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Exploring Sexual Diversity: A Case Report on the Application of Habanero Pepper Juice during Recreational Urethral Sounding

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As most of the information on recreational urethral sounding comes from case reports of men seeking medical treatment, there is limited knowledge regarding the variety of ways that sounding is actually conducted as part of sexual gratification. This article reports on the novel case of a middle-aged man applying habanero pepper juice during the sounding process. Implications for theoretical framing as well as guidance for health care providers and other clinicians are discussed.

Recreational urethral sounding (hereafter *sounding*) is an unconventional but not necessarily rare sexual practice (Breyer & Shindel, 2012). Typically performed by men in conjunction with masturbation and other sexual activities (Rinard et al., 2010), sounding involves the insertion of objects into the urethra, including not only metal or plastic dilators specifically designed for the purpose, but also any of an array of commonly available household items such as pens and pencils, spoon and fork handles, hairpins, and Q-tips (Hogan, Young, Gabbert, & Armstrong, 2011; Rinard et al., 2010). Related activities include recreational catheterization (Hogan et al., 2011), piercing the urethra for sexual or aesthetic purposes (Thomas, Crosby, & Milford, 2015), and the insertion of liquids into the urethra such as wax, alcohol, and baby oil (Hogan et al., 2011; Rinard et al., 2010).

Sounding is associated with health risks including urinary tract infections (Breyer & Shindel, 2012; Hogan et al., 2011), bleeding (Kwong & Larner, 2012), strictures (Amiroune, Bouchikhi, & Adawi, 2014; Rahman, Elliott, & McAninch, 2004), and loss of foreign bodies (Chipde, Pradhan, Yadav, Kapoor, & Kapoor, 2012; Song et al., 2013). Sounding is also associated with psychiatric disturbance (Boyle, Martinez, Mennie, Rafiei, & Carrion, 2013; Rahman et al., 2004; Song et al., 2013), substance abuse (Breyer & Shindel, 2012; Rahman et al., 2004), and high risk sexual behavior (Breyer & Shindel, 2012).

Theoretical Framing

Consistent with the above cited literature, most academic considerations of sounding have been framed in terms of a medical model that clearly pathologizes the practice (Rinard et al., 2010; see Thomas et al., 2015). Yet, in recent years, there have been hints of scholarship (e.g., Ando, Rowen, & Shindel, 2014; Williams & Storm, 2012) that suggest that sounding may be better understood in terms of sexual diversity and/or as a type of leisure activity. Along these lines, an alternative theoretical frame from which to consider sounding is to investigate the practice as a type of BDSM activity (Turley,

2016), particularly from the perspective of understanding BDSM as leisure (Newmahr, 2010; Williams, Prior, Alvarado, Thomas, & Christensen, 2016).

This article presents a novel case that illustrates this framing. Although not generalizable, this case provides the opportunity to explore one of the many ways that sounding is actually conducted, as well as the opportunity to consider how a BDSM as leisure perspective can join with a medical model to provide a more holistic understanding of sounding and the associated contexts in which it is practiced.

Case Report

In this case report, the authors, both behavioral scientists, report on a novel type of sounding practice that they observed during a public event at a BDSM club located in a major metropolitan area of the western United States. At this particular event, a middle-aged man demonstrated his practice of applying habanero pepper juice during the sounding process.

The authors encountered this case while observing more common BDSM activities (such as flogging and bondage) at a public event. During this event, a middle-aged man along with a younger woman performed a medical role playing scene (see Steele, 2001), respectively acting as patient and nurse. As part of this role play, the man wore a standard patient gown while the woman wore an embellished nurse's costume. The scene began with the woman pretending to conduct an anatomical inspection of the man before then taking his oral temperature with what appeared to be a standard thermometer.

Following this, the woman instructed the man to remove his gown and to lie down on an examination table. As he did, the woman put on a pair of latex gloves, and at about this same time, the man's penis became noticeably erect. The woman then brought out what appeared to be a water-based lubricant as well as a small case of Hegar urethral sounds. The man watched as the woman lubricated and prepared to insert one of the sounds. Taking her time, the woman slowly inserted the sound into the man's erect penis to a depth of approximately 3 to 4 inches. At this point, the man appeared to be enjoying himself, and he verbally thanked the woman for inserting the sound.

After a few minutes, the role play continued with the woman removing the sound and instructing the man that he needed "a new medication" that must be "carefully administered" into his urethra. She then brought out a clear plastic bag that contained what we were told was a medium sized, red-orange habanero pepper. Research indicates that this type of pepper is typically estimated to have a heat factor of approximately 250,000 Scoville Heat Units based on Scoville Organoleptic Testing (Bosland & Walker, 2010). The woman carefully pulled apart this pepper and exposed its seeds and juice. She then removed her gloves and put on a new pair in an apparent effort to prevent cross-contamination.

Following this, the woman took the sound that she had previously used and carefully rubbed the tip of the sound into the exposed seeds and juice. The woman then checked to confirm that there was only juice and not seeds or other debris at the tip of the sound. At this point, the woman added more lubricant to the sound and then slowly reinserted it in to the man's still erect penis. While the man was tense at first, he quickly relaxed as the sound was again inserted to a depth of approximately 3 to 4 inches.

Based on the man's reaction, several seconds then elapsed before the effect of the habanero pepper juice was fully felt. While he initially remained calm, his breathing rate soon increased, and at about this same time, the man began to talk rapidly, making comments that suggested he was very much enjoying the activity. The woman seemed quite pleased with this, and after several minutes of waiting, she removed the sound. For some time thereafter, the man continued to breathe rapidly and his body occasionally convulsed. Throughout this time, the woman spoke to him in a quiet and comforting manner.

In total, the intensity of the man's experience seemed to last for approximately 45 minutes. When the sensation had finally subsided, the man's physiological functioning appeared to return to normal, and the encounter ended. The man thanked the woman and stated that he enjoyed the experience. Other individuals who had also been watching the scene noted that although this form of BDSM activity is uncommon, this particular couple enjoys this form of role play from time to time.

At a later point following this event, the authors note that they were able to track down the man and woman whose activities are described above, and the authors were able to secure their consent for the purposes of this case report.

Discussion

When considered from the perspective of a medical model, sounding is frequently presented as absurd (Boyle et al., 2013), pathological (Rahman et al., 2004), and psychotic (Song et al., 2013). Yet as considered from a BDSM as leisure perspective, this case illustrates how sounding can be an enjoyable expression of sexual diversity that is personally meaningful and, at least in this particular case, a practice that can be supported and affirmed by a community context. Furthermore, as is consistent with the academic literature on BDSM (Turley & Butt, 2015), this case demonstrates that the physiological intensity sought and observed in this scenario need not be understood as evidence of psychiatric disturbance, but rather may be better understood as a novel expression of what is a relatively common interest in sensation seeking (Bancroft et al., 2004; Zuckerman, 2007).

Alongside these implications for theoretical framing, this case suggests potential guidance for health care providers and other clinicians. Perhaps most importantly, the particularities of this case should alert health care providers to the fact that sounding is

practiced in a variety of ways and that such variety may be clinically relevant, especially for men seeking medical treatment. Accordingly, health care providers should strive to obtain thorough and detailed information regarding how specific variations in sounding practices may potentially be connected to specific presenting concerns (Hogan et al., 2011; Rahman et al., 2004; Rinard et al., 2010). For example, as shown in this case, it may be valuable to not only inquire about the size and type of object(s) used as part of the sounding process, but also as to any liquids or other substances that may have been used to increase physiological intensity or to enhance erotic stimulation. Although there is only limited academic speculation regarding how liquids or other substances may affect the medical risks associated with sounding—and no published information whatsoever regarding the application of habanero pepper juice—it certainly seems reasonable to warn health care providers that some varieties of sounding practices may potentially incur greater medical risks.

For other clinicians, such as psychologists and therapists, this case also suggests the importance of avoiding assumptions or stereotypes about what sounding is and how and why it is conducted. Instead, clinicians should ask their clients to provide detailed descriptions of their sounding practices and then trust their clients to establish the personal meaning and significance of these practices. Rather than relying on a medical model that pathologizes sounding, clinicians should be open to understanding sounding as an expression of sexual diversity and/or leisure activity.

Finally, the novelty of this case demonstrates the importance of ongoing research in order to not only broaden clinical knowledge of the various ways that sounding is actually conducted but also to expand more generally a sexological understanding of this understudied practice.

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Sexuality Research within Neuroimaging: A Review of Progress toward Greater Gender Equality and Sex Positivity

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Scientific fascination with the brain's role in behavior has an extensive history. In 1937, Penfield and Boldrey used electrical probes to develop maps for sensory and motor cortices of the human male brain. These maps, commonly referred to as the cortical homunculus, are still used today - mostly unaltered. However, only male patients were used and thus, the maps only contain markers for male genitalia. This bias has continued into the present day with research focusing on healthy, typically heterosexual, males (Arnow et al., 2002; Ferretti et al., 2005; Holstege et al., 2003; Mouras et al., 2003; Safron et al., 2007) and predominantly overlooking research on female sexuality, particularly with a sex-positive framework. This gender bias has interfered with clinicians' knowledge of and ability to promote women's physical and mental sexual health. Fortunately, recent progress in neuroimaging research has resulted in greater gender equality within the field. These studies have resulted in important changes to newer versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

Early Neuroimaging Studies

A review of early neuroimaging literature on sexuality contains many studies conducted on healthy males. A plethora of ethical and legal concerns were believed to exist regarding the participation of women in clinical studies (Mastroianni et al., 1994). Historically, a lack of knowledge regarding female reproductive processes and anatomy resulted in numerous regulations concerning their participation in research studies. Concerns were expressed regarding women's ability to have children if they underwent clinical procedures or even exercised vigorously (Beresini, 2013). While pregnant women are still considered a vulnerable population, science does not support the idea that women are incredibly fragile and that running two miles will harm the uterus. Recent studies do continue to exclude women for other reasons. For example, menstrual cycles greatly vary from woman to woman these hormonal differences can make results more difficult to interpret depending on the data (Moyer, 2010).

Arnow et al. (2002) examined sexual arousal in healthy heterosexual males. At that time, little research existed regarding the neural activation associated with sexual response. Although the researchers did not provide a reason for excluding females, they did mention that examining potential differences in brain activation between males and females would be a beneficial future direction for the research. Holstege et al. (2003) conducted a neuroimaging study that examined activation during healthy male ejaculation. Similar to Arnow et al. (2002)'s study, Mouras et al. (2003) examined the neural response of healthy heterosexual males to sexual stimuli.

In 2005, Ferretti et al. continued the male-focused research by examining sexual arousal in healthy heterosexual males, specifically neural activation during penile erection (as opposed to simple sexual arousal) and the timing of the activation. The authors mentioned that further studies are needed to better define neural activations associated with "human sexual behavior" (p. 9185) and pointed out that their findings hold important implications for clinical diagnosis, therapy, and treatment for sexual dysfunction, but failed to acknowledge that the implications only applied to healthy heterosexual males.

Safron et al. (2007) conducted a study to examine neural activations associated with sexual arousal in both heterosexual and homosexual males. The inclusion of homosexual males in this study increased the diversity of this field and the applicability of the study results.

The imaging studies conducted during this earlier period with females are far fewer than those including only males and focus on sexual dysfunction in some manner. This focus on sexual dysfunction promotes a more sex-negative message for the female results. Thus, our understanding of healthy sexual function in females has been severely limited.

However, in 2004, Basson conducted a neuroimaging study to advance the understanding of women's sexual function and dysfunction. This study provided some unexpected results including a poor correlation between women's subjective experience of arousal and activation in brain areas associated with the organization of reflexive genital vasocongestion. These results have since been added to newer models of sexual response for females and resulted in revisions of definitions of women's sexual dysfunction (Basson, 2004). For example, Basson improved an older model of sexual response by creating a new model of a "blended sexual response cycle reflecting spontaneous desire augmenting a cycle initiated for reasons other than desire" (p. 716).

In 2009, Arnow et al. utilized functional magnetic resonance imaging (fMRI) to investigate hypoactive sexual desire disorder (HSDD) in females, comparing 16 females with HSDD to 20 females with no history of HSDD. They used subjective measures of sexual arousal, peripheral sexual response via vaginal photoplethysmograph, and fMRI across three time points. Researchers concluded that compared to those without HSDD, females with HSDD encode arousing stimuli and retrieve past erotic experiences differently and allocate significantly more attention to monitoring their responses. More recent research has also shown that females with HSDD exhibit different limbic and cortical activation associated with the acquisition, encoding, and memory retrieval of information (Woodward, 2013) and greater activation in areas associated with a "heightened attention to one's own physical state" (p. 1068).

Recent Neuroimaging Studies

Recent neuroimaging sex research studies are moving away from exclusively heteronormative male sexuality. In 2011, Komisaruk et al. utilized fMRI methodology to better understand the neural systems that underlie female sexual response. This study provided the first evidence that the genital sensory cortex mapped in men by Penfold and Boldrey in 1937 exists in women. Additionally, this study had a sex-positive approach, addressing sexual response in healthy women and examining a variety of behaviors including both imagining self-stimulation and actual self-stimulation of the vagina, clitoris, cervix, and nipples. The results showed that the genital sensory cortex was activated both by imagining and performing self-stimulation. It also demonstrated that stimulation of the nipples, typically not considered a genital area and not mapped as such by Penfield and Boldrey, resulted in genital sensory cortex activation.

Additional sex-positive studies have been conducted and have been presented at conferences or as part of a dissertation, but may not yet be formally published. This trend signals a continuation of a more sex-positive framework for the future of this field. For example, Wise (2014) conducted two studies as part of a dissertation, which helped elucidate the neural time-course of orgasm in healthy women (lead-up, during, and recovery periods). Wise showed neural orgasm response differences (lead-up) and similarities (during and recovery) between self-stimulation and partner-stimulation. Wise also clarified that although both imagined and actual self-stimulation are associated with genital sensory cortex activation, the imagined stimulation must be erotic for this effect to occur (e.g., imagining genital self-stimulation with a dildo will elicit activation but imagining stimulation with a speculum will not).

Similarly, Komisaruk et al. (2013) investigated how men's anatomy maps onto the sensory cortex in a more sex-positive and progressive manner, seeking to extend the original work of Penfield and Boldrey (1937) which only examined penile response. Komisaruk et al. (2013), investigated multiple regions including penile glans and shaft, scrotum, testicles, urethra, perineum, rectum, prostate, and nipples, and tested both mild and forceful self-stimulation. Their results showed that many of these areas activate the sensory cortex, although in different and distinguishable patterns, illustrating the diversity of sexual responses. Komisaruk et al. also demonstrate that men's responses during nipple self-stimulation were similar to those of women from the Komisaruk et al. (2011) study.

Finally, recent studies have provided us with a richer and broader understanding of sexuality. For example, Huynh, Willemsen, and Holstege (2013) have utilized neuroimaging (in this case positron emission tomography - PET) to better understand sexual pleasure (i.e., orgasms and ejaculation) in both men and women. They studied sexual pleasure in the context of other bodily changes and their evolutionarily important functions. They found that increased pituitary activation may indicate higher plasma concentrations of oxytocin and prolactin, which enhance sperm and egg transport and are involved in ovulation and vaginal and uterine movements.

Clinical Implications and Future Directions

The studies mentioned above inform clinicians' understanding and treatment of patients' sexual dysfunctions as presented in the DSM. Currently, clinicians utilize the DSM-5, which is a recent transition from the DSM-IV-TR. In the DSM-IV-TR and previous editions, sexual-related disorders were categorized under "Sexual and Gender Identity Disorders" and had not been revised since the 1980s. Gender identity disorder was added to the DSM-III in 1980. In 1987, sexual disorders in the DSM-III-R were meaningfully altered based on the extant literature. The category then remained fairly unaltered until 2013.

With the publication of the DSM-5 in 2013, new diagnoses were added and other existing diagnoses were separated, modified, or removed, highlighting the importance of research findings and improvements in research design inclusivity. One major change classified sexual disorders separately from gender dysphoria, the new term for gender identity disorder. Importantly, gender-specific sexual dysfunctions were added to the DSM-5 while the gender-neutral sexual dysfunction diagnosis was removed. Some of the other new diagnoses that were added include; delayed ejaculation, other specified sexual dysfunction, and genito-pelvic pain/penetration disorder. An example of an existing disorder that was modified includes changing female sexual arousal disorder to female sexual interest/arousal disorder implying that "interest" and "arousal" represent two separate and important components.

These changes to the DSM represent steps in the right direction, but there exists room for improvement regarding sexual-related studies and associated clinical diagnoses. For example, factors such as desire and arousability have scarcely been studied in healthy females or females who suffer from sexual dysfunction. Further, several current clinical sexual disorders list criteria that are more fitting for the heterosexual population. These criteria could be amended to better include individuals who do not identify as cisgender and/or heterosexual.

Although the history of sexuality neuroscience has not been particularly sex-positive, the future of this field is more promising as researchers focus on sexual response, rather than simply dysfunction, a diversity of participants, and a variety of sexual behaviors and pleasure responses. As this field continues, we anticipate the emergence of additional studies that help us to better understand and appreciate sexuality in all of its forms, which will contribute to more positive views of sexuality in and out of clinical contexts.

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It's Only a Matter of Time: Insights for Helping Professionals Working with Non-Monogamous Clients

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Introduction

Despite American cultural norms that continue to privilege monogamy, researchers have reported that there are high numbers of people who openly or secretly practice polyamory and various other forms of non-monogamy (Sheff, 2013; Weitzman, 2006). Furthermore, Frank and DeLamater (2009) observed that often "monogamy" is erroneously homogenized, even in academic and professional contexts. In contrast to common monolithic interpretations, Frank and DeLamater found that there are diverse ways that monogamy is negotiated and practiced among couples in committed, long-term relationships, thus simple dichotomizations (monogamous or non-monogamous) fail to reflect the rich diversity of relationship practices, beliefs, and experiences.

Polyamory, of course, is also complex and diverse. In a recent thorough review of the literature on polyamory, Klesse (2014) found that polyamory has been interpreted as an intimate practice, a relationship orientation or style, an identity, and a sexual orientation. Regarding the latter, Klesse warned that while framing polyamory within the trappings of essentialism may have initial appeal for some, such a rigid framing could serve to undermine the rights of polyamorous individuals rather than protecting them. Once again, academics and professionals must learn to grapple with navigating the nuances and complexities of individuals' diverse needs, practices, and preferences regarding intimacy and relationships.

Research on non-monogamy and polyamory is rapidly growing across the social sciences (e.g., Barker, 2005; Barker & Langdridge, 2010, 2011; Frank, 2013; Jenks, 2014; Klesse, 2014; Sheff, 2013; Sheff & Hammers, 2011), including a special issue on the topic in the journal *Sexualities* (Haritaworn, Lin, & Klesse, 2006). However, despite increased attention by scholars to the diversity and complexities of various forms of relationships, along with pointing out fallacies associated with oversimplifying and making assumptions based on traditional norms, the helping professions have been very slow to incorporate such scholarship.

When Helping Professionals Harm Clients

Several scholars have observed that people in non-monogamous relationships function just as well, psychologically, as those in more traditional relationship styles; and, while there are challenges to non-monogamy, there are also significant potential benefits (Barker & Langdridge, 2010; Sheff, 2013; Weitzman et al., 2009). However, many professionals continue to project, unknowingly, their social and cultural biases onto clients who prefer nontraditional relationship styles. Indeed, a study conducted by Knapp (1975) found that a third of marriage counselors in the sample believed that people in open

relationships had some form of psychopathology that was associated with their nontraditional relationship preferences.

More recently, Graham (2014) discussed a case where a bisexual, polyamorous woman sought psychiatric treatment for depressive disorder, yet her psychiatrist mistakenly attributed her mental health condition to her relationship preference. The client felt misunderstood and judged by her mental health provider, but began withdrawing from her poly community. Subsequently, she felt like her social support had deteriorated, and her depression worsened. After switching to different mental health treatment providers who were well-educated regarding sexual and relationship diversity, this client was able to establish a good working alliance with clinicians, was reconnected with her poly community, and her mental health condition was effectively treated. Unfortunately, training on alternative relationships remains virtually nonexistent in educational curricula for helping professionals, though this glaring need is becoming more widely recognized (Barker, 2011; Brandon, 2011; Graham, 2014; Weitzman et al, 2009; Williams & Prior, 2015).

Becoming More Open: Linear and Therapeutic Constructions of Time

Despite the need for clinicians to become more open and accepting of clients' diverse relationship styles and preferences, some helping professionals may have difficulty doing so (see Ribner, 2011; Williams, 2015). Of course, more training and becoming familiar with scholarship on alternative relationships can help substantially. It should also be remembered that effective communication and acting ethically (such as honesty, openness, negotiating boundaries, etc.) are key ingredients for all healthy relationships, regardless of their particular structures (Easton & Hardy, 2009; Weitzman et al., 2009).

In addition, an interesting insight that is often overlooked, yet one that may be very helpful to those who are struggling to become more open and accepting of non-monogamous relationships, is to remember that concepts and meanings of time are culturally constructed. This is important because many of the critiques and perceived challenges of non-monogamy can be addressed by thinking through the distinctions between commitments of time and commitments to multiple partners. When many people think about polyamory, the focus is on number of partners. However, the concept of time, which is just as relevant, is frequently overlooked. Common traditional relationships tend to be serially monogamous; that is, many Americans have had multiple committed relationships (including marriages), just not necessarily at the same time. A serially monogamous individual may have three partners, consecutively, over a span of several years; whereas, a polyamorous relationship may include the same number of partners simultaneously over that same length of time. Obviously, a major difference between the two is associated with time and not the number of partners.

Godbey (2016) recently reported that "Every living thing on earth has its own sense of time as part of its genetic endowment" (p. 253). In summarizing scholarship on time, Godbey emphasized that in ancient and primitive societies, time "was a circle within which humans lived" (p. 253), and it was associated with natural environmental events, such as the passing of seasons, orbits of the sun and moon, and the ebb and flow of tides. Furthermore, diverse cultures understand time differently, and thus have different relationships with it.

Godbey (2016) refers to the work of philosopher J. T. Fraser, an expert on the study of time, in noting that as societies modernized, time became linear, and also a finite commodity. As science and technology rapidly increased, then "time became the ultimate organizing mechanism of the modern world—the ultimate scarce commodity (Godbey, 2016, p. 254).

Many therapists commonly assume, consistent within cultures of industrialized societies, that time is linear (proceeding from past, to present, to future), yet simultaneously realize that, in therapeutic contexts, linear segments of past and present are both quite messily intermingled as present. When the latter therapeutic interpretation of time predominates, any real difference between serial monogamy and polyamory disappears. The point of this discussion, of course, is to show that although non-monogamy may seem unusual or strange to some, its perceived strangeness lies in specific cultural constructions of time.

In contemporary practice, more fully recognizing the implications of time is important. While one of the common critiques of polyamory is that individuals in such relationships must necessarily share their limited time and energy across multiple partners, it is essential to recognize that polyamory may actually be more able to provide the flexibility that can allow and promote long-term relationships. Indeed, as monogamy focuses one's time on just one partner, such a relationship is typically assessed in terms of the immediate quality and benefit of that relationship—and if the relationship is judged as inadequate in some manner, there is a strong incentive to end the relationship and move on. In contrast, polyamory trades the singular focus on one partner for a more diffuse experience of relational time that can better allow for the ways that relationships with specific partners may change and develop, as well as ebb and flow. In doing so, polyamory provides a distinct but just as meaningful experience of relational time—an experience where time and energy spent with a given partner can accumulate over the long haul and thus be less subject to the immediate constraints of one's time and energy and the judgments which may proceed from the realization of those constraints. Of course, the style of relationship that a client chooses to participate in, whether monogamous or non-monogamous, should be a product of that client's ethical right to self-determination, which helping professionals should ultimately respect.

Conclusion

While there has been increased attention by scholars to non-monogamous relationships in contemporary western societies, such research has not been integrated into educational and training programs across the helping professions. Subsequently, clients who prefer alternative relationships and lifestyles are at risk for incurring harm by well-meaning helping professionals. Professionals should recognize that there are diverse ways that healthy functioning relationships may be structured, and that both monogamous and non-monogamous relationships can be designed and negotiated differently by those within them.

While there are excellent resources available to help professionals understand and work effectively with non-monogamous clients, including work cited herein[1], it may be helpful for clinicians to recognize that common interpretations of both "healthy

relationships" and "time" have strong roots in cultural constructions. Thus, professionals who may struggle to become more open to nontraditional relationships are encouraged to assess critically both of the above concepts. Regarding time, helping professionals may explore different ways that "past" and "present" may be constituted and interrelated. Indeed, there exists considerable complexity and diversity in all forms of relationships, the natural and social environments that we inhabit, and the temporal dimension of human life.

Note: [1] Two particularly valuable resources cited here are: Weitzman and colleagues (2009) and Easton and Hardy (2009).

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