexual Dysfunctions?

The causes of sexual dysfunctions include a wide range of scenarios, conditions, beliefs, and hypotheses. In many cases, sexual dysfunctions may be caused by medical conditions as well as legal and illegal drug use. Psychological factors also play an important role in the development of a sexual dysfunction, among both

men and women. Cultural beliefs, traditions and attitudes regarding human sexuality cannot be underestimated. Most of the time, a combination of a multitude of factors may eventually lead to sexual dysfunctions. Some of the most common reasons may include a combination of psychological, medical, cultural, and relationship issues.

For example, medical issues such as illness, disease processes, and medications may affect sexual desire and activity. Some prescription medications are well known to interfere with sexual desire. Medications often prescribed for depression, hypertension, high blood pressure, and other conditions impair sexual activity. The most common prescriptions that cause sexual side effects in a majority of individuals who are prescribed them are the use of antidepressants, including the familiar Paxil, Prozac, Wellbutrin, and more. Indeed, sexual desire in such individuals routinely decreases by 20 to 50%.

The chronic use of alcohol and some illegal drugs such as cocaine also impairs sexual desire. Alcohol causes changes in the blood vessels and has also been closely associated with hormonal imbalances and nerve damage.

Psychological factors that may affect sexual function in capabilities may include but are not limited to experiences of sexual trauma, negative beliefs regarding sexual behavior, as well as anxiety. As a matter of fact, anxiety stemming from a fear of performing badly, or of pregnancy, intimacy, or emotional vulnerability experienced by such individuals can severely decrease a person's ability to perform in what he or she believes to be an adequate manner. Many men are so focused on their performance or ability to perform that they lose sexual enjoyment as well as often suffer from erectile problems and dysfunction.

Sexual dysfunction is one of the most common side effects of anxiety and depression in individuals, although other factors, such as psychological or cultural beliefs regarding sex, and sexual activity also plays a large role in how any given individual perceives or enjoys sex.

Individuals who have experienced sexual trauma in the past also often experience some sexual dysfunction and disorders that may be treated through counseling, but only when he or she is willing to discuss various circumstances or occurrences that may have led or resulted from such trauma. Many victims of childhood sexual abuse find it difficult to disassociate sexual intimacy with physical as well as emotional pain. Therefore, sexual contact is typically avoided as often as possible.

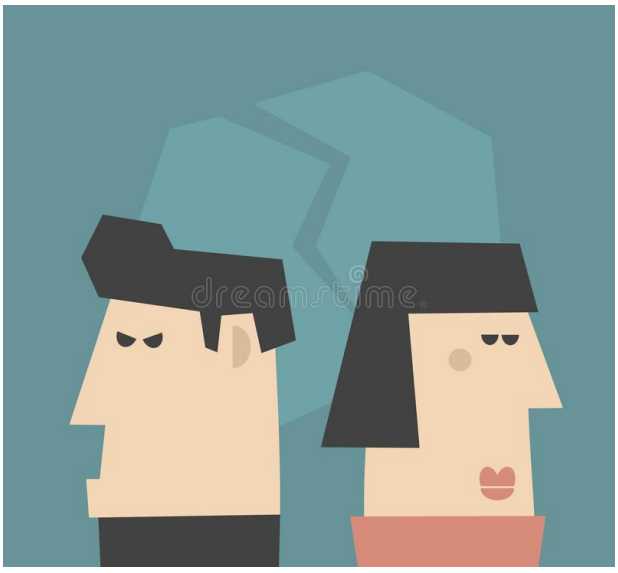
E. Drugs and Sexual Dysfunction

Studies have shown a distinct relationship between drug abuse and sexual dysfunctions. We've already briefly discussed alcohol abuse, which involves both immediate as well as long-term effects on sexual functioning, including erectile disorders and desire disorders.

The use of amphetamines also inhibits sexual function and may lead to the laid or inability to ejaculate, delayed orgasm, erectile dysfunctions and disorders, and inhibitions of orgasm. Anal nitrates decrease the ability to ejaculate as well as decrease lubrication and arousal. Barbiturates decrease desire and interfere with the man's ability to achieve an erection. Drugs such as ecstasy and heroine decrease sexual desire, and may affect hormonal balances in the body, also leading to erectile dysfunctions and disorders.

Short-term and long-term use of tobacco has been shown to produce erectile disorders and problems in many.

F. Relationship Issues



Relationship issues also play a big part in the development of sexual dysfunctions. Conflict, resentment, anger and jealousy are very effective in curbing sexual desire and attractiveness among couples. Because sexual enjoyment and pleasure is not merely a physical reaction, but involves emotions and feelings, a partner's ability to

communicate and trust has a great deal of influence over sexual enjoyment or dysfunctions.

Unexpressed issues regarding resentment, anger, jealousy, worry, or concerned are often detrimental to sexual relationships and attitudes among couples and often leads and contributes to sexual dysfunctions.

Loss of trust, poor communication, lack of respect, and conflicting sexual expectations and demands as well as frequency also play a large role in the development of sexual dysfunctions in relationships.

Cultural Issues

Cultural beliefs and traditions differ among individuals, and also play an important role in the development of sexual happiness or dysfunctions. In most societies, "good girls" are highly prized over those who are "promiscuous". Women are generally raised to restrict discussion regarding sexual preferences, sexual encounters, and indeed their own sexuality. Cultural double standards have often inhibited both men and women to pursue open communication regarding sexuality.

In many cultures, it's perfectly acceptable for males to engage in sexual behaviors, while such behavior is considered unacceptable, and often illegal, for females. Many women are brought up to have negative attitudes regarding sex that often stem from religious upbringing. Some women are brought up in cultures that are male-dominated. Regardless of the reasons for sexual

dysfunctions, various treatments and therapies are available and involve pills, devices, and therapies.

As mentioned earlier, the ability to travel as well as communicate via the Internet has introduced more cultures to one another than any other time in human history. Free economic trade, online dating, and easier travel encourage relationships that cross boundaries and borders. However, cross-cultural dating and relationships should be aware that ethnic, religious and social backgrounds might play an important role in the development of sexual problems, dysfunctions and attitudes among cross-cultural couples.

In many relationships, deeply believed and ingrained expectations and attitudes regarding sex may clash among cultures. In many cultures, attitudes regarding nudity, sexual roles, responsibilities, privacy, modesty, and body parts are different. Cultural differences and expectations must be understood between partners in order to avoid conflicts or development of sexual issues.

G. Treatments and Therapies For Sexual Dysfunction

Retrieved from: Medications that Affect Sexual Function https://my.clevelandclinic.org/health/articles/9124-medications-that-affect-sexual-function

Female sexual dysfunction

https://www.mayoclinic.org/diseases-conditions/female-sexual-dysfunction/diagnosis-treatment/drc-20372556 and

Erectile dysfunction

https://www.mayoclinic.org/diseases-conditions/erectile-dysfunction/diagnosis-treatment/drc-20355782

There are many common medical interventions for a multitude of sexual dysfunction issues. For example, typical medical interventions for various erectile problems may include but are not limited to oral medications, injections, surgery, and the use of constriction devices. Nonmedical methodologies include sex therapy, which helps many couples to reduce performance anxiety fears, address and resolve conflicts within the relationship, as well as Miss beliefs are misconceptions regarding sexual behavior.

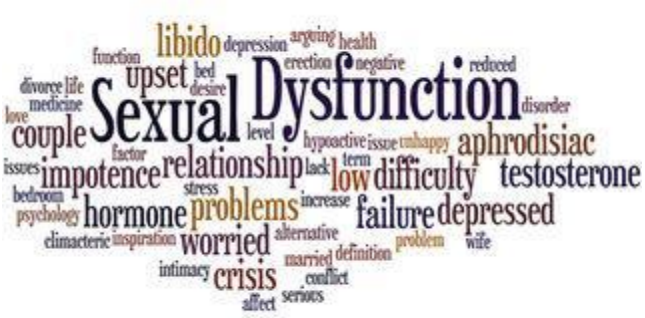
In the last two decades, advanced techniques and approaches to the treatment of sexual dysfunction has become so standard that male and female enhancement drugs are readily advertised on primetime television and in most magazine ads. Another common treatment for sexual dysfunctions is therapy that is focused on providing behavioral as well as educational aspects that are conducted between couples and a marriage counselor, sex therapist, or psychologist.

Regardless of the therapies and treatments designed for sexual dysfunction, most is beneficial and enhanced by the involvement, understanding, and psychological support of sexual partners. Couples who understand the misconceptions and misinformation regarding sexual aptitude and behaviors also enjoy greater benefits from sexual dysfunction treatments and therapies.

At the basis of the many sexual dysfunction treatments and therapies is the question of whether or not a sexual problem actually exists. Many people erroneously believe they have a sexual dysfunction when they don't. Most sexual problems or perceptions are self- diagnosed and are based on perceptions and beliefs of any given individual's sexual behavior.

Evaluating sexual problems involves a three dimensional approach, including:

- Context
- Frequency
- Duration



For example, the context of specific sexual behavior and ability is defined as a problem that occurs for a given individual or couple in various circumstances or settings. For example, concepts regarding sexual dysfunction can be defined as situational or global. A situational sexual dysfunction occurs occasionally, and during specific situations. A global sexual dysfunction is one that occurs during all aspects of sexual behavior and attempts.

Frequency is defined as being partial or total. Total sexual problems or dysfunctions occur every time during given situations, while partial sexual dysfunctions don't occur in every situation, but often enough to cause concern or distress.

Duration of sexual dysfunction can be broken down into two categories; primary or secondary. An individual will be asked how long he or she has been experiencing a particular problem. A sexual dysfunction or problem that is termed primary is one that has been present in the person's sexual life forever. Secondary problems are those that generally occur later in life or over the passage of time.

Some of the most commonly utilized medical treatments for sexual dysfunctions include surgical implants, penile injection therapies, vacuum constriction devices, and vascular surgery. However, one of the most popular and well-known oral medications for erectile disorder is that tiny pill known as Viagra. Introduced in 1998, Viagra was approved by the US Food and Drug Administration for treatment of erectile disorders. The demand for this tiny pill continues to be one of the best-selling pharmaceutical drugs not only in the United States but also around the world. Viagra functions by decreasing blood outflow that results in prolonged erections.

In most situations, oral medications for sexual dysfunctions are preferable and are less invasive and expensive than other treatments. While Viagra may not be cheap, it has been shown to be extremely effective for roughly between 60% and 80% of those taking it. Unfortunately, Viagra also has the reputation of contributing to a number of deaths in its early years of use in individuals who are currently experiencing cardiovascular issues.

In addition, the combination of Viagra and other medications has been known to cause unpleasant side effects and conditions. Because of its success however, studies have developed regarding the potential use of the drug by women.

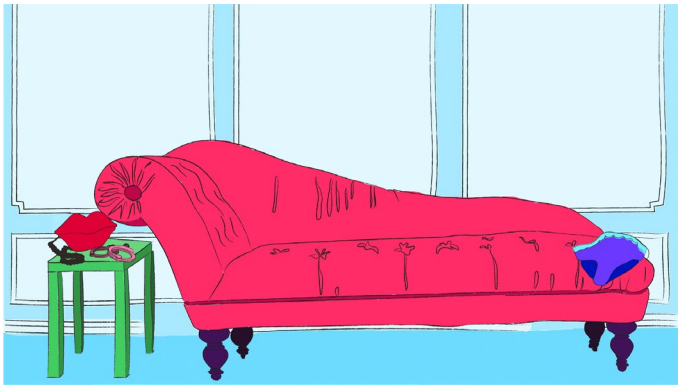
The importance placed on sexual performance within the media has had a large impact on much of society and its expectations. Because of such attention, many men and women who experience "normal" sexual function have been led to believe that he or she is not normal at all, and should be utilizing and enjoying the benefits of performance enhancing drugs and medications. However, it should be noted that Viagra is not an aphrodisiac, a concept that many individuals fail to realize.

Sex Therapy

Sex therapy is defined as a treatment approach for sexual dysfunctions and includes therapy for sexual problems caused by medical conditions as well as those caused by psychological issues. Sex therapy is designed to provide a psychological approach that alleviates problems and anxiety regarding sexual performance.

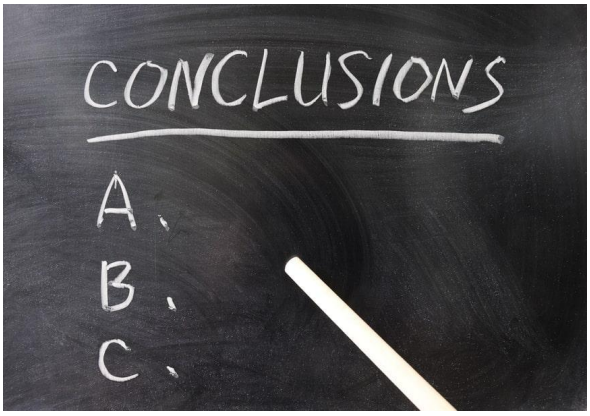
Adequate information and education and understanding the attitudes and expectations of couples are the basis of many sex therapy counseling sessions. In addition, mutual responsibility for sexual dysfunction should focus on both partners rather than blame being placed on one or the other. In addition, the elimination of performance anxiety is the ultimate goal of many sex therapy sessions. Interpersonal beliefs and relationships are also among the basic fundamentals of effective and positive sex therapy results.

One common sex therapy technique is known as **sensate focus**. This therapy is designed to teach and instruct couples how to focus on pleasurable sensations rather than on performance. In many cases, the sensate focus technique is valuable in reducing performance fears and anxieties, and encourages couples to communicate and enjoy intimacy that doesn't always result in sexual intercourse. Such techniques provide couples with self-confidence building skills that help to relieve anxiety regarding sexual performance and capabilities.



H. Conclusion

As you have learned throughout this lesson, there are many different types of sexual dysfunctions. In addition, the multiple causes of such dysfunctions can be physical, cultural, or psychological in origination and require that individuals attempting to overcome such dysfunctions examine relationships, including control issues, fear of intimacy, resentment, as well as cultural beliefs that help to alleviate conflicts, inhibitions, and miscommunication.



Chapter 10: Attitudes and Behavior

Human attraction is inevitable no matter where you are - at school, at the mall or even a charity event, but what happens when it occurs at work? For those working forty or more hours, employees see their co-workers more often than family. They also become a network of individuals who have the same interests, goals and ambitions; perhaps they understand you more than your own family or partner.

A. Sex and the Workplace

Retrieved from: https://www.un.org/womenwatch/osagi/pdf/whatissh.pdf

Each year, thousands of co-workers find themselves getting closer to their peers often resulting in some type of relationship whether it is a causal affair, sex or long term relationship. That is not so strange, considering where else do career driven individuals spend most of their time but work? A new study also showed that more and more women are now entering the professional workforce, where men once dominated industry after industry. In this modern era, men and women are also waiting until later in life to get married, often waiting until after college to get married.

"Old-fashioned dating" - from church, schools or other social events result in less relationships being formed, and bars or clubs are not any better of an option for finding a soul mate. Instead, the workplace is one of the best locations to find people with the same interests, and there are daily opportunities to engage in conversation and get to know one another a little better. In addition to daily interaction, co-workers live within a relatively close distance, unlike instances where people meet at a social event only to find out they live hours apart.

In past years, workplace relationships and romance have been frowned upon. Aside from work and personal conflicts, how many people have dealt with working with a co-worker that they have just ended a relationship with? What about being in a relationship with a supervisor or high-up management personnel? These types of situations happen on a daily basis, but still people are willing to take a risk to get to know someone in the office. Workplace romance is so common in fact, that many companies do not have anything

written about it in the policy book, but rather suggest discretion from both workers to not partake in personal interactions while on the job.

For a company, office romance is very dangerous because of the resulting sexual harassment claims that often arise from males and females. Company management generally discourages or downright forbids it if possible. Side effects to workplace relationships have been known to increase lack of production often initiates discord when the relationship breaks up.

Sexual harassment is a huge factor in the workplace when it comes to men and women working together. Sexual harassment is defined as an event or action where one employee makes continuous, unwelcome sexual advances, requests sexual favors or uses verbal or physical conduct of a sexual nature to another employee against their wishes. For many, sexual harassment also means that the individual being harassed experiences a decrease in work performance or feels intimidated when they reject advances of the harasser, causing a hostile or offensive work environment.

Sexual harassment is also hard to define. There is no clear-cut example of this sort of harassment, unless it seems blatant. Some common examples of sexual harassment from both men and women are:

- Offensive comments, gestures or jokes that are unwelcome by the recipient
- Touching or any bodily contact including patting on the back, blocking a person from moving, or putting hands on the waist
- Asking repeatedly for a date from an individual after they are turned down
- Sharing sexual texts, emails or pictures within the office

- Posting inappropriate pictures or objects within the office
- Playing music, movies or games that have a sexual nature within the office

In order to ensure the rights of all parties involved, once a sexual harassment claim is given to an employee supervisor, an investigation occurs immediately. Once an employee gives a claim to the supervisor, Human Resources steps in and investigates the matter. Unfortunately, some employees find themselves a target of sexual harassment claims for retaliation, so it's always important to go forth with the investigation so individuals can be cleared, or reprimanded, or worse, if necessary.

Since sexual harassment is so subjective, there are many things to remember when it comes to who can be affected. Harassment is not just between men and women, but also often occurs between individuals of the same sex. It's also important to remember that sexual harassment does not have to mean crude innuendo or comments told from one person to the next, but rather a person feels uncomfortable with comments or anything thing else that may occur in their presence. This can mean sexual comments around the water cooler within a group of women talking about the latest good-looking actor, or inappropriate comments about women from a male boss.

Affairs and the Workplace

Working together has its advantages and disadvantages while in a relationship. On the upside, your co-worker turned weekend date has a lot in

common, lives close and shares many of the same interests and goals as yourself. You have the ability to affect work performance in a positive way due to the capability of being more effective when the home life is happier, and the company is able to benefit from it. On the downside, if and when the relationship ends, work productivity is reduced and the personal issues are now being brought into the workplace. Almost half of American workers has been in some type of office relationship, a good majority of those dating managers or supervisors.

Another major issue with sex and the workplace are affairs. Many married couples that divorce do so because of 'office' affairs. As with single people who find relationships in the office, spending many hours away from a spouse has the potential to pose the same risk. Marriages where the couples have different lines of work, different hours and a different understanding of what the other does can run the risk of causing conflict within the home unless open communication and trust are achieved in the home.

At work, a spouse interacts with co-workers daily, many of which share the same life goals, ambitions or interests as those who are single. Spouses who are in a relationship with a person that does not fully support them or seem interested in what they do find that with co-workers, they also are able to connect on a level some married couples cannot. Many of these affairs take place at the office itself, interfering with work and using company time to partaking in personal and extramarital affairs.

Romance in the Workplace

It's not easy dealing with romance in the workplace. In fact, it might seem harder given all of the rules and policies regarding it. However, in the event that you have hit it off with a co-worker and they feel the same way, there are a few ways you can deal with it:

- Be sure to know the ins and outs of the companies policy on office relationships, as well as any unwritten understandings regarding dating or sexual relationships
- Behave professionally. Keep any displays of affection out of the office and done on personal time
- Keep the relationship under wraps until you both are ready and willing to deal with the office and management knowing about it. Some companies might move co-workers to different shifts, departments or even locations when they find out co-workers are dating. If you do not wish to be separated, keep the relationship private.
- If you want to share the news, tell only those who can keep the information confidential for you

With thousands of men and women entering into the workforce each year, more cases of office romance will occur, and many individuals will strike up relationships and even end up getting married. It's important for any individual going to work to remember that finding themselves in an office romance is not very unusual. Just remember that when it is good, it's great, but when things go bad, they can be awkward, not to mention grounds for sexual harassment claims if the attention is unwanted from another.

B. Sex and the Media

Another forum where sex and behavior are rampant is the media. Sex is everywhere. It's used to sell products, get attention and even to be provocative. Movies and TV shows use sex to get attention from certain demographics, and even video games incorporate sexual themes into scenarios and game play. Why? The media uses women and men as objects to show others what they *should* look like, or what they *should* be. Throughout past decades, women and men have been seen in the media wearing less and less clothing, and most media outlets are being used to show the average person that they just aren't pretty, handsome or sexy enough.

Since the beginning of television, the media has used images to send messages to viewers. Within the last few decades, women in particular have

been shown naked or mostly naked when to commercials or print advertisements for items such as perfume, alcohol and even fashion ads. In particular, the female body is made into a sexual object for the sole purpose of getting attention from viewers, especially men. In a majority of print advertisement even today, women are portrayed from the neck down, showing the middle, legs and thighs so that they become objects selling the goods. Often, they don't have an identity.

Within the last few years, sex and the media has become a much more open subject. Women and their sexuality are talked about openly. However, the media still uses women as role models for keeping a man happy. In countless women's magazines on shelves right this minute, check to see how many headlines sound like this: "How to please your man," "How to keep your man," "What you should do to get your boyfriend to listen," "How to attract men," and "How to keep your man interested".

Even in the 21st century, women are still being marketed as sexual objects bent on pleasing and keeping a man. Teenagers and young adults are no longer asking parents about sex or practicing safe sex, but rather get most or all of their information from what they read in magazines or see on TV. With shows such as The OC, Beverly Hills 90210 and Gossip Girl, teenagers are seeing fictional lives and scenarios and trying to imitate them in real life. Young men and women read magazines such as Cosmopolitan or GQ to get tips on how to attract other and satisfy them.

The media even goes so far as to correlate sex and weight loss, supposedly since the better looking and fit a woman is, the better looking or successful man she is able to get. These messages lead to other issues such as peer pressure, body images and even eating disorders as teens or young adults try

to be like people they see in the media. The media is also trying to get the attention of younger teenagers, especially girls. What they see at a young age has been shown to have lasting effects on not only how they view themselves physically, but also emotionally.

This age group, or "tweens" as it is now referred to, is being inundated with movies, music, video games and even advertisements that show people in their same age group partaking in activities that advertisements featuring older men and women also do. Even toys such as dolls are much more sexual than they use to be, with clothing choices being miniskirts or clothing that shows more skin and makeup, being much too grown up for young children's toys.

Tweens are especially vulnerable to feeling inadequate compared to what they see in the world, and from a young age they being to feel as though these images are what they need to be in order to be accepted or liked. Eating disorders, depression, and a lack of self-esteem are all caused by young boys and girls feeling the need to compete with others they see in more provocative settings. Even TV shows are no longer being markets to the older teenagers.

Music videos on channels such as MTV or VH1 constantly show the glamorous life of a rock or rap star, in a fancy house with men and women dancing around them half naked. Young teenagers stay up late to watch shows meant for older teenagers or adults. As mentioned before, shows like Gossip Girl or Beverly Hills 90210 are very popular within the teenage demographics, and they feature adult themes in various episodes.

What about reports of sex in the media leading to more cases of teen sex? According to studies, teens exposed to seeing sexual content are twice more likely to participate in sexual activity than those who are not. Aren't the parents to blame? They could be in a way because they are the judge of what is appropriate or not in a young teenager's life, but sexual content is *everywhere*. It's in the music, the movies, TV shows that aren't even sexual in nature, it's in magazines and books!

It would be impossible for parents to keep their children away from the messages the media gives out on a daily basis. They are responsible however, for giving their children the proper information when it comes to discerning fact from fiction. They need to explain to their children that what you see on TV or the movies does not happen in real life, and that pregnancy is a very real issue when one partakes in those activities. Open communication between parents and their children are vital, especially since the media is using sex to sell more now than ever before.

The media also sets out roles for men and women in life, such as the man hard at work in the office with an endless line of women attracted to him, while the women are seen as gossiping, catty or as single women unable to find a man and keep him.

Often, sex in the media is not all romance when it comes to gender roles. Women are seen as vulnerable and usually in distress, waiting for a man to come and save them. That same vulnerability and innocence makes women a

target for violence, especially in movies and TV shows. In these same media outlets, women are also not taken seriously. Women who say "no" to something end up relenting, giving the message that no does not mean no, it just means try harder. This message has become a perfect excuse for men to get their way, since they are under the impression that all women are just playing hard to get.

Advertising is also used for women to get attention from men. For example in perfume advertisements, women attract men with their perfume scent, implying that all you have to do is dab a little here and there and they come running. On the flip side, advertisements for men show using hair or body products cause women to lose their cool, with some recent commercials showing hordes of women running after a single man because of how good he smelled.

With thousands of billboards, magazine covers, movies and TV shows portraying celebrities and models as the epitome of what every person should look and act like, it might be hard to get the younger generation to not pay so much attention to it. Why do the media use sex to sell and advertise goods? Why is so much money spent on advertising?

Basically, advertising is getting someone to buy something they might not normally buy. How often have we bought something based on how it made someone else look? Cosmetic ads are perfect for making the average woman feel not as attractive and perfect as the models with the makeup. The message

behind these ads is, "If we only had that mascara or lip gloss, we could look like *her*". Advertising uses the inadequacy consumers feel to make them buy what they are selling. In men's magazines such as GQ or Esquire, advertisements for expensive cigars, watches and cars line the magazine. Men readers see it and feel that if they had a nice watch, they too could be taken seriously. Advertising executive spend millions of dollars each year to make society look at what is essentially for sale. Add in attractive and scantily clad men and women, and now you have an audience. Advertisements such as these must work, since they continue to put them out and make money on society purchasing the goods.

It is estimated that each person is exposed to over 2,000 advertisements per day. A majority of those contain sexual themes or suggestions, despite who they are being marketed to. Why do the media use sex to sell products? Sex sells more than the product; it sells an idea. Attractive models pose in a provocative manner, clothes are never worn as they should be, or men and women in advertisements have some sort of sexual attraction or tension. Where can one find advertisements that use sex to sell them? T name a few:

- Clothing and shoes
- Cars
- Perfume and Cologne

The media also uses sex to sell itself to the consumer, and it seems to be an effective way of selling goods because if not, they would try something else. Here is why sex sells products:

- It shows us what we could only have if we bought the product
- It uses emotions to get our attention by feeling envious or inadequate
- It makes us want what we see, being the lifestyle, attractiveness or desire we see in the advertisement aside from the actual product
- It gets attention

Women are not the only ones in the media with an inaccurate role. Some feel that homosexuals have a certain role in the media, and that is to be flamboyant or entertaining to those around them. After finally breaking into mainstream media, homosexuals were immediately typecast in certain roles, which some feel are nothing at all close to how they really feel, behave or function.

The media has a hard time treating minorities, women, and homosexuals as they really are, but instead has fit them in a box of how they should be represented. Often times, they are trying to stay away from "reality", because they do not want to lose viewers, advertisers, or investors if they did not make their material edgy or entertaining enough. Of course, stereotyping is hard not to do, especially where there are millions of people advertisers must reach each day. Stereotypes cause issues such as:

- Turning differences between people into a category
- Making assumptions and proving them right for the sake of entertainment
- Prolonging prejudice in society

- Justify people in their life roles

As we have gone over in this lesson, sex in both the workplace and media are a part of everyday existence. Attraction plays a big part in co-workers establishing a relationship, and the media tries to attract everyone in the same sort of fashion. By inundating the media with advertisements featuring sexual themes or content, consumers begin to compare themselves to those they see in the print ads or on the big screen. With advertising, generally one tries every possible way they can in order to sell a product for businesses to stay afloat.

If portraying sex is doing that, why should they stop? We all can't blame the media for exposing us to these ads that make us feel less attractive, because those feelings we get are what drives us out to by the product. Looking at magazine advertisements of clothing, we imagine ourselves buying those clothes and looking as good. You buy the car on the billboard hoping it gets you as much attention as that young guy. Advertisements sell billions of dollars of products each year because we allow them to. Yes, there are boundaries that should not be crossed like young teenagers watching TV shows that glamorize sex and material things, however they are still watching them.

Staying educated and aware of differentiating fact from fiction is one of the best tools to use against the media. Not allowing yourself to get depressed because you don't look like an airbrushed model is a great example of taking the advertisements as what they are and not setting yourself up for failure.

Sex in the workplace is also inevitable. Hundreds of people go to work each day and come into contact with people that are very similar- ambitious, goal orientated and even have the same interest. For those that spend countless hours at work, meeting someone there seems like the ideal thing to do. Chances are they live close by and meeting on the weekends is easy and convenient. Before getting involved in any office relations, remember these following tips:

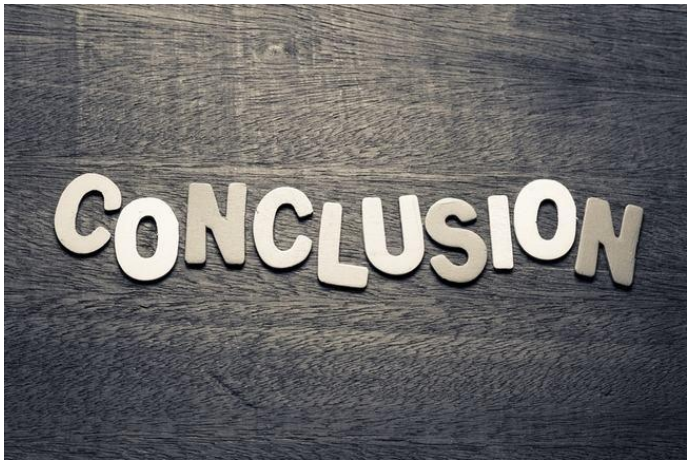
- Act professional
- Keep personal time out of the office
- Check with the company guidelines on office relationships

In the event that one is married, seek counseling before starting an office affair. These usually never end well, with one person always afraid their secret affair will be exposed when the relationship ends. Try working things out with a spouse if there is a rift in understanding, or question why it is much more appealing to have an affair than work things out at home. Avoid getting into

relationships with those higher up, if possible. Many individuals who have been in relationships with their bosses or superiors only find their work environment gets very unpleasant if and when the relationship ends.

Avoid anything that could be construed as sexual harassment. In the event that you are the target of inappropriate comments or touching, report it to the supervisor immediate so they can contact Human Resources in order to file a report and investigate it. If there is ever a case of sexual harassment that is not directed to you, but exists nonetheless still report it to the supervisor so it can be taken care of.

C. Conclusion



As you have read throughout this course on Human Sexuality, there many different aspects and dimensions to sexual behavior and development in all cultures around the world. It's up to each one of us to strive to understand others, as well as the behaviors of others when it comes to our interactions with them, both at school, at work and in our neighborhoods.

Sexuality is not something that many people feel comfortable discussing, but is an important topic for all of us to remember when we're dating and looking

for a marriage partner or a group of friends to hang around with in our downtime.

Different attitudes regarding sexual gender roles and expectations can affect the degree to which we become involved with others and how we perceive them in our family, our neighborhoods and in society. Human sexuality is not a black or white issue, but is filled with tones of gray that offer limitless potential for study.

Chapter 1. Gay and Bisexual Men's Health

For Your Health: Recommendations for A Healthier You

Retrieved from: https://www.cdc.gov/msmhealth/for-your-health.htm

A. Introduction

Just like all other men, gay, bisexual, and other men who have sex with men need to know how to protect their health throughout their life. For all men, heart disease and cancer are the leading causes of death. However, compared to other men, gay, bisexual and other men who have sex with men are additionally affected by:

- Higher rates of HIV and other sexually transmitted diseases (STDs);
- Tobacco and drug use;
- Depression.

There are many reasons why gay, bisexual, and other men who have sex with men may have higher rates of HIV and STDs. Some of them are:

- Prevalence of HIV among sexual partners of gay, bisexual, and other men who have sex with men is 40 times that of sexual partners of heterosexual men;

- Receptive anal sex is 18 times more risky for HIV acquisition than receptive vaginal sex;
- Gay, bisexual, and other men who have sex with men on average have a greater number of lifetime sexual partners.

Other factors that can negatively impact your health and ability to receive appropriate care:

- Homophobia;
- Stigma (negative and usually unfair beliefs);
- Discrimination (unfairly treating a person or group of people differently);
- Lack of access to culturally- and orientation-appropriate medical and support services;
- Heightened concerns about confidentiality;
- Fear of losing your job;
- Fear of talking about your sexual practices or orientation.

These reasons and others may prevent you from seeking testing, prevention and treatment services, and support from friends and family.

In fact, gay, bisexual, and other men who have sex with men make up more than half of the people living with HIV in the United States and experience two thirds of all new HIV infections each year. Further, young gay, bisexual, and other men who have sex with men 13-24 had over 72% of the estimated new HIV infections in 2010. In 2012, 75% of reported syphilis cases were among gay and bisexual men.

The large percentage of gay, bisexual, and other men who have sex with men who have HIV and STDs means that, as a group, they have a higher chance of being exposed to these diseases. Too many men don't know their HIV or STD status (if they have a disease or not), which means they may not get medical care and are more likely to unknowingly spread these diseases to their sexual partners.

Most gay, bisexual, and other men who have sex with men get HIV by having anal sex, which is the riskiest type of sex for getting or spreading HIV. During anal sex, it's possible for either partner—the insertive (top) or the receptive (bottom) to get HIV. However, if you are HIV-negative, bottoming without a condom puts you at much greater risk for getting HIV than topping. If you are HIV-positive, being on the top without a condom is riskier for giving HIV to your partner.

Which tests are recommended to help ensure the sexual health of gay and bisexual men?

Your sexual health is important. There are a number of tests you can get to help you know your status and, if you have HIV or an STD, get treatment.

All sexually active gay and bisexual men should be tested regularly for STDs. The only way to know your STD status is to get tested (you can search for a testing site). Having an STD (like gonorrhea) makes it easier to get HIV or give it to others, so it's important that you get tested to protect your health and the health of your partner. CDC recommends sexually active gay, bisexual, and other men who have sex with men test for:

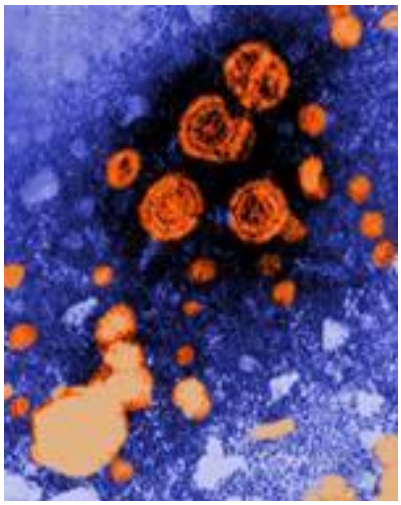
- HIV (at least once a year);
- Syphilis;
- Hepatitis B;
- Hepatitis C if you were born between 1945 to 1965 or with risk behaviors;
- Chlamydia and gonorrhea of the rectum if you've had receptive anal sex or been a "bottom" in the past year;
- Chlamydia and gonorrhea of the penis (urethra) if you have had insertive anal sex (been on the "top") or received oral sex in the past year; and
- Gonorrhea of the throat if you've given oral sex (your mouth on your partner's penis, vagina, or anus) in the past year.

Sometimes your doctor or health care provider may suggest a herpes blood test. If you have more than one partner or have had casual sex with people you don't know, you should be screened more often for STDs and may benefit from getting tested for HIV more often (for example, every 3 to 6 months). Your doctor can offer you the best care if you discuss your sexual history openly. Talk with your doctor about getting vaccinations for Hepatitis A and B, and HPV.

Which vaccinations does CDC recommend for gay and bisexual men?

There are a number of vaccines that can help to protect your health.

Hepatitis



- Hepatitis A and Hepatitis B vaccinations
    - Two doses of the Hepatitis A vaccine are needed for lasting protection and the doses should be given at least six months apart.
    - A series of three doses of the Hepatitis B vaccine are usually given providing long-lasting protection.
    - There is also a combination vaccine for both Hepatitis A and Hepatitis B. It is usually given as a series of three doses in order to provide lasting protection.

Flu

- Seasonal flu
    - The vaccine is a single dose shot given before the start of the flu season in the fall.

Human papillomavirus (HPV)

The human papillomavirus (HPV) vaccine is also available for gay, bisexual, and other men who have sex with men up to 26 years of age to prevent genital warts and other HPV-associated diseases and conditions such

as oropharyngeal or anal cancer external icon. The HPV vaccine is given as a three-dose series over six months. It is best to be vaccinated before your first sexual contact, but later vaccination can still protect you if you have not been exposed to HPV.

How do I lower my risk for STDs?

You can do many things to protect your health. You can learn about how STDs are spread and how you can reduce your chances of getting an STD.

- Talk honestly with your partner about STDs and getting tested—before you have sex.
- Use a condom correctly and use one every time you have sex.
- Think twice about mixing alcohol and/or drugs with sex. They can lower your ability to make good decisions and can lead to risky behavior—like having sex without a condom.
- Limit your number of sexual partners. You can lower your chances of getting STDs if you only have sex with one person who only has sex with you.
- To find out more about lowering your chances of getting HIV, please go to the HIV section of this website.

What other steps can I take to protect my health?

- **Maintain mental health**. Pay attention to your mental health and outlook. Seek counseling if you have persistent negative feelings about yourself or your health.

- **PrEP/PEP**. Talk with your health care provider about whether PrEP or PEP are appropriate for you based on your HIV status and sexual practices.
- **Adhere to taking HIV medications**. If you have HIV, work with your health care provider to ensure that you are taking the right medications the right way.
- **Eat a healthy dietexternal icon**. Choosing healthy meal and snack options can help you avoid heart disease and its complications.
- **Maintain a healthy weight**. To know whether your weight is in a healthy range, doctors often calculate a number called the body mass index (BMI). If you know your weight and height, you can calculate your BMI at CDC's Assessing Your Weight website. Or visit CDC's Healthy Weight website.
- **Exercise regularly**. Exercise can help you maintain a healthy weight and lower cholesterol and blood pressure. Visit CDC's Physical Activity site.
- **Don't smoke**. Cigarette smoking makes your chances of getting heart disease, cancer, and stroke much higher. If you have HIV, smoking also weakens your immune system and can raise your chances of getting tuberculosis (TB), if you come into contact with someone who with TB. So, if you don't smoke, don't start. If you do smoke, quitting will lower your chances of getting or having many medical problems. Visit CDC's Smoking and Tobacco website.

- **Limit alcohol use**. Avoid drinking too much alcohol, which can cause many health problems (high blood pressure or cancer, for example)

and raise your chances of getting injured or participating in risky behaviors. Visit CDC's Alcohol and Public Health website.

- **Cholesterol screenings**. The National Cholesterol Education Program recommends that adults who are 20 years of age or older have their cholesterol checked every five years.
- **Cancer screenings**. Ask your health care provider for information on screening for prostate, testicular, colon, oral, and anal cancers.
- **Check your blood pressure**. Getting your blood pressure checked is important because high blood pressure often has no symptoms.
- **Get checkups**. Ask your doctor or nurse how you can lower your chances for health problems.

B. Stigma and Discrimination

Homophobia, stigma (negative and usually unfair beliefs), and discrimination (unfairly treating a person or group of people) against gay, bisexual, and other men who have sex with men still exist in the United States and can negatively affect the health and well-being of this community.

These negative beliefs and actions can affect the physical and mental health of gay, bisexual, and other men who have sex with men, whether they seek and are able to get health services, and the quality of the services they may receive. Such barriers to health must be addressed at different levels of society, such as health care settings, work places, and schools to improve the health of gay and bisexual men throughout their lives.

The Effects of Negative Attitudes on Gay, Bisexual, and Other Men Who Have Sex with Men

Some people may have negative attitudes toward gay, bisexual, and other men who have sex with men. These attitudes can lead to rejection by friends and family, discriminatory acts and violence, and laws and policies with negative consequences. If you are gay, bisexual, or a man who has sex with other men, homophobia, stigma, and discrimination can:

- Affect your income, whether you can get or keep a job, and your ability to get and keep health insurance.
- Limit your access to high quality health care that is responsive to your health issues.
- Add to poor mental health and poor coping skills, such as substance abuse, risky sexual behaviors, and suicide attempts.
- Affect your ability to have and maintain long-term same-sex relationships that lower your chances of getting HIV & STDs.
- Make it harder for you to be open about your sexual orientation, which can increase stress, limit social support, and negatively affect your health.

Homophobia, stigma, and discrimination can be especially hard for young men who are gay, bisexual, and other men who have sex with men. These negative attitudes increase their chance of experiencing violence, especially compared with other students in their schools. Violence can include behaviors such as bullying, teasing, harassment, physical assault, and suicide-related behaviors.

Gay and bisexual youth and other sexual minorities are more likely to be rejected by their families. This increases the possibility of them becoming

homeless. Around 40% of homeless youth are LGBT. A study published in 2009 compared gay, lesbian, and bisexual young adults who experienced strong rejection from their families with their peers who had more supportive families. The researchers found that those who experienced stronger rejection were about:

- 8 times more likely to have tried to commit suicide
- 6 times more likely to report high levels of depression
- 3 times more likely to use illegal drugs
- 3 times more likely to have risky sex

Reducing the Effects of Stigma and Discrimination

Gay and bisexual men and their family and friends can take steps to lessen the effects of homophobia, stigma, and discrimination and protect their physical and mental health. One way to handle the stress from stigma and discrimination is by having social support. Studies show that gay men who have good social support—from family, friends, and the wider gay community—have:

- higher self-esteem,
- a more positive group identity, and
- more positive mental health.

What Can Parents and Guardians Do?

Parents of a gay or bisexual teen can have an important impact on their child's current and future mental and physical well-being. Parents should talk openly with their teen about any problems or concerns and watch for behaviors that might show their child is being bullied or is experiencing violence. If bullying, violence, or depression is suspected, parents should take immediate action working with school staff and other adults in the community.

In addition, parents who talk with and listen to their teens in a way that invites open discussion about sexual orientation can help their teens feel loved and supported. Parents should have honest conversations with their teens about safer sex, STDS, and HIV prevention. Parents should also talk with their teens about how to avoid risky behavior and unsafe or high-risk situations.

Parents also should develop common goals with their teens, such as being healthy and doing well in school. Many organizations and online information resources exist to help parents learn more about how they can support their gay and bisexual teen, other family members, and their teens' friends.

What Can Schools Do?

Schools can also help reduce stigma and discrimination for young gay, bisexual, and other men who have sex with men. A positive school environment is associated with less depression, fewer suicidal feelings, lower

substance use, and fewer unexcused school absences among LGBT students. Schools can help create safer and more supportive environments by preventing bullying and harassment, promoting school connectedness, and promoting parent engagement. This can be done through the following policies and practices:

- Encourage respect for all students and not allow bullying, harassment, or violence against any students.
- Identify "safe spaces," such as counselors' offices, designated classrooms, or student organizations, where gay and bisexual youth can get support from administrator, teacher, or other school staff.
- Encourage student-led and student-organized school clubs that promote a safe, welcoming, and accepting school environment (such as gay-straight alliances, which are school clubs open to youth of all sexual orientations).
- Make sure that health classes or educational materials include HIV and STD information that is relevant to gay and bisexual youth too, making sure that the information uses inclusive words or terms.
- Encourage school district and school staff to create and publicize trainings on how to create safe and supportive school environments for all students, regardless of sexual orientation or gender identity and encourage staff to attend these trainings.
- Make it easier for students to have access to community-based providers who have experience providing health services, including HIV/STD testing and counseling, and social and psychological services to gay and bisexual youth.

You can also help by reporting discrimination, especially while seeking and receiving healthcare services. This could also have a positive impact on the environment for other gay and bisexual men. Hospitals can't discriminate against people based on sexual orientation and gender identity. Hospitals that receive funding from the Centers for Medicaid and Medicare are required to have nondiscriminatory hospital visitation policies External, so that same-sex partners and other family members can visit loved ones in the hospital.

Whether you are gay or straight, you can help reduce homophobia, stigma, and discrimination in your community and decrease the negative health effects. Even small things can make a difference, such as supporting a family member, friend, or co-worker.

C. HIV/AIDS

Oral Sex and HIV Risk
Retrieved from: https://www.cdc.gov/hiv/risk/oralsex.html

What is HIV?

HIV stands for human immunodeficiency virus. It is the virus that can lead to acquired immunodeficiency syndrome, or AIDS. Unlike some other viruses, the human body cannot get rid of HIV. That means that once you have HIV, you have it for life.

How Is HIV Spread?

In the United States, HIV is spread mainly by:

- Having sex with someone who has HIV. In general:
    - Anal sex is the highest-risk sexual behavior. Receptive anal sex (bottoming) is riskier than insertive anal sex (topping).
    - Vaginal sex is the second highest-risk sexual behavior.
    - Having many sex partners or having other STDs can increase the chances of getting HIV through sex.
- Sharing needles, syringes, rinse water, or other equipment (works) used to make injectable drugs with someone who has HIV.

Less commonly, HIV may be spread by:

- Oral sex. The chances of getting HIV through oral sex are much less than from anal or vaginal sex. Learn more about oral sex and HIV risk.

What are the Signs and Symptoms Of HIV?

Within a few weeks of getting HIV, some people get flu-like symptoms that last for a week or two, but others have no symptoms at all. After initial infection, people may not have any symptoms for years. HIV can be controlled with the right medical treatment and care. However, if it's left untreated, it may develop into AIDS (acquired immunodeficiency syndrome).

How can I prevent HIV?

You can take steps to prevent HIV. Here's what you can do:

- **Understand what are riskier and safer sexual behaviors**. Your chances of getting HIV from oral sex are much less than from anal or vaginal sex. You have the most chance of getting or giving someone HIV from anal sex. If you are HIV-negative, insertive anal sex (topping) is less risky for getting HIV than receptive anal sex (bottoming). You won't get HIV or give it to someone else from sexual activities that do not involve exchanging body fluids.

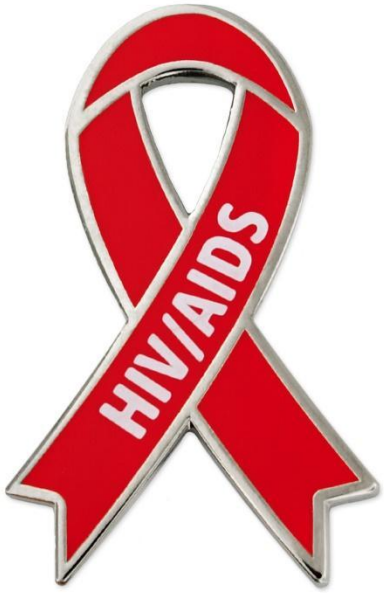
- **Use condoms each time you have sex and make sure to use them correctly each time**.

- **Reduce the number of people you have sex with**. The number of sex partners you have affects your chances of getting HIV. The more partners you have, the more likely you are to have a partner with HIV or who has an STD. Both of these raise your chances of getting HIV.

- **If you have HIV, take HIV antiretroviral treatment (ART) regularly to greatly lower the chances of giving HIV to others and improve your own health**.

- **If your partner is HIV-positive, encourage your partner to get and stay on treatment**. ART reduces the amount of HIV virus (viral loadExternal) in blood and body fluids. ART can keep people with HIV healthy for many years, and greatly reduce the chance of giving HIV to sex partners if taken regularly and correctly.
- **Talk to your doctor about pre-exposure prophylaxis (PrEP), taking HIV medicine daily to prevent getting HIV**. You should consider PrEP if you are

- HIV-negative and are in an ongoing sexual relationship with an HIV-positive partner;
- HIV-negative and are in an ongoing sexual relationship with a sex partner who injects drugs;
- HIV-negative and have had an STD or anal sex with a male partner without condoms in the past 6 months and are not in an exclusive relationship with a recently tested, HIV-negative partner.



- **Talk to your doctor right away (within 3 days) about post-exposure prophylaxis (PEP) if you have a possible exposure to HIV**. An example of a possible exposure is if you have anal or vaginal sex without a condom with someone who is or may be HIV-positive, and you are HIV-negative and not taking PrEP. Your chance of exposure to HIV is lower if your HIV-positive partner is taking antiretroviral therapy (ART) regularly and correctly, especially if his/her viral load is undetectableExternal. Starting PEP immediately and taking it daily for 4 weeks reduces your chance of getting HIV.

- **Get tested and treated for other STDs and encourage your partners to do the same**. If you are sexually active, get tested at least once a year. STDs can have long-term health consequences. They can also increase your chance of getting HIV or giving it to others. Find an STD testing site.

D. Sexually Transmitted Diseases

Sexually Transmitted Diseases (STDs) have been rising among gay and bisexual men, with increases in syphilis being seen across the country. In 2014, gay, bisexual, and other men who have sex with men accounted for 83% of primary and secondary syphilis cases where sex of sex partner was known in the United States. Gay, bisexual, and other men who have sex with men often get other STDs, including chlamydia and gonorrhea infections. HPV (Human papillomavirus), the most common STD in the United States, is also a concern for gay, bisexual, and other men who have sex with men. Some types of HPV can cause genital and anal warts and some can lead to the development of anal and oral cancers. Gay, bisexual, and other men who have sex with men are 17 times more likely to get anal cancer than heterosexual men. Men who are HIV-positive are even more likely than those who do not have HIV to get anal cancer.

How are STDs spread?

- STDs are spread through sexual contact (without a condom) with someone who has an STD. Sexual contact includes oral, anal, and vaginal sex, as well as genital skin-to-skin contact. While condoms are

effective, HPV and HSV can be spread by contact with the area around the genitals not protected by the condom.

- Some STDs—like HIV, chlamydia and gonorrhea—are spread through body fluids, such as semen (cum). Other STDs, including HIV and Hepatitis B, are also spread through blood. Genital herpes, syphilis, and HPV are most often spread through genital skin-to-skin contact.

What are the signs and symptoms of STDs?

- Most STDs have no signs or symptoms, so you (or your partner) could be infected and not know it.
- The only way to know your STD status is to get tested
- Having an STD such as herpes makes it easier to get HIV.

When should I be tested?

All sexually active gay, bisexual, and other men who have sex with men should be tested regularly for STDs. The only way to know your STD status is to get tested. Having an STD (like gonorrhea) makes it easier to get HIV or give it to others, so it's important that you get tested to protect your health and the health of your partner. CDC recommends sexually active gay and bisexual men test for

- HIV (at least once a year);
- Syphilis;
- Hepatitis B;
- Hepatitis C if you were born between 1945 to 1965 or with risk behaviors;
- Chlamydia and gonorrhea of the rectum if you've had receptive anal sex or been a "bottom" in the past year;

- Chlamydia and gonorrhea of the penis (urethra) if you have had insertive anal sex (been on the "top") or received oral sex in the past year; and
- Gonorrhea of the throat if you've given oral sex (your mouth on your partner's penis, vagina, or anus) in the past year.

Sometimes your doctor or health care provider may suggest a herpes blood test. If you have more than one partner or have had casual sex with people you don't know, you should be screened more often for STDs and may benefit from getting tested for HIV more often (for example, every 3 to 6 months). Your doctor can offer you the best care if you discuss your sexual history openly. Talk with your doctor about getting vaccinations for Hepatitis A and B, and HPV.

You should have a doctor or provider you are comfortable with. CDC's Lesbian, Gay, Bisexual and Transgender Health Services page has resources that can help you find health services that are skilled in working with gay and bisexual men. Also, HIV Treatment Works resources have information about how to get in care and stay on treatment, as well as resources on how to live well.

How can I prevent STDs?

For anyone, being sexually active means, you are at risk for STDs. However, you can do many things to protect your health. You can learn about how STDs are spread and how you can lower your chances of getting them.

Get Vaccinated: Gay, bisexual, and other men who have sex with men have a greater chance of getting Hepatitis A, Hepatitis B, and HPV. For this reason, CDC recommends that you be vaccinated against Hepatitis A and Hepatitis B. The HPV vaccine is also recommended for men up to age 26.

Be Safer: Getting tested regularly and getting vaccinated are both important, but there are other things you can do to reduce your risk for STDs.

- Talk honestly with your partner about STDs and getting tested—before you have sex.
- Use condoms correctly every time you have sex.
- Think twice about mixing alcohol and/or drugs with sex. They can lower your ability to make good decisions and can lead to risky behavior—like having sex without a condom.
- Limit your number of sexual partners. You can lower your chances of getting STDs if you only have sex with one person who only has sex with you.

Know Your Status: If you know your STD status, you can take steps to protect yourself and your partners.

Can STDs Be Treated?

Some STDs (like gonorrhea, chlamydia and syphilis) can be cured with medication. If you are ever treated for an STD, be sure to finish all of your

medicine, even if you feel better. Your partner should be tested and treated, too. It is important to remember that you can get the same or a new STD every time you have unprotected sex (not using a condom) and/or have sex with someone who has an STD.

Other STDs like herpes and HIV cannot be cured, but you can take medicines to manage symptoms.

E. Viral Hepatitis

Retrieved from: https://www.cdc.gov/msmhealth/viral-hepatitis.htm

Gay, bisexual, and other men who have sex with men have a higher chance of getting viral hepatitis including Hepatitis A, B, and C, which are diseases that affect the liver. About 10% of new Hepatitis A and 20% of all new Hepatitis B infections in the United States are among gay and bisexual men. Many men have not been vaccinated against Hepatitis A and B, even though a safe and effective vaccine is available. Gay, bisexual, and other men who have sex with men also have a higher chance of getting Hepatitis C if they are involved in high-risk behaviors, such as injection drug use and other

activities that result in blood sharing. While there is no vaccine for Hepatitis C, there are new, effective treatments.

How is Hepatitis A spread?

Hepatitis A is usually spread when a person accidentally swallows fecal matter (stool)—even in really small amounts—that has the Hepatitis A virus in it. The virus can be spread through contact with objects, food, or drinks contaminated by the feces, or stool, of a person who has the virus. Among gay and bisexual men, Hepatitis A can be spread through sexual activity or contact with fingers or objects that have the virus on it.

How is Hepatitis B spread?

Hepatitis B is spread when body fluids—such as semen (cum) or blood—from a person who has Hepatitis B enter the body of someone who does not have it. The Hepatitis B virus is very infectious and is easily spread during sexual activity. Hepatitis B also can be spread through sharing needles, syringes, or other equipment used to inject drugs. It can also be spread during pregnancy from an infected mother to her unborn child.

How is Hepatitis C spread?

Hepatitis C is spread through contact with the blood of someone who has Hepatitis C, mainly through sharing needles, syringes, or other injection drug equipment. Hepatitis C can also be spread when getting tattoos and body piercings in casual places or with non-sterile instruments. Although uncommon, Hepatitis C can also be spread through sexual contact. Having a sexually transmitted disease (STD) or HIV, sex with multiple partners, or rough sex can raise a person's chance of getting Hepatitis C.

What are the symptoms of viral hepatitis?

The symptoms of viral hepatitis vary depending upon a person's age and which type of hepatitis infection it is. There is also a difference between acute and chronic viral hepatitis. For acute hepatitis, symptoms, if they appear, will occur within several weeks to several months of exposure. Symptoms of chronic viral hepatitis can take decades to develop and people can live with an infection for years and not feel sick. When symptoms do appear with chronic hepatitis, it can be a sign of advanced liver disease. Symptoms for both acute and chronic viral hepatitis can include: fever, fatigue, loss of appetite, nausea, vomiting, abdominal pain, dark urine, gray-colored stools, joint pain, and jaundice.

Can viral hepatitis be prevented?

Hepatitis A and B can be prevented through vaccinations. Experts recommend that all gay and bisexual men be vaccinated for Hepatitis A and

B. The Hepatitis A and B vaccines can be given separately or as a combination vaccine. The vaccines are safe, effective, and require 2-3 shots within a six-month period depending on the type of vaccine. A person should complete all shots in the series for long-term protection. There is no vaccine for Hepatitis C.

F. Suicide and Violence Prevention

Violence is a serious public health problem in the United States. It can affect all types of people throughout their lives. Those who survive violence are usually left with permanent physical and emotional scars. Gay, bisexual, and other men who have sex with men are at overall increased risk of violence because of homophobia, harassment, and violent acts directed towards gay persons.

Suicide Prevention

Males in the United States are more likely to take their own life at nearly four times the rate of females and represent 79% of all U.S. suicides. Suicide is the seventh leading cause of death for males in the United States. Gay, bisexual, and other men who have sex with men are at even greater risk for suicide attempts, especially before the age of 25. A study of youth in grades 7-12 found that lesbian, gay, and bisexual youth were more than twice as likely to have attempted suicide as their heterosexual peers. Some risk factors are linked

to being gay or bisexual in a hostile environment and the effects that this has on mental health.

Intimate Partner Violence

Intimate partner violence occurs between two people in a close relationship, including current and former partners. Intimate partner violence can range from one time to ongoing battering. Intimate partner violence includes four types of behavior: physical violence, sexual violence, threats of physical or sexual violence, and emotional abuse. The Victimization by Sexual Orientation Report Cdc-pdf[PDF – 968 KB] has shown that 26% of gay and 37% bisexual men experience intimate partner violence at some point in their lifetime. According to data from Youth Risk Behavior Surveys (YRBS) conducted during 2001-2009 in seven states and six large urban school districts, 19% to 29% of gay and lesbian students across the sites and 18% to 28% of bisexual students across the sites experienced dating violence in the prior year.

Sexual Violence

Sexual violence refers to sexual activity that happens against someone's will. The person responsible for the violence is usually someone known to the victim. Sexual violence does not only include physical sexual contact, such as unwanted touching and rape, it also includes sexual harassment, threats, peeping, and taking nude photos. The National Intimate Partner and Sexual Violence Survey Cdc-pdf[PDF – 1.72 MB] has shown that around 40% of gay men experienced sexual violence (other than rape) in their lifetime and

around 47% of bisexual men experienced sexual violence (other than rape) in their lifetime.

According to data from the Youth Risk Behavior Survey (YRBS) conducted during 2001-2009 in seven states and six large urban school districts, 14% to 31% of gay and lesbian students across the sites and 17% of 32% of bisexual students across the sites had been forced to have sexual intercourse at some point in their lives.

Sexually Transmitted Diseases

A. Bacterial Vaginosis – CDC Fact Sheet

Retrieved from: https://www.cdc.gov/std/bv/stdfact-bacterial-vaginosis.htm#:~:text=There%20is%20no%20research%20to,who%20have%20never%20had%20sex.

Any woman can get bacterial vaginosis. Having bacterial vaginosis can increase your chance of getting an STD.

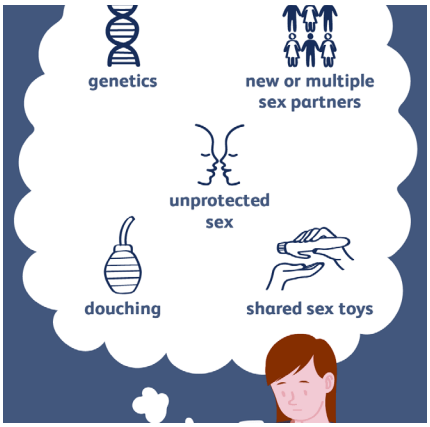
What is bacterial vaginosis?

Bacterial vaginosis (BV) is a condition that happens when there is too much of certain bacteria in the vagina. This changes the normal balance of bacteria in the vagina.

How common is bacterial vaginosis?

Bacterial vaginosis is the most common vaginal infection in women ages 15-44.

How is bacterial vaginosis spread?



Researchers do not know the cause of BV or how some women get it. We do know that the infection typically occurs in sexually active women. BV is linked to an imbalance of "good" and "harmful" bacteria that are normally found in a woman's vagina. Having a new sex partner or multiple sex partners, as well as douching, can upset the balance of bacteria in the vagina. This places a woman at increased risk for getting BV.

We also do not know how sex contributes to BV. There is no research to show that treating a sex partner affects whether or not a woman gets BV. Having BV can increase your chances of getting other STDs.

BV rarely affects women who have never had sex.

You cannot get BV from toilet seats, bedding, or swimming pools.

How can I avoid getting bacterial vaginosis?

Doctors and scientists do not completely understand how BV spreads. There are no known best ways to prevent it.

The following basic prevention steps *may* help lower your risk of developing BV:

- Not having sex;
- Limiting your number of sex partners; and
- Not douching.

I'm pregnant. How does bacterial vaginosis affect my baby?

Pregnant women can get BV. Pregnant women with BV are more likely to have babies born premature (early) or with low birth weight than pregnant women without BV. Low birth weight means having a baby that weighs less than 5.5 pounds at birth.

Treatment is especially important for pregnant women.

How do I know if I have bacterial vaginosis?

Many women with BV do not have symptoms. If you do have symptoms, you may notice:

- A thin white or gray vaginal discharge;
- Pain, itching, or burning in the vagina;
- A strong fish-like odor, especially after sex;
- Burning when urinating;
- Itching around the outside of the vagina.

How will my doctor know if I have bacterial vaginosis?

A health care provider will examine your vagina for signs of vaginal discharge. Your provider can also perform laboratory tests on a sample of vaginal fluid to determine if BV is present.

Can bacterial vaginosis be cured?

BV will sometimes go away without treatment. But if you have symptoms of BV you should be checked and treated. It is important that you take all of the medicine prescribed to you, even if your symptoms go away. A health care provider can treat BV with antibiotics, but BV may return even after treatment. Treatment may also reduce the risk for some STDs.

Male sex partners of women diagnosed with BV generally do not need to be treated. BV may be transferred between female sex partners.

I'm pregnant. How does bacterial vaginosis affect my baby?

Pregnant women can get BV. Pregnant women with BV are more likely to have babies born premature (early) or with low birth weight than pregnant women without BV. Low birth weight means having a baby that weighs less than 5.5 pounds at birth.

Treatment is especially important for pregnant women.

How do I know if I have bacterial vaginosis?

Many women with BV do not have symptoms. If you do have symptoms, you may notice:

- A thin white or gray vaginal discharge;
- Pain, itching, or burning in the vagina;
- A strong fish-like odor, especially after sex;

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A health care provider will examine your vagina for signs of vaginal discharge. Your provider can also perform laboratory tests on a sample of vaginal fluid to determine if BV is present.

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BV will sometimes go away without treatment. But if you have symptoms of BV you should be checked and treated. It is important that you take all of the medicine prescribed to you, even if your symptoms go away. A health care provider can treat BV with antibiotics, but BV may return even after treatment. Treatment may also reduce the risk for some STDs.

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BV will sometimes go away without treatment. But if you have symptoms of BV you should be checked and treated. It is important that you take all of the medicine prescribed to you, even if your symptoms go away. A health care provider can treat BV with antibiotics, but BV may recur even after treatment. Treatment may also reduce the risk for some STDs.

Male sex partners of women diagnosed with BV generally do not need to be treated. BV may be transferred between female sex partners.

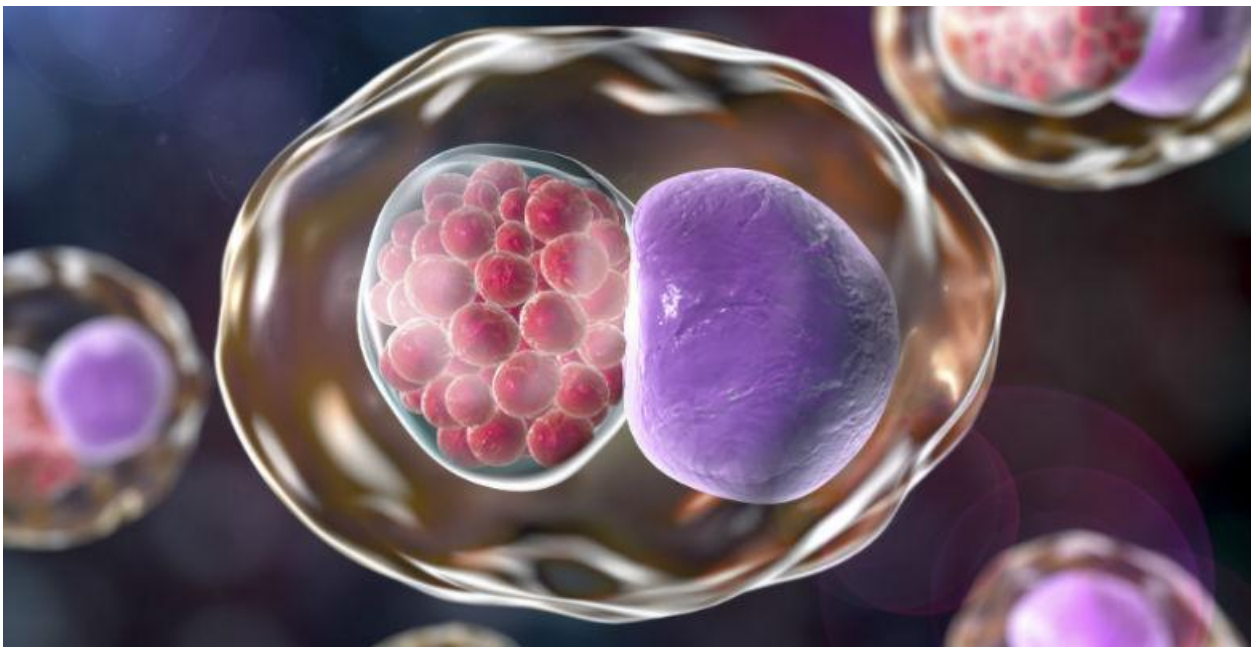
B. Chlamydia - CDC Fact Sheet

Retrieved from: https://www.cdc.gov/std/chlamydia/stdfact-chlamydia.htm

Chlamydia is a common sexually transmitted disease (STD) that can be easily cured. If left untreated, chlamydia can make it difficult for a woman to get pregnant.

What is chlamydia?

Chlamydia is a common STD that can infect both men and women. It can cause serious, permanent damage to a woman's reproductive system. This can make it difficult or impossible for her to get pregnant later on. Chlamydia can also cause a potentially fatal ectopic pregnancy (pregnancy that occurs outside the womb).



How is chlamydia spread?

You can get chlamydia by having vaginal, anal, or oral sex with someone who has chlamydia. If your sex partner is male you can still get chlamydia even if he does not ejaculate (cum).

If you've had chlamydia and were treated in the past, you can still get infected again. This can happen if you have unprotected sex with someone who has chlamydia.

If you are pregnant, you can give chlamydia to your baby during childbirth.

How can I reduce my risk of getting chlamydia?

The only way to avoid STDs is to not have vaginal, anal, or oral sex.

If you are sexually active, you can do the following things to lower your chances of getting chlamydia:

- Be in a long-term mutually monogamous relationship with a partner who has been tested and has negative STD test results;
- Use latex condoms the right way every time you have sex.

Am I at risk for chlamydia?

Anyone who has sex can get chlamydia through unprotected vaginal, anal, or oral sex. However, sexually active young people are at a higher risk of getting chlamydia. This is due to behaviors and biological factors common among young people. Gay, bisexual, and other men who have sex with men are also at risk since chlamydia can spread through oral and anal sex.

Have an honest and open talk with your health care provider. Ask whether you should be tested for chlamydia or other STDs. If you are a sexually active woman younger than 25 years, you should get a test for chlamydia every year. If you are an older woman with risk factors such as new or multiple sex partners, or a sex partner who has an STD, you should get a test for chlamydia every year. Gay, bisexual, and other men who have sex with men; as well as pregnant women should also get tested for chlamydia.

I'm pregnant. How does chlamydia affect my baby?

If you are pregnant and have chlamydia, you can pass the infection to your baby during delivery. This could cause an eye infection or pneumonia in your newborn. Having chlamydia may also make it more likely to deliver your baby too early.

If you are pregnant, you should get tested for chlamydia at your first prenatal visit. Testing and treatment are the best ways to prevent health problems.

How do I know if I have chlamydia?

Most people who have chlamydia have no symptoms. If you do have symptoms, they may not appear until several weeks after you have sex with an infected partner. Even when chlamydia causes no symptoms, it can damage your reproductive system.

Women with symptoms may notice

- An abnormal vaginal discharge;
- A burning sensation when urinating.

Symptoms in men can include

- A discharge from their penis;
- A burning sensation when urinating;
- Pain and swelling in one or both testicles (although this is less common).

Men and women can also get infected with chlamydia in their rectum. This happens either by having receptive anal sex, or by spread from another infected site (such as the vagina). While these infections often cause no symptoms, they can cause

- Rectal pain;
- Discharge;
- Bleeding.

You should be examined by your doctor if you notice any of these symptoms or if your partner has an STD or symptoms of an STD. STD symptoms can include an unusual sore, a smelly discharge, burning when urinating, or bleeding between periods.

How will my doctor know if I have chlamydia?

Laboratory tests can diagnose chlamydia. Your health care provider may ask you to provide a urine sample or may use (or ask you to use) a cotton swab to get a sample from your vagina to test for chlamydia.

Can chlamydia be cured?

Yes, chlamydia can be cured with the right treatment. It is important that you take all of the medication your doctor prescribes to cure your infection.

When taken properly it will stop the infection and could decrease your chances of having complications later on. You should not share medication for chlamydia with anyone.

Repeat infection with chlamydia is common. You should be tested again about three months after you are treated, even if your sex partner(s) was treated.

I was treated for chlamydia. When can I have sex again?

You should not have sex again until you and your sex partner(s) have completed treatment. If your doctor prescribes a single dose of medication, you should wait seven days after taking the medicine before having sex. If your doctor prescribes a medicine for you to take for seven days, you should wait until you have taken all of the doses before having sex.

What happens if I don't get treated?

The initial damage that chlamydia causes often goes unnoticed. However, chlamydia can lead to serious health problems.

If you are a woman, untreated chlamydia can spread to your uterus and fallopian tubes (tubes that carry fertilized eggs from the ovaries to the uterus). This can cause pelvic inflammatory disease (PID). PID often has no symptoms, however some women may have abdominal and pelvic pain. Even if it doesn't cause symptoms initially, PID can cause permanent damage to your reproductive system. PID can lead to long-term pelvic pain, inability to get pregnant, and potentially deadly ectopic pregnancy (pregnancy outside the uterus).

Men rarely have health problems linked to chlamydia. Infection sometimes spreads to the tube that carries sperm from the testicles, causing pain and

fever. Rarely, chlamydia can prevent a man from being able to have children.

Untreated chlamydia may also increase your chances of getting or giving HIV – the virus that causes AIDS.

What is the treatment for chlamydia?

Chlamydia can be easily cured with antibiotics. HIV-positive persons with chlamydia should receive the same treatment as those who are HIV-negative.

Persons with chlamydia should abstain from sexual activity for 7 days after single dose antibiotics or until completion of a 7-day course of antibiotics, to prevent spreading the infection to partners. It is important to take all of the medication prescribed to cure chlamydia. Medication for chlamydia should not be shared with anyone. Although medication will stop the infection, it will not repair any permanent damage done by the disease. If a person's symptoms continue for more than a few days after receiving treatment, he or she should return to a health care provider to be reevaluated.

Repeat infection with chlamydia is common. Women whose sex partners have not been appropriately treated are at high risk for re-infection. Having multiple chlamydial infections increases a woman's risk of serious reproductive health complications, including pelvic inflammatory disease and ectopic pregnancy. Women and men with chlamydia should be retested about three months after treatment of an initial infection, regardless of whether they believe that their sex partners were successfully treated.

Infants infected with chlamydia may develop ophthalmia neonatorum (conjunctivitis) and/or pneumonia. Chlamydial infection in infants can be treated with antibiotics.

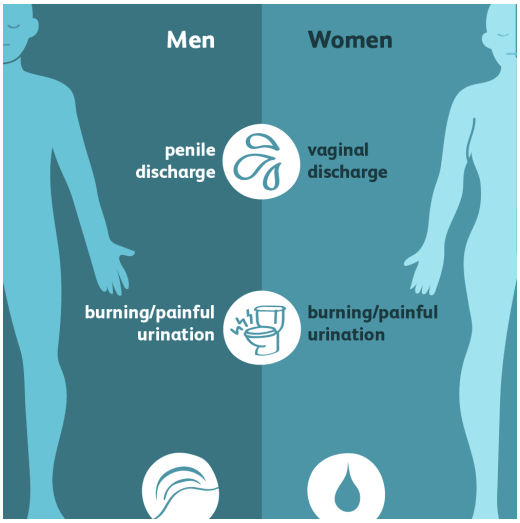
C. Gonorrhea - CDC Fact Sheet

Retrieved from: https://www.cdc.gov/std/gonorrhea/stdfact-gonorrhea.htm

Anyone who is sexually active can get gonorrhea. Gonorrhea can cause very serious complications when not treated, but can be cured with the right medication.

What is gonorrhea?

Gonorrhea is a sexually transmitted disease (STD) that can infect both men and women. It can cause infections in the genitals, rectum, and throat. It is a very common infection, especially among young people ages 15-24 years.



How is gonorrhea spread?

You can get gonorrhea by having vaginal, anal, or oral sex with someone who has gonorrhea. A pregnant woman with gonorrhea can give the infection to her baby during childbirth.

How can I reduce my risk of getting gonorrhea?

The only way to avoid STDs is to not have vaginal, anal, or oral sex.

If you are sexually active, you can do the following things to lower your chances of getting gonorrhea:

- Being in a long-term mutually monogamous relationship with a partner who has been tested and has negative STD test results;
- Using latex condoms the right way every time you have sex.

Am I at risk for gonorrhea?

Any sexually active person can get gonorrhea through unprotected vaginal, anal, or oral sex.

If you are sexually active, have an honest and open talk with your health care provider and ask whether you should be tested for gonorrhea or other STDs. If you are a sexually active man who is gay, bisexual, or who has sex with men, you should be tested for gonorrhea every year. If you are a sexually active woman younger than 25 years or an older woman with risk factors such as new or multiple sex partners, or a sex partner who has a sexually transmitted infection, you should be tested for gonorrhea every year.

I'm pregnant. How does gonorrhea affect my baby?

If you are pregnant and have gonorrhea, you can give the infection to your baby during delivery. This can cause serious health problems for your baby. If you are pregnant, it is important that you talk to your health care provider so that you get the correct examination, testing, and treatment, as necessary. Treating gonorrhea as soon as possible will make health complications for your baby less likely.

How do I know if I have gonorrhea?

Some men with gonorrhea may have no symptoms at all. However, men who do have symptoms, may have:

- A burning sensation when urinating;
- A white, yellow, or green discharge from the penis;
- Painful or swollen testicles (although this is less common).

Most women with gonorrhea do not have any symptoms. Even when a woman has symptoms, they are often mild and can be mistaken for a bladder or vaginal infection. Women with gonorrhea are at risk of developing serious complications from the infection, even if they don't have any symptoms.

Symptoms in women can include:

- Painful or burning sensation when urinating;
- Increased vaginal discharge;
- Vaginal bleeding between periods.

Rectal infections may either cause no symptoms or cause symptoms in both men and women that may include:

- Discharge;
- Anal itching;
- Soreness;
- Bleeding;
- Painful bowel movements.

- You should be examined by your doctor if you notice any of these symptoms or if your partner has an STD or symptoms of an STD, such as an unusual sore, a smelly discharge, burning when urinating, or bleeding between periods.

How will my doctor know if I have gonorrhea?

- Most of the time, urine can be used to test for gonorrhea. However, if you have had oral and/or anal sex, swabs may be used to collect samples from your throat and/or rectum. In some cases, a swab may be used to collect a sample from a man's urethra (urine canal) or a woman's cervix (opening to the womb).

Can gonorrhea be cured?

- Yes, gonorrhea can be cured with the right treatment. It is important that you take all of the medication your doctor prescribes to cure your infection. Medication for gonorrhea should not be shared with anyone. Although medication will stop the infection, it will not undo any permanent damage caused by the disease.

It is becoming harder to treat some gonorrhea, as drug-resistant strains of gonorrhea are increasing. If your symptoms continue for more than a few days after receiving treatment, you should return to a health care provider to be checked again.

I was treated for gonorrhea. When can I have sex again?

You should wait seven days after finishing all medications before having sex. To avoid getting infected with gonorrhea again or spreading gonorrhea to

your partner(s), you and your sex partner(s) should avoid having sex until you have each completed treatment. If you've had gonorrhea and took medicine in the past, you can still get infected again if you have unprotected sex with a person who has gonorrhea.

What happens if I don't get treated?

Untreated gonorrhea can cause serious and permanent health problems in both women and men.

In women, untreated gonorrhea can cause pelvic inflammatory disease (PID). Some of the complications of PID are

- Formation of scar tissue that blocks fallopian tubesexternal icon;
- Ectopic pregnancy (pregnancy outside the wombexternal icon);
- Infertility (inability to get pregnant);
- Long-term pelvic/abdominal pain.

In men, gonorrhea can cause a painful condition in the tubes attached to the testicles. In rare cases, this may cause a man to be sterile, or prevent him from being able to father a child.

Rarely, untreated gonorrhea can also spread to your blood or joints. This condition can be life-threatening.

Untreated gonorrhea may also increase your chances of getting or giving HIV – the virus that causes AIDS.

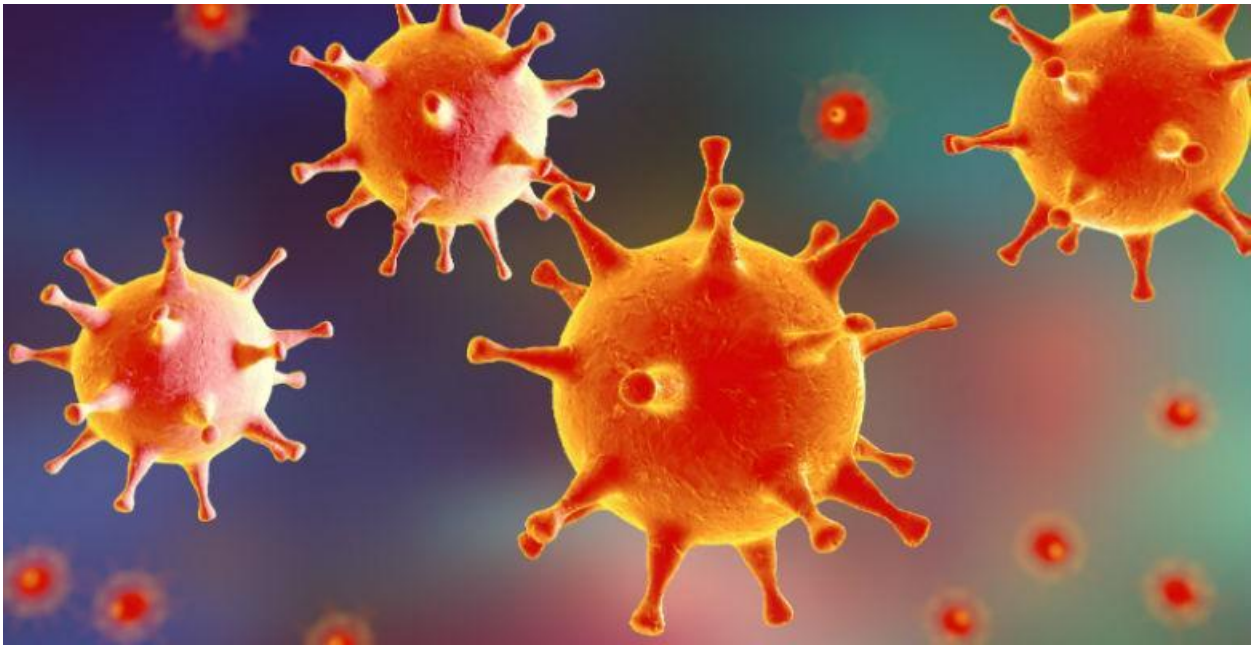
What is the treatment for gonorrhea?

Gonorrhea can be cured with the right treatment. CDC recommends a single dose of 250mg of intramuscular ceftriaxone AND 1g of oral azithromycin. It is important to take all of the medication prescribed to cure gonorrhea. Medication for gonorrhea should not be shared with anyone. Although

medication will stop the infection, it will not repair any permanent damage done by the disease. Antimicrobial resistance in gonorrhea is of increasing concern, and successful treatment of gonorrhea is becoming more difficult. If a person's symptoms continue for more than a few days after receiving treatment, he or she should return to a health care provider to be reevaluated.

D. Genital Herpes - CDC Fact Sheet

Retrieved from: https://www.cdc.gov/std/herpes/stdfact-herpes-detailed.htm



Genital herpes is a common sexually transmitted disease (STD) that any sexually active person can get. Most people with the virus don't have symptoms. Even without signs of the disease, herpes can still be spread to sex partners.

What is genital herpes?

Genital herpes is an STD caused by two types of viruses. The viruses are called herpes simplex virus type 1 (HSV-1) and herpes simplex virus type 2 (HSV-2).

What is oral herpes?

Oral herpes is usually caused by HSV-1 and can result in cold sores or fever blisters on or around the mouth. However, most people do not have any symptoms. Most people with oral herpes were infected during childhood or young adulthood from non-sexual contact with saliva.

Is there a link between genital herpes and oral herpes?

Oral herpes caused by HSV-1 can be spread from the mouth to the genitals through oral sex. This is why some cases of genital herpes are caused by HSV-1.

How common is genital herpes?

Genital herpes is common in the United States. More than one out of every six people aged 14 to 49 years have genital herpes.

How is genital herpes spread?

You can get genital herpes by having vaginal, anal, or oral sex with someone who has the disease.

If you do not have herpes, you can get infected if you come into contact with the herpes virus in:

- A herpes sore;
- Saliva (if your partner has an oral herpes infection) or genital secretions (if your partner has a genital herpes infection);
- Skin in the oral area if your partner has an oral herpes infection, or skin in the genital area if your partner has a genital herpes infection.

You can get herpes from a sex partner who does not have a visible sore or who may not know he or she is infected. It is also possible to get genital herpes if you receive oral sex from a sex partner who has oral herpes.

You will not get herpes from toilet seats, bedding, or swimming pools, or from touching objects around you such as silverware, soap, or towels. If you have additional questions about how herpes is spread, consider discussing your concerns with a healthcare provider.

How can I reduce my risk of getting genital herpes?

The only way to avoid STDs is to not have vaginal, anal, or oral sex.

If you are sexually active, you can do the following things to lower your chances of getting genital herpes:

- Be in a long-term mutually monogamous relationship with a partner who is not infected with an STD (e.g., a partner who has been tested and has negative STD test results);
- Using latex condoms the right way every time you have sex.

Be aware that not all herpes sores occur in areas that are covered by a latex condom. Also, herpes virus can be released (shed) from areas of the skin that do not have a visible herpes sore. For these reasons, condoms *may not* fully protect you from getting herpes.

If you are in a relationship with a person known to have genital herpes, you can lower your risk of getting genital herpes if:

- Your partner takes an anti-herpes medication every day. This is something your partner should discuss with his or her doctor.
- You avoid having vaginal, anal, or oral sex when your partner has herpes symptoms (i.e., when your partner is having an outbreak).

I'm pregnant. How could genital herpes affect my baby?

If you are pregnant and have genital herpes, it is very important for you to go to prenatal care visits. Tell your doctor if you have ever had symptoms of, or have been diagnosed with, genital herpes. Also tell your doctor if you have ever been exposed to genital herpes. There is some research that suggests that genital herpes infection may lead to miscarriage, or could make it more likely for you to deliver your baby too early.

Herpes infection can be passed from you to your unborn child before birth but is more commonly passed to your infant during delivery. This can lead to a potentially deadly infection in your baby (called neonatal herpes). It is important that you avoid getting herpes during pregnancy. If you are pregnant and have genital herpes, you may be offered anti-herpes medicine towards the end of your pregnancy. This medicine may reduce your risk of having signs or symptoms of genital herpes at the time of delivery. At the time of delivery, your doctor should carefully examine you for herpes sores. If you have herpes symptoms at delivery, a 'C-section' is usually performed.

How do I know if I have genital herpes?

Most people who have genital herpes have no symptoms, or have very mild symptoms. You may not notice mild symptoms or you may mistake them for another skin condition, such as a pimple or ingrown hair. Because of this, most people who have herpes do not know it.

Herpes sores usually appear as one or more blisters on or around the genitals, rectum or mouth. The blisters break and leave painful sores that may take a week or more to heal. These symptoms are sometimes called "having an outbreak." The first time someone has an outbreak they may also have flu-like symptoms such as fever, body aches, or swollen glands.

People who experience an initial outbreak of herpes can have repeated outbreaks, especially if they are infected with HSV-2. Repeat outbreaks are usually shorter and less severe than the first outbreak. Although the infection stays in the body for the rest of your life, the number of outbreaks may decrease over time.

You should be examined by your doctor if you notice any of these symptoms or if your partner has an STD or symptoms of an STD. STD symptoms can

include an unusual sore, a smelly genital discharge, burning when urinating, or (for women) bleeding between periods.

How will my doctor know if I have herpes?

Your healthcare provider may diagnose genital herpes by simply looking at your symptoms. Providers can also take a sample from the sore(s) and test it. In certain situations, a blood test may be used to look for herpes antibodies. Have an honest and open talk with your health care provider and ask whether you should be tested for herpes or other STDs.

Please note: A herpes blood test can help determine if you have herpes infection. It cannot tell you who gave you the infection or how long you have been infected.

Can herpes be cured?

There is no cure for herpes. However, there are medicines that can prevent or shorten outbreaks. One of these anti-herpes medicines can be taken daily, and makes it less likely that you will pass the infection on to your sex partner(s).

What happens if I don’t get treated?

Genital herpes can cause painful genital sores and can be severe in people with suppressed immune systems.

If you touch your sores or the fluids from the sores, you may transfer herpes to another part of your body, such as your eyes. Do not touch the sores or fluids to avoid spreading herpes to another part of your body. If you do touch the sores or fluids, immediately wash your hands thoroughly to help avoid spreading your infection.

If you are pregnant, there can be problems for you and your developing fetus, or newborn baby. See "I'm pregnant. How could genital herpes affect my baby?" above for information about this.

Can I still have sex if I have herpes?

If you have herpes, you should talk to your sex partner(s) and let him or her know that you do and the risk involved. Using condoms may help lower this risk but it will not get rid of the risk completely. Having sores or other symptoms of herpes can increase your risk of spreading the disease. Even if you do not have any symptoms, you can still infect your sex partners.

You may have concerns about how genital herpes will impact your overall health, sex life, and relationships. It is best for you to talk to a health care provider about those concerns, but it also is important to recognize that while herpes is not curable, it can be managed with medication. Daily suppressive therapy (i.e., daily use of antiviral medication) for herpes can also lower your risk of spreading genital herpes to your sex partner. Be sure to discuss treatment options with your healthcare provider. Since a genital herpes diagnosis may affect how you will feel about current or future sexual relationships, it is important to understand how to talk to sexual partners about STDsexternal icon.

What is the link between genital herpes and HIV?

Herpes infection can cause sores or breaks in the skin or lining of the mouth, vagina, and rectum. This provides a way for HIV to enter the body. Even without visible sores, having genital herpes increases the number of CD4 cells (the cells that HIV targets for entry into the body) found in the lining of the genitals. When a person has both HIV and genital herpes, the chances are higher that HIV will be spread to an HIV-uninfected sex partner during sexual contact with their partner's mouth, vagina, or rectum.

Is there a cure or treatment for herpes?

There is no cure for herpes. Antiviral medications can, however, prevent or shorten outbreaks during the period of time the person takes the medication. In addition, daily suppressive therapy (i.e. daily use of antiviral medication) for herpes can reduce the likelihood of transmission to partners.

Several clinical trials have tested vaccines against genital herpes infection, but there is currently no commercially available vaccine that is protective against genital herpes infection. One vaccine trial showed efficacy among women whose partners were HSV-2 infected, but only among women who were not infected with HSV-1. No efficacy was observed among men whose partners were HSV-2 infected. A subsequent trial testing the same vaccine showed some protection from genital HSV-1 infection, but no protection from HSV-2 infection.

E. STDs and HIV – CDC Fact Sheet

Retrieved from: https://www.cdc.gov/std/hiv/stdfact-std-hiv.htm

If you have an STD, you are more likely to get HIV or transmit it to others.

Are some STDs associated with HIV?

Yes. In the United States, people who get syphilis, gonorrhea, and herpes often also have HIV, or are more likely to get HIV in the future.

Why does having an STD put me more at risk for getting HIV?

If you get an STD, you are more likely to get HIV than someone who is STD-free. This is because the same behaviors and circumstances that may put you at risk for getting an STD also can put you at greater risk for getting HIV. In addition, having a sore or break in the skin from an STD may allow HIV to more easily enter your body. If you are sexually active, get tested for STDs and HIV regularly, even if you don't have symptoms.

What activities can put me at risk for both STDs and HIV?

- Having anal, vaginal, or oral sex without a condom;
- Having multiple sex partners;
- Having anonymous sex partners;
- Having sex while under the influence of drugs or alcohol can lower inhibitions and result in greater sexual risk-taking.

What can I do to prevent getting STDs and HIV?

The only 100% effective way to avoid STDs is to not have vaginal, anal, or oral sex. If you are sexually active, you can do the following things to lower your chances of getting STDs and HIV:

- Choose less risky sex activities;
- Use a new condom for every act of vaginal, anal, and oral sex throughout the *entire* sex act (from start to finish);
- Reduce the number of people with whom you have sex;
- Limit or eliminate drug and alcohol use before and during sex;
- Have an honest and open talk with your healthcare provider and ask whether you should be tested for STDs and HIV;
- Talk to your healthcare provider and find out if either pre-exposure prophylaxis, or PrEP, or post-exposure prophylaxis, or PEP, is a good option for you to prevent HIV infection.

If I already have HIV, and then I get an STD, does that put my sex partner(s) at an increased risk for getting HIV?

It can. If you already have HIV, and then get another STD, it can put your HIV-negative partners at greater risk of getting HIV from you.

Your sex partners are less likely to get HIV from you if you

- Get on and stay on treatment called antiretroviral therapy (ART). Taking HIV medicine as prescribed can make your viral load very low by reducing the amount of virus in your blood and body fluids. HIV medicine can make your viral load so low that a test can't detect it (an undetectable viral load). If your viral load stays undetectable, you have effectively no risk of sexually transmitting HIV to HIV-negative partners.
- Choose less risky sex activities.
- Use a new condom for every act of vaginal, anal, and oral sex throughout the *entire* sex act (from start to finish).

The risk of getting HIV also may be reduced if your partner takes PrEP after discussing this option with his or her healthcare provider and determining whether it is appropriate. When taken daily, PrEP is highly effective for preventing HIV from sex. PrEP is much less effective if it is not taken consistently. Since PrEP does not protect against other STDs, use condoms the right way every time you have sex.

Will treating STDs prevent me from getting HIV?

No. It's not enough.

If you get treated for an STD, this will help to prevent its complications, and prevent spreading STDs to your sex partners. Treatment for an STD other than HIV does not prevent the spread of HIV.

If you are diagnosed with an STD, talk to your doctor about ways to protect yourself and your partner(s) from getting reinfected with the same STD, or getting HIV.

F. Genital HPV Infection - Fact Sheet

Human papillomavirus (HPV) is the most common sexually transmitted infection in the United States. Some health effects caused by HPV can be prevented by the HPV vaccines

What is HPV?

HPV is the most common sexually transmitted infection (STI). HPV is a different virus than HIV and HSV (herpes). 79 million Americans, most in their late teens and early 20s, are infected with HPV. There are many different types of HPV. Some types can cause health problems including genital warts and cancers. But there are vaccines that can stop these health problems from happening.

How is HPV spread?

You can get HPV by having vaginal, anal, or oral sex with someone who has the virus. It is most commonly spread during vaginal or anal sex. HPV can be passed even when an infected person has no signs or symptoms.

Anyone who is sexually active can get HPV, even if you have had sex with only one person. You also can develop symptoms years after you have sex with someone who is infected. This makes it hard to know when you first became infected.

Does HPV cause health problems?

In most cases, HPV goes away on its own and does not cause any health problems. But when HPV does not go away, it can cause health problems like genital warts and cancer.

Genital warts usually appear as a small bump or group of bumps in the genital area. They can be small or large, raised or flat, or shaped like a cauliflower. A healthcare provider can usually diagnose warts by looking at the genital area.

Does HPV cause cancer?

HPV can cause cervical and other cancers including cancer of the vulva, vagina, penis, or anus. It can also cause cancer in the back of the throat, including the base of the tongue and tonsils (called oropharyngeal cancer).

Cancer often takes years, even decades, to develop after a person gets HPV. The types of HPV that can cause genital warts are not the same as the types of HPV that can cause cancers.

There is no way to know which people who have HPV will develop cancer or other health problems. People with weak immune systems (including those with HIV/AIDS) may be less able to fight off HPV. They may also be more likely to develop health problems from HPV.

How can I avoid HPV and the health problems it can cause?

You can do several things to lower your chances of getting HPV.

Get vaccinated. The HPV vaccine is safe and effective. It can protect against diseases (including cancers) caused by HPV when given in the recommended age groups. (See "Who should get vaccinated?" below) CDC recommends HPV vaccination at age 11 or 12 years (or can start at age 9 years) and for everyone through age 26 years, if not vaccinated already. For more information on the

recommendations, please
see: https://www.cdc.gov/vaccines/vpd/hpv/public/index.html

Get screened for cervical cancer. Routine screening for women aged 21 to 65 years old can prevent cervical cancer.

If you are sexually active

- Use latex condoms the right way every time you have sex. This can lower your chances of getting HPV. But HPV can infect areas not covered by a condom – so condoms may not fully protect against getting HPV;
- Be in a mutually monogamous relationship – or have sex only with someone who only has sex with you.

Who should get vaccinated?

HPV vaccination is recommended at age 11 or 12 years (or can start at age 9 years) and for everyone through age 26 years, if not vaccinated already.

Vaccination is not recommended for everyone older than age 26 years. However, some adults age 27 through 45 years who are not already vaccinated may decide to get the HPV vaccine after speaking with their healthcare provider about their risk for new HPV infections and the possible benefits of vaccination. HPV vaccination in this age range provides less benefit. Most sexually active adults have already been exposed to HPV, although not necessarily all of the HPV types targeted by vaccination.

At any age, having a new sex partner is a risk factor for getting a new HPV infection. People who are already in a long-term, mutually monogamous relationship are not likely to get a new HPV infection.

How do I know if I have HPV?

There is no test to find out a person's "HPV status." Also, there is no approved HPV test to find HPV in the mouth or throat.

There are HPV tests that can be used to screen for cervical cancer. These tests are only recommended for screening in women aged 30 years and older. HPV tests are not recommended to screen men, adolescents, or women under the age of 30 years.

Most people with HPV do not know they are infected and never develop symptoms or health problems from it. Some people find out they have HPV when they get genital warts. Women may find out they have HPV when they get an abnormal Pap test result (during cervical cancer screening). Others may only find out once they've developed more serious problems from HPV, such as cancers.

How common is HPV and the health problems caused by HPV?

HPV (the virus): About 79 million Americans are currently infected with HPV. About 14 million people become newly infected each year. HPV is so common that almost every person who is sexually-active will get HPV at some time in their life if they don't get the HPV vaccine.

Health problems related to HPV include genital warts and cervical cancer.

Genital warts: Before HPV vaccines were introduced, roughly 340,000 to 360,000 women and men were affected by genital warts caused by HPV every year.* Also, about one in 100 sexually active adults in the U.S. has genital warts at any given time.

Cervical cancer: Every year, nearly 12,000 women living in the U.S. will be diagnosed with cervical cancer, and more than 4,000 women die from cervical cancer—even with screening and treatment.

There are other conditions and cancers caused by HPV that occur in people living in the United States. Every year, approximately 19,400 women and 12,100 men are affected by cancers caused by HPV.

*These figures only look at the number of people who sought care for genital warts. This could be an underestimate of the actual number of people who get genital warts.

I'm pregnant. Will having HPV affect my pregnancy?

If you are pregnant and have HPV, you can get genital warts or develop abnormal cell changes on your cervix. Abnormal cell changes can be found with routine cervical cancer screening. You should get routine cervical cancer screening even when you are pregnant.

Can I be treated for HPV or health problems caused by HPV?

There is no treatment for the virus itself. However, there are treatments for the health problems that HPV can cause:

1. **Genital warts** can be treated by your healthcare provider or with prescription medication. If left untreated, genital warts may go away, stay the same, or grow in size or number.
2. **Cervical precancer** can be treated. Women who get routine Pap tests and follow up as needed can identify problems *before* cancer develops. Prevention is always better than treatment. For more information visit www.cancer.orgexternal icon.

3. **Other HPV-related cancers** are also more treatable when diagnosed and treated early. For more information visit www.cancer.orgexternal icon.

CDC now recommends 11 to 12 year olds get two doses of HPV vaccine—rather than the previously recommended three doses—to protect against cancers caused by HPV. The second dose should be given 6-12 months after the first dose. For more information on the updated recommendations, read the press release: https://www.cdc.gov/media/releases/2016/p1020-hpv-shots.html

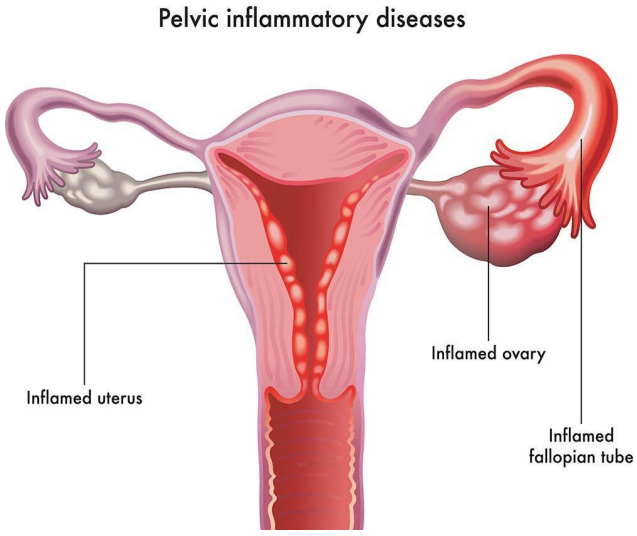
G. Pelvic Inflammatory Disease (PID) - CDC Fact Sheet

Retrieved from: https://www.cdc.gov/std/pid/stdfact-pid.htm

Untreated sexually transmitted diseases (STDs) can cause pelvic inflammatory disease (PID), a serious condition, in women. 1 in 8 women with a history of PID experience difficulties getting pregnant. You can prevent PID if you know how to protect yourself.

What is PID?

Pelvic inflammatory disease is an infection of a woman's reproductive organs. It is a complication often caused by some STDs, like chlamydia and gonorrhea. Other infections that are not sexually transmitted can also cause PID.



How do I get PID?

You are more likely to get PID if you

- Have an STD and do not get treated;
- Have more than one sex partner;
- Have a sex partner who has sex partners other than you;
- Have had PID before;
- Are sexually active and are age 25 or younger;
- Douche;
- Use an intrauterine device (IUD) for birth control. However, the small increased risk is mostly limited to the first three weeks after the IUD is placed inside the uterus by a doctor.

How can I reduce my risk of getting PID?

The only way to avoid STDs is to not have vaginal, anal, or oral sex.

If you are sexually active, you can do the following things to lower your chances of getting PID:

- Being in a long-term mutually monogamous relationship with a partner who has been tested and has negative STD test results;
- Using latex condoms the right way every time you have sex.

How do I know if I have PID?

There are no tests for PID. A diagnosis is usually based on a combination of your medical history, physical exam, and other test results. You may not realize you have PID because your symptoms may be mild, or you may not

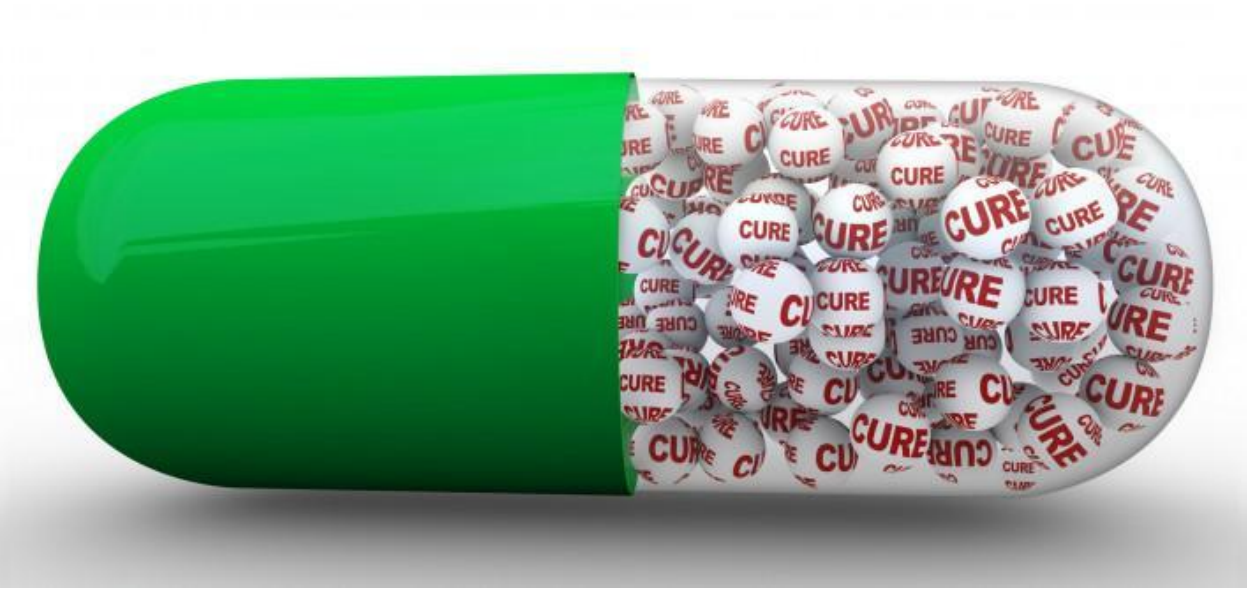
experience any symptoms. However, if you do have symptoms, you may notice

- Pain in your lower abdomen;
- Fever;
- An unusual discharge with a bad odor from your vagina;
- Pain and/or bleeding when you have sex;
- Burning sensation when you urinate; or
- Bleeding between periods.

You should

- Be examined by your doctor if you notice any of these symptoms;
- Promptly see a doctor if you think you or your sex partner(s) have or were exposed to an STD;
- Promptly see a doctor if you have any genital symptoms such as an unusual sore, a smelly discharge, burning when peeing, or bleeding between periods;
- Get a test for chlamydia every year if you are sexually active and younger than 25 years of age.
- Have an honest and open talk with your health care provider if you are sexually active and ask whether you should be tested for other STDs.

Can PID be cured?



Yes, if PID is diagnosed early, it can be treated. However, treatment won't undo any damage that has already happened to your reproductive system. The longer you wait to get treated, the more likely it is that you will have complications from PID. While taking antibiotics, your symptoms may go away before the infection is cured. Even if symptoms go away, you should finish taking all of your medicine. Be sure to tell your recent sex partner(s), so they can get tested and treated for STDs, too. It is also very important that you and your partner both finish your treatment before having any kind of sex so that you don't re-infect each other.

You can get PID again if you get infected with an STD again. Also, if you have had PID before, you have a higher chance of getting it again.

What happens if I don't get treated?

If diagnosed and treated early, the complications of PID can be prevented. Some of the complications of PID are

- Formation of scar tissue both outside and inside the fallopian tubes that can lead to tubal blockage;

- Ectopic pregnancy (pregnancy outside the womb);
- Infertility (inability to get pregnant);
- Long-term pelvic/abdominal pain.

H. STDs & Infertility

CDC Recommends Chlamydia and Gonorrhea Screening of All Sexually Active Women Under 25

Chlamydia and gonorrhea are important preventable causes of pelvic inflammatory disease (PID) and infertility. Untreated, about 10-15% of women with chlamydia will develop PID. Chlamydia can also cause fallopian tube infection without any symptoms. PID and "silent" infection in the upper genital tract may cause permanent damage to the fallopian tubes, uterus, and surrounding tissues, which can lead to infertility.

- An estimated 2.86 million cases of chlamydia and 820,000 cases of gonorrhea occur annually in the United States.*
- Most women infected with chlamydia or gonorrhea have no symptoms.

CDC recommends annual chlamydia and gonorrhea screening of **all sexually active women younger than 25 years, as well as older women with risk factors** such as new or multiple sex partners, or a sex partner who has a sexually transmitted infection.

* Chlamydia and gonorrhea are the first and second most commonly reported notifiable disease in the United States. In 2018, a total of 1,758,668 cases of chlamydia and 583,405 cases of gonorrhea were reported to CDC from 50 states and the District of Columbia. The number of reported cases is lower than the estimated total number because infected people are often unaware of, and do not seek treatment for, their infections and because screening for chlamydia is still not routine in many clinical settings.

I. Syphilis - CDC Fact Sheet

Retrieved from: https://www.cdc.gov/std/syphilis/stdfact-syphilis.htm

Syphilis is a sexually transmitted disease (STD) that can have very serious complications when left untreated, but it is simple to cure with the right treatment.

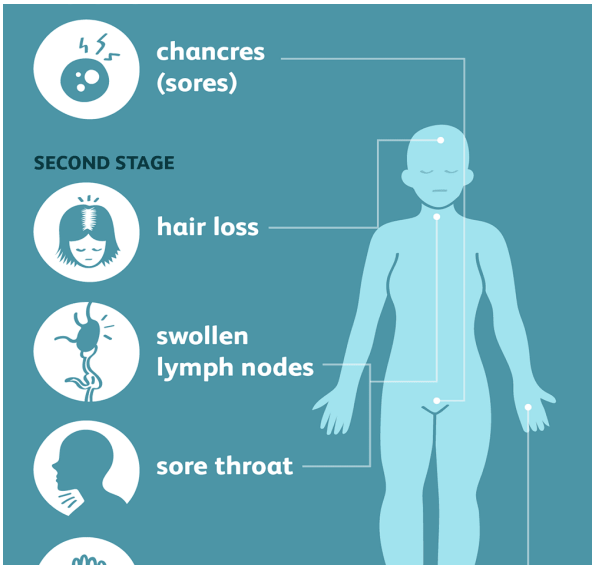
What is syphilis?

Syphilis is a sexually transmitted infection that can cause serious health problems if it is not treated. Syphilis is divided into stages (primary, secondary, latent, and tertiary). There are different signs and symptoms associated with each stage.

How is syphilis spread?

You can get syphilis by direct contact with a syphilis sore during vaginal, anal, or oral sex. You can find sores on or around the penis, vagina, or anus, or in the rectum, on the lips, or in the mouth. Syphilis can spread from an infected mother to her unborn baby.

What does syphilis look like?



Syphilis is divided into stages (primary, secondary, latent, and tertiary), with different signs and symptoms associated with each stage. A person with **primary syphilis** generally has a sore or sores at the original site of infection. These sores usually occur on or around the genitals, around the anus or in the rectum, or in or around the mouth. These sores are usually (but not always) firm, round, and painless. Symptoms of **secondary syphilis** include skin rash, swollen lymph nodes, and fever. The signs and symptoms of primary and secondary syphilis can be mild, and they might not be noticed. During the **latent stage**, there are no signs or symptoms. **Tertiary syphilis** is associated with severe medical problems. A doctor can usually diagnose tertiary syphilis with the help of multiple tests. It can affect the heart, brain, and other organs of the body.

How can I reduce my risk of getting syphilis?

The only way to avoid STDs is to not have vaginal, anal, or oral sex.

If you are sexually active, you can do the following things to lower your chances of getting syphilis:

- Being in a long-term mutually monogamous relationship with a partner who has been tested for syphilis and does not have syphilis;
- Using latex condoms the right way every time you have sex. Condoms prevent transmission of syphilis by preventing contact with a sore. Sometimes sores occur in areas not covered by a condom. Contact with these sores can still transmit syphilis.

Am I at risk for syphilis?

Any sexually active person can get syphilis through unprotected vaginal, anal, or oral sex. Have an honest and open talk with your health care provider and ask whether you should be tested for syphilis or other STDs.

- All pregnant women should be tested for syphilis at their first prenatal visit.
- You should get tested regularly for syphilis if you are sexually active *and*
    - are a man who has sex with men;
    - are living with HIV; or
    - have partner(s) who have tested positive for syphilis.

I'm pregnant. How does syphilis affect my baby?

If you are pregnant and have syphilis, you can give the infection to your unborn baby. Having syphilis can lead to a low birth weight baby. It can also make it more likely you will deliver your baby too early or stillborn (a baby born dead). To protect your baby, **you should be tested for syphilis at**

least once during your pregnancy. Receive immediate treatment if you test positive.

An infected baby may be born without signs or symptoms of disease. However, if not treated immediately, the baby may develop serious problems within a few weeks. Untreated babies can have health problems such as cataracts, deafness, or seizures, and can die.

What are the signs and symptoms of syphilis?

Symptoms of syphilis in adults vary by stage:

Primary Stage

During the first (primary) stage of syphilis, you may notice a single sore or multiple sores. The sore is the location where syphilis entered your body. Sores are usually (but not always) firm, round, and painless. Because the sore is painless, it can easily go unnoticed. The sore usually lasts 3 to 6 weeks and heals regardless of whether or not you receive treatment. Even after the sore goes away, you must still receive treatment. This will stop your infection from moving to the secondary stage.

Secondary Stage

During the secondary stage, you may have skin rashes and/or mucous membrane lesions. Mucous membrane lesions are sores in your mouth, vagina, or anus. This stage usually starts with a rash on one or more areas of your body. The rash can show up when your primary sore is healing or several weeks after the sore has healed. The rash can look like rough, red, or reddish brown spots on the palms of your hands and/or the bottoms of your feet. The rash usually won't itch and it is sometimes so faint that you won't notice it. Other symptoms you may have can include fever, swollen lymph glands, sore throat, patchy hair loss, headaches, weight loss, muscle aches, and fatigue (feeling very tired). The symptoms from this stage will go

away whether or not you receive treatment. Without the right treatment, your infection will move to the latent and possibly tertiary stages of syphilis.

Latent Stage

The latent stage of syphilis is a period of time when there are no visible signs or symptoms of syphilis. If you do not receive treatment, you can continue to have syphilis in your body for years without any signs or symptoms.

Tertiary Stage

Most people with untreated syphilis do not develop tertiary syphilis. However, when it does happen it can affect many different organ systems. These include the heart and blood vessels, and the brain and nervous system. Tertiary syphilis is very serious and would occur 10–30 years after your infection began. In tertiary syphilis, the disease damages your internal organs and can result in death.

Neurosyphilis and Ocular Syphilis

Without treatment, syphilis can spread to the brain and nervous system (neurosyphilis) or to the eye (ocular syphilis). This can happen during any of the stages described above.

Symptoms of neurosyphilis include

- severe headache;
- difficulty coordinating muscle movements;
- paralysis (not able to move certain parts of your body);
- numbness; and
- dementia (mental disorder).

Symptoms of ocular syphilis include changes in your vision and even blindness.

How will I or my doctor know if I have syphilis?

Most of the time, a blood test is used to test for syphilis. Some health care providers will diagnose syphilis by testing fluid from a syphilis sore.

Can syphilis be cured?

Yes, syphilis can be cured with the right antibiotics from your health care provider. However, treatment might not undo any damage that the infection has already done.

I've been treated. Can I get syphilis again?

Having syphilis once does not protect you from getting it again. Even after you've been successfully treated, you can still be re-infected. Only laboratory tests can confirm whether you have syphilis. Follow-up testing by your health care provider is recommended to make sure that your treatment was successful.

It may not be obvious that a sex partner has syphilis. This is because syphilis sores can be hidden in the vagina, anus, under the foreskin of the penis, or in the mouth. Unless you know that your sex partner(s) has been tested and treated, you may be at risk of getting syphilis again from an infected sex partner.

J. Trichomoniasis

What is trichomoniasis?

Trichomoniasis (or "trich") is a very common sexually transmitted disease (STD). It is caused by infection with a protozoan parasite called Trichomonas vaginalis. Although symptoms of the disease vary, most people who have the parasite cannot tell they are infected.

How common is trichomoniasis?

Trichomoniasis is the most common curable STD. In the United States, an estimated 3.7 million people have the infection. However, only about 30% develop any symptoms of trichomoniasis. Infection is more common in women than in men. Older women are more likely than younger women to have been infected with trichomoniasis.

How do people get trichomoniasis?

The parasite passes from an infected person to an uninfected person during sex. In women, the most commonly infected part of the body is the lower genital tract (vulva, vagina, cervix, or urethra). In men, the most commonly infected body part is the inside of the penis (urethra). During sex, the parasite usually spreads from a penis to a vagina, or from a vagina to a penis. It can also spread from a vagina to another vagina. It is not common for the parasite to infect other body parts, like the hands, mouth, or anus. It is unclear why some people with the infection get symptoms while others do

not. It probably depends on factors like a person's age and overall health. Infected people without symptoms can still pass the infection on to others.

What are the signs and symptoms of trichomoniasis?

About 70% of infected people do not have any signs or symptoms. When trichomoniasis does cause symptoms, they can range from mild irritation to severe inflammation. Some people with symptoms get them within 5 to 28 days after being infected. Others do not develop symptoms until much later. Symptoms can come and go.

Men with trichomoniasis may notice:

- Itching or irritation inside the penis;
- Burning after urination or ejaculation;
- Discharge from the penis.

Women with trichomoniasis may notice:

- Itching, burning, redness or soreness of the genitals;
- Discomfort with urination;
- A change in their vaginal discharge (i.e., thin discharge or increased volume) that can be clear, white, yellowish, or greenish with an unusual fishy smell.

Having trichomoniasis can make it feel unpleasant to have sex. Without treatment, the infection can last for months or even years.

What are the complications of trichomoniasis?

Trichomoniasis can increase the risk of getting or spreading other sexually transmitted infections. For example, trichomoniasis can cause genital inflammation that makes it easier to get infected with HIV, or to pass the HIV virus on to a sex partner.

How does trichomoniasis affect a pregnant woman and her baby?

Pregnant women with trichomoniasis are more likely to have their babies too early (preterm delivery). Also, babies born to infected mothers are more likely to have a low birth weight (less than 5.5 pounds).

How is trichomoniasis diagnosed?

It is not possible to diagnose trichomoniasis based on symptoms alone. For both men and women, your health care provider can examine you and get a laboratory test to diagnose trichomoniasis.

What is the treatment for trichomoniasis?

Trichomoniasis can be treated with medication (either metronidazole or tinidazole). These pills are taken by mouth. It is safe for pregnant women to take this medication. It is not recommended to drink alcohol within 24 hours after taking this medication.

People who have been treated for trichomoniasis can get it again. About 1 in 5 people get infected again within 3 months after receiving treatment. To avoid getting reinfected, make sure that all of your sex partners get treated. Also, wait 7- 10 days after you and your partner have been treated to have sex again. Get checked again if your symptoms come back.

How can trichomoniasis be prevented?

The only way to avoid STDs is to not have vaginal, anal, or oral sex.

If you are sexually active, you can do the following things to lower your chances of getting trichomoniasis:

- Be in a long-term mutually monogamous relationship with a partner who has been tested and has negative STD test results;
- Use latex condoms the right way every time you have sex. This can lower your chances of getting trichomoniasis. But the parasite can infect areas that are not covered by a condom – so condoms may not fully protect you from getting trichomoniasis.

Another approach is to talk about the potential risk of STDs *before* you have sex with a new partner. That way you can make informed choices about the level of risk you are comfortable taking with your sex life.

If you or someone you know has questions about trichomoniasis or any other STD, talk to a health care provider.

Sources

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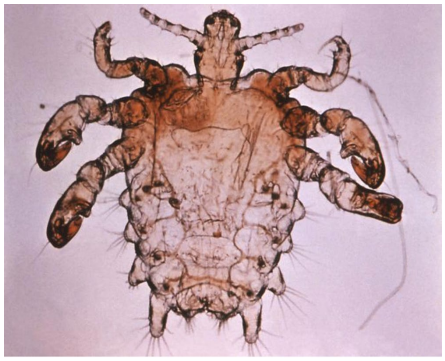
K. Other STDs

Retrieved from: https://www.cdc.gov/parasites/lice/pubic/index.html

Pubic Lice

Adult pubic lice are 1.1–1.8 mm in length. Pubic lice typically are found attached to hair in the pubic area but sometimes are found on coarse hair elsewhere on the body (for example, eyebrows, eyelashes, beard, mustache, chest, armpits, etc.).



Pubic lice infestations (pthiriasis) are usually spread through sexual contact. Dogs, cats, and other pets do not play a role in the transmission of human pubic lice.

Both over-the-counter and prescription medications are available for treatment of pubic lice infestations.

Treatment

A lice-killing lotion containing 1% permethrin or a mousse containing pyrethrins and piperonyl butoxide can be used to treat pubic ("crab") lice. These products are available over-the-counter without a prescription at a local drug store or pharmacy. These medications are safe and effective when used exactly according to the instructions in the package or on the label.

Lindane shampoo is a prescription medication that can kill lice and lice eggs. However, lindane is not recommended as a first-line therapy. Lindane can be toxic to the brain and other parts of the nervous system; its use should be restricted to patients who have failed treatment with or cannot tolerate other medications that pose less risk. Lindane should not be used to treat premature infants, persons with a seizure disorder, women who are pregnant or breast-feeding, persons who have very irritated skin or sores where the lindane will be applied, infants, children, the elderly, and persons who weigh less than 110 pounds.

Malathion* lotion 0.5% (Ovide*) is a prescription medication that can kill lice and some lice eggs; however, malathion lotion (Ovide*) currently has not been approved by the U.S. Food and Drug Administration (FDA) for treatment of pubic ("crab") lice.

Both topical and oral ivermectin have been used successfully to treat lice; however, only topical ivermectin lotion currently is approved by the U.S. Food and Drug Administration (FDA) for treatment of lice. Oral ivermectin is not FDA-approved for treatment of lice.

How to treat pubic lice infestations: (Warning: See special instructions for treatment of lice and nits on eyebrows or eyelashes. The lice medications described in this section should not be used near the eyes.)

1. Wash the infested area; towel dry.
2. Carefully follow the instructions in the package or on the label. Thoroughly saturate the pubic hair and other infested areas with lice medication. Leave medication on hair for the time recommended in the instructions. After waiting the recommended time, remove the medication by following carefully the instructions on the label or in the box.
3. Following treatment, most nits will still be attached to hair shafts. Nits may be removed with fingernails or by using a fine-toothed comb.
4. Put on clean underwear and clothing after treatment.
5. To kill any lice or nits remaining on clothing, towels, or bedding, machine-wash and machine-dry those items that the infested person used during the 2–3 days before treatment. Use hot water (at least 130°F) and the hot dryer cycle.
6. Items that cannot be laundered can be dry-cleaned or stored in a sealed plastic bag for 2 weeks.
7. All sex partners from within the previous month should be informed that they are at risk for infestation and should be treated.
8. Persons should avoid sexual contact with their sex partner(s) until both they and their partners have been successfully treated and reevaluated to rule out persistent infestation.
9. Repeat treatment in 9–10 days if live lice are still found.
10. Persons with pubic lice should be evaluated for other sexually transmitted diseases (STDs).

Special instructions for treatment of lice and nits found on eyebrows or eyelashes:

- If only a few live lice and nits are present, it may be possible to remove these with fingernails or a nit comb.
- If additional treatment is needed for lice or nits on the eyelashes, careful application of ophthalmic-grade petrolatum ointment (only available by prescription) to the eyelid margins 2–4 times a day for 10 days is effective. Regular petrolatum (e.g., Vaseline)* should not be used because it can irritate the eyes if applied.

**Use of trade names is for identification purposes only and does not imply endorsement by the Public Health Service or by the U.S. Department of Health and Human Services.*

Prevention & Control

Pubic ("crab") lice most commonly are spread directly from person to person by sexual contact. Pubic lice very rarely may be spread by clothing, bedding, or a toilet seat.

The following are steps that can be taken to help prevent and control the spread of pubic ("crab") lice:

- All sexual contacts of the infested person should be examined. All those who are infested should be treated.

- Sexual contact between the infested person(s) and their sexual partner(s) should be avoided until all have been examined, treated as necessary, and reevaluated to rule out persistent infestation.
- Machine wash and dry clothing worn and bedding used by the infested person in the hot water (at least 130°F) laundry cycle and the high heat drying cycle. Clothing and items that are not washable can be dry-cleaned OR sealed in a plastic bag and stored for 2 weeks.
- Do not share clothing, bedding, and towels used by an infested person.
- Do not use fumigant sprays or fogs; they are not necessary to control pubic ("crab") lice and can be toxic if inhaled or absorbed through the skin.

Persons with pubic lice should be examined and treated for any other sexually transmitted diseases (STDs) that may be present.

Scabies

Human scabies is caused by an infestation of the skin by the human itch mite (*Sarcoptes scabiei* var. *hominis*). The microscopic scabies mite burrows

into the upper layer of the skin where it lives and lays its eggs. The most common symptoms of scabies are intense itching and a pimple-like skin rash. The scabies mite usually is spread by direct, prolonged, skin-to-skin contact with a person who has scabies.

Scabies occurs worldwide and affects people of all races and social classes.

Scabies can spread rapidly under crowded conditions where close body contact is frequent. Institutions such as nursing homes, extended-care facilities, and prisons are often sites of scabies outbreaks.

Signs and Symptoms

The most common signs and symptoms of scabies are intense itching (pruritus), especially at night, and a pimple-like (papular) itchy rash. The itching and rash each may affect much of the body or be limited to common sites such as the wrist, elbow, armpit, webbing between the fingers, nipple, penis, waist, belt-line, and buttocks. The rash also can include tiny blisters (vesicles) and scales. Scratching the rash can cause skin sores; sometimes these sores become infected by bacteria.

Tiny burrows sometimes are seen on the skin; these are caused by the female scabies mite tunneling just beneath the surface of the skin. These burrows appear as tiny raised and crooked (serpiginous) grayish-white or skin-colored lines on the skin surface. Because mites are often few in number (only 10-15 mites per person), these burrows may be difficult to find. They are found most often in the webbing between the fingers, in the skin folds on the wrist, elbow, or knee, and on the penis, breast, or shoulder blades.

The head, face, neck, palms, and soles often are involved in infants and very young children, but usually not adults and older children.
Persons with crusted scabies may not show the usual signs and symptoms of scabies such as the characteristic rash or itching (pruritus).

Treatment

Suggested General Guidelines

It is important to remember that the first time a person gets scabies they usually have no symptoms. Symptoms can typically take 4-8 weeks to develop after they are infested; however they can still spread scabies during this time.

In addition to the infested person, treatment also is recommended for household members and sexual contacts, particularly those who have had prolonged direct skin-to-skin contact with the infested person. Both sexual and close personal contacts who have had direct prolonged skin-to-skin contact with an infested person within the preceding month should be examined and treated. All persons should be treated at the same time to prevent reinfestation. Scabies may sometimes be sexually-acquired in adults, but is rarely sexually-acquired in children.

Bedding, clothing, and towels used by infested persons or their household, sexual, and close contacts (as defined above) anytime during the three days before treatment should be decontaminated by washing in hot water and drying in a hot dryer, by dry-cleaning, or by sealing in a plastic bag for at least 72 hours. Scabies mites generally do not survive more than 2 to 3 days away from human skin.

Use of insecticide sprays and fumigants is not recommended.

Medications Used to Treat Scabies

Products used to treat scabies are called scabicides because they kill scabies mites; some also kill mite eggs. Scabicides used to treat human scabies are available only with a doctor's prescription. No "over-the-counter" (non-prescription) products have been tested and approved to treat scabies. The instructions contained in the box or printed on the label always should be followed carefully. Always contact a doctor or pharmacist if unsure how to use a particular medicine.

Scabicide lotion or cream should be applied to all areas of the body from the neck down to the feet and toes. In addition, when treating infants and young children, scabicide lotion or cream also should be applied to their entire head and neck because scabies can affect their face, scalp, and neck, as well as the rest of their body. Only permethrin or sulfur ointment may be used in infants. The lotion or cream should be applied to a clean body and left on for the recommended time before washing it off. Clean clothing should be worn after treatment. Both sexual and close personal contacts who have had direct prolonged skin-to-skin contact with an infested person within the preceding month should be examined and treated. All persons should be treated at the same time to prevent reinfestation.

The instructions contained in the box or printed on the label always should be followed carefully. Always contact a doctor or pharmacist if unsure how to use a particular medicine.

Because the symptoms of scabies are due to a hypersensitivity reaction (allergy) to mites and their feces (scybala), itching still may continue for

several weeks after treatment even if all the mites and eggs are killed. If itching still is present more than 2 to 4 weeks after treatment or if new burrows or pimple-like rash lesions continue to appear, retreatment may be necessary.

Skin sores that become infected should be treated with an appropriate antibiotic prescribed by a doctor.

Chapter 3: Condom Effectiveness

Retrieved from: https://www.cdc.gov/condomeffectiveness/index.html

A. Introduction

Correctly using male condoms and other barriers like female condoms and dental dams, every time, can reduce (though not eliminate) the risk of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV) and viral hepatitis. They can also provide protection against other diseases that may be transmitted through sex like Zika and Ebola. Using male and female condoms correctly, every time, can also help prevent pregnancy.

This website provides information for both consumers and public health professionals on the correct use of male and female condoms and dental dams, as well male condom effectiveness for STDs, and links to additional resources.

Consistent and correct use of the male latex condom reduces the risk of sexually transmitted disease (STD) and human immunodeficiency virus (HIV) transmission. However, condom use cannot provide absolute protection against any STD. The most reliable ways to avoid transmission of STDs are to abstain from sexual activity, or to be in a long-term mutually monogamous relationship with an uninfected partner. However, many

infected persons may be unaware of their infection because STDs often are asymptomatic and unrecognized.

Condom effectiveness for STD and HIV prevention has been demonstrated by both laboratory and epidemiologic studies. Evidence of condom effectiveness is also based on theoretical and empirical data regarding the transmission of different STDs, the physical properties of condoms, and the anatomic coverage or protection provided by condoms.

Laboratory studies have shown that latex condoms provide an effective barrier against even the smallest STD pathogens.

Epidemiologic studies that compare rates of HIV infection between condom users and nonusers who have HIV-infected sex partners demonstrate that consistent condom use is highly effective in preventing transmission of HIV. Similarly, epidemiologic studies have shown that condom use reduces the risk of many other STDs. However, the exact magnitude of protection has been difficult to quantify because of numerous methodological challenges inherent in studying private behaviors that cannot be directly observed or measured.

Theoretical and empirical basis for protection: Condoms can be expected to provide different levels of protection for various STDs, depending on differences in how the diseases or infections are transmitted. Male condoms may not cover all infected areas or areas that could become infected. Thus, they are likely to provide greater protection against STDs that are transmitted only by genital fluids (STDs such as gonorrhea, chlamydia, trichomoniasis, and HIV infection) than against infections that

are transmitted primarily by skin-to-skin contact, which may or may not infect areas covered by a condom (STDs such as genital herpes, human papillomavirus [HPV] infection, syphilis, and chancroid)

STDs, including HIV

HIV Infection

- Consistent and correct use of latex condoms is highly effective in preventing sexual transmission of HIV, the virus that causes AIDS.

Other STDs and Associated Conditions

- Consistent and correct use of latex condoms reduces the risk for many STDs that are transmitted by genital fluids (STDs such as chlamydia, gonorrhea, and trichomoniasis).
- Consistent and correct use of latex condoms reduces the risk for genital ulcer diseases, such as genital herpes, syphilis, and chancroid, only when the infected area or site of potential exposure is protected.
- Consistent and correct use of latex condoms may reduce the risk for genital human papillomavirus (HPV) infection and HPV-associated diseases (e.g., genital warts and cervical cancer).

Consistent and Correct Condom Use

To achieve maximum protection by using condoms, they must be used consistently and correctly.

The failure of condoms to protect against STD/HIV transmission usually results from inconsistent or incorrect use, rather than product failure.

- *Inconsistent or nonuse* can lead to STD acquisition because transmission can occur with a single sex act with an infected partner.
- *Incorrect use* diminishes the protective effect of condoms by leading to condom breakage, slippage, or leakage. Incorrect use more commonly entails a failure to use condoms *throughout the entire* sex act, from start (of sexual contact) to finish (after ejaculation).

How to Use a Condom Consistently and Correctly

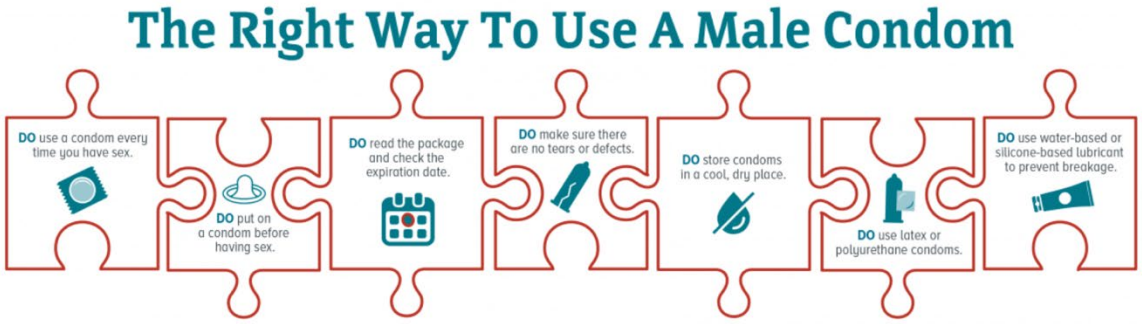
- Use a new condom for every act of vaginal, anal and oral sex throughout the *entire* sex act (from start to finish). Before any genital contact, put the condom on the tip of the erect penis with the rolled side out.
- If the condom does not have a reservoir tip, pinch the tip enough to leave a half-inch space for semen to collect. Holding the tip, unroll the condom all the way to the base of the erect penis.
- After ejaculation and before the penis gets soft, grip the rim of the condom and carefully withdraw. Then gently pull the condom off the penis, making sure that semen doesn’t spill out.
- Wrap the condom in a tissue and throw it in the trash where others won’t handle it.
- If you feel the condom break at any point during sexual activity, stop immediately, withdraw, remove the broken condom, and put on a new condom.
- Ensure that adequate lubrication is used during vaginal and anal sex, which might require water-based lubricants. Oil-based lubricants (e.g., petroleum jelly, shortening, mineral oil, massage oils, body lotions,

and cooking oil) should not be used because they can weaken latex, causing breakage.

Sources

1. Carey, Lytle, & Cyr (1999). Implications of laboratory tests of condom integrity. Sex Transm Dis, 26(4): 216-20.
2. Lytle, Routson, Seaborn, Dixon, Bushar, & Cyr (1997). An in vitro evaluation of condoms as barriers to a small virus. Sex Transm Dis, 24(3):161-164
3. CDC (2006). Sexually Transmitted Diseases Treatment Guidelines, 2006. Morbidity and Mortality Weekly Report, 55(RR-11).
4. Steiner, Cates, & Warner (1999). The real problem with male condoms is non-use. Sex Transm Dis, 26(8): 459-62.
5. Warner, Stone, Macaluso, Buehler, & Austin (2006). Condom use and risk of gonorrhea and Chlamydia: A systematic review of design and measurement factors assessed in epidemiologic studies. Sex Transm Dis, 33(1): 36-51.
6. Weller & Davis (2001). Condom effectiveness in reducing heterosexual HIV transmission. Cochrane Database Syst Rev; 3:CD003255.

B. Male Condom Use



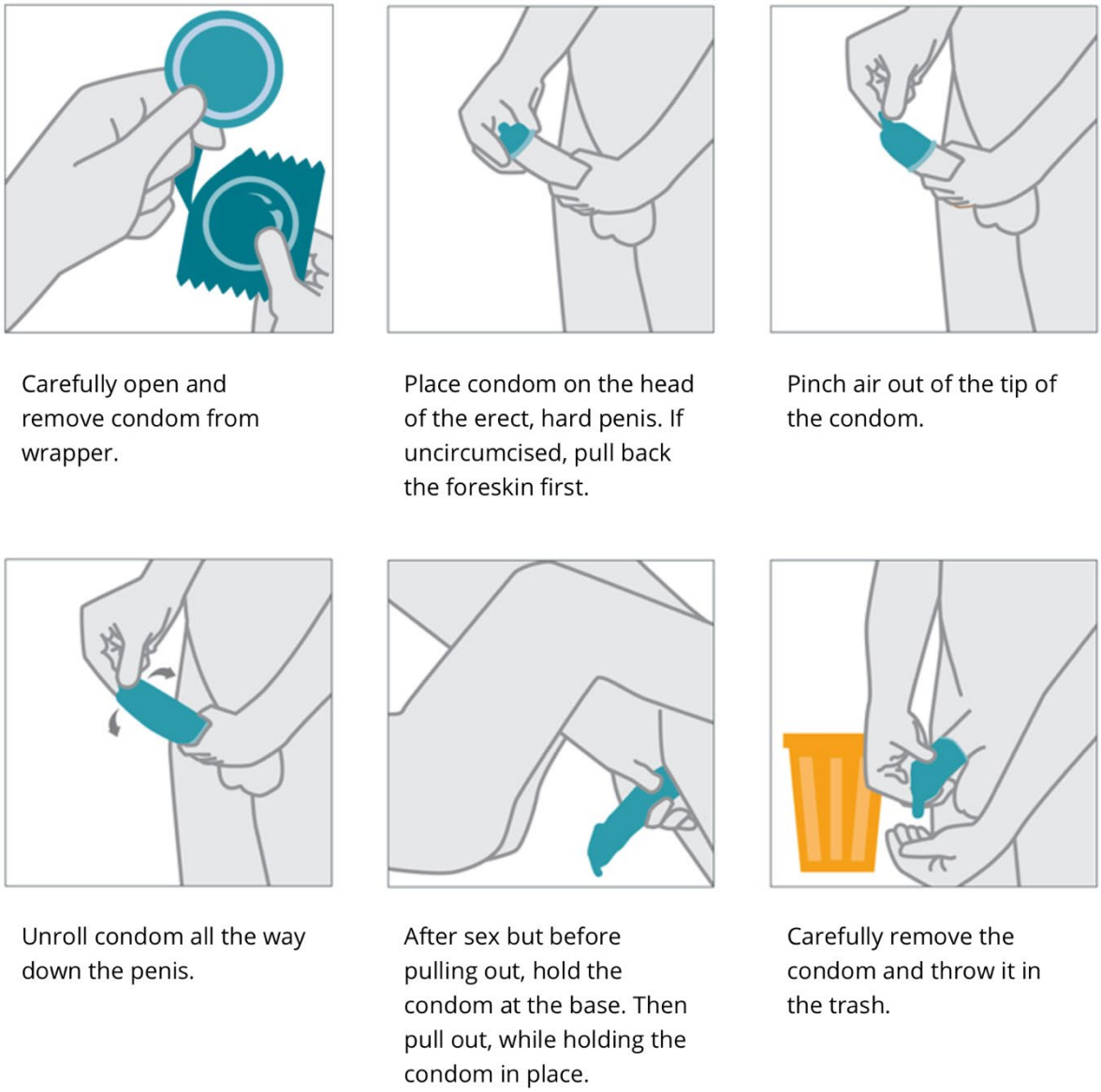
The Right Way To Use A Male Condom

Condom Dos and Don’ts

- DO use a condom every time you have sex.
- DO put on a condom before having sex.
- DO read the package and check the expiration date.
- DO make sure there are no tears or defects.
- DO store condoms in a cool, dry place.
- DO use latex or polyurethane condoms.
- DO use water-based or silicone-based lubricant to prevent breakage.

- DON’T store condoms in your wallet as heat and friction can damage them.
- DON’T use nonoxynol-9 (a spermicide), as this can cause irritation.
- DON’T use oil-based products like baby oil, lotion, petroleum jelly, or cooking oil because they will cause the condom to break.
- DON’T use more than one condom at a time.
- DON’T reuse a condom.

How To Put On and Take Off a Male Condom



B. Female Condom Use

Retrieved from: https://www.cdc.gov/condomeffectiveness/Female-condom-use.html

The Right Way To Use A Female Condom

Female Condom Dos and Don’ts

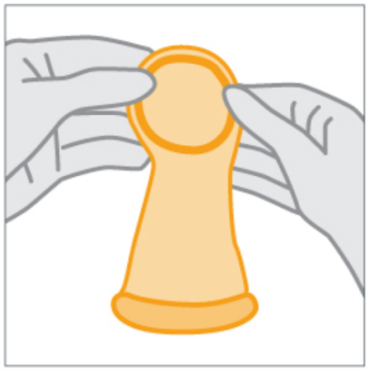
- DO use a female condom from start to finish, every time you have vaginal sex.*
- DO read the condom package insert and check the expiration date.
- DO make sure there are no tears or defects.
- DO use lubricant to help prevent the condom from slipping and tearing.
- DO store female condoms in a cool, dry place.

- DON’T use a male condom with a female condom, as this can cause tearing.
- DON’T reuse a female condom.
- DON’T flush female condoms as they may clog the toilet.

**Female condoms can also be used for anal sex.*

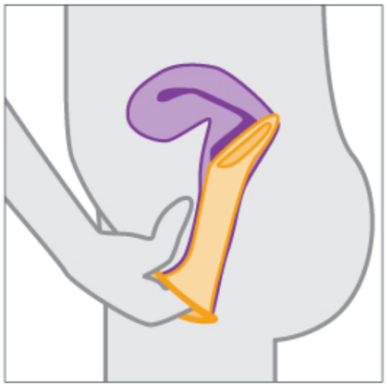
How To Insert and Remove a Female Condom

Carefully open and remove female condom from package to prevent tearing.



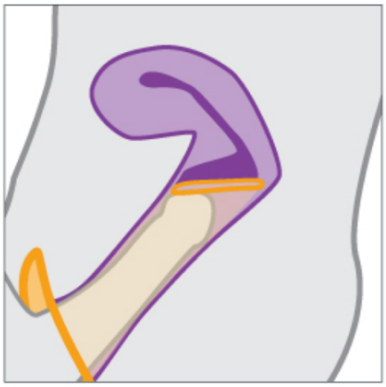
The thick, inner ring with closed end is used for placing in the vagina and holds condom in place. The thin, outer ring remains outside of body, covering vaginal opening.

Find a comfortable position. While holding outside of condom at closed end, squeeze sides of inner ring together with your thumb and forefinger and insert into vagina. It is similar to inserting a tampon.

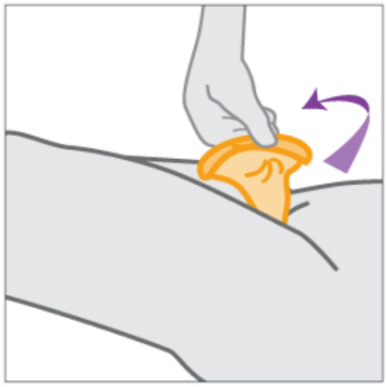


Using your finger, push inner ring as far up as it will go until it rests against cervix. The condom will expand naturally and you may not feel it.

Be sure condom is not twisted. The thin, outer ring should remain outside vagina.



Guide partner's penis into opening of female condom. Stop intercourse if you feel penis slip between condom and walls of vagina or if outer ring is pushed into vagina.



To remove, gently twist outer ring and pull female condom out of vagina.

Throw away female condom in trash after using it one time. Do not reuse.

D. Dental Dam Use

Retrieved from: https://www.cdc.gov/condomeffectiveness/Dental-dam-use.html

How To Use A Dental Dam As A Barrier For Oral Sex

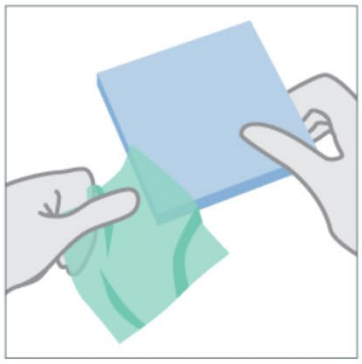
Dental dams are latex or polyurethane sheets used between the mouth and vagina or anus during oral sex. Ready-to-use dental dams can be purchased online.

Dental Dam Dos and Don'ts

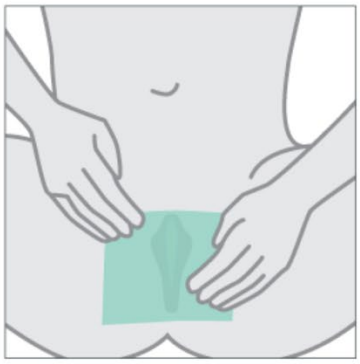
- DO use a new latex or polyurethane dental dam every time you have oral sex.
- DO read the package and check the expiration date.
- DO make sure there are no tears or defects.
- DO put on before starting oral sex and keep it on until finished.
- DO use water-based or silicone-based lubricant to prevent breakage.
- DO store dental dams in a cool, dry place.

- DON'T reuse a dental dam.
- DON'T stretch a dental dam, as this can cause it to tear.
- DON'T use nonoxynol-9 (a spermicide), which can cause irritation.
- DON'T use oil-based products like baby oil, lotion, petroleum jelly, or cooking oil because they will cause the dental dam to break.
- DON'T flush dental dams down the toilet as they may clog it.

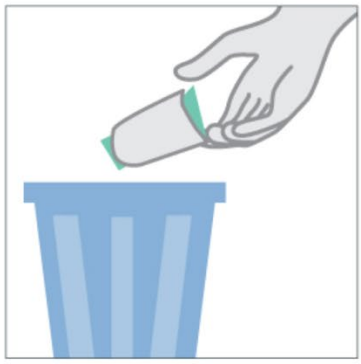
How To Use a Dental Dam



Carefully open dental dam and remove from package.



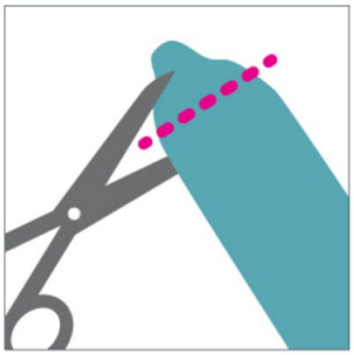
Place dental dam flat to cover vaginal opening or anus.



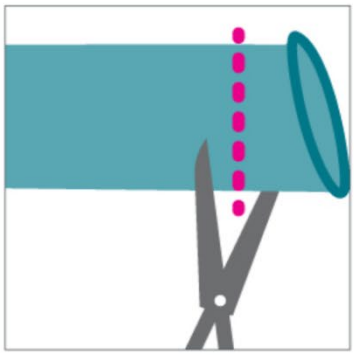
Throw away used dental dam in trash.

How To Make a Dental Dam From a Condom*

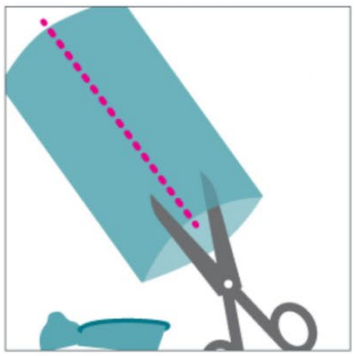
Carefully open package, remove condom, and unroll.



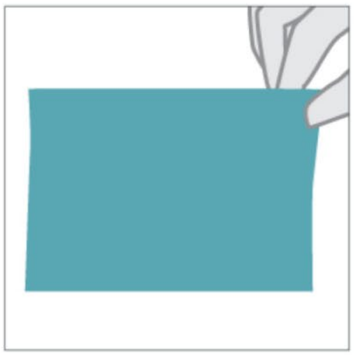
Cut off tip of condom.



Cut off bottom of condom.



Cut down one side of condom.



Lay flat to cover vaginal opening or anus.

**Be sure the condom is made of latex or polyurethane.*

Sex and HIV Risk and Prevention

Retrieved from: https://www.cdc.gov/hiv/risk/analsex.html#:~:text=Being%20a%20receptive%20partner%20during,getting%20HIV%20during%20anal%20sex.

A. Introduction

The risk of getting HIV varies widely depending on the type of sexual activity. Anal sex (intercourse), which involves inserting the penis into the anus, carries the highest risk of transmitting HIV if either partner is HIV-positive. You can lower your risk for getting and transmitting HIV by using condoms the right way every time you have sex; choosing lower risk sexual activities; taking daily medicine to prevent HIV, called pre-exposure prophylaxis (PrEP); and taking medicines to treat HIV if you have HIV, called antiretroviral therapy (ART).

Risk of HIV

Anal sex is the highest-risk sexual behavior for HIV transmission. Vaginal sex has a lower risk, and activities like oral sex, touching, and kissing carry little to no risk for getting or transmitting HIV. The vast majority of men who get HIV get it through anal sex. However, anal sex is also one of the ways women can get HIV.

Receptive Versus Insertive Sex

During anal sex, the partner inserting the penis is called the insertive partner (or top), and the partner receiving the penis is called the receptive partner (or bottom).

Receptive anal sex is much riskier for getting HIV. The bottom partner is 13 times more likely to get infected than the top. However, it's possible for either partner to get HIV through anal sex from certain body fluids—blood, semen (*cum*), pre-seminal fluid (*pre-cum*), or rectal fluids—of a person who has HIV. Using condoms or medicines to protect against transmission can decrease this risk.

- **Being a receptive partner during anal sex is the highest-risk sexual activity for getting HIV.** The *bottom's* risk of getting HIV is very high because the lining of the rectum is thin and may allow HIV to enter the body during anal sex.
- **The insertive partner is also at risk for getting HIV during anal sex.** HIV may enter the *top*partner's body through the opening at the tip of the penis (or urethra) or through small cuts, scratches, or open sores on the penis.

Risk of Other Infections

In addition to HIV, a person can get other sexually transmitted diseases (STDs) like chlamydia and gonorrhea from anal sex without condoms. Even if a condom is used, some STDs can still be transmitted through skin-to-skin

contact (like syphilis or herpes). One can also get hepatitis A, B, and C; parasites like *Giardia* and intestinal amoebas; and bacteria like *Shigella*, *Salmonella*, *Campylobacter*, and *E. coli* from anal sex without a condom because they're transmitted through feces. Getting tested and treated for STDs reduces a person's chances of getting or transmitting HIV through anal sex. If one has never had hepatitis A or B, there are vaccines to prevent them. A health care provider can make recommendations about vaccines.

Reducing the Risk

Condoms and Lubrication

Latex or polyurethane male condoms are highly effective in preventing HIV and certain other STDs when used correctly from start to finish for each act of anal sex. People who report using condoms consistently reduced their risk of getting HIV through insertive anal sex with an HIV-positive partner, on average, by 63%, and receptive anal sex with an HIV-positive partner, on

average, by 72%. Condoms are much less effective when not used consistently. It is also important that sufficient water- or silicone-based lubricant be used during anal sex to prevent condom breakage and tearing of tissue. Female nitrile condoms can also prevent HIV and some other STDs. **Since condoms are not 100% effective, consider using other prevention methods to further reduce your risk.**

PrEP

People who are HIV-negative and at very high risk for HIV can take daily medicine to prevent HIV called pre-exposure prophylaxis (PrEP). If taken daily, PrEP is highly effective for preventing HIV from sex. PrEP is much less effective when it is not taken consistently. Since PrEP does not protect against other STDs, use condoms the right way every time you have sex.

PEP

Post-exposure prophylaxis (PEP) means taking antiretroviral medicines—medicines used to treat HIV—*after* being potentially exposed to HIV during sex to prevent becoming infected. PEP should be used only in emergency situations and must be started within 72 hours after a possible exposure to HIV, but the sooner the better. PEP must be taken once or twice daily for 28 days. When administered correctly, PEP is effective in preventing HIV, but not 100%. To obtain PEP, contact your health care provider, your local or state health department, or go to an emergency room.

ART

For people with HIV, HIV medicine (called antiretroviral therapy or ART) can reduce the amount of virus in the blood and body fluids to very low levels, if taken as prescribed. This is called *viral suppression*—usually defined as having less than 200 copies of HIV per milliliter of blood. HIV medicine can even make the viral load so low that a test can’t detect it. This is called an *undetectable viral load*. People who take HIV medicine as prescribed and

get and stay virally suppressed or undetectable can stay healthy for many years, and they have effectively no risk of transmitting HIV to an HIV-negative partner through sex. Only condoms can help protect against some other STDs.

Other Ways to Reduce the Risk

People who engage in anal sex can make other behavioral choices to lower their risk of getting or transmitting HIV. These individuals can:

- Choose less risky behaviors like oral sex, which has little to no risk of transmission.
- Get tested and treated for other STDs.

Effectiveness of Prevention Strategies to Reduce the Risk of Acquiring or Transmitting HIV

There are now more options than ever before to reduce the risk of acquiring or transmitting HIV. Using medicines to treat HIV, using medicines to prevent HIV, using condoms, having only low-risk sex, only having partners with the same HIV status, and not having sex can all effectively reduce risk. Some options are more effective than others. Combining prevention strategies may be even more effective. But in order for any option to work, it must be used correctly and consistently.

The following tables provide the **best estimates** of effectiveness for various strategies to prevent HIV acquisition or transmission. Each estimate was identified from the published scientific literature and represents the effectiveness of each strategy **when used optimally**. Available measures of optimal use vary by strategy. The principles for prioritizing measures and findings that were most relevant can be found here. A description of each

prevention strategy, corresponding effectiveness estimate, and a summary of the evidence is provided below.

Antiretroviral Therapy (ART) for HIV-Positive Persons to Prevent Sexual Transmission

Population	Effectiveness Estimate	Source	Interpretation
"Optimal Use" (Taking ART daily as prescribed and achieving and maintaining viral suppression)			
Heterosexual Men and Women	100%	Cohen, 2016 Rodger, 2016	For HIV-positive heterosexual men and women, taking ART regularly greatly reduces the risk of HIV transmission to an HIV–negative partner. For persons who achieve and maintain viral suppression, there is *effectively no risk* of transmitting HIV to their HIV–negative sexual partner. This translates to an effectiveness estimate of 100%† for taking ART regularly as prescribed and achieving and maintaining viral suppression. Effectiveness is lower, and there is a risk of transmitting HIV, when persons do not take ART as prescribed or stop taking ART, if viral suppression is not achieved, or if viral suppression is not maintained.
Men who have sex with men (MSM)	100%	Rodger, 2016 Bavinton, 2018 Rodger, 2019	For HIV-positive MSM, taking ART regularly greatly reduces the risk of HIV transmission to a negative partner. For persons who achieve and maintain viral suppression, there is *effectively no risk* of transmitting HIV to their HIV-negative sexual partner. This translates to an effectiveness estimate of 100%† for taking ART regularly as prescribed and achieving and maintaining viral suppression. Effectiveness is lower, and there is a risk of transmitting HIV, when persons do not take ART as prescribed or stop taking ART, if viral suppression is not achieved, or if viral suppression is not maintained.

† Data are not available from these studies to calculate a combined confidence interval for the effectiveness estimate of 100%; however, confidence intervals for transmission rate estimates from each study are presented below. A recent review of many studies, including these, reported a combined HIV transmission risk estimate, across populations, while the HIV-positive person was virally suppressed of 0.00 (95% CI: 0.00 – 0.07) per 100 couple-years (Vernazza, 2019).

Evidence Supporting Effectiveness Estimates:

- **Effectiveness estimates based on suppressive ART ("Optimal Use" of ART) as indicated by achieving and maintaining viral suppression:**
    - Optimal use of ART is defined as taking ART daily as prescribed and achieving and maintaining a suppressed viral load (or viral suppression).
    - Four key studies provide evidence for the effectiveness of ART, *when used optimally*, on preventing the sexual transmission of HIV. These studies – HPTN052 (Cohen, 2016), PARTNER (Rodger, 2016), Opposites Attract (Bavinton, 2018), and PARTNER2 (Rodger, 2018) – observed zero linked sexual transmissions among HIV-discordant couples with viral suppression.
        - Each of these studies followed HIV-discordant couples while the HIV-positive partners were treated with ART with the intent of suppressing HIV replication. The follow-up assessments, at frequencies typical of what experts recommend for clinical care, included regular measurement of plasma HIV RNA concentrations and HIV testing of the HIV-negative partner. In each study, new HIV infections in the uninfected partners were assessed phylogenetically to determine whether they were genetically linked to their HIV-positive partner in the study.
        - The **HPTN052 study (Cohen, 2016)** followed 1,763 HIV-discordant couples (97% heterosexual; 3% MSM) for a

median of 5.5 years. Zero genetically linked transmissions were observed while the HIV-positive partner was virally suppressed, defined as <400 copies/mL of plasma, resulting in a transmission rate estimate of 0.00 per 100 couple-years and an effectiveness estimate of 100%, if calculated (not reported in study). The confidence intervals for the effectiveness and transmission rate estimates were not reported and could not be calculated from data reported. The authors reported six partner infections that occurred during the study period where linkage could not be determined due to the inability to amplify HIV RNA; these infections were excluded from all analyses. Although linked infection could not be definitively ruled out, epidemiologic investigation strongly suggested most were not linked (Eshleman, 2017). Reported condom use was high (93%) among couples (Cohen, 2011) and likely contributed to the observed reduction in HIV transmission risk.

- The **PARTNER study (Rodger, 2016)** followed 1,166 HIV-discordant couples (62% heterosexual; 38% MSM) for a median of 1.3 years while the HIV-positive partner was treated with ART and virally suppressed at baseline. During the 1,238 couple-years of follow-up time included in the analysis, where nearly 900 couples engaged in over 58,000 condomless sex acts, the HIV-negative partner did not use PrEP or PEP, and the HIV-positive partner was virally suppressed, defined as VL <200 copies/mL of plasma, zero genetically linked transmissions were observed. The resulting transmission rate estimate per 100

couple-years was 0.00, with a 95% confidence interval (CI) = (0.00, 0.30). The upper 95% confidence limit varied by risk group and sexual behavior due to the range of couple-years observed across the subgroups. For example, the estimate for the sexual transmission rate of HIV among discordant couples while the HIV-positive partner was virally suppressed was:

  - 0.00 (0.0 – 0.46) per 100 couple-years during **any condomless sex** among **heterosexual men and women**
  - 0.00 (0.0 – 0.89) per 100 couple-years during **condomless anal sex** among **MSM**

- The **Opposites Attract study (Bavinton, 2018)** followed 343 HIV-discordant male-male couples for a median of 1.7 years while the HIV-positive partner was treated with ART, with most taking ART at baseline (80%). During the 232 couple-years of follow-up time included in the analysis, where the HIV-positive partner was virally suppressed (defined as <200 copies/mLof plasma) and couples reported over 12,000 episodes of any condomless anal sex acts and no PrEP use, there were zero genetically linked transmissions observed. This translates to a transmission rate estimate of:
  - 0.00 (0.00 – 1.59) per 100 couple-years during **condomless anal sex** among **MSM**
- The **PARTNER2 study (Rodger, 2019)** was an extension of the PARTNER study that recruited more HIV-discordant male-male couples and extending the follow-up time for those enrolled in the PARTNER study, totaling 972 HIV-

discordant male-male couples enrolled in PARTNER2. The final analysis included almost 800 couples followed for a median of 2.0 years. Over nearly 1,600 couple-years of follow-up while the HIV-positive partner was on ART and virally suppressed, defined as <200 copies/mL of plasma, and couples reported no PrEP use and over 76,000 episodes of condomless anal sex, zero genetically linked transmissions were observed. This translates to a transmission rate estimate of:

        - 0.00 (0.00 – 0.23) per 100 couple-years during **condomless anal sex** among **MSM**

- Additional supporting evidence beyond the four individual studies includes:
    - Combining over 2,600 couple-years of follow-up and more than 125,000 episodes of sex without a condom or PrEP while the HIV-positive partner was virally suppressed, from the PARTNER, PARTNER2, and Opposites Attract studies, results in a combined HIV transmission risk estimate for condomless and PrEP-less sex among heterosexual or MSM couples of 0.00 (0.00 – 0.14) per 100 couple-years (https://www.cdc.gov/hiv/pdf/risk/art/cdc-hiv-art-viral-suppression.pdf pdf icon[PDF – 160 KB]).
    - A recent review at the 2019 CROI conference combined the four studies above along with several previous observational studies, accumulating over 4,000 couple-years of follow-up, and reported a combined HIV transmission risk estimate while the HIV-positive person was virally suppressed, excluding unconfirmed viral loads,

of 0.00 (0.00 – 0.07) per 100 couple-years (Vernazza, 2019).

- No cases of linked HIV transmission to sexual partners when the person with HIV was virally suppressed have been documented.

- **Earlier effectiveness estimates based on original RCT study:**
  - Cohen (2011) was the first published RCT examining the protective benefits of ART for reducing HIV transmission. This paper reported the interim analysis of the HPTN 052 study, a randomized controlled trial (RCT) of providing early ART, compared with delayed ART, among 1,763 mostly heterosexual, serodiscordant couples followed for a median of 1.7 years. The effectiveness estimate for ART was 96%, based on the ITT results using verified linked cases of HIV.
    - Typically, findings from the primary analysis within an RCT include many participants assigned to the intervention strategy but not necessarily using the strategy. In this study, however, most participants in the "early ART" arm were ***taking ART consistently*** as evidenced by a high level of adherence to ART (79% had at least 95% adherence via pill count) and a high rate of viral suppression (89% were virally suppressed by 3 months). Given that this ITT analysis included time periods where the HIV-positive person was not taking ART or not virally suppressed, this effectiveness estimate for consistent use of ART is not an accurate estimate for optimal use of ART, where the HIV-positive person would be taking ART as prescribed and would have achieved viral suppression.

- The 96% effectiveness of taking early ART, as well as a significant reduction in morbidity and mortality among HIV-positive participants, led to ending the RCT and offering all couples ART. Cohen and colleagues have continued to follow participants from this original study and offer ART to participants in both arms (thereby turning the study from an RCT to an observational design, although they continue also to analyze participants per their original random assignment) (Cohen, 2016). By the end of the study, 96% of HIV-positive persons in the "delayed ART" arm had started ART. The final HPTN 052 study ITT effectiveness estimate, including more than 5 years of follow-up, was 93% comparing "early ART" vs "delayed ART" (Cohen, 2016). Given that essentially all participants in both arms has started ART by the end of the study, this finding is not a better estimate of the effectiveness of taking ART (versus not taking ART) on reducing HIV transmission.
- Based on the HPTN 052 RCT (Cohen, 2011), the best estimate for the overall effectiveness of ***taking ART consistently*** among heterosexuals is 96%. There are no comparable RCTs for MSM or PWID.

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Oral Daily Pre-Exposure Prophylaxis (PrEP)[†] for HIV-Negative Persons

Population	Effectiveness Estimate	Source	Interpretation
"Optimal or Consistent Use" [a] (Taking PrEP daily or at least 4 times per week)			
Men who have sex with men (MSM)	~99%	Grant, 2014 Liu, 2015 McCormack, 2015 Volk, 2015 Marcus, 2017	When taking PrEP daily or consistently (*at least 4 times per week*), the risk of acquiring HIV is reduced by about 99% among MSM. While daily use is recommended in the U.S., taking PrEP consistently (*at least 4 times per week*) appears to provide similar levels of protection among MSM. The effectiveness of oral PrEP is highly dependent on PrEP adherence. When taking oral PrEP daily or consistently, HIV acquisition is extremely rare and has not been observed in any of the studies described below. In clinical practice, a few cases of new HIV infections have been confirmed while HIV-negative individuals were on PrEP with verified adherence.
Heterosexual Men and Women	~99%	*N/A*	There is evidence for the effectiveness of PrEP when used recently[b] (based on detecting TFV in plasma), which is estimated to be 88 – 90% as described below. There is no effectiveness estimate of PrEP when taken daily or consistently among heterosexuals; however, it is likely to be greater than the estimates corresponding to recent use and similar to what has been observed for MSM. The effectiveness of oral daily PrEP is highly dependent on PrEP adherence, with maximum effectiveness when taking PrEP daily and lower effectiveness when not taken consistently.

Persons Who Inject Drugs (PWIDs)	74 – 84%	Choopanya, 2013 Martin, 2015	PWID face HIV risks from both injecting and sex behaviors. Studies on the effectiveness of PrEP when taken daily among PWID are limited. However, when taking PrEP consistently, the risk of acquiring HIV is reduced by an estimated 74 – 84% among PWID. These estimates are based on tenofovir alone and among a subset of PWID taking PrEP consistently, as verified by directly observed therapy or daily diary plus monthly pill count. The effectiveness of two-drug oral therapy has not been assessed among PWID but may be higher. The effectiveness of oral daily PrEP is highly dependent on PrEP adherence, with maximum effectiveness when taking PrEP daily and lower effectiveness when missing doses.

Effectiveness of Prevention Strategies to Reduce the Risk of Acquiring or Transmitting HIV

Retrieved from:
https://www.cdc.gov/hiv/risk/estimates/preventionstrategies.html

Evidence Supporting Effectiveness Estimates[c]:

- **Effectiveness estimates based on "Optimal or Consistent Use" of oral daily PrEP.**
    - The effectiveness of oral daily PrEP is highly dependent on PrEP adherence (Riddell, 2018). The effectiveness estimate of PrEP, when taken daily or consistently, is presented here. The

effectiveness estimates of PrEP as assigned within a trial or when used recently are presented below.

- When taking oral PrEP daily or consistently, it is extremely effective in preventing HIV and HIV acquisition is extremely rare. Only three cases of seroconversion have been confirmed to date worldwide, while HIV-negative individuals were on PrEP with verified adherence (http://www.thebody.com/content/80972/has-anyone-gotten-hiv-when-they-were-on-prep.htmlexternal icon)
- The US Preventive Services Task Force (USPSTF) provides a Grade A recommendation for oral daily PrEP in preventing HIV acquisition in persons at high risk. The USPSTF also concludes with high certainty that the benefit of oral PrEP is substantial, but that adherence to PrEP is central to maximizing its benefit (USPSTF, 2019).
- **MSM:** Several studies evaluated the effectiveness of PrEP use among MSM. These studies vary in study design methods (e.g. RCT, observational) as well as how PrEP adherence is measured; but all provide evidence for the effectiveness of PrEP when taken daily or consistently.
    - **iPrEx OLE Study** (Grant, 2014). This open-label extension (OLE) cohort study enrolled 1,603 MSM and transgender women previously enrolled in three PrEP trials (ATN 082; iPrEx; and US Safety Study) and followed participants for 72 weeks. All were offered free daily oral PrEP (TDF/FTC or *Truvada*), and 1,225 elected to take PrEP. PrEP adherence was measured by drug concentration of TFV-DP in dried blood spots. No new HIV infections were observed

among MSM taking PrEP where drug levels indicated they had taken 4 or more doses per week.

  - Among those with the highest drug concentrations indicating daily PrEP use, as verified by drug level of TFV-DP in dried blood spots of >1250 fmol/punch (equivalent to ~7 pills/week), there were no new HIV infections. This resulted in a risk reduction estimate of 100% when compared to the previous placebo group from the iPrEx trial or the concurrent group of participants not on PrEP.
  - In addition, among those with drug concentration levels indicating at least 4 pills/week (>700 fmol/punch), there were no new HIV infections, which resulted in a risk reduction estimate of 100% when compared to either comparison group.

- **DEMO Project** (Liu, 2015). This open-label observational study enrolled 557 MSM and transgender women in 2 STI clinics and a community health center in 3 U.S. cities and offered free daily oral PrEP (TDF/FTC) for 48 weeks. PrEP adherence was measured by drug concentration of TFV-DP in dried blood spots in a large sample of participants at all follow-up visits. At the end of follow-up, 527 had at least 1 follow-up visit, providing a total of 481 person-years of follow-up. Most of the participants (ranging from 80% to 86% of participants across the follow-up visits) of those assessed for PrEP adherence had drug levels considered protective (consistent with >4 pills/week). At the end of the study, 2 participants acquired HIV infection; however, both participants had drug levels indicative of < 2

doses/week or BLQ (below the limit of quantification) throughout the study. This means no new HIV infections were observed among those with protective levels of PrEP use.

- **PROUD Study** (McCormack, 2015). The PROUD study was a randomized-control trial (RCT) evaluating immediate daily oral PrEP (TDF/FTC) vs delayed PrEP among HIV-negative MSM patients in 13 clinics in England from 2012-2014. A total of 554 MSM were randomized, 275 to immediate PrEP and 269 to the delayed group. After an interim analysis, the trial stopped early and all deferred patients were offered PrEP. More than 90% of the patients in each group were retained at the end of the study, providing ~500 person-years of follow up. The mITT results from the trial are reported below. Although there were 3 new HIV infections among those assigned to the immediate PrEP group, there were no HIV infections observed among those actually taking PrEP. All 3 new HIV infections in the immediate PrEP group, based on clinical indications, attendance, and prescription info, were not taking PrEP near the time of seroconversion – 2 never started taking PrEP and 1 infection was identified over 40 weeks after last clinic visit (where 90 PrEP pills were provided).
- **Kaiser Permanente Observational Study** (Volk, 2015; Marcus, 2017). This observational study followed 1,045 Kaiser Permanente (KP) patients, mostly MSM (98-99%), who were referred to a specialized PrEP program in KP San Francisco during 2012-2015, and then later extended

through February 2017. PrEP use was measured based on pharmacy refill data. Among the 2,107 patients never starting PrEP, there were 22 new HIV infections. Among the 4,991 who started PrEP, although we don't know how many were always taking PrEP daily, there were no new HIV infections while PrEP prescriptions were filled (over 12.4 months; 5,104 person-years on PrEP). Of the 1,303 patients who stopped PrEP (prescription not re-filled), 11 new HIV infections were later observed after stopping PrEP, by the end of the follow-up.

- In summary, the effectiveness of PrEP among MSM when used daily or consistently is estimated to be 100% in studies. However, a few cases of new HIV infections have been reported with PrEP verified adherence, indicating that the risk has not been completely eliminated and that the effectiveness of PrEP cannot be exactly 100%. Given the number of persons on PrEP worldwide (prepwatch.orgexternal icon), the risk reduction (or effectiveness of PrEP) would likely need to be very high and close to100% to observe only three confirmed cases of PrEP failure (new HIV infection despite taking PrEP daily or consistently) to date. To represent the protective value of PrEP while also acknowledging the small number of failures, we indicate the effectiveness of PrEP is about 99%.

- **Transgender women:** The **iPrEx OLE** cohort study (Grant, 2014) enrolled mostly MSM, but included 175 transgender women previously enrolled in three PrEP trials (ATN 082; iPrEx; and US Safety Study) and offered free daily oral PrEP (TDF/FTC

or *Truvada*) for 72 weeks. PrEP adherence was measured by drug concentration of TFV-DP in dried blood spots. One transgender woman seroconverted while receiving PrEP and one seroconversion occurred in a woman who elected not to use PrEP. No new HIV infections were observed among transgender women who were taking PrEP where drug levels indicated they had taken 4 or more doses per week. However, the iPrEx trial results described below show no benefit of PrEP among transgender women, likely due to low PrEP adherence (Deutsch, 2015).

- **Heterosexual men and women:** There is no effectiveness estimate of PrEP when taken daily or consistently among heterosexuals. There is evidence for the effectiveness of PrEP when used recently, which is estimated to be 88 – 90%, as described below. These estimates come from subset analyses among heterosexual men or women with evidence of taking PrEP recently (based on detecting TFV in plasma). These subset analyses likely include people who vary in PrEP adherence, including those who used PrEP recently but not consistently, used PrEP consistently but not daily (e.g. ~4 times/week), or used PrEP daily. Given that the effectiveness of PrEP is highly dependent on PrEP adherence, the effectiveness of PrEP when taking PrEP daily or consistently is likely to be greater than when taking PrEP recently; therefore, likely to be greater than 90% and similar to what is observed for MSM. Data show that it takes longer (~13 days longer) to reach a maximum drug level of PrEP in vaginal tissue as compared to rectal tissue (CDC, 2018), but once maximum drug levels are reached, the effectiveness of

PrEP in preventing acquisition during sex should be similar for vaginal or anal sex, and for men or women.

- **PWID:** The **Bangkok Tenofovir Study (BTS)** (Choopanya, 2013) was an RCT evaluating oral daily PrEP use (TDF alone) against placebo among HIV-negative persons who inject drugs (PWID).
    - When taking PrEP (TDF) nearly daily, as verified by TFV detected in plasma and directly observed therapy (DOT) (with at least 70% of days were DOT, with no gaps of >2 days without DOT; equivalent to ~5 days/week), the risk of HIV acquisition was reduced by 74% among HIV-uninfected injecting drug users (subset analysis; BTS; Choopanya, 2013).
    - When taking PrEP (TDF) nearly daily, when defined as 97.5% adherence, based on daily diary (most often confirmed daily by DOT staff) and monthly pill count, the risk of HIV acquisition was reduced by about 84% (subset analysis; BTS; Martin, 2015). This study also showed a dose-response between adherence and protection from PrEP, with greater adherence resulting in a greater effectiveness estimate for PrEP.
    - This BTS study evaluated TDF (Tenofovir) rather than the combination drug TDF/FTC (Truvada). The effectiveness of two-drug oral therapy has not been assessed among PWID but may be higher than TDF alone. TDF alone had been shown to have a slightly lower efficacy than TDF/FTC, although not statistically different, among heterosexual HIV-discordant couples in the Partners PrEP study (Baeten, 2012; Baeten, 2014). In addition, since the measures used

in the BTS study for assessing PrEP adherence included those taking PrEP nearly daily but not daily, the effectiveness of daily PrEP use may in fact be greater.
        - Note that TDF (Tenofovir) is recommended in the U.S. as an alternative to TDF/FTC (Truvada) among PWID (https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf pdf icon[PDF – 2 MB])

- **Effectiveness estimates based on "Recent Use" of oral daily PrEP.**
    - Recent use of oral PrEP is measured based on drug detected, typically detecting FTC or TFV, in plasma. All effectiveness estimates presented here come from subset analyses within larger RCTs restricting to participants with drug detected in plasma indicating recent use of PrEP. These estimates do not reflect optimal or consistent use of PrEP, which resulted in greater effectiveness estimates among MSM and PWID as described above.
    - **MSM:** The **iPrEx Trial** (Grant, 2010) was an RCT evaluating oral daily PrEP use (TDF/FTC) against placebo among MSM. The findings from a case/control sub-analysis show that effectiveness of PrEP, when recently used, was estimated to be 92%. This measure of recent use of PrEP was based on detecting FTC or TFV in plasma or detecting FTC-TP or TFV-DP in PBMC.
    - **Heterosexual men and women:** The **Partners PrEP Study** (Baeten, 2012) was an RCT with three arms, evaluating oral daily PrEP use as TDF/FTC and as TDF alone against a placebo arm, among HIV-discordant heterosexual men and women.

        - The effectiveness of PrEP (TDF/FTC), when used recently, was estimated to be 88% – 90%, which comes from two separate sub-analyses from the Partners PrEP Study.
        - A case/control sub-analysis reported the effectiveness of PrEP, when used recently (based on detecting TFV in plasma), was estimated to be 90% among HIV-uninfected heterosexual men and women (Baeten, 2012).
        - Another restricted analysis of the same study was based on TFV drug levels in plasma. When taking PrEP (TDF/FTC) recently, as defined by >40 ng/ml of TFV in plasma (unknown equivalent pills/week), the risk of HIV acquisition was reduced by 88% among HIV-uninfected heterosexual men and women (Donnell, 2014). Given these levels of TFV in plasma do not translate to a known level of PrEP adherence or known number of pills/week, this finding more accurately corresponds to those taking PrEP recently rather than daily or consistently.
    - **PWID:** The **Bangkok Tenofovir Study (BTS)** (Choopanya, 2013) was an RCT evaluating oral daily PrEP use (TDF alone) against placebo among HIV-negative persons who inject drugs (PWID).
        - A case/control sub-analysis reported the effectiveness of PrEP (TDF), when used recently (based on detecting TFV in plasma), was estimated to be 70% among PWID.
        - This BTS study evaluated TDF (Tenofovir) rather than the combination drug TDF/FTC (Truvada). The effectiveness of two-drug oral therapy has not been assessed among PWID but may be higher than TDF alone. TDF alone has been shown to have a slightly lower efficacy than TDF/FTC when

compared to placebo, although not statistically different, among heterosexual HIV-discordant couples in the Partners PrEP study (Baeten, 2012; Baeten, 2014).

- Note that TDF (Tenofovir) is recommended in the U.S. as an alternative to TDF/FTC (Truvada) among PWID (https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf pdf icon[PDF – 2 MB])

- **Effectiveness estimates based on modified intent-to-treat (mITT) analyses in trials, regardless of level of PrEP use:**
  - **MSM:**
    - **The iPrEx Trial** (Grant, 2010) was an RCT designed to evaluate the efficacy of oral daily PrEP (TDF/FTC) versus placebo in preventing HIV acquisition among 2,499 HIV-uninfected MSM and transgender women. After a median of 1.2 years of follow-up, the risk of HIV acquisition was reduced by 44% among HIV-uninfected MSM assigned to daily PrEP (TDF/FTC) (mITT analysis). This estimate includes all participants assigned to take daily PrEP, regardless of actual use.
    - The **PROUD Study** (McCormack, 2015) was an RCT evaluating immediate daily oral PrEP (TDF/FTC) versus delayed PrEP among HIV-negative patients in 13 clinics in England from 2012-2014. A total of 554 MSM were randomized, 275 to immediate PrEP and 269 to the delayed group. After an interim analysis, the trial stopped early and all deferred patients were offered PrEP. More than 90% of the patients in each group were retained at the end of the study, providing ~500 person-years of follow-up.

        - RCT results (mITT analysis) – At the end of interim analysis, 3 new HIV infections were observed in the immediate PrEP group and 20 in delayed group, resulting in a risk reduction estimate of 86%.
        - There were no HIV infections observed among those taking PrEP. All 3 new HIV infections in immediate PrEP group, based on clinical indications, attendance, and prescription information, were not taking PrEP near the time of seroconversion – 2 never started taking PrEP and 1 infection was identified over 40 weeks after last clinic visit (where 90 PrEP pills were provided).
- The **IPERGAY Trial** (Molina, 2015) was an RCT evaluating the efficacy of "on-demand" PrEP (TDF/FTC) regimen (defined as taking 2 pills 2-24 hours before sex, 1 pill 24 hours later, and a 4th pill 24 hours after the 3rd) versus placebo among 400 MSM. At the interim analysis of the trial, after 1 year of follow-up, the efficacy of "on-demand" PrEP was estimated to be 86% in the mITT analysis and 82% in the ITT analysis. By measured plasma drug levels in a subset of those randomized to TDF/FTC, 86% had TDF levels consistent with having taken the drug during the previous week.
    - The **IPERGAY OLE** (Molina, 2017) study. Following the interim analysis where the efficacy of "on-demand" PrEP was determined, the placebo group was discontinued, all study participants were offered TDF/FTC in an OLE phase of the study, and 361 enrolled. Although not part of the trial, the **IPERGAY**

OLEstudy reported the risk of HIV acquisition was reduced by 97% when comparing the MSM taking PrEP as part of the OLE cohort to the placebo arm of the IPERGAY trial (Molina, 2017). Seventy-one percent of those in the OLE cohort had TDF levels consistent with having taken the drug during the previous week.

- Two participants in the "on-demand" PrEP arm of the RCT seroconverted after enrollment and 1 participant in the OLE cohort seroconverted during follow-up. In all three cases, study records showed that the participants were not taking PrEP at the time of the diagnosis (no drug detected in plasma and all had returned all or most of their PrEP pills at the most recent visit). No new HIV infections were observed among participants taking PrEP.
- A small sub-study of the IPERGAY trial reported high effectiveness of on-demand PrEP among those MSM participants with less frequent sexual intercourse (Antoni, 2017). This subset analysis reported an estimated 100% reduction in HIV incidence among a subset of participants reporting less frequent sexual intercourse (median of 5 sex acts/month) when reportedly taking on-demand PrEP, about 9.5 pills/month (or ~2-3 pills/week), compared to placebo.
- Daily dosing is the only Food and Drug Administration (FDA)-approved schedule for taking PrEP to prevent HIV. However, the International

Antiviral Society-USA supports the "off-label" but evidence-based use of on-demand PrEP, as an alternative to daily PrEP, for gay, bisexual and other men who have sex with men with infrequent sexual exposures (Saag, 2018). Given limited data on the effectiveness of on-demand PrEP for heterosexual men and women, PWID, and transgender persons, IAS-USA does not currently recommend on-demand PrEP for these populations. Several health departments have developed guidance on off label use of on demand PrEP for MSM, including the New York City Department of Health (https://www1.nyc.gov/assets/doh/downloads/pdf/ah/prep-on-demand-dosing-guidance.pdfpdf iconexternal icon) and the San Francisco Department of Public Health (http://www.gettingtozerosf.org/wp-content/uploads/2018/11/HIVUpdate_02122019_v2.pdfpdf iconexternal icon)

- **Transgender women:** A follow-up sub-analysis of the **iPrEx Trial** evaluated the effectiveness of PrEP (TDF/FTC) versus placebo among 339 transgender women (Deutsch, 2015). No benefit of PrEP was identified (HR=1.1, 95% CI: 0.5 – 2.7); however the transgender women appeared to have lower PrEP adherence than MSM within iPrEx.
- **Heterosexual men and women:**
  - The **Partners PrEP study** was an RCT among 4747 HIV-discordant heterosexual couples assessing the efficacy of oral daily PrEP by comparing three treatment arms – TDF/FTC (Truvada), TDF alone, and placebo. The risk of

HIV acquisition was reduced by 75% among HIV-uninfected heterosexual men and women assigned to TDF/FTC (Truvada) compared to placebo (mITT analysis; Baeten, 2012). This estimate included all participants assigned to take daily PrEP, regardless of actual use.

- The **TDF2 study** was an RCT among 1219 HIV-negative heterosexual men and women comparing TDF/FTC (Truvada) to placebo and found the risk of HIV acquisition was reduced by 62% (mITT analysis; Thigpen, 2012). This estimate included all participants assigned to take daily PrEP, regardless of actual use. An as-treated analysis, restricting to those participants taking PrEP recently based on self-reported PrEP use in last 30 days, found the risk of HIV acquisition was reduced by 78%. This, however, was based on self-report and not an objective measure of recent use.
- There are additional PrEP trials among women reported in the literature not summarized here. Riddell (2018) and the USPSTF (2019) reviewed the trial findings for PrEP and described additional trials among women showing no significant effects of PrEP, primarily due to extremely low adherence among women in the studies.

- **PWIDs:** The **Bangkok Tenofovir Study (BTS)** was an RCT evaluating oral daily PrEP use (TDF alone) against placebo among HIV-negative persons who inject drugs. This trial showed the risk of HIV acquisition was reduced by 49% among HIV-uninfected injecting drug users assigned to oral daily PrEP (TDF) (mITT analysis; Choopanya, 2013). This estimate included all participants assigned to take daily PrEP, regardless of actual use.

c The effectiveness estimate for PrEP is estimating the percentage reduction in HIV risk due to PrEP. It is not estimating the risk of HIV acquisition among those on PrEP, but is estimating the relative reduction in that risk due to PrEP. An effectiveness estimate of "about 99%" results in an extremely small estimated risk of HIV acquisition for those taking oral PrEP daily or consistently.

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Male Condom Use

Population	Effectiveness Estimate	Source	Interpretation
"Optimal Use" (Used consistently and correctly during every sex act)			
MSM or Heterosexual Men and Women	Not Avail	Not Avail	Condoms provide an impermeable barrier to HIV. FDA quality control standards and laboratory studies indicate leaks due to product failure are extremely rare. In practice, it is difficult, *if not impossible*, to measure optimal use of condoms during sex. No studies have been able to provide accurate estimates for the effectiveness of condoms in preventing HIV, when used consistently and correctly, in practice. However, such an estimate is likely to be greater than the estimates provided in studies where participants self-reported consistent condom use during sex.
"Consistent Use" (Always used during sex per self-report)			
Heterosexual Men and Women	80%	Weller, 2002	Always using condoms, based on self-report, during sex with an HIV-positive partner reduces the risk of HIV acquisition by an estimated 80% among heterosexual men and women. Self-report may not be entirely accurate, resulting in an underestimate of the true effectiveness for consistent condom use. Condom effectiveness is also likely to be higher when condoms are used correctly every time during sex.
MSM, Receptive Anal Sex	72-91%	Smith, 2015 Johnson, 2018	Always using condoms, based on self-report, during receptive anal sex with HIV-positive partners reduces the risk of HIV acquisition by an estimated 72% (Smith, 2015) and an estimated 91% (Johnson, 2018) among HIV-negative MSM. Self-report may not be entirely accurate, resulting in an underestimate of the true effectiveness for consistent condom use. Condom effectiveness is also likely to be higher when condoms are used correctly every time during sex.

MSM, Insertive Anal Sex	63%	Smith, 2015	Always using condoms, based on self-report, during insertive anal sex with HIV-positive partners reduces the risk of HIV acquisition by an estimated 63% among HIV-negative MSM. Self-report may not be entirely accurate, resulting in an underestimate of the true effectiveness for consistent condom use. Condom effectiveness is also likely to be higher when condoms are used correctly every time during sex.

Evidence Supporting Effectiveness Estimates:

- **Effectiveness Estimates based on "Optimal Use" of Condoms.**
  - Optimal use of condoms is defined here as both consistent and correct use during every sex act.
  - Laboratory studies show that (latex-based, polyurethane, or other synthetic material-based) condoms provide an impermeable barrier to passage of HIV. Even during optimal use, however, condoms may not offer complete protection all the time due to the rare chance of product failure.
  - Measures are in place to ensure high quality control on product development. Condoms are regulated as class II medical devices by the U.S. Food and Drug Administration (FDA). FDA requires every condom to be tested electronically for holes and weak spots before it is packaged and released for sale. In addition, samples of condoms undergo a series of additional laboratory tests for leakage, strength, and other factors. Condom samples must be at least 99.6% effective in laboratory "water leak" tests, which means that at least 996 out of every 1000 condoms sampled must pass the test. (Warner, 2018; FDA link below)

- Other laboratory testing has estimated that the worst-case product failure would lead to less than 0.01% of volume leakage during sex. In other words, the worst-case scenario would still eliminate about 99.99% of volume exposure during sex, in the event of product failure. (Carey, 1992)

- **Effectiveness Estimates based on "Consistent Use" of Condoms.**
  - *Although rare, and not easily measured, condoms may break, slip, or leak during use, even if used correctly. In addition, not using condoms correctly (user failure) increases the risk of breakage, slippage, leakage, or incomplete coverage which can increase exposure to HIV and, thus, may decrease condom effectiveness. Because male condoms are applied by the user during sex, user error or failure is an ongoing risk during each sexual episode. User error is difficult to eliminate; however, over time, as the user becomes more experienced, it is minimized. In addition, not using condoms consistently, meaning during every sex act, may further increase potential exposure to HIV and decrease effectiveness even more. Below are effectiveness estimates for consistently using condoms in practice as measured in observational studies.*
  - **Heterosexual Men and Women:** The Weller 2002 Cochrane review of 13 longitudinal cohort studies among HIV discordant heterosexual couples reported results comparing those reporting "Always" vs "Never" using condoms during vaginal sex from 5 of the 13 studies with data available at the longest follow-up. Vaginal versus anal and insertive versus receptive sex were not distinguished in these analyses. Always using condoms, based on self-report, during sex with an HIV-positive partner reduces the risk of HIV acquisition per person-year of follow-up by an

estimated 80% among heterosexual men and women. This measure does not account for the possibility of different numbers of sex acts over time between condom users and non-users.

- **MSM:** Two recent studies have estimated the effectiveness of consistent condom use on HIV risk among HIV-negative MSM having sex with HIV-positive men.
  - The Smith 2015 study combined data from two longitudinal studies among MSM (EXPLORE & Vax004) and compared HIV-negative MSM who reported "Always" vs "Never" using condoms during receptive anal sex, during insertive anal sex, and during any anal sex, with HIV-positive partners.
    - **MSM, Receptive Anal Sex —** Always using condoms, based on self-report, during receptive anal sex with HIV-positive partners reduced the risk of HIV acquisition per person-year by an estimated 72% among MSM.
    - **MSM, Insertive Anal Sex** — Always using condoms, based on self-report, during insertive anal sex with HIV-positive partners reduced the risk of HIV acquisition per person-year by an estimated 63% among MSM. This analysis does not take into account whether HIV-negative MSM also engaged in receptive anal sex, with or without condoms, which could affect this estimate.
    - **MSM, Any Anal Sex —** Always using condoms, based on self-report, during any (insertive or receptive) anal sex with HIV-positive partners

reduced the risk of HIV acquisition per person-year by an estimated 70% among MSM.
        - These measures do not account for the possibility of different numbers of sex acts over time between condom users and non-users.
    - The Johnson 2018 study examined condom effectiveness per partner in four cohorts of MSM (EXPLORE, Vaxx004, JumpStart, and Vaccine Preparedness Study) by comparing those "Always" using condoms versus "Not always" using condoms, based on self-report, throughout the sexual partnerships. Among HIV-uninfected MSM engaging in receptive anal sex with their HIV-positive partner, always using condoms during receptive anal sex throughout the partnership reduced the risk of HIV acquisition per partner by an estimated 91%. This measure does not account for the possibility of different numbers of sex acts per partner between condom users and non-users.
- The estimates provided here likely underestimate the effectiveness of condoms when used consistently and correctly in practice due to measurement error regarding both aspects of condom use – *consistent use and correct use*.
    - These estimates for "*consistent use*" are based on observational cohort studies because no RCTs exist, due to ethical and feasibility concerns with assigning a no condom use arm. In addition, only subjective measures of condom use (*self-report*) are available in studies with HIV as an outcome, which may overestimate actual condom use, resulting in underestimating condom effectiveness.

Therefore, the effectiveness of consistent condom use is likely greater.

- These studies also did not measure whether condoms were used *correctly*. If used incorrectly, condoms may break, slip, leak, or not provide complete coverage, which may increase exposure to HIV. The studies among MSM, however, did ask MSM to count "breakage" and "slippage" as "not using a condom" in an attempt to account for user failure – but this relies on knowledge of failure and self-report and likely underestimates true failure. If these analyses included any data where condoms were used incorrectly but misclassified as consistent and correct use, then these estimates are likely underestimating condom effectiveness when used correctly, and the effectiveness of correct condom use is likely greater.

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Circumcision of Adult Males

Population	Effectiveness Estimate	Source	Interpretation
MSM, Insertive Anal Sex	Inconclusive	Wiysonge, 2011; Sanchez, 2011; Doerner, 2013	Based on observational studies of circumcision among adult males, there is insufficient evidence at this time to conclude that male circumcision reduces the risk of the insertive partner acquiring HIV during anal sex among MSM.
MSM, Receptive Anal Sex	Inconclusive	Wiysonge, 2011; Schneider, 2012	Based on observational studies of circumcision among adult males, there is insufficient evidence at this time to conclude that male circumcision (*of the insertive partne*r) reduces the risk of the receptive partner acquiring HIV during anal sex among MSM.
Heterosexual Men	50%	Siegfried, 2009	Based on trials of circumcision among adult males, male circumcision reduces the risk of heterosexual men acquiring HIV during sex by 50%.
Heterosexual Women	Inconclusive	Wawer, 2009; Weiss, 2009; Baeten, 2010	Based on several trials and observational studies of circumcision among adult males, there is insufficient evidence at this time to conclude that male circumcision reduces the risk of heterosexual women acquiring HIV during sex.

Strengths and Limitations of Effectiveness Estimates:

- Most of the evidence is based on observational studies and circumcision status is primarily based on self-report; only some studies are based on medical exam (objective measure of exposure).

- MSM Insertive Anal Sex – A Cochrane review of 7 observational studies among MSM reporting mainly or only "insertive" sex reports a significant protective effect of circumcision on acquiring HIV through insertive anal sex, 73% risk reduction (Wiysonge 2011). Exposure (circumcision) was primarily measured via self-report (subjective measure), although genital exams occurred in some studies. Two more recently published observational studies show non-significant effects of circumcision on HIV acquisition during insertive anal sex (Sanchez, 2011; Doerner, 2013). With conflicting results, the evidence is inconclusive and an updated meta-analysis is needed.
- MSM Receptive Anal Sex – A Cochrane review of 3 observational studies among MSM reporting primarily "receptive" sex reports a non-significant effect estimate for circumcision (*of the insertive partner*) on HIV acquisition during receptive anal sex, with exposure measured by self-report (Wiysonge 2011). A more recently published observational study reports a significant effect of circumcision (based on self-report) on HIV acquisition during receptive anal sex among MSM (Schneider, 2012). With conflicting results, the evidence is inconclusive, and an updated meta-analysis is needed.
- Heterosexual Men – A Cochrane review of 3 RCTs synthesizes ITT results on the effects of circumcision on risk of HIV acquisition during sex among HIV-negative heterosexual men (Siegfried, 2009).
- Heterosexual Women – A meta-analysis (including one RCT and several observational studies) reports that there is insufficient evidence to conclude that male circumcision reduces the risk of HIV acquisition during sex among HIV-negative heterosexual women (Weiss, 2009). Two more recent reports, 1 RCT and 1 observational study, also show non-significant effects of male circumcision (confirmed by medical exam) on HIV acquisition in women among HIV-

discordant heterosexual couples (Baeten, 2010; Wawer, 2009). The evidence is inconclusive, and an updated meta-analysis is needed.

Source:

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B. Vaginal Sex

Vaginal Sex and HIV Risk

Retrieved from: https://www.cdc.gov/hiv/risk/vaginalsex.html

Vaginal sex (intercourse) involves inserting the penis into the vagina. HIV can be transmitted during this activity if either partner has HIV. You can lower your risk for getting and transmitting HIV by using condoms the right way every time you have sex; taking daily medicine to prevent HIV, called pre-exposure prophylaxis (PrEP); and taking medicines to treat HIV if you have HIV, called antiretroviral therapy (ART).

Risk of HIV

Some sexual activities are riskier than others for getting or transmitting HIV. For an HIV-negative person, the riskiest activity for getting HIV is being the receptive partner ("bottom") in anal sex. Being the insertive partner ("top") in anal sex or having vaginal sex (insertive or receptive) is less risky, though either partner can get HIV through those activities as well. Activities like oral sex, touching, and kissing carry little to no risk for getting or transmitting HIV.

- **A woman can get HIV during vaginal sex** because the lining of the vagina and cervix may allow HIV to enter her body if her male partner's body fluids carry HIV, including blood, semen *(cum)*, and

pre-seminal fluid *(pre-cum)*. Using condoms or medicines to protect against transmission can decrease this risk.

- **Men can also get HIV from having vaginal sex with a woman who's HIV-positive** because vaginal fluid and blood can carry HIV. Men can get HIV through the opening at the tip of the penis (or urethra); the foreskin if they're not circumcised; or small cuts, scratches, or open sores anywhere on the penis. Using condoms or medicines to protect against transmission can decrease this risk.

Risk of Other Infections

In addition to HIV, a person can get other sexually transmitted diseases (STDs) like chlamydia and gonorrhea from vaginal sex if condoms are not used correctly. Even if a condom is used, some STDs can still be transmitted through skin-to-skin contact (like syphilis or herpes). Hepatitis A and B can also be transmitted through vaginal sex. Getting tested and treated for STDs reduces a person's chances of getting or transmitting HIV through vaginal sex. If one has never had hepatitis A or B, there are vaccines to prevent them. A health care provider can make recommendations about vaccines.

Reducing the Risk

Condoms and Lubrication

Latex or polyurethane male condoms are highly effective in preventing HIV and certain other STDs when used correctly from start to finish for each act of vaginal sex. People who report using condoms consistently reduced their risk of getting HIV through vaginal sex, on average, by 80%. Condoms are

much less effective when not used consistently. It is also important that sufficient water- or silicone-based lubricant be used during vaginal sex to prevent condom breakage and tearing of tissue. Female nitrile condoms can also prevent HIV and some other STDs. **Since condoms are not 100% effective, consider using other prevention methods to further reduce your risk.**

PrEP

People who are HIV-negative and at very high risk for HIV can take daily medicine to prevent HIV called pre-exposure prophylaxis (or PrEP). If taken daily, PrEP is highly effective for preventing HIV from sex. PrEP is much less effective when it is not taken consistently. Since PrEP does not protect against other STDs, use condoms the right way every time you have sex.

PEP

Post-exposure prophylaxis (PEP) means taking antiretroviral medicines—medicines used to treat HIV—*after* being potentially exposed to HIV during sex to prevent becoming infected. PEP should be used only in emergency situations and must be started within 72 hours after a possible exposure to HIV, but the sooner the better. PEP must be taken once or twice daily for 28 days. When administered correctly, PEP is effective in preventing HIV, but not 100%. To obtain PEP, contact your health care provider, your local or state health department, or go to an emergency room.

ART

For people with HIV, HIV medicine (called antiretroviral therapy or ART) can reduce the amount of virus in the blood and body fluids to very low levels, if taken as prescribed. This is called *viral suppression*—usually defined as having less than 200 copies of HIV per milliliter of blood. HIV medicine can even make the viral load so low that a test can’t detect it. This is called an *undetectable viral load*. People who take HIV medicine as prescribed and

get and stay virally suppressed or undetectable can stay healthy for many years, and they have effectively no risk of transmitting HIV to an HIV-negative partner through sex. Only condoms can help protect against some other STDs.

Other Ways to Reduce the Risk

People who engage in vaginal sex can make other behavioral choices to lower their risk of getting or transmitting HIV. These individuals can:

- Choose less risky behaviors like oral sex, which has little to no risk of transmission.
- Get tested and treated for other STDs.

C. Oral Sex

Oral Sex and HIV Risk

- There is little to no risk of getting or transmitting HIV from oral sex.
- Other STDs and hepatitis can be transmitted during oral sex.
- Latex barriers and medicines to prevent and treat HIV can further reduce the very low risk of getting HIV from oral sex.

Oral sex involves using the mouth to stimulate the penis (fellatio), vagina (cunnilingus), or anus (anilingus).

Risk of HIV

- The chance an HIV-negative person will get HIV from oral sex with an HIV-positive partner is extremely low. However, it is hard to know the exact risk because a lot of people who have oral sex also have anal or vaginal sex. The type of oral sex that may be the riskiest is mouth-to-

penis oral sex. But the risk is still very low, and much lower than with anal or vaginal sex.

- Though the risk of HIV transmission through oral sex is low, several factors may increase that risk, including sores in the mouth or vagina or on the penis, bleeding gums, oral contact with menstrual blood, and the presence of other sexually transmitted diseases (STDs).

Risk of Other Infections

- Other STDs, such as syphilis, herpes, gonorrhea and chlamydia, can be transmitted during oral sex. Anilingus can also transmit hepatitis A and B, intestinal parasites like *Giardia*, and bacteria like *E. coli*.

Reducing the Risk

- Individuals can further reduce the already low risk of HIV transmission from oral sex by keeping their male partners from ejaculating in their mouth. This could be done by removing the mouth from the penis before ejaculation, or by using a condom.
- Using a barrier like a condom or dental dam during oral sex can further reduce the risk of transmitting HIV, other STDs, and hepatitis. A dental dam is a thin, square piece of latex or silicone that is placed over the vagina or anus during oral sex. A latex condom can also be cut length-wise and used like a dental dam.
- The risk of HIV transmission through oral sex is even lower if the HIV-negative partner is taking medicine to prevent HIV (pre-exposure prophylaxis or PrEP) or the HIV-positive partner is taking medicine to treat HIV (antiretroviral therapy or ART) and is virally suppressed.

D. Sex Tourism

"Sex tourism" is defined as travel planned specifically for the purpose of sex, generally to a country where sex work is legal.

Be Aware

Disease

HIV and other sexually transmitted infections (STIs) may be common among sex workers. Some common STIs, such as gonorrhea, have become extensively drug-resistant in some parts of the world. Make **sure you ALWAYS use protection when having sex with a new partner.**

Legality

Sex tourism supports human trafficking (slavery), one of the largest criminal industries in the world. Even if prostitution is legal in a country, human trafficking, sex with a minor, and child pornography are **ALWAYS** crimes. Millions of children around the world are victims of commercial sexual exploitation. Children abused by sex tourists suffer not only sexual abuse but also physical, emotional, and psychological abuse, as well as poverty and homelessness. They suffer from health problems including addiction, malnourishment, injuries, STIs and emotional trauma.

Someone who engages in these activities in a foreign country can be prosecuted under that county's law while abroad and under US law after returning to the United States.

Although the age at which someone is considered a minor may vary by country, federal law makes it a crime for US residents to engage in sexual or pornographic activities with a child younger than 18 years anywhere in the

world. It is also illegal to travel abroad for the purpose of having sex with a minor.

How to Prevent Trafficking

To combat trafficking and child sexual abuse, some international hotels and other tourism services have voluntarily adopted a code of conduct that includes training for employees and reporting of suspicious activities. Tourist establishments supporting this initiative to protect children from sex tourism are listed online. Providers and travelers who suspect child sexual exploitation or other trafficking activities occurring overseas can report tips anonymously by:

In the United States, the National Center for Missing & Exploited Children's CyberTipline collects reports of child prostitution and other crimes against children (toll-free at 800-843-5678).

Since 2003, when Congress passed the PROTECT Act, at least 8,000 Americans have been arrested. The PROTECT Act strengthens the US government's ability to prosecute and punish crimes related to sex tourism, including incarceration of up to 30 years for acts committed at home or abroad. Cooperation of the host country is required to open an investigation of criminal activity. For more ways you can help, see the Department of State list of 15 ways to fight human trafficking.

- Using the Operation Predator smartphone app.
- Calling the Homeland Security Investigations Tip Line (866-347-2423).

- ICE Submitting information online.
- HHS National Human Trafficking Hotline,
- ACF National Human Trafficking Hotline

In the United States, the National Center for Missing & Exploited Children's CyberTipline collects reports of child prostitution and other crimes against children (toll-free at 800-843-5678).

Since 2003, when Congress passed the PROTECT Act, at least 8,000 Americans have been arrested. The PROTECT Act strengthens the US government's ability to prosecute and punish crimes related to sex tourism, including incarceration of up to 30 years for acts committed at home or abroad. Cooperation of the host country is required to open an investigation of criminal activity. For more ways you can help, see the Department of State list of 15 ways to fight human trafficking.

Transgender Persons

Retrieved from: https://www.cdc.gov/lgbthealth/Transgender.htm

Transgender is an umbrella term for persons whose gender identity or expression (masculine, feminine, other) is different from their sex (male, female) at birth. *Gender identity* refers to one's internal understanding of one's own gender, or the gender with which a person identifies. *Gender expression* is a term used to describe people's outward presentation of their gender.

Gender identity and sexual orientation are different facets of identity. Everyone has a gender identity and a sexual orientation, but a person's gender does not determine a person's sexual orientation. Transgender

people may identify as heterosexual, homosexual, bisexual, or none of the above.

Figure 7-5: Guidelines for Working With Transgender Clients

Figure 7-5
Guidelines for Working With Transgender Clients

Do	Don't
• Use the pronouns based on their *self-identity* when speaking to or about transgender individuals. • Obtain clinical supervision if you have reservations about working with transgender individuals. • Allow transgender clients to continue the use of hormones when prescribed; advocate for the transgender client who is using "street" or illegally prescribed hormones to receive immediate medical care and legally prescribed hormones. • Ensure that all clinic staff receive training on transgender issues. • Ascertain a transgender client's sexual orientation before treating him or her. • Allow transgender clients to use appropriate bathrooms and showers based on their *gender self-identity and gender role.* • Require all clients and staff to create and maintain a hospitable environment for all transgender clients. Post a nondiscrimination policy, including sexual orientation and gender identity, in the waiting room.	• Call someone who identifies as female "he" or "him," or someone who identifies as male "she" or "her." • Make transphobic comments to other staff or clients. • Ask the transgender client to choose between hormone therapy or substance abuse treatment. • Leave it to the transgender client to educate clinic staff. • Assume all transgender individuals are gay. • Force transgender clients identifying as male to use female facilities; likewise, don't force those identifying as female to use male facilities.

Center for Substance Abuse Treatment. Substance Abuse Treatment for Persons with HIV/AIDS. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2000. (Treatment Improvement Protocol (TIP) Series, No. 37.) [Table], Figure 7-5: Guidelines for Working With Transgender Clients. Available from: https://www.ncbi.nlm.nih.gov/books/NBK64930/table/A67678/

E. Birth Control Methods

Birth Control Methods

Retrieved from:
https://www.cdc.gov/reproductivehealth/contraception/index.htm

Many elements need to be considered by women, men, or couples at any given point in their lifetimes when choosing the most appropriate contraceptive method. These elements include safety, effectiveness, availability (including accessibility and affordability), and acceptability. Voluntary informed choice of contraceptive methods is an essential guiding principle, and contraceptive counseling, when applicable, might be an important contributor to the successful use of contraceptive methods.

In choosing a method of contraception, dual protection from the simultaneous risk for HIV and other STDs also should be considered. Although hormonal contraceptives and IUDs are highly effective at preventing pregnancy, they do not protect against STDs, including HIV. Consistent and correct use of the male latex condom reduces the risk for HIV infection and other STDs, including chlamydial infection, gonococcal infection, and trichomoniasis.

Reversible Methods of Birth Control
Intrauterine Contraception

- **Copper T intrauterine device (IUD)** —This IUD is a small device that is shaped in the form of a "T." Your doctor places it inside the uterus to prevent pregnancy. It can stay in your uterus for up to 10 years. Typical use failure rate: 0.8%.[1]
- **Levonorgestrel intrauterine system (LNG IUD)**—The LNG IUD is a small T-shaped device like the Copper T IUD. It is placed inside the uterus by a doctor. It releases a small amount of progestin each day to keep you from getting pregnant. The LNG IUD stays in your uterus for up to 3 to 6 years, depending on the device. Typical use failure rate: 0.1-0.4%.[1]

Hormonal Methods

- **Implant**—The implant is a single, thin rod that is inserted under the skin of a women's upper arm. The rod contains a progestin that is released into the body over 3 years. Typical use failure rate: 0.01%.[1]
- **Injection or "shot"**—Women get shots of the hormone progestin in the buttocks or arm every three months from their doctor. Typical use failure rate: 4%.[1]
- **Combined oral contraceptives**—Also called "the pill," combined oral contraceptives contain the hormones estrogen and progestin. It is prescribed by a doctor. A pill is taken at the same time each day. If you are older than 35 years and smoke, have a history of blood clots or breast cancer, your doctor may advise you not to take the pill. Typical use failure rate: 7%.[1]

- **Progestin only pill**—Unlike the combined pill, the progestin-only pill (sometimes called the mini-pill) only has one hormone, progestin, instead of both estrogen and progestin. It is prescribed by a doctor. It is taken at the same time each day. It may be a good option for women who can't take estrogen. Typical use failure rate: 7%.[1]
- **Patch**—This skin patch is worn on the lower abdomen, buttocks, or upper body (but not on the breasts). This method is prescribed by a doctor. It releases hormones progestin and estrogen into the bloodstream. You put on a new patch once a week for three weeks. During the fourth week, you do not wear a patch, so you can have a menstrual period. Typical use failure rate: 7%.[1]

- **Hormonal vaginal contraceptive ring**—The ring releases the hormones progestin and estrogen. You place the ring inside your vagina. You wear the ring for three weeks, take it out for the week you have your period, and then put in a new ring. Typical use failure rate: 7%.[1]

Barrier Methods

- Diaphragm or cervical cap—Each of these barrier methods are placed inside the vagina to cover the cervix to block sperm. The diaphragm is shaped like a shallow cup. The cervical cap is a thimble-shaped cup. Before sexual intercourse, you insert them with spermicide to block or kill sperm. Visit your doctor for a proper fitting because diaphragms and cervical caps come in different sizes. Typical use failure rate for the diaphragm: 17%.[1]
- **Sponge**—The contraceptive sponge contains spermicide and is placed in the vagina where it fits over the cervix. The sponge works for up to

24 hours, and must be left in the vagina for at least 6 hours after the last act of intercourse, at which time it is removed and discarded. Typical use failure rate: 14% for women who have never had a baby and 27% for women who have had a baby.[1]

- **Male condom**—Worn by the man, a male condom keeps sperm from getting into a woman's body. Latex condoms, the most common type, help prevent pregnancy, and HIV and other STDs, as do the newer synthetic condoms. "Natural" or "lambskin" condoms also help prevent pregnancy, but may not provide protection against STDs, including HIV. Typical use failure rate: 13%.[1] Condoms can only be used once. You can buy condoms, KY jelly, or water-based lubricants at a drug store. Do not use oil-based lubricants such as massage oils, baby oil, lotions, or petroleum jelly with latex condoms. They will weaken the condom, causing it to tear or break.

- **Female condom**—Worn by the woman, the female condom helps keeps sperm from getting into her body. It is packaged with a lubricant and is available at drug stores. It can be inserted up to eight hours before sexual intercourse. Typical use failure rate: 21%,[1] and also may help prevent STDs.

- **Spermicides**—These products work by killing sperm and come in several forms—foam, gel, cream, film, suppository, or tablet. They are placed in the vagina no more than one hour before intercourse. You leave them in place at least six to eight hours after intercourse. You can use a spermicide in addition to a male condom, diaphragm, or

cervical cap. They can be purchased at drug stores. Typical use failure rate: 21%.[1]

Fertility Awareness-Based Methods

- **Fertility awareness-based methods**—Understanding your monthly fertility patternexternal icon can help you plan to get pregnant or avoid getting pregnant. Your fertility pattern is the number of days in the month when you are fertile (able to get pregnant), days when you are infertile, and days when fertility is unlikely, but possible. If you have a regular menstrual cycle, you have about nine or more fertile days each month. If you do not want to get pregnant, you do not have sex on the days you are fertile, or you use a barrier method of birth control on those days. Failure rates vary across these methods.[1-2] Range of typical use failure rates: 2-23%.[1]

Lactational Amenorrhea Method

For women who have recently had a baby and are breastfeeding, the Lactational Amenorrhea Method (LAM) can be used as birth control when three conditions are met: 1) amenorrhea (not having any menstrual periods after delivering a baby), 2) fully or nearly fully breastfeeding, and 3) less than 6 months after delivering a baby. LAM is a temporary method of birth control, and another birth control method must be used when any of the three conditions are not met.

Emergency Contraception

Emergency contraception is NOT a regular method of birth control. Emergency contraception can be used after no birth control was used during sex, or if the birth control method failed, such as if a condom broke.

- Copper IUD—Women can have the copper T IUD inserted within five days of unprotected sex.
- Emergency contraceptive pills—Women can take emergency contraceptive pills up to 5 days after unprotected sex, but the sooner the pills are taken, the better they will work. There are three different types of emergency contraceptive pills available in the United States. Some emergency contraceptive pills are available over the counter.

Permanent Methods of Birth Control

- **Female Sterilization—Tubal ligation or "tying tubes"**— A woman can have her fallopian tubes tied (or closed) so that sperm and eggs cannot meet for fertilization. The procedure can be done in a hospital or in an outpatient surgical center. You can go home the same day of the surgery and resume your normal activities within a few days. This method is effective immediately. Typical use failure rate: 0.5%.[1]
- **Male Sterilization–Vasectomy**—This operation is done to keep a man's sperm from going to his penis, so his ejaculate never has any sperm in it that can fertilize an egg. The procedure is typically done at an outpatient surgical center. The man can go home the same day. Recovery time is less than one week. After the operation, a man visits his doctor for tests to count his sperm and to make sure the sperm count has dropped to zero; this takes about 12 weeks. Another form of birth control should be used until the man's sperm count has dropped to zero. Typical use failure rate: 0.15%.[1]

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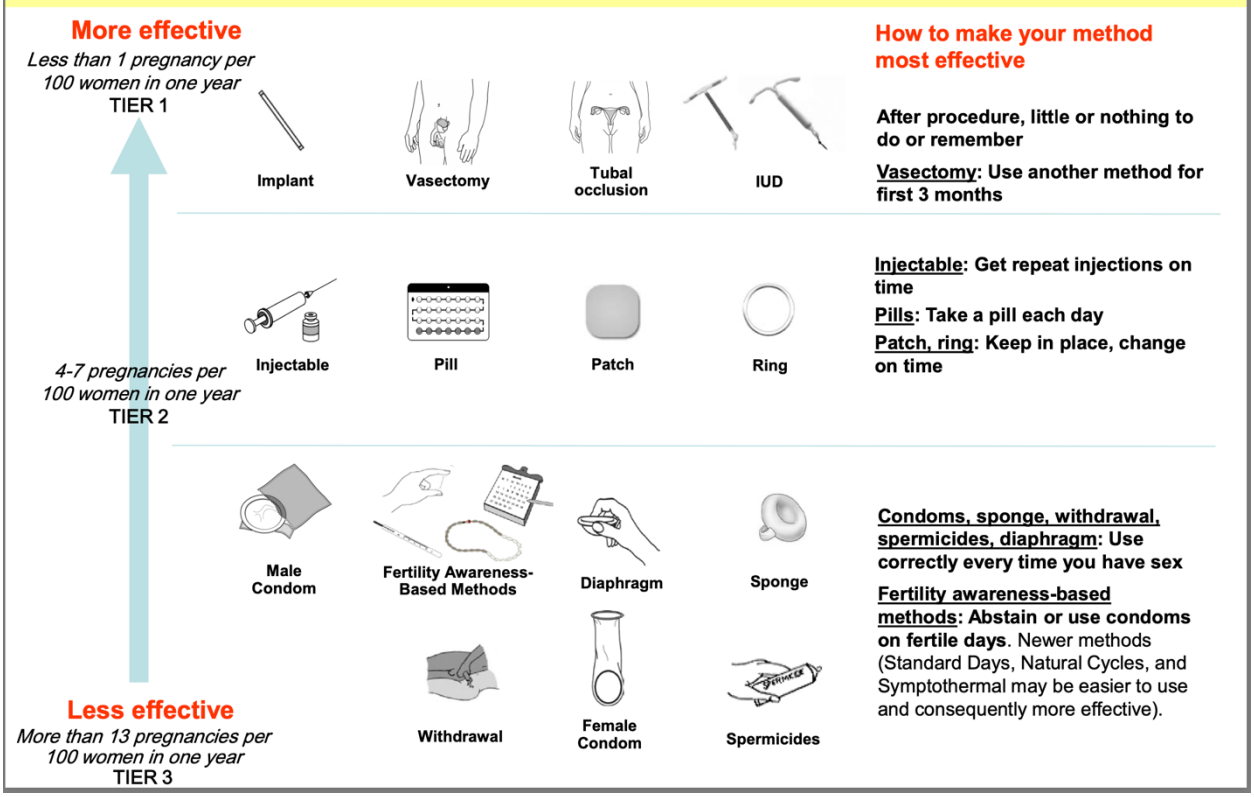
Figure 3-1 Comparing typical effectiveness of contraceptive methods



Chapter 5: Unintended Pregnancy

Retrieved from:

https://www.cdc.gov/reproductivehealth/contraception/unintendedpregnancy/index.htm

An unintended pregnancy is a pregnancy that is either unwanted, such as the pregnancy occurred when no children or no more children were desired. Or the pregnancy is mistimed, such as the pregnancy occurred earlier than desired. The concept of unintended pregnancy helps in understanding the fertility of populations and the unmet need for contraception, also known as birth control, and family planning. Most unintended pregnancies result from not using contraception or from not using it consistently or correctly.

To help women, men, and couples prevent or achieve pregnancy, it is essential to understand their pregnancy intentions or reproductive life plan. A reproductive life plan may include personal goals about becoming pregnant, such as whether they want to have any or more children, and the desired timing and spacing of those children. A reproductive life plan may help identify reproductive health care needs that include contraceptive services, pregnancy testing, and counseling to help become pregnant, or manage a pregnancy with prenatal and delivery care.

A. Pregnancy Prevention

Women who choose to delay or prevent pregnancy should be offered contraceptive services that include:

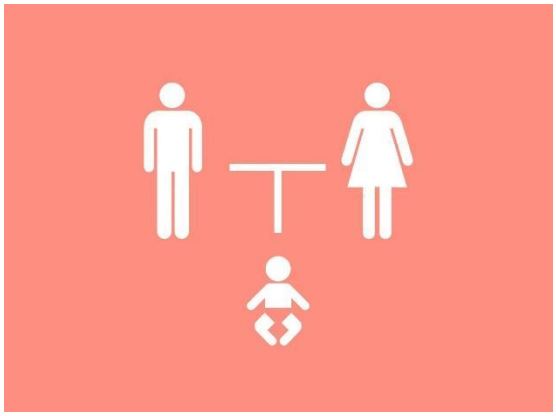
- A full range of FDA-approved contraceptive methods.
- A brief assessment to identify the contraceptive methods that are safe for the client.
- Contraceptive counseling to help a client choose a method of contraception and learn how to use it correctly and consistently.

- Provision of one or more selected contraceptive methods, preferably on site, but by referral if necessary.

Preconception Health Promotion

Preconception health and health care services pdf icon[PDF – 284KB] aim to promote the health of women (and men) of reproductive age before conceiving a child, and thereby help to reduce pregnancy-related adverse outcomes, such as low birthweight, premature birth, and infant mortality. Moreover, preconception health services may improve a woman's health and wellbeing, regardless of her childbearing intentions.

Women of reproductive age can make choices about their health and health care that help to keep themselves healthy, and if they choose to be pregnant, have a healthy baby. Adopting healthy behaviors is the first step women can take to get ready for the healthiest pregnancy possible.



Unintended pregnancy is associated with an increased risk of problems for the mom and baby. If the mom was not planning to get pregnant, she may have unhealthy behaviors or delay getting health care during the pregnancy, which could affect the health of the baby. Therefore, it is important for all women of reproductive age to adopt healthy behaviors such as:

- Take folic acid.
- Maintain a healthy diet and weight.
- Be physically active regularly.
- Quit tobacco use.

- Refrain from excessive alcohol drinking.
- Abstain from alcohol if pregnant or planning to become pregnant.
- Take only medicines prescribed by your doctor.
- Talk to your health care provider about screening and proper management of chronic diseases.
- Visit your health care provider to receive recommended health care for your age, learn about possible health risks, and discuss if or when you are considering becoming pregnant.
- Use effective contraception correctly and consistently if you are sexually active but choose to delay or avoid pregnancy.

Snapshot of Progress

In 2008, women reported that more than half of all pregnancies (51%) were unintended. By 2011, the percentage of unintended pregnancies declined to 45%. That is an improvement, but some groups still tend to have higher rates of unintended pregnancy. For example, 75% of pregnancies were unintended among teens aged 15 to 19 years. Unintended pregnancy rates per 1,000 women were highest among women who:

- Were aged 18 to 24 years.
- Had low income (<100% of federal poverty level).
- Had not completed high school.
- Were non-Hispanic black or African American.
- Were cohabiting but had never married.

Note: Information was obtained from the journal article "Declines in Unintended Pregnancy in the United States, 2008–2011"published in external icon*N Engl J Med.* 2016;374(9):843–852.

The United States set family planning goals in*Healthy People 2020*external iconto improve pregnancy planning and spacing, and to reduce the number of unintended pregnancies. Two ways to reach these goals are to increase:

- Access to contraception that includes the full range of methods, such as long-acting, and reversible forms like intrauterine devices and hormonal implants.
- Correct and consistent use of contraception for sexually active women who choose to delay or avoid pregnancy.

What CDC Is Doing

CDC is working on many things to help prevent unintended pregnancy such as:

- Increase access, use, and dissemination of data to identify groups most at risk for unintended pregnancy; show the health impacts of teen and unintended pregnancy; and close gaps in access to quality, patient-centered family planning services.
- Develop and identify evidence-based strategies to reduce unmet needs for quality family planning services among the most affected groups.
- Provide guidance for health care providers who counsel men, women, and couples about contraception.
- Build capacity for health care providers, states, communities, and partners to improve quality patient-centered family planning services and support states and communities to increase access to contraception services.

Resources

- Association of State and Territorial Health Officials: Increasing Access to Contraception Learning Communityexternal icon

- Zika Contraception Access Network (Z-CAN): Increasing Access to Contraception: A Toolkit for Program Development, Implementation, and Evaluationexternal icon
- CDC Contraceptive Guidance for Health Care Providers: US Medical Eligibility Criteria (US MEC) for Contraceptive Use, 2016
- US Selected Practice Recommendations for Contraceptive Use, 2016.
- Update: Providing Quality Family Planning Services—Recommendations from CDC and the US Office of Population Affairs, 2017.

About Teen Pregnancy

Retrieved from: https://www.cdc.gov/teenpregnancy/about/index.htm#:~:text=In%202017%2C%20a%20total%20of,drop%20of%207%25%20from%202016.&text=Birth%20rates%20fell%2010%25%20for,women%20aged%2018%E2%80%9319%20years.

In 2017, a total of 194,377 babies were born to women aged 15–19 years, for a birth rate of 18.8 per 1,000 women in this age group. This is another record low for U.S. teens and a drop of 7% from 2016.[1] Birth rates fell 10% for women aged 15–17 years and 6% for women aged 18–19 years.[2]

Although reasons for the declines are not totally clear, evidence suggests these declines are due to more teens abstaining from sexual activity, and more teens who are sexually active using birth control than in previous years.[3, 4]

Still, the U.S. teen pregnancy rate is substantially higher than in other western industrialized nations[5], and racial/ethnic and geographic disparities in teen birth rates persist.[6]

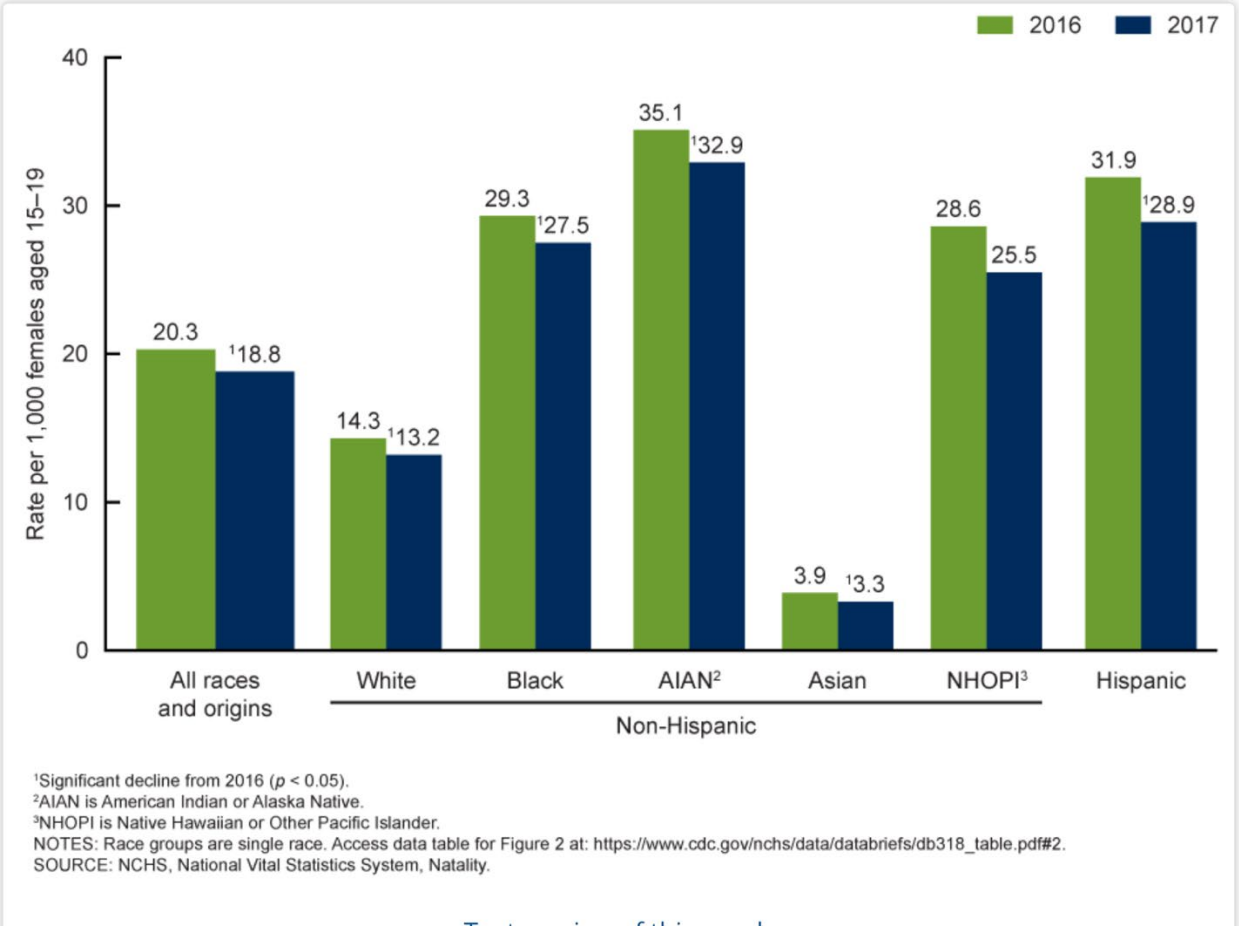
Disparities in Teen Birth Rates

Teen birth rates declined from 2016 to 2017 for most racial groups and for Hispanics.[2] Among 15- to 19-year-olds, teen birth rates decreased:

- 15% for non-Hispanic Asians
- 9% for Hispanics
- 8% for non-Hispanic whites
- 6% for non-Hispanic blacks
- 6% for American Indian/Alaska Natives (AI/AN)[1]

In 2017, the birth rates of Hispanic teens (28.9) and non-Hispanic black teens (27.5) were more than two times higher than the rate for non-Hispanic white teens (13.2). The birth rate of American Indian/Alaska Native teens (32.9) was highest among all race/ethnicities.[1] Geographic differences in teen birth rates persist, both within and across states. Among some states with low overall teen birth rates, some counties have high teen birth rates.[6]

Birth rates for females aged 15-19, by race and Hispanic origin of mother: United States, 2016 and 2017



Less favorable socioeconomic conditions, such as low education and low income levels of a teen's family, may contribute to high teen birth rates.[7] Teens in child welfare systems are at higher risk of teen pregnancy and birth than other groups. For example, young women living in foster care are more than twice as likely to become pregnant than those not in foster care.[8]

To improve the life opportunities of adolescents facing significant health disparities and to have the greatest impact on overall U.S. teen birth rates, CDC uses data to inform and direct

interventions and resources to areas with the greatest need.

The Importance of Prevention

Teen pregnancy and childbearing bring substantial social and economic costs through immediate and long-term impacts on teen parents and their children.

- Pregnancy and birth are significant contributors to high school dropout rates among girls. Only about 50% of teen mothers receive a high school diploma by 22 years of age, whereas approximately 90% of women who do not give birth during adolescence graduate from high school.[10]
- The children of teenage mothers are more likely to have lower school achievement and to drop out of high school, have more health problems, be incarcerated at some time during adolescence, give birth as a teenager, and face unemployment as a young adult.[11]
- On a positive note, between 1991 and 2015, the teen birth rate dropped 64%, which resulted in $4.4 billion in public savings in 2015 alone.[12]

Evidence-based teen pregnancy prevention programs have been identified by the US Department of Health and Human Services (HHS) TPP Evidence ReviewExternal, which used a systematic process for reviewing evaluation studies against a rigorous standard. Currently, the Evidence Review covers a

variety of diverse programs, including sexuality education programs, youth development programs, abstinence education programs, clinic-based programs, and programs specifically designed for diverse populations and settings. In addition to evidence-based prevention programs, teens need access to youth-friendly contraceptive and reproductive health services and support from parents and other trusted adults, who can play an important role in helping teens make healthy choices about relationships, sex, and birth control. Efforts at the community level that address social and economic factors associated with teen pregnancy also play a critical role in addressing racial/ethnic and geographical disparities observed in teen births in the US.

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Progress Pays Off

Retrieved from:

https://powertodecide.org/sites/default/files/media/savings-fact-sheet-national.pdf

As a result of the confluence of successful efforts to prevent unintended births among teens, the United States saved $4.4 billion in public spending in 2015 alone.

Rates of teen births in the United States were 64% lower in 2015 than in 1991, the year that teen birth rates peaked nationally. This tremendous progress means that there were 428,000 fewer births to teens in the U.S. than there would have been had the rate not declined.

New estimates from
Power to Decide indicate that:

- Contraception has been cited as a key factor
  in recent declines in teen pregnancy[1] and
  public investment in contraception is a critical component of these efforts. At a cost of $239 per person or $1.1 billion for all teens in need across the United States[2] it is money well-spent as compared to the costs of supporting an unintended birth. In fact, one recent study looked extensively at public investment in family planning nationally and found a return of $7 for every $1 spent.[3]
- In the U.S., 30%[4] of women age 13-44 are in need of publicly funded contraception. Unfortunately, 98% of these women in need live in areas without reasonable access to the full range of methods.5[5]
- More spending on publicly funded contraception, as well as other supports that enable all young people to avoid unplanned pregnancy is warranted,

- because if we were able to avert all unintended births among teens, it would amount to $1.9 billion in additional public savings each year in the United States.

PROVIDING A SYSTEM OF SUPPORT THAT ENABLES YOUNG PEOPLE TO HAVE THE POWER TO DECIDE IF, WHEN, AND UNDER WHAT CIRCUMSTANCES TO GET PREGNANT NOT ONLY BENEFITS THE YOUNG PEOPLE THEMSELVES, BUT ALSO LEADS TO SIGNIFICANT SAVINGS IN PUBLICLY FUNDED PROGRAMS.

– Ginny Ehrlich, CEO Power to Decide

Our analyses also suggested that:

- We estimate that the cost of providing medical and economic supports during pregnancy and the first year of infancy averaged $16,000 per teen birth nationally in 2015. This includes the cost of prenatal, labor and delivery and postpartum care for the mother, one year of infant care, and receipt of WIC, basic TANF assistance, and SNAP during pregnancy and infancy for those who participated.
- Of the 428,000 teen births that were averted in 2015, we assume that nearly two thirds result in public savings, taking into account the likelihood that some teens merely delayed their childbearing until early adulthood and continued to rely on public programs at that point.[6] This results in $4.4 billion in savings, as mentioned above.
- If all teens were able to avoid unplanned pregnancy and childbearing, we estimate that
  the U.S. could save an additional $1.9 billion in spending each year. This is based on 232,000 teen births that occurred in 2015, the share

of those births that follow unplanned pregnancy (based on published estimates at the national level[7]), the public spending per teen birth, and further adjusting for delayed vs averted births as noted above.

The results we present here are conservative on many levels. They account for the fact that some pregnancies that are prevented in one year may simply be postponed to a future year, and they count spending in only a narrow range of publicly funded programs—specifically those directly tied to benefits for mothers during pregnancy through the first year of infancy and for which reliable estimates could be constructed. Undoubtedly, estimates factoring in the longer-term economic and health impacts of unintended pregnancy and childbearing would be much higher. The potential for additional savings associated with prevention focuses on only those teen births following unintended pregnancies. Finally, while public spending is aggregated among only those teen mothers actually participating in the benefits in question, it is then averaged across all teen births, and is thus lower than what would be observed among actual public program participants.

About Power to Decide

Power to Decide, the campaign to prevent unplanned pregnancy, works to ensure that all young people—no matter who they are, where they live, or what their economic status might be—have the power to decide if, when, and under what circumstances to get pregnant. We do this by increasing information, access, and opportunity. In all we do, we are non-partisan and non-ideological, and we ground our work in research and evidence of what is

most effective. In our 20+ years of work, we've seen historic declines in rates of teen and unplanned pregnancy. But our work is far from done.

Power to Decide gratefully acknowledges support from the Laura and John Arnold Foundation for this work. The views expressed here are those of the authors and do not necessarily reflect those of the foundation.

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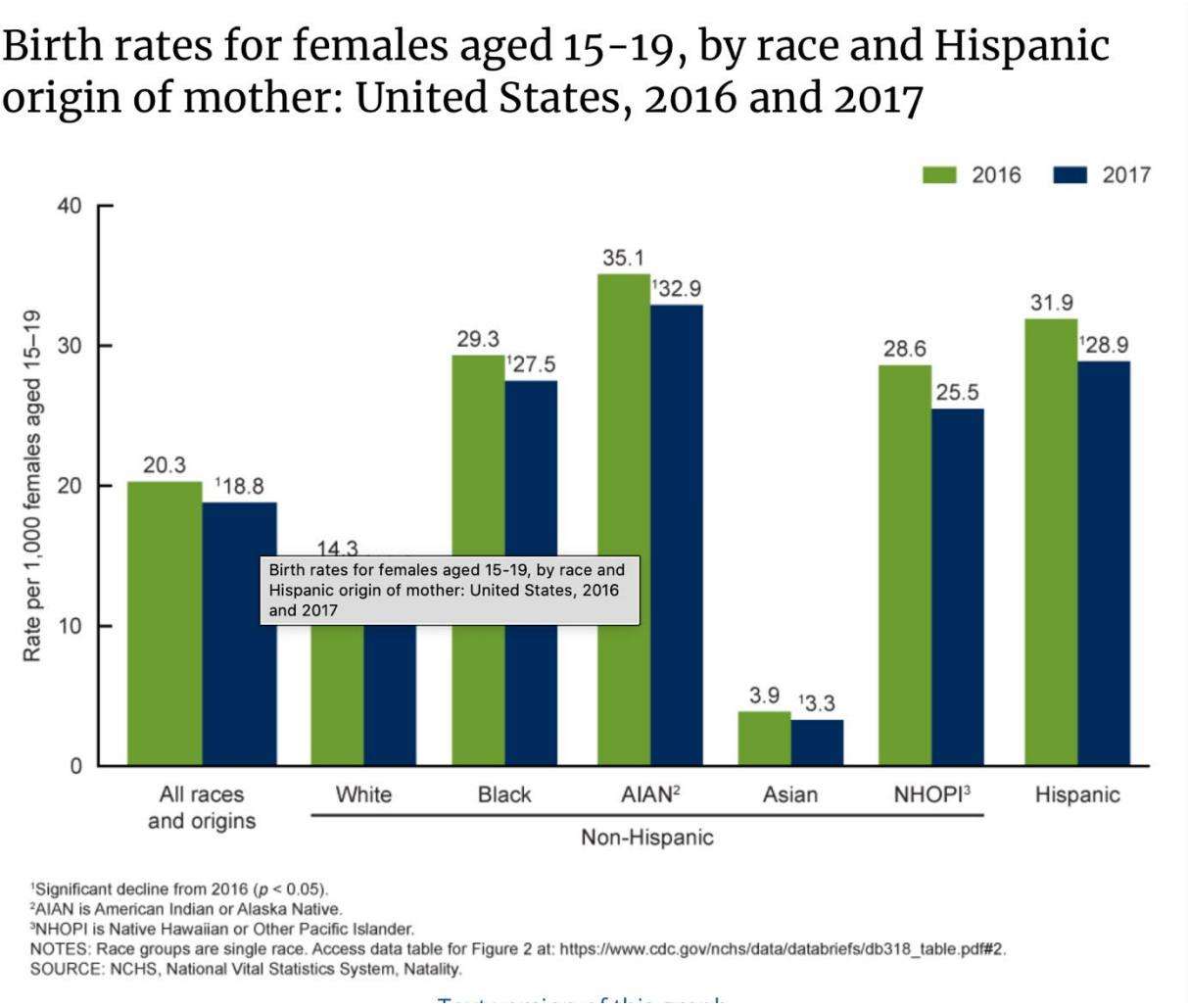
Social Determinants and Eliminating Disparities in Teen Pregnancy

Retrieved from: https://www.cdc.gov/teenpregnancy/about/social-determinants-disparities-teen-pregnancy.htm

US teen birth rates (births per 1,000 females aged 15 to 19 years) decreased 7% overall from 2016 to 2017.[1] Decreases occurred for teens of most racial groups races and for Hispanic teens. Despite these declines, racial/ethnic, geographic, and socioeconomic disparities persist. Achieving health equity, eliminating disparities, and improving the health of all groups is an overarching goal of Healthy People 2020external icon. Evidence-based programs and clinical services to prevent teen pregnancy through individual behavior change are important, but research is also shedding light on the role social determinants of health play in the overall distribution of disease and health, including teen pregnancy.

Disparities by Race and Ethnicity

In 2017, the birth rates for Hispanic teens (28.9 per 1,000) and non-Hispanic black teens (27.5) were more than two times higher than the rate for non-Hispanic white teens (13.2). The birth rate for American Indian/Alaska Native teens (32.9) was highest among all races/ethnicities.[1]



Social Determinants of Health

Social health determinants include a person's age and the environment in which people are born, live, learn, work, play, and worship. The health determinants affect a wide range of health issues and quality-of-life outcomes and risks. (Healthy People 2020external icon). Certain social determinants, such as high unemployment, low education, and low income, have been associated with higher teen birth rates.[2] Interventions that address socioeconomic conditions like these can play a critical role in addressing disparities observed in US teen birth rates.

Health Equity

Health equity is achieved when everyone has an equal opportunity to reach his or her health potential regardless of social position or other characteristics such as race, ethnicity, gender, religion, sexual identity, or disability. Health inequities are closely linked with social determinants of health.

Geographic Disparities

- Disparities between U.S. states persist, with state-specific 2017 teen birth rates ranging from 8.1 in Massachusetts to 32.8 in Arkansas.[1]
- Across counties, teen birth rates vary greatly:
    - Higher-rate counties are clustered in the South and Southwest, but high-rate counties also occur in states with low overall birth rates.[2]
- From 2007 through 2015, the teen birth rate was lowest in large urban counties (18.9) and highest in rural counties (30.9). [3]
- From 2007-2015, the birth rate among teens in rural counties declined only 37%, compared with the decline in large urban counties (50%) and in medium and small counties (44%) during the same period.[3]

Socioeconomic Disparities

- Socioeconomic conditions in communities and families may contribute to high teen birth rates. Examples of these factors include the following:
    - Low education and low income levels of a teen's family.[4]
    - Few opportunities in a teen's community for positive youth involvement.[4]
    - Neighborhood racial segregation.[4]

    - Neighborhood physical disorder (e.g., graffiti, abandoned vehicles, litter, alcohol containers, cigarette butts, glass on the ground).[4]
    - Neighborhood-level income inequality.[4]
- Teens in child welfare systems are at increased risk of teen pregnancy and birth than other groups. For example, young women living in foster care are more than twice as likely to become pregnant than those not in foster care.[5]

Taking Action to Eliminate Disparities and Address Social Determinants of Teen Pregnancy

Eliminating disparities in teen pregnancy and birth rates would do the following:

- Help achieve health equity.
- Improve the life opportunities and health outcomes of young people.
- Reduce the economic costs of teen childbearing.

Efforts that focus on social health determinants in teen pregnancy prevention efforts, particularly at the community level, play a critical role in addressing racial/ethnic and geographical disparities observed in teen births in the United States.

CDC is supporting three organizations from 2015 to 2020 to enhance youth-friendly sexual and reproductive health services in publicly funded health centers and increase the number of young people accessing sexual and reproductive health services. A key focus is working to refer and link vulnerable young people to these services—including those in foster care, juvenile justice and probation, or housing developments. The three organizations funded to conduct this work are Sexual Health Initiative for Teens North Carolina (Durham, North Carolina), Mississippi First, Inc.

(Coahoma, Quitman, and Tunica counties, Mississippi), and the Georgia Association for Primary Health Care, Inc. (Chatham County, Georgia).

The US Department of Health and Human Services' Office of Adolescent Health (OAH) and CDC recently partnered to fund the evaluation of innovative interventions designed for young men aged 15 to 24 years to reduce their risk of fathering a teen pregnancy. Interventions focused on young men at high risk of fathering a teen pregnancy, such as young men at risk of health disparities due to low socioeconomic status, race/ethnicity, or exposure to other social determinants negatively affecting health. Columbia University, New York University, and Promundo were the organizations funded to conduct this work.

As part of the Department of Health and Human Services Teen Pregnancy Prevention Initiative, CDC partnered with OAH and the HHS Office of Population Affairs from 2010 to 2015 to fund nine state- and community-based organizations and five national organizations to implement communitywide initiatives to reduce teenage pregnancy and address disparities in teen pregnancy and birth rates. Addressing social determinants of teen pregnancy was a central principle of each initiative. For tools and resources related to addressing social determinants of teen pregnancy, please see the Working with Diverse Communities webpage.

Resources from CDC and other public health entities for addressing social determinants of health

- Reduced Disparities in Birth Rates Among Teens Aged 15–19 Years — United States, 2006–2007 and 2013–2014, MMWR 2016

- *Public Health Reports*: "Socioeconomic Disadvantage as a Social Determinant of Teen Childbearing in the United States" pdf icon[PDF – 483 KB]external icon
- CDC: *Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health* pdf icon[PDF – 392 KB]
- CDC: Healthy Communities Program Attaining Health Equity Website.
- CDC: Social Determinants of Health Website
- Healthy People 2020: Social Determinants of Healthexternal icon Website
- World Health Organization: Social Determinants of Healthexternal icon Website
- Reproductive Health Equity for Youth: Information, Tools and Resources to Address Social Determinants and Disparities in Teen Pregnancyexternal icon Website(from national partner John Snow, Inc./JSI Research & Training Institute)
- *Public Health Reports*: "Applying Social Determinants of Health to Public Health Practiceexternal icon"
- CDC NCHHSTP White Paper: *Establishing a Holistic Framework to Reduce Inequities in HIV, Viral Hepatitis, STDs, and Tuberculosis in the United States* pdf icon[PDF – 304 KB]
- Robert Wood Johnson Foundation: A New Way to Talk about the Social Determinants of Healthexternal icon Website

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B. Educating and Engaging Young Men in Reproductive Health

Retrieved from: https://www.cdc.gov/teenpregnancy/about/educating-engaging-young-men-reproductive-health.htm

Although US teen birth rates continue to decline, geographic, socioeconomic, and racial or ethnic disparities persist.[a] In 2015, 229,715 babies were born to women aged 15–19 years, for a birth rate of 22.3 per 1,000 women in this age group, and teen fatherhood occurred at a rate of 10.4 births per 1,000 men in this age group.[b] Eighty percent of young men aged 15–19 years report that they would be very upset or a little upset if they were to get a female pregnant.[c] Data suggest that teen fathers attend fewer years of school and are less likely to graduate from high school.[d] When compared with other age groups, young men also are affected disproportionately by sexually transmitted infections.[e],[f]

Young men have an important role to play in promoting reproductive health. Their involvement in contraceptive decision making has been shown to increase the use of effective methods of pregnancy and STD prevention.[g],[h],[i],[j]

CDC has been addressing male reproductive health for almost a decade, convening its first male reproductive health summit, Advancing Men's Reproductive Health in the United States Cdc-pdf[PDF – 45 pages, 2.3MB], in September 2010. CDC supports several projects that educate, engage, and involve young men in reproductive health in innovative ways. These include the following:

Engaging Young Men in Reproductive Health-Evaluating Innovative Approaches

Recognizing the important role of young men in promoting reproductive health, the Office of Adolescent Health (OAH) supports five projects, and OAH and CDC are working together to support three additional projects that implement and evaluate innovative approaches to educate and engage young men in reproductive health and teen pregnancy prevention efforts.

Engaging Young Men in Preventing Premature Fatherhood Project

CDC is collaborating with JSI-Denver, CAI, and Gaston Health and Human Services to pilot the 2013–2018 Engaging Young Men in Preventing Premature Fatherhood project in Gaston County, North Carolina. The purpose of the project is to improve reproductive health services for young men and to increase young men's use of these services.

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C. Preventing Pregnancies in Younger Teens

Retrieved from: https://www.cdc.gov/vitalsigns/young-teen-pregnancy/index.html

1 in 4

More than 1 in 4 teens who gave birth were ages 15 to 17, before teens typically complete high school.

1,700

Nearly 1,700 teens ages 15 to 17 years give birth every week.

27%

Only 1 in 4 (27%) teens ages 15 to 17 have ever had sex.

Teen births in the US have declined over the last 20 years to the lowest level ever recorded, but still more than 86,000 teens ages 15 to 17 gave birth in 2012. Giving birth during the teen years has been linked with increased medical risks and emotional, social, and financial costs to the mother and her children. Becoming a teen mom affects whether the mother finishes high school, goes to college, and the type of job she will get, especially for

younger teens ages 15 to 17. More can be done to prevent younger teens from becoming pregnant, particularly in health care.

Doctors, nurses, and other health care professionals can

- Provide confidential, respectful, and culturally appropriate services that meet the needs of teen clients.
- Encourage teens who are not sexually active to continue to wait.
- Offer sexually active teens a broad range of contraceptive methods and encourage them to use the most effective methods.
- Counsel teens about the importance of condom use to prevent pregnancy and sexually transmitted diseases, including HIV/AIDS.

Problem:
Many younger teens give birth at ages 15 to 17.

More than 1 in 4 teens who give birth are ages 15-17.

- Hispanic, non-Hispanic black and American Indian/Alaska Native teens have higher rates of teen births.
- Only 38% of teens who gave birth at age 17 or younger earned high school diplomas by their 22nd birthday versus 60% of teen who were 18 or older when they gave birth. Among teens not giving birth, 89% earned high school diplomas.

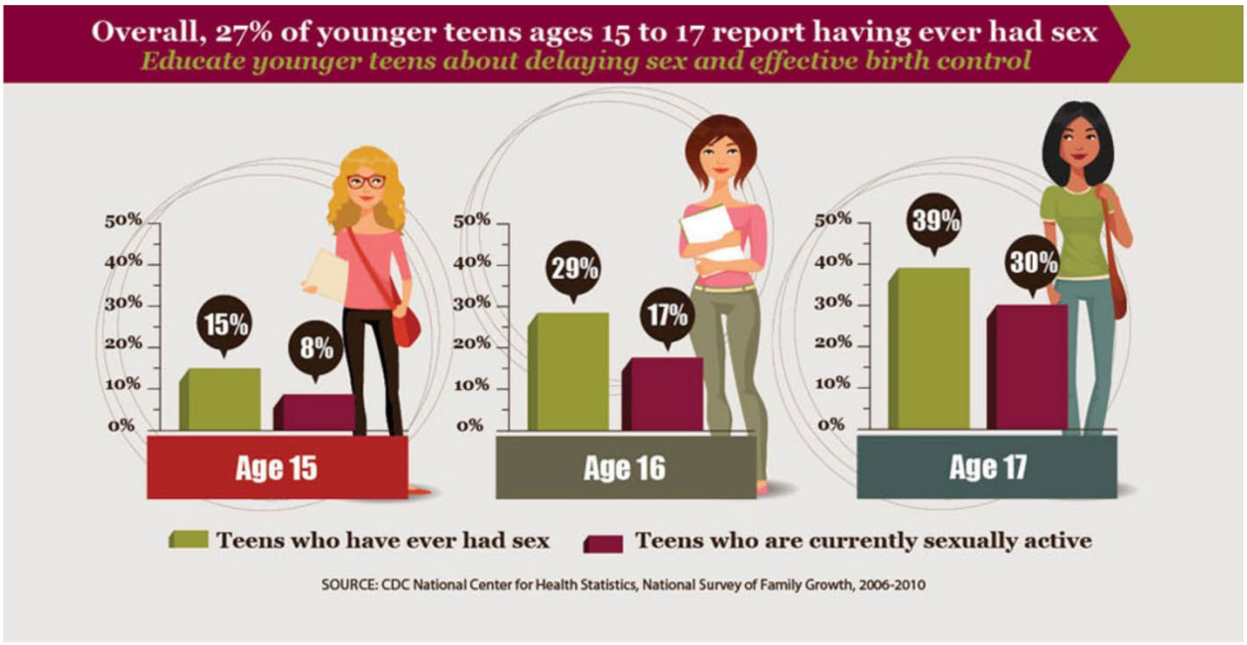
Sexually active teens need ready access to effective and affordable types of birth control.

- Long-acting reversible contraception (LARC) including intrauterine devices (IUDs) and hormonal implants are the most effective reversible methods. These methods do not require taking a pill each day or doing something each time before having sex.

- Nine in 10 (92%) younger teens ages 15 to 17 used birth control the last time they had sex, but only 1% used LARC. The most common methods used were condoms and birth control pills.

There are effective ways to prevent pregnancy among younger teens ages 15-17.

- About 8 in 10 (83%) teens did not receive sex education before they first had sex. Earlier delivery of sex education may enhance prevention efforts.
- More than 7 in 10 (76%) spoke to their parents about birth control or about not having sex. Parents play a powerful role in helping teens make healthy decisions about sex, sexuality, and relationships.
- More than half (58%) of sexually active younger teens made a reproductive health visit for birth control services in the past year. Doctors and nurses could use this opportunity to discuss advantages and disadvantages of different contraceptive methods and the importance of condom use during every sexual encounter.



Infographic: 27% of women ages 15 to 17 report having ever had sex. This infographic shows 3 bar charts representing women ages 15 to 17 who report having ever had sex.

- Age 15: Teens who have ever had sex, 15%. Teens who are currently sexually active, 8%.
- Age 16: Teens who have ever had sex, 29%. Teens who are currently sexually active, 17%.
- Age 17: Teens who have ever had sex, 39%. Teens who are currently sexually active, 30%.

Having youth-friendly reproductive health visits for teens

Having youth-friendly reproductive health visits for teens

JASON:

Jason learns that **free/low-cost services** are available.

A counselor meets with Jason… in a private room and Jason explains that he **doesn't feel ready to have sex.**

The counselor explains…

- Ways to have healthy relationships, communicate with a partner, or abstain from sex.
- That Jason can come back any time if he has questions about having sex, birth control (including condoms), or **testing for sexually transmitted diseases.**

Jason texts his best friend…

That he should schedule and come for his own appointment.

ANITA:

Anita is relieved she can **schedule an appointment that same day**.

Anita in a **private room** with doctor…

- Discusses that she is sexually active and not using birth control.
- She is **unaware of her risk of pregnancy**.

The doctor explains…

- All methods of birth control from most to least effective and pregnancy myths and facts.
- The doctor and Anita agree on the best birth control method for her and also discuss using condoms during every sexual encounter.

- Anita **receives her birth control of choice as well as condoms before she leaves**.

Anita calls a friend…

She encourages her friend to come to the clinic.

What can be done?

Federal government is

- Developing and evaluating programs in communities where teen births are highest.
- Supporting states in efforts to reduce pregnancies, births, and abortions among teens.
- Working to improve the health and social well-being of teens to reach the Healthy People 2020 national objective to reduce pregnancy in teens ages 15-17.

Doctors, nurses, and other health care providers can

- Encourage teens to delay sexual activity.
- Encourage sexually active teens to consider the most effective reversible methods of birth control. Refer to CDC guidelines.
- Make clinic visits suitable for teens by offering convenient office hours and confidential, respectful, and culturally appropriate services .
- Talk about using condoms correctly every time during sex to prevent sexually transmitted diseases, including HIV/AIDS, even if another birth control method is used.
- Discuss normal physical, emotional, and sexual development with teens and parents.

Parents, guardians, and caregivers can

- Talk with teens about sex, including:
- Normal sexual development, and how and when to say "no" to sex.
- Having a mutually respectful and honest relationship.
- Using birth control if they have sex and a condom every time.
- Know where their teens are and what they are doing, particularly after school.
- Be aware of their teen's use of social media and digital technology (e.g., cell phones, computers, tablets).

Younger teens can

- Know both they and their partner share responsibility for preventing pregnancy and resisting peer pressure to start having sex until they are older.
- Talk openly about sexual health issues with parents, other adults they trust, and their friends.
- See a health care provider to learn about the most effective types of birth control and use it and condoms correctly every time.

D. Infertility

Retrieved from: https://www.cdc.gov/reproductivehealth/features/what-is-infertility/index.html

What is infertility?

In general, infertility is defined as not being able to get pregnant (conceive) after one year (or longer) of unprotected sex. Because fertility in women is known to decline steadily with age, some providers evaluate and treat women aged 35 years or older after 6 months of unprotected sex. Women with infertility should consider making an appointment with a reproductive endocrinologist—a doctor who specializes in managing infertility. Reproductive endocrinologists may also be able to help women with recurrent pregnancy loss, defined as having two or more spontaneous miscarriages.

Pregnancy is the result of a process that has many steps.

To get pregnant

- A woman’s body must release an egg from one of her ovariesexternal icon (ovulationexternal icon).
- A man’s sperm must join with the egg along the way (fertilize).

- The fertilized egg must go through a fallopian tubeexternal icon toward the uterusexternal icon (womb).
- The fertilized egg must attach to the inside of the uterus (implantation).

Infertility may result from a problem with any or several of these steps.

Impaired fecundity is a condition related to infertility and refers to women who have difficulty getting pregnant or carrying a pregnancy to term.

Is infertility a common problem?

Yes. About 6% of married women aged 15 to 44 years in the United States are unable to get pregnant after one year of trying (infertility). Also, about 12% of women aged 15 to 44 years in the United States have difficulty getting pregnant or carrying a pregnancy to term, regardless of marital status (impaired fecundity).

Is infertility just a woman's problem?

No, infertility is not always a woman's problem. Both men and women can contribute to infertility.

Many couples struggle with infertility and seek help to become pregnant, but it is often thought of as only a woman's condition. However, in about 35% of couples with infertility, a male factor is identified along with a female factor. In about 8% of couples with infertility, a male factor is the only identifiable cause.

Almost 9% of men aged 25 to 44 years in the United States reported that they or their partner saw a doctor for advice, testing, or treatment for infertility during their lifetime.

What causes infertility in men?

Infertility in men can be caused by different factors and is typically evaluated by a semen analysis. When a semen analysis is performed, the number of sperm (concentration), motility (movement), and morphology (shape) are assessed by a specialist. A slightly abnormal semen analysis does not mean that a man is necessarily infertile. Instead, a semen analysis helps determine if and how male factors are contributing to infertility.

Disruption of testicular or ejaculatory function

- Varicoceles, a condition in which the veins on a man's testicles are large and cause them to overheat. The heat may affect the number or shape of the sperm.
- Trauma to the testes may affect sperm production and result in lower number of sperm.
- Unhealthy habits such as heavy alcohol use, smoking, anabolic steroid use, and illicit drug use.
- Use of certain medications and supplements.
- Cancer treatment involving the use of certain types of chemotherapy, radiation, or surgery to remove one or both testicles
- Medical conditions such as diabetes, cystic fibrosis, certain types of autoimmune disorders, and certain types of infections may cause testicular failure.

Hormonal disorders

- Improper function of the hypothalamus or pituitary glands. The hypothalamus and pituitary glands in the brain produce hormones that maintain normal testicular function. Production of too much prolactin, a hormone made by the pituitary gland (often due to the presence of a benign pituitary gland tumor), or other conditions that damage or

impair the function of the hypothalamus or the pituitary gland may result in low or no sperm production.

- These conditions may include benign and malignant (cancerous) pituitary tumors, congenital adrenal hyperplasia, exposure to too much estrogen, exposure to too much testosterone, Cushing's syndrome, and chronic use of medications called glucocorticoids.

Genetic disorders

- Genetic conditions such as a Klinefelter's syndrome, Y-chromosome microdeletion, myotonic dystrophy, and other, less common genetic disorders may cause no sperm to be produced, or low numbers of sperm to be produced.

What increases a man's risk of infertility?

- Age. Although advanced age plays a much more important role in predicting female infertility, couples in which the male partner is 40 years old or older are more likely to report difficulty conceiving.
- Being overweight or obese.
- Smoking.
- Excessive alcohol use.
- Use of marijuana.
- Exposure to testosterone. This may occur when a doctor prescribes testosterone injections, implants, or topical gel for low testosterone, or when a man takes testosterone or similar medications illicitly for the purposes of increasing their muscle mass.
- Exposure to radiation.

- Frequent exposure of the testes to high temperatures, such as that which may occur in men confined to a wheelchair, or through frequent sauna or hot tub use.
- Exposure to certain medications such as flutamide, cyproterone, bicalutamide, spironolactone, ketoconazole, or cimetidine.
- Exposure to environmental toxins including exposure to pesticides, lead, cadmium, or mercury.

What causes infertility in women?

Women need functioning ovariesexternal icon, fallopian tubesexternal icon, and a uterusexternal icon to get pregnant. Conditions affecting any one of these organs can contribute to female infertility. Some of these conditions are listed below and can be evaluated using a number of different tests.

Disruption of ovarian function (presence or absence of ovulation (anovulation) and effects of ovarian "age")

A woman's menstrual cycleexternal icon is, on average, 28 days long. Day 1 is defined as the first day of "full flow." Regular predictable periods that occur every 24 to 32 days likely reflect ovulation. A woman with irregular periods is likely not ovulating.

Ovulation can be predicted by using an ovulation predictor kit and can be confirmed by a blood test to check the woman's progesterone level on day 21 of her menstrual cycle. Although several tests exist to evaluate a woman's ovarian function, no single test is a perfect predictor of fertility. The most commonly used markers of ovarian function include follicle stimulating hormone (FSH) value on day 3 to 5 of the menstrual cycle, anti-müllerian hormone value (AMH), and antral follicle count (AFC) using a transvaginal ultrasound.

Disruptions in ovarian function may be caused by several conditions and warrants an evaluation by a doctor.

When a woman doesn't ovulate during a menstrual cycle, it's called anovulation. Potential causes of anovulation include the following

- Polycystic ovary syndrome (PCOS).external icon PCOS is a condition that causes women to not ovulate, or to ovulate irregularly. Some women with PCOS have elevated levels of testosterone, which can cause acne and excess hair growth. PCOS is the most common cause of female infertility.
- Diminished ovarian reserveexternal icon (DOR). Women are born with all of the eggs that they will ever have, and a woman's egg count decreases over time. Diminished ovarian reserve is a condition in which there are fewer eggs remaining in the ovaries than normal. The number of eggs a woman has declines naturally as a woman ages. It may also occur due to congenital, medical, surgical, or unexplained causes. Women with diminished ovarian reserve may be able to conceive naturally, but will produce fewer eggs in response to fertility treatments.
- Functional hypothalamic amenorrhea (FHA). FHA is a condition caused by excessive exercise, stress, or low body weight. It is sometimes associated with eating disorders such as anorexia.
- Improper function of the hypothalamus and pituitary glands. The hypothalamus and pituitary glands in the brain produce hormones that maintain normal ovarian function. Production of too much of the hormone prolactin by the pituitary gland (often as the result of a benign pituitary gland tumor), or improper function of the hypothalamus or pituitary gland, may cause a woman not to ovulate.

- Premature ovarian insufficiencyexternal icon (POI). POI, sometimes referred to as premature menopause, occurs when a woman's ovaries fail before she is 40 years of age. Although certain exposures, such as chemotherapy or pelvic radiation therapy, and certain medical conditions may cause POI, the cause is often unexplained. About 5% to10% of women with POI conceive naturally and have a normal pregnancy.
- Menopause external iconMenopause is an age-appropriate decline in ovarian function that usually occurs around age 50. By definition, a woman in menopause has not had a period in one year. She may experience hot flashes, mood changes, difficulty sleeping, and other symptoms as well.

Fallopian tube obstruction (whether fallopian tubes are open, blocked, or swollen)

Risk factors for blocked fallopian tubesexternal icon (tubal occlusion) can include a history of pelvic infection, history of ruptured appendicitis, history of gonorrhea or chlamydia, known endometriosisexternal icon, or a history of abdominal surgery.

Tubal evaluation may be performed using an X-ray that is called a hysterosalpingogram (HSG), or by chromopertubation (CP) in the operating room at time of laparoscopy, a surgical procedure in which a small incision is made and a viewing tube called a laparoscope is inserted.

- Hysterosalpingogram (HSG) is an X-ray of the uterus and fallopian tubes. A radiologist injects dye into the uterus through the cervix and simultaneously takes X-ray pictures to see if the dye moves freely through fallopian tubes. This helps evaluate tubal caliber (diameter) and patency.

- Chromopertubation is similar to an HSG but is done in the operating room at the time of a laparoscopy. Blue-colored dye is passed through the cervix into the uterus and spillage and tubal caliber (shape) is evaluated.

Abnormal uterine contour (physical characteristics of the uterus)

Depending on a woman's symptoms, the uterusexternal icon may be evaluated by transvaginal ultrasound to look for fibroidsexternal icon or other anatomic abnormalities. If suspicion exists that the fibroids may be entering the endometrial cavity, a sonohystogram (SHG) or hysteroscopy (HSC) may be performed to further evaluate the uterine environment.

What increases a woman's risk of infertility?

Female fertility is known to decline with

- Age. More women are waiting until their 30s and 40s to have children. In fact, about 20% of women in the United States now have their first child after age 35. About one-third of couples in which the woman is older than 35 years have fertility problems. Aging not only decreases a woman's chances of having a baby, but also increases her chances of miscarriageexternal icon and of having a child with a genetic abnormality.
- Aging decreases a woman's chances of having a baby in the following ways:
    - She has a smaller number of eggs left.
    - Her eggs are not as healthy.
    - She is more likely to have health conditions that can cause fertility problems.
    - She is more likely to have a miscarriage.

- Smoking.
- Excessive alcohol use.
- Extreme weight gain or loss.
- Excessive physical or emotional stress that results in amenorrhea (absent periods).

How long should couples try to get pregnant before seeing a doctor?
Most experts suggest at least one year for women younger than age 35. However, for women aged 35 years or older, couples should see a health care provider after 6 months of trying unsuccessfully. A woman's chances of having a baby decrease rapidly every year after the age of 30.

Some health problems also increase the risk of infertility. So, couples with the following signs or symptoms should not delay seeing their health care provider when they are trying to become pregnant

- Irregular periods or no menstrual periods.
- Very painful periods.
- Endometriosisexternal icon.
- Pelvic inflammatory disease.
- More than one miscarriage.
- Suspected male factor (i.e., history of testicular trauma, hernia surgery, chemotherapy, or infertility with another partner).

It is a good idea for any woman and her partner to talk to a health care provider before trying to get pregnant. They can help you get your body ready for a healthy baby, and can also answer questions on fertility and give tips on conceiving. Learn more at the CDC's Preconception Health Web site.

How will doctors find out if a woman and her partner have fertility problems?

Doctors will begin by collecting a medical and sexual history from both partners. The initial evaluation usually includes a semen analysis, a tubal evaluation, and ovarian reserve testing.

How do doctors treat infertility?

Infertility can be treated with medicine, surgery, intrauterine insemination, or assisted reproductive technology.

Often, medication and intrauterine insemination are used at the same time. Doctors recommend specific treatments for infertility on the basis of

- The factors contributing to the infertility.
- The duration of the infertility.
- The age of the female.
- The couple's treatment preference after counseling about success rates, risks, and benefits of each treatment option.

What are some of the specific treatments for male infertility?

Male infertility may be treated with medical, surgical, or assisted reproductive therapies depending on the underlying cause. Medical and surgical therapies are usually managed by an urologist who specializes in infertility. A reproductive endocrinologist may offer intrauterine inseminations (IUIs) or in vitro fertilization (IVF) to help overcome male factor infertility.

What medicines are used to treat infertility in women?

Some common medicines used to treat infertility in women include

- Clomiphene citrate (Clomid®*) is a medicine that causes ovulation by acting on the pituitary gland. It is often used in women who have polycystic ovary syndrome (PCOS)external icon or other problems with ovulation. It is also used in women with normal ovulation to increase the number of mature eggs produced. This medicine is taken by mouth.
- Letrozole (Femara ®*) is a medication that is frequently used off-label to cause ovulation. It works by temporarily lowering a woman's progesterone level, which causes the brain to naturally make more FSH. It is often used to induce ovulation in woman with PCOS, and in women with normal ovulation to increase the number of mature eggs produced in the ovaries.
- Human menopausal gonadotropin or hMG (Menopur®*; Repronex®*; Pergonal®*) is a medication often used for women who don't ovulate because of problems with their pituitary gland—hMG acts directly on the ovaries to stimulate development of mature eggs. It is an injectable medicine.
- Follicle-stimulating hormone or FSH (Gonal-F®*; Follistim®*) is a medication that works much like hMG. It stimulates development of mature eggs within the ovaries. It is an injectable medication.
- Gonadotropin-releasing hormone (GnRH) analogs and GnRH antagonists are medications that act on the pituitary gland to prevent a woman from ovulating. They are used during in vitro fertilization cycles, or to help prepare a woman's uterus for an embryo transfer. These medications are usually injected or given with a nasal spray.
- Metformin (Glucophage®*) is a medicine doctors use for women who have insulin resistance or diabetes and PCOSexternal icon. This drug helps lower the high levels of male hormones in women with these conditions. This helps the body to ovulate. Sometimes clomiphene

citrate or FSH is combined with metformin. This medicine is taken by mouth.

- Bromocriptine (Parlodel®*) and Cabergoline (Dostinex ®*) are medications used for women with ovulation problems because of high levels of prolactin.

*Note: Use of trade names and commercial sources is for identification only and does not imply endorsement by the US. Department of Health and Human Services.

Many fertility drugs increase a woman's chance of having twins, triplets, or other multiples. Women who are pregnant with multiple fetuses may have more problems during pregnancy. Multiple fetuses have a higher risk of being born prematurely (too early). Premature babies are at a higher risk of health and developmental problems.

What is intrauterine insemination (IUI)?

Intrauterine insemination (IUI) is an infertility treatment that is often called artificial insemination. In this procedure, specially prepared sperm are inserted into the woman's uterus. Sometimes the woman is also treated with medicines that stimulate ovulation before IUI.

IUI is often used to treat

- Mild male factor infertility.
- Couples with unexplained infertility.

What is assisted reproductive technology (ART)?

Assisted Reproductive Technology (ART) includes all fertility treatments in which both eggs and embryos are handled outside of the body. In general, ART procedures involve removing mature eggs from a woman's ovaries

using a needle, combining the eggs with sperm in the laboratory, and returning the embryos to the woman's body or donating them to another woman. The main type of ART is in vitro fertilization (IVF).

How often is assisted reproductive technology (ART) successful?
Success rates vary and depend on many factors, including the clinic performing the procedure, the infertility diagnosis, and the age of the woman undergoing the procedure. This last factor—the woman's age—is especially important.

CDC collects success rates on ART for some fertility clinics. According to the CDC's 2015 ART Success Rates, the average percentage of fresh, nondonor ART cycles that led to a live birth were

- 31% in women younger than 35 years of age.
- 24% in women aged 35 to 37 years.
- 16% in women aged 38 to 40 years.
- 8% in women aged 41 to 42 years.
- 3% in women aged 43 to 44 years.
- 3% in women older than 44 years of age.

Success rates also vary from clinic to clinic and with different infertility diagnoses.

ART can be expensive and time-consuming, but it has allowed many couples to have children that otherwise would not have been conceived. The most common complication of ART is a multiple pregnancy. This is a problem that can be prevented or minimized by limiting the number of embryos that are transferred back to the uterus. For example, transfer of a single embryo, rather than multiple embryos, greatly reduces the chances of a multiple pregnancy and its risks such as preterm birth.

What are the different types of assisted reproductive technology (ART)?

- In vitro fertilization (IVF), meaning fertilization outside of the body, is the most effective and the most common form of ART.
- Intracytoplasmic sperm injection (ICSI) is a type of IVF that is often used for couples with male factor infertility. With ICSI, a single sperm is injected into a mature egg. The alternative to ICSI is "conventional" fertilization where the egg and many sperm are placed in a petri dish together and the sperm fertilizes an egg on its own.

Older ART methods that are rarely used in the United States today include

- Zygote intrafallopian transfer (ZIFT) or tubal embryo transfer. This is similar to IVF. Fertilization occurs in the laboratory. Then the very young embryo is transferred to the fallopian tube instead of the uterus.
- Gamete intrafallopian transfer (GIFT), involves transferring eggs and sperm into the woman's fallopian tube. Fertilization occurs in the woman's body.

ART procedures sometimes involve the use of donor eggs (eggs from another woman), donor sperm, or previously frozen embryos. Donor eggs are sometimes used for women who cannot produce eggs. Also, donor eggs or donor sperm are sometimes used when the woman or man has a genetic disease that can be passed on to the baby. An infertile woman or couple may also use donor embryos. These are embryos that were either created by couples in infertility treatment or were created from donor sperm and donor eggs. The donated embryo is transferred to the uterus. The child will not be genetically related to either parent.

Gestational Carrier

Women with ovaries but no uterus may be able to use a gestational carrier. This may also be an option for women who shouldn't become pregnant because of a serious health problem. In this case, a woman uses her own egg. It is fertilized by her partner's sperm and the embryo is placed inside the carrier's uterus.

Chapter 6: Sexual Orientation and Estimates of Adult Substance Use and Mental Health:
Results from the 2015 National Survey on Drug Use and Health

[Chapter __ consists entirely of the National Survey on Drug Use and Health Data Review from October 2016]

Authors

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Retrieved from: https://www.samhsa.gov/data/sites/default/files/NSDUH-SexualOrientation-2015/NSDUH-SexualOrientation-2015/NSDUH-SexualOrientation-2015.htm

Abstract

Background. Research suggests that sexual minorities (e.g., people who identify as lesbian, gay, or bisexual) are at greater risk for substance use and mental health issues compared with the sexual majority population that

identifies as being heterosexual. Although sexual orientation is not a new construct, many federally funded surveys have only recently begun to identify sexual minorities in their data collections. In 2015, the National Survey on Drug Use and Health (NSDUH) added two questions on sexual orientation, one for sexual identity and one for sexual attraction, making it the first nationally representative, comprehensive source of federally collected information on substance use and mental health issues among sexual minority adults.

Methods. To assess the validity of the data, NSDUH estimates of sexual attraction and sexual identity were compared with estimates from three other national surveys: the National Survey of Family Growth, the National Health Interview Survey, and the General Social Survey. Adults who self-identified in a question on sexual identity as being heterosexual or straight were defined as being in the sexual majority group. Adults who self-identified as being gay, lesbian, or bisexual in the same question were defined as being in the sexual minority group. This report presents estimates for substance use and mental health issues from the 2015 NSDUH for adults aged 18 or older by sexual identity. Additionally, NSDUH estimates for substance use and mental health issues were compared for sexual minorities and sexual majority members among all adults and within subgroups defined by sex and by age group. For comparisons of substance use and mental health estimates, statistically significant differences are noted between the sexual majority and sexual minority groups.

Results. Estimates from NSDUH for sexual attraction and sexual identity were comparable with estimates from other national surveys. Based on the 2015 NSDUH, 4.3 percent of adults aged 18 or older identified as a sexual

minority, including 1.8 percent who identified as being lesbian or gay and 2.5 percent who identified as being bisexual.

Sexual minorities were more likely than their sexual majority counterparts to have substance use and mental health issues. The greater likelihood of sexual minority adults to have substance use and mental health issues compared with their sexual majority counterparts was observed across subgroups of adults defined by sex and by age group. In particular, sexual minorities were more likely to use illicit drugs in the past year, to be current cigarette smokers, and to be current alcohol drinkers compared with their sexual majority counterparts. Sexual minority adults were also more likely than sexual majority adults to have substance use disorders in the past year, including disorders related to their use of alcohol, illicit drugs, marijuana, or misuse of pain relievers. Sexual minority adults were more likely than their sexual majority counterparts to need substance use treatment. Among adults who needed substance use treatment, sexual minority adults were more likely than their sexual majority counterparts to receive substance use treatment at a specialty facility.

Sexual minority adults were also more likely than sexual majority adults to have any mental illness (AMI), serious mental illness (SMI), and AMI excluding SMI in the past year. Sexual minority adults were also more likely than their sexual majority counterparts to have a major depressive episode (MDE) or to have had an MDE with severe impairment in the past year. Sexual minority adults with AMI were more likely than sexual majority adults with AMI to receive mental health services during the past 12 months.

Conclusions. This first set of findings from NSDUH on substance use and mental health issues for adults by sexual identity is important to the

Substance Abuse and Mental Health Services Administration for understanding the health issues faced by sexual minorities in the United States. Additional years of data will allow changes to be tracked over time for substance use, substance use treatment, mental health issues, and the use of mental health services among sexual minority adults and will enable researchers to examine issues in greater depth for specific sexual minority subgroups. Future research involving NSDUH and other data sources also will be useful for understanding factors associated with substance use or mental health issues among sexual minorities.

A. Introduction

Understanding how health disparities affect different facets of society has long been a goal of public health researchers and policymakers. Research suggests that sexual minorities, such as people who identify as being lesbian, gay, or bisexual, are at greater risk for substance use and mental health issues compared with the majority population that identifies as being heterosexual or "straight." Sexual minorities face multiple challenges in coming to terms with their sexuality and handling social reactions that are not faced by the majority population that identifies as being heterosexual or straight. Sexual minorities also are at greater risk of experiencing harassment or violence compared with the sexual majority population. These types of stressors can place sexual minorities at increased risk for substance use and mental disorders.

Although sexual orientation is not a new social construct, many federally funded surveys only recently have begun to identify sexual minorities in their data collections. The U.S. Department of Health and Human Services'

(HHS's) Healthy People 2020 objectives include increasing the number of population-based data systems that ask questions that identify lesbian, gay, and bisexual populations in the United States. The Substance Abuse and Mental Health Services Administration (SAMHSA) aligned with the Healthy People 2020 initiative by adding questions to the National Survey on Drug Use and Health (NSDUH) that would identify sexual minorities. The addition of these questions to the 2015 NSDUH provides the first nationally representative, federally collected comprehensive information on substance use and mental health of adults by sexual orientation. **Appendix A** includes further background information on NSDUH and some of the other surveys that collect information on sexual attraction and sexual identity.
Sexual orientation has three main components:

- *sexual attraction* refers to an individual's sexual interest in others, according to whether an individual is attracted to men, women, or both men and women;
- *sexual identity* refers to how an individual thinks of himself or herself; and
- *sexual behavior* refers to whether an individual has sex partners who are of the same sex, the opposite sex, or both.

Each of these components may have a different association with substance use and mental health. For the 2015 NSDUH, two questions were added for adults: one for sexual attraction and one for sexual identity (Table 1).

Table 1. Sexual Orientation Questions in the 2015 National Survey on Drug Use and Health

Sexual Attraction[1]	Sexual Identity
People are different in their sexual attraction to other people. Which statement best describes your feelings? - I am only attracted to males - I am mostly attracted to males - I am equally attracted to males and females - I am mostly attracted to females - I am only attracted to females - I am not sure	*Which one of the following do you consider yourself to be?* - Heterosexual, that is, straight - (If female respondent) Lesbian or Gay - (If male respondent) Gay - Bisexual

[1] The table shows the response options for the sexual attraction question for female respondents. For male respondents, the response options were presented in reverse order (i.e., from "I am only attracted to females" to "I am only attracted to males"), except for "I am not sure."

Because this was the first time NSDUH collected sexual orientation data, this report assesses the quality of the new NSDUH data by comparing NSDUH estimates for sexual attraction and sexual identity with estimates from other surveys that collect data for these measures. The report also presents substance use and mental health estimates according to the sexual identity of adults.

B. Survey Background

NSDUH is an annual survey of the civilian, noninstitutionalized population of the United States aged 12 years old or older. The survey is sponsored by SAMHSA within HHS. The survey covers residents of households and individuals in noninstitutional group quarters (e.g., shelters, boarding houses, college dormitories, migratory workers' camps, halfway houses). The survey excludes people with no fixed address (e.g., homeless people not in shelters), military personnel on active duty, and residents of institutional group quarters, such as jails, nursing homes, mental institutions, and long-term care hospitals.

NSDUH employs a stratified multistage area probability sample that is designed to be representative of both the nation as a whole and for each of the 50 states and the District of Columbia. The 2015 NSDUH annual target sample size of 67,500 interviews was distributed across three age groups,

with 25 percent allocated to adolescents aged 12 to 17, 25 percent allocated to young adults aged 18 to 25, and 50 percent allocated to adults aged 26 or older.

NSDUH is a face-to-face household interview survey that is conducted in two phases: the screening phase and the interview phase. The interviewer conducts a screening of the eligible household with an adult resident (aged 18 or older) in order to determine whether zero, one, or two residents aged 12 or older should be selected for the interview. NSDUH collects data using audio computer-assisted self interviewing (ACASI), in which respondents read or listen to the questions on headphones and then enter their answers directly into a NSDUH laptop computer. ACASI is designed for accurate reporting of information by providing respondents with a highly private and confidential mode for responding to questions about illicit drug use, mental health, and other sensitive behaviors. NSDUH also uses computer-assisted personal interviewing (CAPI), in which interviewers read less sensitive questions to respondents and enter the respondents' answers into a laptop computer.

In 2015, screening was completed at 132,210 addresses, and 68,073 completed interviews were obtained, including 51,118 interviews from adults aged 18 or older. There were approximately 3,000 completed interviews from adult respondents aged 18 and older who self-identified as a sexual minority (i.e., gay, lesbian, or bisexual). Weighted response rates for household screening and for interviewing were 79.7 and 69.3 percent, respectively, for an overall response rate of 55.2 percent for people aged 12 or older. The weighted interview response rate was 68.4 percent for adults. Further details about the 2015 NSDUH design and methods can be found on the web at http://www.samhsa.gov/data/.

Notable 2015 NSDUH Questionnaire Changes

The NSDUH questionnaire underwent a partial redesign in 2015 to improve the quality of the NSDUH data and to address the changing needs of policymakers and researchers with regard to substance use and mental health issues. Adding the sexual attraction and sexual identity questions was part of the 2015 NSDUH partial redesign. Details on the 2015 NSDUH questionnaire changes, reasons for the changes, and implications of the changes for NSDUH data users are included in a brief report on these questionnaire changes, in a report on the design changes for the 2014 and 2015 NSDUHs, and in the methodological summary and definitions report for 2015.

Data Presentation and Interpretation

This report presents estimates for adults aged 18 or older based on their sexual attraction and sexual identity. Because 2015 is the first year that NSDUH collected these data, the estimates for sexual attraction and identity are compared with estimates from other surveys that have collected these data to assess the quality of these data.

Estimates for substance use and mental health issues are presented by adults' sexual identity. Adults who self-identified in the sexual identity question as being heterosexual or straight were defined as being in the sexual majority group. Adults who self-identified as being lesbian, gay, or bisexual were defined as being in the sexual minority group. The sexual minority group was further subdivided into (a) gay or lesbian or (b) bisexual. Due to the smaller sample sizes and associated loss of precision when the data are further subdivided into sexual minority subgroups, data for these sexual minority subgroups are not compared and discussed in this report; however, the estimates for these subgroups are included in the supplemental tables in **Appendix B**. Combining the 2015 data with data

from future years would improve the precision of estimates for subgroups of sexual minorities.

All estimates presented in this report are derived from NSDUH survey data that are subject to sampling errors. The estimates have met the criteria for statistical reliability. Estimates that do not meet these criteria for reliability have been suppressed and are not shown. Statistical tests also have been conducted for any comparisons that appear in the text of the report. Statistically significant differences are described using terms such as "higher" or "lower." Estimates are described as "similar" when a difference is not statistically significant. Graphics and tables contain estimates that support the statements in this report, and supplemental tables of estimates (including standard errors) are provided in **Appendix B**.

However, comparisons between sexual majority and sexual minority subpopulations for all adults aged 18 or older should be interpreted with caution because there are demographic differences in the groups being compared that are associated with substance use and mental health outcomes. In particular, a higher percentage of sexual minority adults are young adults aged 18 to 25 compared with the percentage among sexual majority adults (**Table B.3**). In these situations, apparent differences between sexual minority and sexual majority adults could be attributable to demographic differences between the subpopulations rather than differences based on sexual identity. For example, young adults historically have been more likely than people in other age groups to be substance users. Thus, higher estimates of substance use among sexual minority adults than among those in the sexual majority could be attributable to the disproportionate representation of young adults in the sexual minority subpopulation. However, to account for some of these differences, this report does examine substance use and mental health issues within specific subgroups (i.e., by sex and by age group).

Comparison of Estimates for Sexual Attraction and Sexual Orientation

To assess the quality of the sexual attraction and sexual identity data collected for the first time in the 2015 NSDUH, comparisons are presented for NSDUH estimates for sexual attraction and sexual identity with estimates from other surveys that collect data for these measures.

Table A.1 in **Appendix A** provides methodological information on characteristics related to the recency of the data, populations covered, sample design, response rates, and other relevant characteristics for NSDUH and the other sources of data on sexual attraction and identity. The other sources of data include the General Social Survey (GSS), National Health Interview Survey (NHIS), and National Survey of Family Growth (NSFG). Even when surveys cover similar topics, comparisons of the corresponding estimates can be difficult because the surveys can often produce different results for the same measures. These differing results often reflect variations in study purpose and methodologies rather than incorrect results. Therefore, precise agreement among the data sources is not expected. Despite any differences among surveys, comparisons can be useful in assessing data quality. For example, consistency across surveys can confirm or support conclusions about trends and patterns of use, and inconsistent results can point to areas for further study. When surveys have large sample sizes, differences across surveys that are *statistically* significant also may present the same basic information from a *practical* standpoint.

No single source of data can fully cover all issues associated with sexual orientation, substance use, and mental health issues in the United States. Rather, each data source can contribute to a broader understanding of the health issues of sexual minorities.

C. Sexual Attraction

According to the 2015 NSDUH data, the large majority of adults aged 18 to 44 were only or mostly attracted to the opposite sex (93.8 percent of males and 90.5 percent of females in this age group) (**Table B.1** in **Appendix B**). The sexual attraction question in the 2015 NSDUH was based on corresponding questions in and is virtually identical to questions for males and females from the 2011-2013 NSFG (see **Table 1**). Because NSFG respondents are aged 15 to 44 and the sexual attraction question in NSDUH is asked only of adults, NSDUH and NSFG estimates for sexual attraction were produced only for adults aged 18 to 44. NSDUH and NSFG estimates for sexual attraction also were compared separately for males and females in this age group.

Overall, the 2015 NSDUH and the 2011-2013 NSFG sexual attraction data were comparable, with the large majority of adults in both surveys reporting that they were only or mostly attracted to the opposite sex. As noted previously, the 2015 NSDUH data indicated that 93.8 percent of males aged 18 to 44 were only or mostly attracted to females, and 90.5 percent of females in this age group were only or mostly attracted to males (**Table B.1** in **Appendix B**). Corresponding estimates from the 2011-2013 NSFG were 95.3 percent of adult males aged 18 to 44 who were only or mostly attracted to females and 93.4 percent of females in this age group who were only or mostly attracted to males. The NSDUH estimates for males aged 18 to 44 for (a) being equally attracted to males or females and (b) being only or mostly attracted to males were greater than the NSFG estimates, but the differences between the estimates from the two surveys were not significant. Thus, the lower percentage of males in NSDUH who reported opposite-sex attraction was not explained by males in NSDUH being

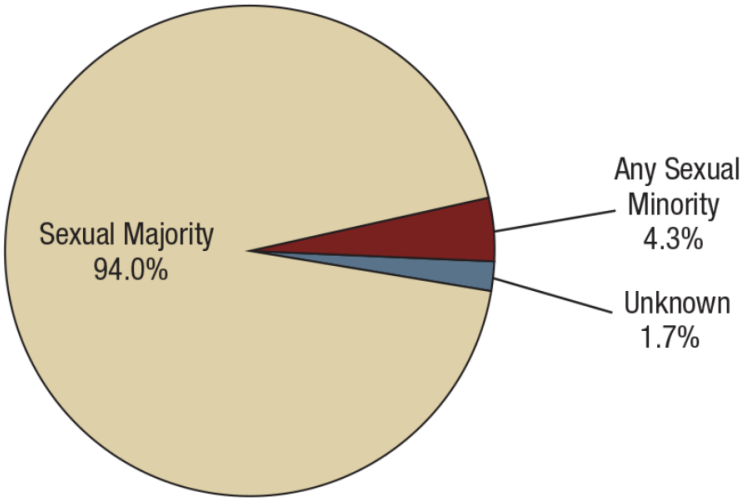
more likely to report same-sex attraction. Rather, the lower percentage of males reporting opposite-sex attraction was partly offset by a higher percentage of males in NSDUH who were not sure of their attraction. Unlike the pattern for males, women in NSDUH were more likely than those in the NSFG to report that they were equally attracted to males or females (4.3 vs. 3.2 percent) or that they were only or mostly attracted to females (2.5 vs. 1.6 percent).

Although estimated percentages for missing data are another indicator of data quality, several percentages for various types of missing data (i.e., "don't know," "refused," or "blank") did not have sufficient precision to be published. However, females aged 18 to 44 in NSDUH were more likely than females in this age group in the NSFG to refuse to report their sexual attraction (1.0 vs. 0.4 percent). In addition, 0.6 percent of males aged 18 to 44 in the 2015 NSDUH refused to report their sexual attraction.

D. Sexual Identity

Based on the 2015 NSDUH data, 4.3 percent of adults aged 18 or older in 2015 identified as a sexual minority, including 1.8 percent who identified as being lesbian or gay and 2.5 percent who identified as being bisexual (**Figure 1** and **Table B.2** in **Appendix B**). An estimated 94.0 percent of adults identified as being heterosexual.

Figure 1. Sexual Identity among Adults Aged 18 or Older: Percentages, 2015



D

Note: Any Sexual Minority includes adults who identified as being lesbian or gay (1.8 percent) or bisexual (2.5 percent). Sexual Majority includes adults who identified as being heterosexual or straight. Unknown includes adults who did not know or refused to report their sexual identity (0.6 and 1.0 percent, respectively) or who had other missing data (0.1 percent).

In addition to the 2015 NSDUH, the 2014 NHIS, 2014 GSS, and 2011-2013 NSFG include questions about sexual identity (**Table 2**). Although the questions are relatively similar across all four surveys, there is notable variation in the response options and response option order. Despite these differences, comparison across all four surveys is still useful for assessing data quality.

Table 2. Sexual Identity Questions in the National Survey on Drug Use and Health (NSDUH), National Health Interview Survey (NHIS), General Social Survey (GSS), and National Survey of Family Growth (NSFG)

NSDUH, 2015	NHIS, 2014	GSS, 2014	NSFG, 2011-2013
Which one of the following do you consider yourself to be? - Heterosexual, that is, straight - (If female respondent) Lesbian or Gay - (If male respondent) Gay - Bisexual	*Which of the following best represents how you think of yourself?* - (If male) Gay - (If female) Lesbian or gay - (If male) Straight, that is, not gay - (If female) Straight, that is, not lesbian or gay - Bisexual - Something else[1]	*Which of the following best describes you?* - Gay, lesbian, or homosexual - Bisexual - Heterosexual or straight	*Do you think of yourself as…* - Heterosexual or straight - (If female) Homosexual, gay, or lesbian - (If male) Homosexual or gay - Bisexual

[1] NHIS respondents who answered "Something else" were asked a follow-up question to clarify what they meant by "something else." Response choices in this question (in addition to "Refused" or "Don't know") were (1) You are not straight, but identify with another label such as queer, trisexual, omnisexual or pansexual; (2) You are transgender, transsexual or gender variant; (3) You have not figured out or are in the process of figuring out your sexuality; (4) You do not think of yourself as having sexuality; (5) You do not use labels to identity yourself; or (6) You mean something else.
Sources: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2015.
Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), National Health Interview Survey, 2014.
NORC at the University of Chicago, General Social Survey, 1972-2014.
CDC, NCHS, National Survey of Family Growth, 2011-2013.

As was the case for sexual attraction, the sexual identity data from NSDUH are reasonably comparable with the data from other surveys (**Table B.2**). Among all adults aged 18 or older, the percentage that identified as being heterosexual ranged from 87.2 percent in the 2014 GSS to 94.5 percent in the 2014 NHIS. Among adults aged 18 to 44, 92.1 percent of those in NSDUH and 93.6 percent of those in the 2011-2013 NSFG identified as heterosexual.

Overall, the percentages of adults aged 18 or older in the GSS who reported being heterosexual were lower than the percentages in NSDUH for all adults and for males and females. In contrast, estimates for specific sexual minority groups (i.e., lesbian or gay, bisexual) were not significantly different between NSDUH and the GSS for all adults and among males and females. However, the estimates for the "blank" category were higher in the GSS than in NSDUH. When responses for "blank," "don't know," and "refused" were not included in the percentages for the GSS, 95.5 percent of all adults in the GSS were estimated to be heterosexual, which was similar to the NSDUH estimate in **Table B.2**. The estimated percentage of adult males in the GSS who were heterosexual when missing data were excluded (95.8 percent) also was similar to the NSDUH estimate for males. An estimated 95.2 percent of adult females in the GSS were heterosexual when missing data were excluded. Excluding missing data in the GSS changed the GSS estimate for heterosexual females from being lower than the NSDUH estimate to being greater than the NSDUH estimate.

Both adult males and adult females in the 2015 NSDUH were more likely to report that they were bisexual compared with their counterparts in the 2014 NHIS. For example, 3.5 percent of adult females in NSDUH and 1.0 percent of adult females in the NHIS reported that they were bisexual. Adult females

in NSDUH were also somewhat less likely than their counterparts in the NHIS to report that they were heterosexual (92.9 vs. 94.3 percent). The inclusion of the "Something Else" category in the NHIS but not in NSDUH does not appear to explain these differences.

Across all surveys, estimates of adults not knowing or refusing to report their sexual identity were low but were somewhat higher in NSDUH than in other surveys (**Table B.2**). For example, 0.6 percent of adults in the 2015 NSDUH did not know their sexual identity compared with 0.4 percent of those in the 2014 NHIS. An estimated 1.0 percent of adults in NSDUH refused to report their sexual identity compared with 0.6 percent of those in the NHIS. A small number of respondents in the 2014 GSS answered the sexual identity question as "don't know" or "refused," such that the corresponding percentages for the GSS rounded to less than 0.1 percent.

Summary of Estimates for Sexual Attraction and Identity in NSDUH and Other Data Sources

The goal of comparing estimates of sexual attraction and sexual identity from NSDUH with estimates from other national data sources is to aid policymakers, researchers, and other users of NSDUH data to better understand the quality of the data that are produced by national studies. Substantial methodological differences across the data sources make it difficult to designate a particular survey's estimates as being the "best." Each study that was reviewed in the previous sections was designed for a different purpose (see **Table A.1** in **Appendix A**) and therefore has different strengths. Although there are methodological differences between NSDUH and the other data sources, the estimates of sexual attraction and sexual identity all indicate that the large majority of adults identifies themselves as being only or mostly attracted to the opposite sex and being

heterosexual. Where statistically significant differences were found, the small differences in the estimates do not raise questions about the validity of the estimates in these surveys.

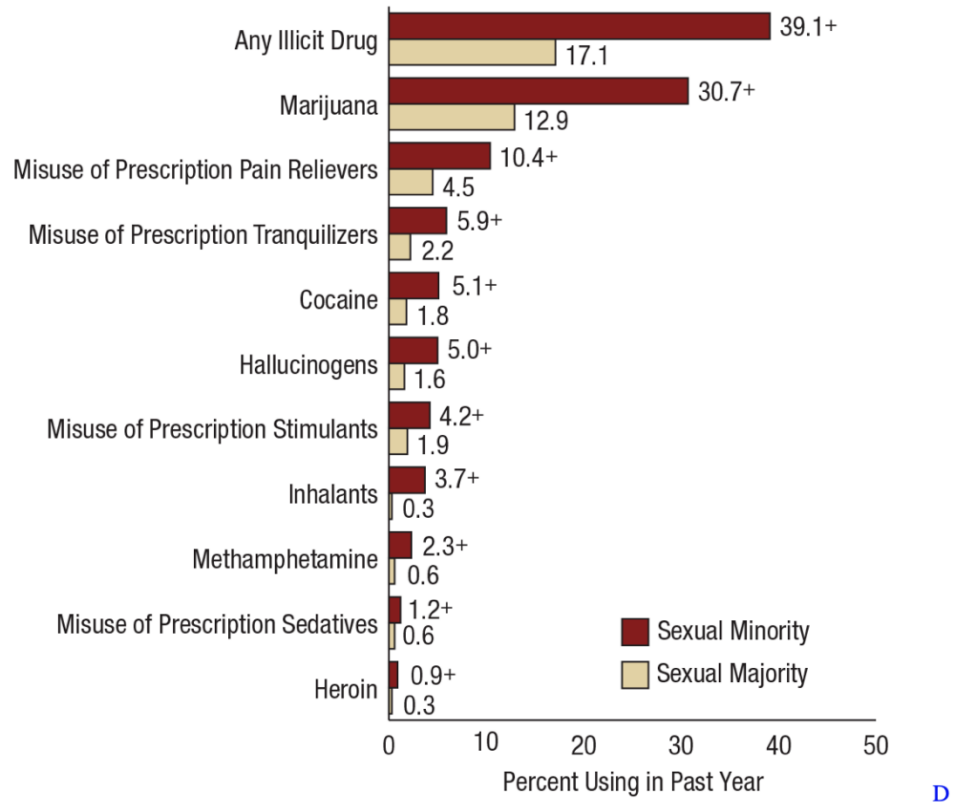
The remainder of this report focuses on NSDUH data and presents substance use and mental health estimates for sexual minority and sexual majority members as defined by the responses to the 2015 NSDUH sexual identity questions. Given the high proportion of adults in NSDUH who identified as part of the sexual majority (94.0 percent), the estimates of substance use and mental health issues for adults who identified as part of the sexual majority are typically similar to those for all adults as a whole. National estimates of substance use and mental health issues among all adults can be found in a separate report and in the 2015 detailed tables that are available at http://www.samhsa.gov/data/.

E. Illicit Drug Use

NSDUH obtains information on 10 categories of illicit drugs: marijuana; cocaine in any form, including crack; heroin; hallucinogens; inhalants; methamphetamine; and the misuse of prescription pain relievers, tranquilizers, stimulants, and sedatives. Misuse of prescription drugs is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told to take a drug; or use in any other way not directed by a doctor. Estimates of "any" illicit drug use reported from NSDUH reflect the data from these 10 drug categories. NSDUH produces estimates of lifetime, past year, and past month (also referred to as "current") illicit drug use. This section focuses on the use of illicit drugs in the past year (i.e., within 12 months of the interview date).

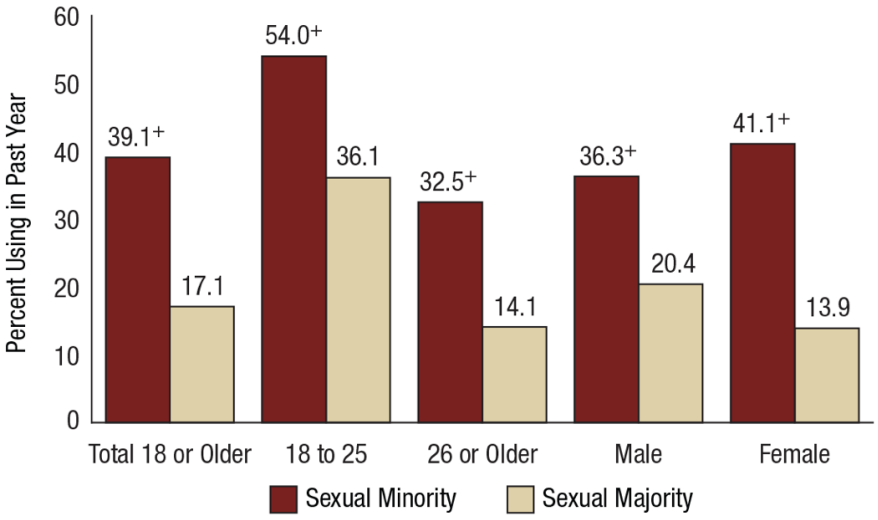
In 2015, sexual minority adults were more likely than sexual majority adults to be past year users of any illicit drug (**Figures 2** and **3**) and to be past year users of each of the 10 categories of illicit drugs in NSDUH (**Figure 2**). Among sexual minority adults, 39.1 percent used illicit drugs in the past year, or nearly 2 out of 5. Nearly one third of sexual minority adults (30.7 percent) used marijuana in the past year (**Figure 4**), and about 1 in 10 (10.4 percent) misused prescription pain relievers (**Figure 5**). In comparison, among sexual majority adults, 17.1 percent used illicit drugs in the past year, 12.9 percent used marijuana, and 4.5 percent misused prescription pain relievers.

Figure 2. Past Year Illicit Drug Use among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Drug Type: Percentages, 2015



+ Difference between this estimate and the sexual majority estimate is statistically significant at the .05 level.
Note: Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight.

Figure 3. Past Year Illicit Drug Use among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015



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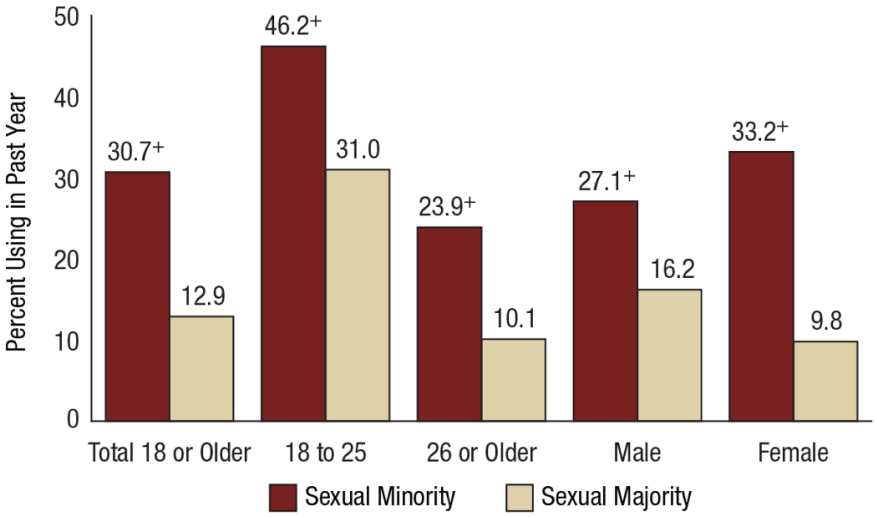
+ Difference between this estimate and the sexual majority estimate is statistically significant at the .05 level.
Note: Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight.

Figure 4. Past Year Marijuana Use among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015



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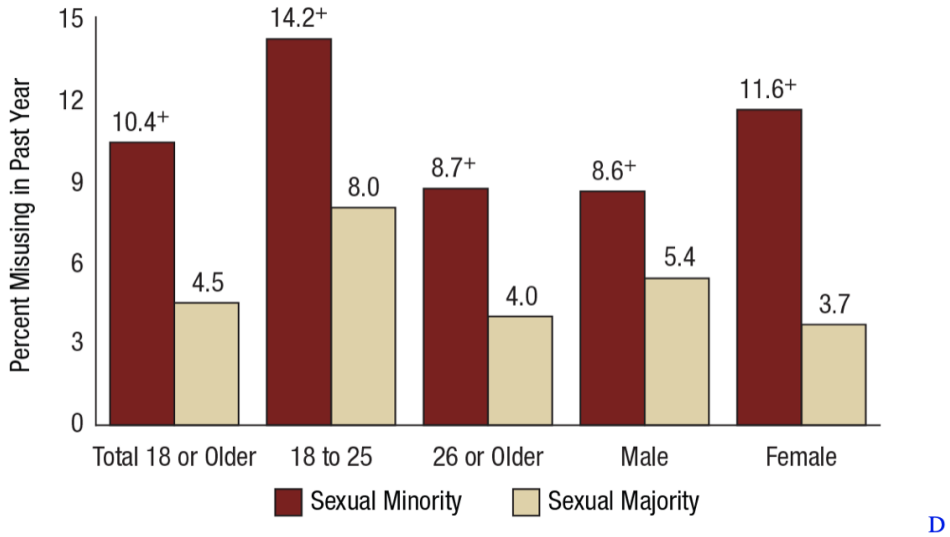
+ Difference between this estimate and the sexual majority estimate is statistically significant at the .05 level.
Note: Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight.

In the past year, sexual minority adults were also more likely than sexual majority adults to have engaged in the following in the past year (**Figure 2** and **Table B.4** in **Appendix B**):

- cocaine use (5.1 vs. 1.8 percent);
- heroin use (0.9 vs. 0.3 percent);
- use of hallucinogens (5.0 vs. 1.6 percent), including use of lysergic acid diethylamide (LSD) (1.7 vs. 0.5 percent) and Ecstasy (3.2 vs. 0.9 percent);
- use of inhalants (3.7 vs. 0.3 percent);
- methamphetamine use (2.3 vs. 0.6 percent);
- misuse of prescription tranquilizers (5.9 vs. 2.2 percent);

Figure 5. Past Year Misuse of Prescription Pain Relievers among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015



D

+ Difference between this estimate and the sexual majority estimate is statistically significant at the .05 level.
Note: Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight.

- misuse of prescription stimulants (4.2 vs. 1.9 percent); and
- misuse of prescription sedatives (1.2 vs. 0.6 percent).

These data consistently indicate higher estimates of substance use among sexual minority adults in comparison with those in the sexual majority. The consistency of these results is underscored in the following sections where comparisons are made by sex and age group for any past year illicit drug use, marijuana use, and the misuse of prescription pain relievers among sexual minority and sexual majority adults
(**Tables B.5** to **B.8** in **Appendix B**).

By Sex

Both adult males and females who were sexual minorities were more likely than their sexual majority counterparts to be illicit drug users in the past year (**Tables B.5** and **B.6** in **Appendix B**). An estimated 36.3 percent of sexual minority males and 41.1 percent of sexual minority females used illicit drugs in the past year (**Figure 3**). Corresponding percentages for sexual majority adults were 20.4 percent for males and 13.9 percent for females.

For sexual minority males, 27.1 percent used marijuana in the past year (**Figure 4**), and 8.6 percent misused prescription pain relievers in that period (**Figure 5**). In comparison, among sexual majority males, 16.2 percent used marijuana in the past year, and 5.4 percent misused prescription pain relievers. Sexual minority men were also more likely than sexual majority males to be past year users of cocaine, hallucinogens, LSD, Ecstasy, inhalants, and methamphetamine and to have misused prescription tranquilizers in the past year.

In particular, 7.5 percent of sexual minority males used inhalants in the past year compared with 0.3 percent of sexual majority males (**Table B.5**). This finding for the use of inhalants in the past year among sexual minority males is noteworthy because the use of inhalants in the general population is more likely to occur among adolescents than adults.[1,22] Estimates of heroin use in the past year and the misuse of prescription stimulants and sedatives in the past year were similar for sexual minority and sexual majority males.

For sexual minority females, 33.2 percent used marijuana in the past year (**Figure 4**), and 11.6 percent misused prescription pain relievers in that period (**Figure 5**). In comparison, among sexual majority females, 9.8 percent used marijuana in the past year, and 3.7 percent misused prescription pain relievers. Sexual minority females were also more likely than sexual majority females to be past year users of cocaine, heroin, hallucinogens, LSD, Ecstasy, inhalants, and methamphetamine and to have misused prescription tranquilizers, stimulants, and sedatives in the past year (**Table B.6**).

By Age Group

Young adults aged 18 to 25 and adults aged 26 or older who were sexual minorities were more likely than their sexual majority counterparts to be past year users of most illicit drugs (**Tables B.7** and **B.8** in **Appendix B**). An estimated 54.0 percent of sexual minority young adults and 36.1 percent of sexual majority young adults used illicit drugs in the past year (**Figure 3**). Among adults aged 26 or older, about 1 in 3 of those who were sexual minorities (32.5 percent) used illicit drugs in the past year compared with about 1 in 7 sexual majority adults (14.1 percent).

Sexual minority young adults aged 18 to 25 were more likely than their sexual majority counterparts to be past year users of marijuana (46.2 vs. 31.0 percent) and to have misused prescription pain relievers in the past

year (14.2 vs. 8.0 percent) (**Figures 4** and **5**, respectively). Young adults who were sexual minorities were also more likely than their sexual majority counterparts to be past year users of cocaine, hallucinogens, LSD, Ecstasy, inhalants, and methamphetamine and to have misused prescription tranquilizers and sedatives in the past year. The estimates for sexual minority and sexual majority young adults were not significantly different for heroin use in the past year or for the misuse of prescription stimulants in the past year.

Sexual minority adults aged 26 or older were more likely than their sexual majority counterparts to be past year users of marijuana (23.9 vs. 10.1 percent) and to have misused prescription pain relievers in the past year (8.7 vs. 4.0 percent) (**Figures 4** and **5**, respectively). In addition, adults aged 26 or older who were sexual minorities were more likely than sexual majority adults in the same age group to be past year users of cocaine, heroin, hallucinogens, Ecstasy, inhalants, and methamphetamine and to have misused prescription tranquilizers and stimulants in the past year. The estimates for sexual minority and sexual majority adults aged 26 or older were not significantly different for the past year use of LSD or the misuse of prescription sedatives in the past year.

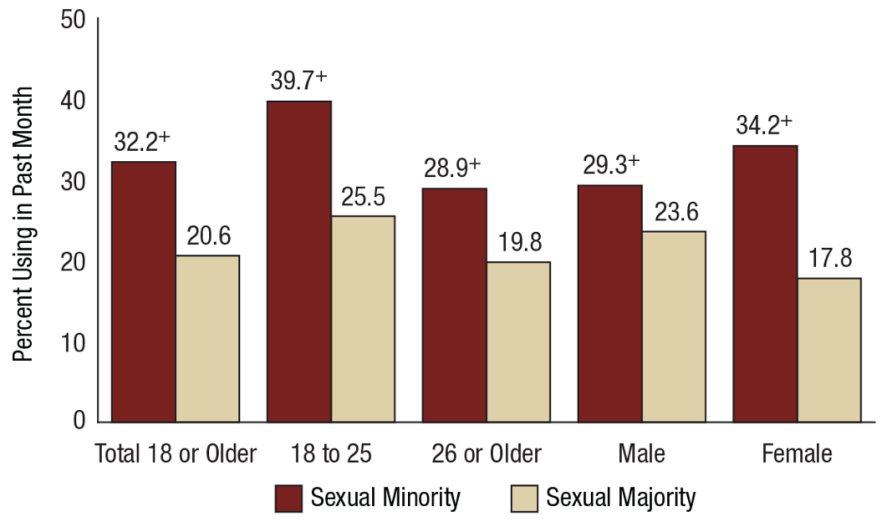
F. Cigarette Smoking

NSDUH asks respondents about their tobacco use in the 30 days before the interview (i.e., current use). Although NSDUH collects information on a variety of tobacco products, including cigarettes, smokeless tobacco (i.e., snuff, chewing

tobacco, and "snus"), cigars, and pipe tobacco, this report focuses only on cigarette use because cigarettes are the most commonly used form of tobacco.[22] Cigarette use in NSDUH is defined as smoking "part or all of a cigarette." This section focuses on any current cigarette smoking. The next section discusses daily smoking among current smokers and smoking a pack or more of cigarettes per day among daily smokers in the past month. **Appendix B** also includes estimates for the current use of other forms of tobacco among sexual minority and majority adults.

In 2015, adults who were sexual minorities were more likely than sexual majority adults to be current cigarette smokers. Specifically, 32.2 percent of sexual minority adults were current cigarette smokers compared with 20.6 percent of sexual majority adults (**Figure 6**).

Figure 6. Past Month Cigarette Use among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015



D

+ Difference between this estimate and the sexual majority estimate is statistically significant at the .05 level.
Note: Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight.

By Sex

For both males and females, higher percentages of sexual minority adults were current cigarette smokers compared with the percentages of sexual majority adults. An estimated 29.3 percent of sexual minority males and 34.2 percent of sexual minority females were current cigarette smokers (**Figure 6**). Corresponding percentages for sexual majority adults were 23.6 percent for males and 17.8 percent for females.

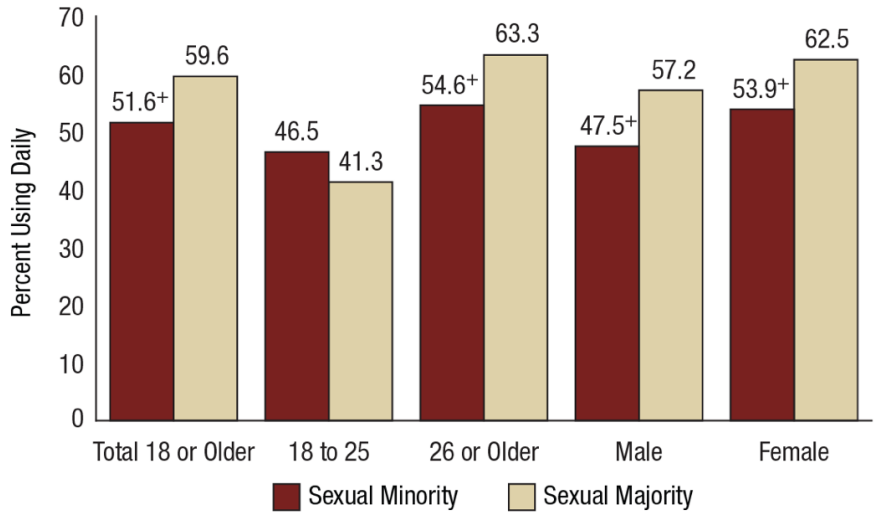
By Age Group

In 2015, young adults aged 18 to 25 and adults aged 26 or older who were sexual minorities were more likely to be current cigarette smokers compared with their sexual majority counterparts. An estimated 39.7 percent of sexual minority young adults and 25.5 percent of sexual majority young adults were current cigarette smokers (**Figure 6**). Among adults aged 26 or older, 28.9 percent of those who were sexual minorities were current cigarette smokers compared with 19.8 percent of those who were part of the sexual majority.

Daily Cigarette Smoking

Compared with their sexual majority counterparts, sexual minority current smokers aged 18 or older were *less* likely to be daily cigarette smokers in the past month or to be daily cigarette smokers who smoked a pack or more of cigarettes per day. This pattern is in contrast to the pattern for current cigarette smoking, where sexual minority adults were more likely than those in the sexual majority to be current smokers. Among adults who were current cigarette smokers, 59.6 percent of sexual majority adults were daily cigarette smokers compared with 51.6 percent of sexual minority adults who were daily cigarette smokers (**Figure 7**).

Figure 7. Daily Cigarette Use among Sexual Minority and Sexual Majority Past Month Cigarette Smokers Aged 18 or Older, by Age Group and Sex: Percentages, 2015



D

+ Difference between this estimate and the sexual majority estimate is statistically significant at the .05 level.
Note: Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight.

In 2015, an estimated 41.8 percent of sexual majority adults who were daily cigarette smokers smoked a pack or more of cigarettes per day (**Table B.9** in **Appendix B**). In comparison, 32.5 percent of sexual minority adults who were daily cigarette smokers reported that they smoked a pack or more of cigarettes per day.

By Sex

Among current cigarette smokers, lower percentages of sexual minority males and females were daily cigarette smokers compared with sexual majority males and females. An estimated 47.5 percent of sexual minority males and 53.9 percent of sexual minority females who were current smokers reported daily cigarette smoking (**Figure 7**). Corresponding percentages for sexual majority adults who were current smokers were 57.2 percent for males and 62.5 percent for females. Because there was not

adequate precision to report some estimates, comparisons are not made for smoking a pack or more of cigarettes per day among males and females for sexual majority and sexual minority adults who were daily smokers.

By Age Group

Among current cigarette smokers, a lower percentage of sexual minority adults aged 26 or older were daily cigarette smokers compared with their sexual majority counterparts. In 2015, an estimated 46.5 percent of sexual minority young adults who smoked cigarettes in the past month and 41.3 percent of their sexual majority counterparts were daily cigarette smokers (**Figure 7**). Among adults aged 26 or older who were current smokers, 54.6 percent of those who were sexual minorities and 63.3 percent of those who were part of the sexual majority were daily cigarette smokers. Among current daily cigarette smokes, a lower percentage of sexual minority young adults aged 18 to 25 smoked a pack or more of cigarettes per day compared with their sexual majority counterparts. In 2015, sexual minority young adults who were daily smokers in the past month were less likely to smoke a pack or more of cigarettes per day compared with their sexual majority counterparts (13.3 vs. 23.7 percent) (**Table B.12** in **Appendix B**). Among adults aged 26 or older who were daily smokers in the past month, 42.5 percent of sexual minority adults and 44.2 percent of sexual majority adults smoked a pack or more of cigarettes per day (**Table B.13**).

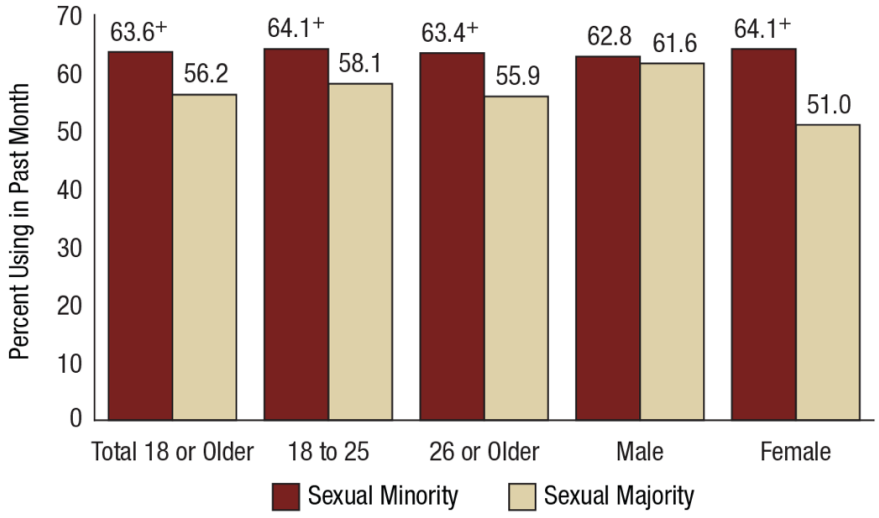
G. Alcohol Use

NSDUH asks respondents about their alcohol use in the 30 days before the interview (i.e., current use). NSDUH also collects information on binge

alcohol use and heavy alcohol use in the past 30 days. Binge drinking is defined for males as drinking five or more drinks on an occasion on at least 1 day in the past 30 days and for females as drinking four or more drinks on an occasion on at least 1 day in that period. Heavy alcohol use is defined as binge drinking on 5 or more days in the past 30 days. Any alcohol use, binge drinking, and heavy drinking are not mutually exclusive categories of use: heavy use is included in estimates of binge and current use, and binge use is included in estimates of current use. This section focuses on current alcohol use and on binge and heavy alcohol use in the past month.

In 2015, sexual minority adults aged 18 or older were more likely than sexual majority adults to be current alcohol drinkers or binge drinkers in the past month. However, similar percentages of sexual minority and sexual majority adults were heavy alcohol users in the past month. Among sexual minority adults, 63.6 percent were current alcohol drinkers (**Figure 8**), and 36.1 percent were binge alcohol drinkers (**Figure 9**). In contrast, among sexual majority adults, 56.2 percent were current alcohol drinkers, and 26.7 percent were binge alcohol drinkers. An estimated 8.2 percent of sexual minority adults and 7.1 percent of sexual majority adults were heavy alcohol drinkers (**Figure 10**).

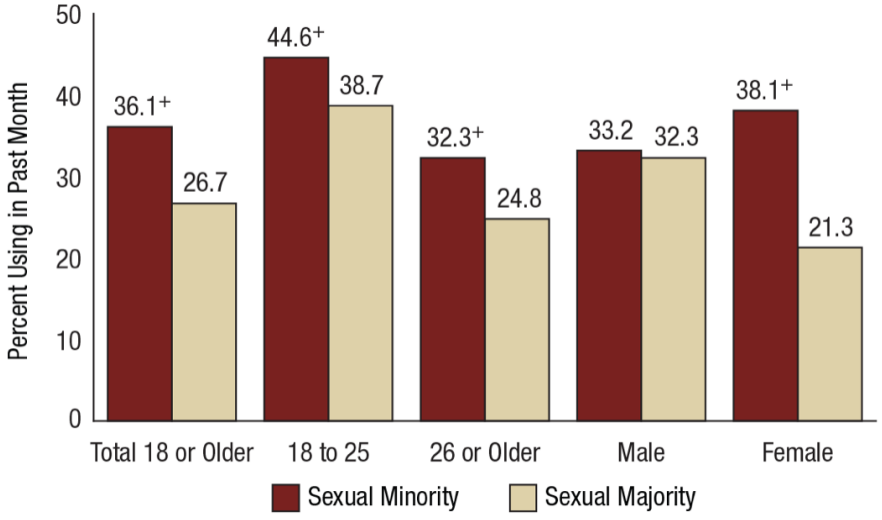
Figure 8. Past Month Alcohol Use among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015



D

+ Difference between this estimate and the sexual majority estimate is statistically significant at the .05 level.
Note: Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight.

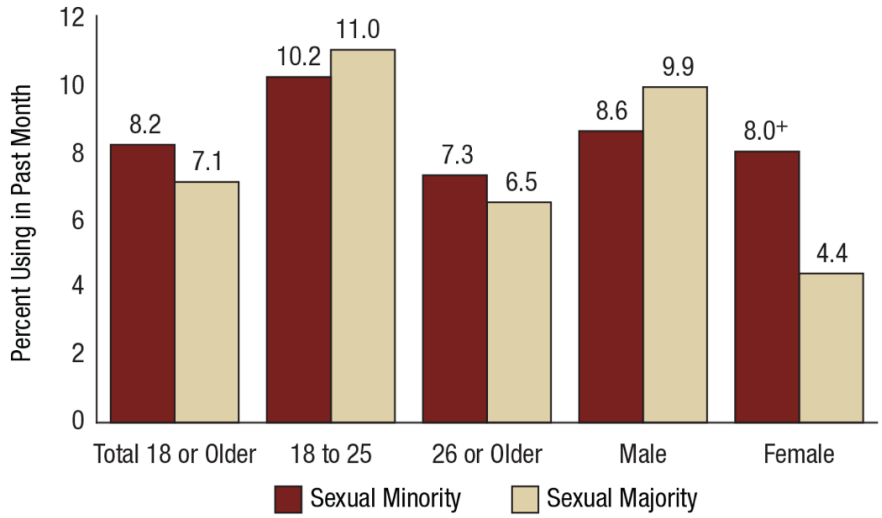
Figure 9. Past Month Binge Alcohol Use among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015



D

+ Difference between this estimate and the sexual majority estimate is statistically significant at the .05 level.
Note: In 2015, the threshold for determining binge alcohol use for females changed from five or more drinks on an occasion to four or more drinks on an occasion.
Note: Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight.

Figure 10. Past Month Heavy Alcohol Use among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015



D

+ Difference between this estimate and the sexual majority estimate is statistically significant at the .05 level.
Note: In 2015, the threshold for determining binge alcohol use for females changed from five or more drinks on an occasion to four or more drinks on an occasion. By definition, heavy alcohol users are binge alcohol users.
Note: Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight.

By Sex

Similar percentages of sexual minority males and sexual majority males were current alcohol users, binge alcohol users, and heavy alcohol users (**Figures 8**, **9**, and **10**). However, sexual minority females were more likely than their sexual majority counterparts to be current alcohol users, binge drinkers, and heavy drinkers. Among sexual minority females, 64.1 percent were current alcohol drinkers, 38.1 percent were binge drinkers, and 8.0 percent were heavy drinkers. Corresponding percentages for sexual majority females were 51.0 percent for current alcohol use, 21.3 percent for binge alcohol use, and 4.4 percent for heavy alcohol use.

By Age Group

In 2015, young adults aged 18 to 25 and adults aged 26 or older who were sexual minorities were more likely to be current alcohol drinkers and binge

drinkers compared with their sexual majority counterparts (**Figures 8** and **9**). The percentages of young adults or adults aged 26 and older who were heavy alcohol users did not differ significantly between sexual minority and sexual majority adults (**Figure 10**).

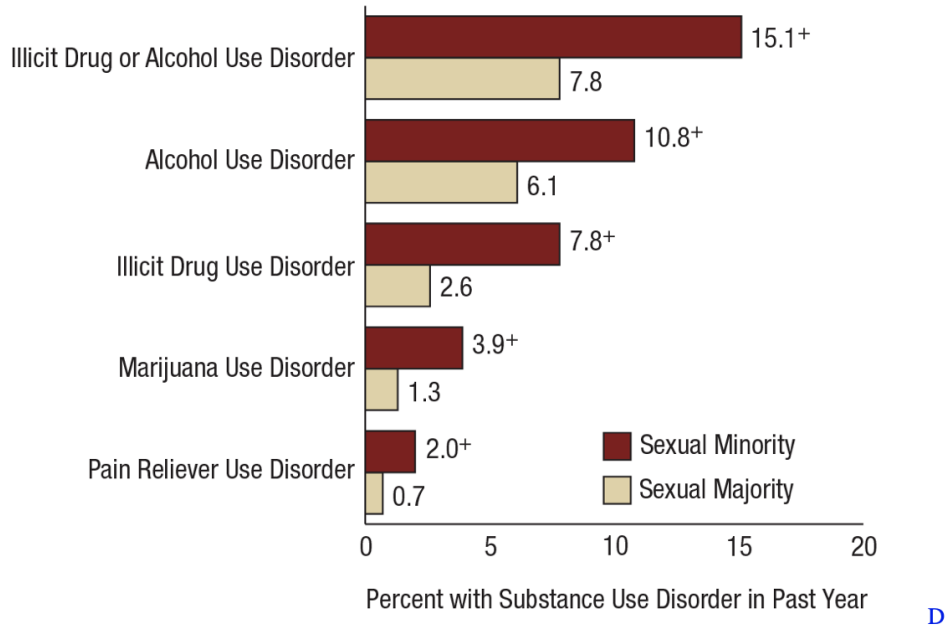
An estimated 64.1 percent of sexual minority young adults and 58.1 percent of sexual majority young adults were current alcohol drinkers. An estimated 44.6 percent sexual minority young adults were binge drinkers compared with 38.7 percent sexual majority adults. Among adults aged 26 or older, 63.4 percent of those who were sexual minorities were current alcohol drinkers compared with 55.9 percent of sexual majority adults in this age group. An estimated 32.3 percent of sexual minority adults and 24.8 percent of sexual majority adults aged 26 or older were binge drinkers.

H. Substance Use Disorders

Substance use disorders (SUDs) represent clinically significant impairment caused by the recurrent use of alcohol or other drugs (or both), including health problems, disability, and failure to meet major responsibilities at work, school, or home. NSDUH includes a series of questions to estimate the percentage of the population aged 12 or older who had SUDs in the past 12 months. Respondents were asked questions about SUDs if they previously reported use in the past 12 months of alcohol or illicit drugs (i.e., marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, and the misuse of prescription pain relievers, tranquilizers, stimulants, and sedatives). These SUD questions classify

people as having an SUD in the past 12 months and are based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV).

Figure 11. Substance Use Disorder in the Past Year among Sexual Minority and Sexual Majority Adults Aged 18 or Older: Percentages, 2015



+ Difference between this estimate and the sexual majority estimate is statistically significant at the .05 level.
Note: The estimated percentages of people with substance use disorders are not mutually exclusive because people could have use disorders for more than one substance.
Note: Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight.

This section focuses on any SUD, alcohol use disorder, overall illicit drug use disorder (including marijuana use disorder, pain reliever use disorder, and disorders for the other illicit drugs mentioned in the previous paragraph), and the occurrence of both alcohol and illicit drug use disorders in the past year. SUD estimates are presented for sexual minority and sexual majority adults aged 18 or older and by sex and by age group.

Sexual minority adults were more likely than sexual majority adults to have SUDs in the past year. In 2015, an estimated 15.1 percent of sexual

minority adults had an alcohol or illicit drug use disorder in the past year (**Figure 11**) compared with 7.8 percent of sexual majority adults.

Sexual minority adults were more likely than sexual majority adults to have disorders related to their use of alcohol, use or misuse of illicit drugs, use of marijuana, or misuse of pain relievers (**Figure 11**). About 1 in 10 sexual minority adults had an alcohol use disorder in the past year (10.8 percent) compared with about 1 in 16 sexual majority adults (6.1 percent). An estimated 7.8 percent of sexual minority adults had an illicit drug use disorder compared with 2.6 percent of sexual majority adults. Sexual minority adults were also more likely than sexual majority adults to have a marijuana use disorder (3.9 vs. 1.3 percent) or a pain reliever use disorder in the past year (2.0 vs. 0.7 percent). In addition, sexual minority adults were more likely than their sexual majority counterparts to have both an alcohol use disorder and an illicit drug use disorder in the past year (3.5 vs. 0.9 percent) (**Table B.16**).

By Sex

Similar to the pattern for all adults aged 18 or older, adult males and females who were sexual minorities were more likely than their sexual majority counterparts to have an SUD in the past year. An estimated 16.7 percent of sexual minority males and 14.0 percent of sexual minority females had an SUD in the past year (**Tables B.17** and **B.18** in **Appendix B**). Corresponding percentages for sexual majority adults were 10.6 percent for males and 5.1 percent for females.

Sexual minority males and females were also more likely than their sexual majority counterparts to have disorders related to their use of alcohol, use or misuse of illicit drugs, use of marijuana, or misuse of pain relievers (**Tables B.17** and **B.18**). An estimated 10.8 percent of sexual minority males and females had an alcohol use disorder in the past year compared with 8.3 percent of sexual majority males and 3.9 percent of sexual majority females. Sexual minority males and females were also more likely than sexual majority males and females to have had an illicit drug use disorder in the past year (9.6 and 6.6 percent for sexual minority males and females, respectively, vs. 3.7 and 1.6 percent for sexual majority males and females, respectively). An estimated 4.5 percent of sexual minority males and 3.5 percent of sexual minority females had a marijuana use disorder in the past year. In comparison, 1.9 percent of sexual majority males and 0.7 percent of sexual majority females had a marijuana use disorder.

Similarly, the 2.5 percent of sexual minority males and 1.7 percent of sexual minority females who had a pain reliever use disorder in the past year were higher than the corresponding percentages for sexual majority males and females (1.0 and 0.5 percent, respectively).

In addition, sexual minority males and females were more likely than their sexual majority counterparts to have both an alcohol use disorder and an illicit drug use disorder in the past year. For males, 3.7 percent of sexual minority males and 1.4 percent of sexual majority males had both alcohol and illicit drug use disorders in the past year. An estimated 3.4 percent of sexual minority females and 0.4 percent of sexual majority females had both alcohol and illicit drug use disorders in the past year.

By Age Group

In 2015, both young adults aged 18 to 25 and adults aged 26 and older who were sexual minorities were more likely to have an SUD compared with their sexual majority counterparts. An estimated 20.1 percent of sexual minority young adults had an SUD in the past year compared with 14.8 percent of sexual majority young adults (**Table B.19**). Among adults aged 26 or older, 12.8 percent of sexual minority adults had an SUD compared with 6.7 percent among adults in this age group who were part of the sexual majority (**Table B.20**).

Among young adults aged 18 to 25 and among adults aged 26 or older, those who were sexual minorities were also more likely than their sexual majority counterparts to have disorders related to their use of alcohol, use or misuse of illicit drugs, use of marijuana, or misuse of pain relievers (**Tables B.19** and **B.20**). An estimated 14.7 percent of sexual minority young adults had an alcohol use disorder in the past year compared with 10.6 percent of sexual majority young adults. Among adults aged 26 or older, 9.1 percent of sexual minority adults had an alcohol use disorder compared with 5.3 percent of sexual majority adults in this age group. An estimated 11.7 percent of sexual minority young adults and 6.8 percent of sexual majority young adults had an illicit drug use disorder in the past year. Among adults aged 26 or older, 6.0 percent of those who were sexual minorities had an illicit drug use disorder compared with 2.0 percent of those who were part of the sexual majority.

The percentages of sexual minority young adults aged 18 to 25 and adults aged 26 or older who had a marijuana use disorder in the past year (7.4 and 2.3 percent, respectively) were greater than the percentages among their sexual majority counterparts (4.9 and 0.7 percent, respectively). An

estimated 2.2 percent of sexual minority young adults and 1.1 percent of sexual majority young adults had a pain reliever use disorder in the past year. Among adults aged 26 or older, 2.0 percent of those who were sexual minorities had a pain reliever use disorder compared with 0.7 percent of those who were part of the sexual majority. In 2015, young adults and adults aged 26 and older who were sexual minorities were also more likely to have both an alcohol use disorder and illicit drug use disorder compared with their sexual majority counterparts (**Tables B.19** and **B.20**).

I. Need for Substance Use Treatment

NSDUH includes questions that are used to identify people who needed substance use treatment in the past year (i.e., treatment for problems related to the use of alcohol or illicit drugs). People are defined as needing substance use treatment if they had an SUD in the past year or if they received substance use treatment at a specialty facility in the past year. This section focuses on the need for substance use treatment for either alcohol or illicit drug use, alcohol use only, and illicit drug use only in the past year. For brevity, the need for treatment for the use of alcohol or illicit drugs is subsequently referred to as the need for "substance use treatment."

Most people who needed substance use treatment in the past year had past year SUDs regardless of their sexual identity. For example, 15.1 percent of sexual minority adults had an SUD in the past year (**Figure 11**), and 15.9 percent needed substance use treatment (**Table B.21** in **Appendix B**).

Among sexual majority adults, 7.8 percent had an SUD, and 8.1 percent needed substance use treatment.

This section presents percentages and estimated numbers of sexual minority adults who needed substance use treatment. Presenting estimated numbers can be useful to policymakers and program planners for assessing the need for substance use treatment services among sexual minorities. Statistical comparisons are made between the percentages of sexual minority and sexual majority adults who needed substance use treatment.
In 2015, 1.7 million sexual minority adults aged 18 or older needed substance use treatment, including 1.2 million sexual minority adults who needed treatment for their use of alcohol and 0.9 million who needed treatment for their use of illicit drugs. The number of sexual minority adults who needed treatment for their use of alcohol or for their use of illicit drugs includes adults who needed treatment for their use of both types of substances. As shown in **Table B.21** in **Appendix B**, higher percentages of sexual minority adults than sexual majority adults needed substance use treatment (15.9 vs. 8.1 percent), alcohol use treatment (11.5 vs. 6.3 percent), and illicit drug use treatment (8.4 vs. 2.9 percent).

By Sex

The 1.7 million sexual minority adults aged 18 or older who needed substance use treatment included 734,000 males and 927,000 females. The 734,000 sexual minority males who needed substance use treatment included 500,000 who needed treatment for their use of alcohol and 428,000 who needed treatment for their illicit drug use. As shown in **Table B.21** in **Appendix B**, higher percentages of sexual minority males than sexual majority males needed substance use treatment (17.5 vs.

11.0 percent), treatment for alcohol use (11.9 vs. 8.6 percent), and treatment for illicit drug use (10.2 vs. 4.0 percent).

Among the 927,000 sexual minority females who needed substance use treatment, 703,000 needed treatment for their use of alcohol, and 453,000 needed treatment for their use of illicit drugs. As shown in **Table B.21** in **Appendix B**, higher percentages of sexual minority females than sexual majority females needed substance use treatment (14.8 vs. 5.3 percent), treatment for alcohol use (11.2 vs. 4.1 percent), and treatment for illicit drug use (7.2 vs. 1.8 percent).

By Age Group

The 1.7 million sexual minority adults aged 18 or older who needed substance use treatment included 659,000 young adults aged 18 to 25 and 1.0 million adults aged 26 or older. The 659,000 sexual minority young adults who needed substance use treatment included 486,000 who needed treatment for their use of alcohol and 389,000 who needed treatment for their illicit drug use. As shown in **Table B.21** in **Appendix B**, higher percentages of sexual minority young adults than sexual majority young adults needed substance use treatment (20.4 vs. 15.1 percent), treatment for alcohol use (15.1 vs. 10.8 percent), and treatment for illicit drug use (12.1 vs. 7.1 percent).

Among the 1.0 million sexual minority adults aged 26 or older who needed substance use treatment, 717,000 needed treatment for their use of alcohol, and 492,000 needed treatment for their use of illicit drugs. As shown in **Table B.21** in **Appendix B**, higher percentages of sexual minority adults aged 26 or older than sexual majority adults in this age group needed substance use treatment (13.9 vs. 7.0 percent), treatment for alcohol use (9.9 vs. 5.6 percent), and treatment for illicit drug use (6.8 vs. 2.2 percent).

Receipt of Substance Use Treatment

NSDUH respondents who used alcohol or illicit drugs in their lifetime are asked whether they received treatment for their use of alcohol or illicit drugs in the 12 months prior to the interview date (i.e., the past year). Substance use treatment refers to treatment or counseling that was received for illicit drug or alcohol use or for medical problems associated with the use of illicit drugs or alcohol. NSDUH collects information on the receipt of any substance use treatment and receipt of substance use treatment at a specialty facility. Receipt of any substance use treatment includes treatment that was received in the past year at any location, such as a hospital (inpatient), rehabilitation facility (outpatient or inpatient), mental health center, emergency room, private doctor's office, prison or jail, or a self help group (e.g., such as Alcoholics Anonymous or Narcotics Anonymous). Receipt of substance use treatment at a specialty facility is defined as substance use treatment that an individual received at a hospital (only as an inpatient), a drug or alcohol rehabilitation facility (as an inpatient or outpatient), or a mental health center. The categories of any substance use treatment and treatment at a specialty facility are not mutually exclusive; substance use treatment at a specialty facility is included in estimates of any substance use treatment. People could report receiving treatment at more than one location.

This section focuses on adults who received any substance use treatment and treatment at specialty facilities. The section presents percentages and estimated numbers of sexual minority adults who received substance use treatment. Statistical comparisons are made between the percentages of sexual minority and sexual majority adults who received substance use treatment.

In 2015, approximately 340,000 sexual minority adults aged 18 or older received any substance use treatment in the past year for their use of alcohol or illicit drugs, and 254,000 received substance use treatment at a specialty facility. These numbers correspond to 3.3 percent of sexual minority adults who received any substance use treatment in the past year and 2.4 percent who received substance use treatment at a specialty facility (**Table B.22** in **Appendix B**).

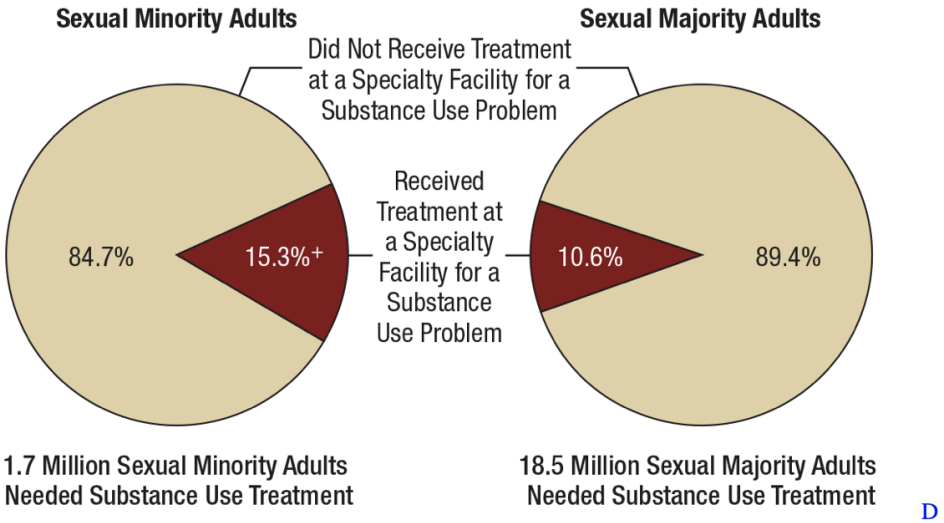
As previously noted, sexual minority adults were more likely than sexual majority adults to need substance use treatment. Sexual minority adults in 2015 were more likely than their sexual majority counterparts to receive any substance use treatment in the past year (3.3 vs. 1.3 percent) or to receive substance use treatment at a specialty facility (2.4 vs. 0.9 percent) (**Table B.22**). This pattern held among most subgroups by sex and age group. The one exception was that there was no significant difference for young adults aged 18 to 25 in the percentages of sexual minority and sexual majority adults who received any substance use treatment in the past year.

Receipt of Substance Use Treatment at a Specialty Facility among Adults Who Needed Treatment

Although sexual minority adults aged 18 or older were more likely than sexual majority adults to need substance use treatment, sexual minority adults who needed substance use treatment were more likely than their sexual majority counterparts to have received substance use treatment at a specialty facility in the past year. An estimated 15.3 percent of sexual minority adults who needed substance use treatment received treatment at a specialty facility compared with 10.6 percent of sexual majority adults who needed treatment (**Figure 12**). This higher percentage of sexual minority

adults who received treatment at a specialty facility among those who needed treatment was driven by the receipt of treatment at a specialty facility among sexual minority adults aged 26 or older who needed treatment. An estimated 18.7 percent of sexual minority adults aged 26 or older who needed substance use treatment received treatment at a specialty facility compared with 11.7 percent of their sexual majority counterparts (**Table B.23** in **Appendix B**). Nevertheless, most adults who needed substance use treatment did not receive treatment at a specialty facility regardless of their sexual identity.

Figure 12. Receipt of Specialty Treatment in the Past Year among Sexual Minority and Sexual Majority Adults Aged 18 or Older Who Needed Substance Use Treatment: Percentages, 2015



D

+ Difference between this estimate and the sexual majority estimate is statistically significant at the .05 level.
Note: The circles for sexual minority adults and sexual majority adults are not drawn to scale.
Note: Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight.

J. Mental Health Issues and Mental Health Service Use

Mental disorders are generally characterized by changes in mood, thought, or behavior. They can make carrying out daily activities difficult and can impair an individual's ability to work or function in school, interact with family, and fulfill other major life functions. This section focuses on past year mental illness and mental health service use among adults.

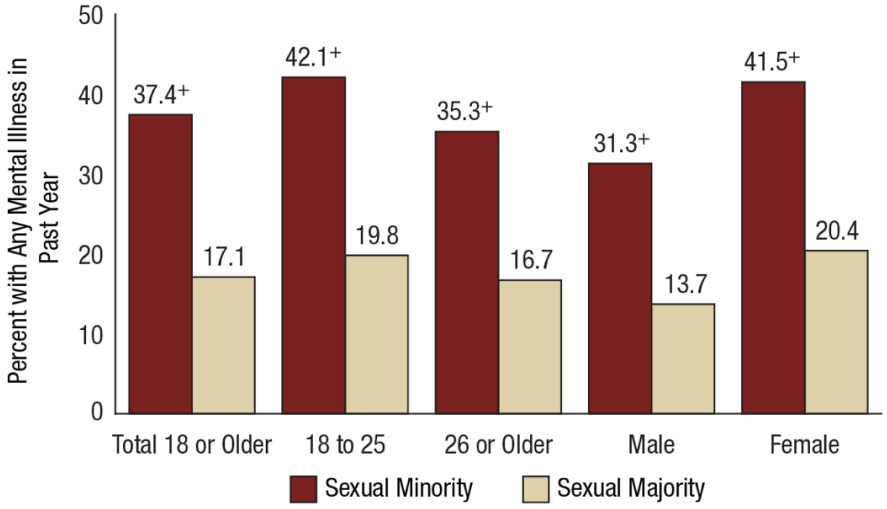
Past Year Mental Illness among Adults

NSDUH provides estimates of any mental illness (AMI) and serious mental illness (SMI) for adults aged 18 or older. Adults were defined as having AMI if they had any mental, behavioral, or emotional disorder in the past year that met DSM-IV criteria (excluding developmental disorders and SUDs). Adults with AMI were defined as having SMI if they had any mental, behavioral, or emotional disorder in the past year that substantially interfered with or limited one or more major life activities. AMI and SMI are not mutually exclusive categories; adults with SMI are included in estimates of adults with AMI. Adults with AMI who do not meet the criteria for having SMI are categorized as having AMI excluding SMI. This section includes past year estimates of adults with AMI, SMI, and AMI excluding SMI.

Among sexual minority adults aged 18 or older in 2015, 3.9 million had AMI, 1.4 million had SMI, and 2.5 million had AMI excluding SMI. These numbers correspond to 37.4 percent of sexual minority adults who had AMI (**Figure 13**), 13.1 percent who had SMI (**Figure 14**), and 24.3 percent who had AMI excluding SMI (**Figure 15**). The percentages of sexual minority

adults who had AMI, SMI, and AMI excluding SMI were greater than the corresponding percentages among sexual majority adults (17.1 percent who had AMI, 3.6 percent who had SMI, and 13.5 percent who had AMI without SMI).

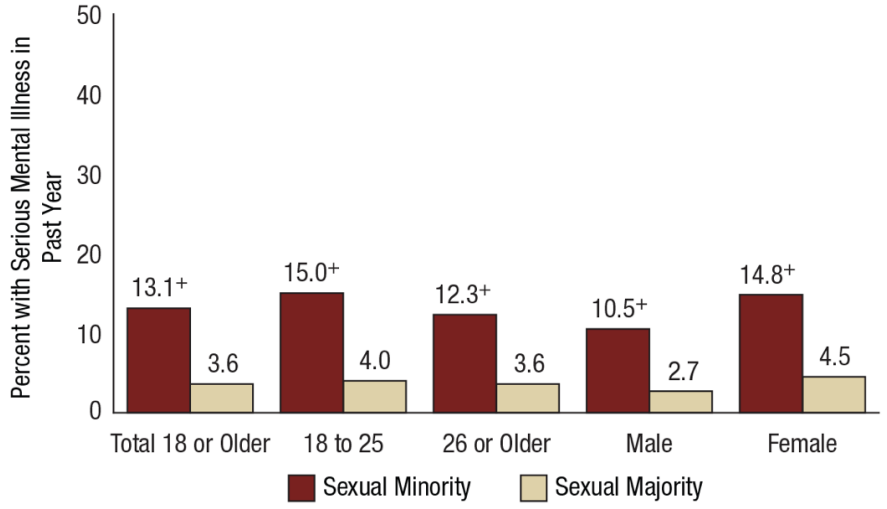
Figure 13. Any Mental Illness in the Past Year among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015



D

+ Difference between this estimate and the sexual majority estimate is statistically significant at the .05 level.
Note: Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight.

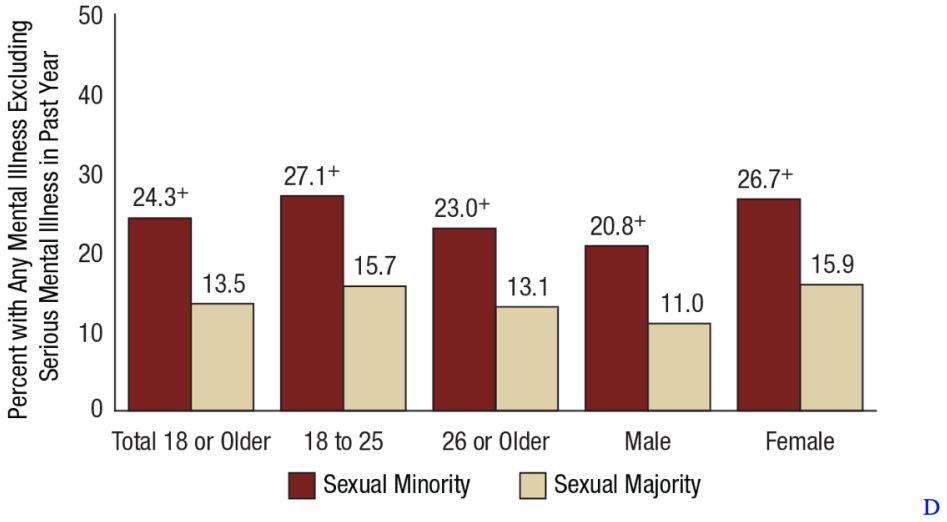
Figure 14. Serious Mental Illness in the Past Year among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015



D

+ Difference between this estimate and the sexual majority estimate is statistically significant at the .05 level.
Note: Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight.

Figure 15. Any Mental Illness Excluding Serious Mental Illness in the Past Year among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015



D

+ Difference between this estimate and the sexual majority estimate is statistically significant at the .05 level.
Note: Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight.

By Sex

The 3.9 million sexual minority adults in 2015 who had AMI included 1.3 million males and 2.6 million females. These numbers correspond to 31.3 percent of sexual minority males and 41.5 percent of sexual minority

females who had AMI in the past year (**Figure 13**). The percentages of sexual minority males and females who had AMI in the past year were greater than the corresponding percentages for sexual majority adults (13.7 percent for males and 20.4 percent for females).

The 1.4 million sexual minority adults in 2015 who had SMI included 441,000 males and 928,000 females. These numbers correspond to 10.5 percent of sexual minority males and 14.8 percent of sexual minority females who had SMI (**Figure 14**). The percentages of sexual minority males and females who had SMI in the past year were greater than the corresponding percentages for sexual majority adults (2.7 percent for males and 4.5 percent for females).

Among the 2.5 million sexual minority adults in 2015 who had AMI excluding SMI, 874,000 were male, and 1.7 million were female. These numbers correspond to 20.8 percent of sexual minority males and 26.7 percent of sexual minority females who had AMI without SMI (**Figure 15**). The percentages of sexual minority males and females who had AMI excluding SMI were greater than the corresponding percentages for sexual majority adults (11.0 percent for males and 15.9 percent for females).

By Age Group

The 3.9 million sexual minority adults in 2015 who had AMI included 1.4 million young adults aged 18 to 25 and 2.6 million adults aged 26 or older. These numbers correspond to 42.1 percent of sexual minority young adults and 35.3 percent of sexual minority adults aged 26 or older who had AMI (**Figure 13**). The percentages of sexual minorities who had AMI were greater than the corresponding percentages for sexual majority adults. An

estimated 19.8 percent of sexual majority young adults and 16.7 percent of sexual majority adults aged 26 or older had AMI.

The 1.4 million sexual minority adults in 2015 who had SMI included 484,000 young adults aged 18 to 25 and 886,000 adults aged 26 or older. These numbers correspond to 15.0 percent of sexual minority young adults and 12.3 percent of sexual minority adults aged 26 or older who had SMI (**Figure 14**). The percentages of sexual minorities who had SMI were greater than the corresponding percentages for sexual majority adults (4.0 percent of sexual majority young adults and 3.6 percent of sexual majority adults aged 26 or older).

Among the 2.5 million sexual minority adults in 2015 who had AMI excluding SMI, 875,000 were young adults aged 18 to 25, and 1.7 million were adults aged 26 or older. These numbers correspond to 27.1 percent of sexual minority young adults and 23.0 percent of sexual minority adults aged 26 or older who had AMI without SMI (**Figure 15**). The percentages of sexual minorities who had AMI excluding SMI were greater than the corresponding percentages for sexual majority adults (15.7 percent for young adults and 13.1 percent for adults aged 26 or older).

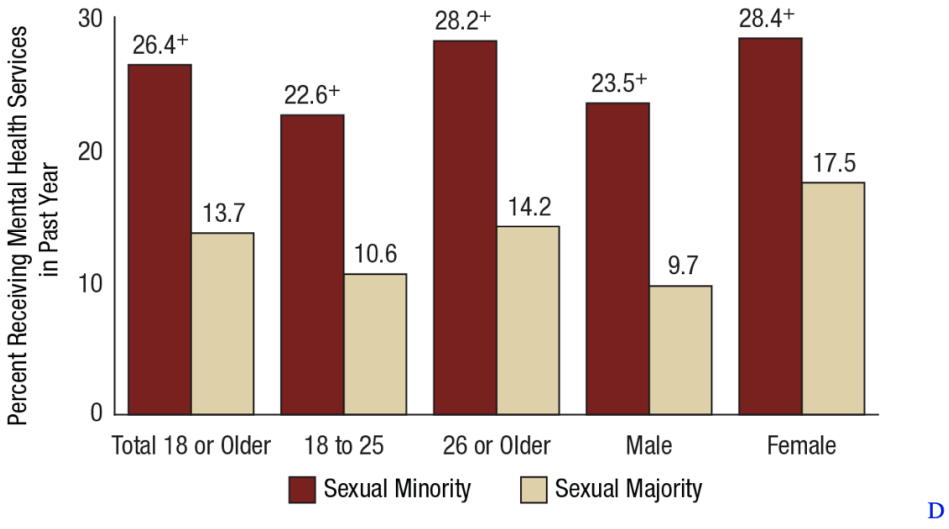
Mental Health Service Use among Adults

In NSDUH, all adults are asked whether they received treatment or counseling for any problem with emotions, "nerves," or mental health in the past year in any inpatient or outpatient setting or if they used prescription medication in the past year for a mental or emotional condition.

Respondents are asked not to include treatment for their use of alcohol or illicit drugs. The questions about the receipt of treatment or counseling for mental health issues do not ask specifically about treatment for a particular mental disorder. Consequently, references to treatment or counseling for any problem with emotions, nerves, or mental health are described broadly as "mental health service use."

This section presents percentages and estimated numbers of sexual minority adults who received mental health services. Statistical comparisons are made between the percentages of sexual minority and sexual majority adults who received mental health services.

Figure 16. Received Mental Health Services in the Past Year among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015

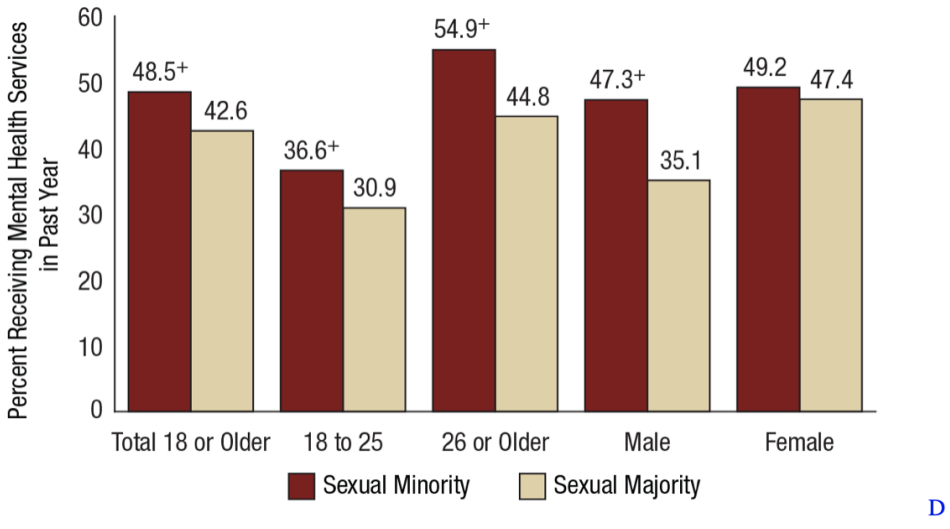


+ Difference between this estimate and the sexual majority estimate is statistically significant at the .05 level.
Note: Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight.

In 2015, an estimated 2.7 million sexual minority adults aged 18 or older received mental health services in the past year. A higher percentage of sexual minority adults than sexual majority adults received mental health services in the past year (26.4 vs. 13.7 percent) (**Figure 16**).

The 3.9 million sexual minority adults aged 18 or older in 2015 who had AMI in the past year included 1.9 million adults who received mental health services in the past year, or 48.5 percent of sexual minority adults with AMI (**Figure 17**). Among adults with AMI, a higher percentage of sexual minority adults than sexual majority adults received mental health services in the past year (48.5 vs. 42.6 percent). Taken together, about half or more of adults who had AMI did *not* receive mental health services in the past year, regardless of their sexual identity.

Figure 17. Received Mental Health Services in the Past Year among Sexual Minority and Sexual Majority Adults Aged 18 or Older with Any Mental Illness in the Past Year, by Age Group and Sex: Percentages, 2015



+ Difference between this estimate and the sexual majority estimate is statistically significant at the .05 level.
Note: Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight.

By Sex

Sexual minority males and females were more likely than their sexual majority counterparts to have disorders related to having received mental health care in the past year. An estimated 23.5 percent of sexual minority males and 28.4 percent sexual minority females received mental health care

in the past year (**Figure 16**). Corresponding percentages for sexual majority adults were 9.7 percent for males and 17.5 percent for females.
Sexual minority males with AMI were also more likely than their sexual majority counterparts to have received mental health services in the past year (47.3 vs. 35.1 percent) (**Figure 17**). Among females with AMI, similar percentages of sexual minority females and sexual majority females received mental health services in the past year.

By Age Group

Sexual minority young adults aged 18 to 25 and adults aged 26 or older were more likely than their sexual majority counterparts to have received mental health care in the past year. An estimated 22.6 percent of sexual minority young adults received mental health care in the past year (**Figure 16**) compared with 10.6 percent of sexual majority young adults. Among adults aged 26 or older, 28.2 percent of those who were sexual minorities received mental health care compared with 14.2 percent of sexual majority adults.

Similarly, among adults with AMI, higher percentages of sexual minority young adults and adults aged 26 or older received mental health services compared with their sexual majority counterparts. An estimated 36.6 percent of sexual minority young adults aged 18 to 25 with AMI received mental health care in the past year (**Figure 17**) compared with 30.9 percent of sexual majority young adults with AMI. However, the majority of young adults who had AMI did not receive mental health care in the past year, regardless of their sexual identity. Among adults aged 26 or older with AMI, 54.9 percent of those who were sexual minorities received mental health care compared with 44.8 percent of sexual majority adults.

Past Year Major Depressive Episode (MDE) and MDE with Severe Impairment

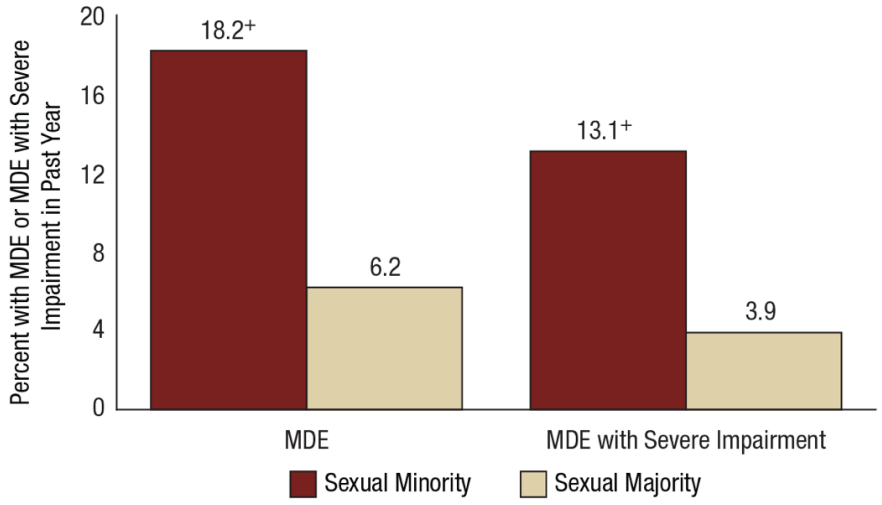
NSDUH also provides estimates of having a past year major depressive episode (MDE) among adults. MDE is defined using the diagnostic criteria from the DSM-IV.[24] Adults were defined as having an MDE if they had a period of 2 weeks or longer in the past 12 months when they experienced a depressed mood or loss of interest or pleasure in daily activities and if they had at least some additional symptoms, such as problems with sleep, eating, energy, concentration, and self-worth. Adults were defined as having an MDE with severe impairment if their depression caused severe problems with their ability to manage at home, manage well at work, have relationships with others, or have a social life.

This section presents percentages and estimated numbers of sexual minority adults who had a past year MDE. Statistical comparisons are made between the percentages of sexual minority and sexual majority adults who had a past year MDE.

In 2015, 1.9 million sexual minority adults aged 18 or older had an MDE in the past year, including 1.4 million who had an MDE with severe impairment in the past year. These numbers correspond to 18.2 percent of sexual minority adults who had an MDE in the past year and to 13.1 percent who had an MDE with severe impairment (**Figure 18**). Sexual minority adults were more likely than their sexual majority counterparts to have an MDE (18.2 vs. 6.2 percent) or to have had an MDE with severe impairment in the

past year (13.1 vs. 3.9 percent).

Figure 18. Major Depressive Episode (MDE) and MDE with Severe Impairment in the Past Year among Sexual Minority and Sexual Majority Adults Aged 18 or Older: Percentages, 2015



D

+ Difference between this estimate and the sexual majority estimate is statistically significant at the .05 level.
Note: Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight.

By Sex

The 1.9 million sexual minority adults in 2015 who had an MDE in the past year included 621,000 males and 1.3 million females. These numbers correspond to 14.8 percent of sexual minority males and 20.4 percent of sexual minority females who had an MDE in the past year (**Table B.14** in **Appendix B**). The percentages of sexual minority males and females who had an MDE in the past year were greater than the corresponding percentages for their sexual majority counterparts (4.3 percent for males and 8.0 percent for females).

The 1.4 million sexual minority adults in 2015 who had an MDE with severe impairment included 438,000 males and 922,000 females. These numbers correspond to 10.5 percent of sexual minority males and 14.9 percent sexual minority females who had an MDE with severe impairment in the past year (**Table B.14**). The percentages of sexual minority males and females who

had an MDE with severe impairment in the past year were greater than the corresponding percentages for sexual majority adults (2.7 percent for males and 5.0 percent for females).

By Age Group

The 1.9 million sexual minority adults in 2015 who had an MDE in the past year included 733,000 young adults aged 18 to 25 and 1.2 million adults aged 26 or older. These numbers correspond to 23.0 percent of sexual minority young adults and 16.0 percent of sexual minority adults aged 26 or older who had an MDE in the past year (**Table B.14**). These percentages for having an MDE in the past year were greater than the percentages for their sexual majority counterparts (9.0 percent of young adults and 5.8 percent of adults aged 26 or older).

The 1.4 million sexual minority adults in 2015 who had an MDE with severe impairment in the past year included 462,000 young adults aged 18 to 25 and 898,000 adults aged 26 or older. These numbers correspond to 14.6 percent of sexual minority young adults and 12.5 percent of sexual minority adults aged 26 or older who had an MDE with severe impairment in the past year (**Table B.14**). These percentages for having an MDE with severe impairment in the past year were greater than the percentages for their sexual majority counterparts (5.7 percent of young adults and 3.6 percent of adults aged 26 or older).

Discussion

Findings from the 2015 NSDUH on substance use and mental health issues for adults by sexual orientation are useful for understanding the health issues faced by sexual minorities in the United States. These findings contribute to that understanding by providing the first nationally

representative, federally collected comprehensive information on substance use and mental health issues among adults by sexual identity. However, this report provides only the first set of findings from a single year of NSDUH data on sexual identity. Additional years of data will allow for the analysis of a broader range of substance use and mental health topics, more detailed analysis across sexual minority subgroups, and a better understanding of the explanatory factors that underlie the descriptive information presented in this report.

As the survey continues to collect these data, a wider variety of analyses will be possible. In particular, additional years of data will allow changes to be tracked over time for substance use, SUDs, the need for and receipt of substance use treatment, mental health issues, and mental health service use for sexual minority subgroups. Trend data will also allow for the examination of underlying patterns of behaviors and issues faced by sexual minority groups over time. In addition, trends can be examined across subgroups of sexual minority adults and can be compared with corresponding trends for sexual majority adults. Ultimately, trend data will provide insight into the changing needs of sexual minority adults and will allow researchers and policymakers to make decisions accordingly.
In addition, the availability of NSDUH data from multiple survey years will help to deepen the understanding of issues that affect subgroups of sexual minority adults. In many situations, the differences discussed in this report between sexual majority (i.e., heterosexual) adults and sexual minority adults as a whole also were observed for subgroups of sexual minority adults. In other situations, however, the sample of approximately 3,000 sexual minority adults did not allow sufficient precision to make meaningful comparisons when data for sexual minority adults were further subdivided into sexual minority subgroups defined by sex or age group. With multiple

years of data, the improved precision of estimates for sexual minority subgroups will aid in making valid comparisons of substance use and mental health issues among sexual minority subgroups and with corresponding groups within the sexual majority. Future investigations also will be useful for better understanding the issues that may affect lesbians, bisexual women, gay men, and bisexual men differently.

A further consideration for future analysis of NSDUH data on sexual orientation concerns demographic differences among sexual minority subgroups. For example, NSDUH data have shown adult females to be more likely than adult males to have had an MDE in the past year. According to the 2015 NSDUH data, however, nearly three fourths of bisexual adults were women (**Table B.3** in **Appendix B**). Therefore, if the percentage of bisexual adults who had a past year MDE is greater than the percentage among heterosexual adults, then analysts need to rule out that this difference is not explained by the disproportionate representation of women among bisexual adults. Where subgroups of sexual minorities (e.g., sexual minority young adults, sexual minority women) are more likely than their sexual majority counterparts to be substance users or to experience mental health issues, however, readers can have greater confidence that differences between sexual minority and sexual majority adults are not completely explained by demographic differences. Nevertheless, analyses with additional years of data can allow statistical adjustments to be made to take into account demographic differences across sexual identity subgroups.

Finally, the NSDUH estimates in this report *describe* differences in substance use and mental health issues between sexual minority adults and those who identified as part of the heterosexual majority. However, the findings presented in this report do not *explain* the reasons for these differences,

such as the influence of stressors that are faced by sexual minorities but not by their sexual majority counterparts.[2,3,4,5,6] An important topic for future research will be further study of the factors that are associated with an increased likelihood of substance use or mental health issues among sexual minorities (i.e., risk factors) and factors among sexual minorities that are associated with a decreased likelihood of substance use or mental health issues (i.e., protective factors).

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and mental health: Results from the 2015 National Survey on Drug Use and Health. NSDUH Data Review. Retrieved from http://www.samhsa.gov/data/

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10. In this report, the terms "sexual minorities," "sexual majority," or similar terms are used broadly to refer to adults in the civilian, noninstitutionalized population that is covered by

NSDUH. Although some people in the general population of the United States are outside of the civilian, noninstitutionalized population, information from the 2010 census suggests that the civilian, noninstitutionalized population includes at least 97 percent of the total U.S. population. See the following reference: Lofquist, D., Lugaila, T., O'Connell, M., & Feliz, S. (2012, April). *Households and families: 2010* (C2010BR-14, 2010 Census Briefs). Retrieved from https://www.census.gov/prod/cen2010/briefs/c2010br-14.pdf

11. Details about the sample design, weighting, and interviewing results for the 2015 NSDUH are provided in Sections A.1, A.3.3, and B.3.1 of CBHSQ (2016). In particular, Tables A.1 and A.2 in CBHSQ (2016) provide sample design information on the targeted numbers of completed interviews by state and by age group, respectively. See the following reference: Center for Behavioral Health Statistics and Quality. (2016). *2015 National Survey on Drug Use and Health: Methodological summary and definitions.* Retrieved from http://www.samhsa.gov/data/
12. The screening procedure involves listing all household members in order to determine whether zero, one, or two individuals aged 12 or older should be selected for the interview.
13. An overall response rate is not calculated for adults because the screening response rate is not specific to age groups.
14. See the CBHSQ (2016) reference in endnote 11
15. Center for Behavioral Health Statistics and Quality. (2016). *2015 National Survey on Drug Use and Health:*

Summary of the effects of the 2015 NSDUH questionnaire redesign: Implications for data users. Retrieved from http://www.samhsa.gov/data/

16. Center for Behavioral Health Statistics and Quality. (2015). *National Survey on Drug Use and Health: 2014 and 2015 redesign changes.* Retrieved from http://www.samhsa.gov/data/
17. See Section C in CBHSQ (2016). See endnote 11 for the reference.
18. For a discussion of the criteria for suppressing (i.e., not publishing) unreliable estimates in NSDUH, see Section B.2.2 in CBHSQ (2016). See endnote 11 for the reference.
19. Center for Behavioral Health Statistics and Quality. (2014). *Results from the 2013 National Survey on Drug Use and Health: Summary of national findings* (HHS Publication No. SMA 14-4863, NSDUH Series H-48). Rockville, MD: Substance Abuse and Mental Health Services Administration.
20. The NSFG does not report percentages that are based on fewer than 100 respondents in the denominator or fewer than 5 respondents in the numerator. See the following reference: Copen, C. E., Chandra, A., & Febo-Vazquez, I. (2016). *Sexual behavior, sexual attraction, and sexual orientation among adults aged 18-44 in the United States: Data from the 2011-2013 National Survey of Family Growth* (National Health Statistics Reports No. 88). Hyattsville, MD: National Center for Health Statistics. Retrieved from http://www.cdc.gov/nchs/data/nhsr/nhsr088.pdf
21. If the majority of the GSS respondents who were coded as "blank" were actually heterosexual, then the estimates for

heterosexuality in the GSS would be more in line with the NSDUH estimates.

22. Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Retrieved from http://www.samhsa.gov/data/

23. In NSDUH, a "drink" is defined as a can or bottle of beer, a glass of wine or a wine cooler, a shot of liquor, or a mixed drink with liquor in it. Times when respondents only had a sip or two from a drink are not considered to be alcohol consumption.

24. American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (DSM-IV) (4th ed.). Washington, DC: Author.

25. The DSM-IV criteria for SUDs include separate criteria for dependence or abuse. Individuals who met the criteria for abuse for a given substance (e.g., alcohol) did not meet the criteria for dependence for that substance. For more information, see Section B.4.3 and the definitions for abuse and dependence in Section D of CBHSQ (2016). See endnote 11 for the reference.

26. Specialty treatment refers to substance use treatment at a hospital (only as an inpatient), a drug or alcohol rehabilitation facility (as an inpatient or outpatient), or a mental health center. This NSDUH definition historically has not considered emergency rooms, private doctors' offices, prisons or jails, and self-help groups to be specialty substance use treatment facilities.

27. The NSDUH definition of the need for treatment does not explicitly indicate the need for treatment at a specialty facility. People who had an SUD in the past year can be considered to

need some form of assistance for their problems with substance use. However, individuals who met DSM-IV criteria for abuse but not dependence may not necessarily need treatment at a specialty facility. For more information about the DSM-IV criteria for having an SUD, see Section B.4.3 and the definitions for abuse and dependence in Section D of CBHSQ (2016). See endnote 11 for the reference.

28. Because there were 20.8 million people aged 12 or older in 2015 with an SUD in the past year, about 96 percent of the people in 2015 who needed treatment for a substance use problem were defined as such because they had an SUD in the past year, regardless of whether they received substance use treatment at a specialty facility.

29. Estimates are not presented in this report for the receipt of any substance use treatment among sexual minority and sexual majority adults who needed substance use treatment because the detailed tables for the 2015 NSDUH do not present the corresponding estimates for all adults who needed treatment. However, the 2015 detailed tables present estimates for the receipt of substance use treatment at a specialty facility among all adults who needed treatment. The estimates of the receipt of substance use treatment at a specialty facility for adults in the sexual majority who needed treatment correspond closely to the corresponding estimates in the 2015 detailed tables for all adults who needed treatment.

30. In order to generate estimates of AMI and SMI in the United States, SAMHSA designed and implemented the Mental Health Surveillance Study (MHSS). Over the 5-year period from 2008 to 2012, a subsample of adults was selected from the main

study to participate in a follow-up telephone interview that obtained a detailed mental health assessment administered by trained mental health clinicians. The MHSS interview used the Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Non-patient Edition (SCID-I/NP). A prediction model created from clinical interview data that were collected from 2008 to 2012 was applied to data from the 2008 to 2014 NSDUHs to produce estimates of AMI for the entire NSDUH adult sample in these years. See the following reference: First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (2002). *Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Non-patient Edition (SCID-I/NP)*. New York, NY: New York State Psychiatric Institute, Biometrics Research.

31. Details about the definitions and estimation methods for mental illness estimates are provided in Section B.4.7 and Section D of CBHSQ (2016). See endnote 11 for the reference.
32. The specific questions used to measure MDE and a discussion of measurement issues are included in Section B.4.8 of CBHSQ (2016). See endnote 11 for the reference.
33. Adults were first asked whether they ever had a period in their lifetime lasting several days or longer when any of the following was true for most of the day: (a) feeling sad, empty or depressed; (b) feeling discouraged about how things were going in their lives; or (c) losing interest in most things they usually enjoy. Adults who reported any of these problems were asked further questions about having an MDE in their lifetime, including whether they had at least five of nine symptoms in the same 2-week period in their lifetime; at least one of the symptoms

needed to be having a depressed mood or loss of interest or pleasure in daily activities. Those who had lifetime MDE were asked if they had a period of time in the past 12 months when they felt depressed or lost interest or pleasure in daily activities for 2 weeks or longer, and they reported that they had some of their other lifetime MDE symptoms in the past 12 months. These adults were defined as having past year MDE. Data on MDE in the past year for adults have been available in NSDUH since 2005. Data on MDE with severe impairment for adults are available since 2009.

34. Center for Behavioral Statistics and Quality. (2014). *Results from the 2013 National Survey on Drug Use and Health: Mental health findings* (HHS Publication No. SMA 14-4887, NSDUH Series H-49). Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from http://www.samhsa.gov/data/

35.

Appendix A: Comparison of Data Sources for Sexual Attraction and Sexual Identity

This appendix presents information for the National Survey on Drug Use and Health (NSDUH) and three other surveys that collect data on sexual attraction and sexual identity among adults. Other surveys that collect information on sexual attraction and sexual identity include the following:

- General Social Survey (GSS),
- National Health Interview Survey (NHIS), and
- National Survey of Family Growth (NSFG).

Table A.1 summarizes information about these surveys, including the scope and purpose of each survey; the target population and sample characteristics; whether the survey collects data on sexual attraction, sexual identity, or both; the mode for collecting data on sexual attraction and sexual identity; and other relevant characteristics (e.g., where interviews are conducted, languages in which interviews can be conducted). Differences in these survey characteristics can affect estimates of sexual attraction and sexual identity.

In particular, the context in which the questions are presented can affect how respondents answer these questions. In all four surveys, the sexual attraction and sexual identity questions appear relatively late in the interview. Nevertheless, the context in which questions about sexual attraction and sexual identity are presented depends on the focus of a given survey. How respondents think about and answer questions about sexual attraction and sexual identity can depend on the general topics they have been thinking about before being asked these questions. Respondents might think about sexual attraction or sexual identity differently, depending on whether they are answering these questions in the broad context of questions about medical conditions and the use of health services (as in the NHIS), in the context of questions about reproductive health issues (as in the NSFG), or in the context of questions about substance use and mental health issues (as in NSDUH).

Also, data collection modes that allow respondents to answer questions themselves (i.e., self-administration) typically yield higher estimates for topics that could be considered sensitive compared with data collection modes that require respondents to report their answers to an interviewer. Respondents are more likely to report that sensitive topics apply

to them (e.g., being a sexual minority) if they can answer the questions without having to give their answer to an interviewer. Conversely, respondents may give answers to an interviewer that they think are socially desirable rather than reporting an applicable trait or behavior that they perceive to be less socially desirable. Also, the added privacy provided by self-administration can be important for encouraging truthful answers in household interview settings where other family members might be present.
Another issue that can affect estimates is who is asked the question and how missing data are handled. For example, the GSS design for administering questions results in some respondents not being asked the sexual identity question. Consequently, 8.7 percent of adults were coded as "not applicable" for sexual identity based on the data on the 2014 GSS public use file and were coded as "blank" in the GSS estimates in **Table B.2** in **Appendix B**. If most of these blanks were for adults who were heterosexual, then the percentage of adults who were classified as heterosexual based on the GSS data would be closer to the percentages from the other surveys.
In addition, **Table 2** in the main body of the report shows the sexual identity questions in these data sources, including NSDUH. The types of response options, the wording of response options, and the order in which response options are presented to respondents also can help to explain differences in estimates among surveys. For example, the NHIS includes a response option for "something else" that is not offered to respondents in the other surveys. Respondents in the other surveys could have chosen this "something else" category instead of the other categories if given the opportunity.
Additional methodological details for NSDUH can be found in a separate report on the web at http://www.samhsa.gov/data/.[5] Additional information about the methods for the other surveys in this appendix can be obtained from their respective websites and the references that were cited previously:[1,2,3]

- GSS: http://gss.norc.org;
- NHIS: http://www.cdc.gov/nchs/nhis.htm; and
- NSFG: http://www.cdc.gov/nchs/nsfg/index.htm.

Table A.1 – Summary of Study Characteristics for the National Survey on Drug Use and Health (NSDUH), National Health Interview Survey (NHIS), General Social Survey (GSS), and National Survey of Family Growth (NSFG)

Characteristic	NSDUH	NHIS	GSS	NSFG
Sponsor	Substance Abuse and Mental Health Services Administration (SAMHSA)	Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS)	NORC at the University of Chicago	CDC, NCHS
Most Recent Data	2015	2014	2014	2011-2013
Purpose and Scope	Provides estimates of substance use (tobacco, alcohol, illicit drugs), substance use disorders, mental health issues, and use of services for substance use or mental health issues.	Provides estimates for health status, access to care and insurance, health service utilization, and health behaviors.	Provides information about Americans' attitudes, beliefs, and behaviors for a variety of social issues, such as civil liberties, crime and violence, intergroup tolerance, morality, national spending priorities, psychological well-being, social mobility, stress, and traumatic events.	Initially designed to be the national fertility survey of the United States, with a focus on factors to explain trends and group differences in birth rates (e.g., contraception, infertility, sexual activity, and marriage).
Population	• Civilian noninstitutionalized population aged 12 or older. • Excludes active-duty military personnel, people in institutions (e.g., prisons, nursing homes), homeless people not in shelters. • Sexual attraction/identity questions are asked of adults aged 18 or older.	• Civilian noninstitutionalized population (no age limits). • Includes institutional group quarters (e.g., dormitories). • Family Core questionnaire collects information about all family members; completed by a family member of legal majority age in the state. • Sample Adult Core collects information from one adult aged 18 or older. • Sexual identity questions are included in the Sample Adult Core. • Sample Child Core collects information for a sampled child (if applicable), completed by a knowledgeable family member (e.g., a parent).	• Adult noninstitutionalized population in the continental United States.	• Noninstitutionalized population aged 15 to 44. • Active-duty military personnel who are living off base are eligible, but the number of active-duty military personnel in the NSFG is small. • Excludes people in institutions and those living on military bases.
Sample Characteristics and Estimates	• Sample in all 50 states and the District of Columbia. • Allows estimates at the national, regional, state, and substate levels. • Sample in 2015 was designed to yield about 25 percent of interviews from 12 to 17 year olds, 25 percent from 18 to 25 year olds, and 50 percent from adults aged 26 or older, including 15 percent from adults aged 26 to 34, 20 percent from adults aged 35 to 49, and 15 percent from adults aged 50 or older. • Final 2015 sample included 68,073 respondents aged 12 or older, including 51,118 adults aged 18 or older.	• Allows estimates at the national and regional levels and within regions by metropolitan and nonmetropolitan area status. • Adults aged 65 or older, blacks, and Hispanics have an increased probability of being selected as the sample adult. • The 2014 NHIS included data for 112,053 individuals for the Family Core, 36,697 adults for the Sample Adult Core, and 13,380 children for the Sample Child Core.	• Two parallel subsamples of approximately 1,500 respondents each per survey year, and each sample is further subdivided into three "ballots." • The total sample for 2014 was 3,464 adults. • Excludes Alaska and Hawaii. • Sexual identity questions are not administered to all respondents in a given survey year.	• National design, including Alaska and Hawaii. • Designed to yield about 20 percent of interviews from adolescents aged 15 to 19 and 55 percent of interviews from females. • The 2011-2013 NSFG had a sample size of 4,815 males and 5,601 females.
Response Rates	• Screening response rate of 79.7 percent in 2015 for dwelling units. • Interview response rate of 69.3 percent in 2015 for individuals aged 12 or older. • Overall response rate of 55.2 percent in 2015 for individuals aged 12 or older. • Interview response rate of 68.4 percent in 2015 for adults aged 18 or older. • An overall response rate is not calculated for adults because the screening response rate is not specific to age groups.	• Final Family Component response rate of 73.8 percent for 2014. • Final Sample Adult Component response rate of 58.9 percent for 2014. • Final Sample Child component response rate of 66.6 percent for 2014.	• Eligibility rate of 81.6 percent for 2014, defined as the net eligible sample among the original sample. • Response rate of 69.2 percent for 2014, defined as completed interviews among the net eligible sample.	• Overall response rate for 2011 2013 of 72.8 percent. • Sex-specific response rates of 73.4 percent for females and 72.1 percent for males in 2011 2013.

Frequency	Continuous since 1992.	Continuous since 1957.	Interviews conducted in February, March, and April and in even-numbered years since 1994.	Continuous since 2006.
Year in Which Sexual Attraction/Identity Questions Were Added	2015	2013	2008	2002
Interview Location	Respondents' place of residence.	Respondents' place of residence.	Respondents' place of residence.	Respondents' place of residence.
Languages	English or Spanish	English or Spanish	English or Spanish	English or Spanish
Includes Sexual Attraction Questions	Yes	No	No	Yes
Includes Sexual Identity Questions	Yes	Yes	Yes	Yes
Data Collection Mode for Sexual Attraction or Identity	ACASI; respondents enter their answers into a laptop computer after reading the questions on the computer screen or listening to the questions on headphones.	CAPI; interviewer reads questions to a respondent and then enters the respondent's answers into a laptop computer.	CASI; respondents enter their answers into a laptop computer after reading the questions on the computer screen.	ACASI; respondents enter their answers into a laptop computer after reading the questions on the computer screen or listening to the questions on headphones.
Other Issues	Since 2002, respondents who complete the interview receive a $30 incentive.	No monetary incentives to respondents to complete the interview.	No indication of monetary incentives to respondents to complete the interview.	• Since 2002, respondents who complete the interview receive a $40 incentive. • The category of "something else" was an available option for the sexual identity question in the 2002 and the 2006 to 2008 NSFGs, until it was dropped in July 2008.

ACASI = audio computer-assisted self-interviewing; CAPI = computer-assisted personal interviewing; CASI = computer-assisted self-interviewing.
Sources: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health.
Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), National Health Interview Survey.
NORC at the University of Chicago, General Social Survey.
CDC, NCHS, National Survey of Family Growth.

Appendix A Endnotes

1. NORC, University of Chicago. (2015). *General Social Surveys, 1972-2014: Cumulative codebook*. Retrieved from http://gss.norc.org/documents/codebook/
2. National Center for Health Statistics. (2015, June). *2014 National Health Interview Survey (NHIS) public use data release: Survey description*. Retrieved from ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHIS/2014/srvydesc.pdf
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4. Tourangeau, R., & Yan, T. (2007). Sensitive questions in surveys. *Psychological Bulletin, 133*, 859-883. doi:10.1037/0033-2909.133.5.859
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Appendix B: Supplemental Tables of Estimates for Sexual Attraction, Sexual Identity, and Substance Use and Mental Health Issues among Sexual Minority and Sexual Majority Adults

Table B.1 – Sexual Attraction among Adults Aged 18 to 44, by Age Group and Gender: Percentages, 2015 NSDUH and 2011-2013 National Survey of Family Growth (NSFG)

Gender/Sexual Attraction	NSDUH, 2015	NSFG,[1] 2011-2013
MALE AGED 18 TO 44		
Only or Mostly Attracted to Females	93.8 (0.26)	95.3* (0.45)
Equally Attracted to Females or Males	1.1 (0.11)	0.8 (0.21)
Only or Mostly Attracted to Males	2.8 (0.19)	2.3 (0.32)
Not Sure	1.3 (0.13)	0.7* (0.17)
Don't Know	0.4 (0.07)	**
Refused	0.6 (0.07)	**
Blank	0.0 (0.02)	**
FEMALE AGED 18 TO 44		
Only or Mostly Attracted to Males	90.5 (0.29)	93.4* (0.58)
Equally Attracted to Males or Females	4.3 (0.18)	3.2* (0.32)
Only or Mostly Attracted to Females	2.5 (0.14)	1.6* (0.22)
Not Sure	1.4 (0.11)	1.2 (0.25)
Don't Know	0.4 (0.07)	**
Refused	1.0 (0.10)	0.4* (0.11)
Blank	**	**

**Low precision; no estimate reported.
NOTE: Estimates shown are percentages with standard errors included in parentheses.
*Difference between this estimate and the NSDUH estimate is statistically significant at the .05 level.
[1] "Not ascertained" responses collected in the NSFG are erroneously skipped items and are shown in this table as blanks.
Sources: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2015.
Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Family Growth (NSFG), 2011-2013.

Table B.2 – Sexual Identity among Adults Aged 18 or Older, by Age Group and Gender: Percentages, 2015 NSDUH, 2014 National Health Interview Survey (NHIS), 2014 General Social Survey (GSS), and 2011-2013 National Survey of Family Growth (NSFG)

Gender/Sexual Identity	NSDUH, 2015, Aged 18 or Older	NHIS, 2014, Aged 18 or Older	GSS,[1] 2014, Aged 18 or Older	NSDUH, 2015, Aged 18-44	NSFG,[2] 2011-2013, Aged 18-44
TOTAL					
Heterosexual	94.0 (0.15)	94.5* (0.18)	87.2* (0.80)	92.1 (0.21)	93.6* (0.39)
Lesbian or Gay	1.8 (0.09)	1.6 (0.10)	1.6 (0.22)	2.1 (0.11)	1.6* (0.18)
Bisexual	2.5 (0.08)	0.7* (0.06)	2.5 (0.36)	4.0 (0.13)	3.7 (0.27)
Something Else[3]	N/A	0.2 (0.03)	N/A	N/A	N/A
Don't Know	0.6 (0.05)	0.4* (0.04)	0.0* (0.00)	0.6 (0.06)	0.2* (0.05)
Refused	1.0 (0.07)	0.6* (0.06)	0.0* (0.00)	1.2 (0.08)	**
Blank	0.1 (0.02)	2.1* (0.11)	8.7* (0.75)	0.0 (0.01)	0.1* (0.03)
MALE					
Heterosexual	95.1 (0.21)	94.6 (0.25)	88.7* (1.02)	94.5 (0.27)	95.0 (0.51)
Lesbian or Gay	2.2 (0.14)	1.8 (0.15)	2.1 (0.45)	2.3 (0.18)	1.9 (0.29)
Bisexual	1.4 (0.11)	0.4* (0.06)	1.7 (0.47)	1.8 (0.14)	2.0 (0.28)
Something Else[3]	N/A	0.2 (0.05)	N/A	N/A	N/A
Don't Know	0.4 (0.07)	0.3 (0.05)	0.0* (0.00)	0.5 (0.08)	**
Refused	0.8 (0.09)	0.5* (0.08)	0.0* (0.00)	0.9 (0.11)	**
Blank	0.1 (0.02)	2.2* (0.17)	7.5* (0.85)	0.0 (0.02)	**
FEMALE					
Heterosexual	92.9 (0.22)	94.3* (0.24)	86.0* (1.06)	89.6 (0.29)	92.2* (0.54)
Lesbian or Gay	1.5 (0.11)	1.3 (0.11)	1.1 (0.26)	1.8 (0.12)	1.3 (0.23)
Bisexual	3.5 (0.13)	1.0* (0.10)	3.2 (0.48)	6.3 (0.22)	5.5 (0.44)
Something Else[3]	N/A	0.2 (0.03)	N/A	N/A	N/A
Don't Know	0.8 (0.08)	0.4* (0.06)	0.0* (0.00)	0.8 (0.10)	**
Refused	1.2 (0.10)	0.6* (0.09)	0.0* (0.00)	1.5 (0.13)	0.7* (0.20)
Blank	0.1 (0.04)	2.1* (0.13)	9.6* (1.00)	**	**

**Low precision; no estimate reported.
N/A: Not applicable.
NOTE: Estimates shown are percentages with standard errors included in parentheses.
*Difference between this estimate and the NSDUH estimate is statistically significant at the .05 level. The NSFG aged 18-44 estimate is compared with the NSDUH aged 18-44 estimate.
[1] Respondents to this item who did not complete a supplemental set of questions were coded as "Not applicable" and are not distinguishable from the other missing responses in the public use data, so they were all coded as blank.
[2] "Not ascertained" responses collected in the NSFG are erroneously skipped items and are shown in this table as blanks.
[3] NHIS respondents who answered "Something else" were asked a follow-up question to clarify what they meant by "something else." Response choices in this question (in addition to "Refused" or "Don't know") were (1) You are not straight, but identify with another label such as queer, trisexual, omnisexual or pansexual; (2) You are transgender, transsexual or gender variant; (3) You have not figured out or are in the process of figuring out your sexuality; (4) You do not think of yourself as having sexuality; (5) You do not use labels to identity yourself; or (6) You mean something else.
Sources: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2015.
Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), National Health and Nutrition Examination Study (NHIS), 2014.
NORC at the University of Chicago, General Social Survey (GSS), 2014.
CDC, NCHS, National Survey of Family Growth (NSFG), 2011-2013.

Table B.3 – Demographic Characteristics among Adults Aged 18 or Older, by Sexual Orientation: Weighted Percentages, 2015

Demographic Characteristic	Heterosexual/Straight	Any Sexual Minority	Lesbian or Gay	Bisexual
TOTAL	100.0 (0.00)	100.0 (0.00)	100.0 (0.00)	100.0 (0.00)
AGE GROUP				
18-25	13.7 (0.20)	30.8* (1.11)	20.1* (1.39)	38.7* (1.55)
26 or Older	86.3 (0.20)	69.2* (1.11)	79.9* (1.39)	61.3* (1.55)
GENDER				
Male	48.8 (0.34)	40.2* (1.43)	57.9* (2.36)	27.2* (1.68)
Female	51.2 (0.34)	59.8* (1.43)	42.1* (2.36)	72.8* (1.68)
HISPANIC ORIGIN AND RACE				
Not Hispanic or Latino	84.8 (0.33)	81.8* (1.22)	80.8 (2.06)	82.5 (1.40)
White	65.5 (0.48)	60.4* (1.50)	62.5 (2.41)	58.9* (1.76)
Black or African American	11.7 (0.31)	12.8 (0.88)	12.4 (1.28)	13.2 (1.10)
American Indian or Alaska Native	0.5 (0.05)	0.8 (0.22)	0.7 (0.20)	0.9 (0.35)
Native Hawaiian or Other Pacific Islander	0.2 (0.03)	0.3 (0.10)	0.5 (0.22)	0.1 (0.06)
Asian	5.3 (0.25)	4.2 (0.67)	3.2* (0.73)	4.9 (1.02)
Two or More Races	1.5 (0.08)	3.2* (0.37)	1.6 (0.35)	4.4* (0.59)
Hispanic or Latino	15.2 (0.33)	18.2* (1.22)	19.2 (2.06)	17.5 (1.40)
EDUCATION				
< High School	13.7 (0.26)	14.1 (0.97)	10.9* (1.38)	16.4* (1.33)
High School Graduate	25.5 (0.33)	21.9* (1.03)	16.3* (1.56)	26.0 (1.37)
Some College or Associate's Degree	30.7 (0.34)	32.7 (1.35)	31.2 (2.27)	33.8 (1.54)
College Graduate	30.1 (0.43)	31.3 (1.40)	41.6* (2.39)	23.8* (1.61)
CURRENT EMPLOYMENT				
Full-Time	49.2 (0.37)	45.2* (1.40)	50.1 (2.32)	41.7* (1.66)
Part-Time	13.3 (0.22)	16.6* (0.91)	13.9 (1.43)	18.6* (1.15)
Unemployed	4.5 (0.13)	9.0* (0.77)	7.2* (1.07)	10.3* (1.08)
Other[1]	33.0 (0.38)	29.2* (1.43)	28.7 (2.47)	29.5* (1.65)

NOTE: Estimates shown are percentages with standard errors included in parentheses. Respondents with missing data for their sexual identity were excluded.
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
[1] The Other Employment category includes students, adults keeping house or caring for children full time, retired or disabled adults, or other persons not in the labor force.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Table B.4 – Types of Illicit Drugs Used in the Past Year among Adults Aged 18 or Older, by Sexual Identity

Drug	Heterosexual/Straight	Any Sexual Minority	Lesbian or Gay	Bisexual
ILLICIT DRUGS	17.1 (0.25)	39.1* (1.28)	34.7* (2.12)	42.4* (1.61)
Marijuana	12.9 (0.22)	30.7* (1.22)	26.1* (1.97)	34.1* (1.55)
Cocaine	1.8 (0.08)	5.1* (0.52)	4.3* (0.77)	5.8* (0.70)
Crack	0.3 (0.04)	0.6 (0.21)	0.5 (0.25)	0.7 (0.31)
Heroin	0.3 (0.03)	0.9* (0.19)	0.5 (0.23)	1.2* (0.29)
Hallucinogens	1.6 (0.07)	5.0* (0.50)	3.7* (0.75)	6.0* (0.64)
LSD	0.5 (0.03)	1.7* (0.27)	0.8 (0.25)	2.2* (0.43)
PCP	0.0 (0.01)	0.0 (0.01)	**	0.0 (0.02)
Ecstasy	0.9 (0.05)	3.2* (0.39)	2.5* (0.55)	3.8* (0.54)
Inhalants	0.3 (0.03)	3.7* (0.54)	5.8* (1.16)	2.1* (0.41)
Methamphetamine	0.6 (0.05)	2.3* (0.43)	2.6* (0.86)	2.1* (0.41)
Misuse of Psychotherapeutics	6.9 (0.15)	14.6* (0.87)	11.8* (1.30)	16.7* (1.15)
Pain Relievers	4.5 (0.12)	10.4* (0.74)	8.0* (1.17)	12.1* (0.98)
Tranquilizers	2.2 (0.08)	5.9* (0.59)	4.9* (0.90)	6.7* (0.76)
Stimulants	1.9 (0.07)	4.2* (0.43)	2.9 (0.55)	5.2* (0.60)
Sedatives	0.6 (0.05)	1.2* (0.23)	0.7 (0.26)	1.5* (0.35)

LSD = lysergic acid diethylamide; PCP = phencyclidine.
**Low precision; no estimate reported.
NOTE: Estimates shown are percentages with standard errors included in parentheses.
NOTE: Respondents with missing data for their sexual identity were excluded.
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Table B.5 – Types of Illicit Drugs Used in the Past Year among Males Aged 18 or Older, by Sexual Identity

Drug	Heterosexual/Straight	Any Sexual Minority	Gay	Bisexual
ILLICIT DRUGS	20.4 (0.39)	36.3* (2.22)	38.5* (2.86)	32.8* (3.33)
Marijuana	16.2 (0.35)	27.1* (2.00)	27.7* (2.68)	26.1* (2.96)
Cocaine	2.5 (0.13)	4.8* (0.87)	5.6* (1.18)	3.4 (1.25)
Crack	0.5 (0.07)	0.8 (0.33)	0.8 (0.43)	0.7 (0.53)
Heroin	0.4 (0.05)	0.8 (0.31)	0.8 (0.40)	0.9 (0.50)
Hallucinogens	2.2 (0.11)	5.3* (0.93)	4.8* (1.16)	6.0* (1.51)
LSD	0.7 (0.06)	1.9* (0.52)	1.1 (0.39)	3.0 (1.17)
PCP	0.0 (0.02)	0.0 (0.01)	**	0.0 (0.02)
Ecstasy	1.3 (0.09)	3.4* (0.72)	3.4* (0.81)	3.4 (1.29)
Inhalants	0.3 (0.04)	7.5* (1.29)	9.7* (1.97)	4.2* (1.18)
Methamphetamine	0.9 (0.08)	3.4* (0.96)	4.1* (1.46)	2.2 (0.90)
Misuse of Psychotherapeutics	7.9 (0.24)	12.5* (1.44)	12.6* (1.88)	12.4* (2.24)
Pain Relievers	5.4 (0.20)	8.6* (1.24)	8.9* (1.75)	8.1 (1.64)
Tranquilizers	2.4 (0.13)	5.2* (1.05)	5.0* (1.20)	5.5 (1.84)
Stimulants	2.3 (0.11)	3.5 (0.69)	3.4 (0.84)	3.6 (1.05)
Sedatives	0.5 (0.06)	0.9 (0.32)	0.9 (0.36)	1.0 (0.59)

LSD = lysergic acid diethylamide; PCP = phencyclidine.
**Low precision; no estimate reported.
NOTE: Estimates shown are percentages with standard errors included in parentheses.
NOTE: Respondents with missing data for their sexual identity were excluded.
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Table B.6 – Types of Illicit Drugs Used in the Past Year among Females Aged 18 or Older, by Sexual Identity

Drug	Heterosexual/Straight	Any Sexual Minority	Lesbian	Bisexual
ILLICIT DRUGS	13.9 (0.28)	41.1* (1.65)	29.6* (3.08)	45.9* (1.85)
Marijuana	9.8 (0.24)	33.2* (1.50)	24.0* (2.80)	37.1* (1.79)
Cocaine	1.1 (0.08)	5.4* (0.64)	2.4 (0.81)	6.7* (0.85)
Crack	0.2 (0.03)	0.6 (0.27)	0.1 (0.10)	0.8 (0.38)
Heroin	0.2 (0.03)	1.0* (0.25)	0.0* (0.03)	1.4* (0.35)
Hallucinogens	0.9 (0.07)	4.9* (0.54)	2.2 (0.77)	6.0* (0.69)
LSD	0.2 (0.03)	1.5* (0.28)	0.4 (0.23)	2.0* (0.38)
PCP	0.0 (0.02)	0.0 (0.02)	**	0.1 (0.03)
Ecstasy	0.5 (0.04)	3.2* (0.44)	1.4 (0.67)	3.9* (0.56)
Inhalants	0.2 (0.03)	1.1* (0.24)	0.5 (0.27)	1.3* (0.34)
Methamphetamine	0.3 (0.04)	1.6* (0.32)	0.4 (0.21)	2.1* (0.44)
Misuse of Psychotherapeutics	6.0 (0.19)	16.1* (1.13)	10.7* (1.85)	18.4* (1.34)
Pain Relievers	3.7 (0.15)	11.6* (1.01)	6.8* (1.52)	13.6* (1.23)
Tranquilizers	1.9 (0.10)	6.5* (0.71)	4.8 (1.49)	7.2* (0.78)
Stimulants	1.4 (0.08)	4.7* (0.54)	2.2 (0.60)	5.8* (0.70)
Sedatives	0.7 (0.07)	1.4* (0.31)	0.6 (0.30)	1.7* (0.42)

LSD = lysergic acid diethylamide; PCP = phencyclidine.
**Low precision; no estimate reported.
NOTE: Estimates shown are percentages with standard errors included in parentheses.
NOTE: Respondents with missing data for their sexual identity were excluded.
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Table B.7 – Types of Illicit Drugs Used in the Past Year among Adults Aged 18 to 25, by Sexual Identity

Drug	Heterosexual/Straight	Any Sexual Minority	Lesbian or Gay	Bisexual
ILLICIT DRUGS	36.1 (0.52)	54.0* (1.68)	57.3* (3.20)	52.8* (1.89)
Marijuana	31.0 (0.49)	46.2* (1.71)	49.3* (3.29)	45.0* (1.91)
Cocaine	5.0 (0.26)	8.9* (1.00)	10.6* (2.07)	8.3* (1.12)
Crack	0.3 (0.06)	0.2 (0.13)	0.3 (0.21)	0.2 (0.16)
Heroin	0.6 (0.08)	1.2 (0.39)	0.9 (0.66)	1.3 (0.48)
Hallucinogens	6.5 (0.29)	12.1* (1.22)	14.4* (3.04)	11.2* (1.17)
LSD	2.6 (0.18)	4.5* (0.68)	4.0 (1.16)	4.6* (0.82)
PCP	0.1 (0.04)	0.1 (0.05)	**	0.1 (0.06)
Ecstasy	3.8 (0.20)	7.1* (0.91)	9.3* (2.16)	6.3* (0.96)
Inhalants	1.2 (0.12)	3.5* (0.67)	6.5* (1.68)	2.3 (0.67)
Methamphetamine	0.8 (0.10)	2.0* (0.52)	1.6 (0.70)	2.2* (0.66)
Misuse of Psychotherapeutics	14.8 (0.38)	20.8* (1.31)	23.2* (2.44)	19.8* (1.48)
Pain Relievers	8.0 (0.27)	14.2* (1.10)	15.1* (2.16)	13.9* (1.29)
Tranquilizers	5.0 (0.22)	9.0* (1.00)	10.8* (2.13)	8.3* (1.06)
Stimulants	7.2 (0.29)	7.9 (0.86)	8.0 (1.48)	7.9 (1.04)
Sedatives	0.7 (0.08)	1.4* (0.31)	1.6 (0.54)	1.3 (0.38)

LSD = lysergic acid diethylamide; PCP = phencyclidine.
**Low precision; no estimate reported.
NOTE: Estimates shown are percentages with standard errors included in parentheses.
NOTE: Respondents with missing data for their sexual identity were excluded.
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Table B.8 – Types of Illicit Drugs Used in the Past Year among Adults Aged 26 or Older, by Sexual Identity

Drug	Heterosexual/Straight	Any Sexual Minority	Lesbian or Gay	Bisexual
ILLICIT DRUGS	14.1 (0.26)	32.5* (1.62)	29.1* (2.43)	35.7* (2.24)
Marijuana	10.1 (0.22)	23.9* (1.49)	20.3* (2.18)	27.3* (2.11)
Cocaine	1.3 (0.08)	3.4* (0.58)	2.7 (0.77)	4.2* (0.89)
Crack	0.3 (0.05)	0.8 (0.30)	0.6 (0.31)	1.1 (0.50)
Heroin	0.3 (0.04)	0.8* (0.22)	0.4 (0.23)	1.2* (0.36)
Hallucinogens	0.8 (0.06)	1.9* (0.39)	1.0 (0.38)	2.7* (0.68)
LSD	0.1 (0.02)	0.4 (0.23)	0.0 (0.05)	0.7 (0.45)
PCP	0.0 (0.01)	**	**	**
Ecstasy	0.4 (0.04)	1.5* (0.36)	0.9 (0.34)	2.2* (0.62)
Inhalants	0.1 (0.02)	3.7* (0.72)	5.6* (1.38)	2.0* (0.51)
Methamphetamine	0.6 (0.05)	2.4* (0.58)	2.8* (1.06)	2.1* (0.50)
Misuse of Psychotherapeutics	5.7 (0.16)	11.9* (1.08)	8.9* (1.46)	14.8* (1.60)
Pain Relievers	4.0 (0.14)	8.7* (0.95)	6.2 (1.33)	11.0* (1.37)
Tranquilizers	1.7 (0.09)	4.6* (0.71)	3.4 (0.93)	5.7* (1.07)
Stimulants	1.0 (0.06)	2.6* (0.46)	1.6 (0.55)	3.4* (0.69)
Sedatives	0.5 (0.05)	1.1 (0.28)	0.5 (0.25)	1.6* (0.49)

LSD = lysergic acid diethylamide; PCP = phencyclidine.
**Low precision; no estimate reported.
NOTE: Estimates shown are percentages with standard errors included in parentheses.
NOTE: Respondents with missing data for their sexual identity were excluded.
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Table B.9 – Tobacco Product and Alcohol Use in the Past Month among Adults Aged 18 or Older, by Sexual Identity

Substance	Heterosexual/Straight	Any Sexual Minority	Lesbian or Gay	Bisexual
TOBACCO PRODUCTS	25.5 (0.29)	35.4* (1.27)	33.9* (2.08)	36.4* (1.58)
Cigarettes	20.6 (0.28)	32.2* (1.23)	30.9* (2.04)	33.2* (1.53)
Daily Cigarette Smoking[1]	59.6 (0.68)	51.6* (2.21)	51.1* (3.80)	51.8* (2.60)
Smoked 1+ Packs of Cigarettes per Day[2]	41.8 (0.90)	32.5* (2.96)	44.3 (5.39)	24.6* (3.08)
Smokeless Tobacco	3.7 (0.12)	1.3* (0.25)	1.4* (0.45)	1.3* (0.29)
Cigars	4.9 (0.14)	7.1* (0.61)	6.5 (1.07)	7.5* (0.74)
Pipe Tobacco	0.9 (0.06)	1.6* (0.30)	1.5 (0.51)	1.7* (0.36)
ALCOHOL	56.2 (0.35)	63.6* (1.46)	65.6* (2.36)	62.1* (1.79)
Binge Alcohol Use	26.7 (0.30)	36.1* (1.30)	35.2* (2.07)	36.8* (1.62)
Heavy Alcohol Use	7.1 (0.16)	8.2 (0.63)	8.8 (1.11)	7.8 (0.76)

NOTE: Estimates shown are percentages with standard errors included in parentheses.
NOTE: Respondents with missing data for their sexual identity were excluded.
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
[1] Percentages for daily cigarette smoking are among past month cigarette smokers.
[2] Percentages for smoking one or more packs of cigarettes per day are among daily cigarette smokers in the past month. Respondents with missing data for number of cigarettes smoked per day were excluded from the analysis.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Table B.10 – Tobacco Product and Alcohol Use in the Past Month among Males Aged 18 or Older, by Sexual Identity

Substance	Heterosexual/Straight	Any Sexual Minority	Gay	Bisexual
TOBACCO PRODUCTS	32.2 (0.43)	32.6 (2.11)	32.8 (2.91)	32.2 (3.30)
Cigarettes	23.6 (0.39)	29.3* (2.08)	30.2* (2.85)	28.0 (3.12)
Daily Cigarette Smoking[1]	57.2 (0.96)	47.5* (4.33)	49.2 (5.74)	**
Smoked 1+ Packs of Cigarettes per Day[2]	46.9 (1.23)	**	**	**
Smokeless Tobacco	7.0 (0.23)	1.4* (0.41)	1.0* (0.53)	2.0* (0.66)
Cigars	8.2 (0.26)	7.4 (1.15)	7.2 (1.68)	7.7 (1.82)
Pipe Tobacco	1.5 (0.10)	2.0 (0.58)	2.1 (0.85)	1.9 (0.66)
ALCOHOL	61.6 (0.49)	62.8 (2.40)	66.0 (3.04)	57.8 (3.69)
Binge Alcohol Use	32.3 (0.46)	33.2 (2.25)	36.2 (2.94)	28.4 (3.34)
Heavy Alcohol Use	9.9 (0.27)	8.6 (1.19)	9.2 (1.63)	7.6 (1.74)

**Low precision; no estimate reported.
NOTE: Estimates shown are percentages with standard errors included in parentheses.
NOTE: Respondents with missing data for their sexual identity were excluded.
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
[1] Percentages for daily cigarette smoking are among past month cigarette smokers.
[2] Percentages for smoking one or more packs of cigarettes per day are among daily cigarette smokers in the past month. Respondents with missing data for number of cigarettes smoked per day were excluded from the analysis.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Table B.11 – Tobacco Product and Alcohol Use in the Past Month among Females Aged 18 or Older, by Sexual Identity

Substance	Heterosexual/Straight	Any Sexual Minority	Lesbian	Bisexual
TOBACCO PRODUCTS	19.1 (0.36)	37.2* (1.57)	35.4* (2.88)	38.0* (1.80)
Cigarettes	17.8 (0.35)	34.2* (1.51)	31.8* (2.74)	35.2* (1.77)
Daily Cigarette Smoking[1]	62.5 (0.99)	53.9* (2.56)	53.6 (4.90)	54.0* (2.83)
Smoked 1+ Packs of Cigarettes per Day[2]	36.0 (1.28)	25.7* (2.81)	**	22.2* (3.16)
Smokeless Tobacco	0.6 (0.07)	1.3* (0.32)	2.0 (0.78)	1.0 (0.32)
Cigars	1.8 (0.09)	6.8* (0.69)	5.5* (1.09)	7.4* (0.80)
Pipe Tobacco	0.3 (0.05)	1.3* (0.32)	0.7 (0.29)	1.6* (0.43)
ALCOHOL	51.0 (0.47)	64.1* (1.81)	65.1* (3.48)	63.7* (1.98)
Binge Alcohol Use	21.3 (0.37)	38.1* (1.62)	33.7* (2.83)	39.9* (1.90)
Heavy Alcohol Use	4.4 (0.18)	8.0* (0.69)	8.2* (1.38)	7.9* (0.81)

**Low precision; no estimate reported.
NOTE: Estimates shown are percentages with standard errors included in parentheses.
NOTE: Respondents with missing data for their sexual identity were excluded.
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
[1] Percentages for daily cigarette smoking are among past month cigarette smokers.
[2] Percentages for smoking one or more packs of cigarettes per day are among daily cigarette smokers in the past month. Respondents with missing data for number of cigarettes smoked per day were excluded from the analysis.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Table B.12 – Tobacco Product and Alcohol Use in the Past Month among Adults Aged 18 to 25, by Sexual Identity

Substance	Heterosexual/Straight	Any Sexual Minority	Lesbian or Gay	Bisexual
TOBACCO PRODUCTS	31.9 (0.50)	44.2* (1.55)	47.8* (2.95)	42.8* (1.84)
Cigarettes	25.5 (0.48)	39.7* (1.49)	44.5* (2.95)	37.9* (1.76)
Daily Cigarette Smoking[1]	41.3 (1.06)	46.5 (2.60)	41.1 (4.58)	49.0* (3.16)
Smoked 1+ Packs of Cigarettes per Day[2]	23.7 (1.24)	13.3* (2.41)	**	11.3* (2.63)
Smokeless Tobacco	5.9 (0.24)	1.4* (0.32)	1.7* (0.62)	1.3* (0.38)
Cigars	8.7 (0.28)	11.1* (1.06)	10.8 (2.10)	11.1* (1.20)
Pipe Tobacco	1.7 (0.13)	1.8 (0.38)	1.6 (0.63)	1.9 (0.47)
ALCOHOL	58.1 (0.55)	64.1* (1.64)	73.4* (2.68)	60.6 (1.91)
Binge Alcohol Use	38.7 (0.54)	44.6* (1.67)	53.0* (3.14)	41.4 (1.96)
Heavy Alcohol Use	11.0 (0.36)	10.2 (0.93)	11.9 (1.93)	9.6 (1.04)

**Low precision; no estimate reported.
NOTE: Estimates shown are percentages with standard errors included in parentheses.
NOTE: Respondents with missing data for their sexual identity were excluded.
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
[1] Percentages for daily cigarette smoking are among past month cigarette smokers.
[2] Percentages for smoking one or more packs of cigarettes per day are among daily cigarette smokers in the past month. Respondents with missing data for number of cigarettes smoked per day were excluded from the analysis.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Table B.13 – Tobacco Product and Alcohol Use in the Past Month among Adults Aged 26 or Older, by Sexual Identity

Substance	Heterosexual/Straight	Any Sexual Minority	Lesbian or Gay	Bisexual
TOBACCO PRODUCTS	24.5 (0.33)	31.4* (1.63)	30.4* (2.46)	32.4* (2.16)
Cigarettes	19.8 (0.32)	28.9* (1.60)	27.5* (2.40)	30.3* (2.12)
Daily Cigarette Smoking[1]	63.3 (0.78)	54.6* (3.13)	55.2 (5.01)	54.1* (3.82)
Smoked 1+ Packs of Cigarettes per Day[2]	44.2 (0.99)	42.5 (4.11)	**	34.0* (4.80)
Smokeless Tobacco	3.4 (0.13)	1.3* (0.34)	1.3* (0.54)	1.3* (0.41)
Cigars	4.3 (0.15)	5.3 (0.74)	5.4 (1.24)	5.2 (1.00)
Pipe Tobacco	0.7 (0.07)	1.5* (0.40)	1.5 (0.62)	1.6 (0.52)
ALCOHOL	55.9 (0.39)	63.4* (1.90)	63.7* (2.82)	63.1* (2.52)
Binge Alcohol Use	24.8 (0.32)	32.3* (1.70)	30.7* (2.42)	33.9* (2.32)
Heavy Alcohol Use	6.5 (0.18)	7.3 (0.83)	8.0 (1.30)	6.7 (1.05)

**Low precision; no estimate reported.
NOTE: Estimates shown are percentages with standard errors included in parentheses.
NOTE: Respondents with missing data for their sexual identity were excluded.
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
[1] Percentages for daily cigarette smoking are among past month cigarette smokers.
[2] Percentages for smoking one or more packs of cigarettes per day are among daily cigarette smokers in the past month. Respondents with missing data for number of cigarettes smoked per day were excluded from the analysis.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Table B.14 – Major Depressive Episode (MDE) and MDE with Severe Impairment in the Past Year among Adults Aged 18 or Older, by Sexual Identity, Age Group, and Gender

Mental Illness/Characteristic	Heterosexual/Straight	Any Sexual Minority	Lesbian or Gay	Bisexual
MDE	6.2 (0.15)	18.2* (0.97)	11.4* (1.28)	23.2* (1.36)
18-25	9.0 (0.28)	23.0* (1.36)	15.8* (2.05)	25.8* (1.68)
26 or Older	5.8 (0.17)	16.0* (1.26)	10.3* (1.51)	21.5* (1.95)
Male	4.3 (0.18)	14.8* (1.60)	11.1* (1.81)	20.7* (2.89)
Female	8.0 (0.24)	20.4* (1.24)	11.8* (1.79)	24.1* (1.52)
MDE WITH SEVERE IMPAIRMENT	3.9 (0.12)	13.1* (0.89)	9.3* (1.22)	15.9* (1.22)
18-25	5.7 (0.23)	14.6* (1.14)	11.4* (1.89)	15.8* (1.34)
26 or Older	3.6 (0.14)	12.5* (1.18)	8.8* (1.45)	16.0* (1.79)
Male	2.7 (0.14)	10.5* (1.43)	8.7* (1.74)	13.2* (2.44)
Female	5.0 (0.19)	14.9* (1.12)	10.0* (1.69)	17.0* (1.36)

NOTE: Estimates shown are percentages with standard errors included in parentheses.
NOTE: Respondents with missing data for their sexual identity were excluded.
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Table B.15 – Level of Mental Illness in the Past Year among Adults Aged 18 or Older, by Sexual Identity, Age Group, and Gender

Mental Illness/Characteristic	Heterosexual/Straight	Any Sexual Minority	Lesbian or Gay	Bisexual
AMI	17.1 (0.25)	37.4* (1.28)	27.1* (1.84)	44.9* (1.63)
18-25	19.8 (0.39)	42.1* (1.54)	31.4* (2.75)	46.2* (1.79)
26 or Older	16.7 (0.28)	35.3* (1.70)	26.1* (2.24)	44.1* (2.43)
Male	13.7 (0.32)	31.3* (2.08)	27.0* (2.56)	38.0* (3.46)
Female	20.4 (0.36)	41.5* (1.62)	27.3* (2.71)	47.5* (1.85)
SMI	3.6 (0.12)	13.1* (0.85)	9.6* (1.28)	15.7* (1.14)
18-25	4.0 (0.20)	15.0* (1.13)	10.0* (1.78)	16.9* (1.44)
26 or Older	3.6 (0.13)	12.3* (1.11)	9.5* (1.53)	14.9* (1.59)
Male	2.7 (0.14)	10.5* (1.37)	9.6* (1.83)	11.8* (2.08)
Female	4.5 (0.18)	14.8* (1.09)	9.5* (1.71)	17.1* (1.34)
AMI EXCLUDING SMI	13.5 (0.22)	24.3* (1.13)	17.5* (1.55)	29.3* (1.53)
18-25	15.7 (0.37)	27.1* (1.37)	21.4* (2.31)	29.3* (1.75)
26 or Older	13.1 (0.24)	23.0* (1.49)	16.6 (1.85)	29.2* (2.20)
Male	11.0 (0.29)	20.8* (1.80)	17.3* (2.19)	26.2* (3.09)
Female	15.9 (0.31)	26.7* (1.41)	17.8 (2.25)	30.4* (1.67)

AMI = any mental illness; SMI = serious mental illness.
NOTE: Estimates shown are percentages with standard errors included in parentheses.
NOTE: Respondents with missing data for their sexual identity were excluded.
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Table B.16 – Substance Use Disorder for Specific Substances in the Past Year among Adults Aged 18 or Older, by Sexual Identity

Past Year Use Disorder	Heterosexual/Straight	Any Sexual Minority	Lesbian or Gay	Bisexual
ILLICIT DRUGS	2.6 (0.09)	7.8* (0.70)	8.1* (1.27)	7.5* (0.72)
Marijuana	1.3 (0.06)	3.9* (0.45)	3.8* (0.79)	3.9* (0.48)
Cocaine	0.3 (0.03)	1.0* (0.24)	0.8 (0.30)	1.1* (0.35)
Heroin	0.2 (0.02)	0.6* (0.16)	0.3 (0.17)	0.8* (0.25)
Hallucinogens	0.1 (0.01)	0.4* (0.13)	0.4 (0.21)	0.4* (0.18)
Inhalants	0.0 (0.01)	0.1 (0.08)	0.3 (0.19)	**
Methamphetamine	0.3 (0.03)	1.0* (0.31)	1.6 (0.68)	0.6 (0.20)
Misuse of Psychotherapeutics	1.0 (0.05)	2.8* (0.43)	2.5* (0.72)	3.0* (0.49)
Pain Relievers	0.7 (0.05)	2.0* (0.36)	1.7 (0.63)	2.3* (0.43)
Tranquilizers	0.2 (0.02)	0.9* (0.28)	1.0 (0.55)	0.8* (0.24)
Stimulants	0.1 (0.02)	0.5* (0.17)	0.3 (0.28)	0.7* (0.20)
Sedatives	0.1 (0.01)	0.0 (0.02)	**	0.0 (0.03)
ALCOHOL	6.1 (0.14)	10.8* (0.77)	9.5* (1.18)	11.8* (0.97)
BOTH ILLICIT DRUGS AND ALCOHOL	0.9 (0.05)	3.5* (0.47)	3.1* (0.77)	3.8* (0.55)
ILLICIT DRUGS OR ALCOHOL	7.8 (0.16)	15.1* (0.96)	14.5* (1.55)	15.5* (1.07)

**Low precision; no estimate reported.
NOTE: Estimates shown are percentages with standard errors included in parentheses.
NOTE: Respondents with missing data for their sexual identity were excluded.
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Table B.17 – Substance Use Disorder for Specific Substances in the Past Year among Males Aged 18 or Older, by Sexual Identity

Past Year Use Disorder	Heterosexual/Straight	Any Sexual Minority	Gay	Bisexual
ILLICIT DRUGS	3.7 (0.15)	9.6* (1.40)	11.1* (2.04)	7.3* (1.51)
Marijuana	1.9 (0.10)	4.5* (0.87)	4.7* (1.23)	4.1* (1.09)
Cocaine	0.5 (0.06)	1.1 (0.39)	1.0 (0.46)	1.2 (0.68)
Heroin	0.3 (0.04)	0.6 (0.26)	0.5 (0.30)	0.7 (0.49)
Hallucinogens	0.1 (0.02)	0.6 (0.30)	0.6 (0.36)	**
Inhalants	0.0 (0.02)	0.3 (0.20)	0.5 (0.32)	**
Methamphetamine	0.5 (0.06)	1.8 (0.73)	2.6 (1.16)	0.5 (0.42)
Misuse of Psychotherapeutics	1.2 (0.08)	3.2* (0.84)	3.5 (1.20)	2.9 (1.06)
Pain Relievers	1.0 (0.07)	2.5* (0.76)	2.4 (1.06)	2.6 (1.04)
Tranquilizers	0.3 (0.04)	1.0 (0.57)	1.5 (0.93)	0.2 (0.18)
Stimulants	0.2 (0.03)	0.4 (0.31)	**	0.3 (0.21)
Sedatives	0.1 (0.02)	0.0* (0.01)	**	0.0 (0.02)
ALCOHOL	8.3 (0.25)	10.8* (1.26)	11.5 (1.74)	9.8 (1.84)
BOTH ILLICIT DRUGS AND ALCOHOL	1.4 (0.09)	3.7* (0.84)	4.4* (1.25)	2.6 (0.88)
ILLICIT DRUGS OR ALCOHOL	10.6 (0.27)	16.7* (1.69)	18.2* (2.37)	14.5 (2.17)

**Low precision; no estimate reported.
NOTE: Estimates shown are percentages with standard errors included in parentheses.
NOTE: Respondents with missing data for their sexual identity were excluded.
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Table B.18 – Substance Use Disorder for Specific Substances in the Past Year among Females Aged 18 or Older, by Sexual Identity

Past Year Use Disorder	Heterosexual/Straight	Any Sexual Minority	Lesbian	Bisexual
ILLICIT DRUGS	1.6 (0.09)	6.6* (0.67)	4.1* (0.93)	7.6* (0.85)
Marijuana	0.7 (0.06)	3.5* (0.45)	2.6* (0.75)	3.9* (0.55)
Cocaine	0.2 (0.04)	0.9* (0.30)	0.4 (0.33)	1.1* (0.40)
Heroin	0.1 (0.02)	0.6* (0.20)	0.0* (0.03)	0.9* (0.29)
Hallucinogens	0.0 (0.01)	0.3* (0.11)	0.1 (0.08)	0.4* (0.15)
Inhalants	0.0 (0.00)	**	**	0.0 (0.01)
Methamphetamine	0.2 (0.03)	0.5 (0.16)	0.1 (0.10)	0.7* (0.22)
Misuse of Psychotherapeutics	0.7 (0.07)	2.5* (0.41)	1.2 (0.45)	3.1* (0.53)
Pain Relievers	0.5 (0.06)	1.7* (0.32)	0.8 (0.35)	2.2* (0.43)
Tranquilizers	0.2 (0.03)	0.8* (0.24)	0.3 (0.25)	1.0* (0.32)
Stimulants	0.1 (0.02)	0.6* (0.19)	0.1 (0.11)	0.8* (0.26)
Sedatives	0.1 (0.02)	0.0 (0.03)	**	0.0 (0.04)
ALCOHOL	3.9 (0.15)	10.8* (0.91)	6.8* (1.29)	12.5* (1.13)
BOTH ILLICIT DRUGS AND ALCOHOL	0.4 (0.05)	3.4* (0.51)	1.4* (0.44)	4.3* (0.69)
ILLICIT DRUGS OR ALCOHOL	5.1 (0.17)	14.0* (1.02)	9.5* (1.55)	15.8* (1.23)

**Low precision; no estimate reported.
NOTE: Estimates shown are percentages with standard errors included in parentheses.
NOTE: Respondents with missing data for their sexual identity were excluded.
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Table B.19 – Substance Use Disorder for Specific Substances in the Past Year among Adults Aged 18 to 25, by Sexual Identity

Past Year Use Disorder	Heterosexual/Straight	Any Sexual Minority	Lesbian or Gay	Bisexual
ILLICIT DRUGS	6.8 (0.26)	11.7* (1.12)	14.2* (2.24)	10.8* (1.23)
Marijuana	4.9 (0.22)	7.4* (0.86)	8.9* (1.81)	6.8 (0.95)
Cocaine	0.6 (0.09)	1.2 (0.37)	1.2 (0.78)	1.1 (0.41)
Heroin	0.4 (0.06)	1.1 (0.38)	0.9 (0.66)	1.1 (0.46)
Hallucinogens	0.3 (0.05)	0.9* (0.32)	1.4 (0.87)	0.8 (0.28)
Inhalants	0.0 (0.02)	0.2 (0.10)	0.5 (0.36)	0.0 (0.01)
Methamphetamine	0.4 (0.07)	0.8 (0.29)	0.6 (0.36)	0.9 (0.37)
Misuse of Psychotherapeutics	1.9 (0.14)	3.2* (0.57)	1.9 (0.75)	3.7* (0.74)
Pain Relievers	1.1 (0.11)	2.2* (0.49)	1.2 (0.63)	2.6* (0.64)
Tranquilizers	0.6 (0.09)	1.0 (0.32)	0.5 (0.35)	1.2 (0.43)
Stimulants	0.4 (0.06)	0.6 (0.19)	0.2 (0.23)	0.7 (0.24)
Sedatives	0.1 (0.02)	0.0 (0.02)	**	0.0 (0.02)
ALCOHOL	10.6 (0.33)	14.7* (1.21)	15.2* (2.07)	14.5* (1.37)
BOTH ILLICIT DRUGS AND ALCOHOL	2.6 (0.16)	6.2* (0.86)	6.3* (1.46)	6.2* (1.00)
ILLICIT DRUGS OR ALCOHOL	14.8 (0.38)	20.1* (1.37)	23.1* (2.52)	19.0* (1.52)

**Low precision; no estimate reported.
NOTE: Estimates shown are percentages with standard errors included in parentheses.
NOTE: Respondents with missing data for their sexual identity were excluded.
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Table B.20 – Substance Use Disorder for Specific Substances in the Past Year among Adults Aged 26 or Older, by Sexual Identity

Past Year Use Disorder	Heterosexual/Straight	Any Sexual Minority	Lesbian or Gay	Bisexual
ILLICIT DRUGS	2.0 (0.09)	6.0* (0.85)	6.6* (1.48)	5.5* (0.87)
Marijuana	0.7 (0.05)	2.3* (0.49)	2.6* (0.86)	2.1* (0.52)
Cocaine	0.3 (0.04)	0.9* (0.30)	0.6 (0.32)	1.2 (0.50)
Heroin	0.2 (0.03)	0.4 (0.16)	0.2 (0.14)	0.7 (0.28)
Hallucinogens	0.0 (0.01)	0.2 (0.14)	0.1 (0.14)	0.2 (0.23)
Inhalants	0.0 (0.01)	0.1 (0.11)	0.2 (0.22)	**
Methamphetamine	0.3 (0.04)	1.1 (0.43)	1.8 (0.84)	0.4 (0.22)
Misuse of Psychotherapeutics	0.8 (0.06)	2.6* (0.54)	2.7* (0.88)	2.6* (0.63)
Pain Relievers	0.7 (0.05)	2.0* (0.48)	1.8 (0.77)	2.1* (0.56)
Tranquilizers	0.2 (0.02)	0.8 (0.36)	1.1 (0.68)	0.5 (0.28)
Stimulants	0.1 (0.02)	0.5 (0.23)	**	0.7* (0.29)
Sedatives	0.1 (0.01)	0.0 (0.02)	**	0.0 (0.04)
ALCOHOL	5.3 (0.16)	9.1* (0.94)	8.1* (1.35)	10.0* (1.31)
BOTH ILLICIT DRUGS AND ALCOHOL	0.6 (0.05)	2.3* (0.54)	2.3 (0.88)	2.3* (0.64)
ILLICIT DRUGS OR ALCOHOL	6.7 (0.17)	12.8* (1.19)	12.4* (1.80)	13.3* (1.46)

**Low precision; no estimate reported.
NOTE: Estimates shown are percentages with standard errors included in parentheses.
NOTE: Respondents with missing data for their sexual identity were excluded.
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Table B.21 – Need for Treatment for Substance Use in the Past Year among Adults Aged 18 or Older, by Sexual Identity

Treatment Type/Characteristic	Heterosexual/Straight	Any Sexual Minority	Lesbian or Gay	Bisexual
Need for Treatment for Illicit Drug or Alcohol Use	8.1 (0.16)	15.9* (0.98)	14.9* (1.55)	16.6* (1.12)
18-25	15.1 (0.38)	20.4* (1.37)	23.6* (2.53)	19.2* (1.52)
26 or Older	7.0 (0.17)	13.9* (1.22)	12.7* (1.80)	15.0* (1.55)
Male	11.0 (0.27)	17.5* (1.76)	18.5* (2.37)	15.9* (2.42)
Female	5.3 (0.18)	14.8* (1.05)	9.9* (1.57)	16.9* (1.28)
Need for Treatment for Illicit Drug Use	2.9 (0.10)	8.4* (0.74)	8.3* (1.27)	8.5* (0.81)
18-25	7.1 (0.26)	12.1* (1.12)	14.7* (2.25)	11.1* (1.23)
26 or Older	2.2 (0.10)	6.8* (0.91)	6.7* (1.48)	6.9* (1.08)
Male	4.0 (0.16)	10.2* (1.48)	11.2* (2.05)	8.6* (1.91)
Female	1.8 (0.10)	7.2* (0.70)	4.3* (0.94)	8.5* (0.90)
Need for Treatment for Alcohol Use	6.3 (0.15)	11.5* (0.82)	10.1* (1.20)	12.5* (1.01)
18-25	10.8 (0.34)	15.1* (1.22)	15.8* (2.10)	14.8* (1.39)
26 or Older	5.6 (0.16)	9.9* (1.02)	8.7* (1.39)	11.1* (1.39)
Male	8.6 (0.25)	11.9* (1.39)	12.2* (1.79)	11.5 (2.17)
Female	4.1 (0.16)	11.2* (0.93)	7.3* (1.31)	12.9* (1.16)

NOTE: Estimates shown are percentages with standard errors included in parentheses.
NOTE: Respondents with missing data for their sexual identity were excluded.
NOTE: Respondents were classified as needing treatment for an illicit drug use problem if they met the criteria for an illicit drug use disorder as defined in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), or received treatment for illicit drug use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient only], or mental health center).
NOTE: Respondents were classified as needing treatment for an alcohol use problem if they met at least one of three criteria during the past year: (1) dependent on alcohol, (2) abuse of alcohol, or (3) received treatment for alcohol use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient only], or mental health center).
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Table B.22 – Receipt of Any Treatment and Receipt of Treatment at a Specialty Facility for an Illicit Drug or Alcohol Use Problem in the Past Year among Adults Aged 18 or Older, by Sexual Identity

Treatment Type/Characteristic	Heterosexual/Straight	Any Sexual Minority	Lesbian or Gay	Bisexual
Any Treatment	1.3 (0.07)	3.3* (0.48)	2.9* (0.73)	3.5* (0.63)
18-25	1.9 (0.14)	2.7 (0.46)	3.2 (1.01)	2.5 (0.54)
26 or Older	1.3 (0.08)	3.5* (0.65)	2.8 (0.88)	4.2* (0.96)
Male	1.8 (0.11)	3.8* (0.98)	4.2 (1.26)	3.1 (1.48)
Female	0.9 (0.08)	2.9* (0.46)	1.0 (0.33)	3.7* (0.66)
Treatment at a Specialty Facility	0.9 (0.05)	2.4* (0.40)	1.9* (0.50)	2.8* (0.58)
18-25	1.1 (0.11)	2.1* (0.43)	2.4 (0.85)	2.0 (0.50)
26 or Older	0.8 (0.06)	2.6* (0.54)	1.7 (0.58)	3.4* (0.89)
Male	1.2 (0.09)	2.8* (0.78)	2.5 (0.82)	3.1 (1.48)
Female	0.5 (0.06)	2.2* (0.41)	0.9 (0.31)	2.7* (0.57)

NOTE: Estimates shown are percentages with standard errors included in parentheses.
NOTE: Respondents with missing data for their sexual identity were excluded.
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Table B.23 – Receipt of Treatment at a Specialty Facility for an Illicit Drug or Alcohol Use Problem in the Past Year among Adults Aged 18 or Older Who Needed Treatment, by Sexual Identity

Characteristic	Heterosexual/Straight	Any Sexual Minority	Lesbian or Gay	Bisexual
Total	10.6 (0.62)	15.3* (2.21)	12.5 (3.04)	17.1* (3.13)
18-25	7.3 (0.70)	10.2 (2.02)	10.1 (3.45)	10.2 (2.50)
26 or Older	11.7 (0.78)	18.7* (3.36)	**	**
Male	10.8 (0.78)	15.8 (3.91)	13.7 (4.03)	**
Female	10.2 (1.02)	14.9 (2.51)	**	16.3 (3.03)

**Low precision; no estimate reported.
NOTE: Estimates shown are percentages with standard errors included in parentheses.
NOTE: Respondents with missing data for their sexual identity were excluded.
NOTE: Respondents were classified as needing treatment for an illicit drug or alcohol use problem if they met the criteria for a substance use disorder as defined in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), or received treatment for illicit drug or alcohol use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient only], or mental health center).
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Table B.24 – Received Mental Health Services in the Past Year among Adults Aged 18 or Older, by Sexual Identity

Mental Health Services	Heterosexual/Straight	Any Sexual Minority	Lesbian or Gay	Bisexual
Any Mental Health Service Use	13.7 (0.23)	26.4* (1.20)	25.4* (2.07)	27.2* (1.48)
18-25	10.6 (0.31)	22.6* (1.32)	19.0* (2.35)	23.9* (1.61)
26 or Older	14.2 (0.26)	28.2* (1.61)	27.0* (2.49)	29.3* (2.21)
Male	9.7 (0.28)	23.5* (2.14)	25.5* (2.84)	20.5* (2.91)
Female	17.5 (0.35)	28.4* (1.54)	25.2* (3.05)	29.7* (1.77)
Inpatient	0.8 (0.06)	3.2* (0.54)	3.4* (0.98)	3.0* (0.59)
18-25	1.2 (0.12)	3.1* (0.55)	4.2* (1.33)	2.6* (0.57)
26 or Older	0.7 (0.07)	3.2* (0.73)	3.2* (1.18)	3.2* (0.89)
Male	0.8 (0.08)	3.2* (0.96)	4.2* (1.51)	1.5* (0.61)
Female	0.8 (0.08)	3.2* (0.63)	2.3* (1.03)	3.6* (0.77)
Outpatient	6.7 (0.17)	16.2* (1.02)	16.3* (1.87)	16.2* (1.16)
18-25	5.8 (0.24)	14.2* (1.12)	11.1* (1.84)	15.4* (1.34)
26 or Older	6.8 (0.19)	17.2* (1.36)	17.6* (2.27)	16.8* (1.64)
Male	4.8 (0.19)	14.2* (1.83)	15.9* (2.59)	11.6 (2.23)
Female	8.5 (0.26)	17.6* (1.25)	16.8 (2.68)	18.0* (1.42)
Prescription Medication	11.5 (0.22)	20.9* (1.10)	19.7* (1.82)	21.7* (1.37)
18-25	7.8 (0.26)	17.5* (1.18)	14.7* (2.08)	18.5* (1.40)
26 or Older	12.0 (0.25)	22.4* (1.50)	21.0* (2.20)	23.8* (2.11)
Male	7.8 (0.25)	18.4* (1.87)	20.7* (2.57)	14.9* (2.44)
Female	14.9 (0.33)	22.5* (1.39)	18.2 (2.51)	24.3* (1.63)

NOTE: Estimates shown are percentages with standard errors included in parentheses.
NOTE: Respondents with missing data for their sexual identity or mental health service information were excluded.
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Table B.25 – Received Mental Health Services in the Past Year among Adults Aged 18 or Older with Any Mental Illness, by Sexual Identity

Mental Health Services	Heterosexual/Straight	Any Sexual Minority	Lesbian or Gay	Bisexual
Any Mental Health Service Use	42.6 (0.77)	48.5* (2.06)	55.0* (3.99)	45.7 (2.34)
18-25	30.9 (1.00)	36.6* (2.35)	37.1 (5.02)	36.5 (2.70)
26 or Older	44.8 (0.89)	54.9* (2.76)	60.5* (4.75)	51.9* (3.42)
Male	35.1 (1.19)	47.3* (4.22)	55.8* (5.61)	37.9 (5.73)
Female	47.4 (1.00)	49.2 (2.33)	53.8 (5.29)	48.1 (2.58)
Inpatient	3.1 (0.26)	6.9* (1.19)	9.8* (2.70)	5.6* (1.23)
18-25	4.0 (0.45)	5.5* (1.08)	10.9 (3.71)	4.2* (0.94)
26 or Older	2.9 (0.30)	7.6* (1.72)	9.4* (3.34)	6.6 (1.92)
Male	3.5 (0.48)	7.4* (2.17)	11.5* (3.84)	2.9 (1.40)
Female	2.9 (0.30)	6.6* (1.42)	**	6.4 (1.53)
Outpatient	24.7 (0.67)	32.6* (2.01)	40.0* (4.08)	29.4* (2.15)
18-25	19.5 (0.88)	25.7 (2.14)	25.1 (4.44)	25.8 (2.36)
26 or Older	25.7 (0.78)	36.3* (2.70)	44.6 (4.99)	31.7 (3.07)
Male	20.9 (1.02)	31.8 (4.00)	42.0* (5.68)	20.4 (4.75)
Female	27.2 (0.87)	33.0* (2.26)	37.2 (5.23)	32.1* (2.47)
Prescription Medication	36.5 (0.75)	39.4 (2.08)	44.1 (4.07)	37.4 (2.25)
18-25	23.3 (0.94)	28.6* (2.14)	29.7 (4.78)	28.3* (2.36)
26 or Older	38.9 (0.88)	45.2* (2.90)	48.6 (5.00)	43.4 (3.48)
Male	29.2 (1.14)	39.2* (4.16)	47.5* (5.73)	30.2 (5.39)
Female	41.1 (0.99)	39.5 (2.26)	39.3 (5.12)	39.6 (2.44)

**Low precision; no estimate reported.
NOTE: Estimates shown are percentages with standard errors included in parentheses.
NOTE: Respondents with missing data for their sexual identity or mental health service information were excluded.
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Table B.26 – Received Mental Health Services in the Past Year among Adults Aged 18 or Older with Serious Mental Illness, by Sexual Identity

Mental Health Services	Heterosexual/Straight	Any Sexual Minority	Lesbian or Gay	Bisexual
Any Mental Health Service Use	65.8 (1.46)	63.6 (3.27)	**	59.0 (3.85)
18-25	48.0 (2.38)	58.0* (4.30)	**	56.8 (4.78)
26 or Older	68.9 (1.68)	66.7 (4.37)	**	60.6 (5.65)
Male	57.5 (2.64)	**	**	**
Female	70.4 (1.74)	64.4 (3.60)	**	61.3* (4.10)
Inpatient	6.2 (0.70)	12.6 (2.59)	**	8.9 (2.20)
18-25	7.9 (1.31)	11.7* (2.61)	**	7.3 (1.89)
26 or Older	5.9 (0.79)	13.0 (3.70)	**	10.0* (3.44)
Male	6.7 (1.31)	**	**	**
Female	5.9 (0.85)	10.3 (2.66)	**	9.3 (2.56)
Outpatient	44.0 (1.60)	42.3* (3.55)	**	36.6 (3.64)
18-25	33.3 (2.33)	42.8 (4.27)	**	42.3 (4.56)
26 or Older	46.0 (1.85)	42.1 (4.87)	**	32.6 (5.13)
Male	38.6 (2.57)	**	**	**
Female	47.1 (1.97)	42.9 (3.89)	**	39.8 (4.06)
Prescription Medication	58.2 (1.57)	52.6 (3.48)	**	50.1 (3.80)
18-25	37.4 (2.30)	46.8* (4.14)	**	45.5 (4.36)
26 or Older	61.9 (1.82)	55.8 (4.83)	**	53.4 (5.78)
Male	49.8 (2.82)	**	**	**
Female	62.9 (1.89)	52.6* (3.81)	**	51.0* (4.03)

**Low precision; no estimate reported.
NOTE: Estimates shown are percentages with standard errors included in parentheses.
NOTE: Respondents with missing data for their sexual identity or mental health service information were excluded.
*Difference between this estimate and the estimate for heterosexual/straight adults is statistically significant at the .05 level.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015.

Long Descriptions – Figures

Long description, Figure 1: Figure 1 is titled "Sexual Identity among Adults Aged 18 or Older: Percentages, 2015." It is a pie chart that shows the percentages of adults who identify as being part of the sexual majority, any

sexual minority, or unknown. A note below the chart says, "Any Sexual Minority includes adults who identified as being lesbian or gay (1.8 percent) or bisexual (2.5 percent). Sexual Majority includes adults who identified as being heterosexual or straight. Unknown includes adults who did not know or refused to report their sexual identity (0.6 and 1.0 percent, respectively) or who had other missing data (0.1 percent)."
Among adults aged 18 or older in 2015, 94.0 percent identified as being in the sexual majority, 4.3 percent identified as being a sexual minority, and 1.7 percent had an unknown sexual identity.

Long description, Figure 2: Figure 2 is titled "Past Year Illicit Drug Use among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Drug Type: Percentages, 2015." It is a bar graph, where the percentage of adults using illicit drugs in the past year is shown on the horizontal axis and the illicit drug types are shown on the vertical axis. Eleven drug types are shown:
(1) any illicit drug,
(2) marijuana,
(3) misuse of prescription pain relievers,
(4) misuse of prescription tranquilizers,
(5) cocaine,
(6) hallucinogens,
(7) misuse of prescription stimulants,
(8) inhalants,
(9) methamphetamine,
(10) misuse of prescription sedatives, and
(11) heroin. Each drug type on the vertical axis has two bars: one is for adults who identified as being in the sexual minority and the other is for adults who identified as being in the sexual majority. Tests of statistical

significance at the .05 level were performed between adults who identified as a sexual majority and adults who identified as a sexual minority; significant results are indicated where appropriate. A note below the figure says, "Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight." Among adults aged 18 or older in 2015 who identified as being in the sexual minority in the past year, the following used illicit drugs in the past year in descending order for the following drug types: 39.1 percent used any illicit drug, 30.7 percent used marijuana, 10.4 percent misused prescription pain relievers, 5.9 percent misused prescription tranquilizers, 5.1 percent used cocaine, 5.0 percent used hallucinogens, 4.2 percent misused prescription stimulants, 3.7 percent used inhalants, 2.3 percent used methamphetamine, 1.2 percent misused prescription sedatives, and 0.9 percent used heroin. Among adults aged 18 or older in 2015 who identified as being in the sexual majority in the past year, the following used illicit drugs in the past year for the following drug types: 17.1 percent used any illicit drug, 12.9 percent used marijuana, 4.5 percent misused prescription pain relievers, 2.2 percent misused prescription tranquilizers, 1.8 percent used cocaine, 1.6 percent used hallucinogens, 1.9 percent misused prescription stimulants, 0.3 percent used inhalants, 0.6 percent used methamphetamine, 0.6 percent misused prescription sedatives, and 0.3 percent used heroin. The estimates for adults who identified as a sexual majority are significantly different from the estimates for adults who identified as a sexual minority for each drug type.

Long description, Figure 3: Figure 3 is titled "Past Year Illicit Drug Use among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015." It is a bar graph, where three age groups (Total 18 or older, 18 to 25, 26 or older) and sex (male and female) are shown on the horizontal axis and the percentage of adults who used

illicit drugs in the past year is shown on the vertical axis. For each age group and/or sex, the figure shows a bar representing sexual minority and a bar representing sexual majority. Tests of statistical significance at the .05 level were performed between adults who identified as a sexual majority and adults who identified as a sexual minority; significant results are indicated where appropriate. A note below the figure says, "Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight."

Percentages of adults aged 18 or older who used illicit drugs in the past year in 2015 were 39.1 percent for adults who identified as a sexual minority, and 17.1 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority.
Percentages of young adults aged 18 to 25 who used illicit drugs in the past year in 2015 were 54.0 percent for young adults who identified as a sexual minority, and 36.1 percent for young adults who identified as a sexual majority. The estimate for young adults who identified as a sexual majority is significantly different from the estimate for young adults who identified as a sexual minority.

Percentages of adults aged 26 or older who used illicit drugs in the past year in 2015 were 32.5 percent for adults who identified as a sexual minority, and 14.1 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority.

Percentages of adult males aged 18 or older who used illicit drugs in the past year in 2015 were 36.3 percent for adult males who identified as a sexual

minority, and 20.4 percent for adult males who identified as a sexual majority. The estimate for adult males who identified as a sexual majority is significantly different from the estimate for adult males who identified as a sexual minority.

Percentages of adult females aged 18 or older who used illicit drugs in the past year in 2015 were 41.1 percent for adult females who identified as a sexual minority, and 13.9 percent for adult females who identified as a sexual majority. The estimate for adult females who identified as a sexual majority is significantly different from the estimate for adult females who identified as a sexual minority.

Long description, Figure 4: Figure 4 is titled "Past Year Marijuana Use among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015." It is a bar graph, where three age groups (Total 18 or older, 18 to 25, 26 or older) and sex (male and female) are shown on the horizontal axis and the percentage of adults who used marijuana in the past year is shown on the vertical axis. For each age group and/or sex, the figure shows a bar representing sexual minority and a bar representing sexual majority. Tests of statistical significance at the .05 level were performed between adults who identified as a sexual majority and adults who identified as a sexual minority; significant results are indicated where appropriate. A note below the figure says, "Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight."

Percentages of adults aged 18 or older who used marijuana in the past year in 2015 were 30.7 percent for adults who identified as a sexual minority, and 12.9 percent for adults who identified as a sexual majority. The estimate for

adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority.

Percentages of young adults aged 18 to 25 who used marijuana in the past year in 2015 were 46.2 percent for young adults who identified as a sexual minority, and 31.0 percent for young adults who identified as a sexual majority. The estimate for young adults who identified as a sexual majority is significantly different from the estimate for young adults who identified as a sexual minority.

Percentages of adults aged 26 or older who used marijuana in the past year in 2015 were 23.9 percent for adults who identified as a sexual minority, and 10.1 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority.
Percentages of adult males aged 18 or older who used marijuana in the past year in 2015 were 27.1 percent for adult males who identified as a sexual minority, and 16.2 percent for adult males who identified as a sexual majority. The estimate for adult males who identified as a sexual majority is significantly different from the estimate for adult males who identified as a sexual minority.

Percentages of adult females aged 18 or older who used marijuana in the past year in 2015 were 33.2 percent for adult females who identified as a sexual minority, and 9.8 percent for adult females who identified as a sexual majority. The estimate for adult females who identified as a sexual majority is significantly different from the estimate for adult females who identified as a sexual minority.

Long description, Figure 5: Figure 5 is titled "Past Year Misuse of Prescription Pain Relievers among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015." It is a bar graph, where three age groups (Total 18 or older, 18 to 25, 26 or older) and sex (male and female) are shown on the horizontal axis and the percentage of adults who misused prescription pain relievers in the past year is shown on the vertical axis. For each age group and/or sex, the figure shows a bar representing sexual minority and a bar representing sexual majority. Tests of statistical significance at the .05 level were performed between adults who identified as a sexual majority and adults who identified as a sexual minority; significant results are indicated where appropriate. A note below the figure says, "Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight."

Percentages of adults aged 18 or older who misused prescription pain relievers in the past year in 2015 were 10.4 percent for adults who identified as a sexual minority, and 4.5 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority.

Percentages of young adults aged 18 to 25 who misused prescription pain relievers in the past year in 2015 were 14.2 percent for young adults who identified as a sexual minority, and 8.0 percent for young adults who identified as a sexual majority. The estimate for young adults who identified as a sexual majority is significantly different from the estimate for young adults who identified as a sexual minority.

Percentages of adults aged 26 or older who misused prescription pain relievers in the past year in 2015 were 8.7 percent for adults who identified as a sexual minority, and 4.0 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority.

Percentages of adult males aged 18 or older who misused prescription pain relievers in the past year were 8.6 percent for adult males who identified as a sexual minority, and 5.4 percent for adult males who identified as a sexual majority. The estimate for adult males who identified as a sexual majority is significantly different from the estimate for adult males who identified as a sexual minority.

Percentages of adult females aged 18 or older who misused prescription pain relievers in the past year in 2015 were 11.6 percent for adult females who identified as a sexual minority, and 3.7 percent for adult females who identified as a sexual majority. The estimate for adult females who identified as a sexual majority is significantly different from the estimate for adult females who identified as a sexual minority.

Long description, Figure 6: Figure 6 is titled "Past Month Cigarette Use among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015." It is a bar graph, where three age groups (Total 18 or older, 18 to 25, 26 or older) and sex (male and female) are shown on the horizontal axis and the percentage of adults who used cigarettes in the past month is shown on the vertical axis. For each age group and/or sex, the figure shows a bar representing sexual minority and a bar representing sexual majority. Tests of statistical significance at the .05

level were performed between adults who identified as a sexual majority and adults who identified as a sexual minority; significant results are indicated where appropriate. A note below the figure says, "Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight."

Percentages of adults aged 18 or older who used cigarettes in the past month in 2015 were 32.2 percent for adults who identified as a sexual minority, and 20.6 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority. Percentages of young adults aged 18 to 25 who used cigarettes in the past month in 2015 were 39.7 percent for young adults who identified as a sexual minority, and 25.5 percent for young adults who identified as a sexual majority. The estimate for young adults who identified as a sexual majority is significantly different from the estimate for young adults who identified as a sexual minority.

Percentages of adults aged 26 or older who used cigarettes in the past month in 2015 were 28.9 percent for adults who identified as a sexual minority, and 19.8 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority. Percentages of adult males aged 18 or older who used cigarettes in the past month in 2015 were 29.3 percent for adult males who identified as a sexual minority, and 23.6 percent for adult males who identified as a sexual majority. The estimate for adult males who identified as a sexual majority is significantly different from the estimate for adult males who identified as a sexual minority.

Percentages of adult females aged 18 or older who used cigarettes in the past month in 2015 were 34.2 percent for adult females who identified as a sexual minority, and 17.8 percent for adult females who identified as a sexual majority. The estimate for adult females who identified as a sexual majority is significantly different from the estimate for adult females who identified as a sexual minority.

Long description, Figure 7: Figure 7 is titled "Daily Cigarette Use among Sexual Minority and Sexual Majority Past Month Cigarette Smokers Aged 18 or Older, by Age Group and Sex: Percentages, 2015." It is a bar graph, where three age groups (Total 18 or older, 18 to 25, 26 or older) and sex (male and female) are shown on the horizontal axis and the percentage of adults who used cigarettes daily in the past month is shown on the vertical axis. For each age group and/or sex, the figure shows a bar representing sexual minority and a bar representing sexual majority. Tests of statistical significance at the .05 level were performed between adults who identified as a sexual majority and adults who identified as a sexual minority; significant results are indicated where appropriate. A note below the figure says, "Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight." Percentages of adults aged 18 or older who used cigarettes daily in the past month in 2015 were 51.6 percent for adults who identified as a sexual minority, and 59.6 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority. Percentages of young adults aged 18 to 25 who used cigarettes daily in the past month in 2015 were 46.5 percent for young adults who identified as a

sexual minority, and 41.3 percent for young adults who identified as a sexual majority.

Percentages of adults aged 26 or older who used cigarettes daily in the past month in 2015 were 54.6 percent for adults who identified as a sexual minority, and 63.3 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority. Percentages of adult males aged 18 or older who used cigarettes daily in the past month in 2015 were 47.5 percent for adult males who identified as a sexual minority, and 57.2 percent for adult males who identified as a sexual majority. The estimate for adult males who identified as a sexual majority is significantly different from the estimate for adult males who identified as a sexual minority.

Percentages of adult females aged 18 or older who used cigarettes daily in the past month in 2015 were 53.9 percent for adult females who identified as a sexual minority, and 62.5 percent for adult females who identified as a sexual majority. The estimate for adult females who identified as a sexual majority is significantly different from the estimate for adult females who identified as a sexual minority.

Long description, Figure 8: Figure 8 is titled "Past Month Alcohol Use among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015." It is a bar graph, where three age groups (Total 18 or older, 18 to 25, 26 or older) and sex (male and female) are shown on the horizontal axis and the percentage of adults who used alcohol in the past month is shown on the vertical axis. For each age group and/or sex, the figure shows a bar representing sexual minority and a bar

representing sexual majority. Tests of statistical significance at the .05 level were performed between adults who identified as a sexual majority and adults who identified as a sexual minority; significant results are indicated where appropriate. A note below the figure says, "Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight."

Percentages of adults aged 18 or older who used alcohol in the past month in 2015 were 63.6 percent for adults who identified as a sexual minority, and 56.2 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority.
Percentages of young adults aged 18 to 25 who used alcohol in the past month in 2015 were 64.1 percent for young adults who identified as a sexual minority, and 58.1 percent for young adults who identified as a sexual majority. The estimate for young adults who identified as a sexual majority is significantly different from the estimate for young adults who identified as a sexual minority.

Percentages of adults aged 26 or older who used alcohol in the past month in 2015 were 63.4 percent for adults who identified as a sexual minority, and 55.9 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority.
Percentages of adult males aged 18 or older who used alcohol in the past month in 2015 were 62.8 percent for adult males who identified as a sexual minority, and 61.6 percent for adult males who identified as a sexual majority.

Percentages of adult females aged 18 or older who used alcohol in the past month among female adults in 2015 were 64.1 percent for adult females who identified as a sexual minority, and 51.0 percent for adult females who identified as a sexual majority. The estimate for adult females who identified as a sexual majority is significantly different from the estimate for adult females who identified as a sexual minority.

Long description, Figure 9: Figure 9 is titled "Past Month Binge Alcohol Use among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015." It is a bar graph, where three age groups (Total 18 or older, 18 to 25, 26 or older) and sex (male and female) are shown on the horizontal axis and the percentage of adults who were binge alcohol users in the past month is shown on the vertical axis. For each age group and/or sex, the figure shows a bar representing sexual minority and a bar representing sexual majority. Tests of statistical significance at the .05 level were performed between adults who identified as a sexual majority and adults who identified as a sexual minority; significant results are indicated where appropriate. Two notes are below the figure, the first of which says, "In 2015, the threshold for determining binge alcohol use for females changed from five or more drinks on an occasion to four or more drinks on an occasion." The second note says, "Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight."

Percentages of adults aged 18 or older who were binge alcohol users in the past month in 2015 were 36.1 percent for adults who identified as a sexual minority, and 26.7 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority.

Percentages of young adults aged 18 to 25 who were binge alcohol users in the past month in 2015 were 44.6 percent for young adults who identified as a sexual minority, and 38.7 percent for young adults who identified as a sexual majority. The estimate for young adults who identified as a sexual majority is significantly different from the estimate for young adults who identified as a sexual minority.

Percentages of adults aged 26 or older who were binge alcohol users in the past month in 2015 were 32.3 percent for adults who identified as a sexual minority, and 24.8 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority. Percentages of adult males aged 18 or older who were binge alcohol users in the past month in 2015 were 33.2 percent for adult males who identified as a sexual minority, and 32.3 percent for adult males who identified as a sexual majority.

Percentages of adult females aged 18 or older who were binge alcohol users in the past month in 2015 were 38.1 percent for adult females who identified as a sexual minority, and 21.3 percent for adult females who identified as a sexual majority. The estimate for adult females who identified as a sexual majority is significantly different from the estimate for adult females who identified as a sexual minority.

Long description, Figure 10: Figure 10 is titled "Past Month Heavy Alcohol Use among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015." It is a bar graph, where three age groups (Total 18 or older, 18 to 25, 26 or older) and sex (male and female) are shown on the horizontal axis and the percentage of people who were

heavy alcohol users in the past month is shown on the vertical axis. For each age group and/or sex, the figure shows a bar representing sexual minority and a bar representing sexual majority. Tests of statistical significance at the .05 level were performed between adults who identified as a sexual majority and adults who identified as a sexual minority; significant results are indicated where appropriate. Two notes are below the figure, the first of which says, "In 2015, the threshold for determining binge alcohol use for females changed from five or more drinks on an occasion to four or more drinks on an occasion. By definition, heavy alcohol users are binge alcohol users." The second note says, "Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight."

Percentages of adults aged 18 or older who were heavy alcohol users in the past month in 2015 were 8.2 percent for adults who identified as a sexual minority, and 7.1 percent for adults who identified as a sexual majority. Percentages of young adults aged 18 to 25 who were heavy alcohol users in the past month in 2015 were 10.2 percent for young adults who identified as a sexual minority, and 11.0 percent for young adults who identified as a sexual majority.

Percentages of adults aged 26 or older who were heavy alcohol users in the past month in 2015 were 7.3 percent for adults who identified as a sexual minority, and 6.5 percent for adults who identified as a sexual majority. Percentages of adult males aged 18 or older who were heavy alcohol users in the past month in 2015 were 8.6 percent for adult males who identified as a sexual minority, and 9.9 percent for adult males who identified as a sexual majority.

Percentages of adult females aged 18 or older who were heavy alcohol users in the past month in 2015 were 8.0 percent for adult females who identified as a sexual minority, and 4.4 percent for adult females who identified as a sexual majority. The estimate for adult females who identified as a sexual majority is significantly different from the estimate for adult females who identified as a sexual minority.

Long description, Figure 11: Figure 11 is titled "Substance Use Disorder in the Past Year among Sexual Minority and Sexual Majority Adults Aged 18 or Older: Percentages, 2015." It is a bar graph, where the percentage of adults with a substance use disorder in the past year is shown on the horizontal axis and specific substance use disorders are shown on the vertical axis. Five substance disorders are shown: (1) illicit drug or alcohol use disorder, (2) alcohol use disorder, (3) illicit drug use disorder, (4) marijuana use disorder, and (5) pain reliever use disorder. Each substance disorder on the vertical axis has two bars: one is for adults who identified as being in the sexual minority and the other is for adults who identified as being in the sexual majority. Tests of statistical significance at the .05 level were performed between adults who identified as a sexual majority and adults who identified as a sexual minority; significant results are indicated where appropriate. Two notes are below the figure, the first of which says, "The estimated percentages of people with substance use disorders are not mutually exclusive because people could have use disorders for more than one substance." The second note says, "Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight."

Among adults aged 18 or older in 2015 who identified as being in the sexual minority, the following had a substance disorder in the past year in

descending order for the following types: 15.1 percent had an illicit drug or alcohol use disorder, 10.8 percent had an alcohol use disorder, 7.8 percent had an illicit drug use disorder, 3.9 percent had a marijuana use disorder, and 2.0 percent had a pain reliever use disorder. The estimates for adults who identified as a sexual majority are significantly different from the estimates for adults who identified as a sexual minority for each substance use disorder type.

Among adults aged 18 or older in 2015 who identified as being in the sexual majority in the past year, the following had a substance disorder in the past year in descending order for the following types: 7.8 percent had an illicit drug or alcohol use disorder, 6.1 percent had an alcohol use disorder, 2.6 percent had an illicit drug use disorder, 1.3 percent had a marijuana use disorder, and 0.7 percent had a pain reliever use disorder.

Long description, Figure 12: Figure 12 is titled "Receipt of Specialty Treatment in the Past Year among Sexual Minority and Sexual Majority Adults Aged 18 or Older Who Needed Substance Use Treatment: Percentages, 2015." It shows two pie charts: one on the left and another on the right. The leftmost pie chart is representative of sexual minority adults, and the rightmost pie chart is representative of sexual majority adults. Both pie charts show the percentage who did and who did not receive treatment at a specialty facility for a substance use problem in the past year. Tests of statistical significance at the .05 level were performed between adults who identified as a sexual majority and adults who identified as a sexual minority; significant results are indicated where appropriate. Two notes are below the figure, the first of which says, "The circles for sexual minority adults and sexual majority adults are not drawn to scale." The second note

says, "Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight."
A note below the leftmost pie chart says, "1.7 million sexual minority adults needed substance use treatment." The leftmost pie chart shows the following: In 2015, 84.7 percent of sexual minority adults aged 18 or older did not receive treatment at a specialty facility for a substance use problem, and 15.3 percent of sexual minority adults did receive treatment at a specialty facility for a substance use problem. The estimate for adults who identified as a sexual majority and did receive treatment at a specialty facility for a substance use problem are significantly different from the estimate for adults who identified as a sexual minority and did not receive treatment at a specialty facility for a substance use problem.

A note below the rightmost pie chart says, "18.5 million sexual majority adults needed substance use treatment." The rightmost pie chart shows the following: In 2015, 89.4 percent of sexual majority adults aged 18 or older did not receive treatment at a specialty facility for a substance use problem and 10.6 percent of sexual majority adults did receive treatment at a specialty facility for a substance use problem.

Long description, Figure 13: Figure 13 is titled "Any Mental Illness in the Past Year among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015." It is a bar graph, where three age groups (Total 18 or older, 18 to 25, 26 or older) and sex (male and female) are shown on the horizontal axis and the percentage of adults with any mental illness in the past year is shown on the vertical axis. For each age group and/or sex, the figure shows a bar representing sexual minority and a bar representing sexual majority. Tests of statistical

significance at the .05 level were performed between adults who identified as a sexual majority and adults who identified as a sexual minority; significant results are indicated where appropriate. A note below the figure says, "Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight." Percentages of adults aged 18 or older with any mental illness in the past year in 2015 were 37.4 percent for adults who identified as a sexual minority, and 17.1 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority. Percentages of young adults aged 18 to 25 with any mental illness in the past year in 2015 were 42.1 percent for young adults who identified as a sexual minority, and 19.8 percent for young adults who identified as a sexual majority. The estimate for young adults who identified as a sexual majority is significantly different from the estimate for young adults who identified as a sexual minority.

Percentages of adults aged 26 or older with any mental illness in the past year in 2015 were 35.3 percent for adults who identified as a sexual minority, and 16.7 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority. Percentages of adult males aged 18 or older with any mental illness in the past year in 2015 were 31.3 percent for adult males who identified as a sexual minority, and 13.7 percent for adult males who identified as a sexual majority. The estimate for adult males who identified as a sexual majority is significantly different from the estimate for adult males who identified as a sexual minority.

Percentages of adult females aged 18 or older with any mental illness in the past year in 2015 were 41.5 percent for adult females who identified as a sexual minority, and 20.4 percent for adult females who identified as a sexual majority. The estimate for adult females who identified as a sexual majority is significantly different from the estimate for adult females who identified as a sexual minority.

Long description, Figure 14: Figure 14 is titled "Serious Mental Illness in the Past Year among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015." It is a bar graph, where three age groups (Total 18 or older, 18 to 25, 26 or older) and sex (male and female) are shown on the horizontal axis and the percentage of adults with a serious mental illness in the past year is shown on the vertical axis. For each age group and/or sex, the figure shows a bar representing sexual minority and a bar representing sexual majority. Tests of statistical significance at the .05 level were performed between adults who identified as a sexual majority and adults who identified as a sexual minority; significant results are indicated where appropriate. A note below the figure says, "Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight."

Percentages of adults aged 18 or older with a serious mental illness in the past year in 2015 were 13.1 percent for adults who identified as a sexual minority, and 3.6 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority. Percentages of young adults aged 18 to 25 with a serious mental illness in the past year in 2015 were 15.0 percent for young adults who identified as a sexual minority, and 4.0 percent for young adults who identified as a sexual

majority. The estimate for young adults who identified as a sexual majority is significantly different from the estimate for young adults who identified as a sexual minority.

Percentages of adults aged 26 or older with a serious mental illness in the past year in 2015 were 12.3 percent for adults who identified as a sexual minority, and 3.6 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority. Percentages of adult males aged 18 or older with a serious mental illness in the past year in 2015 were 10.5 percent for adult males who identified as a sexual minority, and 2.7 percent for adult males who identified as a sexual majority. The estimate for adult males who identified as a sexual majority is significantly different from the estimate for adult males who identified as a sexual minority.

Percentages of adult females aged 18 or older with a serious mental illness in the past year in 2015 were 14.8 percent for adult females who identified as a sexual minority, and 4.5 percent for adult females who identified as a sexual majority. The estimate for adult females who identified as a sexual majority is significantly different from the estimate for adult females who identified as a sexual minority.

Long description, Figure 15: Figure 15 is titled "Any Mental Illness Excluding Serious Mental Illness in the Past Year among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015." It is a bar graph, where three age groups (Total 18 or older, 18 to 25, 26 or older) and sex (male and female) are shown on the horizontal axis and the percentage of adults with any mental illness

excluding serious mental illness in the past year is shown on the vertical axis. For each age group and/or sex, the figure shows a bar representing sexual minority and a bar representing sexual majority. Tests of statistical significance at the .05 level were performed between adults who identified as a sexual majority and adults who identified as a sexual minority; significant results are indicated where appropriate. A note below the figure says, "Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight." Percentages of adults aged 18 or older with any mental illness excluding serious mental illness in the past year in 2015 were 24.3 percent for adults who identified as a sexual minority, and 13.5 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority.

Percentages of young adults aged 18 to 25 with any mental illness excluding serious mental illness in the past year in 2015 were 27.1 percent for young adults who identified as a sexual minority, and 15.7 percent for young adults who identified as a sexual majority. The estimate for young adults who identified as a sexual majority is significantly different from the estimate for young adults who identified as a sexual minority.

Percentages of adults aged 26 or older with any mental illness excluding serious mental illness in the past year in 2015 were 23.0 percent for adults who identified as a sexual minority, and 13.1 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority.

Percentages of adult males aged 18 or older with any mental illness excluding serious mental illness in the past year in 2015 were 20.8 percent for adult males who identified as a sexual minority, and 11.0 percent for adult males who identified as a sexual majority. The estimate for adult males who identified as a sexual majority is significantly different from the estimate for adult males who identified as a sexual minority.
Percentages of adult females aged 18 or older with any mental illness excluding serious mental illness in the past year in 2015 were 26.7 percent for adult females who identified as a sexual minority, and 15.9 percent for adult females who identified as a sexual majority. The estimate for adult females who identified as a sexual majority is significantly different from the estimate for adult females who identified as a sexual minority.

Long description, Figure 16: Figure 16 is titled "Received Mental Health Services in the Past Year among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015." It is a bar graph, where three age groups (Total 18 or older, 18 to 25, 26 or older) and sex (male and female) are shown on the horizontal axis and the percentage of adults who received mental health services in the past year is shown on the vertical axis. For each age group and/or sex, the figure shows a bar representing sexual minority and a bar representing sexual majority. Tests of statistical significance at the .05 level were performed between adults who identified as a sexual majority and adults who identified as a sexual minority; significant results are indicated where appropriate. A note below the figure says, "Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight." Percentages of adults aged 18 or older who received mental health services in the past year in 2015 were 26.4 percent for adults who identified as a sexual minority, and 13.7 percent for adults who identified as a sexual

majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority.

Percentages of young adults aged 18 to 25 who received mental health services in the past year in 2015 were 22.6 percent for young adults who identified as a sexual minority, and 10.6 percent for young adults who identified as a sexual majority. The estimate for young adults who identified as a sexual majority is significantly different from the estimate for young adults who identified as a sexual minority.
Percentages of adults aged 26 or older who received mental health services in the past year in 2015 were 28.2 percent for adults who identified as a sexual minority, and 14.2 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority.

Percentages of adult males aged 18 or older who received mental health services in the past year in 2015 were 23.5 percent for adult males who identified as a sexual minority, and 9.7 percent for adult males who identified as a sexual majority. The estimate for adult males who identified as a sexual majority is significantly different from the estimate for adult males who identified as a sexual minority.
Percentages of adult females aged 18 or older who received mental health services in the past year in 2015 were 28.4 adult females or people who identified as a sexual minority, and 17.5 percent for adult females who identified as a sexual majority. The estimate for adult females who identified as a sexual majority is significantly different from the estimate for adult females who identified as a sexual minority.

Long description, Figure 17: Figure 17 is titled "Received Mental Health Services in the Past Year among Sexual Minority and Sexual Majority Adults Aged 18 or Older with Any Mental Illness in the Past Year, by Age Group and Sex: Percentages, 2015." It is a bar graph, where three age groups (Total 18 or older, 18 to 25, 26 or older) and sex (male and female) are shown on the horizontal axis and the percentage of adults with any mental illness who received mental health services in the past year is shown on the vertical axis. For each age group and/or sex, the figure shows a bar representing sexual minority and a bar representing sexual majority. Tests of statistical significance at the .05 level were performed between adults who identified as a sexual majority and adults who identified as a sexual minority; significant results are indicated where appropriate. A note below the figure says, "Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight."

Percentages of adults aged 18 or older with any mental illness who received mental health services in the past year in 2015 were 48.5 percent for adults who identified as a sexual minority, and 42.6 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority.

Percentages of young adults aged 18 to 25 with any mental illness who received mental health services in the past year in 2015 were 36.6 percent for young adults who identified as a sexual minority, and 30.9 percent for young adults who identified as a sexual majority. The estimate for young adults who identified as a sexual majority is significantly different from the estimate for young adults who identified as a sexual minority.

Percentages of adults aged 26 or older with any mental illness who received mental health services in the past year in 2015 were 54.9 percent for adults who identified as a sexual minority, and 44.8 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority.

Percentages of adult males aged 18 or older with any mental illness who received mental health services in the past year in 2015 were 47.3 percent for adult males who identified as a sexual minority, and 35.1 percent for adult males who identified as a sexual majority. The estimate for adult males who identified as a sexual majority is significantly different from the estimate for adult males who identified as a sexual minority.
Percentages of adult females aged 18 or older with any mental illness who received mental health services in the past year in 2015 were 49.2 percent for adult females who identified as a sexual minority, and 47.4 percent for adult females who identified as a sexual majority.

Long description, Figure 18: Figure 18 is titled "Major Depressive Episode (MDE) and MDE with Severe Impairment in the Past Year among Sexual Minority and Sexual Majority Adults Aged 18 or Older: Percentages, 2015." It is a bar graph, where MDE type (MDE or MDE with Severe Impairment) is shown on the horizontal axis and the percentage of adults with each type of MDE in the past year is shown on the vertical axis. For each MDE type, the figure shows a bar representing sexual minority and a bar representing sexual majority. Tests of statistical significance at the .05 level were performed between adults who identified as a sexual majority and adults who identified as a sexual minority; significant results are indicated where appropriate. A note below the figure says, "Sexual minority adults identified

as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight."

Percentages of adults aged 18 or older with a major depressive episode (MDE) in the past year in 2015 were 18.2 percent for adults who identified as a sexual minority, and 6.2 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority.
Percentages of adults aged 18 or older with a major depressive episode (MDE) with severe impairment in the past year in 2015 were 13.1 percent for adults who identified as a sexual minority, and 3.9 percent for adults who identified as a sexual majority. The estimate for adults who identified as a sexual majority is significantly different from the estimate for adults who identified as a sexual minority.

End of the Course!!!