Sexy Feminisms & Sexual Health: Theorizing Heterosex, Pleasure, and Constraint in Public Health Research

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Abstract
After outlining the "pleasure deficit" in public health research on family planning, this article applies feminist theorizations of heterosex to study contraceptive use and sexual pleasure. The author considers the limitations and potentials of theorizing heterosex variously as agential, transgressive, and/or constrained for public health research.

Résumé
Après avoir fait l'esquisse du « déficit du plaisir » dans la recherche de la santé publique sur la planification familiale, cet article applique les théories féministes sur la relations hétérosexuelle pour étudier l'emploi de contraceptifs et le plaisir sexuel. L'auteure considère les limites et le potentiel de faire de diverses théories sur la relation hétérosexuelle comme étant agénital, transgressif ou restreint, pour la recherche sur la santé publique.

Introduction

In 1995, I spent my first summer working with women who had experienced unintended pregnancies and who were seeking abortions. Each day, low-income women came to the clinic who had conceived contrary to their plans or wishes. Although they had been well aware of their fertility, a surprisingly large number of women had become pregnant not due to contraceptive failure but because they and their partners had not used contraceptives consistently, even though they had relatively good knowledge of and access to them. I remember one patient who groaned, "We had condoms on the bedside table, but we didn't use them that time. Sometimes it just...feels better not to." Another client told me how she often, but not always, used a diaphragm with her partner. "Everybody does it - you know, occasionally starts without something, or doesn't use anything from time to time," she said. "This time it finally caught up to me." For these women and others, something about the fabric of the sexual experience led to contraceptive abandonment, whether consistently or intermittently.

Years later, as a graduate student in women's studies and public health, I explored the effect of sexual pleasure on unintended pregnancy and HIV risk. In the meantime, I had learned that the dominant public health models explaining contraception use are largely devoid of an understanding of women's sexual agency (Dixon-Mueller 1993) or a concern with the sexual side effects of family planning methods (Graham 2002). I set out to research the ways in which sexual pleasure and the eroticisation of pregnancy risk shape women's use of contraception. In this paper, first I examine "the pleasure deficit" in public health research; then, after describing my own categorization of feminist theories' various renderings of heterosex, I outline my research project and draw upon my empirical findings, in broad sweeps, to illustrate the

limitations and applications of these theoretical approaches. This article, rather than offering an exhaustive account of the study's findings, shows how my struggles with feminist theorizations of sexuality improved, and were improved by, my public health research in sexual risk taking.[1] I explore what we can learn from this study about building better public health programs and about theorizing pleasure and heterosex.[2]

Addressing the Public Health Pleasure Deficit: Putting Pleasure on the Map

Sexuality and reproduction are central to feminist theory; of course, they are of enormous public health concern as well. The rate of unintended pregnancy in the United States (US) remains among the highest in the Western world, with one out of every two pregnancies unintended (Finer and Henshaw 2006). Canada's rate of 39 percent (versus 55 percent in the US) is significantly lower but nonetheless signifies that more than one in three Canadian pregnancies are unintended (Delbanco et al. 1997). With the domestic and global rise of HIV/AIDS, disease prevention has become an even more dire concern than pregnancy prevention. Heterosexual women have become the fastest growing HIV risk group in the world (UNAIDS 2005), with poor women of color in North America disproportionately affected (CDC 2002).

Thanks to the contributions of feminists, the public health approach to women and male condoms has greatly evolved since the beginning of the AIDS pandemic. Early on in the heterosexual epidemic, women were considered "targets" of condom promotion programs, even though they are not the ones to use or wear condoms (Exner et al. 2003). Feminist researchers argued that gender inequality places women in unequal power positions that make pressing for condom use difficult if not impossible (Amaro et al. 2001; Ehrhardt and Exner 1991). Other feminist research suggests that women may be able to negotiate for condom use, but they may not want to because condoms seem antithetical to sex that is "close," loving and monogamous (Hirsch et al. 2002; Sobo 1995). Women's social reliance on love and romantic relationships (Cancian 1986), as well as their emotional and financial dependence on men (Blanc 2001), may make women more motivated to seek love and affection and less motivated to protect themselves against HIV and other sexually transmitted infections (STIs).

Despite its feminist contributions, this research may also perpetuate the notion that women are rarely motivated by pleasure. Whereas public health research tends to work from the assumption that men will be disinclined to use condoms because they detract from sexual enjoyment, far fewer studies examine how women, too, may dislike the way condoms feel sexually. Needed was an examination of the ways in which physical pleasure and "sexual aesthetics" shape women's interest in both condoms and other contraceptive methods. Guiding me - as well as cautioning me - in this analysis were feminist theorizations of heterosex.

Pleasure, Pain and Danger: Feminist Approaches to Heterosex

Sex, especially heterosex, has been long contested within feminist theory and women's studies research. Many feminist scholars have theorized heterosex as always precarious for women, putting them at risk for sexual victimization and violence, unwanted pregnancy, disease, and reputation loss. However, a related feminist project has been to outline the ways in which sex is physically and emotionally pleasurable, purposeful (i.e., a way to negotiate for other social or emotional gains), and/or transgressive for women. Two approaches particularly inform my research on sexual pleasure and contraceptive use: 1) heterosex as site of oppression and victimization; and 2) sex as dangerously pleasurable.

Anti-heterosex sentiments resurged with the Second Wave and the rise of radical feminist thought, which portrayed heterosex as a prime site of women's victimization and oppression. In Sexual Politics (1971), Kate Millet was among the first to make this analysis and theorists such as Andrea Dworkin (1987) and Catharine MacKinnon (1982) followed suit. MacKinnon, using the models laid out by Marxist class analysis, suggested that sexual exploitation is at the core of sexual domination and gender inequality, just as the exploitation of labor is at the heart of capitalist class inequality. Taking an essentialist view, these and other scholars (Daly 1978) suggested that the essence of heterosex was unchangeable within the context of patriarchy; at its core, heterosex facilitated male

domination, both physical and psychological. Under these terms, heterosex could never contribute positively to well being, and celibacy, autoeroticism and/or lesbianism were seen as healthier choices for women (Jackson and Scott 1996). Because both the body and women's and men's sexualities are relatively fixed and static within this framework, the potential for social change or even agency is limited.

More recent work in this vein rejects an essentialist approach, but still links heterosex to physical and mental consequences for women. For example, Doyal (1995) discusses the psychological distress caused by sex that is expected or required rather than being jointly desired, the costs of which range from the subtler stresses of "giving in" to the traumatic injury of sexual violence. Citing the work of Lori Heise (1995), John Gagnon (2004) lists the myriad heterosexual perils than can befall women across the life course: childhood sexual molestation, coerced sex and sexual assault, reputational injury, sexual harassment at work, and abandonment by partners (and women are often the ones who retain childrearing responsibilities when marriages fail). (An emphasis on heterosexual dangers also characterizes current policy discourses of sexual trafficking, child marriage, and the feminization of AIDS, which have largely portrayed women as prey to men's sexual aggressions and philandering ways (Girard 2004).)

In a second approach, theorists have considered heterosex as dangerously pleasurable for women and as a site for play, performance, and negotiation. Critical of the scarcity of pleasure in mainstream feminist thought, these theorists have argued that heterosex can fulfill deeply emotional needs for women; the experience mustn't be inevitably negative (Hollibaugh 1984; Segal 1994; Snitow et al. 1983; Vance 1984). With the recent rise of "do-me" feminism and (middle class) women's ongoing search for the "zipless fuck" (Jong 1973), feminists have tried to re-negotiate a sexual space in which women can seek heterosex for a number of non-self-destructive reasons - physical, emotional, or in order to play with various sexual behaviors, roles, and identities (e.g., a one-night-stand-er, dominatrix, "sex slave," bisexual, etc.). In Jane Sexes it Up (Johnson 2002) and Sex & Single Girls (Damsky 2000), Third Wave contributors argue that yes, sex is shaped by heterosexist and patriarchal norms, but women can be resilient in reclaiming their own sexual power and desires, even after experiencing sexual violence. Less cautious than Vance and her contemporaries, they boldly reclaim women's sexual agency, suggesting that all forms of women's (hetero)sexual expression, even S&M, commercial sex work, or the consumption of pornography, can be potentially libratory and/or transgressive.

Such sex-positive approaches encourage us to consider how the schema of the sexual actor, rather than the act itself, may matter more in terms of when and how patriarchy influences women's sexual experience. However, this scholarship also seems strikingly culture- and class-bound. While a certain class of Western feminist may now be able to embrace patriarchal sexual practices such as stripping or spanking, women in other situations or from other demographic backgrounds may be less able - and/or less compelled - to have transgressive sex. It remains relatively unexplored how we can embrace heterosex as pleasurable for all women while simultaneously making larger interrogations of the socio-cultural and political economic workings of heterosex and sexual violence. I wondered: how could women's descriptions of (dis)pleasurable contraceptive use help us to better theorize heterosex? With that in mind, I turn to how selected findings in my study affirm this need for a cautious but sex positive approach. I begin with a brief sketch of the study's methodology.

(Constrained) Pleasure Matters: Selected Findings & Their Implications for the Agency-Constraint Debate

I recruited twenty-four women and twelve men to participate in three-hour, open-ended sexual history interviews. Women were the focus of this project and thus the majority of the sample, given that their experiences with pleasure and family planning have been less documented than men's experiences with pleasure and condoms. I ensured adequate representation of a range of variables, especially social class, race/ethnicity, and age, all of which have been associated with contraceptive use patterns (Mosher et al. 2004), and all of which are also important signifiers of shared cultural meanings among subpopulations (Parker 1999). Recruiting participants from more than one social class and racial/ethnic group also enabled me to explore some of the structural factors that shape sexual and

contraceptive behaviors. The final sample included half middle class, half "lower" class (working class and poor) respondents, as well as half whites and half African Americans. I found repeatedly that social class seemed to trump race. That is, contraceptive use patterns and sexual health outcomes, as well as sexual attitudes and experiences, were far more similar among members of a particular social class than within racial groups. Thus, gender and class comparisons feature more prominently in this paper.

Interview instruments were developed that would elicit information about respondents' relationship, contraceptive and sexual histories (including unintended pregnancies, HIV, and other sexually transmitted infections); their experience, if any, with the eroticization of unsafe sex and pregnancy risk; their sexual attitudes and preferred sexual activities and experiences; and their descriptions of the ways in which various contraceptive methods affect sexual enjoyment.

While outcomes varied by gender as well as class, the overwhelming majority of respondents described the influence of sexual experience as shaping at least some aspect of contraceptive use and preferences. Both women and men were more likely to consistently use, or not use, contraceptives so as to maximize sexual enjoyment - however they defined it - while minimizing sexual discomfort and interruption (Higgins and Hirsch nd). However, respondents' "sexual aesthetic," meaning the physical and emotional attributes they sought in sex, as well as the ways in which that aesthetic shaped contraceptive use, were constrained by gender and other forms of social inequality. Thus, while pleasure mattered, it mattered in ways that both reflected and perpetuated patriarchal norms and structural violence.

Respondents consistently detailed the ways in which contraceptives made sex feel, both physically and emotionally, and how this affected their adherence - or aversion - to a given method. Lydia[3] (33, middle class, white), for example, who had an intrauterine device (IUD) inserted after the birth of her second child, exclaimed:

> This IUD thing is fantastic. Why didn't I hear more about it before? Why don't they encourage more women to get these things? The sex is fantastic. There's skin-on-skin contact, he can come inside me and I'm not worried, there are no hormones, and I never have to think about it. The sex has never been this good!

Because the IUD had enhanced her sexual experience and required neither premeditation nor artificial hormones, Lydia planned to continue using the method and singing its praises to her friends. In contrast, Rose (50, lower class, African American) said her "loop" (IUD) was uncomfortable when she had sex. "It feels like it's pinched and everything. My husband said it pinched him, too." This displeasure led her to ask her practitioner to remove it upon her next visit to the public clinic. These two women had different experiences with the same method, but both highlighted the role of sexual pleasure in shaping contraceptive use and, in Rose's case (since she and her partner used withdrawal after the IUD was removed), in subsequent susceptibility to unintended pregnancy.

Like the IUD, a number of methods enhanced some women's sexual experience while they diminished other women's. Beth (33, middle class, white) loved the NuvaRing ("I don't have to stop and put it in like my old diaphragm; our sex is much more flowing now") while Maya (23, lower class, African American) disliked the "excess [vaginal] wetness" caused by her ring, and Benjamin (25, middle class, white) reported that the ring had diminished his partner's libido and she thus intended to discontinue. In other words, there were few unidirectional relationships between a given method and a particular sexual experience, suggesting the need for public health programs to recognize and appreciate the range of women's sexual experiences and preferences. Like the theorists who criticized the absence of pleasure in feminist theory, these women's accounts suggest that women want to maximize their pleasure and they actively choose methods that help them achieve this.

Male condoms, however, received overwhelmingly negative reviews from respondents.[4] With the exception of a couple of risk-averse respondents who disliked physical contact with partners' semen, the overwhelming majority of women strongly disliked male condoms and preferred not to use them. Echoing previous research (Hirsch et al.

2002; Sobo 1995), a number of women experienced the condom as a barrier to emotional intimacy, trust, and love. Condoms made sense to them at the very beginning of a relationship, but much less so as intimacy deepened and as a couple sought maximum closeness. For example, Shirley (50, lower class, African American) explained her dislike of male condoms by linking them to infidelity: "If I know he's not fooling around, then no condoms. No, never."

The majority of women respondents also mentioned disliking the physicality of condoms. In the words of three women: "I don't like that condoms decrease sensation for both of us," (37, middle class, African American); "...with condoms, it's like something's covering you during sex; you can't feel as much" (25, lower class, African American); "I hate the way condoms feel!" (23, lower class, African American). In surprising contrast, most male respondents presented themselves as resigned to the way condoms feel. Miles (42, middle class, white) said that "...sensation is lessened with condoms, but the interruption is no big thing," while Joseph (30, lower class, African American) said, "It would definitely be better if I didn't have to deal with [condoms], but it's not that bad." These findings challenged the assumption that women want to use male condoms while men do not (e.g., women are "unable to insist upon" condom use); they also problematized the public health paradox: even though women often dislike how condoms feel, they remain the targets of condom promotion programs (Exner et al. 2003). Women's physical resistance to condoms provided yet another reason to underline women's hetero(sexual) agency and pleasure seeking, and not just their quest for "closer" or more emotional sex.

The findings also illustrated how sexual agency and pleasure seeking were constrained by gendered social norms, which indicate the way women and men should be sexually. Vaginal dryness serves as one example. Over a third of women (9 out of 24) reported that they had experienced periods of consistent or uncomfortable vaginal dryness during sex, and this dryness shaped several women's contraceptive use patterns. Abby (25, middle class, white) preferred oral contraceptives to condoms since they did not exacerbate her vaginal dryness, which was such a concern for her that she had consulted at least one physician about the matter. Sally (white, 50, lower class) described frequent experiences of dryness that would contribute to male condom breakage, leading her and her partners to simply continue having intercourse without any prophylaxis.

Rather than interpreting the high prevalence of vaginal dryness in the sample as an epidemic of vaginal pathology, I suggest we consider how "hot sex" is defined in the US and what wetness comes to signify. Socially constructed sexual norms suggest that, ideally, women should be deeply aroused before and during intercourse. Wetness serves as a discernable marker of this arousal. As such, heavy vaginal lubrication allows women to appear stimulated and stirred, thereby fulfilling their social roles as sexual women. Vaginal wetness also becomes a marker of mens' skills, their desirability as lovers and sexual performers. Women in both this study and others (Graham et al. 2004) struggled with these norms, not wanting to appear "frigid" and/or not wanting their partners to think them un-aroused in the absence of lubrication.[5] Women respondents never suggested that dryness was partner dependent (i.e., a marker of insufficient foreplay), nor did they criticize social norms that pathologize dryness. In other words, despite the numerous ways that sufficient lubrication is connected to social and relational factors, women were quick to blame their own bodies or minds for vaginal dryness. Many women preferred to simply abandon methods that exacerbated dryness (namely, male condoms), thereby increasing their susceptibility to STIs.

The way respondents described the importance of pleasing one's partner serves as another example of the ways in which women's sexual agency and pleasure was shaped by gender inequality. Many women expressed that a primary sexual goal was to attend to their partners' sexual pleasure and enjoyment. Women were thus sometimes disinclined to press for use of male condoms or withdrawal, not necessarily to facilitate emotional closeness, but to facilitate men's, and thus their own, ability to enjoy sex. Alex (27, middle class, white) reported that when her partner didn't wear a condom, "...it's sexier for both of us" (emphasis in original). Melanie (33, middle class, white) said, "I dislike [male condoms] because of the way they make my [partner] feel." Similarly, Margie (41, middle class, white) said with condoms, "I get concerned for my husband. I know it

feels better for him not to use it even when he doesn't complain or say anything." All of these women chose alternative methods instead.

In contrast, men were much less likely to mention concern with how contraceptive methods limited their partner's ability to enjoy sex or experience maximum pleasure. To be sure, numerous men worried about whether they were sexually pleasing their partners; men were keenly aware of the social pressures on them to be skilled and experienced lovers.[6] Far fewer, however, associated contraceptives with diminished sexual fulfillment for women. While numerous women reported concern with how contraceptives detract from men's pleasure, men rarely expressed concern about a method's ability to decrease the sexual enjoyment of their women partners.

Gendered constraints on women's sexual agency could also be seen in how women sought often not to maximize pleasure through contraceptive use, but to minimize displeasure. This phenomenon was particularly present in women's discussion of side effects. Respondents spoke of how hormone-based side effects such as weight gain, breast tenderness, and moodiness shaped their interest in sex (libido), their concerns about their bodies in bed, and their "at home-ness" in their bodies more generally. Alex (27, middle class, white) spoke of oral contraceptives as draping a "veil" over her sexual desire. Beth (37, middle class, white) said she felt "less attractive" on the pill because of weight gain, on which she fixated during her sexual encounters and which affected her interest in sex. And Matthew (27, middle class, white) spoke in detail about the "significant" amount of weight his partner gained while taking oral contraceptives, which harmed her body image and "dramatically" affected their sex life. Significant social emphasis on women's slimness and physical attractiveness meant that many women worried about what their bodies looked like in bed. Hormone-based weight gain only increased these concerns. Side effects such as mood swings or diminished libido also affected women's experiences of themselves as sexual beings.

Poorer women of color in the sample were especially likely to experience more extensive side effects such as heavy bleeding, headaches, and outright pain, illustrating another way that social inequality shaped the relationship between sexual experience and contraceptive use. These women had fewer and shorter visits with clinicians, and in keeping with national patterns (Mosher et al. 2004), they were more likely to have used long-acting, more intrusive methods such as Depo Provera, Norplant, and the IUD (Hatcher 1998). Frances (47, lower class, African American) had an IUD inserted first when she was 14 years old at her mother's insistence, and then again after the birth of her first son at her doctor's urging. She experienced "pain" and "pinching" from this method. After several months (in both cases), Frances had it removed and decided to "use her head" instead - a homegrown combination of rhythm, withdrawal, periodic abstinence, "and luck." While she knew this was less effective than the IUD, she was tired of feeling pain during intercourse. Destiny (25, lower class, African American), whose doctor told her she wouldn't remember to take a birth control pill every day, said that her Depo Provera shots led to side and back pain. The deep discomfort described by these and other lower class women often meant that they would abandon contraceptive use, which put them at greater risk for unintended pregnancies. Social inequality, racism, classism, and a mismatching of methods meant that respondents were sometimes less interested in maximizing pleasure than they were in minimizing displeasure or discomfort.

Physical discomfort caused by contraceptive side effects is one thing; discomfort or pain caused from sex itself is another. A full discussion of sexual violence in the sample is beyond the scope of this paper. However, respondents' descriptions of negative sexual experiences were the gravest example of the dangers of heterosex and of the many ways in which women worked to protect themselves from physical, emotional, and reputational harm. Half of the women (12 out of 24), but none of the men, reported sexual abuse, assault, and coercion. Negative sexual experiences were classed as well as gendered. Two-thirds of the lower class women, as compared to one-third of the middle class women, reported sexual victimization, and lower class women were more likely to be sexually assaulted by a stranger (five cases versus zero). The fabric of lower class communities, which were disproportionately affected by all types of violence as well as drug use, meant that lower income - as compared to middle class - women were

relatively less protected from certain sexual experiences (e.g., drug or gang related sexual assault).

Regardless of the shape of the sexual assault, women framed their negative sexual experiences in similar ways. Like the respondents in Lynn Phillips (2000) ethnography of college girls, a number of women blamed themselves for the sexual violence suffered (e.g., "Why did I go back to his room with him when I was so drunk? I was such an idiot." - Alex, 27, middle class, white) and/or devised mechanisms that allowed them to frame the encounters in non-coercive terms. Rashani (25, African American, lower class) said she was forced into her first vaginal intercourse experience, but "I came away from that as a good experience. I got it out of the way. After that, [...] I learned that if I don't want to, I won't." Others suggested they had "gotten off lucky" or suffered mildly compared to other women. Reluctant to portray themselves as victims and to criticize men, women often blamed themselves in some way or, like Rashani, portrayed the encounter as a learning experience. In the meantime, men's hegemonic sexual privilege remained unquestioned.

Men moved through the world with comparative immunity to sexual violence and greater ease of access to sexual pleasure. When asked about negative sexual experiences, men largely described unpleasurable sex, compared to women's descriptions of forced or unwanted sex. Other men spoke about sexual regrets, especially after having sex with women they deemed undesirable. Jay (23, lower class, African American) spoke about spending money on drinks and a hotel room, but then being unable to have sex with a certain woman because her genitals smelled distasteful to him. Men were accustomed enough to pleasurable sexual experiences that when they did not experience satisfying sex, they felt disappointed and even resentful.

Respondents' negative sexual experiences, along with the other themes discussed above, highlighted that regardless of women's desires for sexual agency, pleasure, and power, patriarchal norms and other forms of social inequality could limit their access to that pleasure and power. Yet many women described and sought - whether with or without contraceptives - pleasurable sex, even if the very characteristics of that pleasure (e.g., making him feel good, minimizing displeasure) were constrained by gender or class inequality.

Conclusions: Future Directions for Public Health and Women's Studies

Some of the recent sex positive feminist scholarship discussed above suggests that a woman can transgress patriarchal constraints by re-claiming her (hetero)sexual experience as personally powerful. To be sure, my findings strongly suggest that women not only sought pleasure, but chose contraceptives that maximize that pleasure. Yet others have argued (Blanc 2001; Doyal 1995) that women may be less immediately concerned with experiencing liberating sex than they are with poverty, structural violence, racism, or lack of educational opportunities and meaningful employment. Further, respondents in this study indicated that desire and sexual enjoyment themselves can be gendered, thereby confirming Tolman and Diamond's (2001) findings. An understanding of the powers of pleasurable heterosex, and its influence on contraceptive and condom use, must go hand in hand with an exploration of the ways in which heterosex can serve as the enactment of sexism and social injustice.

What do these findings mean both for a "sexy feminism" and for public health research? An ideal sexy feminism would frame heterosex as the enactment not only of pleasure and power, but also of sexism and social injustice. Heterosex serves both a site for social domination of women and an avenue toward agency, intimacy, and empowerment (Heise 1995; Jackson and Scott 1996). Attending to the ways in which heterosex serves male privilege does not necessitate a re-victimization of women or a portrayal of them as "cultural dupes" (Davis 1995). We can enlist a theory that embraces women's capacity for sexual pleasure while also recognizing the very social constraints on that pleasure - in other words, framing women as agents "...who negotiate their bodies and lives within the cultural and structural contracts of a gendered social order" (Davis, 5).

Similarly, an approach to heterosex that considers sexuality as the site of both women's empowerment and victimization has implications for public health. It requires newfound attention to women's pleasure in its various forms, especially in the context of contraceptive and HIV programming

and development (e.g., research on how new contraceptives and HIV prevention technologies such as microbicides affect sexual functioning and enjoyment). Women can no longer be the sole targets of male condom programs (Exner et al. 2003), since they may dislike condoms as much if not more so than men, for both physical and emotional reasons. We also need to eroticize contraceptive use in our campaigns and programs and to better match contraceptive clients with those contraceptives best suited to their sexual aesthetic (that is, "pleasure profiling"). However, none of these efforts can be divorced from violence and poverty reduction efforts. A significant constraint on women's full sexual agency is the ongoing threat of sexual violence or coercion. Indeed, even as we recognize that all women (and men) are entitled to healthy and pleasurable sex, public health practitioners can never turn our attention from the ways in which gender, class, and other forms of inequality influence sexual health outcomes.

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Endnotes

1. More detailed accounts of the study findings are forthcoming (Higgins and Browne nd; Higgins and Hirsch nd).
2. The term "heterosex," used widely in British feminist theory, is meant to refer to sexual activity between women and men (as opposed to autoeroticism, or sex between women or between men). I find the term useful not only in its specificity, but also because it denaturalizes the idea that all sex takes place between a man and woman. This paper concerns itself primarily with heterosex, as I am interested in the sexual activities that lead to pregnancy, as well as diseases that are heterosexually transmitted. Thus, while numerous feminist theorists have discussed the emancipatory potential of lesbianism and transgressiveness of queer politics, their work will not be discussed here.
3. All names are pseudonyms.
4. No respondents in the study reported prior or current use of female condoms.
5. Very few women spoke of using store-bought lubricants to decrease dryness. Whereas lubricants have widespread circulation among North American gay men, their everyday use among heterosexual couples appears much more limited. Women may hesitate to use lube so as not to appear frigid or insufficiently aroused by their partners; women may feel they should be sufficiently wet by their own volition and/or their partners' skill. Lube's mainstream appeal may be on the rise, however, as demonstrated in the explosion of heterosexually-oriented lubricant marketing in the past few years.
6. A number of men formed their attitudes about condoms based on how they were able to perform sexually when using them. Some men liked that they could last longer during sex with condoms, while others struggled to maintain erections while using condoms and therefore renounced them.

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