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The Nature of Sexual Capital

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Abstract

This paper offers a conceptual scheme, an economic approach, by which sexual behaviors can be analyzed, showing how sensible the relationships are among a person's preferences, capabilities, actions, and satisfactions regarding sex. The paper makes analytic sense of these relationships, it explores how preferences, resources, and habits are related to several sexual activities and it links these, in turn, to outcomes. There is no formal model proposed although the elements of the sexual landscape are organized through the lens of a traditional economic model of product demand. There are no "policy implications" discussed here as the empirical relationships are correlational and at best only suggestively causal. Much of the literature regarding sexual behaviors is wholly descriptive, and while description can be valuable, a cohesive intellectual organization of the sexual activities, feelings, experiences, and beliefs is itself a step forward. That is the step taken in this paper, first through a discussion of the several aspects of sexual behaviors and attitudes, and then through an empirical investigation using measures of most of those concepts and showing their cohesive organization. The data file used contains sexual-partner-specific information about sexual practices and outcomes; it is constructed from the publicly available National Health and Social Life data set collected in 1992.

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I. Introduction

It is surprising that there has been so little economic research on the subject of sexual behavior. Few topics engender greater general fascination than sex. The behavior involves much expenditure of some resources (according to the New York Times Magazine (2001) even one aspect of sex is of considerable magnitude: “pornography is a bigger business than professional football, basketball and baseball put together”); it lies at the heart of some of society’s deepest social conflicts including abortion rights, gay rights, gender discrimination and harassment; and sexual behavior is surely fraught with uncertainty and well-characterized by choices and strategic behavior. Moreover, it matters in terms of public health expenditures and is clearly implicated as the cause of much morbidity. No one would argue that it is unrelated to individual utility and while the average household may expend little current consumption expenditure on it directly, despite the assertion by the New York Times Magazine, it occupies a non-trivial amount of time and attention by most adults.

The reasons why there has been little research on the subject of sex lie more in politics than science and is not the subject of this article (see Laumann, Gagnon & Michael, 1994). Instead, this essay offers a conceptual scheme, an economic approach, by which we might analyze the behaviors and products of sexual activity. It implements that scheme empirically, showing how sensible the relationships are between a person’s preferences, capabilities, actions and satisfactions regarding sex. The orientation is that a person accumulates skills, habits and attributes that can be considered “sexual capital” and these, in turn, influence the sexual behaviors undertaken and the outcomes that yield utility. I first delineate the several domains of interest, describing how each can be measured and how they intersect to characterize a person’s sexual nature and experience. The essay has no policy implications, per se; it is an intellectual exercise, using standard notions of microeconomics to add something to our understanding of this important, if shunned, subject. The paper uses a specific data set of adult sexual behaviors and outcomes, and so the discussion is framed in terms of that data set, as for instance in the definition of what “sex” is: a voluntary partnered activity involving genital contact and sexual excitement or arousal, even if intercourse or orgasm does not occur.

II. An Economic Framework

An economic framework for understanding sexual behavior begins from the perspective that one’s utility function has sex as an argument, that sexual activity results in several distinct “products” or outcomes each of which impacts utility. I will assume that sexual behavior is a productive activity – it generates those products and has some of the usual properties of a household or nonmarket production function. This activity takes time, and sometimes requires expenditures of money as well as effort and forethought.

II.a. Sexual Preferences: The Three R’s of Sexuality.

People have quite different preferences regarding sex and these might be characterized in many different ways. Here, a general characterization is made about the nature of sexual preferences or values, defined by opinions about proper sexual behaviors and a few judgments about what is important in one’s sexual life. In studying adult sexuality, *The Social Organization of Sexuality* (Laumann, Gagnon, Michael & Michaels, 1994) (referred to as SOS below) used a set of nine questions about sexual attitudes and, based on a cluster analysis, contended that adults can be described as falling into one of a few distinguishable types of normative orientations toward sex.¹ Condensing the content of that discussion somewhat, adults were characterized as falling into one of three types: reproductionists, relationalists and recreationalists.

Reproductionists hold a relatively strict and religiously based view of when sex is appropriate, expressing attitudes opposed to premarital or extramarital sex, same-gender sex, sale of pornography to adults and abortion; the primary purpose of sex is procreation in the view of this group. Recreationalists hold relatively permissive attitudes toward most of the behaviors just listed and see most sex between consenting adult as acceptable. The third group, relationalists, hold more moderate views than either of these other two, stressing the importance of sex within an established caring relationship but they have a relatively situational ethic, permissive of sex outside of marriage if it is in a longer term relationship. This group doesn't agree that premarital sex is always wrong, although they tend to think extramarital sex is always wrong, and while they do not strongly agree that sale of pornography to adults should be outlawed, they do tend to agree that they would not have sex with someone unless they were in love with them. Without too much distortion to the facts presented in *SOS*, the adult population (age 18-59) is distributed with about one-quarter of the population as reproductionists and recreationalists, each, and about half the population in the group of relationalists. That study, in *SOS*, documents that the three types differ substantially on average in their demographic characteristics and in their sexual practices and habits.

If the complex landscape of sexual beliefs or attitudes and sexual behaviors can in fact be fruitfully characterized in terms of a few categories such as these three R's, there is good reason to do so. Studies have shown that it is a small percentage of the population that engages in risky behaviors that perpetuate the transmission of sexually transmitted infections (STIs). *SOS*, for example, documented that a relatively small number of adults expose themselves and their partners to considerable risk by having many partners and they are disproportionately from the group of men and women who are "recreationalists." (*SOS*, p.532) To better understand their attitude toward sex and its antecedents may help in public health or public educational efforts to discourage exposure to high risks.

From a quite different perspective, one of the major challenges in social policy legislation in the arena of sexual behavior – pertaining to contraception, abortion, pornography, same-gender partnerships, and more – is the dramatically different opinions held by the population. *SOS* showed evidence that these differences of opinion are not casually held, are often based in part on religious beliefs, are often reinforced by social networks of friends, partners, and families, are reasonably internally consistent, and do in fact correlate with reported sexual behaviors. Tolerance for diversity regarding sex is not the norm in the U.S. (see Reiss 1997), consequently, setting goals for social policies is fraught with contention. (see Michael, Wadsworth, et al, 1998) Progress toward resolving some of these more controversial social policy issues may be made if we better understood the antecedents, or motivations for these strongly held beliefs or opinions about sexual behaviors.

II.b. Outcomes from Sexual Behavior.

"Sex" or "sexual activity" yields several outcomes or distinguishable products, and one useful list of these includes six joint products that may be assumed to affect utility: physical pleasure, emotional satisfaction, intimacy, peer reputation, risk of fertility, and risk of disease (see Michael 2001). While the first four are positive arguments in a utility function, the sixth yields disutility, and fertility may differ in its impact as the person's circumstances vary. These six *outcomes* from sex are distinct from and generated by sexual *practices*. These practices include the number of one's sexual partners, say, in

one year's time, the frequency of sex, the duration of sexual events, and the specific sexual acts or actions that are undertaken during a sexual event, such as vaginal intercourse, oral or anal sex, and the use of a condom or of other forms of birth control. Different practices impact the several outcomes differently. The importance an individual places on these various outcomes from sex is expected to influence the choices of sexual practices in which one engages. If, for example, a Recreationalist places greatest emphasis on the physical pleasures of sex, with far less concern for intimacy, then s/he would be expected to undertake a different pattern of sexual practices than would a Reproductionist who places much greater importance on fertility.

It is useful to consider each of these six outcomes from sex, separately, and to reflect on practices that may influence their production. In general, practices may alter the likelihood of an outcome, or its level of production, but cannot uncouple the joint nature of the production. That is, a sex event that is limited to oral sex, for example, can avoid the likelihood of a pregnancy and so affect that outcome, but it also has some effect on the level of intimacy, the extent of physical pleasure and emotional satisfaction from that sexual event. We briefly consider each of these six outcomes in turn, in no particular order.

The Risk of Disease

Let: P = probability that a sexual partner is infectious,
 I = infectivity rate of the relevant disease,
 C = effectiveness of a sexual practice (ie, condom) in preventing transmission ($C=1$ if it is wholly ineffective, and $C=0$ if it is completely effective)
 N = number of partners
 n = number of exposures or sexual events with the partner.

Then the risk of contracting a disease in one sexual event is

$$\text{Prob} = PIC$$

and the risk of contracting a disease in t sexual events, each with a separate partner, is

$$\text{Prob}(N=t, n=1) = 1 - (1 - PIC)^N.$$

If instead that same number of events, t , are all with the one partner, the risk is zero if the partner is not infectious and is $1 - (1 - IC)^n$ if the partner is infectious, so the expected risk is:

$$\text{Prob}(N=1, n=t) = P[1 - (1 - IC)^n]. \quad (\text{see Michael 2004})$$

A person's choices about sexual practices determine n and C and these both may be time-dependent, chosen each period separately, although habits, consistency, and expectations probably lead to strong correlation over time in these choices about the frequency of sex and the nature of protection and sexual practices. (Those habits constitute part of the sexual capital discussed below.) Longer-term habits or broader choices determine N and greatly influence P . I is exogenous to the person. The aspects of personal physiology and physical attributes that may affect infectivity can be classed as part of C , the practices that raise or lower the likelihood of transmission of a given disease from an infectious partner to an uninfected partner.

The effect of number of partners, frequency of sex, and the practices that affect C all interact with the infectivity, I , in determining the risk of disease. For example, in the case of an infection such as gonorrhea for which $I=0.5$ (see Holmes et al, 1990), and if $C=.10$ and the potential partners all have $P=0.1$, then if $n = 100$ and if each sexual act is with the same person, the risk of contracting the disease is 0.099, whereas if each sexual act is with a different partner, the risk is 0.394, nearly

four times as high! As the value of IC declines, the impact of the number of partners falls dramatically: for example, if $IC=.005$ (about the risk of one exposure to a partner infected with gonorrhea using very effective protection that has $C=.01$), and n remains at 100 and P at 0.1, then the risk of disease from one or 100 partners differs trivially: 0.039 with the same partner compared to 0.049 with a different partner each time. We will return to this discussion when we consider sexual capital.

Probability of Pregnancy

Here, let: F = the couple's fecundity

p = the likelihood of conception from an act of vaginal intercourse, randomly timed over the menstrual cycle for a fertile couple (for $F=1.0$)

n' = the number of acts of vaginal intercourse (not all sex events involve vaginal intercourse so $n' < n$, but it is the only practice that produces a pregnancy)

BC = the effectiveness of practices intended to prevent or end conception (this is not identical with C)

W = the couple's circumstance regarding the desire to conceive a child, the "wantedness" of a conception/child at this time. ($0 < W < 1$, with $W=1$ implying very great desire to conceive)

PP = the probability of a pregnancy in a month, so

$PP = f(F, p, n', BC(W))$ in general and

$PP = 1 - [1 - Fp(BC)]^{n'}$ under reasonable assumptions.

The variable F is biological and relatively exogenous, affected by health and certain prior exposures but essentially not a choice variable for most couples for most of their lives. It has a well-understood age pattern, different for the male and female. P has been estimated to be close to 0.03 for fertile couples (see Tietze, 1960 and Wilcox et al, 2001 (this doesn't change over time!)). BC is distinct from C since condoms and certain sex practices influence the couple's C while a wider array of medical products and behaviors can influence BC , some associated with a single sexual event and practice, some involving a periodic choice such as the use oral contraceptives or another fertility control method. W may affect the care with which certain BC means are used or the timing, nature, and frequency of sexual events.

Suppose $p = 0.03$, $F = 1.0$, and for illustration, let $BC = 0.99$, a very ineffective birth control technique. Then if $n = 7$ in the month (a typical frequency), $PP = 0.19$ and the waiting time to conception ($1/PP$) is 5.3 months. If instead highly effective birth control is practiced (i.e., $BC = 0.01$), the $PP = 0.002$ and the waiting time to a conception is 500 months or essentially a lifetime.

Intimacy

One of the more interesting aspects of sex may be in the role intimacy plays in defining the nature of a sexual relationship. Elsewhere intimacy has been defined as "an attribute of a dyadic relationship involving the willful and mutual sharing of private facts that reveal what each considers his or her deepest nature. Familiarity and trust accompany intimacy and give it value." (Michael 2004) Intimacy is not always part of a sexual relationship, and intimacy can be experienced by a dyad in ways that do not involve sex. Yet a sexual event often involves exposures that have the potential to produce embarrassment and both physical and emotional harm as well as pleasure. The willingness to put oneself at these risks, to create these vulnerabilities and to trust the partner to make positive use of them and not to abuse them is in part how sex promotes

intimacy. To successfully develop and use that trust to produce sexual pleasure creates a sense of self-worth and emotional satisfaction, and it creates affection for the partner who shares that trust. This is surely close to the concepts of love and affection and is the essence of intimacy.

Reputation or peer judgment

Intimacy helps us understand why sexual relationships are so frequently associated with a measure of the quality of one's character: the abuse or misuse of the trust involved in sexual intimacy is evidence of poor character. One's reputation among peers is in some measure influenced by one's sexual interactions, habits, interests, and behaviors. Reputation affects utility, as was stressed by Bentham [need cit. – in Chicago] as one of this fundamental desiderata from which utility is derived.

While Bentham did not (I don't think – check – although he did write on "buggery;" he was opposed to punishment for homosexuality) discuss sexual reputation, we have from literature and history an inexhaustible number of examples of sexual behavior defining the quality of the person, both self-assessed and publicly, as we know from Homer to Nicholson Baker, from Casanova to Bill Clinton.

Physical pleasure, and emotional satisfaction

Many of the public dimensions of sex are its negative products such as disease, harassment or abuse, unwanted fertility or infidelity. And much public discussion pertaining to sex focuses on public policy aspects about which our society has so much difficulty reaching consensus – access to contraception, abortion, nudity, pornography, homosexuality, extra-marital sex or young teenage sex, for example. These negative products and these complex social issues give sex a bad reputation, publicly. Yet a fact that is seldom disputed, if not explicitly acknowledged, is that sex generates great pleasure, both physical and emotional. One might model the physical pleasure produced by sexual practices in terms of their frequency, n , and their "quality," q , somehow calibrated, and similarly the emotional satisfaction from sex might be related to the partnership quality, P_Q , but these will not be elaborated here. P_Q is partnership quality, q is the quality of the sex. They may be nearly overlapping or symmetric but may be not so. The physical pleasure and emotional satisfaction from sexual activity are somehow related to both n and q , presumably positively in both cases, but not necessarily strictly in a simple mathematical way.

"Having sex" is an activity, a process that yields these six outcomes in some measure. The nature of the sexual practices involved in a sexual event and in a sexual repertoire reflect the individual's (and the couple's) utility from these six. The capacity to generate or to produce the outcomes that are valued and to avoid or diminish the outcomes that are unwanted is affected by innate endowments, acquired skills, and efforts expended in that process.

II.c. Sexual Skills or Sexual Capital

The concept of human capital has become commonplace not only in the literature of economics but in litigation, in policy discussions and in general social discourse. The notion is that individuals purposely invest time, money, and energy in acquiring skills and attributes within themselves that pay off in terms of enhanced productivity of their time, and thus in higher rates of remuneration when they offer their time to employers or engage in self-employed efforts and, as well, when they engage in nonmarket production. (e.g., Becker 1964, Mincer 1974) The investments are typically made early in life for several reasons including (a) the value of time spent in training is typically lower at a young age before experience has yielded much product; (b) for many skills learning itself is more effective or easier at young ages and the capacity to acquire human capital assets may be enhanced by the amount already

acquired as “learning begets learning” so beginning the investments early has greater payoff (Ben Porath, 1967, Heckman 2000); and of course (c) the period of direct payoff from an investment can be no longer than a lifetime, and so investments early in life have a potentially longer period of return. The investments are made at a cost, the asset is embedded in the person, and the return is realized over the subsequent life. Those returns are greater when the particular assets are utilized more extensively – this both better exploits the asset and dampens its rate of deterioration from disuse.

The stuff of human capital is less often a focus of attention than is the amount of enhanced productivity or realized earnings. The stuff of education or learning-by-doing on-the-job or elsewhere is skill or know-how or knowledge of some aspect of production or cooperation that causes the person’s inputs to yield a higher product and thus to warrant a higher remuneration. Call this stuff “skill capital,” however acquired. It is to be distinguished from raw or native ability that may itself enhance productivity or may enhance the person’s capacity to transform the investment of money or effort into those skills.

Another type of human capital is health capital (Grossman 1972), also an asset embedded within the person, partially by investments of money, time and efforts that enhance one’s health or that reduce exposure to unhealthy influences, and partially by endowment of one’s genetic capabilities, and partially by luck since there is an important stochastic element to the creation and preservation of health. One explicit definition of “health capital” is “the present value of the expected flow of health consumption over the course of the person’s remaining life.” (Cutler & Shapiro, 2004) This definition suggests that we know what good health is and health capital is the stuff embedded within the person that produces that good health. There are types of human capital other than skill capital or health capital: i.e., these include location capital perhaps acquired by migration, and information capital perhaps acquired by search, if it is distinguished from skill capital.

Sexual behavior also involves skills and capabilities. Some of these are innate, others acquired through purposive effort and investment, some specifically influence one or another of the six outcomes from sex while others may have affect on sexual outcomes more generally. It seems natural to consider the acquisition of sexual attributes as a form of human capital, here called “sexual capital.” A definition of sexual capital is the capabilities, skills and habits embedded within the person that yield a flow of benefits from sex. This would be analogous to the concepts of skill capital or health capital: each involves embedded capabilities and habits that yield the product for which that capital investment is intended.

Habits or behavior patterns are an essential part of any human capital: consider the relatively good health of a non-smoker: he has both clean lungs and a pattern of behavior that means he breathes cleaner air. Both constitute his health capital, not just the current state of his lungs. Here, we have some understanding of the linkage between the investment and the product: he does not smoke which may entail cost in foregone consumption value, and he has better health because of the protection of his lungs over the past and because of the exposure to cleaner air currently as he continues to be a nonsmoker. Economic thinking does not usually focus on the mechanism by which the investment of money or time or foregone consumption utility leads to the desired product of better health or higher earnings. Typically, we measure the cost and measure the benefit and thus we can calculate the return on the investment or explain the observed differences in the health or earnings; we do not focus on the mechanisms that transform the one into the other.

Similarly, in making a financial investment in a firm – buying a few shares of stock – essentially what one wants to know is the cost of a share of stock and the dividend and likely capital gain from holding that stock. But somewhere out there, someone is doing something in that firm with that financial asset that produces and successfully sells a product that generates that dividend and the optimism that causes that capital gains. Similarly with an investment in human capital: while we typically focus on the cost of that capital and the value of the flow of benefits, somewhere out there that skill or new knowledge is transformed into a habit or an interaction with machines or people, with activities or choices of strategies for getting a job done, and from these come higher production, and hence the grounds for higher earnings and other benefits. Few papers address the topic of what the stuff is, or how the embedded asset actually contributes to enhanced production.

In considering sexual capital, however, it may be useful to consider the nature of the various products from sex and to explore the connections between the sexual capital and those outcomes. The assets that generate these several products differ and together they constitute the stock of sexual capital. So how might sexual capital influence outcomes? In the same ways any form of human capital influences outcomes, and there are two dominant routes: one way is what Welch (1970) called “allocative efficiency” meaning that skills and know-how help a person select the tools and procedures best suited to the production. (This is an application of the old adage that if the only tool in your toolkit is a hammer, every problem looks like a nail. One with a better toolkit will do better at diagnosing the problem and selecting the right tool.) In this case, that means that an individual with more sexual capital will do a better job of selecting the practices that best generate a desired mix of outcomes. For a given person, the more sexual capital s/he has, the better the choices made about the practices selected. Now, the key choice here is one this paper does not investigate: the choice of the partner. Indeed, one of the measures of sexual capital used here is the homophily of respondent and partner in terms of age, education, race and religion. As explained below, the structure of the data file used in this paper is a partner-specific file, so the investigation here focuses on choices made within a sexual partnership, not across partners. So, to be specific about it, if we are considering the risk of disease from sex, conditional upon the partner, a key choice is the use of a condom. One with more sexual capital would be expected to be more likely to use a condom with a risky partner.

The second route through which human capital influences outcomes is the efficacious use of a given tool: being better at the use of the hammer – called a “worker effect.” A more skilled worker produces more per unit of time by being more productive with the same tools. The condom is a fine example of this point: technologically a condom works effectively in preventing pregnancy and the transmission of infection practically every time, but in actual use, the way in which it is used has a big influence on its efficacy – skilled users experience far fewer condom “failures.”

Consider for a moment the way we routinely measure skill capital in the form of education. We have adapted the convention of measuring it in years of exposure to school, years attended, or years completed. The measure isn’t a measure of skill, it is an indicator of the magnitude of the cost incurred and presumably it is a positive indicator of the level of skills acquired. Similarly, we seldom study how a specific human capital skill influences the production of a particular product. Instead, we typically map years of schooling onto a gross indicator of total product reflected by wages. Much, indeed most, is left behind the scene in our analyses of investments in human capital. With sex, we have the potential to parse several skills and several outcomes. The strategy

adopted in this paper is to measure several distinct elements of sexual capital, not a composite that would be the equivalent of years of school completed. In terms of outcomes as well, rather than using a composite measure of sexual satisfaction, the six outcomes are separately the focus of study. So we can in principle see how specific elements of sexual capital are associated with specific outcomes from the choices about sexual practices.

Sexual capital influences the production of all six outcomes from sex. In terms of the brief model sketched above regarding the *risk of disease*, skills can impact several of the parameters, P , C , N , and n . The number of sexual events, n , is a choice made by the person and his or her partners. Indirect evidence suggests that it is, modally, about 7 per menstrual cycle or a little less than twice per week, but there is wide variation among people. A couple's primary social characteristics that are typically associated with n are age and marital status – an inverted U-shaped pattern with age and a higher rate in marriage or cohabitation, especially at relatively short durations. So n at about 100 is a year of sexual activity for many people. C can be influenced by the nature of the sexual acts engaged in, by the intensity or force of many of those acts as it might affect slight tearing of flesh and thus influence the exposure of fluids and blood, and by the use of (and care in the use of) condoms that inhibit the exchange of fluids and thus block transmission of infectious agents. These are relatively short-term choices, alterable by simply deciding to change, but much influenced by and reflecting habits and skills that are sexual capital.

By contrast, choices about N and P are much more influenced by habits and longer term habits and considerations. They can be altered on a whim although limited evidence suggests this is not ordinary behavior. N and P are key factors affecting the probability of contracting an STI. Choices about them reflect one of the more complex aspects of sexual behavior: they are closely linked. The decisions about with whom to have sex and about how many different people to have sex with are intricately intertwined with the choice of a partner for all kinds of other, nonsexual relationships: for companionship, for financial pooling, for procreation and child-rearing, etc. These decisions involve choices about the nature of the sexual partnership, its expected exclusivity, one's behavior in terms of that expectation (fidelity), and the longevity of the relationship. In making these choices about the nature of the sexual partnership, N is determined; in the process of selecting the partners, P is influenced.

Two findings from recent study of sexual behaviors bear on this subject: First, as the number of one's sex partners rises, the likelihood rises that some of these partners are relatively unfamiliar (i.e., he or she has known them a very short while or does not know very much about them) and additionally the probability rises that some of those partners also have many other partners. This suggests that as N rises, P rises as well: a partner who has had more partners is more likely to have a higher P . A weaker commitment to caring about a partner who is less well known implies a lower likelihood that a disease will be acknowledged and avoided. So choosing to have a higher N tends to also expose one to a higher average P .

Second, evidence suggests that there is a quite high correlation between the personal characteristics of sexual partners: in their age, their ethnicity, their race, their education, their religious affiliations the percentages of partnerships that share common values is very high: 70 to 90 percent, and not only for the couples who are formally married. These same high percentages are observed for cohabiting couples, and for long term boyfriend/girlfriend relationships and practically as high for very short term "casual" liaisons. (Michael, et al, 1994, p.46) Even in the

short run, we choose as sex partners people much like ourselves. If we select a sex partner from a social network of people much like ourselves, it is likely we select partners who have broadly similar sexual experiences to our own, in terms of exposure to disease. So if our habits, expectations, and behaviors involve a choice of having few sex partners, it is likely we select those few from networks of friends who also have few, and thus have relatively low values of P . Alternatively, if we have habits and behaviors that involve having many sex partners, so too do some of them, so the network of our friends will likely have a higher average value of P . The risk of exposure to disease rises with the number of partners not just because one is exposed to a constant risk with more frequency, but also because the risk itself is higher.

This is part of sexual capital: those habits and expectations influence the social networks from which we select our sex partners; we acquire skills and reputations by our behaviors and choices that in turn constrain some options and facilitate others. We embed within ourselves the capacity to meet effectively our objectives in terms of whom and how many we have sex with. These attributes constitute part of our sexual capital; it is an asset that can be destroyed or devalued, but not one that can as easily be created in a short time period.

In terms of the risk of disease, prior choices about sexual behaviors and more general choices affect the ability to acquire partners with low risk: one's own attributes influence the pool of potential sex partners. By the nature of one's own attributes and prior choices, the set of potential partners from which a selection is most likely made is highly proscribed or restricted. In this key sense, one acquires over time personal attributes – sexual capital – that influence the pool of available partners, and thus P . The sexual capital related to the product of risk of contraction of disease, then, is the capital associated with one's own characteristics that place him in a social network of people who have some specific level of P , also his or her marital status and expectation of sexual exclusivity, and the related habits regarding n , C , and certain other sexual practices.

Regarding the *prospects of conception* from sex, again sexual capital plays a role. Skills and habits influence a person's capacity to affect BC , both by broad medical decisions (i.e., vasectomy or tubal ligation) and through the practice of non-coital sex as well as the care in using certain birth control devices or techniques. More broadly, the nature of the sexual partnership will have major influence on W , as married couples exhibit higher levels of child "wantedness" traditionally. This then translates into different motivations and efforts to avoid a conception among couples. Since these all involve the sexual partnership, the selection of the partner is an important element in this asset. (We will consider good health that affects F to be health capital.)

Peer reputation is quintessential human capital: an embedded asset earned by prior behaviors and sacrifices, non-transferable, much more easily damaged or destroyed than created, and generally highly valued. All this seems to apply to one's sexual reputation as well as to a general reputation. It is created by the accumulation of behaviors over time, it has current value and it can be continually reinforced or eroded. The component of a person's reputation that involves his or her sexual actions, interests, attitudes and attributes constitute sexual capital.

Developing and experiencing *intimacy* involves skill and requires mutual trust. Sexual intimacy requires skills of trusting and revealing, of exposing and of effective actions when a partner is receptive, so the skills one acquires regarding intimacy are in part general skills and in part they are very specific to the particular partner. This sexual capital, then, is the stock of these skills,

both general and partner-specific as they relate to the capacity to promote and effectively use intimacy for the satisfaction of self and partner. One would think that a couple that succeeds in developing this skill, in having a satisfying intimacy that reflects great trust, will experience dyadic bonding that will represent great value to them and will promote stability in their overall relationship.

Suffice it to say that there are, surely, skills involved in the production of *sexual pleasure* and *emotional satisfaction* from sex, and they are in part general skills, in part skills and knowledge of relevance with a particular sexual partner, and in part self-knowledge. These, like other skills are honed by experience and effort, reinforced by use, and affected by general health, age, and other personal attributes.

III. Research Strategy.

The framing of sexual behaviors above identifies six joint outcomes from sex and suggests that all six enter an individual's utility function with various weights. Having identified three distinct sexual preference groups of individuals, it is sensible to assume that those characterized as belonging to one of these three groups will place different weights on some of these outcomes than those in another of the preference groups. For example, the "recreationalists" presumably place particularly great weight on the outcome of physical pleasure while the "relationalists" are likely to put relatively heavy emphasis on intimacy while the "reproductionists" must place special weight on the issues of fertility, with low or negative valuation on practices that cannot lead to fertility. I see no grounds for supposing that any of the three preferences types have particularly strong or weak interest in reputation or peer judgment, or in emotional satisfaction, or in avoiding the risks of disease. While the importance of these outcomes surely vary among people, those variations will be considered randomly distributed except for the systematic differences reflected by membership in the three preference groups. One other preference that is measured in the data and included in the analysis below is same-gender sex and aside from the inability of this activity to produce a pregnancy from their preferred sexual practices, again, I see no particular reason to hypothesize a difference for persons with homosexual or heterosexual preferences in terms of the other five outcomes from sex: we should expect to see differences in practices, to be sure, and there will be differences in the content of, say, sexual reputation, but not so in the value one places on a good reputation however one's peers might define that, or in the value of physical pleasure, emotional satisfaction, intimacy, or in avoiding the transmission of disease. (see Black, Sanders, Taylor, 2007)

The individual – an adult in the age range from 18 to 60 in the context of this essay – has a set of personal and background characteristics, has a set of preferences or judgments about sexuality and its salience in his or her life, and has a set of resources that include native endowments, general human capital, and sexual skills and habits. Subject to the resource constraints and these preferences, the individual selects sexual partnerships and sexual practices that result in outcomes that affect utility. Certain sexual practices impact one or another but not most of the six outcomes from sex, other practices may affect several outcomes. The practices describe the process of production that yields these joint outcomes; by varying the mix of practices, the person (or the partners) affects the composition of outcomes, but not completely as there are stochastic elements involved in some of these outcomes.

With an ideal data set, a good research strategy would be to identify and measure each of the six sexual outcomes, as well as a wide array of sexual practices that influence them. One would have

measures of personal attributes, characteristics, and general human capital as well as measures of sexual capital. With these data one could investigate how the practices impact those outcomes and the ways in which personal characteristics, preferences and capital influence those relationships. Both the choices of the practices and the outcomes from a given array of practices would be scrutinized. Even with an ideal data set both the theoretical modeling and the empirical investigation would need to be focused on some time frame – an entire lifetime, or, for example, a stage in the life course such as the interval of a first marriage.

In the context of the empirical effort described below, a very good but less than ideal data set is used and the context is *a specific sexual partnership within the past twelve months*. For each respondent in the data set, up to two sexual partnerships, currently active, have been identified and described, separately, and for each a series of facts about sexual practices and outcomes, and the respondent's assessment of the sexual partnership is recorded. This helps define the context in which this investigation is undertaken: the partners have been selected and so the choice of these partners is not a focus here. The duration of each partnership, its type (e.g., a marital spouse, a cohabiting partner, a casual sexual partner), the long term expectations for this partnership, and several other interesting dimensions of that partnership are measured. The focus of the empirical study is the sexual practices and sexual outcomes with this partner over the past 12 months, as reported by one of the two partners, the survey respondent.

Multivariate regression models are estimated, controlling for personal background, preferences, general human capital and measures of sexual capital, some general and some specific to that particular partnership. All regressions adjust the standard errors for the fact that some 15% of the observations are the same respondent reporting on a second sex partner, as described below. In terms of sexual capital, theory suggests that we should see that a person with more capital will exhibit both a greater “allocative efficiency” and a greater “worker effect.” That implies that in a multivariate model of factors influencing a sexual practice, sexual capital would have influence through the selection of one or another practice – the allocative effect. But similarly, in a statistical model describing factors associated with one of the outcome from sex, controlling for practices, the sexual capital would exhibit an influence here as well, showing its “worker effect.”

IV. The Data File The data used in this study come from the National Health and Social Life Survey (NHSLs) conducted in 1991 as a one-time, cross-sectional face-to-face interview with a stratified random sample of adult Americans. The interview was 90 minutes in length on average and has been described and analyzed extensively. (Laumann et al, 1994; Michael et al, 1994; Laumann & Michael, 2001) One of the sections of that interview focused exclusively on sexual behavior within the past 12 months and did so separately for up to two sex partners whose characteristics were described separately as was the sex with each. This partner-specific data file on sexual behaviors is used in the empirical inquiry in this paper. Thus, the ten percent or so of 3,432 NHSLs respondents who had no sex partner within the past 12 months are not included here. The data are organized with each respondent-and-partner as an observation for a total of 3,522 paired observations reported by 2,990 respondents (so some 532 respondents report on a second partner as well). It is important to note that the partner was not directly interviewed so the characteristics of the partner and of the sex with that partner are reported only by the NHSLs respondent.

The variables used in this analysis are summarized in Table 1. The first column of numbers shows the mean (and standard deviations) for all the respondents from the entire NHSLs data set, while the right-hand two columns show the means for the female and male respondents in the respondent-and-partner data file, including the respondent's reports about their partner(s). The measured personal characteristics of the respondents include age, gender, race and a few facts about the family of origin, such as the mother's education level and whether the respondent lived with both biological parents at age 14 and whether he or she lived in a urban residence at that age. Several measures of the respondent's human capital are available, including years of schooling completed, a self-assessment of general health, whether health impaired his or her sexual activity², and the family's annual income. One sees in Table 1 very few differences between the whole sample of cases (NHSLs) and the subsets of partnered observations; there are a few important gender differences seen in the table.

Four potentially salient "life experiences" are measured: (1) whether the respondent reported having been touched sexually before puberty (an experience that may have affected subsequent sexual behavior, see Browning and Laumann 2001); (2) whether the respondent reported having ever been forced to do something sexual which he or she did not want to do; (3) whether the respondent ever spent time in jail, another experience that might also influence subsequent sexual behavior; and (4) whether the respondent served in the military (other than the reserves). For some of these experiences there are substantial gender differences.

The table also shows the distributions of the three categories of sexual preferences, the three Rs. In this paper these three groups are defined by answers to no more than four specific questions, each. "Reproductionists" are defined by: (1) an affirmative answer to a question that "my religious beliefs have shaped and guided my sexual behavior": (2) by the judgment that "sexual relations between two adults of the same sex" is "always wrong" or "almost always wrong"; (3) by the judgment that "if a man and a woman have sex relations before marriage" that is "always wrong" or "almost always wrong"; and (4) if they "strongly agree" or "agree" that "there should be laws against the sale of pornography to adults." So these reproductionists are guided in their own sexual behaviors by their religion and they disapprove of homosexual sex, premarital sex and pornography. "Recreationalists" also are defined by their responses to four questions: (1) they "strongly agree" or "agree" that "any kind of sexual activity between adults is okay as long as both persons freely agree to it"; (2) they consider it "not wrong at all" for "sexual relations between two adults of the same sex"; (3) they consider it "not wrong at all" "if a man and a woman have sex relations before marriage"; (4) and they "disagree" or "strongly disagree" that "there should be laws against the sale of pornography to adults." So the recreationalists see all consenting sex as acceptable and have no objection to homosexual sex, premarital sex or the sale of pornography to adults. "Relationalists" are defined by only two questions: (1) they "strongly agree" or "agree" that "I would not have sex with someone unless I was in love with them" or (2) they say it is "always wrong" or "almost always wrong" for "a married person having sexual relations with someone other than the marriage partner." So the relationalists stress love in sex or emphasize the importance of monogamy within marriage. The algorithm first determines if the respondent is a reproductionist or a recreationalist and of those not defined as either, the determination of the relationalists is made. There are a few respondents (fewer than 5 percent) who meet none of the three criteria and they are designated "other" in this sexual preference typing of adults.

The reproductionists and the recreationalists each constitute about one-in-six to one-in-eight of the sample except for the much smaller incidence of ‘reproductionist’ among males. About two-thirds of all respondents fit the criteria as a relationalist, without a strong and consistent judgment regarding controversial sexual behaviors but stressing the importance of love in sexual relations or contending that extramarital sex is always or nearly always wrong. The table also shows that a very small percentage of the respondents of either sex has experienced same-gender sexual partnering within the past 12 months (This question was asked in the SAQ-2: “Have your sex partners in the last 12 months been exclusively male; both male and female; exclusively female.” The variable, STRAIGHT, is a dummy defined as 1 if all the partners were of the opposite sex to the respondent. Very similar prevalence of same-gender preference is seen when self-identification as heterosexual or homosexual or bisexual is used or when “appeal” instead of behavior is the basis of the designation. See SOS, Chapter 10). While there is no necessary linkage between the three Rs and gender preference, it is interesting to note that the percent heterosexual is notably lower among the recreationalists (88.5%) than among either the relationalists (98.5%) or the reproductionists (98.7%).

The table organizes the information about sex under several categories. Sexual capital, as discussed above, includes the skills, habits, and attributes that affect sexual outcomes. The table contains several variables that reflect “general” sexual capital, separate from the particular relationship with any one partner. These include the respondent’s marital history – single and never having cohabited, cohabited but never married, married spouse present, and post-married as divorced, widowed or separated. Age at puberty and age at first vaginal intercourse are additional measures of general sexual capital. The dataset includes information about whether the respondent’s job involves any intimacy such as touching clients, or being alone in a closed room or space with clients, or involves discussion of an intimate nature with clients. Here the variable “wkintimate” is the simple sum of the number of these three employment circumstances that pertain; the table shows that on average respondents reported about doing one of the three (the distribution is: 40% do none, 35% do one, 16% do two, and 9% do all three). A person who engages in intimate interactions in their work-life presumably acquires skills useful in dealing with intimacy in their sexual life, so this is a form of general sexual capital.

The respondent was asked a few questions to determine his or her state of knowledge about how “to prevent getting the AIDS virus through sexual activity” and these are scored as two dummy variables, one indicating the respondent did know the most effective means (monogamy with an uninfected partner, and use of condoms), and one variable indicating the respondent had the erroneous judgment that use of a diaphragm, spermicidal jelly, foam or cream, or a vasectomy was a very effective means of preventing the spread of the AIDS virus. (While nearly 90% had the correct answer to the first, about 10% had the incorrect answer to the latter. The two dummy variables are independent of each other – a respondent could have the same value (1 or 0) for both. In fact, about 8% of the data file had a value of 1 for both and about 11% had a value of 0 for both.)

If the respondent has ever had an STI, that too is part of their sexual capital and overall about one-in-six reported having had one at some time over the lifetime (not surprisingly a bit higher for those who are sexually active within the past year). Some one-third of the women reported themselves sterile (this included, of course, those who had experienced menopause) while 11% of the men did so. The total number of sexual partners over the lifetime (since age 18) is also part of

general sexual capital, reflecting one type of experience; the strong positive skew to the distribution makes the median [in brackets] a more useful summary statistic of the lifetime number of sex partners. The data set also measures the number of sex partners within the past 12 months. This might be considered a sexual practice also, but in the context of this investigation that treats each sexual partnership as an observation, the number of partners within the past year is treated as general sexual capital. Sterility as well is a general condition in the current year and is included among the general sexual capital variables, measured as separate variables for the female and for the male respondents.

Sexual capital also can be partner specific. Since the information used in this study pertains to the partner with whom the sexual behavior was described, I can measure several aspects of this partner-specific sexual capital. The particular partnership relationship is a key factor here: the partner is defined as either the spouse, or the cohabiter or another type of partner, and this information is separate, logically and measurably, from the respondent's current marital status. That is, a "married" respondent has potentially reported on sex within the past 12 months with both a spouse and with a second partner and the two are separate observations in these data, as set up here. Also, we know the duration of time (in months) since the respondent first had vaginal intercourse with each particular partner, so we can investigate the effect of duration of exposure with this partner, again distinct from the interval of the lifetime since first intercourse. The respondent was asked if he or she expected this partner to be sexually exclusive with him/her and separately if that partner expected him/her to be sexually exclusive with her/him. The measure of "exclusivity" is a dummy defined as 1.0 if both respondent and this partner expected the relationship to be monogamous (all reports, remember, are made by the respondent; the partner was never interviewed). Another important aspect of a sexual partnership is the familiarity of the two partners, here measured by a dummy defined as 1.0 if the two had known each other for more than a year before they first had sex, and separately a "not familiar" dummy defined as 1.0 if the two had known each other only two days or less before they first had sex. [The question asked was: "How long did you know (PARTNER) prior to having sexual activity for the first time?"] The time at which this circumstance occurred may have been some years ago, but it is considered a couple-specific fixed-effect here, and measured accordingly. For each partner (as well as for the respondent, of course) we also know the age, education level, race/ethnicity and religious affiliation; four dummy variables are defined as 1.0 if the respondent and this partner were of the same age (within 5 years), education (within one education level category), race/ethnicity, or religion (Protestant, Catholic, Jewish, etc). The variable "SAME4i" is the simple sum of the number of these four pairs of attributes that are the same; the mean is about 3 of the four attributes similar for the average partnership.

Table 1 also summarizes information on the sexual practices and sexual outcomes from each partnership. Partner-specific measures of sexual practices include the frequency of sex in the past 12 months with this partner³, the use of condoms, and the practice of "always or usually" or "never" engaging in oral sex given by the respondent to the partner. While no further analysis is reported here of several other sexual behaviors with this partner, they too are summarized in Table 1; they include the frequency ("always or usually," or "never") of the practices of oral sex received by the respondent, vaginal intercourse, and anal intercourse.

Regarding the sexual outcomes, information on four of the six outcomes are featured here. I have no useful indicator of peer reputation. I have chosen not to include pregnancy in this paper, so the

four other sex outcomes are measured here. *Physical pleasure* is measured in two respects. The respondent's frequency of orgasm, this past 12 months with this partner, is one measure. It is a cardinal scale based on a five-point scale converted into a percent of time orgasm was experienced: "never" (0.0), "rarely" (0.2), "sometimes" (0.5), "usually" (0.8), or "always" (1.0). The same question was asked of the respondent about the orgasm experience by the partner. This too is scaled in the same manner; RORGQ is the response about the respondent, and PORGQ is the response about the respondent's partner. The other measure of physical pleasure from sex, "phypls12", is an ordinal scale from 0 to 4 based on the respondent's reply to the direct question, asked in the context of the sex you had with that partner: "How physically pleasurable did you find your relationship with [this partner, asked by name] to be: extremely pleasurable, very pleasurable, moderately pleasurable, slightly pleasurable or not at all pleasurable?" (The values are 0 for "not at all" up to 4 for "extremely pleasurable.") It is interesting to note that the simple correlation of the reported frequency of own-orgasm and the assessment of one's own physical pleasure is stronger for females (0.34) than for males (0.11) and stronger still among older females (age 30-60: 0.38) than among younger females (age 18-29: 0.27) but not so for males.

One measure of the outcome of *emotional satisfaction* is provided by the response to the question "How emotionally satisfying did you find your relationship with [partner, by name] to be: extremely satisfying, very satisfying, moderately satisfying, slightly satisfying, or not at all satisfying?" (Again, this variable, "emosat12", is scaled 0 to 4 with higher values reflecting more favorable responses.) There are also questions about specific feelings regarding sex with that partner. This sequence of questions was prefaced by: "Now I would like to ask you how sex with [that partner, named] made you feel. Please tell me if sex with [partner] made you feel:" (yes or no, separately for each of these, in this order): "satisfied, sad, loved, anxious or worried, wanted or needed, taken care of, scared or afraid, thrilled or excited, guilty, and other (specify)." Two of these are best described as positively reflecting the outcome of emotional satisfaction from sex with that partner: feeling thrilled and feeling satisfied. They are summed, here, yielding the measure of emotional satisfaction "feelemogood2." It is positively correlated with the direct measure emosat12: 0.46. Four of these, in contrast, are best described as negatively reflecting the outcome of emotional satisfaction from sex: feeling sad, anxious, scared, and guilty. They too are summed to create a negative measure of emotional satisfaction, "feelemobad4" which is correlated with the direct measure emosat12: -0.38. Overall the two direct measures of physical pleasure and emotional satisfaction are correlated at 0.72.

Regarding sexual intimacy, this same series of questions about how the sex made the respondent feel offers a reasonably good measure. The sum of the answers about feeling loved, wanted or needed, cared for defines the variable "feelint3." It is correlated with the measure of physical pleasure: 0.49, a little stronger for females (0.53) than for males (0.46); it is slightly more strongly correlated with the measure of emotional satisfaction. 0.55, and identically so for females and males.

A final outcome from sex during the 12 months that is not necessarily directly associated with this specific partner is a dummy defined as 1.0 if the respondent had a sexually transmitted infection during the past 12 months, "stiy." One other measure indicates that the respondent had a bacterial STI in that year, "stibactyr" which is a subset of "stiy." Empirical results are not shown for it since they are quite similar to the patterns for "stiy."

Table 1 shows means, by gender, for these several sexual practices and sexual outcomes within the past 12 months with a specific partner. Single-equation, multivariate models are estimated empirically below for three of these sexual practices – the frequency of sex per week, the use of a condom, and the practice of giving oral sex. Other of these practices are not included in the tables below because either they yielded qualitatively similar results to those reported, i.e. the models for receiving oral sex are very similar to those for giving oral sex, or the frequency was so common (i.e., vaginal intercourse as a sexual practice) or so uncommon (i.e., anal intercourse) that there was not sufficient variation to warrant study. Subsequent to these results, tables report multivariate models estimated for eight of the measures of outcomes from sexual behavior with a specific partner within the past year – three capturing aspects of physical pleasure, three measures of emotional satisfaction, one reflecting intimacy, and one indicating a sexually transmitted infection.

V. Correlates of Sexual Practices

Tables 2-4 show OLS or logistic regression models for three sexual practices: the frequency of sex per week with a specific partner, condom use with that partner in the past 12 months, and oral sex with that partner in the past 12 months. The right-hand side covariates are grouped by category for presentation. Some are person background descriptors such as age, gender, and race; some are basic human capital indicators including level of schooling (in years), health status, and the log of income. Additionally, a set of four variables measure life experiences; these indicate if the respondent reported being molested as a child, reported ever being forced to do something s/he did not want to do sexually, ever spent time in jail, or was ever in the military. Three variables capture aspects of sexual preferences, dummy variables based on the respondents attitudes defining “reproductionists” and “recreationalists” and whether the respondent reported that all his/her sexual partners were opposite sex or not (the dummy is “1” if all partners are opposite sex). There are also several variables labeled “general sexual capital” including marital history, age at puberty, age of first vaginal intercourse, whether s/he had a job that involves intimacy, whether he/she knows well or poorly the ways to avoid a sexually transmitted infection, sterility status for the male and female respondent, and the number of sexual partners within the past 12 months. Finally, there are seven variables that reflect “partner-specific sexual capital” and these, of course, are defined with respect to that one partner only – whether that partner is a spouse or cohab partner, the duration of sexual relations with that partner, whether that couple expects exclusivity, whether they were acquainted for a while before beginning sexual relations and whether they are similar in age, education, race and religion. The OLS regressions (for frequency of sex per week) and the logistic regressions (for whether the respondent reported that a condom was used “usually” with that partner, and reported ever giving oral sex to that partner) are shown for all respondents, and for younger (age 18-29) and older (age 30-60) females and males separately.

The *frequency of sex* averaged about 1.4 times a week, with about 1.5 for those with only one partner and a bit less per partner for those with two or more partners. The OLS regressions in Table 2 tell us that the frequency declines gradually but systematically with age, overall and after age 30 for females. Except for the “partner-specific sexual capital” variables there are few other robust findings except that those who reported that health interfered with their sexual activity report lower frequency after age 30. Among the partner-specific sexual capital measures, however, the correlates are several, robust and substantial in magnitude. Partners who are the spouse or the cohabitational partner share more frequent sex than other partnerships. Frequency is

substantially greater for couples who have the expectation of sexual exclusivity. These patterns hold for men and women, young and older.

In the logistic regressions on *condom use*, Table 3, younger respondents are more likely to use them, especially as reported by the males. Whites are less likely to use condoms, overall and particularly among younger males. Heterosexuals are much more likely to use them as are more educated respondents and those who are “recreationalists.” Those who report themselves to be sterile are dramatically less likely to report using a condom. Condom use is higher, however, among those with more sex partners within the past year. The partner-specific sexual capital variables exhibit reasonably strong association with condom use: respondents are much less likely to use a condom with a spouse or cohab partner and if the relationship is understood to be exclusive, and they are more likely to use a condom, all else equal, if the couple has known each other a long while before beginning to have a sexual relationship – this is interpreted to be an indication of concern for the well-being of that partner, a concern less shared with a partner who is not a long-term acquaintance.

The evidence on *oral sex* is seen in Table 4. Models were run on four distinct behaviors – ever gave oral sex, “usually” gave oral sex, ever received oral sex, and “usually” received oral sex. Table 4 shows only the logistic regressions on the first of these behaviors since qualitatively the models on the other measures reveal quite similar patterns. While about two-thirds of adults report ever giving and receiving oral sex, only about one-sixth report doing so “usually” when they have sex. Several factors show statistically significant association with this behavior: younger adults are slightly more likely to report the behavior, and whites are quite dramatically more likely to do so. There is a mildly positive association of this behavior with family income and with education level – either the respondent’s own education level or his/her mother’s education level.⁴ Those who reported that their health interfered with their sexual activities in general are less likely to engage in oral sex, but oddly those who said their health never interfered with their sexual activities also reported less oral sex. Women who reported ever being forced to do something sexual that they did not want to do are more likely to engage in oral sex; similarly, women who report having been touched sexually as a child also are more likely to have oral sex in their current sexual repertoire. One of the most consistent associations found in these logistic regressions is that those who are “reproductionists” (based on their sexual attitudes and beliefs) are far less likely to report oral sex, while those who are “recreationalists” are much more likely to do so. Those who experienced puberty at a later age report less oral sex as do young females whose first vaginal intercourse occurred at a later age. Older males who report themselves sterile report having more oral sex. In terms of the measures of partner-specific sexual capital, the practice of oral sex is more prevalent with a spouse or a cohab partner, and it is much more likely in partnerships that are considered sexually exclusive.

Considering these three sexual practices, I suggest that the patterns described in these regression models are, nearly all, imminently sensible statistical correlations. The most salient finding here is that the measures of partner-specific sexual capital are consistently strong factors in all these models: they seem to be more systematically correlated with frequency of sex, with the use of condoms and with the practice of oral sex than do any of the other categories of covariates. This does not prove that “sexual capital” is at work here, but that is not the point: the point is that the application of a standard notion of human capital in the domain of sexual skills and habits is a useful tool in understanding the observed pattern of several sexual practices. In terms of the

categories of variables explored here, partner-specific sexual capital variables are among the more influential and robust. Specific variables such as being a “recreationalist,” age, race, and age at first intercourse also show a modestly strong association with these three sexual practices. In general, the other life experiences do not. It is interesting to note that there is practically no evidence of any association with any of these three sex practices with gender, growing up in an intact family, general health, knowledge of the risks of STIs, having served in the military or having been in jail.

VI. Sexual Outcomes

Turning to the sexual outcomes, Tables 5-12 report OLS or logistic regression models for the several measures of the joint outcomes from sex with the specific partner. These models include the personal background life experiences, preference categories as well as measures of human capital, general and partner-specific sexual capital and also the measure of sexual practices. These latter variables are analogous to controlling for the nature of the production function in an output function. The practice of condom use, for example, might be expected to affect favorably the outcome of risk of an STI but not be related to the outcome of emotional satisfaction from sex with this partner. The frequency of sex with this partner, by contrast, might be expected to affect nearly all the outcomes, some positively (physical pleasure or emotional satisfaction) and some adversely (the risk of disease). By including both the partner-specific sexual capital variables and the sexual practices, the coefficients on the elements of sexual capital can be interpreted as reflecting the “worker effect” of a skill, since much of the “allocative efficiency” effect is captured by the choices of sexual practices that are controlled in these regressions.

Table 5 reports results for *physical pleasure*. In terms of personal background and human capital, only poor health that was described as influencing sex shows any systematic relationship with physical pleasure. Having experienced forced sex, and having spent time in jail are related to lower levels of reported physical pleasure from sex but it is the partner-specific sexual capital measures that show relatively robust statistical relationships with this measure of physical pleasure from sex with this partner. The relationship is strongly positive if the partnership is considered to be sexually exclusive, positive as well for the spouse. Sharing several personal characteristics (age, education, race and religion) with the partner is positively associated with a higher level of physical pleasure. In terms of the sexual practices, frequency is very strongly related to physical pleasure as is oral sex and, especially for older females and older males, so too is the practice of usually or nearly always involving vaginal intercourse in sexual events.

Table 6 reports on the measure of the *frequency of orgasm* in sexual events (as described above, this is calibrated as the percent of time, from none to always (0.0 to 1.0) with several intervening levels so these are OLS regressions on a dependent variable that takes one of five values). Females report far lower levels of orgasm, as do white women in particular. Reported health as related to sexual activity shows the direction of effects one would expect. Overall, the relationships are not strong or robust across the gender-age groups. Only the frequency of sex seems to be reasonably consistently positively associated with a higher rate of orgasm. Table 7 shows the comparable results for the partner’s rate of orgasm, as reported by the respondent. These are somewhat suspect measures, perhaps of interest as reflecting what the respondent thinks is going on, and shown here for completeness. The only results here worthy of note are that again there is a strong relationship for female (positive in this context because the female respondent is

reporting on her partner's frequency of orgasm during sex) and a relatively persistent but small positive relationship with frequency of sex.

Table 8 shows the relationship with *emotional satisfaction* and these are much stronger. One sees here, as with physical pleasure, a negative association with having experienced forced sex and having spent time in jail (particularly for young men). Poor health inhibits the respondent's sense of emotional satisfaction from sex with this partner. There is an indication here that the "reproductionists" experience somewhat greater sense of emotional satisfaction. Again, the partner-specific sexual capital variables show far more robust associations. Emotional satisfaction is substantially higher with a spouse, and somewhat so, for some groups, for a cohab partner as well. Exclusivity is again a strong factor, as is sharing more of the four personal attributes. Being not familiar with the partner for more than a few days prior to beginning a sexual relationship shows a clear negative association with emotional satisfaction from that partnership, in particular for men both young and older. The sexual practices as well show strong and robust association with emotional satisfaction: frequency of sex is very strongly associated with greater satisfaction. Oral sex and vaginal intercourse are as well. Emotional satisfaction is lower for those with a higher number of partners within the year.

Tables 9 and 10 consider two subsets of emotional feelings (these are not used in the measure of emotional satisfaction in Table 8, which is an independent measure asked separately). Table 9 includes the emotions of feeling "thrilled" and "satisfied" sexually, while Table 10 includes the four negative emotions of feeling sad, anxious, scared and guilty from the sex with this partner. Health influences these emotions in the directions one would expect, but not consistently across the gender-age groups. Having experienced an inappropriate sexual event as a young child shows up as lowering the likelihood of feeling these two good emotions while being forced to do something sexual is associated with a greater likelihood of experiencing these unpleasant emotions of sadness, anxiety, fear or guilt. The more restrictive reproductionists report more of these good emotions from sex while the recreationalists, perhaps true to form, experience a somewhat lower rate of feeling sad, anxious, scared or guilty from their sex with this partner. As in most other of these tables on outcomes from sex, the partner-specific sexual capital variables show rather strong and robust associations with both the positive and the negative emotions. Sex with a spouse is associated with a better outcome in both regards, as is an exclusive sexual relationship. Here again, sharing more of the four personal attributes with the partner – age, education, race and religion – is associated with a higher level of the good emotions and, overall but not so for the sub-groups, a lower level of the unpleasant emotions. The same general pattern is exhibited for the sexual practices measured specifically here: the frequency of sex with this partner is strongly associated with more of the good and less of the unpleasant emotions, and similarly for both oral and vaginal sex.

Table 11 considers *intimacy* from sex (specifically, the simple sum of affirmative answers to three questions about whether sex with this partner made the respondent feel loved, feel wanted or needed, and feel taken care of). The results are strong, sensible, and interesting. Overall, intimacy rises with age but is somewhat lower for whites, and surprisingly somewhat lower for more educated respondents. None of these patterns, however, are strong enough to be robust across the gender-age sub-groups. Again, overall, experiencing an inappropriate childhood sex event is associated with less intimacy in sex with the current partner. The reproductionists report stronger levels of intimacy with their partner. Confirming, somewhat, that intimacy in one domain

influences another, the variable reflecting intimacy in ones job is statistically associated with this quite separate measure of intimacy with the current sex partner. Those who have quite poor understanding of how to prevent and STI, however, also report somewhat higher levels of sexual intimacy. As with the other measures of outcomes, the partner-specific sexual capital variables show a strong relationship with sexual intimacy. Spouses share greater levels of intimacy for all sub-groups. Cohabiting partners experience greater intimacy as well, but not so for all the sub-groups. Exclusivity is strongly associated with intimacy as is familiarity (and conversely non-familiarity shows a lower amount of intimacy). Again those who share more personal attributes have a slightly higher level of intimacy. Among the sexual practices, frequency once again exhibits a strong and robust association with intimacy, as does the practice of oral sex, and for older females vaginal intercourse does as well.

Table 12 reports on the final outcome measure, contracting an *STI in the past 12 months*. This is not necessarily linked to this sexual partner, unlike all the other outcome measures explored here. (The questionnaire made no effort to determine from whom the respondent contracted a disease). The results here are much stronger for the males than for the females. Among the men, whites report far higher rates of an STI, as do those with more education and those who have spent time in jail. The men who are reproductionists report dramatically lower rates of disease, as do those whose jobs involve intimacy. Men who share more personal characteristics with their partner also have far less disease, while those with more partners and a higher frequency of sex with their partner have higher rates of disease. (There were so few cases of STIs within the past year among the older men (only four cases) that these models are shown by gender and age group.)

VII. Conclusion

Sexual behavior is a complex, fascinating, quintessentially private, and important aspect of human behavior. It undeniably influences ones sense of well-being; it has immediate and intense, as well as very long run, personal consequences. It influences relationships with partners, family members, colleagues and friends. It spans some of the best and some of the worst of personal experiences. The study of sexual behavior, from many perspectives and with the tools of many sciences, is warranted. In this essay, I have attempted to address the question of what an economic approach to this subject might contribute to our understanding of sexual behavior. I have emphasized the fact that preferences and attitudes, habits and skills influence varied aspects of sexual behavior. The behavior can be understood as a whole, and the several components organized in a sensible manner using conventional notions from micro-economics of a production relationship among preferences, resources, actions and outcomes.

Some elements of sexual behavior are best categorized as practices or as the process of generating outcomes. Others are those outcomes, and the activity of sexual behavior yields not a single product but several joint outcomes. Here I've identified six distinct products from sex, and argued that by altering the nature of the production process – the sexual practices – the relationship among those six outcomes can be varied according to ones preferences for them. I have featured “sexual capital” as an organizing concept, and been able to identify a few aspects of that capital that are general – applicable in most any sexual interaction – and others that are specific to a particular partner. The data allows me to link that partner-specific sexual capital to practices and outcomes with that particular partner. These attributes of general and specific capital, of course, mirror those notions used effectively as the study of human capital in the field of labor economics.

The data set used in this study has many attractive attributes, but it is becoming dated (collected in 1992). Yet it remains the only nationally representative data set that spans the adult ages (18-59), the whole of the U.S., and delves in considerable detail into the various sexual events and behaviors and attitudes. The data file exploited in this paper is but one way of organizing the information in that data set and this particular structure has not previously been used. Because I have taken the reports about sex with a specific partner over the past 12 months as my focus, there are important sexual practices that have not been studied here, including the choice of number of partners or the choices about the characteristics of those partners, the relationship between sexual practices and fertility, or the longer term development of the sexual partnership outside the scope of the past 12 months, and so on. There is much more to be studied here. There are as well several additional good data sets that focus on other aspects of sexual behaviors in the U.S. that can be investigated for specific age groups, both young and old. Other nations, especially Great Britain and France, also have equally good broad data sets, and the British data, in particular, includes much more recent information. {I have not as yet done an adequate job of integrating my findings here with literatures.}

Substantively, the findings from this investigation include the following. Regarding sexual practices, the frequency of sex per week with a specific partner declines with age, with the duration of that partnership, and is lower as well if the individual had his or her first sexual experience at a later age. The frequency is substantially greater with a spouse or with a cohabiting partner, and greater if the partners expect sexual exclusivity. Several of these relationships reflect the importance of partner-specific sexual capital. Condom use with the partner is less at older ages; whites report less use of condoms while more educated adults report greater usage. Heterosexuals report far greater use of condoms and those characterized as recreationalists do so as well. Use of condoms is far less frequent with a spouse or cohabiting partner and less frequent as well if the partnership is understood to involve sexual exclusivity. Interestingly, couples who were acquainted with each other for a longer time period prior to beginning a sexual relationship use a condom with greater frequency; perhaps this reflects a deeper commitment to the health of the partner. The sexual practice of oral sex declines somewhat with age, and among those who went through puberty at an older age, but it is much more frequent among whites and among the more educated. Those who had experienced inappropriate childhood sex and those ever forced to do something sexual they didn't want to do engage in more oral sex, while, the "recreationalists" have more oral sex while the "reproductionists" have far less. As for the partner-specific sexual capital measures, oral sex is more common with a spouse or cohabiting partner and in a sexually exclusive relationship and declines with duration of the relationship and is lower among those who were acquainted for a longer while prior to beginning to have sex together.

The partner-specific sexual capital is consistently associated with the measures of the four outcomes of sexual behavior. Physical pleasure and emotional satisfaction from sex, as well as specific good emotional feelings (feeling thrilled or satisfied), and intimacy (feeling loved, cared for and wanted or needed) are all much more prevalent in partnerships that are considered sexually exclusive, are among spouses or cohabiting partners, and where the two partners are more similar in age, education, race and religion. The sexual practices also are closely associated with these same outcomes: these desirable outcomes are greater in partnerships that report a greater frequency of sex, more oral sex, and more vaginal intercourse. Several of these patterns are seen as well, in reverse, for the two negative outcomes studied here, unpleasant emotional feelings associated with sex with that partner – feeling sad or anxious, scared or guilty – and having an STI

within the past 12 months. These emotions are less prevalent with a spouse or cohabiting partner and if the partnership involves sexual exclusivity, and if the partners share similar personal characteristics. They are also less prevalent in partnerships where the frequency of sex is greater and where oral and vaginal sex is more common. In terms of the STIs, two key factors are seen: the risk is much greater if the number of partners is greater and if the frequency of sex is greater with the partner.

The preferences reflected by the three Rs show an interesting pattern: In terms of sexual practices, the recreationalists exhibit the most robust associations. They are much more likely to engage in oral sex and to use condoms, while the reproductionists are much less likely to engage in oral sex, which is logically consistent with their stated attitudes. In terms of the sexual outcomes, by contrast, the recreationalists exhibit almost no relationships while the reproductionists report higher levels of physical pleasure from sex, greater emotional satisfaction as well, and greater intimacy with their partner. The male reproductionists also report lower rates of STIs within the past 12 months.

These relationships cannot be thought of as evidence of “causation” – having sex with a partner more frequently may, indeed, increase the sense of intimacy, for example, but just as reasonably, an intimate relationship is likely to involve a greater frequency of sex. So the association that is found here empirically does not tell us which caused the other. This implies that these findings cannot be interpreted as suggesting that if a couple engaged in more of that practice, the level of that outcome would necessarily increase. There are however statistically strong relationships reported in these tables; most of them make much sense and their organization through this economic lens provides coherence and order on these varied activities and experiences. There is considerable value, I contend, in using this economic approach, this conceptualization of sexual behaviors into practices and outcomes influenced by the accumulated skills, habits, and attributes called sexual capital. There is much more that can be done and it is a challenging intellectual endeavor that I hope this essay will encourage.

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Table 1: NHSLS Summary Statistics: whole sample and partner file

		NHSLS	Partner file	
Personal Background			Females	Males
Age	AGE	36.4 (10.9)	35.1 (10.6)	35.2 (10.8)
Female	FEMALE	0.56 (0.50)	1.00	0.00
White	WHITE	0.76 (0.43)	0.73	0.77
Lived in intact family	FAM14INTACT	0.72 (0.45)	0.70	0.72
Mother's Education	MOMED	11.6 (2.62)	11.63 (2.56)	11.84 (2.57)
Lived in a city at 14	CITY	0.31 (0.46)	0.31	0.31
Human Capital				
Years of Schooling	SCHYRS	13.4 (2.23)	13.35 (2.18)	13.57 (2.27)
Health [1-4, 1=excel]	HEALTH (-)	1.71 (0.72)	1.72 (0.72)	1.62 (0.67)
Health impairmt-sex-none	HSEXGOOD	0.37(0.48)	0.26	0.40
Health impairmt-yes	HSEXBAD	0.34 (0.47)	0.42	0.30
Income	INCOME(aug)	36,108 (27781)	34,574 (26k)	37,498 (26k)
Ln(Income)	LNINCAUG	10.15 (0.99)	10.11 (0.98)	10.26 (0.88)
Life Experiences				
Childhood sex	MOLEST	0.16 (0.37)	0.19	0.18
Forced sex'ly ever	EVERFORCED	0.10 (0.30)	0.18	0.03
Spent time in Jail	JAIL	0.13 (0.34)	0.06	0.26
In Military, ever	MILITARY	0.13 (0.33)	0.02	0.26
Sexual Preferences: 3-Rs				
R1 (reproductionist)	TYPE-R1	0.15 (0.36)	0.14	0.08
R2 (relationalist)	TYPE-R2	0.68 (0.47)	0.69	0.67
R3 (recreationalists)	TYPE-R3	0.13 (0.34)	0.15	0.17
R0 (none of the three)	TYRP-R0	0.04 (0.19)	0.02	0.07
All partners hetero	STRAIGHT	0.97 (0.16)	0.98	0.96
General Sexual Capital				
Single, never cohab/married	SINGLE	0.16 (0.37)	0.12	0.20
Cohab (only; never Mar)	MHCOHAB	0.12 (0.33)	0.14	0.17
Married spouse present	MARRIED	0.48 (0.50)	0.50	0.44
Div, Wid, Sep	DIVWIDSEP	0.23 (0.42)	0.25	0.20
Age at Puberty	PUBERTY	12.87 (1.51)	12.66 (1.63)	13.09 (1.35)
Age at First Sex (VI)	VI1	17.75 (3.24)	17.74 (2.88)	17.00 (3.17)
Intimacy at work (3)	WKINTIMATE	0.92 (0.96)	1.00 (103)	0.85 (0.85)
Knowledge re STI	KNOWSTI-YES	0.86 (0.35)	0.87	0.88
No knowledge re STI	KNOWSTI-NO	0.10 (0.30)	0.10	0.10
Ever had an STI	STIEV	0.17 (0.37)	0.21	0.19
Sterile (female)?	STERILEF	0.20 (0.40)	0.33	--
Sterile (male)?	STERILEM	0.07 (0.25)	--	0.11
No. Partners since 18	P18	10.15 (38.39)	7.19 *[3]	18.34 *[7]
No. Partners past 12 mos	N1YR	1.31 (1.42)	1.54 (1.30)	2.16 (2.09)
(cont.)				

Table 1: Summary Statistics, Continued

		NHSLS	Partner file	
			Females	Males
Partner-Specific Sexual Capital				
Spouse	SPOUSEi	**	0.53	0.45
Cohab	COHABi		0.16	0.14
Duration of partnership	DURPYi [0-46yrs]		9.94 (10.0)	8.25 (9.6)
Exclusivity	EXCLUSi		0.78	0.73
Familiarity	FAMILIARi		0.38	0.34
Not Familiar	FAMILIARNOTi		0.04	0.11
Same-age	AGESAMEi		0.72	0.73
Same-educ	EDUCSAMEi		0.81	0.80
Same-race	RACESAMEi		0.89	0.89
Same-religion	RELSAMEi		0.64	0.59
No. same (4 max)	SAME4i		3.06 (0.90)	2.99 (0.95)
Sexual Behaviors				
Frequency of sex with P	FREQi	**	1.44 (1.71)	1.35 (1.70)
Condom usage with P	CONDOMi		0.20	0.27
Oral sex: gave, usually	ORALGUi		0.13	0.20
Oral sex: gave, never	ORALGNPOSi		0.62	0.66
Oral sex: receive, usually	ORALRECU		0.16	0.20
Oral sex: receive, never	ORAGRECNPOS		0.64	0.68
VI: usually	VIUSUALLY		0.90	0.89
VI: never	VINEVERPOS		0.02	0.02
Anal sex: usually	ANALUSU		0.01	0.02
Anal sex: never	ANALNPOV		0.11	0.11
Sexual Outcomes				
Orgasm frequency w/ P	RORGQi [0.2,.5,.8,1.0]	**	0.73 (0.27)	0.93 (0.17)
Partner's Orgasm Freq	PORGQi [0.2,.5,.8,1.0]		0.94 (0.14)	0.83 (0.22)
Physical Pleasure w/ P	PHYPLSi [1-4]		3.07 (0.96)	3.13 (0.90)
Emotional satisfaction w/P	EMOSATi [1-4]		2.92 (1.07)	2.93 (1.06)
Feel emot. satisf. (positive)	FEELEMOGOOD2		1.76 (0.55)	1.84 (0.43)
Feel emot. satisf. (negative)	FEELEMOBAD4		0.39 (0.87)	0.37 (0.81)
Intimacy w/P (3)	FEELINT3		2.57 (0.84)	2.45 (0.94)
STI in past year	STIYR	0.02 (0.13)	0.03	0.01
Bacterial STI in past yr.	STIBACHYR	0.01 (0.10)	0.02	0.01
N		3,432	1,850	1,672
Number of respondents			1,642	1,348
Number with two partners in the file			208 (12.7%)	324 (24.0%)

*median; **partner-specific capital, behaviors and outcomes (i) are not defined for the whole NHSLS file, only for those who had a sexual partner within the past 12 months.

Table 2: Frequency of Sex per Week with Partner
[OLS Regressions; all variables included; only those with |t|>2.0 shown]

	All	Females		Males	
		Age 18-29	Age 30-60	Age 18-29	Age 30-60
Personal Background					
Age	-0.01 (-3.35)		-0.03 (-3.92)		
Female		--	--	--	--
White				0.51 (3.16)	
In intact fam.					
Mom's Educ					
Human Capital					
School (yrs)					
Health					
Healthsexgood					
Healthsexbad	-0.31 (-4.45)		-0.43 (-3.91)		-0.33 (-2.61)
Ln(Income)					
Life Experiences & Preferences					
Childhood sex	0.17 (2.13)				
Forced sex'ly ever				0.32 (2.17)	
Spent time in Jail					
In Military, ever					
R1 (reproductionist)				-0.44 (-3.27)	
R3 (recreationalists)				-0.29 (-2.22)	
All partners hetero					
General Sexual Capital					
Married		-0.85 (-2.19)		-0.88 (-2.11)	
Divwidsep					
Puberty age		-0.10 (-2.06)			
Age at First sex	-0.03 (-2.88)		-0.04 (-2.16)		
Intimacy at work					
Good knowl. STI					
Poor knowl STI		-0.72 (-3.47)			
SterileFemale				--	--
SterileMale					0.30 (2.19)
No. Partners 1 Yr		-0.11 (-2.12)			
Partner-Specific Sexual Capital					
Spouse	0.80 (5.69)	1.50 (3.80)		1.88 (4.55)	1.05 (4.75)
Cohab	0.85 (7.93)	0.65 (2.59)	0.54 (2.80)	1.77 (7.22)	0.67 (3.40)
Duration (yr)	-0.02 (-4.15)				-0.02 (-2.92)
Exclusivity	1.10 (16.87)	1.22 (8.04)	0.99 (9.19)	1.30 (8.92)	1.00 (8.17)
Familiarity	-0.17 (-2.85)		-0.25 (-2.72)	-0.39 (-2.61)	
Not Familiar			0.77 (2.04)		
Same-4 (age,educ,race,rel)					
R ²	0.180	0.201	.173	0.346	0.186
N	3083	562	1078	514	929
	scL1117/3	scL1117/3	scL1117/5	scL1117/5	scL1117/6

Table 3: Condom use with Partner in past 12 Months
[Logistic Regressions; all variables included; only those with |z|>2.0 shown]

	All	Females		Males	
		Age 18-29	Age 30-60	Age 18-29	Age 30-60
Personal Background					
Age	0.96 (-4.09)			0.88 (-2.57)	0.93 (-3.31)
Female		--	--	--	--
White	0.73 (-2.23)			0.34 (-3.36)	
In intact fam.					
Mom's Educ					
Human Capital					
School (yrs)	1.11 (3.17)	1.30 (2.87)	1.16 (2.45)		
Health					
Healthsexgood				1.99 (2.13)	
Healthsexbad					0.51 (-2.29)
Ln(Income)					
Life Experiences & Preferences					
Childhood sex					
Forced sex'ly ever					
Spent time in Jail					
In Military, ever					
R1 (reproductionist)					
R3 (recreationalists)	1.50 (2.57)		1.76 (2.05)	2.66 (2.44)	
All partners hetero	15.35 (4.27)		10.57 (2.36)	22.25 (2.85)	17.67 (2.61)
General Sexual Capital					
Married					
Divwidsep					
Puberty age					
Age at First sex				1.17 (2.70)	
Intimacy at work					
Good knowl. STI					
Poor knowl STI					2.00 (2.05)
SterileFemale	0.33 (-4.68)		0.25 (-5.05)	--	--
SterileMale	0.26 (-3.21)				0.32 (-2.35)
No. Partners 1 Yr		1.75 (5.03)		1.16 (2.27)	
Partner-Specific Sexual Capital					
Spouse	0.40 (-3.68)				0.32 (-2.85)
Cohab	0.57 (-3.72)			0.48 (-2.22)	0.51 (-2.07)
Duration (yr)					
Exclusivity	0.51 (-4.77)		0.47 (-2.81)		0.40 (-3.28)
Familiarity	1.68 (4.29)		1.65 (2.27)		2.07 (2.93)
Not Familiar					
Same4					
R ²	.205	.233	.175	.224	.210
N	3121	558	1057	519	939
	scL11117/7	scL11117/7	scL11117/8	scL11117/9	scL11117/10

Table 4: Oral Sex (ever gave) with Partner in past 12 months
[Logistic Regressions; all variables included; only those with $|z| > 2.00$ shown]

	All	Females		Males	
		Age 18-29	Age 30-60	Age 18-29	Age 30-60
Personal Background					
Age	0.98 (-3.30)		0.93 (-5.52)		0.95 (-3.37)
Female		--	--	--	--
White	2.76 (9.68)	2.56 (3.96)	4.35 (7.79)	2.37 (2.86)	2.52 (4.38)
In intact fam.				0.52 (-2.46)	
Mom's Educ	1.06 (2.99)		1.09 (2.43)		1.08 (2.02)
Human Capital					
School (yrs)	1.12 (4.43)	1.36 (3.88)	1.14 (2.94)		
Health		1.41 (2.17)			
Healthsexgood	0.69 (-3.32)	0.50 (-2.45)			
Healthsexbad	0.69 (-3.34)	0.53 (-2.44)	0.66 (-2.28)		
Ln(Income)	1.11 (2.00)				
Life Experiences & Preferences					
Childhood sex	1.33 (2.36)		1.81 (2.74)		
Forced sex'ly ever	1.42 (2.27)		1.92 (2.70)		
Spent time in Jail					
In Military, ever					
R1 (reproductionist)	0.46 (-5.39)		0.47 (-3.59)		0.45 (-2.97)
R3 (recreationalists)	1.54 (3.15)		1.61 (2.02)		1.89 (2.42)
All partners hetero					
General Sexual Capital					
Married		0.21 (-2.85)		0.24 (-2.02)	
Divwidsep		0.43 (-2.24)		0.32 (-2.35)	
Puberty age	0.90 (-3.68)	0.86 (-2.37)	0.90 (-2.34)		
Age at First sex		0.87 (-2.42)			
Intimacy at work					
Good knowl. STI				2.56 (2.32)	
Poor knowl STI			1.75 (2.06)		
SterileFemale			1.58 (2.68)	--	--
SterileMale	1.54 (2.36)				1.73 (2.37)
No. Partners 1 Yr					
Partner-Specific Sexual Capital					
Spouse	1.81 (2.76)	5.25 (2.76)		5.89 (2.57)	
Cohab	2.18 (5.55)			3.38 (3.90)	3.01 (3.51)
Duration (yr)	0.98 (-2.77)			1.18 (2.72)	
Exclusivity	1.75 (5.04)	2.70 (3.91)	1.73 (2.66)	3.13 (4.17)	
Familiarity	0.74 (-3.39)				0.56 (-3.36)
Not Familiar					2.14 (2.45)
Same4					
R ²	.153	.209	.226	.205	.170
N	3121	553	1095	519	939
	1117/10	1117/11	1117/12	1117/13	1117/13

Table 5: OLS Regression on Sexual Outcomes: Physical Pleasure

	ALL	Females		Males	
		Age 18-29	Age 30-60	Age18-29	Age 30-60
Personal Background					
Age					
Female		--	--	--	--
White					
In intact fam.					-0.13 (2.01)
Mom's Educ					
Human Capital					
School (yrs)					
Health					-0.11 (-2.51)
Healthsexgood					
Healthsexpoor	-0.12 (-3.35)		-0.14 (-2.45)	-0.20 (-2.05)	
Ln(Income)					
Life Experiences & Preferences					
Childhood sex					
Forced sex'ly ever	-0.16 (-2.71)	-0.24 (-2.56)			
Spent time in Jail	-0.14 (-2.72)		-0.45 (-3.14)		
In Military, ever					
R1 (reprod'ist)					0.20 (2.56)
R3 (recreat'lists)					
All partners hetero			-0.45 (-2.23)		
General Sexual Capital					
Single					
Married		-0.55 (-2.16)			
Divwidsep		-0.36 (-2.37)			
Puberty age					
Age at First sex					0.02 (2.34)
Intimacy at work					
Good knowl. STI					
Poor knowl STI					
SterileFemale				--	--
SterileMale					
Partner-Specific Sexual Capital					
Spouse	0.27 (3.16)	0.61 (2.40)			0.49 (3.41)
Cohab					
Duration (yr)	-0.01 (-2.13)				
Exclusivity	0.23 (4.72)	0.24 (2.04)	0.30 (3.50)		0.22 (2.56)
Familiarity					
Not Familiar					
Same4	0.05 (2.69)			0.11 (2.06)	
Sexual Practices					
No. Partners 1 Yr			-0.15 (-4.22)		
Frequency of sex	0.09 (9.25)	0.11 (5.66)	0.08 (4.58)	0.12 (5.65)	0.04 (2.03)
Condom					
Oralsex	0.25 (6.44)	0.29 (3.02)	0.18 (2.64)	0.37 (4.06)	0.16 (2.39)
VI, usually	0.28 (4.18)		0.46 (3.78)		0.38 (3.10)
R ²	.175	.262	.178	.302	.184
N	3069	560	1075	511	923
	scL1112b/14	scL1112b/16	scL1112b/17	scL1112b/18	scL1112b/19

Table 6: OLS Regression on Sexual Outcomes: Frequency of Orgasm (R)

[Respondent]	ALL	Females		Males	
		Age 18-29	Age 30-60	Age18-29	Age 30-60
Personal Background					
Age		0.01 (2.72)			
Female	-0.19 (-16.79)	--	--	--	--
White	-0.02 (-2.24)	-0.07 (-2.36)	-0.04 (-2.19)		
In intact fam.					
Mom's Educ					
Human Capital					
School (yrs)					
Health					
Healthsexgood	0.02 (2.04)				0.04 (2.97)
Healthsexpoor	-0.02 (-2.26)				
Ln(Income)	0.01 (2.17)				
Life Experiences & Preferences					
Childhood sex					
Forced sex'ly ever					
Spent time in Jail					0.02 (2.12)
In Military, ever					
R1 (reprod'ist)				0.07 (2.23)	
R3 (recreat'lists)					
All partners hetero	-0.08 (-2.83)		-0.17 (-2.89)		
General Sexual Capital					
Single	-0.07 (-3.38)				
Married	-0.04 (-2.03)				-0.05 (-2.61)
Divwidsep					
Puberty age					
Age at First sex	-0.01 (-3.27)				-0.01 (-2.53)
Intimacy at work					
Good knowl. STI					
Poor knowl STI					
SterileFemale				--	--
SterileMale				-0.12 (-2.87)	
Partner-Specific Sexual Capital					
Spouse					
Cohab	-0.04 (-2.14)		-0.08 (-2.47)		
Duration (yr)					
Exclusivity			0.06 (2.30)		
Familiarity					
Not Familiar			0.10 (2.31)		
Same4					
Sexual Practices					
No. Partners 1 Yr					
Frequency of sex	0.01 (3.59)		0.01 (2.86)		0.01 (2.43)
Condom					0.03 (2.29)
Oralsex					
VI, usually	0.09 (4.87)		0.09 (2.64)	0.15 (3.54)	
R ²	.206	.110	.100	.132	.085
N	3053	557	1068	510	918
	scL1112b/2	scL1112b/5	scL1112b/6	scL1112b/6	scL1112b/7

Table 7: OLS Regression on Sexual Outcomes: Frequency of Orgasm (P)

[R's Partner]	ALL	Females		Males	
		Age 18-29	Age 30-60	Age18-29	Age 30-60
Personal Background					
Age			-0.002(-2.75)		
Female	0.12 (12.74)	--	--	--	--
White			-0.02 (-2.09)		
In intact fam.					
Mom's Educ					
Human Capital					
School (yrs)					
Health	-0.01 (-2.76)				-0.03 (-2.75)
Healthsexgood	0.03 (3.14)			0.07 (2.57)	0.05 (2.63)
Healthsexpoor					
Ln(Income)					
Life Experiences & Preferences					
Childhood sex	0.02 (2.14)				0.05 (2.50)
Forced sex'ly ever					
Spent time in Jail					
In Military, ever		0.05 (2.73)			
R1 (reprod'ist)					
R3 (recreat'lists)					
All partners hetero				-0.18 (-3.26)	-0.16 (-3.43)
General Sexual Capital					
Single				-0.08 (-2.41)	
Married					
Divwidsep					
Puberty age					
Age at First sex	-0.003(-2.36)				
Intimacy at work					
Good knowl. STI					
Poor knowl STI				0.06 (2.11)	
SterileFemale				--	--
SterileMale					
Partner-Specific Sexual Capital					
Spouse		0.06 (2.18)			
Cohab					
Duration (yr)					
Exclusivity					
Familiarity					
Not Familiar		0.04 (2.00)			
Same4					
Sexual Practices					
No. Partners 1 Yr					
Frequency of sex		0.01 (2.48)	0.01 (2.35)	0.01 (2.41)	
Condom					
Oralsex					
VI, usually	0.09 (5.00)		0.10 (3.51)	0.09 (2.07)	0.10 (2.36)
R ²	.128	.109	.119	.119	.087
N	3029	555	1070	503	901
	scL1112b/8	scL1112b/5	scL1112b/11	scL1112b/12	scL1112b/13

Table 8: OLS Regression on Sexual Outcomes: Emotional Satisfaction

	ALL	Females		Males	
		Age 18-29	Age 30-60	Age18-29	Age 30-60
Personal Background					
Age					0.02 (3.02)
Female		--	--	--	--
White					
In intact fam.					-0.28 (-3.74)
Mom's Educ					
Human Capital					
School (yrs)				-0.05 (-2.08)	
Health					
Healthsexgood		0.37 (3.46)			
Healthsexpoor	-0.15 (-3.56)		-0.24 (-3.53)	-0.37 (-3.30)	
Ln(Income)					
Life Experiences & Preferences					
Childhood sex					
Forced sex'ly ever	-0.17 (-2.45)				
Spent time in Jail	-0.16 (-2.78)			-0.23 (-2.01)	
In Military, ever					
R1 (reprod'ist)		0.41 (3.03)			0.28 (3.54)
R3 (recreat'lists)					
All partners hetero			-0.67 (-2.81)		
General Sexual Capital					
Single					
Married					
Divwidsep					
Puberty age					
Age at First sex					
Intimacy at work					
Good knowl. STI					
Poor knowl STI					
SterileFemale				--	--
SterileMale			0.35 (2.24)		
Partner-Specific Sexual Capital					
Spouse	0.49 (5.55)	0.60 (2.36)		0.76 (2.58)	0.59 (4.07)
Cohab	0.24 (3.35)				0.32 (2.59)
Duration (yr)	-0.01 (-2.08)				-0.01 (-2.17)
Exclusivity	0.32 (5.84)		0.46 (4.82)	0.26 (2.07)	0.25 (2.49)
Familiarity					
Not Familiar	-0.23 (-2.81)			-0.41 (-2.51)	-0.35 (-2.84)
Same4	0.11 (5.07)		0.09 (2.71)	0.21 (3.35)	0.09 (2.45)
Sexual Practices					
No. Partners 1 Yr	-0.04 (-2.27)		-0.12 (-2.73)		-0.06 (-2.11)
Frequency of sex	0.10 (9.84)	0.10 (4.67)	0.10 (5.66)	0.12 (4.84)	0.06 (3 .06)
Condom					
Oralsex	0.22 (5.04)			0.37 (3.32)	0.23 (3.11)
VI, usually	0.21 (2.85)		0.42 (3.43)		0.32 (2.41)
R ²	.235	.271	.242	.368	.279
N	3071	560	1076	512	923
	scL1112c/3	scL1112c/6	scL1112c/6	scL1112c/7	scL1112c/8

Table 9: OLS Regression on Sexual Outcomes: Good Emotional Feelings(2)

[thrilled, satisfied]	ALL	Females		Males	
		Age 18-29	Age 30-60	Age18-29	Age 30-60
Personal Background					
Age					
Female	-0.09 (-3.80)	--	--	--	--
White					
In intact fam.					
Mom's Educ					
Human Capital					
School (yrs)					
Health					
Healthsexgood		0.13 (2.30)			
Healthsexpoor					
Ln(Income)					
Life Experiences & Preferences					
Childhood sex	-0.07 (-2.60)	-0.19 (-2.80)			-0.10 (-2.21)
Forced sex'ly ever					
Spent time in Jail					
In Military, ever					
R1 (reprod'ist)	0.06 (2.40)	0.19 (2.80)			0.11 (3.76)
R3 (recreat'lists)					
All partners hetero					
General Sexual Capital					
Single				0.21 (2.05)	
Married					
Divwidsep					
Puberty age					
Age at First sex					
Intimacy at work					
Good knowl. STI					
Poor knowl STI					
SterileFemale				--	--
SterileMale		0.23 (2.21)			
Partner-Specific Sexual Capital					
Spouse	0.10 (2.00)	0.37 (2.47)			
Cohab			-0.15 (-2.12)	0.19 (2.06)	
Duration (yr)					
Exclusivity	0.14 (4.71)		0.21 (3.93)	0.14 (2.18)	
Familiarity		-0.11 (-2.20)			
Not Familiar					-0.12 (-2.03)
Same4	0.04 (3.42)		0.06 (2.86)	0.06 (2.09)	0.04 (2.20)
Sexual Practices					
No. Partners 1 Yr			-0.09 (-3.56)		
Frequency of sex	0.02 (4.55)	0.04 (3.51)	0.03 (3.28)		
Condom					
Oralsex	0.13 (5.51)	0.24 (4.04)	0.09 (2.21)		0.14 (3.90)
VI, usually	0.09 (2.25)		0.22 (2.75)		
R ²	.110	.202	.169	.193	.099
N	3068	560	1073	512	923
	scL1112c/9	scL1112c/11	scL1112c/12	scL1112c/13	scL1112c/14

Table 10: OLS Regression on Sexual Outcomes: Bad Emotional Feelings(4)

[sad, anxious, scared, & guilty]	ALL	Females		Males	
		Age 18-29	Age 30-60	Age18-29	Age 30-60
Personal Background					
Age					
Female		--	--	--	--
White					
In intact fam.					
Mom's Educ					
Human Capital					
School (yrs)					-0.03 (-2.81)
Health			0.09 (2.18)		
Healthsexgood	-0.14 (-4.01)				-0.21 (-3.53)
Healthsexpoor			0.13 (2.47)		
Ln(Income)					0.09 (2.46)
Life Experiences & Preferences					
Childhood sex					
Forced sex'ly ever	0.27 (4.14)	0.29 (2.62)	0.25 (2.82)		
Spent time in Jail					
In Military, ever					
R1 (reprod'ist)					
R3 (recreat'lists)	-0.09 (-2.15)				
All partners hetero					
General Sexual Capital					
Single			0.47 (2.32)		-0.39 (-2.61)
Married					
Divwidsep			0.31 (2.41)		
Puberty age					
Age at First sex					
Intimacy at work					
Good knowl. STI					
Poor knowl STI					
SterileFemale				--	--
SterileMale					
Partner-Specific Sexual Capital					
Spouse	-0.50 (-5.80)	-0.77 (-3.39)	-0.30 (-2.36)		-0.46 (-2.89)
Cohab	-0.16 (-2.24)	-0.45 (-2.47)			
Duration (yr)					
Exclusivity	-0.11 (-2.26)		-0.27 (-3.61)		
Familiarity					
Not Familiar					
Same4	-0.04 (-2.05)				
Sexual Practices					
No. Partners 1 Yr					
Frequency of sex	-0.04 (-4.37)	-0.06 (-3 .26)		-0.05 (-2.52)	
Condom					
Oralsex	-0.13 (-3 72)				-0.15 (-2.57)
VI, usually	-0.18 (-2.63)		-0.38 (-3.25)		
R ²	.136	.192	.214	.161	.151
N	3066	560	1074	512	920
	scL1112c/15	scL1112c/17	scL1112c/18	scL1112c/19	scL1112c/19

Table 11: OLS Regression on Sexual Outcomes: <u>Intimacy</u>					
[loved, wanted or needed, cared for]	ALL	Females		Males	
		Age 18-29	Age 30-60	Age18-29	Age 30-60
Personal Background					
Age	0.01 (2.51)				
Female		--	--	--	--
White	-0.09 (-2.22)				-0.16 (-2.24)
In intact fam.					
Mom's Educ					
Human Capital					
School (yrs)	-0.02 (-2.68)	-0.05 (-2.21)			
Health					
Healthsexgood					
Healthsexpoor					
Ln(Income)		0.09 (2.41)			
Life Experiences & Preferences					
Childhood sex	-0.11 (-2.63)				
Forced sex'ly ever					
Spent time in Jail					
In Military, ever					
R1 (reprod'ist)	0.11 (2.92)	0.23 (2.29)			0.15 (2.65)
R3 (recreat'lists)					
All partners hetero					
General Sexual Capital					
Single			0.39 (2.01)		
Married				-0.66 (-2.66)	
Divwidsep					
Puberty age					
Age at First sex					
Intimacy at work	0.03 (2.23)				
Good knowl. STI					
Poor knowl STI	0.12 (2.32)	0.25 (2.37)			
SterileFemale				--	--
SterileMale				-0.45 (-2.52)	
Partner-Specific Sexual Capital					
Spouse	0.45 (5.77)	0.51 (2.40)	0.23 (2.11)	0.90 (3.84)	0.51 (3.51)
Cohab	0.21 (3.32)				0.37 (3.37)
Duration (yr)					
Exclusivity	0.27 (5.47)		0.35 (4.42)	0.34 (2.71)	0.23 (2.56)
Familiarity	0.07 (2.32)		0.10 (2.12)		
Not Familiar	-0.25 (-3.32)				-0.36 (-2.94)
Same4	0.06 (3.18)			0.18 (3.18)	
Sexual Practices					
No. Partners 1 Yr					
Frequency of sex	0.06 (7.79)	0.06 (3.22)	0.06 (4.64)	0.08 (3.47)	0.05 (2.69)
Condom					
Oralsex	0.23 (6.31)	0.24 (2.87)		0.36 (3.42)	0.25 (3.81)
VI, usually			0.26 (2.39)		
R ²	.218	.207	.227	.315	.239
N	3065	559	1074	511	921
	scL1112d/1	scL1112d/4	scL1112d/5	scL1112d/6	scL1112d/7

Table 12: Logistic on Sexual Outcomes: Sexually Transmitted Infection

[past 12 Months]	ALL	Females	Males
Personal Background			
Age			
Female		--	--
White			22.25 (3.03)
In intact fam.			
Mom's Educ			
Human Capital			
School (yrs)			1.74 (3.75)
Health			
Healthsexgood	0.37 (-2.19)		0.14 (-2.07)
Healthsexpoor			
Ln(Income)			
Life Experiences & Preferences			
Childhood sex			
Forced sex'ly ever			
Spent time in Jail			4.09 (2.71)
In Military, ever			
R1 (reprod'ist)			0.04 (-2.33)
R3 (recreat'lists)			
All partners hetero			
General Sexual Capital			
Single			
Married			
Divwidsep			
Puberty age			
Age at First sex			
Intimacy at work			0.10 (-2.46)
Good knowl. STI	0.43 (-2.25)	0.34 (-2.23)	
Poor knowl STI			
SterileFemale			
SterileMale			
Partner-Specific Sexual Capital			
Spouse			
Cohab			
Duration (yr)			
Exclusivity			
Familiarity			
Not Familiar			
Same4			0.48 (-2.74)
Sexual Practices			
No. Partners 1 Yr	1.17 (2.41)		1.44 (2.84)
Frequency of sex	1.19 (3.03)		1.47 (2.07)
Condom			
Oralsex			
VI, usually			
R ²	.204	.256	.448
N	3083	1614	1100
	scL1112d/7	scL1112d/8	scL1112d/9

References

- Becker, G. S. 1964. Human Capital. NYC: Columbia Univ Press for NBER.
- Ben Porath, Y. 1967 "The Production of Human Capital and the Life Cycle of Earnings." J. Political Economy. 75(August): 352-65.
- Bentham, J. 1988. (originally 1789). The Principles of Morals and Legislation. Buffalo, NY: Prometheus Books.
- Black, D. A., S. G. Sanders & L. J. Taylor. 2007. "The Economics of Lesbian and Gay Families." J. Economic Perspectives. 21(2):53-70.
- Browning and Laumann 2001 [to come; a chapter in Laumann & Michael, below]
- Cutler & Shapiro, 2004 (full reference to come; it is in Abraham, Katherine G. & Christopher Mackie, eds. 2005. Beyond the Market: Designing Nonmarket Accounts for the United States. Washington: National Academies Press. as a chapter drafted by David Cutler and Matthew Shapiro, "Chapter 5: Measuring Health" dated February 2004. (page 19) .)
- Grossman, M. 1972. The Demand for Health. NYC: Columbia Univ. Press for NBER.
- Heckman, James J. 2000. "Policies to Foster Human Capital." Research in Economics. 54: 3-56.
- Holmes, K. K., P-A. Mardh, P. F. Sparling, & P. J. Wiesner. 1990. Sexually Transmitted Diseases, 2ed ed. NYC: McGraw-Hill.
- Laumann, E. O., J. H. Gagnon & R. T. Michael. 1994. "A Political History of the National Sex Survey of Adults." Family Planning Perspectives. 26(1,Jan/Feb):34-38.
- Laumann, E. O., J. H. Gagnon, R. T. Michael, & S. Michaels. 1994. The Social Organization of Sexuality. Chicago:Univ. of Chicago Press. [SOS]
- Laumann, E. O. & R. T. Michael, eds. Sex, Love, and Health in America: Private Choices and Public Policies. Chicago: Univ. of Chicago Press. 2001.
- Michael, R. T. 2001. "Private sex and public policy". in E. O. Laumann and R. T. Michael, eds, Sex, love and health in America: Private choices and public policies. Chicago:Univ. of Chicago Press. pp.465-491.
- Michael R. T.. 2004. "Sexual Capital: An Extension of Grossman's Concept of Health Capital." Journal of Health Economics. Vol 23/4. pp.643-652.
- Michael, R. T., J. H. Gagnon, E. O. Laumann and G. Kolata, 1994, Sex in America. NY:Little Brown & Co. [SIA]
- Michael, R. T., J. Wadsworth, J. Feinleib, A. M. Johnson, E. O. Laumann & K. Wellings. 1998. "Private Sexual Behavior, Public Opinion, and Public Health Policy Related to Sexually Transmitted Diseases: A U.S. -- British Comparison." American J. of Public Health. Vol. 88, No. 5 (May): 749-754
- Mincer, J. 1974. Schooling, Experience, and Earnings. NYC: Columbia Univ. Press for NBER.
- New York Times Magazine (2001) [full site to come; (in Chicago)]
- Reiss, I. L. with H. M. Reiss. 1997. Solving America's Sexual Crises: Rape, Aids, Child Sexual Abuse and Teen Pregnancy. Amherst, NY: Prometheus Books.
- Tietze, C., 1960, "Probability of Pregnancy Resulting from a Single Unprotected Coitus". Fertility and Sterility. 11: pp. 485-488.
- Welch, F. 1970. "Education in Production". J. of Political Economy. 78: pp.764-771.
- Wilcox, A. J., D. B. Dunson, C. R. Weinberg, J. Trussell, D. D. Baird. 2001. "Likelihood of Conception with a Single Act of Intercourse: Providing benchmark rates for assessment of post-coital contraceptions". Contraception. 63: pp.211-215.

¹ The nine questions, listed here in order of the percentage holding an opinion toward the more liberal end of the spectrum in each case (the percentage agreeing is shown), are:

Q8 A woman should be able to obtain a legal abortion if she was raped	(88% agree)
Q1 Premarital sex always wrong	(80% disagree)
Q5 There should be laws against sale of pornography to adults	(66% disagree)
Q9 A woman should be able to obtain a legal abortion, if she want it for any reason.	(52% agree)
Q7 My religious beliefs have guided my sexual behavior	(48% disagree)
2Q Premarital sex <i>among teenagers</i> is always wrong	(39% disagree)
Q4 Same-gender sex is always wrong	(35% disagree)
Q6 I would not have sex with someone unless I was in love with them	(34% disagree)
Q3 Extramarital sex is always wrong	(23% disagree).

See SOS Table 14.1 for details, SIA p.234 has these summary percentages.

² Three questions were asked: “During the past 12 months, how much of the time has your physical health interfered with your sexual activities?” “During the past 12 months, how much of the time have emotional problems interfered with your sexual activities” and “During the past 12 months, how much of the time has stress or pressures in your life interfered with your sexual activities?” The dummy variable “Hsexgood” is defined as 1 if the response was “none of the time” for all three. The dummy variable “Hsexbad” is defined as 1 if any of the three responses was “all of the time” or “most of the time” or “some of the time.” There was a fifth category of possible answer, “a little of the time” but that was not used in the definitions of either good or bad sexual health. Roughly, one-third of the sample is coded as Hsexgood, as Hsexbad, and as neither, with some gender differences.

³ The frequency of sex was asked, for each partner, as a pair of questions. The first revealed if the respondent had sex with that person “only one time” or “2-10 times only,” or more than that. These have been coded as a frequency per week of 0.02 (=1/50 weeks) or 0.1 (5/50 weeks). The frequencies of these responses in the data analysis file, respectively, were 7% and 20%. The second question asked the frequency with a set of categories. Those categories (and the value per week assigned to it and its percentage distribution in the data) were: “once a day or more” (value: 7 times; 3%); “3 to 6 times a week” (4 times; 20%); “once or twice a week (1 time; 30%); “2 to 3 times a month” (0.5 times; 16%); “once a month or less” (0.25 times; 4%).

⁴ The reader may note that the reported frequency of oral sex in Table 1 differs for females and males but this difference does not appear in the multivariate models in Table 5. In the Table of means one sees that females report less oral sex, but there is an inconsistency or illogic here as men report both giving and receiving more oral sex than do women. (Recall, however, that these men and women are not pair partners, they are independent samples of men and of women.)