

Oral sex and young people

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Oral sex has become more common among young people in recent years and is seen by many of them as safer than intercourse. Yet many adult commentators are alarmed by this. Do young people see oral sex differently from older generations? Is oral sex safe? Should it be recommended in health promotion?

Most Australian adults have had oral sex—79% of men and 67% of women interviewed in the Australian Study of Health and Relationships in 2001–02 reported that they had ever had fellatio or cunnilingus (de Visser et al., 2003). But it was not always so. The practice of oral sex has changed over recent decades. Among young people aged 16 to 19, men and women were equally likely to report having engaged in it. People over 50, especially women, were less likely to report having had oral sex: only 54% of women in their 50s had ever had it. Older adults had usually had oral sex for the first time some years after they had first had vaginal intercourse; in the case of young people, it often preceded first intercourse (Richters & Rissel, 2005).

In 1998 in a survey at Macquarie University, 545 students were asked which activities counted as 'having sex' with someone (Richters & Song, 1999). Only 7% thought of tongue kissing as sex, but over 99% agreed that vaginal intercourse with ejaculation was sex. Oral sex was in between: 54% considered oral sex without orgasm as sex, and 58% considered it sex if orgasm had occurred. Although all of

the mature-aged students over 40 regarded oral sex with orgasm as sex, only 49% of the school-leaver students under 20 did so.

The same results were reflected at a national level: overall, 72% of Australians considered that if two people had had oral sex but not intercourse then they had had sex together, but only 46% of young men and 37% of young women under 20 agreed with this (Rissel et al., 2003). Findings of US studies are similar (e.g. Sanders & Reinisch, 1999).

Is oral sex safe?

Concerning oral sex, the NSW Sexual Health website says: 'If you are concerned about catching HIV or other STIs [sexually transmissible infections] use condoms during oral sex or avoid oral sex.' It acknowledges the possibility of HIV transmission through oral sex, but stresses that this is very rare and states that: 'In most of these cases the person had sores, wounds, gum disease, ulcers, cuts, herpes or infections in the mouth. Without those factors it isn't considered easy for HIV to enter the bloodstream via the mouth or throat.'



Herpes, chlamydia, gonorrhoea and syphilis can be passed on through oral sex (see Summaries 4 and 5, page 4). It is important to give young people advice about avoiding oral sex (or using a barrier) if either partner has a cold sore or herpes lesion on the mouth or genitals. A doctor treating someone with a mucopurulent sore throat should bear in mind the possibility of exposure to infection via fellatio. However, in practice, young people in New South Wales would almost never encounter syphilis unless they were sexually active on the gay scene. Young people are more likely to encounter chlamydia, which is very common as a genital infection in the 15–24 age group, and to a lesser extent gonorrhoea. Both are readily curable with antibiotics.

For much of the 20th century, herpes simplex virus type 1 (HSV 1) was associated with oral disease, i.e. cold sores, and type 2 (HSV 2) with genital disease. However, in recent years a greater proportion of initial attacks of genital herpes have been caused by HSV 1 (Lafferty et al., 2000; Löwhagen et al., 2000; Roberts et al., 2003).

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Funded by NSW Health

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One reason for this is that nowadays, because of better hygiene, fewer people acquire HSV 1 in childhood, so more people reach their sexual debut without having been infected and are therefore vulnerable to HSV 1 infection, whether oral or genital. Another reason is presumably the growing popularity of oral sex.

Condoms

To reduce the very small risk of HIV transmission during fellatio, or of contracting chlamydia or gonorrhoea, condoms can be used. However, such counsel of perfection has never been adopted by ACON (the AIDS Council of NSW), and condom use for oral sex is almost unheard of among gay men. To protect their own health at work, female sex workers often use condoms for fellatio, though the matter has been contentious in recent years, with some brothels advertising 'bareback blow jobs'. Most safe-sex advice addressed to heterosexuals mentions condom use only for vaginal or anal intercourse.

Dental dams

Dental dams are sheets of latex rubber designed for use during dental

procedures, which can also act as a barrier between the vagina or anus and the mouth for cunnilingus or rimming (oral–anal contact). Since the 1980s, dental dams have been made available in some developed countries for the prevention of sexually transmissible infections, including HIV, in sex between women. 'Safe-sex' packs distributed by ACON formerly included dams as well as gloves, lubricant and condoms. Dental dams are still available at ACON offices and are available free from dispensing machines in women's prisons. However, there is very little evidence of their use by lesbians (Richters et al., 2005), although it is anecdotally reported that they are used by gay men for rimming (licking the anus).

Some sources of safe-sex advice mention the possibility of using dental dams as a barrier during heterosexual cunnilingus, though as Celia Roberts et al. (1996; Summary 3) remark, one gets the impression that the advice-givers are being extra careful and do not really expect this advice to be followed.

Many health promotion practitioners believe that other more readily available barriers such as cling wrap cannot be

recommended for cunnilingus. There is no evidence for this belief. Dental dams have never been evaluated or approved, e.g. by the US Food and Drug Administration, for effectiveness in preventing transmission of sexual infections (US CDC, 2002). Where an oral–genital barrier is desired—for example, if one partner has herpes or HIV—cling wrap would be more easily obtainable and less obtrusive because it is thinner and does not taste or smell of rubber. As long as there are no visible tears, any waterproof film such as cling wrap or a cut-open condom is likely to be an effective barrier during oral sex. If cling wrap does tear during use, it can be readily replaced.

Safe-sex advice for young people

The paper on the 'fellatio epidemic' (see Summary 1, below) raises several issues about adults' reactions to oral sex among adolescents. Distaste for oral sex, or alarm about 'meaningless' or exploitative casual interactions, leads adults to frame oral sex exclusively in terms of risk. It is tempting to make ideal safe-sex recommendations that permit no possibility of infection,

ARTICLE SUMMARY 1 A fellatio epidemic? Adults' reactions


In Canada, the case of an 18-year-old high-school athlete charged with receiving fellatio initiated by two under-age girls provoked extensive media attention.

Although oral sex has become common heterosexual practice, much anxiety has focused on fellatio between teenagers. Curtis and Hunt argue that the casual oral sex that gave rise to this court case did not fit into adults' frameworks, either in the law or in the popular imagination. The boy was 18, so it was not children's sex play, but the girls were under 14, so they could not legally give consent. Thus the girls, who willingly offered fellatio, were depicted as victimised, irrational or ignorant. In contrast, the sexuality of teenage boys was depicted as predatory and rampant. The media insisted that oral sex was 'sex', and that young girls who did it outside the context of an emotional relationship were 'demeaned' or 'duped'. Males could have sex for fun, but if girls did it they were either damaged to begin with, or would be damaged by doing it: 'their self-esteem is lost; never will they be able to enjoy "healthy" sexuality in the future'.

The authors, however, contest the manner in which performing fellatio is positioned as 'subservient', question the assumption that teenage girls are victims of teenage boys'

predatory sexuality, and regret that few press commentators suggested that the 'terms of [sexual] practice be altered ... to produce more egalitarian relations'. But this case was not a matter of boyfriend–girlfriend relations. Perhaps the authors, both male, found it hard to identify imaginatively with post-pubertal young teenage girls who are interested in boys and sex but are beneath the notice of older boys, while their own male age-mates are still pre-pubertal and not yet ready for dating. As the authors point out, we understand little about the sexual motivations and understandings of teenage girls under 16, and current rules make it impossible to research them directly.

In the North American context, sexual advice in the popular media is unambiguously pro-sexual, but official strategies such as sex education warn about the risks of sex and exclude any discussion of sexual pleasure. Curtis and Hunt conclude by pointing out that adults still talk about teenage behaviour in terms of an earlier set of conditions and attitudes. Obviously it distresses adults that today's teenagers use their new sexual freedom to do things that were not imagined by the feminists who fought for that freedom.

 Curtis, B., & Hunt, A. (2007). The fellatio 'epidemic': Age relations and access to the erotic arts. *Sexualities*, 10, 5–28. Abstract available free from <http://sexualities.sagepub.com/cgi/content/abstract/10/1/5>

but are too perfect to be followed in the real world.

Older people understand events in terms of conceptual frameworks that applied a generation earlier. For most over-40s nowadays, oral sex was elaborated sexual practice, more intimate than intercourse. Today, media access to the erotic arts, including internet pornography, means that young adolescents' first flickerings of interest in partnered sex are accompanied by a broader knowledge of sexual practices. This is the world that contemporary sex education and sexual health policy need to address.

Sex education needs to be useful to the people who are receiving it. The 'marital education' of the 1950s proved to be inadequate to the needs of those growing up in the Swinging Sixties. 1980s-style sex education framed around warnings, concentrating on protecting teens from rape, pregnancy and HIV, is likewise inadequate for a generation growing up in a different moral and sexual universe. Safe-sex advice must be based on a realistic balancing of demonstrable medical risks against pleasures, or it may do more harm than good.

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Richters, J., Song, A., Prestage, G., Clayton, S., & Turner, R. (2005). *Health of lesbian, bisexual and queer women in Sydney: The 2004 Sydney Women and Sexual Health survey*. Monograph 2/2005. Sydney: National Centre in HIV Social Research.

Rissel, C. E., Richters, J., Grulich, A. E., de Visser, R. O., & Smith, A. M. A. (2003). Sex in Australia: Attitudes toward sex in a representative sample of adults. *Australian and New Zealand Journal of Public Health, 27*, 118–123.

Roberts, C. M., Pfister, J. R., & Spear, S. J. (2003). Increasing proportion of herpes simplex virus type 1 as a cause of genital herpes infection in college students. *Sexually Transmitted Diseases, 30*, 797–800.

Sanders, S. A., & Reinisch, J. M. (1999). Would you say you 'had sex' if ... ? *JAMA: The Journal of the American Medical Association, 281*, 275–277.

US CDC. (2002, January/February). *At risk: Young, minority, and lesbian women*. Division of HIV/AIDS Prevention, US Centers for Disease Control and Prevention. Retrieved 11 January 2008 from www.thebody.com/content/whatis/art30935.html

2 Is oral sex more popular than in the past?

Over 10 years, NCHSR carried out surveys with first-year behavioural science students at Macquarie University asking about their sexual behaviour and about attitudes and knowledge relevant to HIV prevention. More male students reported having had experience of each practice (tongue kissing, oral sex and vaginal intercourse) and they were more likely to admit to having had casual partners. However, over the 10-year period more female students reported most practices, and their experience of oral sex (both given and received) rose significantly. By 1999 the women's behaviour was similar to the men's.

Grunseit, A., Richters, J., Crawford, J., Song, A., & Kippax, S. (2005). Stability and change in sexual practices among first-year Australian university students (1990–1999). *Archives of Sexual Behavior, 34*, 557–568.

3 Do people really like oral sex?

In interviews and focus groups with university students and working-class young people, Roberts et al. found ambivalence around oral sex. Oral sex was largely accepted as a required or expected part of a sexual encounter, especially by the university students, but was often described without pleasure or excitement, and men expressed reluctance to go down on women they did not know well. Women—even though some said they really enjoyed cunnilingus—also expressed anxiety about being 'clean', and about the greater degree of nudity and of intimacy or sense of vulnerability involved in being given oral sex rather than having intercourse, making it less suitable for a casual encounter. Men were quite happy about a woman going down on them, though some disquiet was expressed about contact with their own semen if they were expected to kiss her afterwards. Women appeared to give fellatio

continued overleaf

Points of note

- Oral sex carries no risk of pregnancy and a much lower risk of STI transmission than vaginal or anal intercourse.
- A large minority of young people have oral sex before they have intercourse for the first time. Many see it as less serious in relationship terms.
- Sexual health education materials should not equate 'sex' with intercourse. Kissing, cuddling, stroking, oral sex and manual stimulation of the genitals are pleasurable and important parts of sexual learning for young people.
- Health promotion material on STI risks should be written carefully so as not to alarm young people about remote dangers of oral sex, as this may discourage them from choosing safer practices than intercourse.

to satisfy their partners, and mentioned dislike of gagging or of semen in the mouth. Roberts et al. suggest that women feel powerless to resist demands for fellatio that they do not enjoy. All the interviewees saw vaginal intercourse as natural, as 'sex', and oral sex as foreplay or occasionally as a substitute when intercourse was not available.

Roberts, C., Kippax, S., Spongberg, M., & Crawford, J. (1996). 'Going down': Oral sex, imaginary bodies and HIV. *Body & Society*, 2(3), 107–124.

4 Can viral STIs be transmitted through oral sex?

In two articles, one on viral and one on non-viral STIs, Edwards and Carne review the literature on orogenital transmission of infection. Although HIV transmission through oral sex is possible (see Summary 7), the risk is substantially less than from vaginal or anal intercourse. There is a small risk of human papillomavirus infection. Oral sex is an important risk factor for transmission of herpes simplex virus type 1. Transmission between anus and mouth can occur with hepatitis A (and other non-viral infections that live in the gut). The authors conclude that 'the relative importance of oral sex as a route for the transmission of viruses is likely to increase as other, higher risk sexual practices are avoided for fear of acquiring HIV infection.' This does not mean, of course, that oral sex is more risky than before, only that if people avoid riskier practices such as anal intercourse, a greater proportion of STIs will be caught through oral sex.

Edwards, S., & Carne, C. (1998). Oral sex and the transmission of viral STIs. *Sexually Transmitted Infections*, 74, 6–10.

5 Can other STIs be transmitted through oral sex?

Edwards and Carne's review concluded that oral sex is a route of transmission for gonorrhoea, syphilis, chlamydia and some other less common STIs. Infection can pass from the penis to the mouth or throat. There are some reports of candidiasis (vaginal thrush) being more common among people who have more frequent oral sex, but this may be due to some other mechanism than infection from the mouth. There is also evidence that some respiratory tract organisms can be found in the genital tract.

Edwards, S., & Carne, C. (1998). Oral sex and transmission of non-viral STIs. *Sexually Transmitted Infections*, 74, 95–100.

6 Oral transmission of HIV: reality or fiction?

In this update, Campo et al. conclude from epidemiological and physiological evidence that the mouth is an extremely uncommon place for HIV to be passed on. Although HIV can be found in saliva, it is not common, and saliva itself may have an inhibitory effect on the virus. Oral trauma such as ulcers or inflamed gums may make transmission easier. Exposure to saliva is much less risky than exposure to blood.

Campo, J., Perea, M. A., del Romero, J., Cano, J., Hernando, V., & Bascones, A. (2006). Oral transmission of HIV, reality or fiction? An update. *Oral Diseases*, 12, 219–228.

7 HIV transmission through oral sex among Sydney gay men

Interviews with 75 men with recently acquired HIV explored their risk behaviour and attempted to establish the most likely route by which they had become infected. Most had had unprotected anal intercourse. In five cases oral sex was judged to have been the most likely source of infection. Three of these men had a penile piercing and appeared to have become infected through insertive fellatio. One of the other two had had receptive fellatio with ejaculation when he had an open wound in the mouth due to dental treatment. These rare cases raise the possibility that piercings in the lip or tongue, popular with some young people, might increase the risk of infection if they were to perform oral sex on an HIV-infected person.

Richters, J., Grulich, A., Ellard, J., Hendry, O., & Kippax, S. (2003). HIV transmission among gay men through oral sex and other uncommon routes: Case series of HIV seroconverters, Sydney. *AIDS*, 17, 2269–2271.

For further information

Finding out more about safe oral sex:

- **NSW Sexual Health website**
www.health.nsw.gov.au/sexualhealth/
- **ACON website**
www.acon.org.au/health/
(Click on 'Safe Sex'.)

Secondary students and sexual health

Download the survey report from www.latrobe.edu.au/arcs/shs/scdry_stdnts_sxl_hlth.html

For the *Talking Sexual Health* teacher resource, visit www.latrobe.edu.au/cleu/TSH.htm

For sex workers

www.swop.org
www.scarlettalliance.org.au/library/bestpractise

Oral sex and STIs among gay men

The NCHSR report *HIV/AIDS, hepatitis and sexually transmissible infections in Australia: Annual report of trends in behaviour* presents data on the use of throat swabs to test for STIs among gay men. Download the report from http://nchr.arts.unsw.edu.au/publications_annual.html

Condom use for fellatio is assumed to be so rare among gay men that most surveys (for example, the Sydney Gay Community Periodic Survey) do not ask men about condom use for oral sex. Download the latest survey report from http://nchr.arts.unsw.edu.au/pdf%20reports/sydney_gcps_feb2007.pdf.

Tip for searching the medical literature regarding oral sex

Medline does not have a MeSH (medical subject heading) term for oral sex. To find papers in Medline that concern oral sex, you need to search on 'sexual behavior' and then specify a number of text words (keywords) such as 'fellatio', 'cunnilingus', 'orogenital sex' and 'oral sex'. Searching for orally acquired infections such as 'pharyngeal gonorrhoea' will locate additional relevant papers.