HECOL 211
HUMAN SEXUALITY

LECTURE MANUAL

Compiled by: Shaniff Esmail

Department of Human Ecology
University of Alberta

HECOL 211: HUMAN SEXUALITY

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1. SEXUALITY: INTRODUCTION

ASSUMPTIONS

1. Sexual feelings are natural; sexual expression is a learned behaviour
2. Sex is part of sexuality
3. Sexuality is a health issue
4. Sexual health involves both competence and relationships
5. A person may need more than his/her personal experiences or private opinions to find the best answers to sexual concerns
6. An individual's ability to solve sexual concerns is frequently handicapped by personal experiences, biases, prejudices, and over-reactions to sexual information
7. We are not responsible for having feelings, but we are responsible for what we do with them
8. Each person has a right to her/his own beliefs
9. Sexuality is an integral part of one's total personality and is expressed in all that he/she does

(Adapted from University of Minnesota Medical School SAR Program)

DEFINITIONS

For the purposes of our discussions the following definitions will be used:

SEX:
Genetic and physical characteristics that differentiate male and female

GENDER:
Psychosocial characteristics that differentiate masculinity and femininity.

SEXUALITY:

The physical, psychological, social, cultural and spiritual aspects of an individual that make up his or her unique sexual being.

Dailey (1984) described five aspects of sexuality: sensuality, intimacy, sexual identity, reproduction, and sexualization.

SENSUALITY

The need and ability to be aware of and accepting of our own body:

- knowledge of anatomy and physiology
- understanding sexual response
- body image
- satisfaction of skin hunger
- attraction template - kick starts our arousal
- fantasy - most sexuality is in the mind

INTIMACY

The need and ability to experience emotional closeness to another human being - reciprocal:

- caring
- sharing
- risk taking
- vulnerability
- self disclosure

Sexual intimacy: ability to give feedback & be heard in sexual relationships

SEXUAL IDENTITY

The continual process of discovering who we are in terms of our sexuality: one part of our total identity. It includes:

- gender roles
- orientation
- self esteem
- confidence level
- relationship - family and friends
- roles as child & adult
- perception of self as male/female

REPRODUCTION

Our values, attitudes and behaviours related to reproduction

- reproductive bias re values and attitudes
- renewal of life - morality issues
- anatomy and physiology
- lifestyles
- contraception and fertility issues
- STD including AIDS

SEXUALIZATION

Use of our sexuality to influence, control or manipulate others:

- style of dress - appearance - body language
- advertising

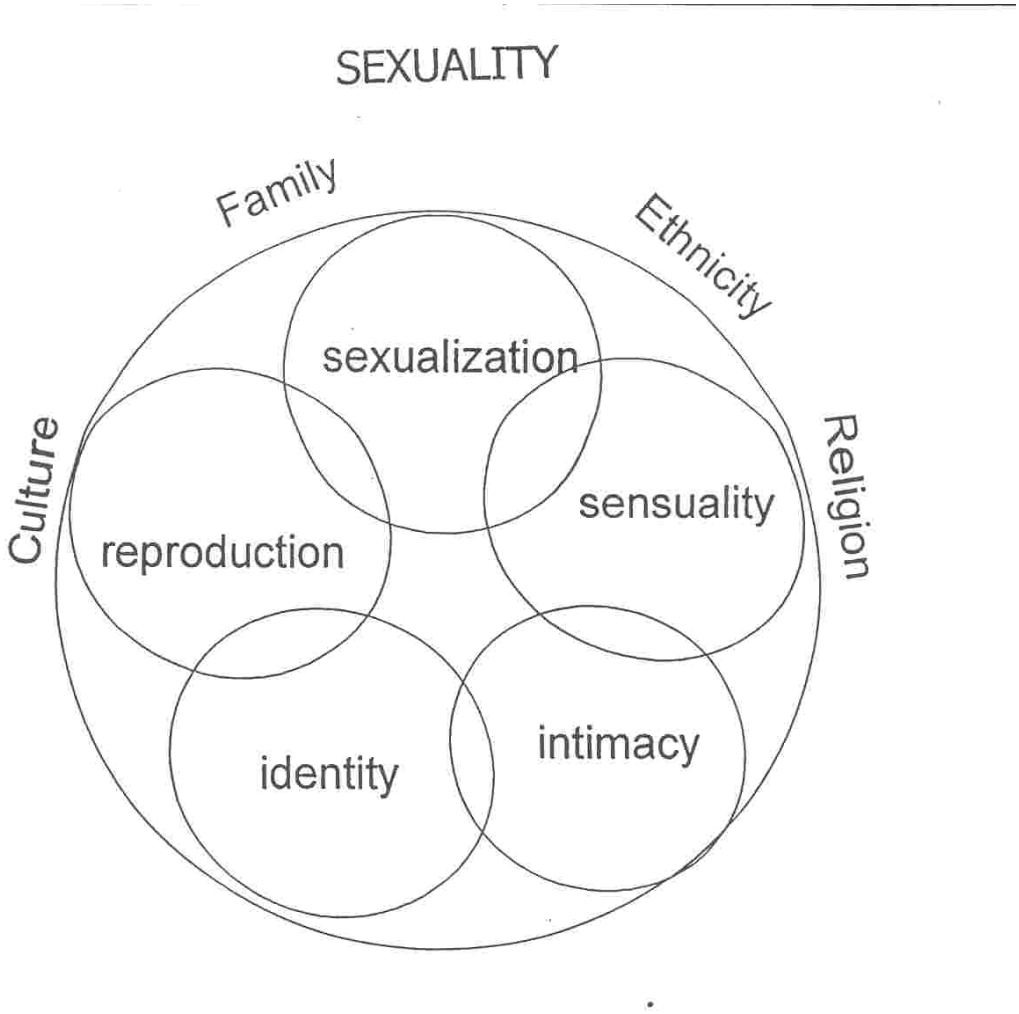
Sexualization, continued ...

- movies/talk shows etc - overwhelming!
- harassment and sexual assault
- paraphilias - voyeurism, exhibitionism, obscene calls, etc.

THE DEGREE OF OVERLAP OF THE ABOVE FIVE FACTORS REPRESENTS THE DEGREE OF INTEGRATION OF THE INDIVIDUAL'S "SEXUAL BEINGNESS"

ALL THE ABOVE EXIST WITHIN AN ENVIRONMENT OF SOCIO-CULTURAL INFLUENCES - FAMILY, ETHNIC BACKGROUND, RELIGION

(Dailey 1984)



VALUES

VALUES:

The qualities in life that are deemed important or unimportant, right or wrong, desirable or undesirable.

MORAL VALUES:

Relate to our conduct with and treatment of other people, more than just right or wrong. Looks at the whole picture.

SEXUAL MORAL VALUES:

Relate to the rightness and wrongness of sexual conduct and when and how sexuality should be expressed.

As with other behaviours, each of us must decide which sexual conduct, feelings and actions are of the greatest worth to us personally.

SOURCES OF SEXUAL VALUES:

Our sexual values are learned in different ways, at different rates, and with different results.

We acquire our sexual values from our social environment (parents, friends, media, religion etc..)

Discussing Sexuality - Value Clarification Exercise

For this exercise you will work with another participant; please take turns to respond to each statement below.

1. As a child, I remember sex being talked about when .....
2. The first question I remember asking about sex was .....
3. In high school, my teachers discussed sex when .....
4. When my mother told me about sex I .....
5. What my father told me about sex was .....
6. My adolescent sexual experimentation took place in .....
7. My friends explained that sex was .....
8. My religion taught me that sex was .....
9. My early sexual experiences were with .....
10. My best discussions about sexuality happen when .....
11. I am most comfortable with the topic of sex when .....
12. I am most uncomfortable with the topic of sex when .....
13. When a child asks me now about sexuality I .....
14. After completing these statements I realize .....

(Adapted from Lion, E.M. (Ed.). (1982) Human Sexuality in Nursing Process, Toronto: Wiley & Sons. p. 5.)

2. PERSPECTIVES ON HUMAN SEXUALITY

The complexity of human sexuality makes it necessary to study it from many perspectives ... historical, biological, cross-species, cross-cultural, psychological, and sociocultural

1. HISTORICAL

Moral and ethical behaviours tied to the supernatural and religion;

PREHISTORIC ...Stone Age ... evidence that female body was revered for reproductive ability ... Agrarian Society ... aware of male role in reproduction, phallic worship began .. penis a symbol of fertility and power ... (9000 BC)

ANCIENT HEBREWS ... positive about marital reproductive sex ... disapproved homosexuality ... women property of husbands ...

ANCIENT GREEKS ... 500 - 300 BC ... valued family life ... male sexual roles varied, eg. pederasty ... admired male bodies and slim, sensual women ... prostitution flourished ... viewed men and women as bisexual ... women under male dominance...

ANCIENT ROMANS ... sexual excesses in upper classes ... our terminology from Latin roots ... male-male threat to family which was strength of society ... women more involved socially but still property of husbands ...

EARLY CHRISTIANS ... St. Paul (1st C.), Augustine (4th C.) ... sex distraction from God ... marital sex accepted, but not passion... behaviours non-procreative disapproved ...

EASTERN RELIGIONS ...
Islam ... valued family and pleasure in marital sex ... punished pre-marital sex ... double social and sexual standards for men and women

China ... sexuality linked to spirituality ... first manual art of lovemaking ... wasteful to Aspill seed≅ ... women kept to domestic role...

India ... ancient Hindus erotica ++ ... Kama Sutra code of sexual conduct (3rd-5th C.) ... sex religious duty ... more restrictive after 1000 AD. ...

MIDDLE AGES ... western history 1st - 15th C.
R.C. church strong influence ... Crusaders influenced change from women as sinful (Eve) to revered (Virgin Mary) ... upper classes courtly love, chivalry and romance ...

PROTESTANT REFORMATION: 16TH C.
Luther and Calvin split from R.C. church ... priest could marry ... pleasurable marital sex ... non-marital sex disapproved ... women mostly restricted to home until 19th C...

VICTORIAN PERIOD ... sexually repressive on the surface ... furniture legs covered ... but behaviours varied ... prostitution flourished but Aproper≅ women believed not interested – "sexual anaesthesia" ... mens' "vital fluids" limited in amount ... Graham crackers ...

EARLY 20th C ... until 1950s believed women did not desire sex ... double standard ... sexual scenes in media limited ...

SEXUAL REVOLUTION mid 60s - mid 70s ... science, politics, social (fashion, music, media) and economics all part of change

LATE 20th C. REVERSE PENDULUM SWING to more conservative attitudes ... open discussion about sexuality, more sexually active teens, AIDS, access to birth control, liberation of women, sex education ..... where to from here?

2. BIOLOGICAL

Anatomical structures and physiological function of the sexual and reproductive organs ... reproductive technology ... what is possible ... interactive with psychosocial aspects regarding what is acceptable or pleasurable ...

3. CROSS-SPECIES

Some similarities in human and non-human sexual behaviours ... same sex interaction, oral-genital contact, etc ... higher mammals less instinct driven ... dissention re. role of genes and hormones in male/female sexual/social behaviours ...

4. CROSS-CULTURAL

Learned behaviour unique to particular culture ... kissing, higher rate of intercourse for young adults, incest taboo and some societal controls almost universal ... greater variance in attitudes re. same sex, masturbation, monogamy vs polygamy etc.

5. PSYCHOLOGICAL

Psychoanalytic Theory - Freud ... sexual instinct (id) vs. reason (ego) ... defense mechanisms ... developmental stages ... psychoanalysis

Learning Theory - Behaviourists Watson and Skinner ... reward and punishment determine behaviour ... Social-Learning Theory includes effects of cognitive activity - anticipating, planning, etc. - as well as learning by observing others (modeling) ...

6. SOCIOCULTURAL

Study of sexual behaviours within a given society ... differences in sub groups by age, gender, religion, ethnicity, education, etc.

3. SEXUALITY: RESEARCH

FOUNDERS OF SEXUAL RESEARCH

Havelock Ellis (1859-1939) English physician, Studies in the Psychology of Sex ... problems as psychological ... female sexual desires normal and homosexuality acceptable and inborn ...

Richard von Krafft-Ebbing (1840 - 1902) German psychiatrist ... 200 case histories of sexual deviancies ... Psychopathia Sexualis ... viewed deviances as mental illnesses that should be treated.

Sigmund Freud (1856 - 1939) Austrian Physician theory of personality based on sex drive as our principle motivating force ...

Alfred Kinsey (1894 - 1956) U.S. zoologist first comprehensive survey 12,000 subjects interviewed ... Sexual Behaviour in Human Male 1948 and ... Human Female 1953 ...

William Masters & Virginia Johnson 1960s lab. observations approx. 700 subjects ... Human Sexual Response 1966 ... similar gay study ... Homosexuality in Perspective 1979. Four stage sexual response described.

"MODERN" NORTH AMERICAN SEX RESEARCH SURVEYS

Most reliable since Kinsey ...
Edward Laumann et. al. National Health & Social Life Survey USA 1990s ... 3,432 subjects interviewed ... included variety of ethnic groups but had limitations re. Asian, Native & Jewish ...

Others include ...

Morton Hunt, Playboy Foundation Survey 1970s - 2,000 plus random from phone books 24 cities

Shere Hite's Report 1976 on females (3000) & 1981 on males (7000) ... questionnaires mailed out to specific groups ... return rate 3% & 6%.

Kinsey Institute Reports on Gays, 1978 & 1981 over 900 openly gay subjects from San. Fran.

Samuel & Cynthia Janus report 1993, written questionnaires 2,500 voluntary subjects

Multiple magazine surveys completed by readers

University of Alberta - Student Sexual Behaviour Survey 1995-1997

Prof. M. Poirier Prof. B. Munro, S. Barnsley, Grad. Asst. F. Molenkamp, Grad. Asst.

Part of a national survey entitled: Sexuality Behaviour of Canadian Youth
Purpose: to determine students' sexual attitudes and their knowledge about STD's and HIV/AIDS

Respondents: 2,300 students from selected U of A classes were invited to participate -- 48% completed the survey

Survey: included 360 items and took 1 hr to complete
Main complaints of respondents:
- survey much too long (70%) [it was!]
- too many similar questions (40%)
- questions too personal (20%)
- difficult to complete when others around (10%)

Overall students were happy to participate.

Note: these are selected results only; some given for total respondents, others by gender.
71.2% female & 28.8% male respondents

I am a happy person ... 55.6% agreed

I often feel depressed ... 44.9% disagreed

How much alcohol do you usually drink at one time?
none: 5.6% 1-2: 29.1% 3-4: 30.1% 5 or more: 23.6%

Have you been really drunk?
never: 12.5% once: 8.1% 2-3 times: 17.9%
4-10 times: 21% more than 10 times: 29.2%

How often do you use alcohol?	**Female**	**Male**
never	6.6%	6.8%
special occasions	25.6	15.4
about once a month	16.6	14.8
2-3 times a month	22.7	19
once a week	14	20.3
2-3 times a week	5.7	12.2

every day	0.1	1.3
I believe:	**Female**	**Male**
sex is sacred - marriage	14.5%	14.1%
sex is right - committed	30.1	21.5
sex is right - love	24.6	18.3
sex is right - feels right	28.4	39.9
sex is right any time	1.6	5.1

I practise:	**Female**	**Male**
sex is sacred - marriage	15.1%	14.5%
sex is right - committed	31.6	19.9
sex is right - love	24.9	17
sex is right - feels right	25.7	41.2
sex is right any time	1.3	5.8

Age of first mutual sexual experience:

	Female	**Male**
23+	1.8%	1.6%
20-22	4.6	6.4
18-20	20.5	17.4
16-18	31	34.7
14-16	19.8	15.1
before 14	2	5.5
no sex	19.2	18.6

How often have you had vaginal sex?

	Female	**Male**
never	22.2%	24.1%
once	3.5	2.6
few times	10.3	15.1
often	55.8	48.6

How often have you had anal sex?

	Female	**Male**
never	70.9%	70.4%
once	10.2	7.7
few times	10	10.3
often	0.9	2.3

How often have you had oral sex?

never	19.3
once	5.3
few times	25
often	41.9

How often have you had group sex?

never	86.8
once	3.2
few times	1.1
often	0.6

How often have you had sex with violence?

never	86.3
once	2.7
few times	1.9
often	0.7

With how many people have you had ...

	anal sex	**vaginal sex**		**oral**	
		Female	**Male**	**Female**	**Male**
9+	0%	0.4%	12.2%	5.5%	10.9%
8	0	2.2	0.6	2	1.9
7	0.4	2.6	3.5	2	3.2
6	0.2	3.4	4.2	3.5	3.5
5	0.1	4.6	4.2	3.5	3.5
4	0.1	4.7	4.2	6.3	5.1
3	0.7	7.7	6.1	12.1	10.6
2	3.3	9.1	10.6	13	10.3
1	16.5	24.1	20.3	25.2	22.2
0	70.4	22.7	23.8	18.9	17.7

During sexual intercourse, how often was a condom used?

	Female	**Male**
always	10.6%	11.3%
most of the time	22.4	21.9
sometimes	16.9	16.4
occasionally	15.8	11.6
never used a condom	5.0	6.8
never had intercourse	20.7	20.9

4. ANATOMY AND PHYSIOLOGY

EMBRYONIC DEVELOPMENT

CHROMOSOMES
23 from males, 23 from female - form 23 pairs.

Ovum has X chromosomes
sperm has X or Y chromosomes

XX - female embryo
XY - male embryo

5-6 wks primitive gonads, ducts, external genital
7 wks begins to differentiate to male/female
Basic blueprint female - some become male

HORMONES:
Androgens, especially testosterone, produced in testes influence male development
Lack of androgens leads to female development
(Female hormones important in puberty)

Testes & Ovaries begin high in abdomen - ovaries descend to pelvis, testes to scrotal sac. Undescended testes may correct in early life - if not, moved surgically. (Risk of cancer & sterility)

A variety of developmental anomalies. Early decisions re: gender assignment vital.

FEMALE SEXUAL ANATOMY AND PHYSIOLOGY

Mons Veneris

- fatty tissue that covers the joint of the pubic bones in front of the body, below the abdomen and above the clitoris.

Function: Mons cushions a woman=s body during intercourse.

Labia Majora

- Large folds of skin that run downward from the mons along the sides of the vulva.

Function: amply supplied with nerve endings that respond to stimulation. They also shield the inner portions of the female genitals.

Labia Minora

- 2 hairless, light coloured membranes located between the major lips. They surround the urethral and vaginal opening. At the top they join at the prepuce (hood) of the clitoris.

Function: Rich in blood vessels and nerve endings, the labia minora are highly sensitive to sexual stimulation. When stimulated they darken and swell.

Clitoris

- a female sex organ consisting of a shaft and glans located above the urethra opening.

Function: unique in that it serves no known purpose other than sexual pleasure.

Prepuce of clitoris

- **"**hood" cover the clitoral shaft

Urethral opening

- opening through which urine passes from the female's body

Vaginal opening

- also called introitus. **Hymen** is a fold of tissue across the vaginal opening is usually present at birth and remains at least partially intact until the women engages in intercourse.

Pubo coccygeus muscle

- the muscles that encircle the entrance to the vagina.

  Kegel exercises

The Vagina

- extends back and upward from the vaginal opening. It is usually 3 to 5 inches long at rest. Menstrual flow and babies pass from the uterus to the outer world through the vagina. During coitus, the penis is contained within the vagina.

The Cervix

- is the lower end of the uterus. Its walls, like those of the vagina, product secretions that contribute to the chemical balance of the vagina. The opening in the middle of the cervix, or "os" is normally about the width of a straw, although it expands to permit passage of a baby from the uterus to the vagina during childbirth.

The Uterus

- or womb is the organ in which a fertilized ovum implants and develops until birth. The uterus usually slants forward (is antroverted), although about 10% of women have uteruses that tip backward.

    - fundus

    - body

    - cervix,

Endometrium, the innermost layer, is richly supplied with blood vessels and glands. Endometrial tissue is discharged through the cervix and vagina at menstruation.

Endometriosis endometrial tissue may grow in the abdominal cavity or elsewhere in the reproductive system. Most common symptom is menstrual pain, however can lead to infertility if left untreated.

Myometrium is the well muscled second layer of the uterus. It endows the uterus with flexibility and strength, and creates the powerful contractions that propel a fetus outward during labour.

Perimetrium is the fibrous third or outermost layer, provides an external cover.
The Fallopian Tubes - the tube or duct that connects the ovary to the uterus. Serves to convey the ovum from the ovary to the uterus and the sperm from the uterus toward the ovary. The part of each tube nearest the uterus is the

- isthmus

- ampulla

- infundibulum -> fimbriae

The Ovaries - are almond-shaped organs that are each about 1.5 inches long. The ovaries produce ova (egg cells) and the female sex hormones **estrogen** and **progesterone.**

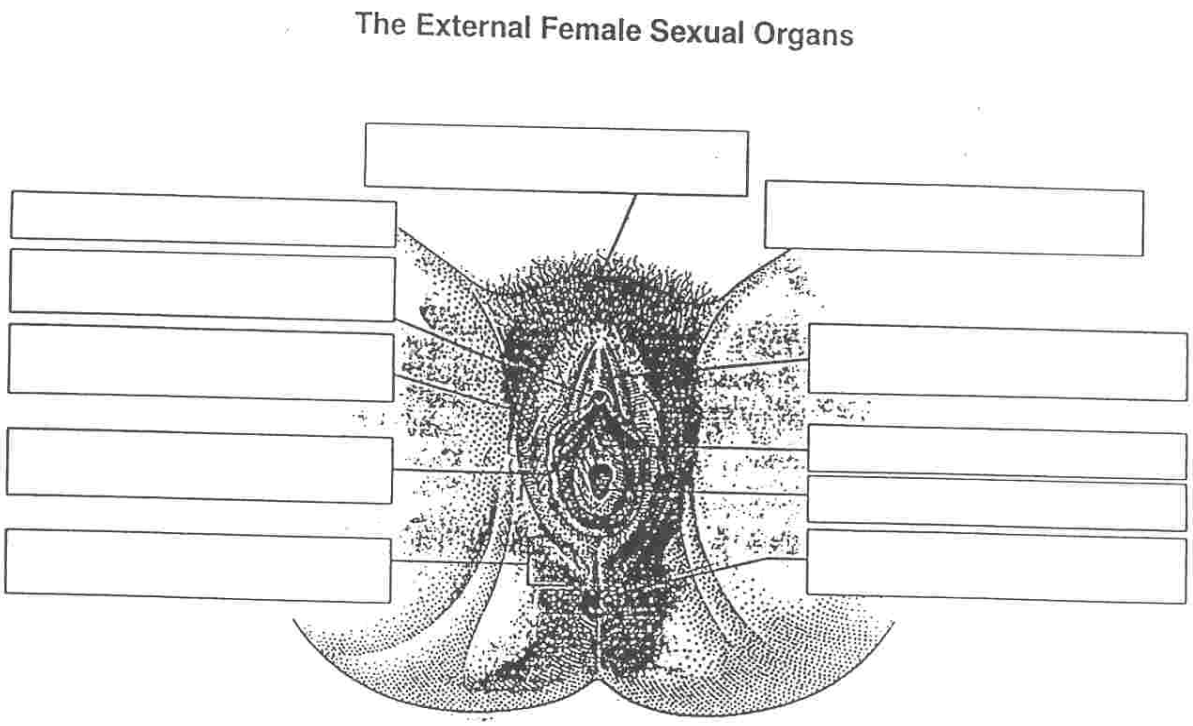
Hysterectomy

Surgical removal of the uterus. **A complete hysterectomy** involves the surgical removal of the ovaries, fallopian tubes, cervix, and uterus. It is usually performed to reduce the risk of cancer spreading throughout the reproductive system.

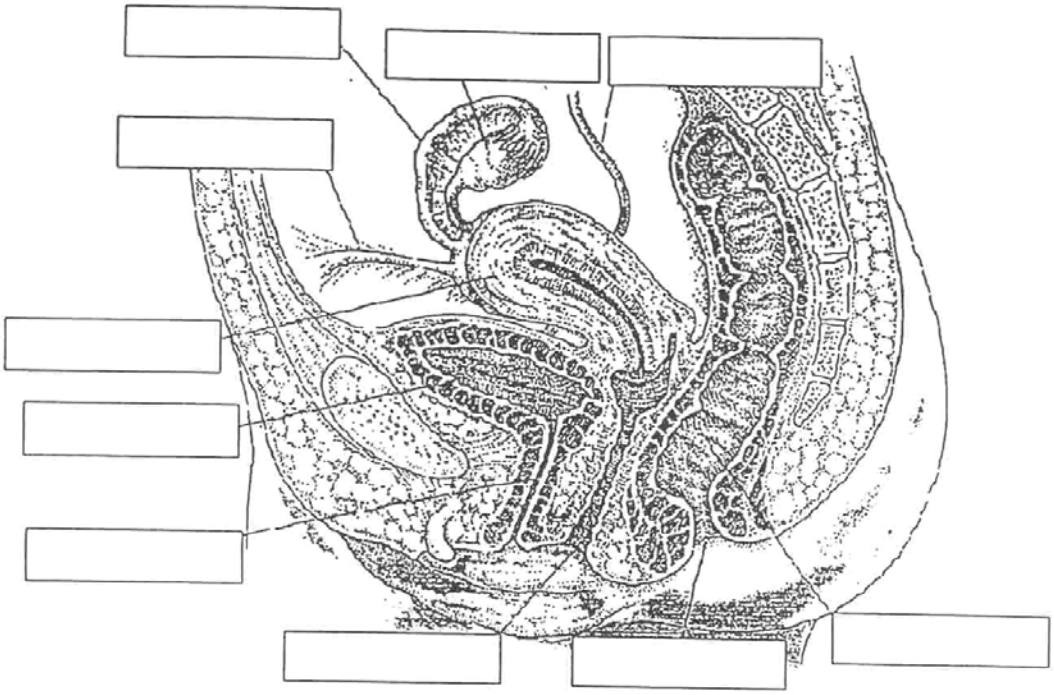
The Breasts

Each breast contains 15 to 20 clusters of milk-producing **mammary glands**. Each gland opens at the nipple through its own duct.

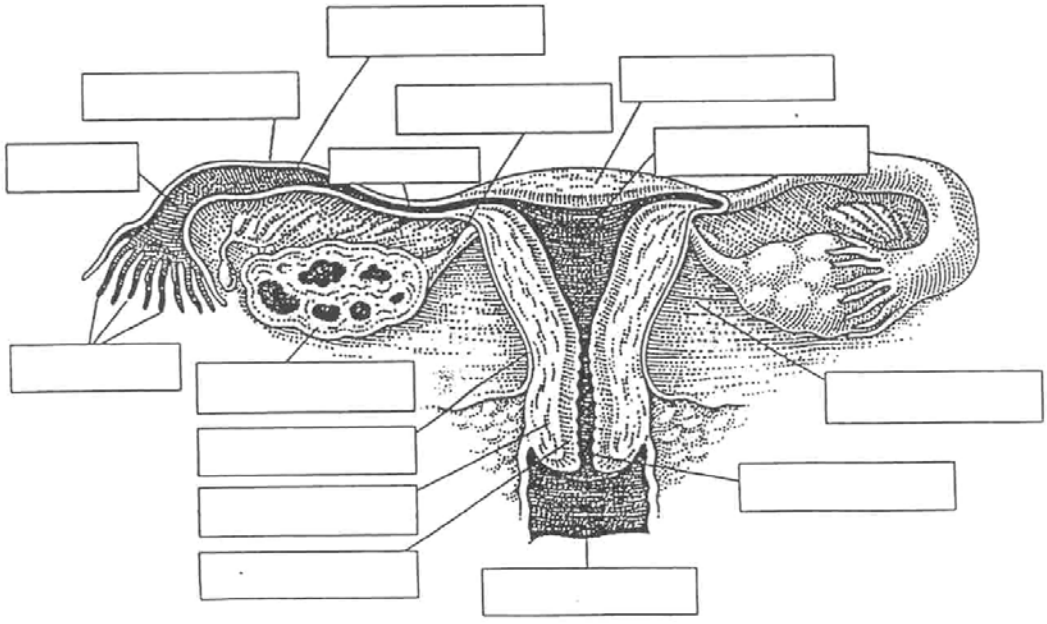
The nipple, which lies in the centre of the **areola**, contains smooth muscle fibres that make the nipple become erect when they contract. The areola, or area surrounding the nipple, darkens during pregnancy and remains darker after delivery. Oil-producing glands in the areola help lubricate the nipples during breast-feeding.



The Female Reproductive System



Internal Female Reproductive Organs



Rathus, Nevid & Fichner-Rathus. (1997)
Human Sexuality in a World of Deversity. Study Guide (3rd Ed.)

MALE SEXUAL ANATOMY AND PHYSIOLOGY

The Penis

The male organ of sexual intercourse. It contains the opening through which semen and urine pass.

Corpus cavernosum

Cylinders of spongy tissue in the penis that become congested with blood and stiffen during sexual arousal.

Corpus spongiosum

The spongy body that runs along the bottom of the penis, contains the penile urethra, and enlarges at the tip of the penis to form the glans.

Corona

The ridge that separates the glans from the body of the penis. (From the Latin for "crown")

Frenulum

The sensitive strip of tissue that connects the underside of the penile glans to the shaft. (From the Latin *frenum*, meaning "bridle".)

The Scrotum

The **scrotum** is a pouch of loose skin that becomes covered lightly with hair at puberty. The scrotum consists of two compartments that hold the testes.

- spermatic cord
- vas deferens
- cremaster muscle
- dartos muscle

The Testes

The testes serve two functions analogous to those of the ovaries. They secrete sex hormones and produce mature **germ cells**. In the case of the testes, the germ cells are **sperm** and the sex hormones are **androgens**. The most important androgen is **testosterone**.

Testosterone

Testosterone is secreted by **interstitial cells**, which are also referred to as **Leydig's cells**.

- stimulates prenatal differentiation of male sex organs, sperm production, and development of **secondary sex characteristics**, such as the beard, deep voice, and growth of the muscle mass.

The Vas Deferens

Each epididymis empties into a vas deferens (also called *ductus deferens*). The vas is a thin cylindrical tube about 16 inches long that serves as a conduit for mature sperm.

Vasectomy

An operation in which the right and left vas deferens are severed - a convenient means of sterilization.

The Seminal Vesicles

The two **seminal vesicles** are small glands, each about 2 inches long. They lie behind the bladder and open into the **ejaculatory ducts**, where the fluids they secrete combine with sperm. The fluid produced by the seminal vesicles is rich in fructose, a form of sugar, which nourishes sperm and helps them become active, or motile.

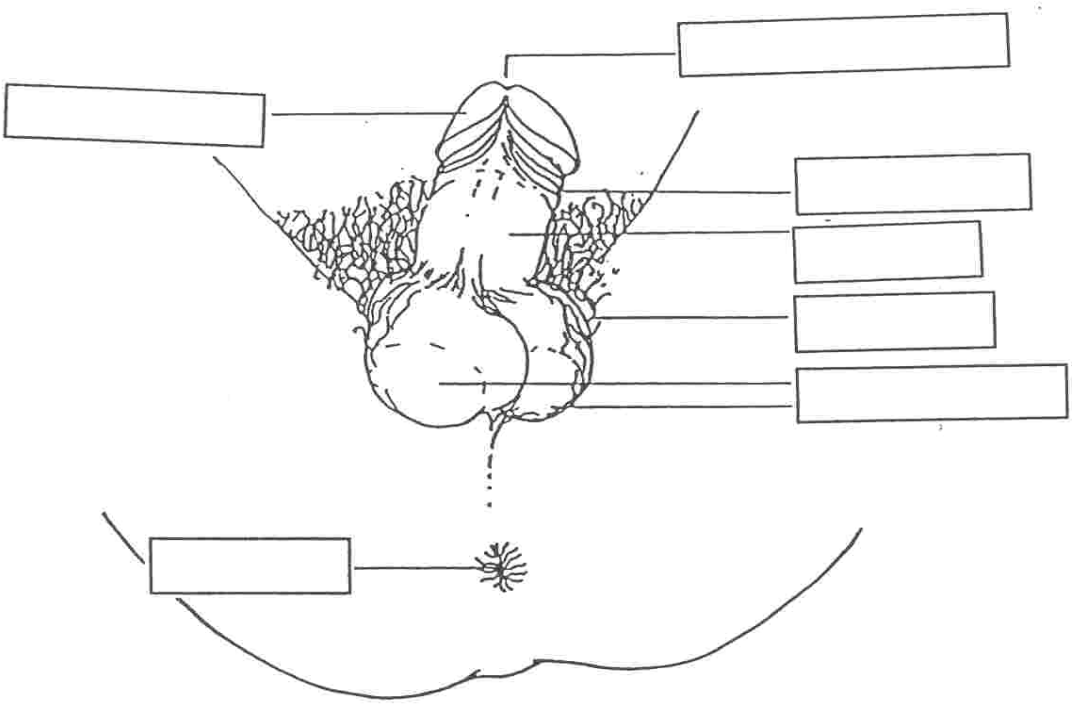
The Prostate Gland

lies beneath the bladder and approximates a chestnut in shape and size (about 3/4 inch in diameter). The prostate gland contains muscle fibres and glandular tissue that secrete prostatic fluid. Prostatic fluid is milky and alkaline. It provides the characteristic texture and odour of the seminal fluid. The alkalinity neutralizes some of the acidity of the vaginal tract, prolonging the life span of sperm as seminal fluid spreads through the female reproductive system.

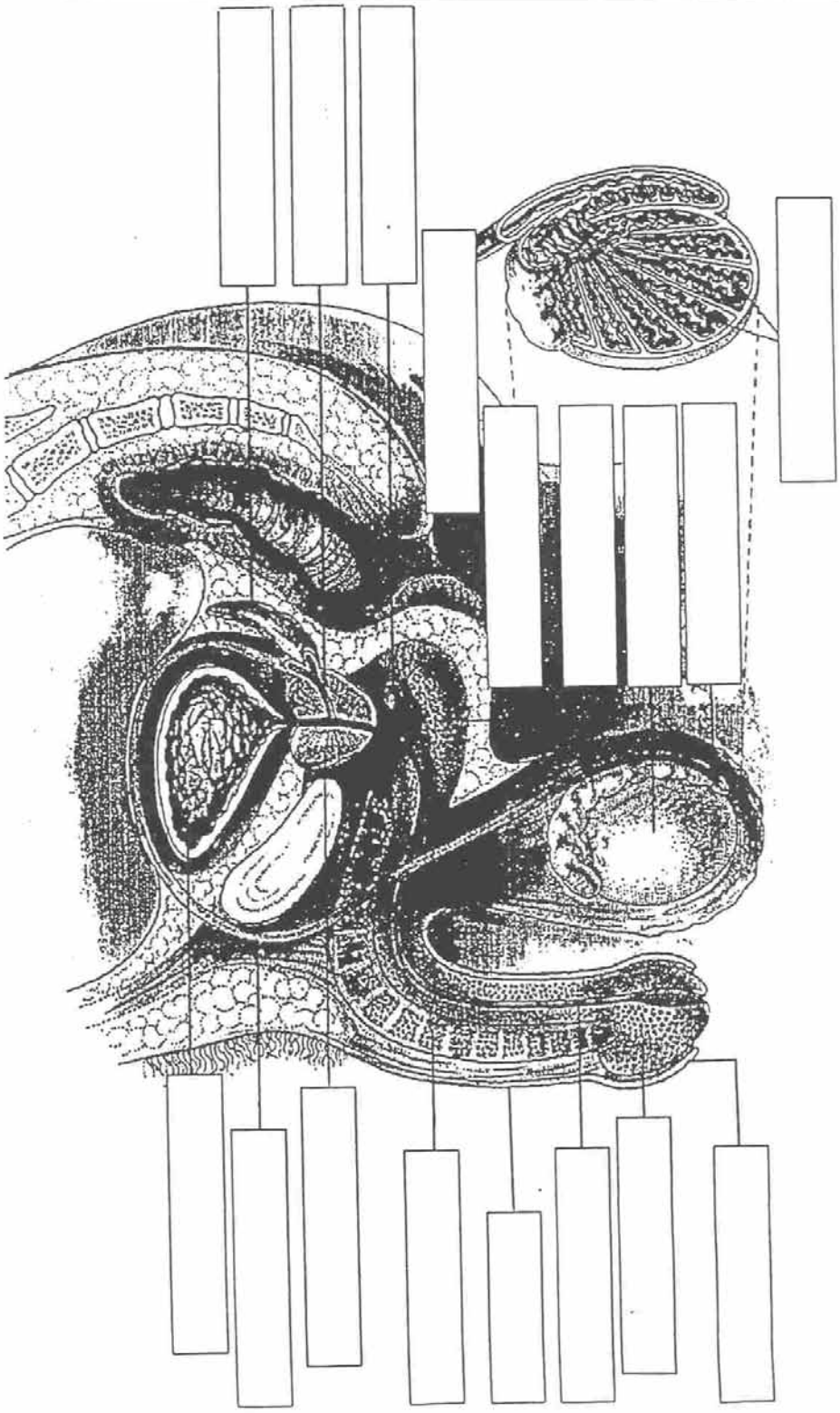
Cowper's Glands

The **Cowper's glands** are also know as the **bulbourethral glands**, in recognition of the shape and location. These two structures lie below the prostate and empty their secretion into the urethra. During sexual arousal they secrete a drop or so of clear, slippery fluid that appears at the urethral opening. The functions of this fluid are not entirely understood.

The External Male Sexual Organs



The Male Reproductive System



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ROLE OF 5 SENSES

Sight - appearance

Smell - synthetic more than natural - clean

Touch - skin largest organ - very important

Taste - body fluids "+" & "-"

Hearing - music, whispers, distractions

Aphrodisiacs and other drugs - no scientific evidence of direct affect on sexual function - may act as placebo.

SEXUAL RESPONSE CYCLE

Sexual response is highly individual, however certain common patterns exist.

Masters & Johnson describe four steps in both women and men:

excitement

plateau

orgasm

resolution

Kaplan, suggests three phases, namely, **desire, excitement, and orgasm** to be a more accurate and useful description.

DESIRE

Sexual **desire** is the drive and interest level for sexual activity. Testosterone - key hormone for desire level in both men and women. Desire arises in the brain and is strengthened by fantasy and by appropriate stimulation of all the senses.

EXCITEMENT

During sexual **excitement**, both sexes experience increased muscle tension, heart rate, and blood pressure. Sex flush and nipple erection often occur, especially noticeable in women.

Women – experience engorgement of the clitoris, labia, and vagina, together with vaginal lubrication, elevation and enlargement of the uterus, and breast enlargement.

Men - experience penile erection, enlargement and elevation of the testes, and sometimes Cowper's glands secretions.

PLATEAU

The **plateau** stage is marked by increased myotonia, hyperventilation, heart rate, and blood pressure.

Women - the clitoris withdraws under its hood, the labia minora deepen in colour, the orgasmic platform forms in the vagina, the uterus is fully elevated, and the areolas become swollen.

In men the corona becomes fully engorged, the testicles continue both elevation and enlargement, and the Cowper's glands are active.

ORGASM

During **orgasm** involuntary muscle spasms occur throughout the body, most significantly in the vagina and the penis. Blood pressure, heart rate, and respiration rate peak.

- Orgasm is slightly longer in duration in females.

- Male orgasm typically occurs in two stages, emission and expulsion.

The first phase, **emission stage**, involves contraction of the prostate, seminal vesicles, and the upper part of the vas deferens (the **ampulla**). The force of these contractions propels seminal fluid into the prostatic part of the urethral tract--a small tube called the **urethral bulb** -- which balloons out as muscles close at either end, trapping the semen.
The second stage **expulsion stage,** involves the propulsion of the seminal fluid through the

urethra and out of the urethral opening at the tip of the penis. In this stage, muscles at the base of the penis and elsewhere contract rhythmically, forcefully expelling semen. The second stage is generally accompanied by the highly pleasurable sensations of orgasm.

Retrograde Ejaculation

Some men experience **retrograde ejaculation,** which the ejaculate empties into the bladder rather than being expelled from the body. During the normal ejaculation an external sphincter opens, allowing seminal fluid to pass out the body.

RESOLUTION

The body returns to its non-excited state.

SOME DIFFERENCES BETWEEN THE SEXES

- Important primary differences remain.
- As a group, females demonstrate a wider variability in their sexual response patterns.
- Multiple orgasms occur with greater frequency in females, more often while masturbating than during coitus.
- The presence of a refractory period in only the male cycle is one of the most profound differences between the sexes.
- This period, in which the male is unable to be aroused, varies greatly in time, but usually lengthens as the man ages.

HEALTH ISSUES

MALE CIRCUMCISION

Surgical removal of part of the foreskin (prepuce) of the penis. The removal of the foreskin fully exposes the glans of the penis.

Reasons: hygiene, religious or cultural.

FEMALE CIRCUMCISION
(Female Genital Mutilation)

- widespread practice in some parts of the world, primarily Africa, the Middle East, Indonesia, Malaysia, and Australia.

Various Forms

- removal of the hood of clitoris
- removal of entire clitoris
- removal of entire clitoris, labia minora and parts of the labia majora. For this type the remaining portions of the labia majora are then pulled over the vaginal opening and held together with sutures (stitches) or thorns. (infibulation). The opposite sides heal together closing the vaginal opening except for a small opening left for urination and menstrual flow.

Usually performed at about age 7.

Lots of risk: shock, haemorrhage or infection.

When the woman is later married the vagina must be reopened. Usually her husband uses his penis, or sharp knife, or fingernail specially grown for this purpose.

During childbirth, the opening must be further enlarged.

Reasons for female circumcision - economic factors, sexual control of women, religious and cultural beliefs and supposed cosmetic and curative effects.

MENSTRUATION

Menstruation is the cyclical bleeding that stems from the shedding of the uterine lining (endometrium) when fertilization has not occurred.

- attitudes toward menstruation vary from culture to culture
- rather than being viewed as a normal, physiological function relating to femininity and fertility, menstruation is too often viewed as "the curse".

Five Common Types of Taboo found in various cultures:

1) Ban on sexual intercourse

2) Restrictions on activities and contact with other people

3) Taboos against contact with men's ritual equipment or weaponry

4) Taboos on cooking or handling food

5) Total seclusion in a special living area

PREMENSTRUAL SYNDROME (PMS)

Combination of bodily and psychological symptoms that afflict women during the four to six day interval that precedes their menses each month. Three in four women report having some sort of symptoms. Symptoms include - some combination of anxiety, depression, irritability, weight gain due to fluid retention, and abdominal discomfort. About 10% report PMS severe enough to impair their social, academic, or occupational functioning. But fewer than 1% ever reported missing work for it.

CERVICAL CANCER

Beginning in their late teens, or earlier if they are sexually active, women should have an annual pelvic exam done by a physician. More frequent examination is required if the woman is over 35 or taking birth control pills. External and internal examination is followed by a Pap test to detect cervical cancer and a sample of vaginal discharge may also be taken to test for STDs.
Women should examine their pelvic area using a hand mirror to detect any abnormalities in colour or size of their external genitalia. They should discuss any unusual vaginal pain or discharge with their partner and physician.

BREAST CANCER

Breast Self Examination: Method women employ to detect suspicious lumps in the breast. 80 - 90% of all breast lumps are benign. Should be conducted one week after menstruation, once a month.

Physical - using fingertips in a circular motion around the areola, check for lumps, hard knots, or thickening.

Visual - look for changes in contour

Mammograms: annually after age of 50, if there is a strong family history on maternal side annually after age 40.

TESTICULAR CANCER

Testicular Self Examination

Testicular cancer is the most common malignancy in men between 29 - 35 years of age.

Early detection is the key. Should be done once a month after a warm shower or bath, so the scrotum is relaxed.

Using thumb and fingertips, the man should feel the entire surface of the testes for any lumps, hardening, or enlargements.

Other warning signs include:

1) slight enlargement of one of the testicles

2) a change in the consistency of the testicle

3) a dull ache in the lower abdomen or groin (however, there may not be any pain at all)

4) sensation of dragging and heaviness in the testicles

PROSTATE CANCER

Incidence rate of 1 in 8 men.

Second most common form of cancer for men behind skin; more men get prostrate cancer then women get breast cancer.

Early signs mimic those of benign prostrate enlargement:

- urinary frequency
- difficulty in urinating
- blood in the urine
- pain or burning when urinating
- pain in the lower back
- no symptoms at all

Annual Rectal Examination and Blood Test recommended after age 40

5. LOVE, RELATIONSHIPS, AND COMMUNICATION

GREEK HERITAGE

The Greeks distinguished four concepts related to the modern meanings of love:

Storge: is loving attachment, deep friendship, or nonsexual affection.

Agape: is similar to generosity and charity.

Philia: is closest in meaning to friendship.

Eros: is closest in meaning to our concept of passion.

STYLES OF LOVE
(Clyde and Susan Hendrick 1986)

1. **Romantic love (eros):** "My lover fits my ideal"; "My lover and I were attracted to one another immediately."

2. **Game-playing love (ludus):** "I keep my lover up in the air about my commitment."; "I get over love affairs pretty easily."

3. **Friendship (storge, philia):** "The best love grows out of an enduring friendship"

4. **Logical love (pragma):** "I consider a lover's potential in life before committing myself."; "I consider whether my lover will be a good parent."

5. **Possessive, excited love (mania):** "I get so excited about my love that I cannot sleep."; "When my lover ignores me, I get sick all over."

6. **Selfless love (agape):** "I would do anything I can to help my lover."; "My lover's needs and wishes are more important than my own."

APPLICATION OF SOCIAL-INFLUENCE THEORY

ATTRACTIVENESS:

appearance - character-profession
behaviours - perceived similarities....

TRUSTWORTHINESS:

confidentiality - credibility - appropriate
use of power - understanding ...

COMPETENCE:

related to:
- role
- reputation
- behaviour
- accomplishment

STERNBERG'S TRIANGULAR THEORY OF LOVE

1. **Intimacy:** the experience of warmth toward another person that arises from feelings of closeness, bondedness, and connectedness to the other.

2. **Passion:** an intense romantic or sexual desire for another person, which is accompanied by physiological arousal.

3. **Decision/commitment:** a component of love that involves both short-term and long-term issues.

ABC(DE)s OF ROMANTIC RELATIONSHIPS

A's Attraction

B's Building

C's Continuation

D's Deterioration

E's Ending

TYPES OF LOVE

PASSIONATE LOVE

1. Emotionally very intense
2. The focus of one's life
3. Highly sexualized feelings
4. Sexual activity may be present or absent
5. Fear of rejection
6. Relationship feels unstable

COMPASSIONATE LOVE

1. Emotionally less intense
2. A focus of one's life
3. Less highly sexualized feelings
4. Sexual activity may be present or absent
5. Emotional trust
6. Relationship feels strong and stable

COUPLE'S JOURNEY

STAGE **DEVELOPMENTAL TASKS**

Romance	We sense our possibilities and create a shared vision
Power Struggle	We learn to recognize and validate differing needs and perceptions. We learn to say who we are and ask for what we want
Stability	Learn to take responsibility and expand our senses of identity through dialogue with each other
Commitment	Experience ourselves as interdependent – "we". Learn to live with paradoxes and insoluble dilemmas
Co-creation	Learn to create our own universe and work toward a better world - interdependent with all of life

PRACTICAL CONSIDERATIONS IN DEVELOPING AND MAINTAINING INTIMACY

- time
- togetherness/privacy
- meshing individual differences
- conflict management
- adjustment to change
- spontaneity
- other relationships
- prioritizing intimate relationship
- surviving "dry" spells

REJECTION OF INTIMACY

A) FEARS:

- being controlled or possessed by another
- being loved then left alone

B) INAPPROPRIATE TIME

- after break up of close relationship
- emotional or physical; trauma

Most problems in relationships can be viewed as resistances to getting closer or getting more independent

MYTHS OF RELATIONSHIPS

1) Relationships will make you feel complete and whole.
2) Your partner should change for you if he/she really loves you.
3) If you truly love each other, romance should continue to flourish.
4) Your partner should understand you.
5) Any differences should always be negotiated.
6) In a good relationship, the partners have identical dreams and goals.
7) A relationship must be stable in order to be healthy.
8) The more open you are with your partner, the more satisfying the relationship.
9) If you are not feeling fulfilled, your relationship must be at fault.
10) Sexual disinterest is inevitable in a long-term relationship.

M. Kinder & C. Cowan, 1989, Husbands and Wives.

FEAR OF COMMUNICATING

Fear of speaking out:

Afraid of sounding silly or being rejected

Fear of fighting:

Belief that fighting means relationship cannot work

Fear of intimacy:

Unable to reveal inner self, afraid of ridicule or rejection

Fear of commitment:

Afraid of failure, difficulty saying no, lack of confidence

POWER struggles are characterized by such issues as:

- Who gets to be right?
- Who has to be wrong?
- Whose problem is this?
- What process are we going to use to solve problems?
- Who has the power to end the relationship?

PROCEDURE SETTING

1. Establish agreement on what you want to talk about
2. Clarify whose issue it is
3. Determine who is involved
4. Pick a suitable time - include length of time & method of termination
5. Select an appropriate location

Miller, S., Wackman, D., & Nunnally, E.(1982). Straight talk. Signet

6. GENDER IDENTITY AND GENDER ROLES

SEXISM (GENDERISM)

Parents/adults with newborns/infants:
- decorating the nursery
- colour of clothing
- toy selection
- degree of touching
- type of touching
- language/tone

Children:

- preferences for gender typed toys (2-3 yrs)
- aware of gender specific occupations
- prefer gender appropriate games
- girls more talkative in early childhood
- boys dominate classroom discussions

Teens:

- Conform to gender stereotype roles of the day
- put down non conformists - often as “fags” or “les” gender specific activities predominate eg. sports, dating - more prevalent for male to ask

  Generally some evidence that:

  - females develop verbal ability faster
  - males more reading difficulties
  - males greater visual-spatial abilities (maps!)
  - females better math skills in lower grades
  - males better math skills in higher grades

These are small differences based on group scores. Possibly emphasised by traditional education and socialization. More within group than between group differences.

Adult Relationships:

- take stereotypes into courtship and relationships
- expectations of families of origin
- parenthood decisions - preference for male children
- child rearing - agreement/disagreement on roles
- financial/health stress may accentuate or alter roles
- aging may merge roles - mellowing/maturing

PERSPECTIVES ON GENDER ROLES AND ABILITIES

Biological	no conclusive evidence that one
Cross Cultural	theory can account for gender
Psychological	differences or similarities

ANDROGYNY: Some evidence that:
- androgynous individuals have higher self esteem and are better adjusted
- benefits (e.g. more popular with their peers) more strongly related to presence of "masculine" traits

QUESTIONS:
1. Would we be a happier society if more people were androgynous?
2. Are male female traits a continuum or two separate scales of behaviours and attitudes?
3. By calling traits "masculine" and "feminine" do we perpetuate the unhealthy aspects of
4. gender differences?

MALE PERSONALITY TRAITS

Control personality traits associated with the traditional male role:
- Aggressiveness
- Emotional toughness
- Independence
- Feelings of superiority
- Decisiveness
- Power-oriented
- Dominance
- Competitiveness

Above characteristics may be useful in the corporate world, politics, military and even sports but are rarely helpful to a man in his intimate relationships which require:
- understanding
- cooperation
- communication
- nurturing

MALE MYTHS RE: CONNECTING AND SEX

1. We're liberated folk who are very comfortable with sex.
2. A real man isn't into sissy stuff like feelings and communicating
3. All touching is sexual or should lead to sex
4. A man always wants sex and is ready for it.
5. A real man performs in sex
6. Sex is centered on a hard penis and what's done with it
7. Sex equals intercourse.
8. A man should be able to make the earth move for his partner, or at least knock her socks off
9. Good sex requires orgasm
10. Men don't have to listen to women in sex
11. Good sex is spontaneous, with no planning and no talking
12. Real men don't have sex problems

Bernie Zilbergeld (1993)

7. SEXUAL TECHNIQUES AND BEHAVIOURS

SEXUALITY AND ADULTHOOD: VALUE CLARIFICATION EXERCISE

Working with a partner take turns to read and complete each of the following sentences. Do NOT take more than 1-2 minutes with each sentence; complete the sentence, listen to your partner's completion, briefly discuss the issue, and move on to the next sentence. The purpose is to increase your awareness of your own attitudes towards certain sexual issues. You have approximately 20 minutes to complete this exercise.

1. For young adults, sex is .....
2. Sexually, older adults are .....
3. Orgasm is .....
4. Penile-vaginal intercourse is .....
5. Premarital intercourse is .....
6. Adults who masturbate .....
7. If I were totally free sexually, I would .....
8. Menopause seems .....
9. Fellatio is .....
10. I enjoy sex when .....
11. Good sex doesn't mean .....
12. Anal intercourse is .....
13. I think sexual aids, like vibrators, are .....
14. Compared to intercourse, cunnilingus is .....
15. I like/don't like French kissing because .....

Ref. Adapted from Lion, E.M. (Ed.), (1982). Human Sexuality in Nursing Process, Toronto: J. Wiley & Sons, p. 109

DEFINITIONS

Abstain: (Dictionary definitions)

Keep from .... refrain from .... especially in relation to alcohol or voting

Abstinence: (Medical Dictionary)

going without voluntarily, especially from indulgence in food, alcoholic beverages, or sexual intercourse.

Celibate/ Celibacy:

single life... unmarried state .... bound or resolved not to marry....

SOLITARY SEXUAL BEHAVIOUR

PAST:

Onanism - biblical story – Onan “spilled seed” (misnomer - withdrawal) - against reproductive concept - believed limited semen in lifetime
Punishment/Treatment: torture, devices, death, diet, psychoanalysis

TODAY:

beliefs/attitudes varied, myths of harmfulness...

-normal sexual release, part of variety of eroticism, learn about body ....

versus

-dirty, selfish, unnecessary eroticism, non-procreative, unhealthy ....

MASTURBATION

-touching and stimulating own genitals - appropriate throughout lifespan - even if accepted often taught substitute for "real thing" only acceptable in given situations, eg. Single.....

REASONS FOR MASTURBATION BY RESPONDENTS TO NHSLS STUDY

Reasons for Masturbation	Men (%)	Women (%)
To relax	26	32
To relieve sexual tension	73	63
Partners are unavailable	32	32
Partner does not want to engage in sexual activity	16	6
Boredom	11	5
To obtain physical pleasure	40	42
To help get to sleep	16	12
Fear of AIDS and other STDs	7	5
Other reasons	5	5

SELF PLEASURE

- pleasuring of body in SENSUAL way -- warm bath, shower, relaxation, movement/dance ... learn about/accept body, enhance relationships, heal after abuse

SEXUAL FANTASIES:

- May occur when alone or with partner. May be shared or kept to self. May involve rehearsal for situations likely to occur or may allow for exploration of events unlikely to be achieved, or even not wanted in actuality.

NOCTURNAL ORGASMS

Most males (83 percent) and more than a third of all females (37 percent) have reported erotically stimulating dreams that led to orgasms during sleep, called **nocturnal orgasms.** Since for males these orgasms are often accompanied by an ejaculation, they are known as **nocturnal emissions**, or Awet dreams.≅

FOREPLAY

... fooling around .. Petting ... necking

May include, but not limited to:

fantasy - general and sexual
kissing - simple, deep, body
general touching/cuddling/firm vs. Soft
breast caressing
genital touching
oral-genital contact

Often seen as something that (should) leads to intercourse - less valued as an activity in and of itself.

Duration and choice of behaviours varied - differences between males and females.

TOUCHING:

Gender differences:
Erogenous Zones:

Parts of the body, including but not limited to the sex organs that are especially sensitive to tactile sexual stimulation.

Some areas that are particularly sensitivity to sexual arousal include
the clitoris (particularly the glans) ♀ ♂
the penis (particularly the glans and corona) ♂
the shaft of the penis ♂
the labia ♀
the urinary opening ♀ ♂
the vaginal opening ♀
the area around the genitals ♀ ♂
the perineum (the area b/w the genitals and anus) ♀ ♂
the anus ♀ ♂
the breasts (particularly the nipples) mostly♀
the buttocks ♀ ♂
the inner surfaces of the thighs ♀ ♂
the mouth (lips, tongue, and interior) ♀ ♂
the ears (especially the lobes) ♀ ♂

What makes these zones erotic is the setting in which they are touched and the meanings given to that touching.

ORAL-GENITAL STIMULATION

Widely practiced by heterosexual and same sex couples in western society and elsewhere. Higher incidence in more highly educated and in Caucasian North Americans vs. African-Americans. Lower incidence in casual relationships than in committed relationships. Reasons for abstaining: hygiene, odours, body fluids (especially semen), non-procreative ....

FELLATIO

Oral stimulation of the male genitals. Fellatio is referred to by slang terms such as "blow job," "sucking," "sucking off," or "giving head."

CUNNILINGUS

Oral stimulation of the female genitals, which is referred to by slang expressions such as "eating" (a woman) or "going down" on her.

The popularity of oral-genital stimulation has increased dramatically since Kinsey's day, especially among young married couples. WHY?

HETEROSEXUAL INTERCOURSE: POSITIONS AND TECHNIQUES

The Male-Superior (Man-on-Top) Position

Has been called the missionary position. In this position the partners face one another. The man lies above the woman, perhaps supporting himself on his hands and knees rather than applying his full weight against his partner.

Advantages:

Disadvantages:

FEMALE-SUPERIOR (WOMAN-ON-TOP) POSITION

In the female-superior position the couple face one another with the woman on top. The woman straddles the male from above, controlling the angle of penile entry and the depth of thrusting. Some women maintain a sitting position; others lie of top of their partners. Many women vary their position.

Advantages:

Disadvantages:

LATERAL-ENTRY (SIDE-ENTRY) POSITION

In the lateral-entry position, the man and woman lie side by side, facing one another.

Advantages:

Disadvantages:

SITTING POSITIONS

In sitting coital positions, the man is usually sitting in a chair or on a bed, while the woman sits astride him and either faces toward or away from him. Unless the woman's weight is excessive, these positions can be very restful for both partners.

Advantages:

Disadvantages:

ANAL INTERCOURSE

Penal/rectal penetration
Practiced by male-female and male-male couples. Education level and ethnic background influence incidence. Religion a major restraint.

Anilingus - oral stimulation to anal area. Rich nerve supply to area leads to arousal.

Safe sex practices essential.

8. SEXUAL DYSFUNCTIONS

DEFINITION:

Disorders that make normal arousal and sexual response difficult or impossible.

Note: Conditions that are categorized as dysfunctions in the literature or by clinicians may not be of concern to an individual or couple.

Dysfunctions should be differentiated from paraphilias in which arousal and response are dependent on unusual objects or behaviours, but physiological response is intact.

TYPES OF SEXUAL DYSFUNCTIONS

1. Sexual desire disorders

2. Sexual arousal disorders

3. Orgasmic disorders

4. Sexual pain disorders

CAUSES:

Organic

- physical trauma, illness, developmental differences, drug use, hormone changes. Any possible organic cause should be investigated before other causes are explored.

Psychogenic

- associated with low self esteem and confidence, conflict of personal values, history of abuse, anxiety and lack of sexual information.

Cultural/interpersonal

- problems arising from predominantly sexual repressive societal values and the feelings and desires of the individual or couple. Lack of sexual experience or information.

COURSE OF THE PROBLEM

It is important to determine if the problem has always existed, if it is a recent and consistent change or if it is situational. Situational dysfunctions occur in given circumstances only, eg. with a specific partner or in a specific place. They may be primary (present all of life) or secondary (occurring now or sometimes).

TREATMENT STRATEGIES

Early treatment methods focused on Freud's psychoanalytic model. Masters and Johnson introduced the behavioural approach and Kaplan used a combination model that she called psychosexual therapy. Most practitioners today use an eclectic approach that allows them to individualize their therapy and counseling to meet the needs of their clients.

SEX COUNSELLING

Changing attitudes

Providing information

Giving permission

Reducing anxiety

SEXUAL DYSFUNCTIONS FOR BOTH MEN AND WOMEN

1. SEXUAL DESIRE DISORDERS

A) Low or Inhibited Sexual Desire

- lack of interest, does not initiate, does not respond, but normal physiological function. Most common complaint, difficult to resolve.

Cause:

- hormonal deficiencies, illnesses
- depression and anxiety
- relationship dissatisfaction
- history of assault or abuse

Treatment:

- relationship counseling and sex education
- therapy for psychological illnesses and abuse
- behavioural exercises e.g. Sensate focus

b) Compulsive Sexual Behaviour

- constant sexual desire with pursuit of gratification, but an inability to have satisfying sexual interpersonal relationships.

Cause:

- organic, e.g. disease or injury to the brain
- strong need for love but inability to relate

Treatment:

- lifestyle counseling or therapy
- medications

2. SEXUAL AVERSION

- extreme negative reaction to sexual activity
- repulsed by genital
  (more often women)

Cause:

- shame, fear and anxiety
- history of abuse or assault

Treatment:

- medications
- psychological counseling

3. FREQUENCY OF SEXUAL ACTIVITY & CHOICE OF BEHAVIOURS

- partners' differences in timing, sex drive, and lifestyle demands, emotional needs and activity preferences.

Treatment:

- identify and treat underlying causes
- relationship counseling

4. DYSPAREUNIA

- painful intercourse (most often women) See notes on male/female issues.

1. AROUSAL DISORDERS

- inadequate excitement and vaginal lubrication

Cause:

- diabetes
- reduced estrogen levels
- neurological disorders e.g. SCI
- anxiety or stress
- narcotics, alcohol, medications
- negative experiences such as abuse

Most often psychological cause related to specific situations

Treatment:

- medical intervention for physical causes
- sexual counseling to reduce performance anxiety
- relationship counseling

2. ORGASMIC DISORDERS

(anorgasmic or pre-orgasmic)

- difficulty or inability to achieve orgasm

Cause:

- guilt or anxiety
- insufficient clitoral stimulation

Often situational, e.g. Orgasmic in masturbation but not during intercourse

Treatment:

- counseling and education to counteract negative attitude toward sex
- self exploration and massage
- couple education on female sexual response
- education and counseling on alternative sexual activities and use of devices such as vibrators

3. DYSPAREUNIA

- painful intercourse or penetration of the vagina

Cause:

- most often inadequate vaginal lubrication
- vaginal infection of STD's
- P.I.D., endometriosis, other diseases

Treatment:

- medical intervention for physical causes
- use of artificial lubricants
- counseling for psychological causes.
  e.g. Low self esteem, anxiety
- education on sexual techniques
  e.g. Increased foreplay

4. VAGINISMUS

- involuntary contractions of the pelvic muscles surrounding the outer third of the vaginal barrel

Cause:

- fear of vaginal penetration often related to history of assault or abuse

Treatment:

- use of graduated plastic vaginal dilators
- couples sexual activities with women in control
- intercourse with women on top
- counseling regarding prior abuse

MALE SEXUAL DYSFUNCTION

Sexual dysfunction can be related to:

desire

arousal

penetration

erection maintenance

orgasm and ejaculation

MOST COMMON DYSFUNCTIONS

1. Erectile dysfunction (impotence)

- inability to achieve or maintain an erection of sufficient firmness to have intercourse.

Causes:

- diabetes (2 of all diabetics)
- stress and fatigue
- low testosterone
- vascular problems
- general illness
- use of abuse of narcotics, alcohol, and meds.
- anxiety about sexual performance

Treatment:

50% psychological - therapy aimed at decreasing anxiety so sexual response can occur normally. Treatment could include sensate focus etc.
- medical intervention for physical causes

2. Premature Ejaculation

- is an inability to delay ejaculation as long as he wishes to.

Causes:

Most have psychological causes.
- Masturbating in secret, learned for immediate gratification.
- 1st sexual experience in less than ideal situations etc...
- anxiety

Treatment:

Goal of therapy is to train the man to focus his sensations. This focusing teaches him to anticipate orgasm and to gain control over the timing of his ejaculation.

Two primary methods:

a) Stop - go technique

b) Squeeze techniques

3. Ejaculatory Incompetence

- inability to ejaculate after penetration despite firm erection and sufficient arousal.

Causes:

Primarily psychological, anxiety related with penetration and ejaculation

Treatment:

Focus on the psychological causes for the inhibition along with the use of sensate focus exercise. Also can use a behaviour approach.

4. Dyspareunia

- Recurrent or persistent genital pain occurring either before, during or after intercourse. Not very common.

Causes:

Usually associated with an organic condition, such as herpes, prostatitis, or Peyronie's disease (curvature of penis caused by sclerotic plaques on the penis.

Treatment:

Medical intervention to address underlying organic causes.

9. SEXUALITY IN CHILDHOOD AND ADOLESCENCE

SEXUALITY IN INFANCY AND CHILDHOOD

Infancy: 0-3 yrs

World of sensual delight

Thrives on touch

Erections and lubrication from beginning

Orgasm as early as 5 months

Pelvic thrusting 8-10 months

Masturbation 6-12 months

Physically or emotionally deprived infants may rock, bang their heads but won't masturbate

Healthy children tend to be more involved with genital play and pelvic thrusting

Genital play with others 2 yrs

Appropriately name body parts

Unsure of appropriateness of touch always err in the direction of affection rather than pulling away

- This is just one part of the child's expanding world, let them explore

The Terrible Two's and Three's

Hunger for facts "natural curiosity"

Concrete, needs things to be specific

Potty training - careful to distinguish between excretory and sex organs

"I'm a boy" "I'm a girl."

Masturbation - requiring new social manners

Proper names (penis, vulva)

Confine the area of sex talks to people rather than Abirds and flowers≅

Comment on masturbation - appropriate but in private

See behaviour from child's perspective "feel good do it"

Privacy - theirs and yours

EARLY CHILDHOOD

The Innovative Fours and Fives

- Parents start to reduce amount of touch they give their children
- A lot of touch between peers
- Sex play is rampant “peeking” and curiosity
- Sex games “sex is something that must be shrouded in mystery or explored under other motivations”
- They should by this age know the names and general functions of all parts of their bodies
- Masturbation increases 4-5 yrs
- Should have a clear concept of public and private

The School-age Child Six to Eleven

- Sexual basics are understood
- Modesty, greater need for privacy
- Sexual exploration appears reduced as they become more adept at hiding sexual interest
- Prime time for the development of attitudes
- Teaching one does not act out on every feeling goes a long way
- Focus on competency control and skill building
- Increase influence of media. Censorship is almost impossible but what is seen may be used as a springboard for teaching
- Accidental voyeur - discuss
- Dirty words and sexual play
- Consolidating masculinity and femininity
- How to bring “it” up
- Male/female and same sex exploration
- Little awareness of orientation

Pre Adolescence: 9-13 yrs

Increased self consciousness

Peer approval important

Sexual urges starting to emerge

Masturbation main outlet

Continue same/other sex exploration

Increased awareness of orientation

Provision of sexual information and discussion of values increases in importance

SEXUALITY IN ADOLESCENCE

Adolescence: 13-18 yrs

Puberty - secondary sexual characteristics conflict physical development vs child roles

Females:

Menarche 10-18 yrs - average 13 yrs
May not ovulate for up to 2 yrs
Increased estrogen production

Males:

- Nocturnal emissions
- First ejaculation 8-20 yrs - av. 14 yrs.
- May not have active sperm immediately

Activities:

- Masturbation
- Petting
- Dating
- Experimentation with both genders
- Oral sex (increased x3 since Kinsey 40% 17 yrs+)
- Intercourse av. Age 16 yrs F, 15.5 yrs M (Hormones, peer pressure, myths)
- Greater awareness of orientation
- Need for information on safe sex and relationships

SEX EDUCATION

All people are sexual and have sexual needs ...

The goal of sex education is to enrich lives and encourage responsibility...

Sex education must be thought of as being education not moral indoctrination ...

Equip youngsters with the skills, knowledge and attitudes that will enable them to make intelligent sexual choices and decisions.

ISSUES IN PARENT/CHILD COMMUNICATION ABOUT SEXUALITY

- COMMUNICATION
- INFORMATION
- TERMINOLOGY
- POSITIVE ATTITUDES
- VALUES
- ONE'S OWN SEXUAL EXPERIENCES
- COMFORT

FACTORS THAT MAY AFFECT SEXUAL IDENTITY

- Parent/child communication abilities
- Segregation: school and/or home
- Formal/informal sex ed.
- Biases in words/signs
- Parental/others' attitudes
- Opportunity for sexual expression
- Ability to understand sexual concepts

DISCUSSING SEXUALITY WITH YOUR CHILDREN

Four Points to Remember

1. Facts

Provide your children with unbiased factual information

2. Values

Tell your children what you think and feel about the facts

3. Responsibility

Let your children know what you expect of them - ask them how they can be responsible for sexual decisions

4. Self-Esteem

Help your children feel positive about themselves and their bodies. The more confident and comfortable you are, the easier this will be.

SOME RECOMMENDATIONS TO KEEP IN MIND

- Start early
- There are no taboo subjects
- Don't wait for them to ask
- Make sexuality education a family activity
- Both parents should educate
- Stamp out double standard
- Don't be shocked by four-letter words
- Identify the question before you answer
- Be prepared for criticism
- Teaching sex ed. is like teaching anything else

DEALING WITH THE WORLD

- Media, TV
- Peer information
- Fear of sexism

LIVING IN THIS WORLD

- Effects of behaviour modeling
- Modeling sexual attitudes
- Home life

BEGIN AT THE BEGINNING

Message you want to give is you are always available, and askable.

- Begin gently
- Give permission for discussion
- Get comfortable
- Be honest
- Allow for privacy
- Be open
- Don't be pushy
- Be flexible
- Take your time
- Team up
- Try not to overreact
- Don't talk too long
- Always clarify
- Don't force an issue
- It's OK to say "I don't know"
- Never laugh or put down your child's questions
- Be a good listener
- Give concrete examples
- Strive for balance

10. SEXUALITY IN ADULTHOOD

SINGLES:

Late 20s early 30s single group more than doubled since 1970s.

Later marriage, more education years, less stigma to being single, female careers.
Many have serial monogamy, but range from celibate to swingers

POSSLQ- people opposite sex sharing living quarters - doubled 1980-92
Approx. 50% never married, 30% divorced
60-70% below 35 yrs but greatest increase since 1980 is in over 35 yr group.
Less committed than married couples
Cohabitors who marry more likely to divorce as more independent, less traditional people

MARRIAGE - in all societies

Historically patriarchal - gives sanction to relationship, maintenance of home, child rearing and support, transition of inheritance

Arranged marriage – in many cultures choice of appropriate partner governed by the culture – family selects – often when child still young

Free choice in marriage – usually choose partner similar to self in ethnicity, religion, age, size, interests – **Homogomy**

Mating Gradient – trend for some women to marry up economically and men to marry down

Current patterns in USA
65% adult men & 60% adult women married
Age of 1st marriage up 3 years from 1975
26.5 yrs. Men 24.4 yrs. Women
50% marriages end in divorce

Current patterns in Canada
Number of marriages down by 24% since 1972
Age of 1st marriage up from 1972
29.5 yrs. Men 27.4 yrs. Women
33% marriages end in divorce
Divorce rate in Canada was very rare before 1960 and tripled from 1960 to 1970

MARITAL SEXUALITY

Kinsey (1950s) Hunt (1970s) NHSLS (1990s)

Changes in society affected marital sexuality as well as sexuality of young singles
Societal changes:
Reduced male dominant role

Media (including explicit) more influence, and greater availability
Scientific findings made public
Contraceptive technology

Marital sexual changes:
increased time in foreplay
increased frequency of sex (7 x month)
greater variety of positions in intercourse
greater variety of behaviours, e.g. Oral sex
longer duration in lovemaking
still decrease in frequency over time related to aging and time in marriage

Homogamy - tend to choose partner similar to self - ethnicity, age, size, interests.

ADULT LIFESTYLES

EXTRAMARITAL SEX

Conventional adultery - not known to partner ranges from once to many years.

Consensual adultery - known to partner
Data unreliable - most still disapprove
Men more accepting and higher incidence than women.

SWINGING - both partners openly involved with others - white, affluent, well educated
Avoid emotional connection with others as this threatens primary relationship.

OPEN MARRIAGE - either partner may have relationship outside marriage.

GROUP MARRIAGE - three or more share intimate relationship although cannot be legally married - more committed than swingers.

DIVORCE - 50% marriages end in divorce - men more likely to remarry.
Factors: No fault divorce, improved economics for women, social acceptance.
Most common reason: poor communication and lack of understanding.
High costs - emotional & financial and children.

11. SEXUALITY AND AGING

THE FOLLOWING MAY BE AFFECTED TO VARYING DEGREES:

GENERAL ISSUES:

Body image
Self esteem
Family/public attitudes

REPRODUCTION AND SEXUAL RESPONSES:

Fertility
Arousal
Orgasm
Ejaculation

CHOICES OF SEXUAL BEHAVIOURS:

Opportunity for privacy
Positions for sexual intercourse and other sexual behaviours
Intellectual abilities
Availability of partner(s)

COMMON MYTHS ABOUT SEXUALITY RELATED TO THE AGED POPULATION

1. Sexuality is the province of the young

2. Sexual interest and activity declines rapidly with age

3. Older bodies are not sexually attractive

4. Sexual activity for elderly people is inappropriate and even ridiculous

5. Older people do not have sexual thoughts and desires

6. Older people go into relationships for companionships only

7. The only true and acceptable means of sex is through intercourse

SEXUALITY IN MID - LIFE AND LATER YEARS (40-55 & 55 UP)

- Biological aging varies -- persons of same age can appear to be 20 years apart in age. Diet, lifestyle, substance abuse etc. have significant effect

- Sexual response cycle slower -- may increase pleasure in less hurried sexual activity, but may also be of concern and result in impotence in males and painful intercourse in females

- Attitudes of selves and others may lead to reduction in sexual activity – i.e. not expected to be sexual ... conversely sexual activity may increase as pregnancy no longer possible

- More women than men widowed - often seen as threat to married friends and rejected in old social circle - both widows and widowers have difficulties dating in a changed social environment

AGE-RELATED PHYSIOLOGICAL CHANGES AND SEXUAL RESPONSE

MALE

1. Erection is slower, less full; disappears quickly after orgasm; has a longer refractory period often 12-24 hours after ejaculation to achieve erection again.

2. Decrease in muscle tone.

3. Testicles do not achieve full elevation and do not increase in size.

4. Decreased volume of sperm; although fertility level is decreased, men do not become sterile.

5. Ejaculation is less powerful and orgasm is often less intense

6. Gradual decline in testosterone from 20 - 60 years of age

7. Urgency of sexual desire decreases

8. More control of orgasm - can lead to increase in sexual pleasure - or to concern and impotence

9. Job pressures usually greatest at this time and may affect relationships

10. Increase in weight may affect sexual function physically or because of lowered self esteem

FEMALE

Menopause (cessation of menstruation)

1. Estrogen & progesterone decreased

2. Periods less frequent, differences in blood flow; may not cease completely for several years

3. Sometimes headaches, insomnia, dizziness, irritability & weight gain

4. Night sweats and hot flushes

Other changes:

5. Decrease in rate and amount of vaginal lubrication may lead to painful intercourse

6. Orgasmic changes include a decrease in the number of involuntary contractions by 50% and an acceleration of return to pre-aroused state.

7. Structural changes or atrophy of the labia, uterus, and a reduction in the expansion of the vagina width.

8. Thinning of the lining of the vagina reduced elasticity etc.. that can result in irritation and painful intercourse.

HORMONE REPLACEMENT THERAPY (HRT)

- became popular in 1960s - initially only given estrogen - found to increase chance of uterine cancer - now given with progestin - lessens chance of cancer - increased use of HRT in >80s

- risk considered worthwhile by many as estrogen decreases chance of osteoporosis and cardiovascular disease

12. SEXUALITY AND DISABILITY

DEFINITIONS

SEXUALLY ELITE:

Those whose activity does not violate reproductive bias and could lead to socially sanctioned conception and pregnancy.
(E.g. Heterosexual married couple)

SEXUALLY OPPRESSED:

Those who are perceived as not conforming to the reproductive bias and who tend to be systematically asexualized.
(E.g. People who are elderly or disabled)

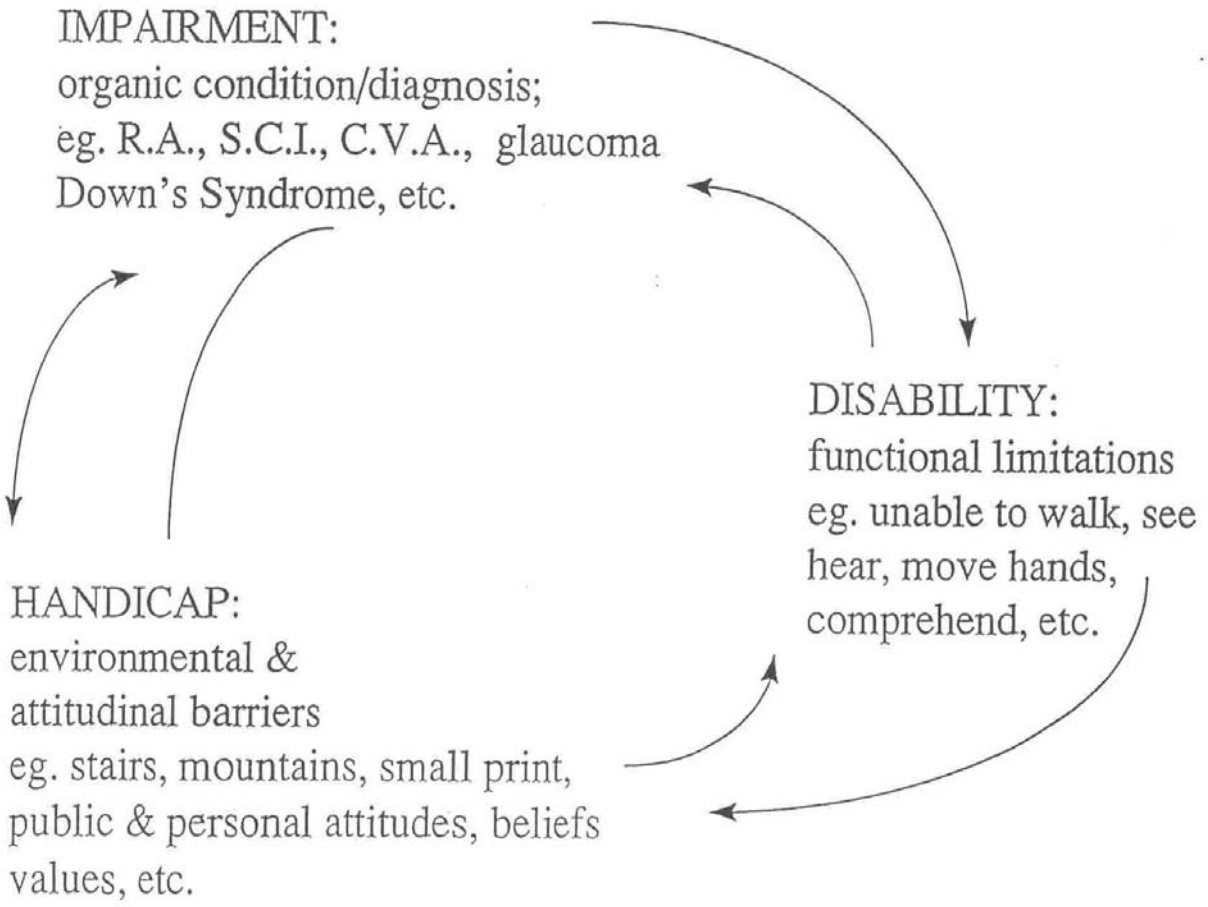
SEXUALLY UNUSUAL:

Those who society views as deviant, weird, sick, or criminal.
(E.g. Pedophiles, exhibitionists, transvestites, etc..)

(Most people do not fit into one category only)

(Gochros, H.L., & Gochros, J.S.(Eds.). (1977). The Sexually Oppressed. New York: Associated Press

WORLD HEALTH ORGANIZATION
Impairment – Disability - Handicap



DISABILITY AND SEXUALITY

Factors that affect adjustment:

Congenital	vs.	Acquired (age)
Mild/localized	vs.	Severe/systemic (Perception)
Stable	vs.	Progressive (rapidity)
Visible	vs.	Invisible (to public)

Degree and constancy of pain (medications)

Degree control and/or effective management of bladder and bowel function

Currently in committed relationship	vs.	Looking for relationship(s)

Attitudes/acceptance of significant others (partner, family, friends)

EXAMPLES OF DISABILITIES:

VISIBLE	INVISIBLE
- multiple sclerosis	- heart disease
- spinal cord injury	- diabetes
- stroke	- mastectomy
- cerebral palsy	- ostomies
- amputations	- burns/scars/skin disorders
- head injuries	- hearing loss
- arthritis	- developmental disabilities
- blindness	- psychiatric illness
- burns/scars/skin disorders	- pain
- cancer	- cancer
- developmental disabilities	- chronic fatigue
- psychiatric illness	- epilepsy

SEXUALITY AND PEOPLE WHO HAVE DISABILITIES

The following MAY be affected by disease or injury

General:

- body image
- self esteem
- public attitudes

Reproduction and Response:

- fertility
- pregnancy & delivery
- arousal
- potency
- orgasm & ejaculation

Behaviours:

- self pleasure & masturbation
- choices of sexual activities
- positioning for sexual intercourse
- and other sexual behaviours

CEREBRAL PALSY

Damage to the brain &/or central nervous system before or during birth resulting in some degree of spastic paralysis and speech difficulties. Most normal intelligence

Depending on degree of disability, general issues may include:

- Parents may be overprotective
- Some physical dependency
- Communication difficulties
- Limited socialization opportunities
- Body image & self esteem
- Attitudes of others

SENSORY DEFICITS

Blindness and Deafness. Can affect any age group. Varies in severity

Many live independent, satisfactory lives, however individuals vary in their ability to adapt. Much depends on the age of onset, family support, and the self esteem / confidence of the individual. They may have decreased socialization and educational opportunities.

SPINAL CORD INJURY

Bruising, tearing, cutting of the spinal cord resulting in partial or total loss of voluntary movement and sensation below injury

Quadriplegia: neck injuries - arms, trunk and legs affected

Paraplegia: upper/lower back injuries - trunk and legs affected

Majority young males, all ages M & F potential
Approx. 50% vehicle accidents
other: sports, work related, assault etc
In USA 6-10 thousand/year
Relatively normal life expectancy

Quads: wheelchair - semi independent
Paras: wheelchair, crutches, canes - independent

Advent of computers, sophisticated devices and electro myography changing potential for independent living and employment ...

ARTHRITIS

Conditions that affect the small and large joints of the body causing pain, swelling, stiffness, and immobility. Progressive

More women- can occur at any age - different types affect different age groups

Ranges from mild pain in some joints to severe limitation of movement and use of crutches or a wheelchair

AMPUTEES

Loss of limb(s) from trauma or illness
Usually non-progressive but complications may change status later

More males - all ages - often vehicle and work related

Level of independence, self esteem, ability to work depends on the personality of the individual, the support of family or friends, and the severity of injury or progression of disease.

PSYCHOLOGICAL DISABILITIES

INTELLECTUALLY IMPAIRED:
Inadequate development of the brain - varying degrees of severity. Often physical as well as intellectual limitations

BRAIN INJURY:
Injury to brain at any age - varying degrees mental and physical limitations

MENTAL ILLNESS:
Psychiatric conditions - such as depression, anxiety, schizophrenia etc. Mild to severe

All of the above cause issues regarding:
self esteem, independence, decision making, appropriate behaviours, relationships, employment etc

Sexual issues include:

- sex education often withheld
- limited social life - lack of partners
- low sex drive/high sex drive
- inability to discriminate re. sexual behaviours difficulties experienced by partner in relationship

INTELLECTUAL IMPAIRMENT AND SEXUALITY

*IQ=s less than 70

Mild- IQ 50 - 70
Moderate - IQ 35 - 49
Severe - IQ 20 - 34
Profound - IQ below 20

- mature sexually in a normal way.
- often receive little training regarding their bodies and sexuality.
- sex drives similar to those of other people, socialization and learning patterns are different (Bernstein 1985).

Questions:

Do persons who are intellectually impaired have sexual rights?

When the persons' ability to understand and to choose is limited, what are their rights?

Who is responsible in the area of pregnancy, birth control etc?

Who decides about relationships within an institution?

Guidelines When Working with Individuals with A Mental Disability

1. Masturbation is normal sexual expression no matter how frequently and at what age it occurs

2. All sexual activity involving the genital should occur in privacy

3. Any time a sexually mature girl and boy have intercourse they risk pregnancy

4. Unless a couple clearly wants a baby they need to understand and practice effective birth control.

5. Society decrees that no one should have intercourse until about age eighteen. At which age men and women are ready to make such a decision for themselves.

6. Adults must never use children sexually

7. With appropriate safeguards, sexual expression may be encouraged

8. Private sexual activity is acceptable between consenting adults.

9. Nobody is allowed to touch you in any way without your permission.

MENTAL ILLNESS AND SEXUALITY

Psychoneurosis:

Disturbances in thought, feelings, attitudes and behaviour; usually in touch with reality
Characterized by predominant symptom, e.g. anxiety, depression, obsessional, phobias

Psychosis:

Disorder that include the disintegration of personality and loss of contact with reality and usually require hospitalization e.g. schizophrenia

SEXUALITY ISSUES INCLUDE:

- Self esteem & body image
- Sexual identity & male/female roles
- Attitudes of others - especially partners
- Reduced sex drive
- Sexual dysfunctions - erectile/lubrication
- Poor judgment/impulsive/vulnerable
- Unsafe sex practices - forget/can't be bothered
- Drug side effects
- Too few sexuality education programs in mental health care facilities

13. ATYPICAL SEXUAL VARIATIONS

ATYPICAL SEXUAL VARIATIONS

Behaviours can be described on a continuum .....
Normal <----- Atypical or Unusual -----> Deviant

Statistics are a poor measure of normal sex, behaviour must be examined in relation to social norms as well ... these norms vary over time and between cultures

PARAPHILIAS...Term used by APA in DSM
... recurrent, atypical patterns of sexual arousal that are problematic to individual or society...

Unusual behaviours not always problematic.

Non-coercive:
i.e. Arousal with objects, pain or humiliation

Coercive:
These are problematic - arousal with non-consenting and unsuspecting persons

INCIDENCE ... range from isolated, infrequent acts to frequent compulsive behaviour

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

Psychosexual disorders:

a) gender identity disorders

b) paraphilias

c) psychosexual dysfunctions

d) other psychosexual disorders

Sexually Elite usually defined under (c)
Sexually Unusual under (a) & (b)
although (c) also applicable
Sexually Oppressed not defined here

Tend to categorize by least acceptable
aspect – e.g. Transvestite with erectile dysfunction placed in category (b) not (c).

PARAPHILIAS

- specialized sexual fantasies and intense sexual urges which are repetitive in nature and distressing to the person
- involving non-human objects, suffering and humiliation of self or partner, children or non consenting adults
- fantasy and behaviour pervade life
- often acted out in times of stress or conflict
- very poor statistics except in paedophilia where it is known that 10-20% of all children are victims by age 18
- largely male disorders
- 50% onset before 18
- frequently have several conditions at once
- peeks between 15 and 25 and gradually declines
- classify all these disorders as mild, moderate or severe

PAEDOPHILIA

- intense sexual urge or arousal to children 13 or younger over a period of at least 6 months
- individual with paedophilia must be 16 or older and at least 5 years older than the victim
- vaginal or anal penetration unusual except in the case of incest
- 99% of nontouching offences are against females
- 60% of victim who are touched are male
- 95% of paedophiliacs are heterosexual
- younger children serve largely as masturbatory aids, very impersonal

Refs. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 1982.
Dailey, D.M. (Ed.) The Sexually Unusual, 1988

FETISHISM

"magic charm" - inanimate article for arousal used in fantasy/masturbation and in relationships.
Sometimes combined with unacceptable behaviour such as robbery, touching strangers
Varies from seldom to frequent

Objects include: underwear, high heeled shoes, silk, rubber, fur, leather

Sub category ... **partialism**:
excessive arousal by specific body part such as feet, breasts, buttocks, amputees

As many variations as objects. Rituals in most sexual interactions, these more unusual. Not understood well, may be associated with a pleasurable experience when young. Difficulties arise when partner unwilling to participate.

TRANSVESTISM (TV)

Cross dressing - associated with sexual arousal or pleasure. Mostly heterosexual males, but includes gay males. One garment to complete wardrobe. Private or public. Partners may or may not know.
TV clubs as support and social network.

Some straight and gay men cross dress to entertain ... Drag Queens

Research suggests starts in childhood, close to mother, eldest child. Escapes male role - let out feminine side. In the past not discriminated from transgenderism. May be considered a fetish.

Common in some cultures as part of family and community rituals.

SADOMASOCHISM (S & M)

Variations known as:

Dominance & Submission (D/S)
Bondage & Discipline (B/D)

Actual behaviours very specific to individual or couple. Seldom to frequent practice. Low level to intense. Do **NOT** enjoy pain in other contexts. Only paraphilia with significant participation by females.

When urge overshadows all other sources of arousal becomes problematic.

PHYSICAL ELEMENTS:

Bondage - loose restraints - can escape - to total immobility - helpless

Discipline - slapping, whipping, caning: no marks to bruising and welts

Intense stimulation - scratching, biting, ice or hot wax

Sensory deprivation - blindfold, hood, earplugs, gags. Hypoxyphilia (dep. Oxygen)

Body alteration - tattoos, piercing, branding, burns - proof of S/M commitment, beautifying, sensory enhancement

PSYCHOLOGICAL ELEMENTS

Masochism/Submission/Bondage

- Humiliation
- Degradation
- Uncertainty
- Apprehension
- Powerlessness
- Anxiety
- Fear

responses to verbal statements or actions taken ... i.e. Put downs or menial tasks

Sadism/Dominance/Discipline:

- Aggression
- Control
- Dominance
- Powerfulness

reaction to giving commands and insults to others

Many report pleasure from taking a role they normally do not play – e.g. Dominant, powerful executive who likes to submit. "High" from trust level in agreed relationship and behaviour.

The following behaviours vary from fantasy to actual repeated acts.
The perpetrators are usually heterosexual, male, unhappy, shy, and sexually repressed.
The behaviours involve victims, so are classified as coercive.

EXHIBITIONISM

Arousal from exposure of genitals to strangers.
Rarely aggressive to victim. Starts in teens & diminishes after 40.
Stripping not considered exhibitionism - purpose to arouse viewer not dancer

OBSCENE PHONE CALLS

Arousal by shocking people on the phone, often masturbate during call. Verbal exhibitionism.

VOYEURISM (Peeping Tom)

Strong, repetitive urge to observe unsuspecting strangers nude or in sexual behaviour.
Starts in teens, may masturbate when watching or when recollecting.
May take great risks - heightens arousal.

FROTTEURISM (mashing)

Arousal from rubbing against or touching non-consenting person, usually in crowded place.

Victim may be unaware.

LESS COMMON PARAPHILIAS include:

ZOOPHILIA - strong sexual urges and fantasies of sexual contact with animals
Bestiality - actual sexual contact with animals.
Men: farm animals. Women: household pets.
Found in history and in Greek mythology

KLISMAPHILIA - arousal derived from enemas

COPROPHILIA & UROPHILIA - sexual arousal connected with feces and urine.
These three may be associations from childhood.

NECROPHILIA - desire to have sex with corpse.
Motivation - to completely sexually possess a non-resistant partner. Many clearly disturbed.
Three types: fantasy, regular (act), homicide. May take job to facilitate access.

HOW MUCH IS TOO MUCH?

Values are attached to words beyond the literal meaning of the terms - do some of the terms below reflect the "double standard" of sexuality?

NYMPHOMANIA - (bride-madness)
excessive sex drive in women

SATYRIASIS - (mythological man/beast)

DON JUANISM - (fictional Spanish character) excessive sex drive in men

HYPERSEXUALITY (less pejorative term)
excessive/insatiable sex drive that disturbs persons' life and leads to indiscriminate acts.

HYPOSEXUALITY - (inhibited sexual desire [ISD] or hypoactive sexual desire disorder)
low sexual desire, seldom initiates or responds to sexual activity

COMMENT: given the negative views of society toward "excessive" sex it's ironic that ISD is the prevalent concern in 1990's clinical sexology

THEORETICAL PERSPECTIVES ON PARAPHILIAS

BIOLOGICAL - brain damage or abnormality

PSYCHOANALYTICAL - defense against unresolved castration anxiety

LEARNING - experiences, especially childhood, determine later behaviours

SOCIOLOGICAL - erotic appeal to reversing or changing societal/gender roles

INTEGRATED - childhood experiences etch "Love Maps" in the brain - determine arousal patterns

No substantial evidence to support any one of these perspectives - none account for people who do not develop according to the theory.

TREATMENT OF PARAPHILIAS

Few individuals come for treatment voluntarily as their "paraphilic" behaviour is pleasurable to them. Most treatment occurs through courts or when family or partners urge person into treatment.

Ethical conflict for helping professionals who are asked to stop behaviour when client does not see the need. Less success with resistant clients.

APPROACHES

PSYCHOTHERAPY

- resolve unconscious conflicts - little evidence of significant success.

BEHAVIOUR THERAPY

- modify behaviours

  Systematic desensitization
  Aversion therapy & covert sensitization
  Social skills training & orgasmic retraining

BIOCHEMICAL

- no drug or surgery known to eliminate urges but some help control them. Prozac (antidepressant) reduces compulsive behaviours. Anti-androgens reduce sex drive.

Refs. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 1982.
Dailey, D.M. (Ed.) The Sexually Unusual, 1988

GENDER IDENTITY DISORDERS

Gender identity disorder:

transsexual is a common title
psychological gender does not match their biological sex
gender dysphoria:

1. Discontent with biological sex
2. Desire to possess body of opposite sex
3. Desire to be regarded by others as the opposite sex

wishes to go through sex reassignment surgery, must go through a process
process:

1. Live in new gender role 1-2 years
2. Male to female: facial & body hair removal, take female hormones
3. Female to male: testosterone

14. COMMERCIALIZATION OF SEXUALITY

DEFINITIONS

EROTIC

of love...pertaining to sexual passion...
(Greek: eros-love)

PORNOGRAPHY

Description of manners etc of harlot...
Treatment of obscene subjects in literature ... written or graphic forms of communication which either are intended to, or may, incite sexual interest...indecent literature or films.
(Greek: porne-prostitute, graphein - to write)

POCKET CRIMINAL CODE OF CANADA

Section 163 ... offences tending to corrupt morals
...anyone making, printing, distributing, etc...
Obscene written, picture, model, recording, etc.

OBSCENE

... any publication a dominant characteristic of which is the undue exploitation of sex, or of sex and any one or more of the following subjects namely, crime, horror, cruelty, and violence, shall be deemed to be obscene.
(No definition of pornographic)

COMMERCIALIZATION OF SEXUALITY

Questions for class discussion

What effects - if any - does advertising (TV, magazines, etc) have on self esteem, male/female roles, your view of sexuality?

What should be the responsibility of the entertainment industry in setting or following community standards regarding portrayal of sex and sexuality?

What are the differences between erotic materials and pornography? Who should set standards for these and how should we restrict their distribution?

What are the limits that should be set for various businesses in the sex trade?
E.g. Prostitution, strip shows, lap dancing, peep shows, etc.

What effect - if any - do all of the above have on you and your sexual relationships?

SELLING WITH SEX and SEX FOR SALE.....

Sexual content ranges from implied to explicit and from erotic to pornographic....

ART: painting - sculpture - drama - music - dance

PRINT MEDIA: magazines - novels - advertising

ELECTRONIC MEDIA: movies - home videos - music videos - CDS - Internet

MERCHANDISE: sex toys & specialized clothing

ENTERTAINMENT: strip shows - peep shows - lap dancing - XXX video shows - sex clubs - leather bars

SERVICES: escorts - telephone “900" - prostitutes - massage parlours

PROSTITUTION

Sale of sexual activity for money or goods of value. Almost universal - changed over time and between cultures. Majority female prostitutes & male clients. Occasional to full time job.

Types - females - serve straight men (johns):
Streetwalkers - bars/hotels - brothels - massage parlours - escort services - call girls

Street workers most danger for abuse & STDs, poorest, bottom of hierarchy. Call girls most independent, better paid, less danger.
Most start young, short career, have abusive background. Many low skills & self esteem.
Money main motivation.

CUSTOMERS: occasionally, habitual & compulsive
WHY? Sex without negotiation or commitment, eroticism & variety, sociability, sexual problems, away from home - most common reason now

Types - male:

a) gigolos (few): serve females - mostly older, unattached, wealthy women
b) hustlers: straight, gay & bisexual men who serve mostly gay men, also straight men bar and street hustlers - brothels (few) - kept boys (with sugar daddy) - call boys - punks (prisoners given protection/drugs as payment) - drag prostitutes (TVS & TSs)

Street workers least well off, younger & in greatest danger. May be HIV positive. Most hustlers part-time and pimps not involved. Money is main motivation.

CUSTOMERS: gay/straight men in bars/clubs & on the street. Bisexual customers conduit for HIV to female partners.

Reasons: no commitment, lack of relationship, source of male contact for bisexuals

15. SEXUAL COERCION