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CONTINUUM *Complete*

International

ENCYCLOPEDIA OF SEXUALITY

Updated, with More Countries

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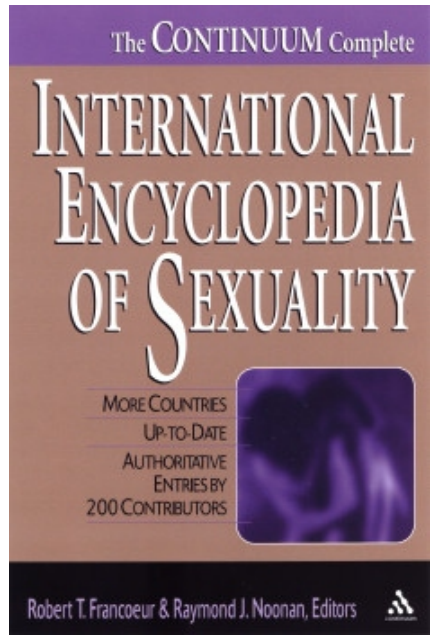

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Extensive updates and some sections rewritten by the original authors as noted in the text

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(CIA 2002)

Demographics and a Brief Historical Perspective

A. Demographics

ROBERT T. FRANCOEUR

The United Kingdom, composed of England, Wales, Scotland, and Northern Ireland, faces the northwestern edge of Europe. The British Isles, with 94,525 square miles (244,820 km^2) is about the size of New York State. The English Channel separates the British Isles from France on the south, Belgium, the Netherlands, Denmark, and the southern tip of Norway to the east. To the west, across the Irish Sea, is the Republic of Ireland. In 1920, the British Parliament divided Northern Ireland from Southern Ireland and gave each its own parliament and government. A few years later, when Ireland became a dominion and then an independent republic, six of the nine counties of Ulster in the northeast corner of the country chose to remain a part of the United Kingdom. The Crown Colony of Hong Kong and Asia is now part of the People's Republic of China (see separate chapter on Hong Kong). There was devolution to a Scottish Parliament in 1999. The formation of a multiparty Northern Ireland assembly was initiated in 1999, although it was temporarily suspended in early 2000.

Geographically and culturally, the main island of the British Isles has three regional entities, England, Scotland, and Wales. The Principality of Wales in western Britain has an area of 8,019 square miles (20,769 km^2) and a population of about three million. After early Anglo-Saxon invaders drove the Celtic people into the mountains of Wales, these people, who became known as Welsh ("foreign"), developed their own distinct nationality. English is the dominant language, with less than 20% of the people of Wales speaking both English and Welsh; some 32,000 speak only Welsh. The former kingdom of Scotland occupies the northern third of the main British island. The central lowlands, a belt approxi-

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mately 60 miles (96.5 km) wide stretching from the Firth of Clyde to the Firth of Forth, divides the farming region of the Southern Uplands from the granite Highlands in the north. About three quarters of Scotland's five million people live in the Lowlands, concentrating in the industrial center of Glasgow (population: three quarters of a million) and the capital, Edinburgh (population: half a million). The Hebrides, Orkney, and Shetland Islands are also part of Scotland. England, the heart of the United Kingdom, has a population of close to 50 million people. London, the capital, has a population of about seven million; Birmingham, the second largest city, has a population of about a million.

The United Kingdom of Great Britain also includes the Channel Islands, the Isle of Man, Gibraltar (between Spain and Africa), the British West Indies and Bermuda in the Caribbean, the Falkland Islands and dependencies in the South Atlantic, and Pitcairn Island in the Pacific Ocean. This chapter focuses on the sexuality in England, Wales, and Scotland.

In July 2002, the United Kingdom had an estimated population of 60 million. (All data are from *The World Factbook 2002* (CIA 2002) unless otherwise stated.)

Age Distribution and Sex Ratios: *0-14 years*: 18.7% with 1.05 male(s) per female (sex ratio); *15-64 years*: 65.5% with 1.02 male(s) per female; *65 years and over*: 15.8% with 0.72 male(s) per female; *Total population sex ratio*: 0.97 male(s) to 1 female

Life Expectancy at Birth: *Total Population*: 77.99 years; *male*: 75.29 years; *female*: 80.84 years

Urban/Rural Distribution: 89% to 11%

Ethnic Distribution: English: 81.5%; Scottish: 9.6%; Irish: 2.4%; Welsh: 1.9%; Ulster: 1.8%; West Indian, Indian, Pakistani, and other: 2.8%

Religious Distribution: Anglican: 27 million; Roman Catholic: 9 million; Muslim: 1 million; Presbyterian: 800,000; Methodist: 760,000; Sikh: 400,000; Hindu: 350,000; Jewish: 300,000

Birth Rate: 11.34 births per 1,000 population

Death Rate: 10.3 per 1,000 population

Infant Mortality Rate: 5.45 deaths per 1,000 live births

Net Migration Rate: 1.06 migrant(s) per 1,000 population

Total Fertility Rate: 1.73 children born per woman

Population Growth Rate: 0.21%

HIV/AIDS (1999 est.): *Adult prevalence*: 0.11%; *Persons living with HIV/AIDS*: 31,000; *Deaths*: 450. (For additional details from www.UNAIDS.org, see end of Section 10B.)

Literacy Rate (*defined as those age 15 and over who can read and write*): 100%; education is compulsory from age 5 to 16

Per Capita Gross Domestic Product (*purchasing power parity*): $24,700 (2001 est.); *Inflation*: 1.8%; *Unemployment*: 5.1%; *Living below the poverty line*: 17%

B. A Brief Historical Perspective KEVAN R. WYLIE

Until about 10,000 years ago, Britain was connected to the European continent by a land bridge that made it convenient for peoples to migrate back and forth. With the end of the last great Ice Age, and the slow but inevitable melting of the ice masses that covered Europe and North America, the sea level gradually rose, separating the continent from the British Isles with the English Channel. Despite the new obstacle, people continued migrating, as the Celts did to the isles some 2,500 to 3,000 years ago. This Celtic influence can still be found in the language and culture of the Welsh and Gaelic (Irish) enclaves. England became part of the Roman Empire in 43 of the Common Era. The Roman legions withdrew in 410. In subsequent centuries, particularly the 8th through 11th centuries, waves of Germanic Jutes, Angles, and Saxons competed with Danish invaders for control of the island. In 1066, Duke William led the Norman conquest of Britain, bringing continental feudalism and the French language, essential elements in later English culture.

In 1215, the nobles forced King John to sign the Magna Carta, guaranteeing the rights of the people and the rule of law, and setting the stage for the development of a parliamentary system of government. Defeat in the Hundred Years War with France (1338-1453) was followed by a long civil war, the War of the Roses (1455-1485). While European countries were racked by wars, English culture and a strong economy flourished under the powerful Tudor monarchy and a long period of domestic peace. Establishment of the Church of England in 1534 under the monarch separated England's religious institutions from the authority of Rome. Under Queen Elizabeth I, England became a major naval power, with colonies in the Americas. Britain's trade throughout Europe and the Orient also expanded. Scotland became part of England in 1603 when James VI of Scotland became James I of England. A struggle between Parliament and the Stuart kings, a bloody civil war (1642-1649), and establishment of a republic under the Puritans, ended with the restoration of the monarchy in 1688. The sovereignty of Parliament was confirmed in the "Glorious Revolution" of 1688 and a Bill of Rights in 1689.

The 18th century in England was distinguished by a strengthening of the parliamentary system and technical and entrepreneurial innovations that produced the Industrial Revolution. England lost its colonies in the American Revolution, expanded its empire with growing colonies in Canada and India, and strengthened its position as a leading world power. The 19th century was marked by extension of the vote in 1832 and 1867, formation of trade unions, development of universal public education, the spread of industrialization and urbanization, and, under Queen Victoria (1837-1901), the addition of large parts of Africa and Asia to the empire.

Britain suffered huge casualties and economic dislocations as a result of World Wars I and II. Although industrial growth returned after the wars, Britain lost its leadership role to other nations. Ireland became an independent republic in 1921, but the Irish question has persisted. In recent years, the socialized medicine, social security support systems have posed increasing questions for the government and people.

1. Basic Sexological Premises

PAULA NICOLSON [*Rewritten and updated in late 2001 by P. Nicolson*]

A. Character of Gender Roles

Gender roles in the United Kingdom have been influenced both by social class, which has ensured the maintenance of gender segregation, particularly among the upper and working classes, and fluctuating demographic, political, and cultural changes over the past 80 years, which have stimulated shifts in traditional patterns. For example, during World War II, women were employed in manufacturing, commerce, and agriculture, accompanied by good state provision of daycare for children. However, following the demobilization of the male population in the 1950s, there was a political emphasis on 'pronatalism' in order to replenish the population and to free up employment possibilities for men. Therefore, women's responsibility for the mental and *physical* health of their families was encouraged, which meant a return to traditional gender lifestyles.

Although since the mid 1980s there has been a clear political commitment to seeing men and women as equal, a division of labor remains in the home, which spills over into

the workplace. This distinguishes men's and women's behavior and expectations along traditional stereotypical lines: Men are seen as powerful, rational, and "naturally" the breadwinners, and women are seen as dependent, emotional, and "naturally" suited to the domestic sphere.

Feminist influence, hand in hand with high levels of male unemployment since the early 1980s among all social classes, has meant that many men have taken greater responsibility and interest in childcare than previously. The resulting image of the "new man" in touch with his emotions, with nurturing skills, remains a contestable one, however.

Increased educational opportunities have enabled women to enter professional life, a process that has increased since the 1970s, although few women rise above middle-management level.

During the 1990s, biological essentialist explanations of gender roles have emerged as a "backlash." Darwinist natural selection theory, embraced by evolutionary psychology and sociobiology, has been enthusiastically taken up by the conservative forces within the academic community and the British media. They espouse the view that there are natural, irrefutable, and irreversible reasons why women are better suited to childcare than men. Also, women are less suited by their "natures" to reach the top of their professions. Women are "naturally" averse to the risk-taking and aggressive behaviors appropriate to high-powered work. These are the predominant explanations of gender-role differences as we enter the 21st century.

B. Sociolegal Status of Males and Females

Males and females officially have equal status in the United Kingdom in terms of human rights, but there remain certain sociopolitical distinctions. For instance, many women receive reduced unemployment benefits and pensions because they have not had to pay full contributions during their working lives and have had career breaks. However, women are entitled to a retirement pension at the age of 60, while the retirement age for men remains 65. This is currently the subject of political debate and statutory changes.

The legal age of consent for heterosexual women and men is 16. It is only recently that the age of consent for homosexual men was reduced from 21 to 18. The ban on homosexuals of both sexes in the armed services was lifted at the end of 1999.

The age of heterosexual consent means that it remains illegal for doctors to prescribe contraceptives to women and men under the age of 16 without parental consent, a contentious issue, which remains unresolved. The Labour Government elected in 1997 pledged to cut teenage pregnancies. However, recent evidence suggests that teenage girls do not wish to take oral contraception on a regular basis because of the well publicized "health scares." Many consider an abortion to be safer.

Certain legal judgments have demonstrated inequalities in attitudes towards women and men. For instance, some adolescent and older men found guilty of rape have received relatively light punishments; in some rape cases, women have been portrayed as guilty of "contributory negligence"; men who have killed their female partners because they "nagged" or were unfaithful were given light sentences or had the murder charge changed to manslaughter; conversely, women who killed male partners after years of violent physical and sexual abuse have been found guilty of murder and given long-term prison sentences. This is indicative of the underlying ideology that favors male domestic authority and the traditional view of the male sex drive as dominant.

Lone mothers are frequently portrayed by politicians as irresponsible, and their entitlement to state benefits questioned. This was counterbalanced to some extent by the creation of the controversial Child Support Agency, which pursued absent fathers for maintenance. Recent developments, however, have encouraged single parents to work outside the home, and benefits have been withdrawn from those who resist.

C. General Concepts of Sexuality and Love

The majority of the population in the United Kingdom are able to choose their sexual partners on the basis of attraction and love. This, however, does not apply among some minority ethnic groups, nor to social-class groups where a socially suitable marriage is encouraged.

Since the late 1960s, there has been an increased liberalization of attitudes towards sexuality. The age of first heterosexual intercourse for women has come down from a median age of 21 for those born in the 1930s and 1940s, to 17 for those born between 1966 and 1975. The gap between the age of first intercourse for women and men has decreased over the past 50 years, and for the current generation of young people, it is virtually the same for both sexes. A sizeable minority of both sexes is sexually active before the age of 16. A high proportion of sexually active 16-year-olds do not use contraception (Wellings et al. 1994).

The category 'homosexual' is no longer seen as discrete and exclusive, with more people changing sexual orientation over the course of their life (Dancey 1994). However, it remains the case that heterosexuality is taken as the norm, and sexual satisfaction is understood to be orgasm for both partners during intercourse (Nicolson 1993). There has been an increase in the availability of practitioners, and the willingness of couples and individuals to seek psychosexual counseling when they fail to achieve sexual satisfaction. The availability of Viagra has influenced the debate on sexual satisfaction, and declarations that a female version will soon be on the market have been welcomed as an antidote to anorgasmia in women.

Serial monogamy rather than lifetime marriage remains the norm in the U.K. as in the U.S.A., with fewer people getting married and as many as one-in-two marriages ending in divorce.

2. Religious, Ethnic, and Gender Factors Affecting Sexuality

JOSÉ VON BÜHLER

A. Sources and Character of Religious Values

Since the 1950s, Britain has become increasingly a pluralistic country in terms of cultures, ethnicity, and religion. Hinduism mixes with Roman Catholicism, Islam with Judaism, and Methodism with Buddhism. Some of these religions are almost inseparable from their social fabric, culture, and ethnic grouping. Others offer a moral and spiritual framework separate from ethnic practices. The common denominator in the existence of this pluralism is that, apart from the establishment franchise of Anglicanism, which in reality makes it the "state religion," all religious bodies in the United Kingdom are equal under the law of the land. This equality confers certain rights and privileges in respect of education, worship, social welfare, and democratic political rights.

However, the multifaceted character implied in interdenominationality in many instances is generally not understood by the public at large, or even the members of the various groups. Philosophically and socially, there is frequently a disconnection that does not allow for cross-fertilization of ideas. Nor does it allow for comparative analysis of the positive approach to sexual concepts and even sexual activities in many religions when their scriptures are properly understood! In this climate, it is easy for fundamentalists of every denomination to represent human sexuality in the religious/spiritual content as negative and somehow

taboo. This tension was noted in a 1992 report from the Sex Education Forum, an umbrella body for several religious and secular organizations concerned with providing and supporting sex education for young people. The report, *An Enquiry into Sex Education: Report of a Survey of LEA Support and Monitoring of School Sex Education* (Thompson & Scott 1992), clearly identified "anxieties concerning ethnicity and religious issues to be a significant barrier to the effective provision of sex education." Indirectly, the report confirmed that the distance between religious legal equality and ethnic, social, and moral framework patterns and concepts is rather unequal among the various religious and ethnic groups in the United Kingdom.

Prior to the 1950s, the religious influences forming sexual constructs came almost exclusively from "the official church" of England, and "unofficially" from the other Christian denominations. In recent decades, the picture has become more complex. Since midcentury, the Church of England's approach to social morality and sexuality has fluctuated between two poles, the traditionalists and the modernists, or the "permission givers" and the "orthodox moral directors." With the national religious scene resembling the circular approach of the politicians to sexual knowledge and attitudes, the sociosexual control and influence appears to bounce back and forth between church and state according to a mutually cooperative formula. In many cases, however, liberal attitudes have triumphed, as evidenced by the Church's acceptance of divorce, homosexuality, and contraception. In other cases, the traditionalists have retained a firm moral control. This doctrinal "pendulum" is confusing for the majority of the population who are not experts at moral and theological niceties and subtleties. The people themselves are part of the system of confusion: While expecting clear and definite moral messages from both establishment and Church, they reserve the right to judge the validity of those messages, even when they are biblically based.

With quiet, behind-the-curtains efficiency, the Roman Catholic Church has been influential in shaping national morality and sexuality. Its most authoritarian pronouncements about homosexuality and abortion have been tempered by professions of love for the individual while condemning same-gender sexual activity. To the democratic soul of the British people, Roman Catholic moral doctrine appears autocratic and dictatorial, even while it provides a secure, unchangeable frame of reference that is not answerable to cultural and ethnic differences, a characteristic attractive to the orderly British. Other Christian denominations, such as Methodism and the evangelical Protestant churches, swing between permission and condemnation. Methodists, for instance, accept that sexual learning should present the biologically functional principles and, at the same time, should be equally aware of human relationships and their influence in the happiness of the individual.

Whatever the sexual-moral code of the many Christian traditions in Britain, the individual appears to have the final word in moral choices, as long as these choices are based on "fairness" and "not hurting other people." Nonetheless, it appears that religious beliefs are still a major influence on sexual attitudes and values. In this regard, for instance, the findings of the research study, *Sexual Attitudes and Life Styles* (Johnson, Wadsworth, Wellings, & Field 1994), regarding first sexual intercourse are rather revealing:

> Respondents belonging to the Church of England or other Christian Churches (excluding the Roman Catholic Church) were less likely to experience sexual intercourse before the age of 16, and those from non-Christian religions even less likely to do so. More surprisingly perhaps, given the position of the Roman Catholic Church on sexual behaviour, those reporting Roman Catholic affiliation are no less likely than those reporting other affiliations to report intercourse before the age of 16, and if anything slightly more so.

Notice that this applies exclusively to first sexual intercourse and not to other sexual intimacies.

In the ever-swinging pendulum of action and counteraction, an example of final-choice control is that of the decision made recently by members of the Church of England regarding homosexuality. Whereas the moral traditionalists within the hierarchy of the Church have tried to reverse the acceptance of gay priests, priest advocates of homosexual rights have topped the polls in the Southward and London dioceses in elections for the Church of England's General Synod, the "church's parliament."

Nonetheless, Christianity no longer has total influencing control over the sexual morality of the British people. The pluralistic and interdenominational society in existence in Britain has seen to that. The influence of Islam, for instance, is evident in national moral pronouncements because of the increasing number of adherents to the faith and its sexual moral code. In common with Catholicism, Islamic sexual and moral teachings transcend ethnicity and culture. Human sexuality is not a taboo subject, but must be dealt with in the context of the family with an open mind and in a way enriching to the individual's developmental and religious perspectives.

The influence of Hinduism and its sexual-moral code on the general population has not been as public. Hinduism is a pragmatic religion, and perhaps because of this pragmatism, issues of sex and sexual activities and practices are rarely discussed. Traditionally, there is an association between religion, erotica, and the highly culturally priced art of love, but in modern culture, one suspects that this connection is the domain of the "literati" and quite foreign to the contemporary Hindu family. Judaism teaches that sexual pleasure is an integral part of the marital/sexual relationship. In its positive view of sexual relations, the principle of pleasure and sharing mutual happiness by a physical relationship is validated.

[*Update 2001*: The dawn of the 21st century brought with it, contrary to liberal expectations, a much greater reentrenchment of the ecclesiastical negative status in terms of sexual freedoms. The axis of dialogue and understanding moved considerably to the right. Within the Anglican Church, the sense of fear about individualistic decision-making was significantly expressed in some of the pronouncements of individual bishops. These pronouncements traveled uncomfortably between narrow lines. The Anglican Church, or at least one of its Bishops, apparently chastised married couples who did not respond to the extraordinary insistence of the churches in the procreative model for the "selfishness" of not having children. The whole episode, as is often the case in modern times, became the domain of all the spin-doctors, albeit of the theological variety, and in doing so, lost all of its potential strength for change.

[The Roman Catholic Church seemed to forget, at least temporarily, its focus on the sins of the flesh in favor of a partial examination of conscience in the matters of violence, cruelty, and persecution of others by Church members in the past. In what I believe to be one of the most personally brave and spiritually significant gestures of any Pope in history, John Paul II knelt and expressed his sorrow for past injustices of the Roman Catholic Church in a special penitential on Sunday, March 12, 2000. The reaction by friend and foe was mixed, precisely because of the partial condition of the ex-

pression of sorrow. The apology was about the past. The apology was further diluted by considering that historical activities, however much in error, cannot be judged with the same measuring rods of the present. George Monbiot in *The Guardian* (March 9, 2000) made the comment, in discussing Cardinal Biffi's "medievalist" approach, that "those who believe in absurdities will commit atrocities." The Papal apology recognized, directly or indirectly, that the belief in the exclusive goodness of one religion might have led to the atrocities leading to the apology, that perhaps, in the past, the Church believed in absurdities and committed atrocities. In the light of history and future revision, might it not be possible that the Roman Catholic Church might acknowledge an absurdly fundamental antipathy towards sexuality and its scientific and humanistic study? Might it not be possible that the Church's undoubtedly rich and full contribution to the healthy study of sexual processes and their spiritual value might lead to a further apology? An apology this time in terms of all those, regardless of sexual orientation, whose sexuality is denied or condemned without the compassion of, at least, analysis of the life journey of that individual?

[The impact of the millennial developments, either from Rome or Canterbury, as it affects the British, is still to be seen. There is no doubt that new avenues for dialogue, criticism, expressed resentments, and outright dismissal of the religious developments will exist. We must wait to see if what appears to be the fear of the religious establishment about secularization are realized. History has a proven record for reinventing the wheel, and spirituality can be reinvented too. In the midst of this confusion, sexology in England has a unique opportunity to restructure its approach in relation to its preparedness to encounter spirituality ecumenically. (*End of update by J. von Bühler*)]

B. Character of Ethnic Values

As suggested above, ethnicity plays an important part in the development of sexual and moral values, sometimes in connection with and sometimes apart from its religious connections. Four major cultural and ethnic components constitute the United Kingdom, the Irish, Scottish, Welsh, and the English themselves. Even within these groups, geographical position and class are influential. It is interesting to see that, although the various Christian denominations have adherents in every area of the British Isles, the ethnic groupings are numerically visible in the denomination of choice geographically. The Scottish have a tradition of Calvinism and Presbyterianism, the Northern Irish of Orange Protestantism, the Welsh of Chapel Christianity and Methodism, and the English as loyal but convenient subjects of Anglicanism in the tenets of the Church of England. This is, of course, a simplification of the religious/ethnic distribution, but it gives an idea of the association between ethnic values, religious tradition, and the influence of moral-theological principles on sexual values, and the acceptance or denial of sexual behavior. In this mixing pot of cultures, colors, religions, and nationalities, the views are almost infinite, and the British public has an almost inexhaustible amount of choices, although the majority of them are still of the prohibitive (sex-negative) kind. Yet, despite the many ethnic and religious prohibitions of sex, the British show an almost universal acceptance of sex before marriage, teenage sexuality, and the public discussion of topics, such as homosexuality, that were avoided not too long ago.

The British, according to Johnson et al. (1994), view sex outside a regular relationship as wrong, monogamy is upheld more by women than men, women show a greater tolerance of homosexuality than men, and, in general, there appears to be an attitudinal trait for permissiveness. In the United Kingdom today, moral, religious, and ethnic influences on sexual attitudes, values, and behavior are no longer a case of *Roma locuta est, causa finita est* ("Rome has spoken, the argument is closed"), but more one of *Vox Populi* ("the voice of the people") with spiritual insurances.

3. Knowledge and Education about Sexuality

JOSÉ VON BÜHLER and PATRICIA BARNES

A. Government Policies and Programs

Historically, there has been a reluctance to legislate in the area of sex education in England and Wales. The government has taken formal responsibility for this only in recent years, prior to that issuing general "guidelines" on the general content and moral code. The actual responsibility for the delivery of sex education was undertaken by independent voluntary agencies. Prior to World War II, the focus was on social hygiene, public health, and personal morality, addressing predominantly issues of sexually transmitted disease and unplanned pregnancy.

In the postwar years, educational philosophy and research adopted a sociological perspective and centered on the family. A partnership developed between educational and health establishments, and slowly the form and content of sex education became more concerned with the general well-being of the individual.

In 1968, the government provided funding to the newly formed Health Education Authority and the voluntary agencies, particularly the Family Planning Association (F.P.A.) and National Marriage Guidance Council (N.M.G.C.), to train teachers and provide resources for sex education. Although the political agenda was predominantly preventative in terms of public health, developments in sociological and psychological thinking were woven into educational efforts. These Personal and Social Educational Programmes (PSE) inevitably had a heterosexual and reproductive orientation. The medical and nursing professions began to teach from a "humanistic" platform, but it would be some time before a clear definition of humanistic principles in the discussion and delivery of sex education existed. The union of social trends and public policy brought about the beginning of social awareness of a sexuality in which the individual's personal growth mattered and sexual concepts started moving away from the purely biological.

The late 1970s and early 1980s saw the public face of feminism, antiracism, and gay liberation. The impact on local government and education was in the form of legislation on equal opportunities and antiracist policies. Despite a growing social need and awareness, a formal educational curriculum in sexuality for secondary, higher, and professional education did not exist. Some medical schools experimented, not without problems, with seminars and study days. They were influenced by a growing number of professional counselors and sex therapists, pioneers in the principles of particularity and personal entitlements in the field of sexual development. The Local Education Authorities, for example, were responsible for providing sexual curriculum guidance to schools, but the government did not involve itself in the growing revisionist consensus developing between education, health, and voluntary agencies, which put the person at the center of this consensus.

The political ethos of the 1980s concentrated on a dramatic return to a "new moral framework," which in essence represented a return to Victorian values. The role and function of the local education authorities and F.P.A. were inherently discredited. The responsibility for sex education in secondary schools (11- to 18-year-olds) suddenly trans-

ferred to the individual school governing bodies (H.M.S.O. 1987). The requirement was that sex education should be delivered within a moral framework, and that parents had to be consulted about the curricular nature. In 1987, the Department for Education issued guidelines and specific directives to school governors on the teaching of so-called controversial subjects, such as HIV, AIDS, and homosexuality. The guidelines and directives conveyed a clear public message that sex education was viewed by the government as inherently controversial. This message caused a fundamental dilemma between the needs of pupils and the requirements of the system. This dilemma was also present between the health needs in an age in which sexual awareness became part of a larger social picture and the apparent reluctance of responsible government bodies to accept sex education in its wider context of human sexuality.

At this time, there was politically little to be done regarding sex education in colleges, universities, and medical and nursing education. The academic input in these areas was neither of an official nature nor sufficiently effective to present a case for socially individualistic approaches. In many ways, this was supportive of the political status quo. The legislative disinterest in the activities of higher and professional education in the field of human sexuality and the dedicated work of individuals allowed universities and medical schools to design and deliver functional and integrative programs in human sexuality. Thankfully, these educational programs provided the United Kingdom with practitioners, teachers, and researchers in the field of sexuality since the mid-1980s. At the same time, voluntary agencies became repositories of the considerable body of knowledge and skills in the education and therapeutic interventions in human sexuality. It is difficult to understand today how such dichotomies could exist hand in hand with the World Health Organization's definition of sexual health. That definition clearly affirms the primacy of a "social and personal ethic." It also affirms the need for "freedom from fear, shame, guilt, false beliefs and other psychological factors inhibiting sexual response and impairing sexual relationships." University, medical, and professional education and the therapeutic professions tried to synthesize the issues of education and health, particularity by establishing working and investigative groups. The advantage of these groups was that many of their members were experts in the field of human sexuality.

In 1988, Section 28 of the Local Government Act was enacted to prohibit the Local Education Authorities from "promoting homosexuality." Much confusion ensued. In reality, this clause only applied to the Local Education Authorities' activities and not to educational processes in the classroom. However, this act firmly reestablished the religious/moral influence on sex education.

Also in 1988, a National Curriculum in education was introduced. This differentiated between the "core" or mandatory subjects of mathematics, English, and science that had specific curricula to cover at different key stages and the "noncore" subjects. Sex education was a "noncore" item. In the interest of public health, however, the reproductive and disease components were included in the core science curriculum, and therefore were obligatory to teach.

In 1990, the National Curriculum Council published *Curriculum Guidance 5: Health Education*, which recommended that the nine health education themes (of which sex education was one) should be coordinated across the curriculum. Four key stages representing age bands were identified to assist delivery of appropriate information in a developmental manner. However, many revisions in both guidance and legislation occurred subsequently with particular reference to the sex education component.

Advised by counselors and sexual and marital psychotherapists, the medical and nursing professions perceived sex education as important in their own clinical effectiveness in the treatment of sexual dysfunction. Some medical schools and nursing colleges established their own sexual health curriculum, but once more, the teaching input focused primarily on the organic and health content of sexuality. The integrative delivery of the subject, supposedly suited to increase knowledge and change attitudes both in higher and professional education (von Bühler & Tamblin 1995), depended on the clinical and scientific expertise of a few professionals, who, in many cases, had to fight against long-held concepts and prejudices. This situation led to an educational lottery with little academic cohesion and, of course, the unavoidable controversy between the purely medical and the more-eclectic approach.

Health economics and a realistic awareness of social needs obliged the government to produce the *Health of the Nation* document in 1992, identifying key areas for intervention. Among the goals listed were the reduction of pregnancies of girls aged 13 to 15 by 50%, from 9.5 per 1,000 girls in 1989 to no more than 4.8 per 1,000 girls by the year 2000. England has the highest rate of teenage pregnancies among western European countries. In the document, school sex education was seen as a central means by which the pregnancy targets might be achieved.

Meanwhile, an amendment to the Education Act of 1993 was passed without debate in Parliament (effective from September 1994). This required:

1. all secondary schools to have a sex education policy that includes teaching on HIV/AIDS and sexually transmitted disease,
2. biological aspects of sexual behavior to be taught in the science curriculum, and
3. a parental right to withdraw children from all or part of the nonscience sex education.

The implications of these amendments are daunting, both in terms of the individual and society. There is much evidence to suggest that the majority of parents do not have the skills or desire to be responsible for the sex education of their children (Allen 1987). More often than not, the needs of girls are understood and addressed more effectively than those of the boys or groups of people with special needs.

The recent authoritative study by Wellings, Field, Johnson, and Wadsworth (1994), *Sexual Behaviour in Britain: The National Survey of Attitudes and Lifestyles*, examined trends in age at first sexual intercourse, and these trends show that during the past four decades, the median age at first heterosexual intercourse has fallen from 21 years to 17 years for women and from 20 to 17 for men. The proportion of respondents reporting sexual intercourse before the age of 16 has increased from fewer than 1% in women aged 55 and over, to nearly one in five of those in their teens. (*Note*: This study has also been published as Johnson et al. 1994, *Sexual Attitudes and Lifestyles*.)

The people of the United Kingdom need to ask what are the real risks for sexually active children and young people? What are the implications for children who receive either none or fragmented and perhaps unreliable sex education? Human sexual activity is associated with increasing levels of risk and disease, unplanned pregnancy, and marital relationship breakdown. The health and sex education of the British government are far too vulnerable to the swings of political and moral pressures. Adolescent sexuality and sexual activity are realities. Effective sex education should offer adequate information, enable the development of communication and social skills, and provide opportunities

to explore attitudes, values, and beliefs in a pluralistic society. The balance of these three elements is crucial if sexual issues for the individual and the nation are to be tackled realistically.

[*Update 2001*: The General Election of 1997 appeared to have brought a wind of sexual education fresh air. The Blair Government wanted to modernize Britain and, what better vehicle of modernization than to overhaul the education system? Part of that overhaul was to address the evidently comatose life of Section 28 of the Local Government Act. Britain has never been clear about the social position of this legal clause. Does it deal with fundamental homosexual issues, with human rights issues, or with purely educational curricular issues? Does it deal with the responsibilities of local councils or moral boundaries for teaching? Whatever the reason behind its enactment during the Thatcher administration, its re-presentation for repeal to the House of Lords has been fraught with political danger for the present-day authorities. Similar attempts to sexual modernization, such as the reduction of the age of consent to 16 in parity with heterosexual usage for homosexual acts, met with a barrage of loudly expressed prejudice by the right tendency in the establishment. Neither those for repeal nor those against repeal have been able to present a research-validated argument, perhaps sending a clear message for sexology to address scientifically issues of everyday importance, of humanistic importance. The opponents of the repeal of Section 28 have expansively used the word "promotion" of homosexuality in the national debate. This has needed a strong voice advocating the "promotion" of health and knowledge of those being educated, as well as the obligation of education authorities to protect those being educated against man's inhumanity to man. Unfortunately, such a voice has not usually been provided by sexology, but by voluntary pressure groups.

[Significantly, the drive against change comes strongly from the newly devolved Scotland, where an alliance of commerce, politic, and religion demands the recognition by the rest of the country to acknowledge the devolved political muscle.

[On Thursday, March 16, 2000, England awoke to an announcement by the Education Secretary: There would be new rules on sex education via an amendment to the Learning Skills Bill. The amendment supposedly gives legal backing to teaching that describes "marriage and permanent relationships as key building blocks of community and society." The morning newspapers commented that the announcement was a "bid to defuse the row over Clause 28 [Section 28] of the Local Government Act, which forbids the 'promotion' of homosexuality." One evening paper published a column titled, "Pupils may not be taught that marriage is best." The journalists appear as confused as the Education Secretary in the issue of the academic administration of a good, positive, nonpartisan sexual education.

[It appears that the change will be slow in the ability of politicians in the United Kingdom to enact intelligent legislation in favor of a comprehensive sexual education curriculum. (*End of update by J. von Bühler*)]

B. Informal Sources of Sexual Knowledge

In common with most Western European countries, the media plays an important and increasingly more acceptable role in popular sex education. British television frequently uses specialists in human sexuality and human relationships in research and program presentation. Sex programs are scientifically based in some instances, and in others positive learning occurs through humor and candid discussion of issues. These programs are pluralist. Likewise, radio has increased its importance and credible influence in sex education. Magazines for all ages are available, usually with literary articles of sexual relevance. In 1993, a new educational resource emerged: that of the Sex Education Video in which sexually explicit images are used to teach, for instance, the nature of orgasm and the importance of masturbation. Accustomed to total censorship of more-explicit material, the British public still has to pass judgment on these "educational videos."

Professional and voluntary agencies independent of the government frequently publish books or guides on sexuality covering all aspects of sexual function and meaning, from infertility to menopause, from the realities of being gay to the psychodynamics of marriage. Of course, the newspapers are a good fountain of information reporting on sexual matters, particularly after these have been debated in Parliament. Unfortunately, not all newspapers are married to the truth scientifically or philosophically. The theater, cinema, music, and advertising images are also part of the informal sex education movement. Finally, the United Kingdom is rich in voluntary and professional organizations dealing with sexual and relationship issues whose members are active in teaching and bringing to the notice of the general public the importance of sexual knowledge in ownership of their sexuality.

4. Autoerotic Behaviors and Patterns

MARGOT HUISH

The *Shorter Oxford Dictionary* cites the derivation of the word *masturbate* from the Latin root *manus* (hand) and *stuprare* (to defile) and defines "to masturbate" as "to practice self abuse," with the added definition of "abuse or revilement of oneself, self-pollution." Colloquial and slang forms of the word continue to be used as terms of abuse and derision. However, there are many rich colloquial words and phrases for masturbation, such as "the five knuckle shuffle," "playing the one-eyed piccolo," and "tossing the caber," which graphically describe male rather than female activity. Sex therapists often find that clients express discomfort with the word *masturbation* and all that it implies. The impression is that clients will use *masturbate* to describe autoerotic behavior, but will frequently use other forms of expression to describe similar mutual activity in their relationship. This perhaps reinforces the notion that sole masturbation is considered undesirable, whereas mutual or shared masturbation is more acceptable.

Historically, attitudes regarding masturbation have been negative and condemnatory. Masturbation has been seen both as a sin and as a sickness in the teachings of Judaism and Christianity. Not until the end of the 19th century was there a shift from the belief that masturbation was the cause of insanity to the suggestion that it was the cause of neurosis and neurasthenia. David S. G. Kay (1992) comments that:

> Following World War I, the major focus shifted from the purely medical to the psychological and to psychiatric analysis of masturbation. . . . Between the two world wars, medical professionals began to perceive masturbation as a harmless sexual behaviour. . . . The Psychoanalytic Society reinforced a conviction that masturbation was not the cause of medical or psychiatric disorders. Recidivistically, various preachers and educators continued to reinforce the Judeo-Christian sex ethic with their condemnation of masturbation . . . [while] psychologists and psychiatrists began to research the relationship between anxiety, guilt and masturbation, since the guilt and anxiety related to masturbation were considered emotionally damaging when transmitted by the family, religion, medicine, law and education.

The impression gathered informally from seven United Kingdom sex therapists is that a high percentage of clients and their partners regard self-masturbation as embarrassing, while others view it as an undesirable practice, cloaked in secrecy and creating feelings of shame and guilt. These negative views appear to have been replicated by respondents involved in the question design work for the survey of *Sexual Attitudes and Lifestyles in the United Kingdom* (1990/1991) (Wellings 1994). Questions on masturbation were reluctantly excluded because the discussion on masturbatory practice had met with distaste and embarrassment. The view of masturbation as a sexually separate, secret, and dark activity may be reinforced in some people's minds when they read national newspaper reports of occasional accidental deaths resulting from unusual autoerotic practices, such as autoasphyxiation and various extreme forms of bondage.

Despite, or perhaps because of, the Victorian legacy of repression and negative attitudes towards masturbation, the activity is frequently mentioned in some comedy programs on United Kingdom television and radio. However, the subject has also been presented with a refreshingly positive image in television and video sex education programs. This reflects the therapeutic value of masturbation as held by professionals within the psychosexual counseling and therapy practices, which reinforces its "normality" and status as a pleasurable sexual expression in its own right. It is perhaps also reflective of the need to encourage safer sex in the age of HIV and AIDS. Therapists have noticed how clients have responded to the "permission giving" aspects of the recent programs when they discuss masturbation. However, within the multicultural mix in the United Kingdom, there are many who associate masturbation, and especially ejaculation, with illness, fatigue, anxiety, mental illness, and loss of power. The more "open" attitude towards masturbation is reflected in radio phone-in programs and in magazines, especially those geared towards the young.

In a recent sex survey in *More!* magazine, completed by over 3,000 females aged between 16 and 25 years, 33% said they never masturbated, 33% did so rarely, 15% masturbated once a week, and 14% did so more than once weekly. Forty-four percent of the respondents used fantasies during masturbation, but surprisingly, only 11% reported masturbation as the best way to reach orgasm—oral sex and penetrative sex scored higher at 41% and 28%, respectively.

In an unpublished study, Sevda Zeki reported that out of 20 women aged 65 to 74 years, and 20 aged 75 to 91 years, more-permissive attitudes towards sex had significant statistical relationships with higher reported amounts of masturbation and orgasms in masturbation. A higher level of composite knowledge had a significant relationship with higher reported amounts of masturbation, while women who knew the role of the clitoris in achieving orgasm were more likely to masturbate than those who did not understand clitoral function. Women who had the most-permissive attitudes towards women masturbating in their later years were more likely to report that they themselves masturbated.

Sex therapists confirm that sexual knowledge, education, and permissiveness are significant in all age groups when considering views, attitudes, and experience of sex in general and masturbation in particular. The impression given by sex therapy clients during history taking is that a small number of male clients report self-masturbation between ages 4 and 10, but the highest percentage recall starting masturbation between 10 and 14 years. Female clients report starting to masturbate anywhere between 10 and 25 years, but far greater numbers are concentrated at 15 years and upwards, with an impression that a significant number of women have never chosen self-masturbation as a way of expressing their sexuality. It is also the impression that male partners are less likely to expect their female partners to self-masturbate, while these same female partners expect that their husbands/boyfriends do masturbate in secret, especially when there is a sexual dysfunction that precludes or limits the opportunity for penetrative sex. Clients, especially female clients, in individual therapy sessions often admit to self-masturbation, but do not wish their partners to know this information. Therapists report a greater acceptance of masturbation among single clients, and point out that there are many people with physical and learning disabilities for whom masturbation may be the only outlet for the expression of sexual feelings.

Project SIGMA, the first British in-depth study of sex, gay men, and AIDS, surveyed l,083 gay and bisexual men over a four-year period between 1987 and 1991. Self-masturbation was reported during their lifetime by 99.5% of men, while 90% reported doing so within the previous month (average 17 times). The percentages by age group of those engaging in self-masturbation during the previous month were: under age 21, 86%; 21 to 30, 92%; 31 to 40, 94%; and 40-plus, 81%. As David S. G. Kay (1992) states:

> Although the high incidence of masturbation is useful information for encouraging its acceptance by clients, the ability of masturbation to produce orgasm has more therapeutic importance. Masturbation has been used in the treatment of erectile failure, premature and retarded ejaculation, general sexual dysfunction, and primary and secondary orgasmic dysfunction. . . . There appear to be no rational arguments for regarding masturbation as undesirable as a private form of sexual activity.

[*Update 2001*: The last two years prior to March 2000 saw an increase in U.K. television airtime given to shows with a sexual content, whether educational, informative, comedy, news, specialist subject area, or soft pornography. While the subject of masturbation does crop up on these programs, it has found a regular forum in some late-evening light-entertainment hosted shows in front of live audiences. One show host has frequently and openly discussed various aspects of masturbatory practice with members of his audience, has shown Internet images of masturbation, and on one occasion, discussed the potential merits of a tongue-shaped vibrator with a female guest who is a Member of Parliament. Some magazines also appear to be more forthcoming about mentioning masturbation. *More* magazine, which focuses on a readership from age 19 to 27 years, published a supplement in April 1999 called "Back to Basic Bonking Guide," featuring a step-by-step master class in masturbation and education called "know your bits." In mid-2000, this magazine ran an article featuring men and masturbation. During 1999, *More* encouraged readers to send in their most embarrassing sex questions, one of which was concerned with potential health problems following the use of inserting various fruits during masturbation. While there has always been a U.K. market for masturbatory devices though sex shops and mail-order catalogues, masturbation seems to have finally arrived in the mainstream of U.K. acceptability, now that the National Family Planning Association has produced a "Sexwares" catalogue of vibrators for men and women. (*End of update by M. Huish*)]

5. Interpersonal Heterosexual Behaviors

A/B. Children and Adolescents DANYA GLASER

Little research has been conducted on the sexual behavior of children and adolescents in the United Kingdom. Findings from one study of children in different preschool

settings show that many children are curious about each others' genitalia, expressing this curiosity by looking at and touching each other. The extent to which such exploratory behavior has mature sexual meaning is unclear. A smaller proportion of preschool children enact sexual intercourse, usually by lying on top one another while fully dressed. It is likely that such behavior is imitative of adult behavior based on prior observation. These behaviors do not generally give rise to adult concerns unless the children appear preoccupied by genitally oriented activity or the behavior is coercive towards other children.

Oral-genital contact appears to be very rare, as are attempts to insert fingers or objects into another child's vagina or anus. Coercive, preoccupied, or very explicitly imitative behavior is associated with previous significant and inappropriate exposure to adult sexual activity, or sexual abuse of the child.

C. Adults

JANE WADSWORTH, ANNE M. JOHNSON, KAYE WELLINGS, and JULIA FIELD

The National Survey of Sexual Attitudes and Lifestyles

In 1990 and 1991, Wadsworth, Johnson, Wellings, and Field undertook a large population survey in Great Britain, *The National Survey of Sexual Attitudes and Lifestyles* (Johnson et al. 1992, 1994; Wellings et al. 1994). A key aim of this survey was to provide information for models to predict the epidemic of HIV using data on partnerships and activity, but in addition, this study provided valuable information about sexual behavior in the United Kingdom, as well as specific information of practical use in the planning of sexual health services—genitourinary medicine clinics, family planning, and sex education—and healthpromotion strategy.

The national study involved interviews of a random sample of 18,876 men and women aged 16 to 59. The responses were obtained partly through a face-to-face interview and partly from a booklet, which was completed by the respondent and sealed in an envelope out of sight of the interviewer to ensure complete confidentiality. Questions were asked about first sexual experiences, sex education, contraception, fertility, numbers and sex of partners, frequency of sexual intercourse, prevalence of different sexual practices, and, for men, contact with prostitutes. Other topics included attitudes towards sexual behavior and AIDS, family of origin and current family circumstances, educational achievements, and employment. The full methodology has been published (Johnson et al. 1994; Wadsworth et al. 1993). Among the more important findings were the following:

1. Age at First Heterosexual Intercourse (Sexarche). The median age at first intercourse for men and women now in their 50s was 20, while for those under 20, it was 17, a decline of three years over three decades. An increase among young people in intercourse under the age of 16—in Britain the age of legal consent for women—is closely associated with this change. Seven percent of men and 1% of women now in their 50s first had intercourse before they became 16, while 28% of the men and 19% of the women aged 16 to 19 had done so.

2. Number of Partners of the Opposite Sex. The numbers of heterosexual partners reported in different time intervals are shown in Table 1. Very similar proportions of both men and women had no partners in the previous year, in the last five years, or ever. Three quarters of men and women had only one partner in the previous year, while half the men and two thirds of the women had one partner in the previous five years. However, men were more likely to report large numbers of partners than women.

The number of partners was strongly related to age and marital status. Twenty percent of young people, aged 16 to 24, reported no partners in the previous five years, but they were twice as likely as those aged 25 to 34 to report ten or more partners. In contrast, over 80% of those aged 45 to 59 had one partner in the previous five years. Married people were less likely to have had more than one partner in the previous year (5% of men and 2% of women) than single people (28% of men and 18% of women).

Those who were cohabiting (by their own description as living with a partner of the opposite sex to whom they were not married) were less likely to have had only one partner than those who were married (15% of men and 8% of women had more than one partner in the last year). Multivariate analysis showed that age and marital status were most strongly associated with numbers of partners, but first intercourse before age 16 was also positively associated with numbers of partners.

3. Frequency of Sexual Intercourse. The median frequency of intercourse was three times during the preceding four weeks. But this varied with age as well as with the length and status of the current relationship. Among married or cohabiting people aged 16 to 24, the median frequency was seven times in the previous four weeks. Multivariate analysis showed that in addition to age and marital status, frequency of intercourse was inversely related to the duration of the current relationship, but positively associated with numbers of partners in the last five years.

4. Sexual Practices. For the majority of respondents, sexual intercourse involved vaginal intercourse. Oral sex (fellatio and/or cunnilingus), anal sex, and nonpenetrative sex were less commonly practiced (see Table 2). Younger people were more likely to report sexual practices other than vaginal intercourse, as were those in long-term relationships.

Those who had more than one partner in the previous year were also more likely to report oral, anal, and nonpenetrative sex than those who had one partner. Oral sex and nonpenetrative sex have become more commonly prac-

Table 1

Number of Partners of the Opposite Sex in Different Time Intervals (in Percentages)

Time Interval	Number of Partners	Male (n = 8,047)	Female (n = 10,059)
Ever	0	6.8	5.9
	1	20.9	39.1
	2	10.7	17.0
	3-4	18.6	18.4
	5-9	19.5	13.2
	10+	24.5	6.8
In the past 5 years	0	8.9	9.3
	1	56.4	67.1
	2	10.1	11.3
	3-4	12.2	8.2
	5-9	8.1	3.7
	10+	4.8	0.2
In the past year	0	13.3	14.2
	1	72.5	78.6
	2	8.4	4.9
	3-4	4.1	1.8
	5+	1.8	0.1

Percentages approximated from the authors' bar graph (adapted from Johnson, Wadsworth, Wellings, and Fields 1994, 115).

ticed among respondents who became sexually active in recent decades compared with those who became sexually active in the 1950s and 1960s, but no such trend is shown for anal sex.

5. Sexual Diversity. Sexual experience with a partner of the same sex at some time in their lives was reported by 3.6% of the men and 1.8% of women. These proportions appear not to have changed with successive generations, but there are pronounced geographical variations, particularly among men. In the previous five years, 1.4% of the men had had a male partner in Great Britain as a whole. In greater London, however, this proportion was 4.6%, just over three times as many.

Considering only those who have ever had a homosexual partnership (see Table 3), only 9% of men and 5% of women have been exclusively homosexual throughout their life. In the last year, 19% of the men had male partners, 62% had female partners, and 10% had both male and female partners. Similar patterns were found for women respondents, but a slightly higher proportion had exclusively male partners.

6. Attitudes to Sexual Behavior. Data on attitudes towards sexuality showed that people in Great Britain have a strong commitment to monogamy, together with marked toleration of premarital sex. Fewer than 10% of respondents believed that sex before marriage is wrong, but 80% of respondents felt that sex outside marriage is wrong.

Commitment to a regular ("steady") relationship was valued almost as highly as marriage, particularly among women. Homosexual relationships were considered to be wrong by almost 60% of women and 70% of men. Attitudes towards sexuality varied considerably with experience. For example, fewer than 50% of the men who have experienced sex outside marriage considered adultery to be wrong, compared with 80% of the men who had not had this experience.

These data show considerable diversity of sexual behavior in the general population of the United Kingdom. The majority have faithful relationships with one partner ("serial monogamy"), even if during their lifetime the majority of British men and women have had more than one partner.

Frequency of sexual intercourse is strongly related to the duration of the relationship, as well as to the respondent's age. Vaginal intercourse is the most popular form of having sex, and experience of anal intercourse is reported by only about one in 20 respondents, slightly more by men than women. Greater diversity in sexual practices is more likely among those who report more partners.

Patterns of homosexual behavior show geographical variations, with a markedly increased prevalence in central London. More than half of those of either sex who have ever had a partner of the same sex have had one or more partners of the opposite sex also. There have been changes in heterosexual behavior across the generations, particularly in the age of first sexual intercourse and the increase in those who have experienced sexual intercourse before the age of 16.

The pattern of partnerships clearly shows that people in Great Britain have larger numbers of partners when they are young and if they have not settled into a committed relationship. Men have more partners than women and nearly a quarter of men reported ten or more partners. There are, however, some differences between couples who are married and those who are living together without being married. In particular, the data suggest that extra relationships are more likely among those who are cohabiting than among married couples.

[*Update 2003*: As mentioned earlier in this section on adult heterosexual behavior, Wadsworth, Johnson, Wellings, and Field undertook a large population survey in Great Britain in 1990 and 1991, *The National Survey of Sexual Attitudes and Lifestyles* (Johnson et al. 1992, 1994; Wellings et al. 1994). In 2001, Johnson et al. published the results of a second *National Survey of Sexual Attitudes and Lifestyles*, conducted in the late 1990s. These two surveys have resulted in new and more-robust estimates of the distribution of sexual behavior within the population of the United Kingdom. The 1990-1991 survey and a comparison between findings in the two surveys provide evidence of increased reporting of a range of sexual behaviors within the population. The authors recognize that the magnitude of measured change is likely to be a combination of both actual changes in behaviors, along with increasing willingness to report previously socially censored behaviors, such as tolerance of homosexuality and casual partnerships.

[Some differences merit consideration. Just over three quarters of men and women report more than one lifetime partner, although the number reporting at least 10 lifetime partners is substantially lower in women (19.4%) than in men (34.6%). These numbers decline with increasing age for both genders, although the survey is limited to men and women 16 to 44 years of age. Nearly a third of men and just over a fifth of women had formed new heterosexual or homosexual relationships in the previous year, ranging from a mean of 2.04 new relationships among single men aged 25 to 34 years to 0.05 new relationships among married women aged 35 to 44 years. New partner acquisition is highest among the single or previously married. The authors estimate that 14.6% of men and 9% of women had concurrent partnerships at some time in the past year, although, again, the prevalence declined with increasing age. More than twice as many men as women reported new sexual partners outside the U.K. in the past five years.

[Overall, according to the authors' review, the number of single, separated, divorced, and widowed individuals remained unchanged over the decade. However, the number of people reporting cohabitation rose from 9.6% in 1990 to

Table 2

Prevalence of Different Sexual Practices in the Previous Year (in Percentages)

	Men (n =7,870)	Women (n = 9,786)
Vaginal intercourse	85.6	84.7
Cunnilingus/fellatio	62.6	56.6
Nonpenetrative sex	65.6	60.5
Anal sex	6.9	6.1

Percentages approximated from the authors' bar graph (adapted from Johnson, Wadsworth, Wellings, and Fields 1994, 164).

Table 3

Sex of the Partners of Respondents Who Ever Had a Homosexual Relationship

Time Interval		Exclusively Male	Exclusively Female	Male & Female	No Partners
Ever	Men	10.0%	0.0%	90.0%	0.0%
	Women	0.0	5.0	95.0	0.0
Last 5 years	Men	16.8	56.2	22.0	5.0
	Women	58.0	9.0	27.0	6.0
Last year	Men	20.0	61.0	9.0	10.0
	Women	66.0	11.0	9.0	14.0

Percentages approximated from the authors' bar graph (adapted from Johnson, Wadsworth, Wellings, and Fields 1994, 210).

17.3% in 2000. During the same period, the number reported as married dropped from 51.5% in 1990 to 42% in 2000. First sex with a new partner took place within one month of meeting their most recent sexual partner for 56.5% of all men, compared with 42.8% of all women. Cohabitation is associated with a higher rate of partner change. The authors suggest that the proportion of the population reporting two or more sexual partners in the past year and inconsistent condom use in the past month is an indicator that unsafe sex has increased significantly among both men and women between the two surveys. The proportion of the population who regarded themselves as at-risk of HIV/AIDS remained low (4.5% of men and 2.9% of women).

[Looking at heterosexual practices, the proportion reporting vaginal intercourse in the previous month has varied very little over the past decade, whereas there has been an increase in oral-genital contact in the previous year for both genders and a considerably increased practice of anal sex in the previous year for both men and women. There was also an increase in reported homosexual partnerships, at any time and in the previous five years, among both women and men (Johnson, Mercer, Erens et al. 2001). (*End of update by K. R. Wylie*)]

D. Sex and Persons with Disabilities

TINA BALL

Historically, the whole area of sexuality for people with disabilities has been seen as problematic and negative within the United Kingdom. Fears of "moral degeneracy" and eugenic theories led to the mass segregation of people with learning disabilities in institutions throughout most of the 20th century (Burns 1993). People with physical disabilities have often been seen as asexual (Williams 1993). The sexual and relationship difficulties of people with acquired cognitive impairments (and their partners) have been particularly unmentionable and even unthinkable.

At present, there are several strands contributing to changes in this picture. Some people continue to believe that sexuality should not be considered for those with disabilities. Some parents of young people with congenital disabilities often express fears and anxieties as their children begin to express sexual interests and wish they could stay as "holy innocents." However, the growing self-advocacy movements and the political movements of people with disabilities have ensured that disabled people's own voices have been heard asserting their sexual natures and needs. An example of this would be the way in which the leadership of the Association to Aid the Sexual and Personal Relationships of People with a Disability (formerly SPOD) has been taken over by people with disabilities.

Professionals have developed a range of sex education approaches and packages for persons with disabilities. Typical of these materials are those designed for people with learning disabilities (Craft 1991; McCarthy & Thompson 1992). Involving parents in these educational initiatives has been shown to be very valuable (Craft & Crosby 1991). Another example is the sex education materials created by people with learning disabilities for their own use (People First 1993).

The incidence of sexual problems is probably higher among people with all kinds of disabilities than it is in the general population. Negative attitudes towards people with disabilities lead to restricted opportunities for the development of sexual relationships; at the same time, an impaired or negative self-image can inhibit healthy sexual functioning. Some kinds of physical disabilities directly cause sexual problems, e.g., spinal cord injuries and multiple sclerosis. The growth in importance of physical treatments for erectile dysfunction, in particular, appears to be leading to a much more active approach to the assessment and treatment of such difficulties in specialist services, with many employing nurses and other healthcare professionals to work with persons who have sexual problems linked with or resulting from their disabilities. There remains much room for improvement in this area. The awareness and understanding of the impact of particular disabling conditions on women's sexual functioning and relationships remains less well understood and has certainly received less attention in the literature (Williams 1993).

Sexual dysfunction in people with learning disabilities has also received little attention. Studies have indicated a high level of negative experiences of sex, including dyspareunia in women with learning disabilities (e.g., McCarthy 1993). There is undoubtedly a higher than average incidence of sexual abuse of both women and men with learning disabilities (Turk & Brown 1993). The law recognizes this vulnerability and there are specific laws designed to protect people with learning disabilities from sexual exploitation (Gunn 1991). The complexity of the legal situation at times deters staff members who are working with people with learning disabilities from offering appropriate support and education, especially if they are already uneasy with sexual issues. Several local authorities, health authorities, and voluntary agencies have designed policy statements on sexuality in an attempt to provide clear guidelines for care staff and other professionals (e.g., East Sussex 1992; Hertfordshire County Council 1989). There are also increasing moves to work to prevent and treat sexual abuse in people with learning disabilities (Craft 1993).

E. Incidence of Oral Sex and Anal Sex

KEVAN R. WYLIE

The *National Survey of Sexual Attitudes and Lifestyles* (1994) revealed that oral sex was a common experience, although less so than vaginal intercourse and nonpenetrative sex. Experience of cunnilingus was slightly greater for both men (72.9%) and women (66.2%) than fellatio (69.4% of men and 64.0% of women). Overall experience of oral sex was reported by 75.2% of men and 69.2% of women. More than 80% reported practicing both forms of oral sex in the previous year, and it was usually practiced alongside vaginal intercourse.

Anal intercourse was practiced by less than 7% of all men and women, although a higher percentage of men had experience with it (13.9% of men and 12.9% of women). It was rarely practiced in isolation from other sexual activities. At the time of the survey, legal restrictions made such a practice an offense, which has subsequently been changed. (See also Section 8C, Significant Unconventional Sexual Behaviors, on rape.)

[*Update 2001*: The United Kingdom sociosexual investigations of gay men and AIDS (Project SIGMA) was used to analyze the extent to which acts of anal intercourse are distributed among gay men (Coxon & McMannus 2000). Most individuals (60%) who engage in anal intercourse do so only once or twice a month, but there is also a long tail of the sample who engage in this activity much more, with one tenth of the individuals performing half of the total acts of anal intercourse. The factors which most affected rates in concentration of risk behavior included relationship status, HIV-negative status, and concordant/disconcordant partner status. Highest-risk anal intercourse is primarily in the relatively infrequent acts of a relatively large number of gay men (rather than in the very frequent acts of a few), and it is this which is likely to lead to more-rapid diffusion of infection and ultimately higher levels of infected individuals. (*End of update by K. R. Wylie*)]

6. Homoerotic, Homosexual, and Bisexual Behaviors

ANTHONY BAINES

Heterosexism, the assumption that everyone is heterosexual and the subsequent discrimination against same-sex desire and attraction in men and women, is a significant cultural ideology in the United Kingdom. Sexual diversity in all its manifestations is not encouraged legally, socially, or politically.

The legal situation for lesbians and gay men in the United Kingdom is not a positive one. There are no laws to protect lesbians and gay men from discrimination. Male homosexuality was only partially decriminalized in 1967, for those men over the age of 21, with the stipulation that it would occur in private and with no more than two persons present. The age of consent for sex between men has since been reduced to age 18 (The Criminal Justice and Public Order Act 1994), but this is still two years above that for heterosexuals. Significantly, legislation has never stipulated an age of consent for lesbians, because of the invisibility of, and public refusal to accept, lesbian sexuality.

Other examples of discrimination against lesbians and gay men include their being banned from the Armed Forces and being ineligible for marriage under British law. A piece of legislation in the late 1980s also legitimized prejudice and discrimination against homosexuals. Section 28 added a new Section 2A to the Local Government Act of 1986, which states that a local authority shall not "intentionally promote homosexuality or publish material with the intention of promoting homosexuality." It would appear that such legislation is supported to a significant extent by social attitudes. Wellings et al. (1994) reported that 70.2% of men and 57.9% of the women surveyed believe that sex between two men is always or mostly wrong.

The experience of institutionalized or personal homophobia and heterosexism can affect the self-esteem of lesbians, gay men, and bisexuals, with implications for their emotional and mental well-being. In the face of such marginalization and stigmatization, the process of "coming out"—informing people of one's homosexuality or bisexuality and thus challenging preconceptions of heterosexuality—can be incredibly empowering. Acknowledging one's own sexual identity, informing those who share one's surroundings, and meeting people who share one's sexual identity to gain support and solidarity can be a major step on the road to healthy self-acceptance for many lesbians, gay men, and bisexuals.

In spite of the oppressive culture towards lesbians, gay men, and bisexuals—or perhaps because of this—strong, diverse lesbian, gay, and bisexual communities have developed, predominantly in the larger cities of the United Kingdom, such as London, Manchester, and Edinburgh. There are networks across the United Kingdom, reaching into the more rural areas, to provide a range of services to lesbians, gay men, and bisexuals, including telephone helplines, counseling, and social groups. There are also numerous lobbying groups from all shades of the political spectrum, working for lesbian, gay, and bisexual rights.

The emergence of HIV and its devastating impact on gay communities has led to a huge community response, with many of the United Kingdom's major national and local voluntary groups being set up by gay men.

Lesbians, gay men, and bisexuals meet each other in a variety of settings, and through various means, at pubs and cafés, saunas, social groups, parties, parks, and other "cruising areas," as well as through personal advertisements in a variety of publications. Most of the United Kingdom's larger cities and towns have a commercial gay scene and some semblance of a visible lesbian, gay, and bisexual community. The media has also been used to exchange information and promote this sense of community. There are national and local lesbian and gay newspapers, magazines, radio programs, and film festivals. The mainstream-quality media also often run stories and features from a lesbian and gay perspective. Lesbian and gay film seasons and programs have also been screened on television.

The growing confidence among lesbian, gay, and bisexual communities has also been illustrated by the increasing number and scale of festivals and parades around the United Kingdom, where lesbians, gay men, and bisexuals have come together, building and promoting a sense of community. In 1995, the annual Lesbian, Gay, and Bisexual Pride Festival in London attracted approximately 200,000 people.

The lesbian, gay, and bisexual communities of the United Kingdom are diverse, with same-sex desire cutting across age, class, ethnicity, religion, culture, ability, and health status. This is illustrated by the plethora of support and interest groups that have emerged to address these concerns.

[*Update 2003*: There have been some changes in the legal, social, and political lives of lesbians and gay men in the U.K. since the original United Kingdom chapter was written in 1996.

[The European Court recently ruled that the ban on lesbians and gay men serving in the Armed Forces is unlawful. As of 2002, the U.K. Forces were reviewing their employment policies in light of this. In relation to immigration rules, same-sex couples can apply to stay in the U.K. if the foreign partner is living in the country legally, and the relationship has existed for at least two years. However, the age of consent for gay men remains at 18 (two years above that for heterosexuals) despite attempts by the Labour Government to reduce it to 16. This should change within the life of the current Parliament. Section 28 also remains on the statute books despite promises of repeal.

[Rather more positively, developments in HIV treatments have raised optimism among people affected by HIV, particularly gay and bisexual men, who have been one of the communities most affected by the epidemic. Combination therapy has reduced levels of illness in people with HIV and enabled some people to return to work. (*End of update by A. Baines*)]

[*Update 2003*: In December 2002, Barbara Roche, U.K. minister for social exclusion and equalities, announced that gay men, lesbians, and bisexuals would be granted many of the same rights as married couples in Britain, though not the legal status of marriage itself, under government plans to officially recognize civil same-sex partnerships. The partnerships would give homosexual and bisexual couples property and inheritance rights and grant each person the status of next-of-kin to the other. According to Roche, the proposals would end situations where homosexuals were refused hospital visits to partners or excluded from funerals.

[Arguing that there was now an "extremely strong case" for giving legal recognition to gay unions, she said, "I do think society has moved on, and I think that we recognize that there are very many people in gay relationships who are in very loving relationships—indeed they may have been very long enduring relationships—but their partnership has no recognition in law."

[Detailed legislation will not be worked out at least until early 2004, and even then, the proposals would not amount to "gay marriages." However, same-sex couples would be free to arrange their own private ceremonies to mark the event.

[The opposition Conservatives, who have frequently seen their traditional and liberal wings fall out over gay

rights and "family values" issues, came out in support. "Whilst we attach a huge importance to the institution of marriage, we do recognize that gay couples suffer from some serious particular grievances," the party's shadow home secretary, Oliver Letwin, said. The third-party Liberal Democrats said the proposals were "welcome but long overdue. Couples of any sex must be made equal before the law."

[In leading up to this legislation, homosexuality was legalized in 1967; the age of consent for gay men was cut to 18 from 21 in 1994, and then to 16 in 2000; in 2001, the mayor of London set up the first register for gay couples, and in November 2002, gay couples gained the same legal right as heterosexual couples to adopt (Hoge 2002).

[While the government debates the issue of civil rights of gay couples, an ongoing, often emotional debate has heated up in the Church of England over the ordination of homosexual clergy, with warnings from the Archbishop of Canterbury, Dr. George Carey, that this issue could provoke a schism. Unexpectedly, a triad of events, in the U.K., Canadian and American branches of the Anglican Church, provoked extensive and emotional public debate of what had been an "in-house" issue.

[In October 2002, news reports confirmed that Canon Gene Robinson, who left his wife and children to move in with his male lover, was almost certain to stand for election as the next bishop of New Hampshire in the United States. In June 2003, Canon Robinson was elected bishop of New Hampshire on the second ballot. In July, following heated debate and refutation of allegations of "inappropriate behavior," the bishops, clergy, and lay delegates at the late-July 2003 General Convention of the national Episcopal Church in the U.S.A. ratified Canon Robinson's election as bishop of New Hampshire by a two-thirds majority.

[Meanwhile, in Vancouver, British Colombia (Canada), Bishop Michael Ingham announced that he would be the first bishop in the Anglican Communion to bless same-sex unions. In a strongly negative response, the bishops representing 38 million Anglicans in Africa and Asia said that Ingham's decision represented "a defining moment in which the clear choice has to be made between remaining a communion or disintegrating into a federation of churches (Kraus 2003).

[In June, while the Canadian and American debates fueled extensive media coverage, the Reverend Jeffrey John was nominated as the new bishop of Reading, south of London. John confirmed his nomination in a *Times of London* interview, and also the fact that he is homosexual and in a 27-year relationship with a fellow clergyman. He added that the relationship has been platonic for years—in keeping with church policy opposing homosexual acts by clergy members. Despite his celibate life, Jeffrey John was pressed to withdraw his candidacy after a private meeting with the new Archbishop of Canterbury, Rowan Williams, that lasted hours. (*End of update by R. T. Francoeur*)]

7. Gender Diversity and Transgender Issues

STEPHEN WHITTLE and GWYNETH A. SAMPSON

[*Rewritten and updated in late 2001 by S. Whittle and G. A. Sampson*]

Transvestism and transsexualism are moderately visible phenomena in United Kingdom society in the 21st century. However, this is a recent state of affairs, visibility having grown considerably in the 1990s. The reasons for this are manifold, despite the fact that there is still little legal recognition of the new gender status of a person who has undergone sex-reassignment treatment.

Male transvestism has long been a feature of the theater from the late medieval period when cross-dressing males provided the female characters for the stage. Cross dressing, or drag as it is referred to, as a stage act remains popular, with artists such as Danny la Rue and, more recently, Lily Savage gaining a national popularity. Female cross-dressing has not had such prominence, the writer Radclyffe Hall and the entertainer Vesta Tilly being notable exceptions in the 1920s and 1930s.

However, transvestism has remained a peripheral activity, with little social acceptance on a more personal level. Since the organization of the Beaumont Society in the late 1960s, which was originally founded to provide advice and safe social meeting venues for heterosexual transvestites, there has been a gradual proliferation of similar groups. There now exist a variety of organizations and settings throughout the country where men may cross dress in discrete venues. The development of "gay village" areas in the late 1980s and 1990s in many major cities also provided other locales, such as public houses and clubs where heterosexual and homosexual transvestites may meet and socialize. There is also a large underground network of "contact magazines," which allow homosexual and bisexual transvestites to make sexual contacts. It is difficult to estimate the total numbers of transvestites in the United Kingdom, as there has been little, if any, work to extrapolate figures.

There is little social acknowledgement of female cross dressing, it being seen to belong to some radical lesbians and "butch dykes" and a subgrouping of lesbian culture. However, the U.K.'s first "drag king" club, Naïve, opened in London, and several temporary venues now exist where events such as "drag king" competitions take place.

Transsexual people are a much more visible feature of British society, having gained considerable media interest. Newspapers, women's magazines, and television have regular features concerning transsexualism. Nonetheless, the individual transsexual person may be, in fact, far more hidden than this media interest otherwise portrays. The first recorded transsexual surgery in Britain was performed in 1944 by Sir Harold Gilles, an eminent plastic surgeon, on Michael Dillon, a (female-to-male) transsexual man. Since then, several thousand transsexual people have gained sex-reassignment surgery in the U.K. or abroad. Again, little work has been done to count the total number of transsexual people, but estimates based upon the numbers who have attended recognized Gender Identity Clinics, those who have joined self-help organizations, and those who have gained media attention, put the figures at around 10,000 to 15,000 transsexuals in the United Kingdom (McMullen & Whittle 1995). Several have published highly regarded autobiographical accounts, most notably racing-car driver Roberta Cowell (1954), the Mt. Everest climber and *Times* journalist Jan Morris (1974), and models April Ashley (1982) and Caroline Cossey (Tula) (1991). In recent years, there have appeared autobiographies from (female-to-male) transsexual men, including journalist Paul Hewitt (1995), Raymond Thompson, (1995) and Mark Rees (1996).

The first formal Gender Identity Clinic was set up by psychiatrist John Randell at Charing Cross Hospital in London in the early 1970s. Specifically catering to the needs of transsexual people, this clinic remains at the forefront of psychiatric and surgical services in this field. Currently, it has as its Head of Research, Richard Green, former president of the Harry Benjamin International Gender Dysphoria Association, which provides an academic and medical research base for those working in the field. There are several other clinics throughout the country, as well as a small clinic catering to the needs of transsexual adolescents and their families at the Portman Clinic in London.

The current legal position for transsexual people was embodied in the common-law decision in the case of *Corbett v Corbett* (1970, 2 All E.R., 33-48). In this case, the marriage between a male-to-female postsurgical-reassignment transsexual woman and a male partner was declared to be void. It was held that, for the purposes of marriage, a transsexual person would always be of their original sex designation at birth. It has also been held that the birth certificate records in the United Kingdom are a record of historical fact and, hence, are unalterable unless there was a substantial mistake at the time of registration. As a result, though, transsexual people, on one level, seem to be accommodated by the U.K. law, in that most of their personal documentation can be altered to show their new gender grouping and their new name; their birth certificate records, which are used as a form of identification for many purposes, will still show their old status and name, and they cannot marry a member of the opposite gender (i.e., same-sex) grouping. This means that for all legal purposes, they remain a member of their natal sex grouping. The iniquities that result from this, not only in terms of personal privacy, but also inadequate protection in employment legislation, have meant that transsexuals in the United Kingdom have taken the government to the European Court of Human Rights on several occasions. The case of *Rees v UK* (1987, 9 E.H.R.R. 56) led to a compromise solution whereby passports may now record the new name and gender status of the transsexual person on production of a sworn declaration of name change and a doctor's letter to the effect that the gender change undergone is permanent. Similarly, driving licenses will now record the new gender role, as can all other documents apart from the birth certificate.

However, transsexual people have not been satisfied with this solution and have continued to plead their cause to the government through the campaigning group, Press for Change (PFC). Press for Change provides legal advice and encourages parliamentary lobbying. Currently (2000), PFC is supporting cases concerning an issue of pension rights, which has been referred to the European High Court of Justice; a request for the declaration of validity of a transsexual person's marriage before the High Court; many employment cases; and cases involving several other areas of the law.

There are numerous self-help organizations for transsexual people, and many join these, albeit often only in their initial stages of transition. The largest are: the Gender Trust, which predominately caters to male-to-female transsexual women, and the FTM Network, which caters to female-to-male transsexual men. At any one time, both of these organizations have almost 2,000 members between them. Transsexualism is becoming increasingly socially accepted in the United Kingdom, with transsexual people finally succeeding in retaining or obtaining high-status job positions, including positions in education and local government, and high-profile positions in the entertainment industry.

In May 1999, the Home Secretary, Jack Straw, announced the creation of a Government Inter-Departmental Working Group with the following terms of reference:

> to consider, with particular reference to birth certificates, the need for appropriate legal measures to address the problems experienced by transsexual people, having due regard to scientific and societal developments, and measures undertaken in other countries to deal with this issue.

The report was published in April 2000, and the Working Group identified three options for future consideration by the government of the United Kingdom:

1. to leave the current situation unchanged;
2. to issue birth certificates showing the new name and, possibly, sex; and
3. to grant full legal recognition of the acquired sex, subject to certain criteria and procedures.

The report indicates that the first two of these options would be unlikely to resolve the problems that transsexual people face because of their current lack of appropriate legal status. As such, the report indicates that the U.K. government would only meet its obligations under Human Rights legislation if they granted full recognition of the transsexual person's acquired sex. It must now only be a matter of time before transsexual people obtain full legal recognition of their new status alongside their increased social acceptance.

8. Significant Unconventional Sexual Behaviors

KEVAN R. WYLIE

A. Child Sexual Abuse, Incest, and Pedophilia

Any form of sexual contact between adults and children evokes an emotive reaction. Sexual abuse of young children, intrafamilial sexual abuse (usually incestuous), and extrafamilial (usually pedophilia) are all offenses in the United Kingdom. Increasing awareness of child sexual abuse (CSA) has ensured a more-sympathetic approach to dealing with victims. It is accepted that sexual abuse is a traumatic event for most children, and for some, that it is followed by a post-traumatic stress reaction. The advantages and limitations in applying therapy to such a framework in the United Kingdom have been described by Jehu (1991).

There is evidence of an increased number of proceedings against offenders over the last decade, but it remains unclear whether this is a real increase in the number of offenses or improved methods of securing evidence for prosecution. While real or reporting patterns may have changed through the influences of feminism, media attention, academic acceptance, and public sensitization to such crimes, it is probably the case that "old attitudes die hard." There have been cases in the United Kingdom in which public opinion has turned surprisingly against those reporting child sexual abuse (the Cleveland affair, Orkney ritual abuse, and Rochdale Satanic abuse cases).

Police, social services, educational, and health services are now duty-bound to inform each other when cases of alleged abuse occur. Regional units within the United Kingdom have facilities to record interview sessions on video of children being asked open questions about the alleged abuse. Recent changes brought about by the Criminal Justice Act (1994) allow the use of video disclosure of abuse to a social worker for presentation in court. Video links within the court allow questioning of the minor in a room separate from the court to avoid the minor's facing the offender directly. Social workers have a statutory duty to be involved with families when children are placed on the "At Risk" register and must act on the balance of probability. The police, on the other hand, must establish beyond reasonable doubt that an offense has occurred. Offenders are charged with indecent assault. Inappropriate touching and the circumstances of the event are pivotal in deciding to embark with criminal proceedings. Corroborative statements, whenever possible, and medical evidence are often vital. There is however, no time limit for bringing such offenses to court.

There is currently debate in the United Kingdom regarding the reality of "false memory syndrome," with cases of

abuse being alleged up to 20 years or later than the alleged offenses took place. There are reports in the United Kingdom of men in their 60s and 70s being given short custodial sentences for offenses of sexual abuse or incest that occurred many years previously.

In 1994, prosecution of around 2,000 cases of indecent assault on females under 16 years of age were initiated and around 65% of those charged were found guilty. Only half of these were given custodial sentences. The punishment can be ten years imprisonment. It has been argued by Fisher and Howells (1993) that significant social-skill deficits occur in some sex offenders. Where these exist, the deficit is in the cognitive component of social competence. Sex offenders often have major difficulties in establishing and maintaining longer-term intimate relationships, with factors likely to include empathy deficits and inappropriate culturally induced expectations concerning sexual relationships. A recent article presented opinion as to whether a sexual offender should be allowed castration where there is a history of persistent sexual abuse (Alexander et al. 1993).

In law, incest is the act of intercourse by a man with a woman he knows to be his daughter, granddaughter, sister (or half sister), or mother. Three quarters of the cases reported involve father-daughter incest. Incest implies consent—although this is no defense—and is differentiated from unlawful sexual intercourse with a girl under the age of 13 or 16. All are offenses under the Sexual Offences Act 1956. The punishment for incest is seven years custodial sentence, unless the girl is under 13. If this is the case (effectively constituting rape), the punishment is life imprisonment. The number of persons proceeded against on the offense of incest are a small proportion of those charged with child sexual abuse.

The incidence of pedophilia is unknown in the United Kingdom. A small central unit exists to investigate this area, and while the offense is abhorred, limited resources are available to seek out actively and investigate crimes being committed by pedophiles. Several lobby groups now exist to promote awareness of the existence of this problem and the need for active targeting of police time towards preventing the continuation of such practices. Further, to date no national register exists to identify individuals when changing residence. It is not normally the case that such offenders are offered therapy unless supervised probation is ordered. (See also Section 8E below for information on child pornography.)

[*Update 2001*: In July 2000, the Home Office released a summary report and recommendations to reform the law on sex offenses: *Setting the Boundaries*. This is a consultation document. As a matter of public policy, the age of legal consent is recommended to remain at 16 years of age. With regard to specific offenses against children, the law should state that below the age of 13, a child cannot effectively consent to sexual activity. A recommendation of an offense of adult (over 18) sexual abuse of a child (under 16) is recommended, which would cover all sexual behavior that was wrong because it involved a child, and would compliment other serious nonconsensual offenses, such as rape, sexual assault by penetration, and sexual assault. It is recommended there should be no time limit on prosecution for the new offense of adult sexual activity with a child. An offense of the persistent sexual abuse of a child reflecting a course of conviction should be reintroduced. There is some recognition that children sexually abuse other children and that sentencing decisions should reflect specialist assessment of risk and potential for longer-term offending and include treatment options. The concept of familial sexual abuse for the modern family is suggested. (*End of update by K. R. Wylie*)]

B. Sexual Harassment

HELEN MOTT and ROHAN COLLIER
[*Rewritten and updated in late 2001 by H. Mott and R. Collier*]

Incidence

Sexual harassment is a widespread problem in British society. What marks it as an unconventional behavior, therefore, is not a question of rarity, but the fact that it is recognized as wrongful conduct under the law, particularly in the workplace (see below). Its roots in patriarchal society mean that, for the most part, it is women who suffer most from sexual harassment inflicted by men, although the concept has been extended to cover alternative permutations. While sexual harassment, as an exercise in gendered power relations, can be seen to affect women in all walks of life (cf. Wise & Stanley 1997), in general usage, the term is understood to refer primarily to the experience of women in the workplace.

There are as many definitions of sexual harassment as there are theoretical approaches to it, although most contain the common elements of citing conduct based on sex or of a sexual nature that is unwelcome or offensive, and/or detrimental to the interests of the recipient. The emphasis on the recipient creates a tension between objective and subjective standards, so that although the term *sexual harassment* is common currency, the people's ideas about what constitutes it can vary widely. Thus, a National Opinion Polls survey in 1991 found that one in six women said they had experienced sexual harassment, but when they were asked whether they had experienced certain kinds of (unwanted sexual) behavior that offended them, the figure rose to one in three (Collier 1995). The results of this survey, and others like it, suggest that people may be reluctant to label the full range of potentially sexually harassing behaviors as harassment *per se*.

The likelihood of a formal complaint being made to the authorities in the case of sexual harassment also appears to be low. Davidson & Earnshaw (1991) found that 65% of personnel directors in their study believed that between 70% and 100% of cases were never reported to them. This supports North American research (e.g., Livingston 1982, which claims that only 2.5% of harassment victims took any official action). For reasons such as these, it is, therefore, very difficult to attempt to quantify the incidence of sexual harassment. Recent surveys in Britain seem to show that, on average, between 30% and 50% of women claim to have experienced sexual harassment at work (Alfred Marks 1991; Industrial Society 1993; London Buses Ltd. 1991; Mott & Condor 1995), although in certain occupations, such as the police force, the figure has been as high as 90% (Her Majesty's Inspectorate of Constabulary 1993). The scale of the problem suggests that it is ill advised to concentrate upon the likely psychological profile of the harasser (or indeed the recipient). While individual factors may be relevant to individual cases, it is clear that sexual harassment is essentially a social problem.

Legal Penalties

As noted above, it is rare for complaints to reach any level of authority and it is, therefore, rarer still for the legal system to become formally involved. Sexual harassment cases in Britain can be brought within the ambit of several laws. Presently, most cases are dealt with by the Industrial Tribunal under the Sex Discrimination Act (1975). This act, which is applicable to all institutions, makes it unlawful to discriminate by treating a woman less favorably on the grounds of her sex. It also makes it unlawful to victimize a woman who has complained of sexual harassment, to promise or withhold benefits in exchange for sexual favors, or to subject her to detri-

ment. All of these elements of the Sex Discrimination Act can be relevant to sexual harassment in the workplace, and are applicable to men as well as women, although the scarcity of recorded cases successfully brought by men tends to suggest that this application is more theoretical than practical. Generally, both the individual harasser and the relevant organization will be jointly liable, unless the organization can prove that it has taken reasonable steps to prevent sexual harassment. Complainants can expect to receive monetary compensation (for which there is no upper limit) for financial loss, medical expenses, and damages, such as injury to feelings. Tribunals may also require that the organization take steps to prevent harassment happening again, or to transfer the harasser within the organization. Cases can also be brought to the Industrial Tribunal under the Employment Protection (Consolidation) Act (1978) when a person has been an employee of the relevant organization for at least two years full-time. Victims of harassment might claim constructive dismissal if they were in fact obliged to resign, or unfair dismissal if, as a direct or indirect consequence of being sexually harassed, they were dismissed from work. The Tribunal can rule for the reinstatement, re-engagement, or compensation of the injured party (subject to certain financial limits).

The number of cases involving sexual harassment brought to the Industrial Tribunal in Britain under the Sex Discrimination Act has been steadily increasing since 1986. There has been concern that the requirement under the Act to prove disparate treatment of the sexes prevents some cases from being adequately addressed. The aim of the Tribunal is to uphold the rights of the victim, and thereby, to provide a remedy, such as compensation. This can certainly penalize the perpetrator by the award of damages, but there is no power to punish. For these reasons, legal commentators such as Dine & Watt (1995) have called for more victims of harassment to take their cases to the civil or criminal courts, a practice which was rare, given that victims needed to mould their experiences to existing law, e.g., suing for breach of contract; trespass to the person (civil courts); or assault or false imprisonment (criminal courts).

In 1991, the EC issued a Code of Practice concerning sexual harassment following a Recommendation asking member states to promote awareness of the unacceptable nature of sexual harassment. This Code points out that sexual harassment is a form of sex discrimination and is, therefore, unlawful under the Equal Treatment Directive (1976). The Code also provides for the inclusion of harassment on the grounds of sexuality (in addition to gender) as sexual harassment. In addition, the Code recommends that organizations provide a clear policy prohibiting sexual harassment in the workplace and guaranteeing prompt and efficient action in the event of harassment. This Code of Practice strengthened the hand of those seeking to challenge the prevalence of sexual harassment in the workplace.

In 1997, a new law, the Protection from Harassment Act, came into force. The intention behind the Act was primarily to deal effectively with stalkers, although all types of harassment are theoretically covered. The Act states that a person must not pursue a course of conduct, which a reasonable person should know would amount to the harassment of another. It is necessary for two incidents constituting harassment to have occurred. The Act gives powers to both the criminal and the civil courts. Harassment is now an arrestable criminal offense carrying a maximum of six months in prison and/or a fine of up to £5,000. Should the offender have caused fear of violence, the offense carries up to 5 years' imprisonment and unlimited fine. The Court may also issue a Restraining Order upon the offender. A victim of harassment may also bring a civil claim under the Act, and may be awarded damages (including damages for anxiety), and may be granted an injunction against the perpetrator, the violation of which would constitute a criminal offense.

Social Response

The category of behavior, which we now call sexual harassment, has a very long history, although its naming has only come into being very recently. Sexual harassment as a concept came to Britain from North America in the late 1970s and early 1980s with the publication of Farley's (1978) and MacKinnon's (1979) highly influential texts. These texts, however, were academic, and it is only much more recently that "sexual harassment" has passed into the wider domain, so that since the late 1980s, it has been a topic for public discussion and debate. Since that time, there has been coverage in the press of successful Industrial Tribunal cases, and the subject has been addressed as a storyline in the two most popular television soap operas. In the year running from May 1993 to 1994, no less than 90 articles in *The (London) Times* newspaper discussed sexual harassment.

Women are now much more aware of their rights, and have higher expectations in terms of how they are treated at work than in the past. However, a recent study (Mott & Condor 1995) revealed that women continue to find it difficult to confront sexual harassment, as dominant workplace ideologies that legitimize unsolicited sexual behavior and mitigate against confrontation, remain. It is also clear that the pervasive and everyday nature of much sexual harassment (especially in the form of sexual remarks and joking) in many workplaces makes it unrealistic to expect an immediate changeover to zero tolerance.

Results from many studies have shown that sexual harassment can have a devastating effect for victims, both in terms of their performance at work and their personal well-being. Eighty-six percent of harassment victims in the COHSE (1991) study reported an adverse effect on emotional well-being, while 33% said that their quality of work deteriorated. Despite this, and despite the potential risks of litigation, the response of many organizations and trade unions to the problem has not been adequate. In the study mentioned above, over half the employees who complained of harassment felt that their complaints had not been dealt with adequately, and 10% found that they (rather than the harasser) had effectively been punished by being transferred to another job or department. An Industrial Society Survey (1993) found that 60% of British employers had no sexual harassment policy in place.

C. Rape

KEVAN R. WYLIE

In England and Wales, rape is defined as sexual intercourse with a woman without her consent. This must involve penile penetration "to the slightest degree" of the vagina. Emission is not necessary for the act to constitute rape. Penetration of the anus constitutes "buggery," and penetration of the mouth constitutes "gross indecency" or "indecent assault." Attitudes towards rape have changed over the last couple of decades, with women feeling more able to report cases to the police. There was a twofold increase in the proportion of rapes committed by "intimates" (30% of all rapes by 1985) and in the number of rapes taking place indoors, particularly in the home of the victim, which had similarly doubled (30% of all rapes by 1985).

Police forces now have dedicated nonpolice-station units where persons alleging rape are counseled. These units often resemble living dwellings rather than the institutional nature of the police station. Within the units are video interview rooms and a medical suite. Premises and facilities of victim

examination suites are reviewed by Lewington and Rogers (1995). Should the victim be willing to make a formal statement, attempts to trace the offender take place to allow for questioning of the suspect. It remains the case that victims of rape experience anonymity during court proceedings, while the offender is not offered such protection.

Victims are offered support by Rape Crisis and Victim Support units. Cohn (1990) found that the incidence of rape, as well as assault, burglary, collective violence, and domestic violence, increased with ambient temperature, at least up to about 85° Fahrenheit (29° C), and concluded that, in general, the most violent crimes against persons occurred linearly with increasing ambient temperature, while property crimes did not strongly relate to temperature changes.

The issue of "date rape" has started to make an impression in the United Kingdom, although it does not constitute a specific offense as such. The issue of stranger rape has been construed by some as "clumsy seduction." Marital rape is now accepted as an offense.

Rape is an offense under the Sexual Offences Act 1956 and there has been a threefold increase in the number of cases in which proceedings have started in the courts in England and Wales over the last decade. Of the 1,625 cases proceeded against in 1994, just under a quarter were found guilty and sentenced. Almost all of these cases were punished with immediate custodial sentences, which is normally life imprisonment. Sentencing has shown a general trend towards an increased length of custodial sentence passed. In sentencing, judges are less likely to regard prior consensual contact as a valid reason for passing noncustodial sentences on convicted rapists (Lloyd 1991).

A number of male partners of rape victims remain seriously troubled many months after the rape (Bateman & Mendelssohn 1989) and have become profoundly worried about their identity as men, shunning their male friends, avoiding sexual contact with their partner, and withdrawing from regular social interaction. They may require intensive psychoanalytic therapy to begin to understand what it means for them that their partner has been raped.

In a review of sexual offenders, rapists were found more likely to report having a current female partner and to have experienced consenting heterosexual intercourse with an adult, than were nonincest offenders against male children. However, no evidence emerged that rapists and nonincest offenders against female children differed significantly in this respect (Bownes 1993). Using the GRIMS and GRISS questionnaires, the investigation found evidence of marital and relationship difficulties and sexual problems among all offense categories of those sentenced for sexual offenses as being substantially higher than those among the general population. A prevalence of 62% for marital/relationship dysfunction among offenders who had a current relationship with an adult female partner, and a prevalence of 57% for sexual dysfunction amongst offenders who had experienced heterosexual intercourse with an adult, were reported. Treatment programs need to address these elements.

Until recently, buggery with a male under the age of 21, or with a woman or with an animal, led on conviction to punishment with life imprisonment. However, when Section 143 of the Criminal Justice and Public Order Act 1994 came into force on November 3, 1994, the amended Section 12 of the Sexual Offences Act 1956 (The Acts of Buggery) in effect legalized anal intercourse for consenting couples over 18 years of age, be they gay or heterosexual. About 10% of cases are thought to be heterosexual and, unless force accompanies the act, these cases rarely proceed to court. Where anal intercourse occurred as a result of sexual assault, this amendment would obviously not apply.

While Mezey and King (1989) had difficulty in getting victims to cooperate with an interview for their research project on male rape, their results indicated that failure to report to the police was a problem. Most of the assailants and subjects were homosexual or bisexual, and only a few cases conformed to the stereotype of sudden unprovoked attack by complete strangers in a public place. The assault had considerable impact on the subjects' sexual identity. It was concluded that these findings suggest that male victims' immediate and long-term responses were similar to those described by female rape victims.

A study by Hickson et al. (1994) reported the prevalence of nonconsensual sex amongst homosexually active men as 27.6%, of which 3.9% involved female assailants. A third of the men had been forced into sexual activity, usually anal intercourse, by men with whom they had previously had consensual sexual activity. These results supported the belief that male rape is not usually committed by men identified as heterosexual.

The majority of those persons found guilty of buggery were given immediate custodial sentences. Around 40% were found guilty of the 379 cases in which proceedings took place in 1994.

What is commendable is the high detection rate by the United Kingdom police of sexual offenses that are reported as having been committed, particularly for rape, unlawful sexual intercourse with girls under 16, incest, and buggery. There are less-successful detection rates with indecent assault on females aged 16 years and over, when compared to the offenses of indecent assault on females under 16 years of age, with a similar but less marked pattern seen with indecent assault on a male in both age groups. The "clear-up" rates for sex crimes are generally considered to be substantially higher than those for other crimes. There are, of course, an unestimatable number of sex crimes never reaching the police.

[*Update 2001*: A Government consultation paper detailing law changes, giving better protection for victims of child sex abuse and rape, went into effect in the summer of 2000. A sexual offenses review group is currently advising the Government. In 1999 to 2000, rape and other sex crimes rose overall by 4.5%, with a 10% rise in rape of women and a 19% rise in rape of males. Experts believe part of this, especially the male rape figures, is also because of more reporting of the crime. Increasing numbers of the accused are friends or ex-boyfriends of the victims, indicating a greater willingness to report date or acquaintance rapes—notoriously the most difficult type to prove in court.

> The above mentioned Home Office document setting the boundaries (for consultation) recommends the offence of rape should be retained as penile penetration without consent and extend it to include oral penetration. This should be defined as penetration of the anus, mouth or genitalia to the slightest extent and for the avoidance of doubt, surgically reconstructed male or female genitalia should be included in the definition in law. ("Attacks and Sex Crime Up as Robberies Soar," *Daily Mail* newspaper, July 18, 2000)

[A new offense of sexual assault by penetration should be introduced for all other penetration without consent. Consent should be defined in law as "free agreement." A non-exhaustive list of examples is given within the draft documentation. (*End of update by K. R. Wylie*)]

D. Prostitution

KEVAN R. WYLIE

It has been estimated that in major cities in the United Kingdom outside of London, between 800 and 1,000 women work as prostitutes at any one time. An excess of 10,000

male clients use such services in any one city. Paying for sex remains a stigmatized behavior, although 6.8% of men reported paying for sex with a woman at some time and 1.8% had done so within the last five years (Wellings et al. 1994). Recent experience was most common in the age group of men aged 25 to 44, although prevalence of ever paying for sex was five times more common in the older age group (10.3% vs. 2.1%). It was most common in widowed, separated, and divorced men within the last five years, and the men were more likely to be from social classes I and II (possibly away from home on business). A history of a homosexual partner (at any time) was associated with specifically raised odds of commercial sex contact (possibly some bisexual men).

The prostitute population is not stable. Women enter and leave, depending upon life circumstances. The risk of HIV through sexual services is very low, and the risk of contracting HIV is much greater through the use of drug injecting. It has been argued that if a sexual act is consensual and does not harm others, it should be acceptable to repeal the laws prohibiting soliciting. By doing so, it would free street workingwomen from harassment, and reduce police and court time of those who are attempting to uphold a law that does little to abolish the "trade" (Carr 1995). The *National Vice Squad Survey* (Benson & Matthews 1995) found that one third of police vice squads want brothels to be legalized.

Prostitution can constitute one of several offenses. These include "curb crawling" (approaching a prostitute and being a "nuisance") and soliciting under the Sexual Offences Act 1985, behaving in an indecent manner in a public place under the Vagrancy Act 1824, loitering or soliciting for the purposes of prostitution under the Street Offences Act 1959, and procurement of persons for immoral purposes under the Sexual Offences Acts 1956 and 1967. Women offer sexual services to men within several settings. Such services are usually offered within the so-called red light areas of a town or city. Establishments offering saunas and massage parlors are usually a cover for offering such services. These can range from masturbation of the man ("hand relief") and oral sex to intercourse (usually with the insistence of using a condom).

Establishments known as brothels exist, usually a house with several rooms being used by women offering sexual services. Such brothels are usually run by a "madam." The equivalent on the street are girls working for a "pimp." Both the provider and organizer, as well as the user, can be charged with one or more of the above offenses. The policy of many police forces in the United Kingdom would be to caution a prostitute on a couple of occasions and advise her of support services to try and help her move away from using such activity as the route for financial gain. Often such persons need assistance in severing the link with their "pimp," to whom they may be in debt or exploited through addiction to drugs. Many of the punishments carry short custodial sentences as an option, although the vast majority are dealt with by fine. The average fine for curb crawlers in 1995 was £110. The exceptions are conviction of living on the earnings of prostitution or exercising control over a prostitute, where a custodial sentence is much commoner. However, cases cannot be brought on the uncorroborated word of a prostitute or solely on police evidence.

Soliciting by a man is an offense usually dealt with by the courts by a fine, if indicted. There is increasing awareness of male prostitution, particularly in the capital city. Such men are called "call boys" and many offer their services to visiting businessmen in hotels. This is an area where detection by the police is very low. Low levels of reporting occur and usually the police are only aware as a consequence of robbery or associated assault. Of the 124 cases proceeded against in 1994, 89 were found guilty.

It is generally felt that the tolerance towards prostitution in England and Wales is fairly high, provided that such occurs in private. Much of the action of the police is in an attempt to appease complaining residents. An interesting development in the United Kingdom has been the call by the Inland Revenue for disclosure of such income by prostitutes for payment of Income Tax.

In mid-1996, the Government-controlled telephone company, British Telecom, joined Westminster, London's largest borough, in a crackdown on prostitutes who paste sexually explicit business cards advertising their services on the 700 bright red phone kiosks available to the public on the streets. After using computers to locate the offending prostitutes, telephone inspectors notify them they have one week to cease their postings. If the postings continue, the telephone company blocks their incoming calls. In announcing their effort, authorities said their objection "is not with prostitution as such, but with the people who illegally litter and deface the city's streets with this offensive and often pornographic advertising material." School teachers had complained that schoolchildren have been found collecting and trading the cards, many of which are illustrated.

In early 1996, British Telecom and Westminster sanitation teams, starting as early as 6 A.M. each day, removed 150,000 cards a week, 1.1 million such cards in an eight-week period; an estimated seven million cards are removed in a year. "Vice-carders," mostly young men hired by a half dozen prostitutes to post their cards, follow the sanitation teams, creating a no-win situation.

In 1991, the last time Westminster officials tried a similar scheme, Oftel, the Government telecommunications-regulating authority, said that blocking incoming calls was a violation of advertisers' rights. Before the current campaign, British Telecom changed its contract for all its customers, stipulating that they cannot advertise their telephone number in public phone kiosks. Whatever the success this effort has in controlling this advertising, it will not stop prostitutes from advertising their sexual services. Prostitution is legal in Britain, and so sex workers will continue advertising in other outlets, such as community newspapers. (See the discussion of *pikku bira* in Section 8B of the chapter on Japan.)

[*Update 2001*: A redefinition of terms such as *prostitution* was part of the U.K. government consultation paper to change the sex laws in Britain. The document, *Setting the Boundaries*, suggests consideration be given to the regulation of soliciting by men for the purposes of prostitution under Section 1 of the Street Offences Act 1959 on the same basis as soliciting by women. It also recommended that a specific trafficking offense with powers to trace assets overseas be introduced. Offenses regarding commercial sexual exploitation of children will be listed. It also recommended a new offense for the sexual exploitation of adults to include an offense for anybody in England and Wales who recruits people for sex work anywhere in the world. (*End of update by K. R. Wylie*)]

E. Pornography and Erotica KEVAN R. WYLIE

There has been a general relaxation within England and Wales over erotica and nudity when displayed within newspapers and on television. There has been a trend away from the "page 3" bare-breasted girl in the tabloid press, in part fueled by complaints from feminists, but also because of increased availability of such material elsewhere. Hard pornography cannot be shown on British television, nor can scenes of an erect penis or bondage. Among European

nations, only Ireland appears stricter than the United Kingdom, with no nudity or pubic hair permitted.

Despite such liberalism, there remains tight enforcement against many forms of pornographic material. Possession of adult pornography does not in itself constitute an offense. However, possessing obscene material for gain, whether that be to lend, publish, or display, would constitute an offense under the Obscene Publications Act 1959/1964. The law explicitly forbids pornography involving minors and extends to taking indecent photographs of children (Protection of Children Act 1978). The sentence on conviction is three years imprisonment. Possession of photographs of child pornography carries punishment usually by fine (but six months custodial sentence is possible), and associated investigation may ensue for possible child sexual abuse and of pedophilia. A proactive measure against pedophilia exists whereby photographic developers are requested to inform the police when they notice suspicious photographs of young children. The increasing incidence of transfer of pornographic material using personal computers over the Internet has led to rising concern. However a group, Parents Against Injustice (PAIN), campaigns against overzealous misinterpretation of innocent family photographs of children bathing, running in the garden naked, or being bounced on grandfather's knee. The fact is that photographs can be very subjective.

Many book classics were banned under the Obscene Publications Act, and the infamous 1960 obscenity trial prevented copies of *Lady Chatterley's Lover* and *Queen Mab*, first published in 1829, from home ownership. Daniel Defoe was one of the earliest English authors to include superpermissive parent figures, incestuous relationships, and lower-class characters who were all sexually uninhibited, passionate, and with responsive female characters. The links between poverty and exploitation and between sexual attitudes and cultural practice have been noted many times over. However, pornography has certainly moved more from the "peep shows" and cinemas to the home, with the increasing numbers of videotapes displaying such material.

Pornographic videotapes are now obtainable through mail order, both within the United Kingdom and from Europe. Self-help videos, like *The Lover's Guide*, had sold 1.3 million copies by late 1995. Although explicit, they are considered educational and have a license. The importation of obscene pornography, however, constitutes a criminal offense, although it is acknowledged that it occurs in considerable volume, given relaxed cross-country border controls within Europe. Political action was taken in 1993 to prevent satellite programming of pornographic material from Red Hot Dutch into the United Kingdom. This involved making it an offense to sell "smart cards" or advertise and publish information about the service. A similar course of action was taken in 1995 to ban the Swedish channel TV Erotica. The 1990 Broadcasting Act forbids programs that might "seriously impair the physical, mental or moral development of minors."

The United Kingdom now has three subscription-pay-TV adult soft-porn channels, Adult Channel, Television X, and Playboy TV, all of which operate in a scrambled form at nighttime. There are approximately 100,000 subscribers. The Church of England and Methodist Church have sold their shares in the BSkyB company because of this new venture.

[*Update 2001*: Recent court rulings have introduced a "Restricted 18" or R18 certification for explicit-sexual-act videotapes which are on sale only in the U.K. through official sex shops. In 2000, the High Court ruled that "extremely explicit" videos could go on sale in licensed sex shops, and dismissed a challenge by the British Board of Film Classification against the decision of its own Video Appeals Committee (VAC). The VAC was established by Parliament in 1984 to rule on appeals from firms that feel they have been harshly treated by the British Board of Film Classification. The Home Secretary (Home Office) responded by stating that ways of protection of children from exposure to sexually explicit material was under consideration. The British Board of Film Classification Guidelines reads as follows:

> 'R18'—TO BE SUPPLIED ONLY IN LICENSED SEX SHOPS TO PERSONS OF NOT LESS THAN 18 YEARS
>
> The 'R18' category is a special and legally restricted classification for videos where the focus is mainly on real sexual activity and the purpose is primarily to induce sexual arousal. Such videos may be supplied to adults only in licensed sex shops, of which there are only about 60 in the UK. 'R18' videos may not be supplied by mail order.
>
> The sex scenes in all 'R18' videos must be non-violent and between consenting adults. They must also be legal, both in the acts portrayed and in the degree of explicitness shown. There are no limits on length and strength apart from those of the criminal law. Group sex is allowed and, insofar as the law permits, there is parity as between homosexual and heterosexual sex.
>
> Erections may be shown, as may a broader range of mild fetish material, but no threats of humiliation or realistic depictions of pain are permitted.
>
> There must be no clear sight of penetration, oral, vaginal or anal, or of masturbation.
>
> Ejaculation must not be shown.
>
> Context may justify exceptions.

[(*End of update by K. R. Wylie*)]

9. Contraception, Abortion, and Population Planning

A. Contraception Attitudes and Use

FRAN READER [*Rewritten and updated in late 2001 by F. Reader*]

Contraception is widely accepted, although there remains considerable variance between knowledge about and actual use of contraception. There is a constant trend towards a more open discussion about contraception and sexuality that has been accelerated by the arrival of HIV and AIDS.

The Education Reform Act of 1988 places a statutory responsibility on schools to provide a broad and balanced curriculum that "promotes a spiritual, moral, cultural, mental, and physical development of pupils at the school and in society," and which "prepares pupils for the opportunities, responsibilities, and experiences of adult life." This philosophy forms the basis of Personal and Social Education (PSE), which is a theme running throughout a child's life at school. Sex education is part of the wider topic of health education. Health education is not a mandatory foundation subject, but it is expected to be a theme that is incorporated across the whole curriculum. School governors have the responsibility to decide whether and/or what sex education should be taught. Parents have the right to withdraw their children from the PSE aspect of sex education, but not from the biological science aspects of the National Curriculum, which provide information about human sexual behavior and sexually transmitted infections, including HIV and AIDS. In Scotland, there is no legislation regarding the teaching of sex education in schools. Each Local Authority decides or delegates the decision to the individual school, and the curriculum guidelines define sexuality and relation-

ships as an important area of health education. In Northern Ireland, heath education is given as one of six mandatory cross-curricula themes in the Education Reform Order of 1989. Sex education is not specifically mentioned, but it is widely expected to form a major component of health education.

The age of consent for heterosexual sexual activity is 16 in England, Wales, and Scotland, and 17 in Northern Ireland. Doctors may prescribe contraception to those under 16 years old. The present legislation in England and Wales follows the House of Lords Ruling in the Gillick case of 1985. In that case, the Lords ruled that "a girl under 16 of sufficient understanding and intelligence may have the legal capacity to give valid consent to contraceptive advice and treatment including necessary medical examination." In Scotland, the Age of Legal Capacity Act came into force in September 1991, bringing Scotland in line with England and Wales. In Northern Ireland, a similar legal situation exists, except the age of consent for medical advice is 17.

In 1993, the Conservative Government launched a *Health of the Nation* initiative. Sexual Health was one of the key sections, with one of the targets being to halve the rate of unplanned pregnancy in under-18-year-olds by the year 2000. This did not happen. The present New Labour Government has therefore established a Teenage Pregnancy Unit to research the reasons for unplanned teenage pregnancy and establish strategies that will tackle the problem effectively. This forms part of a wider Government initiative to address the causes of social exclusion. A Sexual Health Strategy document was anticipated in the autumn of 2000.

Since 1974, all contraceptive advice provided by the National Health Services, and all prescribed supplies, were made available free of charge, irrespective of age and marital status. In the United Kingdom, most contraceptive services are provided by either general practitioners (GPs) or by Community and Hospital Clinics. Community and Hospital Family Planning Clinics have always been able to supply condoms free of charge. This has not been available to GPs, although some medical practices now offer this service. Government policy supports the dual provision and choice to maximize the use of services; however, there has been a marked reduction in the number of Community Family Planning Clinics with a shift to GP providers. Since 1990, new contractual arrangements were introduced for GPs that affected their fees and allowances, encouraging a greater emphasis on Health Promotion. This system has continued to shift contraceptive care to general practice. The Community Family Planning Clinics have, therefore, looked to complement GP services, and specifically target teenagers and vulnerable groups that may have problems in accessing care from GPs.

Community Clinics, backed up by specialist contraceptive clinics in hospitals, also tend to provide a wider range of contraceptive methods than are available from GPs. Snowdens' research in 1985 showed that only 55% of the women using Family Planning Clinics were prescribed the pill as opposed to 84% of GP patients. This trend has continued. Community Clinics, therefore, remain a service of choice for those women wishing to use the less-common methods of contraception, and they remain the main source of training for physicians and nurses.

Contraception is now recognized as a part of core training for all GPs, obstetricians and gynecologists, and specialists in genitourinary medicine. Specialists in the field undergo training with the Faculty of Family Planning and Reproductive Health Care, which is part of the Royal College of Obstetricians and Gynaecologists. Initial training is recognized as the Diploma of the Faculty of Family Planning (DFFP) and the specialist training as Membership (MFFP). The Faculty also aims to maintain standards for various skills by awarding letters of competence to practitioners who have completed training in techniques of fitting intrauterine devices or implants. The Faculty has also introduced a process of five-year recertification for all its certificates.

Since the *Health of the Nation* initiative, there has been an increasing shift to integrate the community and hospital contraceptive services with community and hospital services for sexually transmitted infections (STIs/STDs). Doctors and nurses initially trained in one or the other discipline are entering into programs of combined training, or at least improving their appreciation and understanding of the other discipline. The integration of family planning and sexual health is providing a "one stop shop" approach to the management of all potential problems arising from sexual activity. It is now common practice to be advised to use contraception to prevent unplanned pregnancy backed up by either the male or female condom for the prevention of sexually transmitted infections.

Contraceptive methods currently available in the United Kingdom are combination oral contraception, progesterone-only pills, long-acting injectable progestogens, a three-year etonogestrel implant, an intrauterine system with Levonorgestrel (IUS), copper intrauterine devices (IUD), including GyneFix, male and female condoms, diaphragms and cervical caps, natural family planning, including Persona, and male and female sterilization. The 1997 statistics for Great Britain show that the combined oral contraceptive pill is still the most common method of contraception used by women under 30. In total, it is used by 26% of women between the ages of 16 and 49. Conversely, sterilization is the most common method used over the age of 30, with male and female sterilization being equally represented. In total, 21% of 16- to 49-year-olds use sterilization as their method. Condom usage has increased in recent years, and with this, there has been a decrease in the use of oral contraceptives. The use of combined oral contraception always fluctuates, tending to fall after media-publicized concern about safety. In October 1995, the Committee on Safety of Medicines (CSM) raised concern about pills containing the progestogens, desogestrel and gestodene, and an increased risk of venous thrombosis. As with similar pill scares in the past, this generated a fall in the uptake of the combined pill, and may have been responsible for the rise in the abortion rate seen across all age groups.

Methods of contraception introduced over the past 10 years include the female condom (Femidom), introduced in 1992. So far, this method has not caught on, and the male condom maintains dominance as the most popular barrier method. The five-year capsule Levonorgestrel implant (Norplant) was introduced in 1993 and withdrawn in 1999, to be replaced by a single rod etonogestrel implant (Implanon). An intrauterine system (IUS) with Levonorgestrel (Mirena) was introduced into the United Kingdom in 1995 and now has a five-year license. This new method has been widely accepted in the United Kingdom, particularly for the management of contraception in older women as an alternative to female sterilization. The Personal Contraceptive System for the electronic prediction of the fertile phase (Persona) was introduced in 1996. It is not available on the NHS and has not proved to be as successful as was anticipated. It is mostly used by women looking to space pregnancies. In 1998, the fixed, frameless, and flexible intrauterine device (GyneFix) was introduced. A training program is underway to teach doctors the new fitting technique. The copper IUD, Gyne T 380, with a 10-year license, became unavailable in the U.K.

at the end of 1999 following its withdrawal by the manufacturer for commercial reasons. This was considered a retrograde step by family planning specialists in the U.K., who saw this device as the gold standard IUD. It is hoped that a similar device will be reintroduced, but in the meantime, the introduction of the Nova T 380 IUD has been welcomed as an alternative, although it only has a 5-year license at present, and is currently not available to GPs on their drug tariff.

Emergency contraception with both the hormonal and IUD method are widely available within the United Kingdom through general practitioners, community clinics, sexually transmitted disease (STD) clinics, and accident and emergency departments. In 2000, the progesterone-only emergency contraceptive (POEC) method was licensed and marketed as Levonelle 2. The concept of advance-prescribing of POEC is gaining favor, and there is an expectation that it will become an over-the-counter (OTC) medicine in the near future.

B. Teenage (Unmarried) Pregnancy

MARY GRIFFIN

United Kingdom data specifically relating to unmarried teenagers are scarce. Official statistics have been collected by separate organizations in England and Wales, Scotland, and Northern Ireland, but uniform data have not been gathered for the three groupings. The information given in this section is mainly for England and Wales, with a little, where available, on Scotland and Northern Ireland.

The trend in the United Kingdom is increasingly towards teenage mothers not marrying (Family Planning Association 1994). Some prefer to cohabit with their partner, since there is little stigma attached to this, although many maintain a single-parent lifestyle. Indeed, it can be advantageous for teenagers not to marry in terms of welfare benefits and housing, although cohabiting teenage mothers do have the highest rate of reported homelessness (18%), according to recent research from the *National Child Development Survey* (Joseph Rowntree Foundation 1995). The trend away from marriage is reflected in the outcome of conceptions in England and Wales for 1992 for all women under 20, the total number being 93,000, of which 8,300 were conceptions inside marriage. Of the 84,700 conceptions outside of marriage, 37% were legally aborted, 58% led to maternity outside of marriage, and only 5% to maternity inside marriage (OPCS 1992). Looking at live births for 16- to 19-year-olds in England and Wales, in 1983, 56.3% were registered outside of marriage, but this had increased to 87.8% by 1993 (OPCS). In Scotland, for the 15-to-19 age group, the percentages rose from 54.5% in 1984 to 89.3% in 1994 (General Register Office for Scotland). Even in Northern Ireland, which tends to be more conservative and a few years behind social trends on the mainland, single parents are no longer a rarity and are increasingly accepted without social stigma.

While 16 years is legally the lowest age for marriage in the United Kingdom, parental consent is required up to the age of 18 in England, Wales, and Northern Ireland, but not in Scotland. In the first three regions, written consent of both parents is required, even if they are estranged, so that some teenagers wishing to marry may not be able to do so before the birth of the baby if this legal requirement cannot be fulfilled.

Looking at trends over the last two decades, the introduction of free contraception in 1974 led to a decline in teenage pregnancy rates. In 1973, the total conception rate per 1,000 teenagers in England and Wales was 9.2 for 13- to 15-year-olds (and therefore unmarried) and 75.2 for 15- to 19-year-olds (marital status unspecified). Ten years later, the rates were 8.3 and 56.0, respectively, of which just over half were terminated for the 13-to-15 age group and a third for the 15-to-19 age group. Thereafter, rates increased until a peak in 1990 (10.1 for the 13-to-15 group, with half legally terminated, and 69.0 for the 15- to 19-year-olds, with just under a third terminated) (OPCS). The peak came a year later in Scotland, but there was no particular trend in Northern Ireland.

Several factors probably contributed to this phenomenon. Firstly, the Gillick case, which eventually concluded in 1985 in favor of young people's rights, caused a great deal of confusion over teenagers' access to confidential help and advice, and anxieties still persist (Wareham & Drummond 1994), despite the joint statement referred to by Mrs. Gillick in a letter to the *British Medical Journal* (Gillick 1994). Secondly, the onset of economic recession led to a decline in young people's job opportunities. A third contributory factor was cuts in family planning clinics, thereby restricting access to services (Brook Advisory Centres 1995). The Government's concern over the rise in teenage pregnancies led to teenage sexual health being identified as one of the key areas targeted for action in their policy document, *Health of the Nation* (Department of Health 1992)—a specific aim being to reduce the 1989 conception rate in under-16-year-olds by at least 50% by the year 2000. Rates are already falling again and teenagers are far less likely to have a baby today than 25 years ago.

In England and Wales, the total conception rate per 1,000 for 13- to 15-year-olds in 1993 was 8.1 (with 50% legally terminated) and for 15- to 19-year-olds, 59.6 with just over one third terminated. In Northern Ireland, the total number of live births to under-15-year-olds for 1990 to 1993 inclusive ranged between 4 to 7, but rose to 11 in 1994. Total live births to 15- to 19-year-olds (marital status unspecified) rose to 1,856 in 1992, but has since fallen to 1,486 in 1994 (General Register Office for Northern Ireland). Since Northern Ireland is not as liberal towards abortion as the other three countries, some pregnant teenagers go to the larger cities on the mainland to obtain abortions. Legally, the situation with regard to abortion in Northern Ireland is a very gray area, and those involved in women's health and welfare agencies are aware that doctors there are increasingly prepared to widen grounds for justifying therapeutic abortion in the interests of a teenager's physical or mental health. This trend may be reflected in the statistics, though official figures for terminations were unavailable because of the legal situation.

With regard to the social background of young parents, longitudinal data from the *National Child Development Survey* show that half the teenage mothers who were single when their babies were born went on to cohabit with or marry the father. The study found no significant differences in childhood factors between young parents whose babies were born within marriage and those who were single or cohabiting when they gave birth. The data also suggested that the predisposition to have a child when young was independent of any thoughts about marriage, cohabitation, or single parenthood. Sixty-seven percent of those married at the time of conception had planned the pregnancy, compared with 26% of those cohabiting, 17% who married during pregnancy, and 8% who had no live-in relationship before birth (summarized by Joseph Rowntree Foundation 1995).

Despite the expansion of services and increased provision of information for teenagers in the United Kingdom since *Health of the Nation*, it seems that risk-taking behavior, failure to anticipate risk, lack of knowledge, and errors in the use of contraception are still major causes of un-

wanted teenage pregnancies (Lo et al. 1994; Pearson et al. 1995; Wareham & Drummond 1994).

[*Summary and Update 2001*: Within Western Europe, the United Kingdom has the highest rate of teenage births. However, data specifically relating to unmarried teenagers are scarce. As noted above, the trend in the U.K. is increasing toward teenage mothers not marrying (Family Planning Association 1994). Some prefer to cohabit with their partner. Many maintain a single-parent lifestyle, although there is still stigma attached to this. Indeed, it can be advantageous for teenagers not to marry in terms of welfare benefits and housing, although cohabiting teenage mothers have the highest rate of reported homelessness, with 18% recorded in the *National Child Development Survey* (Joseph Rowntree Foundation 1995). Even in Northern Ireland, which tends to be more conservative and a few years behind social trends on the mainland, single parents are no longer a rarity and are increasingly accepted without social stigma. While 16 years is legally the lowest age for marriage in the United Kingdom, parental consent is required up to the age of 18 in England, Wales, and Northern Ireland, but not in Scotland. In the first three regions, written consent of both parents is required, even if they are estranged, so that some teenagers wishing to marry may not be able to do so before the birth of their baby if this legal requirement cannot be fulfilled.

[Looking at trends over the last three decades, the introduction of free contraception in 1974 led to a decline in the pregnancy rate. In 1973, the total conception rate per 1,000 teenagers in England and Wales was 9.2 for 13- to 15-year-olds (and therefore unmarried), and 75.2 for 15- to 19-year-olds (marital status unspecified). Ten years later, the rates were 8.3 and 56.0, respectively, all of which, just over half, were terminated for the 13-to-15 age group and a third for the 15-to-19 age group. Thereafter, rates increased until a peak in 1990 (OPCS). Several factors probably contributed to this phenomenon. First, the Gillick case, which eventually concluded in 1985 in favor of young people's rights, caused a great deal of confusion and anger over teenagers' access to confidential help and advice, and anxieties still persist despite the joint statement referred to by Mrs. Gillick in a letter to the *British Medical Journal* (Gillick 1994). Second, the onset of economic recession led to a decline in young people's job opportunities. A third contributory factor was cuts in family planning clinics, thereby restricting access to services (Brook Advisory Centres 1995).

[With regard to abortion, since Northern Ireland is not as liberal as the other three countries, some pregnant teenagers go to the larger cities on the mainland to obtain abortions. Legally, the situation with regard to abortion in Northern Ireland is a very grey area, and those involved in women's health and welfare agencies are aware that doctors are increasingly prepared to widen grounds for justifying therapeutic abortion in the interests of a teenager's physical or mental health. This trend may be reflected in the statistics, though official figures for terminations were unavailable because of the legal situation. Currently in England, just over half of all teenage pregnancies are terminated, and this ratio has changed little since the mid 1970s. Over a third of conceptions to women in their 20s are terminated, with the figure rising (ONS1998). Pregnant teenagers are one-and-a-half times more likely than women in their 20s to have an abortion at 13 weeks or later (ONS 1997).

[The government's concern over the rise in teenage pregnancies through the 1980s led to teenage sexual health being identified as one of the key areas targeted for action in their policy document, *Health of the Nation* (Department of Health 1992). A specific aim of the new policy was to reduce the 1989 conception rate in under-16-year-olds by at least 50% by the year 2000. However, the target was not met and U.K. rates have stuck at around 25 live births per 1,000 women aged 15 to 19. Rates for Scotland, Northern Ireland, and England have tended to be similar, but Wales has a higher rate, as have certain areas in England.

[The following information is mainly for England, and based on the Report in 1999 of the Social Exclusion Unit (SEU) on Teenage Pregnancy (Cm 4342), in response to a remit from the Prime Minister to develop an integrated strategy to reduce rates of teenage parenthood and propose solutions to combat the risk of social exclusion for vulnerable teenage parents and their children. The newly developed administrations for Scotland, Wales, and Northern Ireland, and their Government Offices, are also considering what action set out in the Report could be applied in the light of the particular circumstances present in each country.

[The report highlighted the following facts:

- There are nearly 90,000 conceptions a year to teenagers, of which approximately 7,700 are to under-16-year-olds and 2,200 to girls aged 14 or under, with 56,000 conceptions resulting in live births. However, more than two thirds of girls under 16 do not have sex, and most reach their 20s without getting pregnant.
- Teenage parenthood is more common in areas of deprivation and poverty and for those with poor educational attainment, but even in the most prosperous areas, teenage births are higher than in some comparable European countries.
- Half of those sexually active at the time they are 16 do not use contraception for the first time, and for a significant group, sex is forced or unwanted.
- Half of under-16s and more than a third of 16- and 17-year-olds opt for abortion if they get pregnant. This totals just over 15,000 abortions a year for girls under age 18.
- Ninety percent of teenage mothers have babies outside marriage (20 years ago, it was around 40%).
- Fifty percent of relationships started in the teenage years break down.
- The death rate for the babies of teenage mothers is 60% higher than those of older mothers, and these babies are more likely to be of low birthweight, have childhood accidents, and be admitted to the hospital.
- The daughters of teenage mothers have a higher chance of becoming teenage mothers themselves.

[Although the Social Exclusion Unit (SEU) on Teenage Pregnancy could not identify a single explanation for the U.K.'s relative failure to reduce teenage birthrates, they drew attention to three important factors: namely low expectations of young people disadvantaged in childhood and with little prospect of a job; ignorance about contraception, what to expect in relationships, and what it means to be a parent; and "mixed messages," with one part of the adult world bombarding teenagers with explicit messages that sexual activity is the norm and another part that is embarrassed by any mention of sex and more often silent about it, hoping that if sex is not talked about, it won't happen. In studying the phenomenon of social exclusion, the Unit identified certain risk factors for teenage parenthood—namely poverty, children who had been in foster care, children of teenage mothers, those with educational problems or not continuing in education after 16, those who had been sexually abused in childhood, mental health problems, and crime. It has been estimated that 24% of the 11,000 prisoners in Young Offenders Institutions are fathers (HMIP 1977). The unit suggests that multiple risk factors may explain the overrepresentation of some ethnic minorities

among teenage parents. Information from the *Labour Force Surveys* (1985-1995), the *Fourth National Survey of Ethnic Minorities* (1994), and the *Health and Lifestyle Surveys* (1994) show that four groups in particular—Bangladeshis, Africans, Caribbeans, and Pakistanis—are all at substantially greater risk of teenage parenthood than the national average. The Unit's analysis highlighted two main goals—reducing the rate of teenage conceptions, with a specific aim of halving the rate of conceptions among under-18-year-olds by the year 2010, and getting more teenage parents into education, training, or employment to reduce their risk of long-term social exclusion. The action plan for achieving these goals is quoted below:

- A national campaign involving government media, the voluntary sector, and others to improve understanding and change behavior.
- Collaborative action with new mechanisms to coordinate action at both the national and local levels and ensure that the strategy is on track (until now, there has not been an agency or individual prepared to take responsibility for tackling the problem as a whole).
- Better prevention of the causes of teenage pregnancy, including better education in and out of school, access to contraception, and targeting of at-risk groups, with a new focus on reaching young men . . ., who have often been overlooked in past attempts to tackle this issue.
- Better support for pregnant teenagers and teenage parents, with a new focus on returning to education with childcare to help, working to a position where no under-18 single parent is put in a lone tenancy, and pilot programs around the country providing intensive support for parents and child.

[The report recommends the implementation of a 10-year program to improve the climate in which young people prepare for adulthood and the support for teenage parents and their children. Funding some £60 million over the following three years is envisaged. A new unit in the Department of Health to coordinate the work has been set up. However, despite the expansion of services and increased provision of information for teenagers in the U.K. since *Health of the Nation*, recent studies, such as *Effective Health Care—Preventing and Reducing Adverse Effects for Unintended Teenage Pregnancies* (1997), and *Teenage Mothers—Decisions and Outcomes* (1998), indicate that risk-taking behavior, failure to anticipate risk, lack of knowledge, and errors in the use of contraception, remain major causes of unwanted pregnancies. It remains to be seen whether the changes called for in the *Report*—"fewer unwanted pregnancies, fewer children brought up in poverty, and successive generations of children and young people having better chances for the future" are achievable. (*End of update by M. Griffin*)]

[*Update 2003*: In an attempt to reduce the high rates of teenage pregnancy, the U.K. Departments of Health and Education have backed Exeter University in training teachers to discuss various pre-sex "stopping points" with teenagers under age 16 and encouraging them to discover "levels of intimacy," including holding hands and oral sex, instead of full sexual intercourse. Early in 2003, more than 100,000 children were taking the course at one in every 30 secondary schools.

[Critics of the course, called "A Pause," objected that the program has no framework for talking about responsibility or the emotional side of relationships and, in effect, implicitly supports underage sexual activity and excites the sexual interest of children.

[Opponents of the program expressed hope that the Sexual Offences Bill, then going through the House of Lords, would lead to the course being banned. A provision in the Bill would make it an offense for anyone to "arrange or facilitate the commission of a child sex offence" (Owen 2003). (*End of update by R. T. Francoeur*)]

C. Abortion

JANE READ and LINDA DELANEY

Legal Status and Availability

Until 1967, most pregnancies could not lawfully be terminated by abortion. The Offences Against the Person Act of 1861 specifically criminalized both successful and unsuccessful abortion attempts by those who assisted women and by pregnant women themselves (curiously, the former, but not the latter, could be convicted, even if there was found to be no pregnancy). However, as prosecutions under the 1861 Act had to establish that the accused acted "unlawfully," it became possible to defend a criminal charge by showing that the abortion was carried out in the honest belief, based on reasonable grounds and adequate knowledge, that the continuance of the pregnancy would turn the woman into "a physical or mental wreck"; this was the outcome of the famous case of R. vs. Bourne (1939-1KB 687), brought after an eminent surgeon performed an abortion on a 14-year-old who had been raped and whose mental well-being was said to have been gravely threatened by the resulting pregnancy.

In 1967, Parliament provided statutory defenses by passing the Abortion Act. Substantially amended by the Human Fertilization and Embryology Act of 1990, the Abortion Act of 1967 permits abortion on liberal therapeutic and eugenic grounds if two registered medical practitioners—one would suffice in an emergency—certify the existence of such a ground, and the abortion is carried out by a registered medical practitioner. In brief, the amended law allows abortion when it is performed to prevent grave permanent injury to the mental or physical health of the woman, or risk to her life, or the birth of a "seriously handicapped" child. For these three situations, there is no time limit; in other cases, the limit is the end of the 24th week of pregnancy.

An important change in the 1967 Act resulting from enactment of the Human Fertility and Embryology Act 1990 is the severance of the link that applied previously with the Infant Life (Preservation) Act 1929. The effect of this has been, paradoxically, a slight liberalization of the Abortion Act as it was between 1967 and 1990. Prior to 1990, women could not, under any circumstance, have their pregnancy terminated after the 28th week of pregnancy, since, under the Infant Life (Preservation) Act of 1929, this was considered to be the point at which a fetus became viable. Although Clause (a) (given below) states a limit of 24 weeks of pregnancy, there is no mention of a time limit for the other three clauses. In effect, the situation in England and Wales is that abortion is rarely done after 22 weeks of pregnancy. Essentially, any woman who is considering a decision to terminate her pregnancy, whether as a result of her social, economic, personal, family, or medical circumstances, must have the consent of two medical practitioners before the abortion may be performed.

The clauses in the Abortion Act 1967, as amended by the HFE Act 1990, under which she can do this and to which the two doctors must conform are as follows:

1. that the pregnancy has not exceeded its 24th week and that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated; or

2. that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or
3. that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or
4. that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped. (The Abortion Act 1967 as amended, HMSO)

Thus, it is clear that the procedures for a woman to have a legal termination of her pregnancy are grounded not only in the medical aspects, but are based on the need to adhere to the law of abortion. When a woman presents for consideration of an abortion, therefore, she is entering a legal process.

There is no requirement on the part of Health Authorities to provide abortion services, and abortion provision is not consistent across the country. In some areas, the service may be relatively available through the Health Service, and in other areas, there will be little provision, and women will either have to pay for a legal termination in the private sector or nonprofit charity sector, as well as possibly having to travel some distance to get to a private clinic.

Social Attitudes Toward Abortion

There is evidence that attitudes toward abortion and provision of abortion have liberalized over the past 10 to 15 years. In a fact sheet on the legal and ethical issues surrounding abortion, the Family Planning Association quotes the *British Social Attitudes Survey*, in which it was shown that the number of United Kingdom people who felt abortion should be allowed when a woman's health was endangered increased from 87% in 1983 to 95% in 1989. This trend was consistent when other questions, such as the economic situation of the woman and her family, and the woman's own choice, were considered (FPA *Factsheet 6B* 1992, 4).

This trend is also reflected in the medical profession. "A national survey of consultant gynecologists in 1989 found that 73% believed that a woman should have the right to choose abortion" (Paintin 1992, 968). This same survey, carried out by Savage and Francome, also showed that 87% of gynecologists at the Royal College of Obstetricians and Gynaecologists had been right to oppose one of the more recent changes to the Abortion Act, the Alton Bill. There seems to be a general understanding that people feel that the current system works quite well.

Incidence

The latest available figures (Office of Population Census and Surveys *Monitor* April 11, 1995) show that during 1993, a total of 168,711 abortions were performed in England and Wales, 2% fewer than in 1992, when the total was 172,063. The 1992 total figure included both the resident and nonresident figures, with 160,495 resident women obtaining abortions and the remainder being accounted for mainly by Irish women seeking an abortion abroad, since it is not legal in the Republic of Ireland. The 1992 TOP (terminations of pregnancy) rate for residents of the United Kingdom was 12.51 per 1,000 women.

The reason most frequently cited by women seeking an abortion was risk of injury to the physical and mental health of the pregnant woman. The main provider was the National Health Service. Section 4 of the Abortion Act of 1967 affords legal protection to healthcare workers who refuse to participate in abortion on grounds of conscience. Prospective fathers, on the other hand, were, in *Paton vs. Trustees of BPAC* (1979—QB 276), denied the right to intervene to prevent an abortion.

There has been little change in the proportion of women seeking abortion since the introduction of the 1967 Abortion Act. In a 1992 article in the *British Medical Journal*, David Paintin, then a Research Fellow at St. Mary's Hospital, London, observed that: "The lack of change in the proportion of pregnancies ending in legal abortion suggests that the behavior factors that lead to unwanted conception and abortion are intrinsic to our society and that easy availability is not a primary factor in the decision concerning abortion" (Paintin 1992, 967). This is an important point, since those who oppose abortion seem to believe that should abortion become more "freely" available, there would be a marked increase in the number of women who choose legal abortion, and that any "loosening" of the restrictions that pertain to abortion in England and Wales should therefore be opposed. In England and Wales, in 1991, the vast majority of legal abortions—88%—were performed before the 13th week of pregnancy (Family Planning Association *Factsheet 6A* 1994, Table 6, 7).

D. Population Planning Programs and Policies

PETER SELMAN

"No population policy please, we're British!" (Coleman & Salt 1992).

Despite the fact that birthrates in the United Kingdom have been falling since the late 19th century, and the fertility rate has dropped below replacement level (namely, a Net Reproduction Rate below 1.00), between 1927 and 1943 and since 1973, the population of the United Kingdom has grown steadily, with a reduction in size evident only in the late 1970s, when the population fell from 55,922,000 in 1974-1975 to 55,835,000 in 1978-1979. Since then, the population has increased steadily to 58 million in 1992. Experts project the population of the United Kingdom will surpass 62 million by the year 2031, after which a steady decline is expected, with the population returning to the 1992 level by the year 2061 (OPCS 1994).

The initial fall in the birthrate occurred, as in most countries, without any government pressure and in the face of opposition to birth control. In England and Wales, the period total fertility rate fell from 4.8 in the 1870s to a low point of 1.72 in 1933 (OPCS 1987). It was at this stage that we find the first signs of concern over population decline, as birthrates fell to below replacement level, and differences in fertility became apparent as middle-class groups married late and had few children while lower-working-class people had a substantially higher fertility. This led to concern about the quality of the population and to the development of the eugenics movement. A number of publications warned of the dangers of depopulation (Charles 1936; Glass 1936; Hogben 1938), a national decline (Reddawa 1939), "race suicide" (McCleary 1943), and a rejection of parenthood (Titmuss 1942). Charles (1938) projected the British population for 1995 at 20 million, a little more than a third of the actual population today.

In 1944, a Royal Commission on Population was set up to consider whether Britain was indeed facing a population decline and whether measures should be taken "in the national interest" to influence future trends. The Royal Commission reported in June 1949, soon after the 1947 crude birthrate was announced as 20.5, the highest figure since the end of World War I, and the net reproduction rate (NRR) had risen to 1.21. The commission saw this as a temporary aberration and projected a long-term decline in population. The Commission did not, however, recommend any counter action and no official population policy followed. Others

were less sanguine (McCleary 1943; Titmuss 1942); in the same year, Eva Hubback (1947) projected the 1999 British population at 34 million.

No one predicted that within a decade the birthrate would be rising sharply to the highest level since the end of World War I (Holmans 1963). Nor was there any expectation that migration would play a role in boosting population growth: "The Royal Commission never dreamt that 2.5 million colored immigrants and their descendants would be living in Britain just thirty years after their report" (Coleman & Salt 1992). Restrictions on Commonwealth immigration were introduced in the early 1960s and have since been maintained by both political parties. However, these policies are more because of racist concerns than to any fear of excess population. Nevertheless, it is important to note that, without such immigration and the consequent births to immigrants and their descendants, Britain's population would by now most certainly be in decline.

By 1964, the crude birthrate had risen to 18.5 and the total fertility rate to 2.93 (0PCS 1987), and in 1965 the General Register Office projected a population for England and Wales in 2001 of over 66 million. This led to new concerns about overpopulation. In 1971, a Population Panel was appointed following the publication in that year of a *White Paper* responding to a report from the House of Commons Select Committee on Science and Technology on the Population of the United Kingdom, which had concluded that "the government must act to prevent the consequences of population growth becoming intolerable for the every day conditions of life."

The *Report of the Population Panel* was published in March 1973, by which time the birthrate had fallen substantially and the net reproduction rate was once again below 1.00. It concluded that the population of Great Britain would "almost certainly rise from 54 million in 1971 to around 64 million in the course of the first decade of the next century . . . [and to] over 80 million around the middle of the next century." If, however, fertility were to fall rapidly, population could decline to 40 million by 2050, and there would be "profound changes in the age structure" with serious social consequences. Reviewing the implications of anticipated growth, the Panel concluded that "there is no reason to suppose that 64 million (by the beginning of the 20th century) would be in any way intolerable or disastrous," but that "to absorb a further 20 million by 2051 could be much more intractable" so that "a slower rate of increase . . . is clearly preferable." Less attention was paid to the possibility of a population decline, other than to state that "if there were to be a fall in fertility which led . . . to an excess of deaths over births, this should not be a cause of public concern."

No explicit population policy was recommended, although the Government was advised to extend family planning services and inform people about the fact of the population problem. The panel was less happy about persuading people of the advantages of smaller families and opposed fiscal and other disincentives to having children. By 1977, the crude birthrate had fallen to 11.5 and the total fertility rate to 1.66, the lowest levels since records began, and any further measures to discourage parenthood were viewed as inappropriate.

Since then, the crude birthrate has risen again and has remained steady between 13 and 14 since 1985. In 1990, the total fertility was 1.8, below replacement level, but high in comparison with other European countries such as Italy (1.29) and Spain (1.3). The population is, nevertheless, projected to grow until the second quarter of the 21st century (OPCS 1994). Concern is expressed over the implications of an aging population (Johnson & Falkingham 1992), but there is no overt policy to increase fertility, and recently, more concern has been focused on rising divorce rates, the decline in marriage, and the associated increase in childbearing outside marriage, especially among teenagers (Selman 1996).

Despite two substantial reports on population, the United Kingdom has never developed a population policy, which is probably just as well, given the wrong assumptions each report made about the future. Whether this will continue to be the case in the 21st century, if a significant population decline occurs alongside a more rapidly aging population, remains to be seen.

10. Sexually Transmitted Diseases and HIV/AIDS

A. Sexually Transmitted Diseases

PETER GREENHOUSE

Incidence, Patterns, and Trends

The United Kingdom's unique network of specialist clinics (see Treatment and Prevention, below) collect detailed statistics for the Department of Health (HMSO 1995/16), which reflect trends in sexually transmitted diseases (STD) with a high degree of accuracy. These statistics give a better indication of the true incidence of STD in the United Kingdom than those of most other countries, because of the relative low proportion of infections treated outside the National Health Service (NHS). It is estimated that over 95% of the epidemic STDs, namely, syphilis and gonorrhea, are managed at the NHS clinics. The proportion is somewhat less for the more endemic diseases—chlamydia, genital herpes, and genital warts—because of their covert nature, with the proportion for chlamydia being recently reduced by a belated surge of interest among gynecologists, contraceptive-care professionals, and general practice physicians. The majority of HIV care is also organized from the NHS clinics (see Section 10B, HIV/AIDS, below).

Control of syphilis and gonorrhea has been particularly successful in the United Kingdom (see Table 4). There are fewer cases of infectious syphilis per year in men in England (194 cases in 1994) than there are clinics in the United Kingdom, 230. The figure for women was roughly half the male figure, 110 cases in 1994. Twenty percent of the male cases were acquired through homosexual contact. The median age for new cases of syphilis is higher than for other STDs, 33 for men and 28 for women. Syphilis has become an imported disease, having been virtually eliminated as a congenital infection, with only one infection reported in 700,000 live births in 1993.

The pattern of gonorrhea cases during the 1900s (see Table 4) can act as a surrogate marker for other sexual activity, closely reflecting changes caused by demographics, war, travel, contraceptive practice, and sexual mores (Greenhouse 1994). The gonorrhea pattern can also illuminate these

Table 4

Incidence of Gonorrhea and Syphilis, England, 1918 to 1994

	Number of New Cases in Selected Years (in Thousands of Cases)										
Disease	**1918**	**1920**	**1922**	**1930**	**1940**	**1946**	**1955**	**1964**	**1977**	**1987**	**1994**
Gonorrhea	17.4	37.9	27.9	40.5	26.3	47.4	17.4	37.9	58.7	24.5	11.6
Syphilis	26.8	42.1	24.2	18.9	11.4	24.2	5.0	3.8	4.2	1.8	1.3

Percentages approximated from the authors' line graph.

social trends. The post-World War II decline in gonorrhea cases was because of the arrival of penicillin and the reactionary morality of the 1950s. This was followed by a tremendous rise in the 1960s, as the baby boomers reached adolescence, sexual behavior gradually changed, and contraception increased. The maximum incidence of gonorrhea occurred in 1976, with 58,725 cases, in conjunction with the all-time peak in prescriptions for the oral contraceptive pill. Starting in 1986, the incidence of gonorrhea dropped by 50% in two years following the public HIV-education campaign directed at the heterosexual population. There is now less gonorrhea in the United Kingdom than at any time since record keeping began. The current rate is around one sixth that of 20 years ago. Statistics for 1994 record 11,574 cases, with an overall rate of 37 per 100,000 population aged 15 to 64 (HMSO 1995/16). However, the rate varies considerably with age and sex; the highest incidence occurred in women aged 16 to 19 years, and increased from 95 cases to 123 per 100,000 between 1993 and 1994 (HMSO 1995/16; *Communicable Disease Report* 1995, 62-63). Detailed information on geographic distribution, antibiotic-resistant strains, and location of acquisition is also published (*Communicable Disease Report* 1995, 62-63).

Chlamydia trachomatis, the principal preventable cause of pelvic inflammatory disease, infertility, and ectopic pregnancy, is the commonest curable STD in the United Kingdom. All isolation rates for chlamydia substantially underestimate its true incidence, since screening tests are, at best, 75 to 80% sensitive, and most infected men and women show no symptoms. The cases identified at NHS STD clinics represent only the tip of the iceberg. The differential age and sex rates for chlamydia (*Communicable Disease Report* 1995, 122-123) are similar in distribution to those of gonorrhea (*Communicable Disease Report* 1995, 62-63), herpes and warts (*Communicable Disease Report* 1995, 186-187), and representative of all STDs combined, with the highest rates in adolescent women, and a late lower peak in male cases. The peak incidence of 360 cases per 100,000 women aged 16 to 19 years—four times more than in men of the same age—should be compared with observed rates from 9.5% to 23% in studies of women of this age who are having an abortion. No significant differences were found in the chlamydial isolation rates (of around 10%) in women attending clinics for either contraception, abortion, or STD (Radcliffe 1993), although, even nowadays, most women are not routinely screened in the contraception clinics. Chlamydia and nonspecific genital infection rose steadily until 1986, peaking at 157,792 cases, and has shown a slight decline since then, despite improved diagnostic techniques.

At least 85% of all pelvic inflammatory disease (PID) is sexually acquired, a minimum of 75% because of chlamydia. Around 10% of pelvic inflammatory disease is treated in a hospital. The massive drop in gonorrhea in the United Kingdom in 1986 to 1988 was not matched by a significant drop in hospital cases of acute salpingitis. A similar phenomenon in 1970-1977 in Sweden alerted Westrom (1988) to the true etiology of salpingitis, and appropriate diagnosis, treatment, contact tracing, and education was initiated. In both countries, salpingitis incidence had doubled between 1965 and 1974. From 1978 to 1983, salpingitis admissions were halved in Sweden (Westrom 1988), but increased by 50% from 1975 to 1984 in Britain, which almost two decades later has yet to introduce a similar salpingitis-prevention campaign. Contact-tracing studies indicate very high infection rates of over 70% in male partners of women with salpingitis, the vast majority of whom are asymptomatic.

There has been a continuing long-term upward trend in first-attack incidence of both genital herpes and genital warts, full details of which have been published (*Communicable Disease Report* 1995, 186-187). Herpes is more common in women, increasing from 32 to 98 per 100,000 between 1981 and 1994. Seroepidemiological studies in the United Kingdom show that around 90% of men and women aged 25 to 34 have antibodies to both herpes viruses (HSV 1 and 2), of which about one third are HSV 1. Up to 50% of oral lesions have been found to harbor HSV 1. Thus, although oral and genital herpes infection is ubiquitous, relatively few individuals suffer overt symptoms, and many will have acquired oral infection in childhood. This information is of considerable value in diffusing the stress of a first-episode attack acquired sexually.

Full details of the minor STDs are also available from published statistics (HMSO 1995/16). Long-term trends in total attendance for all diagnoses shows a continuous increase to a current high of 671,281 in 1993. Records show an increasing proportion of clinic attendees are female, from one seventh in 1950 to one quarter in 1960 and one third in 1970. Now, 51% of all attendees are women, with some clinics up two thirds, depending on the extent of contraceptive and other sexual health services provided. These trends are set to continue as the clinical workload comes closer to reflecting the gross disparity in STD morbidity suffered by women.

Treatment and Prevention

Thanks to exceptional, far-sighted public-health legislation, the United Kingdom has had specialist clinics offering free and entirely confidential STD advice and treatment in every major town since 1917. Accessible care is available to all regardless of nationality or domicile. Voluntary contact tracing and treatment of partners is facilitated by health advisers, without the intrusion of coercive legislation. The United Kingdom is the only country where Venereology (currently known as Genito-Urinary Medicine) developed as a distinct medical specialty in its own right (Waugh 1990), rather than as a minor adjunct to other fields, such as dermatology in Europe, or infectious diseases and public health in the United States. Consequently, Britain has a well-trained, academically based specialist body, whose numbers have doubled in the last decade as the result of substantial government investment in improved premises, equipment, and expanded support staff. The specialty coordinates clinical care and epidemiologic research, and can implement rapid and consistent responses to changing public-health priorities in the control of STD, having been ideally placed to take the lead in caring for HIV (see Section 10B, below). The advantage of this approach is evidenced by the relatively low prevalence of HIV and other STDs compared to most countries other than Scandinavia (see Incidence, Patterns, and Trends above).

An important disadvantage is that other specialists are poorly trained or are unaware of STD, and are unlikely to be able to broach the subject (Clarke 1995) without either embarrassment or moralism. (This holds the greatest potential for damage in women's heathcare.) Not only are most genitourinary physicians untrained in gynecology, most gynecologists and family planning specialists were, until recently, ignorant of the significance of covert STD in their patients. This resulted in considerable morbidity from uterine instrumentation during abortion or IUD insertion, and multiple recurrences of salpingitis because of reinfection from untreated partners, leading to increased chronic dyspareunia, ectopic pregnancy, and infertility.

Despite governmental interference in school sex education policy (see Section 3A), there have been substantial advances in the general level of education on HIV and, to a lesser extent, on contraception, aided by the government's

Health of the Nation initiative on sexual health. Education on conventional STD, however, has been almost entirely neglected. Sexual health education is usually delivered by those without specific knowledge or experience of STD care. Thus, the public as a whole, including health professionals, remain largely ignorant in this area. In the recent international survey on STD awareness for the American Social Health Association (Clarke 1995), the United Kingdom compared poorly against five other countries. Only 1% of Britons had heard of chlamydia, and 75% said that their doctors would not talk about sex or STD. This ignorance, combined with the traditional British attitude of prurience and prudishness about sex, creates the societal taboo of STD. This stigma, causing guilt, shame, and blame, is based on misinformation, fear, and an automatic presumption of infidelity, which is often erroneous because of the very asymptomatic nature of most STDs that causes them to be endemic. This major pitfall results in substantial psychosexual trauma that plagues work in all fields of sexology.

A simple solution will be found in the increasing integration of sexual health promotion with clinical service provision. Teaching that most STDs produce no symptoms, can be present for many years, are acquired from partners who are likewise unaware, and may, therefore, have been present before the current relationship, should do much to destigmatize the subject. Furthermore, a national consensus of specialists in public health, family planning, genitourinary medicine, and health education has recently promoted a concise definition of sexual health: "the enjoyment of sexual activity of one's choice without causing or suffering physical or mental harm" (Greenhouse 1994). This same consensus agreed that these specialties should progressively converge to provide services for contraception, abortion, STD/HIV, sexual assault, psychosexual care, and health promotion under the banner of sexual health clinics (Greenhouse 1994). Broadening the scope of these services allows access to more appropriately coordinated care "under one roof." This is essential for the youngest in the most vulnerable situations, and may persuade people to attend a clinic to check that they are healthy rather than waiting until they are ill. With careful education input, this should improve public understanding, reduce stigma, prevent iatrogenic morbidity, and achieve even more-effective control of STD in clinical situations where they would previously have gone undetected.

B. HIV/AIDS

JANE CRAIG and GEORGE KINGHORN
[*Rewritten and updated in late 2001 by J. Craig and G. Kinghorn*]

Based on anonymous seroprevalence data, there were, in 2001, an estimated total of 30,000 people living with HIV in the United Kingdom, a third of them undiagnosed. Newly diagnosed HIV infections appear to be increasing to over 2,900 in 1999. Antiretroviral therapy is delaying the onset of AIDS and deaths in many of those who are treated; deaths fell by two thirds between 1995 and 1991. As a result, the number of individuals living with HIV is increasing, from 16,891 in 1998 to 19,179 in 1999. Nevertheless, the prevalence still remains lower than in many European countries.

By the end of March 2000, a total of 41,174 HIV-infected individuals had been diagnosed and reported in the U.K. since 1984. Of these, 7,198 (17%) were female. A cumulative total of 16,995 (2,113, or 12% of which were female) cases of AIDS have been reported and 11,793 (69%) are known to have died. A further 1,753 HIV-infected individuals have died without AIDS being reported. A total of 967 HIV infections and 411 AIDS cases in children aged less than 15 years at diagnosis have been reported by the end of March 2000. Most were infected by maternal transmission. London and its surrounds have reported 62% of all HIV infections and AIDS cases in the U.K. to date. Scotland reports 7% of all U.K. HIV infections and 6% of AIDS cases.

Within the U.K., sexual intercourse between men remains the major route of infection for people who have been diagnosed as having HIV. The number of infections being diagnosed where sex between men and women is the route of infection has risen steadily, so that newly diagnosed cases infected by heterosexual exposure exceeded those transmitted by sex between men in 1999. The majority of these, however, are attributed to heterosexual exposure while in areas of higher prevalence, usually sub-Saharan Africa, rather than other exposure categories, such as partners of injecting drug users. Injecting drug use has made a relatively small contribution to the HIV epidemic in the U.K., except in Scotland, where it has been responsible for more of the diagnosed infections than sex between men.

In England, Wales, and Northern Ireland, the proportion of reported HIV infections attributable to sex between men has fallen from 92% in 1985 to 46% in 1999. The proportion attributed to injecting drug use has remained fairly static over the same period (5% in 1985, and 3% in 1999), but the proportion of reported HIV infections attributed to heterosexual exposure has risen from 3% to 49%.

In Scotland, the trend is somewhat different, in that the proportion of reported HIV infections attributed to sex between men has risen from 9% in 1985 to 39% in 1999. The proportion of incident HIV infections attributed to heterosexual exposure has also risen, from 2% to 50% over the same period. Those attributable to injecting drug use have fallen from 90% to 11%. This may reflect the efforts of locally targeted prevention programs amongst drug users.

For U.K. residents, medical care and treatments are provided free of charge under the National Health Service. Genitourinary medicine (GUM) clinics offer a voluntary, open-access, confidential HIV-testing service nationwide and are the major providers for HIV treatment and care. There are ongoing anonymous unlinked HIV-seroprevalence studies at selected sites, including attendees at GUM clinics and women attending antenatal clinics. Since 1999, it has been recommended that all pregnant women throughout England should be offered HIV testing, and targets for the proportions of pregnant women accepting testing have been set. In the first half of 1999, 71% of HIV-infected pregnant women in inner London had been diagnosed by the time they gave birth. This is substantially higher than in previous years. However, elsewhere in the U.K., a majority of infected pregnant women still remain undiagnosed. This places their neonates at risk of vertical transmission, which is now largely preventable with combination antiretroviral treatment, cesarean-section delivery, and avoidance of breastfeeding. All blood donors have been tested for HIV since 1985. There have been no reports of HIV transmissions in the U.K. since the introduction of heat treatment of blood products.

The gay community has become well organized and motivated with self-initiated prevention and education campaigns. There are also numerous patient-interest and support groups. Initiatives, such as outreach work among targeted groups rather than didactic healthcare messages, seem to be more successful, and many have accepted safer-sex practices. There is also recent evidence that suggests that transmission is less common from those who have learned of their infection from voluntary testing programs, as compared with those who choose to remain ignorant of their HIV status. Nevertheless, maintenance of lifelong safer sexual practice often proves difficult for those whose prognosis has vastly improved since the advent of successful combination antiretroviral treatments. Continuing sup-

port and dialogue about the sexual health needs of HIV-positive patients is essential.

National needle and syringe-exchange programs have been operational since 1990 and have contributed to reduced transmission from the use of equipment shared by injecting drug users, although in closed communities, such as prisons, the potential for HIV spread by this route still persists. Although sexual health no longer has the key health-priority status originally set in England in 1992, a new national Sexual Health and HIV strategy is now being formulated, and a final report was due in 2001. This should help to increase better coordination and collaboration between local sexual health service providers, and increase the involvement of primary care in screening and management of sexually transmitted infections and HIV.

School sex education remains a controversial topic. Opponents often claim that such lessons reduce the age of first sexual activity. At present, attendance at sex education classes is voluntary and parents have the right to withdraw their children. However, sex education programs have been shown to be effective in delaying the onset and frequency of sexual activity, and may also result in an increased use of contraception, in particular, condoms. Effective programs seem to be those focusing on reducing specific risk behaviors, combined with opportunities to improve personal development and communication skills. This has obvious implications for the provision of school-based sex education in the future.

Overall, there is a greater awareness of HIV infection, but risk recognition remains an issue for many, as is reflected by the increasing number of heterosexual infections acquired from those parts of the world with explosive rates of HIV. Increasing rates of sexually transmitted infections among HIV-positive individuals is a concern because of the associated increased risk of HIV transmission. It also suggests increasing unsafe sexual practices. Prevention programs need to target such groups, as well as continuing their efforts amongst other high-risk communities.

[*Update 2002*: UNAIDS Epidemiological Assessment: By mid-2001, the country reported a cumulative total of 46,131 cases of HIV infection. Risk of HIV acquisition in the U.K. is highest for gay men. Two thirds of the U.K. burden is in London. High levels of risk behavior are present among young heterosexuals.

[There are improved survival rates, as well as a decline in numbers of deaths and new AIDS cases with the availability of antiretroviral therapies. There is rising prevalence of diagnoses of infections requiring care and treatment, a 13% increase in prevalence of diagnosed HIV infection between 1997 and 1998. From 1999 onwards, there have been more diagnoses of heterosexually acquired HIV infection; 64% of HIV diagnoses heterosexually acquired were probably acquired in sub-Saharan Africa. There has been increased sharing of injection equipment and rising hepatitis B cases among injection drug users, but so far, HIV infection rates in injection drug users remain low. In addition, there have been increases in other STDs, especially gonorrhea, chlamydia, and genital warts. Changes in HIV infection worldwide, especially in South Asia, have the potential to have an impact on the U.K. because of high immigration rates.

[Testing is mandatory for blood donors, and voluntary otherwise. All detected HIV-infected cases are reported in a national database, using an identifying code. Continuous universal assessment testing (UAT) surveys have been conducted among newborns since 1988 in the Thames region (in the southeast of England including London), Oxford, and four other regions since 1993. UAT surveys have been carried out among pregnant women since 1990 in selected centers of England and Wales, using sera collected for rubella screening during antenatal visits. In both studies, the prevalence increased steadily in London. In parallel, UAT surveys of women having abortions found a twofold higher prevalence (4.6 to 7.8 per 1,000) compared to that found among women attending antenatal centers. The majority of HIV-infected women originate from high-prevalence countries and have mostly been infected heterosexuality. In Scotland, continuous UAT of newborns indicates that prevalence was substantially higher in Edinburgh (up to 2.5 per 1,000) and Dundee (up to 2.8 per 1,000) than in the rest of Scotland (less than 0.2 per 1,000), including in Glasgow (less than 0.3 per 1,000). However, prevalence has decreased significantly in Edinburgh (from 2.5 in 1990 to 0.8 in 1994; $p < 0.05$), while no clear trend could be detected in other parts of Scotland. UAT surveys have been conducted also in STD patients and injection drug users in treatment centers. A prevalence survey of all patients seen for care within the year is carried out annually; this shows rising prevalence.

[The estimated number of adults and children living with HIV/AIDS on January 1, 2002, were:

Adults ages 15-49:	34,000	(rate: 0.1%)
Women ages 15-49:	7,400	
Children ages 0-15:	550	

[An estimated 460 adults and children died of AIDS during 2001.

[No estimate is available for the number of British children who had lost one or both parents to AIDS and were under age 15 at the end of 2001. (*End of update by the Editors*)]

11. Sexual Dysfunctions, Counseling, and Therapies

KEVAN R. WYLIE

A. Concepts of Sexual Dysfunction

British society appears to be having a reemergence of sexual awareness. After a very conservative attitude towards sex in the first half of the 20th century, there was an awakening in the 1960s alongside the increased use of illicit drugs, the emergence of rock and roll, and a "free" society. The permissive society continued into the 1970s and early 1980s, until, like many other countries, the fear of AIDS changed the sexual behavior of many in the mid-1980s. Out of this has grown a more-cautious approach to sexual encounters with others and a reemergence of encouraging more satisfying sexual relationships within a monogamous relationship.

There is wider access to articles and books on sexual fulfillment, and awareness of dysfunction has increased, primarily as a result of articles in the popular press and lifestyle magazines. There is some evidence that there has been a reversal of the age of the first sexual experience of teenagers, and there has been an increase in patients requesting help over the wide spectrum of sexual dysfunction. One area where this has become particularly evident is male erectile disorder, for which a proliferation of treatment centers, both within the health service and in the private sector, has developed. A recent attempt to define sexual dysfunction is "the persistent impairment of the normal patterns of sexual interest or response."

B. The Availability of Diagnosis and Treatment

[*Rewritten and updated in late 2001 by K. R. Wylie*]

Within the United Kingdom, all patients are entitled to free consultation under the National Health Service. The planning and availability of sexual dysfunction clinics varies widely from area to area. Traditionally, these have been within family planning clinics, and have gradually been ex-

tended by interested clinicians within gynecology, psychiatry/psychosexual, and genitourinary clinics. The Family Planning Association Service has been traditionally run by doctors, although there has been a gradual introduction of nursing and psychology staff into these and other treatment clinics. Seminars held by Drs. Balint and Main in the 1960s and 1970s developed the concept of psychosexual medicine and emphasized the importance of using the physical (vaginal) examination in the management of female sexual problems. In the 1980s, patients with male erectile disorder started to be seen within urology, rather than psychosexual clinics, although in the 1990s, it is becoming generally agreed that, because around half of these cases are of a psychological nature and a proportion have both organic and psychological components, there is a need for either dual clinics or access to either. There is an interesting awareness of the need to consider cultural factors in sexual dysfunction, and this is particularly important for various clinic groups.

A non-Health Service organization offering treatment for sexual dysfunction is available from Relate (formerly Marriage Guidance). Paul Brown, a psychologist, showed in 1974 that psychodynamically trained counselors were able to focus specifically on sexual dysfunctions using behavioral approaches. This organization has a network of specially trained sex therapists who have training in relationship work. This service is not provided free, but clients are charged nominal sums according to their income, typically £20.00 to £30.00 per session. Other agencies include the Catholic Marriage Advisory Council and the Jewish Marriage Council. Private facilities for diagnosis and treatment of sexual disorders do exist, but are primarily around major cities or areas where no NHS provision is easily accessible.

Treatment approaches include the traditional medical approach using medication, intracavernous injections, VCDs, and so on. Psychotherapeutic treatments are usually based on the behavioral model proposed by William Masters and Virginia Johnson, although increasingly with cognitive and systemic strategies incorporated. Some workers continue to use a dynamic model of working with patients. Increasingly, couple therapy is adopted incorporating both relationship and sexual therapy. Surrogacy services are available from the Birmingham clinic run by Martin Cole.

Specialist services for transsexualism and gender dysphoria exist, with assessment for treatment and surgery available at several centers in the U.K. These are primarily Charring Cross Hospital in London, and the gender-dysphoria services in Sheffield, Leicester, Nottingham, Leeds, and Glasgow. Surgery is confined to specialist centers, namely London, Brighton, Leicester, and Rhyl.

In a wider context, the funding from the government for marriage support was subject to review by Sir Graham Hart for the Lord Chancellor's Department, and a report was issued in 1999. In summary, fewer people now get married in the U.K. (around 75% now marry by the age of 50 compared to 95% in the 1960s), and marriage is much more likely to be deferred and preceded by a period of cohabitation. Divorce now occurs about seven times more often than in the 1960s, with about four in ten marriages likely to end in divorce. The United Kingdom Government through the Lord Chancellor's Department, until the year 2000, provided three million pounds sterling to marriage support in various agencies. The total allocation of funds will increase to five million in 2002-2003, covering both strategic funding of bodies with a significant national loan and research and developmental grants. Marriage-support services in the United Kingdom are provided by Relate (formerly known as the National Marriage Guidance Council), the London Marriage Guidance Council (ex-part of the former National Marriage Guidance Council), Catholic Marriage Care, Jewish Marriage Care, Tavistock Marital Studies Institute, Family Welfare Association, and One Plus One. In addition to these seven major agencies, there are numerous other smaller bodies, which provide counseling for couples or individuals in marital difficulties.

In England and Wales, the main responsibilities for marriage, relationships, and sexual problems can be subdivided into the Lord Chancellor's Department, which includes funding of marriage-support services and deals with divorce law and private law and Children Act proceedings, and the Department of Health, which is involved with a variety of areas, including family planning, family health services, and hospital services, as well as Public Law Children Act proceedings. The Department for Education and Employment also handles a variety of areas, including personal and social education in schools. The Home Office is involved with substantive marriage law and a coordinating role on family policy and the Department of Social Security for state benefits and the Child Support Agency.

C. Therapist Training and Certification

As of 1996, there was no central certification body within the United Kingdom. The main association is the British Association for Sexual and Marital Therapists (BASMT), which was formed in 1974. This organization approves certain training courses and provides an accreditation process for which individuals can apply. The majority of new therapists will complete an approved course and a further 200 hours of supervised work, alongside fulfilling other criteria (first detailed in 1992) before accreditation. The approved training courses are listed in Section 12. The address for BASMT is P.O. Box 62, Sheffield, S10 3TL United Kingdom.

Since 1997, a group of BASMT members (The Committee for European Affairs) has met as an approved task force for the European Federation of Sexology. The goals are to establish a consensus within Europe as to what precisely constitutes a multidisciplinary profession of sexology, and subsequently, to devise European Codes of Ethics and Practice for those defining themselves as sexologists; they also seek to define European standards of training and to draw up a European register of accredited practitioners within given subspecialities of sexology.

Medical practitioners may become members of BASMT. Alternatively, they may follow a training course of seminars run by the Institute of Psychosexual Medicine (IPM) and are subsequently examined to become members of the institute. Members are recognized as competent to receive referrals. A diploma recognizes the skills of those who have been training for two years, but do not wish to make the treatment of sexual problems a specialist field. Contact: IPM, 11 Chandos Street, Cavendish Square, London, W1M 9DE United Kingdom.

The Diploma in Sexual Medicine (DSM) is awarded to doctors who can produce evidence of training and experience, as well as successfully passing written and oral examinations in the fields of sexual medicine. Areas in which the above must be demonstrated are gynecology, sexual medicine, and the physical and psychological aspects of assessing and treating sexual problems. Details are available from the Institute of Obstetrics and Gynaecology, Queen Charlotte's Hospital, Goldhawk Road, London, W6 0XG United Kingdom.

The Royal Medical Colleges do not offer training or accreditation in sexual dysfunction, but membership does reflect postgraduate training and examination to an advanced level within a given speciality. Three relevant colleges are:

Royal College of Obstetrics and Gynaecology, 27 Sussex Place, Regents Park, London, NW1 4RG United Kingdom—The Faculty of Family Planning and Reproductive

Health Care (RCOG) have a particular interest in the field of psychosexual medicine.

Royal College of Surgeons of England, 35-43 Lincoln's Inn Fields, London, WC2A 3PN United Kingdom.

Royal College of Psychiatrists, 17 Belgrave Square, London, SW1X 8PG United Kingdom.

[*Update 2001*: The British Association for Sexual and Marital Therapy became known as the British Association for Sexual and Relationship Therapy, effective May 1999. The Committee for European Affairs was renamed the Committee for the International Sexological Societies (CISS). This Committee has been influential in encouraging the development of a multidisciplinary profession of sexology and European codes of ethics and practice for those defining themselves as sexologists. CISS continues to work towards defining European standards of training, with the ultimate aim of drawing up a European register of accredited practitioners within given subspecialties of sexology. (*End of update by K. R. Wylie*)]

12. Sex Research and Advanced Professional Education

KEVAN R. WYLIE [*Rewritten and updated in late 2001 by K. R. Wylie*]

A. Institutes and Programs for Sexological Research

The support and financial availability for research within the United Kingdom remains limited. Several sexological research units exist, including the MRC unit in Edinburgh, the Institute of Psychiatry, and teams in Oxford, Sheffield, and Southampton. There remain many political pressures to frustrate sexological research, with the government declining to finance the United Kingdom National Survey of Sexual Attitudes in Lifestyle in 1989. Political influence is also exerted on education with the Health Education Authority shelving a *Pocket Guide to Sex* after the government attacked its colloquial frankness.

B. Programs for the Advanced Study of Human Sexuality

Sex education is now compulsory in state secondary schools as a result of the 1993 Education Act, although reference to nonbiological behavior has been removed from the national science curriculum. Guidance on sex and relationship education in schools was reissued in 2000 (DFEE) "to take account of the revised National Curriculum, published in September 1999, the need for guidance arising out of the new Personal, Social and Health Education (PSHE) framework and the Social Exclusion Unit report on teenage pregnancy."

The training in human sexuality in the United Kingdom Medical Schools for medical undergraduates has been reviewed by Reader (1994). Education and training in human sexuality, including postgraduate training, has been considered by Griffin (1995).

Postgraduate training exists for various professions. These courses are usually attended by both medical graduates, as well as workers from other healthcare disciplines. As courses expand to the master's level, the qualifications required for entry into these courses become more stringent. These courses are classified as either a course approved or nonapproved by the British Association for Sexual and Relationship Therapy (BASRT). The BASRT approved courses are:

Diploma in Psychosexual Therapy (Marriage Guidance), Herbert Gray College, Little Church Street, Rugby CV21 3AP United Kingdom.

Master of Science degree; Post Graduate diploma and Post Graduate certificate in the Theory and Practice of Psychotherapy for Sexual Dysfunction, The Porterbrook Clinic, 75 Osborne Road, Nether Edge, Sheffield S11 9BF United Kingdom.

Diploma in Psychosexual Health Care, Department of Psychiatry, Withington Hospital, Didsbury, Manchester M20 8LR United Kingdom.

Master of Science degree in Human Sexuality, Human Sexuality Unit, 3rd Floor Lanesborough Wing, St. George's Hospital Medical School, Cranmer Terrace, London SW17 0RE United Kingdom.

Master of Science degree in Therapy with Couples, The Registry, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF United Kingdom.

Certificate in Psychosexual Counselling and Therapy, South East Hants Health Authority, c/o Myrtle Cottage, Selbourne, Nr Alton, Hants GU34 3LB United Kingdom.

The Master of Science degree in Human Sexuality and Relationship Psychotherapy offered by East Berkshire College has not been approved.

C. Sexological Journals and Periodicals

The major sexological journals in the United Kingdom are:

Sexual and Relationship Therapy. Editor: Kevan R. Wylie, Porterbrook Clinic, 75 Osborne Road, Nether Edge, Sheffield S11 9BF United Kingdom (published four times a year from 1996) http://www.tandf.co.uk/journals.

The International Journal for Impotence Research. Editors: William L. Furlow and Gorm Wagner Smith-Gordon and Company Ltd., Number 1, 16 Gunter Grove, London SW10 0UJ United Kingdom (published quarterly).

British Journal of Family Planning. Editor: Fran Reader, RGOG, 27 Sussex Place, Regent's Park, London NW1 4RG United Kingdom.

The Institute of Psychosexual Medicine Journal. Editors: Dr. H. Montford and Dr. R. Skrine, c/o 11 Chandos Street, London, United Kingdom (published three times a year).

The British Journal of Sexual Medicine. Editor: Paul Woolley, Hayward Medical Communications Ltd., 44 Earlham Street, Covent Garden, London WC2H 9LA, United Kingdom (currently suspended).

Journal of Sexual Health. Editor: Dr. Alan Riley, MAP Publishing, Sussex Court, 10 Station Road, Chertsey, Surrey KT16 8BE United Kingdom (no longer published).

Perversions: The International Journal of Gay and Lesbian Studies. Editors: Neil McKenna and Linda Semple, BM Perversions, London WC1N 3XX United Kingdom (published three times a year).

The Journal of Gender Studies. Editors: Jenny Wolmark and Jenny Hockey, University of Humberside, Ing Lemine Avenue, Hill HU6 7RX United Kingdom (published twice a year).

The Journal of Sexualities. Editor: Ken Plummer, University of Essex, Colchester, U.K. (published by Sage Publications four times a year).

D. Important National and Regional Sexological Organizations

Organizations dealing with sexuality include the following:

SIMSED, Bredon House, 321 Tettenhall Road, Wolverhampton WV6 0JZ United Kingdom.

British Association for Sexual and Relationship Therapy (BASRT), P.O. Box 13686, London SW20 9ZH United Kingdom.

Family Planning Association, 27-35 Mortimer Street, London W1N 7RJ United Kingdom; tel.: 44-71-636-7866; fax: 44-71-436-328.

Marie Stopes U.K., 6 Grafton Mews, London W1P 5LF United Kingdom; tel.: 44-71-382-2494; fax: 44-71-388-1885.

Sex Education Forum and National Children's Bureau, 8 Walkley Street, London C1V 7QE United Kingdom; tel.: 44-71-278-9441; fax: 44-71-278-9512.

Institute of Psychosexual Medicine, 11 Chandos Street, Cavendish Square, London W1M 9DE United Kingdom.

British Society for Psychosomatic Obstetrics, Gynaecology and Andrology, 11 Chelmsford Square, London NW10 3AP United Kingdom.

Marce Society (Mental illness related to childrearing), c/o Dr. T. Friedman, Liaison Psychiatry Service, Leicester General Hospital, Gwendoeln Road, Leicester LE5 4PW United Kingdom.

Tavistock Marital Studies Institute, The Tavistock Centre, 120 Belsize Lane, London NW3 5BN United Kingdom.

Institute for Sex Education and Research, 40 School Road, Moseley, Birmingham B13 9SN United Kingdom.

Relate, Herbert Gray College, Little Church Street, Rugby CV21 3AP United Kingdom.

13. Significant Differences in Sexual Attitudes and Behaviors among Ethnic Minorities

KEVAN R. WYLIE

It is well acknowledged that sexual function and behavior is affected by both social and cultural influence. Until recently, there has been a trend towards trying to fit patients into existing services without considering development of new therapist skills to meet a patient's individual cultural needs. Specific skills for counseling clients of different cultures have only recently been developed. The approach proposed by d'Ardenne and Mahtani (1989) has been practiced based on using an essentially client-centered and non-hierarchical model. The use of English language and nonverbal communication, as well as bilingualism and the use of interpreters, are important factors to consider. Within their text, there is a large resource list of organizations in the United Kingdom that may help therapists develop cultural knowledge in a certain field.

Clulow (1993) has considered ethnic and religious differences in couple relationships. The presentation of ethnic minorities to sexual dysfunction clinics poses particular problems to clinicians in addition to the cultural issues mentioned above. There are high expectations that physical remedies will be available (Ghosh et al. 1985). An excellent review of presentation of sexual problems within different cultures, clinical assessment, and their management has recently been presented by Bhugra and De Silva (1993). As newer medications become recognized as having potentially beneficial applications in sexual dysfunction, the clinician may have a further armamentarium towards helping some patients within this group.

The issue of HIV, sexuality, and ethnic minorities, particularly Afro-Caribbeans, is an area where there is increasing interest in the United Kingdom.

[Black and Ethnic Minority Groups

DINESH BHUGRA

[*Update 2001*: Cultural and social factors are well known to influence attitudes towards sex, the purpose of sex (whether it is seen as a pleasurable or procreative activity), and the type of sexual activity. Therapists need to be aware of social and cultural attitudes, taboos, and expectations arising from within the specific culture. The therapist must use strategies that are culturally appropriate and acceptable to the patients. The issues of family, the role of marriage within the relationship, and expectations from the female within a set of expected gender roles need to be part of any assessment. A non-hierarchical and client-centered approach is the way forward. The use of family or the partner as an interpreter must be avoided wherever possible.

[Differences in religious attitudes to sex and procreation will influence couple and sexual therapy. Often patients present with unrealistic expectations, such as seeking physical treatments and not using psychological approaches, because of the lack of privacy and social taboos. Under these circumstances, the therapists must be prepared to modify their approach by using a combination of strategies (see Bhugra & de Silva 1993, 2000). The role of newer therapeutic modalities, such as sildenafil (Viagra) are bound to increase demand, and expectations will change further. Homosexual orientation may well be seen as extremely negative in some cultures. It is likely that certain paraphilias may well be less or more prevalent in some cultures. The attitudes towards HIV and AIDS and preventive strategies will vary, and therapists in the U.K. need to be aware of heterogeneity and cultural differences.

[In the U.K., black and ethnic minority groups form around 6% of the population. They are not seen very frequently in sexual dysfunction clinics. It is possible that South Asians will use visiting alternative health practitioners and herbal medicines. The data on such usage are not available. For African and African-Caribbean populations, the data from sexual dysfunction clinics are even sparser. Johnson et al. demonstrated in a community survey that sexual practices do differ across ethnic groups, as do same-sex experiences and attitudes to one-night stands, abortions, and same-sex experiences. For any service, planning providers must take into account the composition of local communities. (*End of update by D. Bhugra*)]

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