human sexuality in a world of diversity
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chapter 1: what is human sexuality?

DEFINITIONS

Sex: refers to whether we are anatomically male or female and the anatomical structures (sexual organs) that play a role in reproduction and sexual pleasure.
Erotic: arousing sexual feelings, experiences or desires. This can include sexual fantasies and thoughts, sexual urges and feelings of sexual attraction.
Gender: one's personal, social, cultural and legal status as a male or female. Gender is the anatomical or biological category of sex.
Gender roles: complex clusters of the ways males and females are expected to behave within a given culture. For example, one may say that the "reproductive anatomy appears to depend on the sex (not gender) of the individual, but in so-called traditional societies, gender roles are often seen as polar opposites."
Human sexuality: the way we refer to experience and how we express ourselves as sexual beings. Our awareness of ourselves as females or males is part of our sexuality, as is the capacity we have for erotic experiences and responses. Our knowledge of the gender roles in our culture also has a profound influence on us.
Values: the beliefs and qualities in life that are deemed important or unimportant, right or wrong, desirable or undesirable.
Phallic worship: veneration of the penis as a symbol of generative power, due to awareness of the male role in reproduction.
Phallic symbol: an object that represents the penis. The ancient Greeks created art that suggests they revered phalluses, rendering them into rings and necklaces. Some phalluses were given wings, suggesting power. In ancient Rome, a large phallus was carried like a float in a parade honoring Venus, the goddess of love.
Incest taboo: the prohibition against intercourse with close blood relatives.
Polygamy: the practice of having two or more spouses at the same time.
Monogamy: the practice of having only one spouse.
Pederasty: sexual love between a man and a boy. Pederasty, prostitution and male-male adult sexual behaviour are three aspects of Greek sexuality are of particular interest to the study of sexual practices in the ancient world. The Greeks viewed men and women as bisexual. Male-male adult sex was deemed normal, and tolerated so long as it did not threaten the institution of the family.
Courtesan: a prostitute, especially the mistress of a noble or wealthy man. Courtesans could play musical instruments, dance, engage in witty repartee, ad discuss the latest political crises. They were also skilled in the arts of love. No social stigma was attached to visiting a courtesan.
Concubine: a secondary wife, usually of inferior legal and social status.
Evolution: the development of a species by means of many small, cumulative adaptations to its environment.
Natural selection: the evolutionary process by which adaptive traits enable members of a species to survive long enough to reproduce and transmit these traits to their offspring.
Evolutionary psychology: the theory that a disposition toward a behaviour pattern that enhances reproductive success may be genetically transmitted.
Analogue: something that is similar or comparable to something else. There are animal examples of human male-male, female-female, oral-genital, and oral-oral sexual behaviour.
Queer theory: a theory that challenges heteronormativity and heterosexism. It challenges a number of commonly held assumptions about gender and sexuality, such as the assumption that heterosexuality is normal and superior to homosexuality.

ANCIENT VIEWS ON SEX

The Ancient Hebrews viewed sex within marriage as least, as a fulfilling experience intended to satisfy the divine injunction to be fruitful and multiply. Male-male, female-female and adultery sexual behaviours were strongly condemned, because they were thought to threaten perpetuation of the family.
The Ancient Greeks believed in the value of family life like the ancient Hebrews. Greek men admired the well-developed male body and enjoyed nude wrestling among men in the arena. Erotic encounters and jokes characterized the works of playwrights. Male-male adult sex was deemed normal, and tolerated so long as it did not threaten the institution of the family.
The Ancient Romans had many sexual excesses especially among the emperors and ruling families. Orgies were sponsored which guests engaged in a wide variety of sexual practices. Male-male sexual behaviour was thought of as a threat to the integrity of the Roman family and to the position of the Roman woman.
The Early Christians believed that adultery and fornication were a sin as they were rampant at the time. The Christian ideal recognized celibacy. Christians demanded virginity of their brides. Prostitution was condemned. The goal of procreation should govern sexual behaviour. Masturbation, male-male sexual behaviour, female-female sexual behaviour, oral-genital contact and anal intercourse were viewed as abominations in the eyes of God.
The Muslims treasured marriage and sexual fulfillment in marriage. Premarital sex invited shame and social condemnation – and harsh penalties in some states. Men may take up to four wives, but women are permitted only one husband. Public social interactions between men and women are severely restricted in conservative societies. Women must be veiled at all times and may not have contact with any man but their husband.
The Hindus have cultivated sexual pleasure as a spiritual ideal to the same extent as the ancient Hindus. Temples from the 5th century show sculptures of gods, nymphs, and ordinary people in erotic poses. Sexual practices were codified in the Karma Sutra. Hindu deities were often portrayed as engaging in same-sex as well as male-female sexual activities.

The Taoists believed that sex was a sacred duty – a form of worship that led toward harmony with nature and immortality. They were the first to produce a detailed sex manual, which came into use about 200 BCE. The man was expected to extent intercourse as long as possible to absorb more of his wife's natural essence. Taoists believed that it was wasteful to spill his seed so masturbation was not acceptable for men even though it was for women.
The Protestant Reformers believed that priests should be allowed to marry and rear children. Sexual expression in marriage fulfilled other purposes that procreation. It served as strengthening the marriage and helping to relieve stress. Extramarital sex and premarital sex was a taboo.
The Victorians believed that sex is a marital duty to be performed for procreation or to satisfy their husbands' cravings. Sex as not to be discussed in public. It was believed that sex drained a man of his natural vitality. It was recommended that intercourse be practiced infrequently as ejaculation deprived men of their vital fluids. Masturbation or frequent marital intercourse was viewed as wasting the seed. Same-sex sexual behaviour was considered indecent.

SIGMUND AND FREUD PSYCHOANALYTIC THEORY

Psychoanalysis: the theory of personality originated by Freud, which proposes that human behaviour represents the outcome of clashing inner forces. Freud believed that we were all born with biologically based sex drives. These drives must be channeled through socially approved outlets if family and social life are to carry on without undue conflict.
Unconscious mind: those parts or contents of the mind that lie outside of conscious awareness. Freud proposed that the mind operates on conscious and unconscious levels. The conscious level corresponds to our state of present awareness.
Ego: in psychoanalytic theory, the past of the mind that mediates between the id and the superego and that deals with external reality. The ego shields the conscious mind from awareness of our baser sexual and aggressive urges.
Defense mechanism: in psychoanalytic theory, automatic processes that protect the ego from anxiety by disguising or ejecting unacceptable ideas and urges.
Repression: the automatic ejection of anxiety-evoking ideas from consciousness.
Erogenous zones: parts of the body, including but not limited to the sex organs, that are responsive to sexual stimulation.
Psychosexual development: in psychoanalytic theory, the process by which sexual feelings shift from one erogenous zone to another.
Fixation: in psychoanalytic theory, arrested development that includes attachment to traits and sexual preferences characteristic of an earlier stage of psychosexual development.
Oedipus complex: a complex of emotions raised by a young child, especially a boy, by a subconscious sexual desire for the parent of the opposite gender.
Social-cognitive theory: a cognitively oriented learning theory in which observational learning, values, and expectations play key roles in determining behaviour.

RESEARCHERS AND THEIR FINDINGS

Meaney and Rye (2007) – conceptualized sex as a fun, healthy activity that can be considered leisure when voluntary, is not seen as works, and serves some personal need. Analyzed three distinct ethical framework: the ethics of divinity (religious roots), community (greater good) and autonomy (rights and freedoms).
Randall and Byers (2003) – determined that university students believed that the only behaviour defined as sex is penile-vaginal intercourse and penile-anal intercourse.
Trotter and Anderson (2007) – determined that university students only defined the loss of virginity as penile-vaginal intercourse and only half believed the same about penile-anal intercourse.
Brotto et al. (2005) – a degree of acculturation to mainstream Canadian society was significantly related to sexual attitudes and experiences, but length of residence in Canada was not. Asian students who kept the strongest ties to their cultureal heritage had the most conservative sexual attitudes and experiences.
Woo and Brotto (2008) – Asians who identified less with Canadian culture had higher rates of sexual problems and less communication with their partners about sexual issues. They were more likely to avoid sexual contact.
Maticka-Tyndale et al. (2007) – female immigrants from Iran expressed concern about engaging in oral sex which is acceptable in Canada but not Iran.
Laumann et al. (2006) – surveyed 27,500 men and women over age 40 from 29 countries, asking about their levels of sexual satisfaction. Men in general reported higher satisfaction than women. Categorized moral values into three categories of traditional, relational and recreational.
The World Association for Sexual Healthy (WAS) (2008) – declared sexual healthy goals for the global community to ensure gender equality, sexual rights, condemn sexual violence, provide sexual education, provide sexual health, halt and reverse the spread of HIV/AIDS and STIs, treat sexual concerns and disorders, and to achieve sexual pleasure and well-being.
Tyndale and Smylie (2008) – noted that the concept of sexual rights is contentious, particularly in cultures with different perspectives toward sexuality.
Kleinplatz and Krippner (2007) – are tantric teachers who focus on the sexual techniques but neglect the spiritual foundations of this approach to sexual relationships.
Fischstein, Herold and Demarais (2007) – collected data from a national survey of 1479 Canadian adults over the age of 18 to determine whether gender differences still exist when we take into account other social variables. The researchers examined how gender, age, marital status, education, religiosity and geographic region affects the sexuality variables of frequency of sexual thoughts, oral sex, age of first intercourse, number of sexual partners and intentions to engage in casual sex.

CRITICAL THINKING PRINCIPLES

1. Be skeptical
2. Examine definitions of terms
3. Examine the assumptions or premises of underlying arguments
4. Be cautious in drawing conclusions from evidence
5. Consider alternative interpretations of research evidence
6. Consider the strengths and weaknesses of different perspectives on sexuality, even ones you don't agree with
7. Don't oversimplify
8. Don't overgeneralize

chapter 2: research methods

RESEARCH METHODS

Empirical: derived from or based on observation and experimentation.
Demographic: concerning the vital statistics of a human population (i.e. density, race, age, education).
Variables: quantities or qualities that vary or that may vary.
Population: a complete group of organisms or events.
Sample: part of a population selected for a study.
Generalize: use information from a particular case or sample to draw conclusions about a larger phenomenon or population.
Random sample: a sample in which every member of a population has an equal chance of participating.
Stratified random sample: a random sample in which known subgroups of a population are represented in proportion to their numbers within the population.
Volunteer bias: a slanting of research data caused by the characteristics of individuals who volunteer to participate (i.e willingness to discuss intimate behaviour).
Case study: a carefully drawn, in-depth biography of an individual or small group of individuals. This information may be obtained through interviews, questionnaires, and historical records.
Surveys: a detailed study of a sample obtained through such methods as interviews and questionnaires.
Incidence: a measure of an event's occurrence.
Validity: the degree to which a rest measures what it purports to measure.
Social desirability: a response bias caused by a subject's tendency to provide a socially acceptable answer to a questionnaire or interview question.
Naturalistic observation: a study method in which organisms are observed in their natural environments.
Ethnographic observation: a study method in which behaviours and customs are observed within a group's native environment.
Participant observation: a study method in which observers interact with their subjects as they collect data. Katherine Frank worked as a stripper at several clubs to earn cash for graduate school as well as to participate in the feminism theory project investigating female objectification and body image.
Vasocongestion: congestion resulting from blood flow to the genitals.
Correlation: a statistical measure of the relationship between two variables.
Correlation coefficient: a statistic that expresses the strength and direction (positive or negative) of the relationship between two variables.
Penile strain gauge: a device for measuring a man's sexual arousal in terms of changes in penis circumference.
Vaginal photoplethysmograph: a tampon-shaped probe that is inserted into the vagina to measure the light reflected from the vaginal walls, thereby determining the level of vasocongestion.
Experiment: a scientific method that seeks to confirm cause and effect relationships by manipulating independent variables and observing their effects on dependent variables.
Treatment: an experimental intervention (such as a test, drug or sex education program) that's administered to participants so its effects can be observed.
Independent variable: a condition in a scientific study that is manipulated so its effects can be observed.
Dependent variable: the condition in a scientific study that is believed to be affected by the independent variables. The results of the study are assessed by measuring changes in the dependent variable.
Experimental group: a group of study participants who receive the experimental treatment.
Control group: a group of study participants who do not receive the experimental treatment. All other conditions are kept the same for the control group as for the experimental group.
Selection factor: a research bias that may operate when people are allowed to determine whether they will receive an experimental treatment.
Quantitative methodology: the collection of numerical data (percentages) to produce statistics.
Qualitative methodology: the use of interviews, focus groups, diaries, or other methods to record people's attitudes and experiences.

THE SCIENTIFIC METHOD

1. Formulating a research question
2. Framing the research question in the form of a hypothesis
3. Testing the hypothesis
4. Drawing conclusions

STUDIES

Kinsey Report (1948, 1953) – interviewed 5300 men and 5940 women in the US and asked array of questions about various types of sexual experience including masturbation, oral sex, and coitus before, during and outside of marriage.

The National Health and Social Life Survey (NHSLS) – intends to provide general information about sexual behaviour in the US, as well as specific information that might be used to predict and prevent the spread of AIDS. The sample included 3432 people who were 18 to 59.

The Canadian Youth, Sexual Health, and HIV/AIDS Studies (CYSHHAS) – had two national surveys to focus on the sexual health of Canadian adolescents. The objective was to understand the determinants of adolescent sexuality and sexual health for different age groups, involving students in grades 7, 9 and 11.

The Canadian Community Health Survey (CCHS) – provides data on the health status of Canadians who are aged 12 and up. Surveys more than 100,000 every two years. The survey questions sexual identity, age of first intercourse, number of sexual partners in the past 12 months and condom use.

The Contraception Studies – national survey on contraceptive use by 15-44 year old women from across Canada. It looked at contraception awareness, attitudes and behaviours among women of childbearing age.

The Compass Survey – the survey asked about sexual orientation, age of first intercourse, number of intercourse partners, sexual frequency, oral sex, sexual communication, sexual problems, sex and the workplace, attitudes toward casual sex, and attitudes toward toplessness and prostitution.

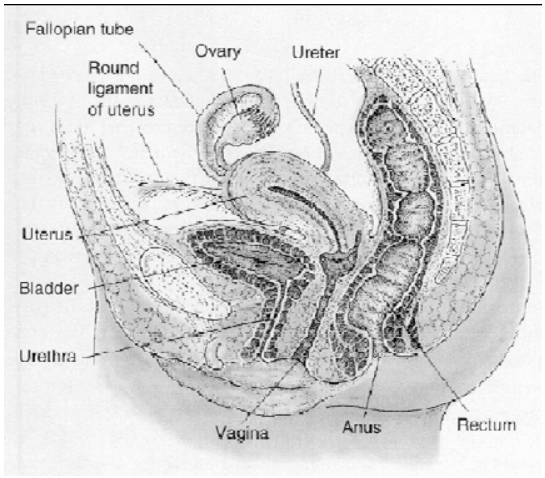
ETHICAL ISSUES IN SEX RESEARCH

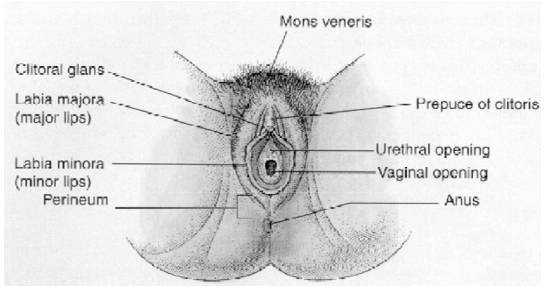
- Exposing participants to harm
- Confidentiality
- Informed consent
- The use of deception

chapter 3: female & male anatomy & physiology

FEMALE ANATOMY AND PHYSIOLOGY

THE EXTERNAL FEMALE SEX ORGANS





Vulva: the external sexual structures of the female. The vulva consists of the **mons veneris** (a mound of fatty tissue that covers the pubic bone which cusions a woman's body during intercourse and pubic hair grows during puberty), the **labia majora** (large folds of skin that run downward from the mons along the side of the vulva, shields the labia minora and urethral and vaginal openings, outer surfaces covered with pubic hair) and **labia minora** (hairless, light coloured membranes located between the labia majora, surround the urethral and vaginal openings, outer surgaces of the labia minora merges with the major lips and at the top they join at the hood of the clitoris) also called the major and minor lips. The **vestibule** refers to the area within the labia minora that contains the openings to the vagina and the urethra, It is very sensitive to tactile and other sexual stimulation due to the large amount of nerve endings.

Clitoris: a female sex organ consisting of a shaft and a glans, located above the urethral opening. It's extremely sensitive to sexual sensation. The clitoral shaft is about 2.5cm long and 0.5cm wide. It consists of erectile tissue, which contains two spongy masses called **corpora cavernosa** (become engorged with blood and stiffen in response to sexual stimulation) and the **prepuce** (the fold of skin covering the glans of the clitoris (or penis in a male)). The clitoris and the penis develop from the same embryonic tissue, which makes them similar in structure (**homologs**) although different in function (**analogs**).

Urethral opening: the opening through which urine passes from the female's body. It lies behind the clitoral glans and in front of the vaginal opening. The proximity of the urethral opening to the external sex organs may pose hygienic problems for sexually active women. The urinary tract includes the urethra, bladder, and kidneys which may become infected by bacteria that are transmitted from the vagina to the rectum.

Cystitis: is a bladder inflammation that may stem from any of these sources: infectious microscopic organisms passing from the male's sex organs to the female's urethral opening during sex, manual stimulation of the vulva with dirty hands may transmit bacteria through the urethral opening to the bladder, and anal intercourse followed by vaginal intercourse may transfer microscopic organisms from the rectum to the bladder and cause infection. The following precautions can prevent serious inflammation of the bladder:

- Drink 2L of water a day to flush bladder
- Drink orange or cranberry juice to maintain an acidic environment discouraging the growth of infectious organisms
- Reduce intake of alcohol and caffeine which may irritate the bladder
- Wash hands prior to masturbation or self-examination
- Wash partner's and own genitals before and after intercourse

- Prevent objects that have touched the anus from subsequently coming in contact with the vulva
- Cover sex toys with condoms to prevent possible infection
- Urinate soon after intercourse to help wash away bacteria

Introitus: the vaginal opening. It lies behind the smaller urethral opening. Across the vaginal opening is a fold of tissue called the **hymen** that is usually present at birth and remains at least partly intact until a woman engages in sexual intercourse.
Perineum: the skin and underlying tissue that lies between the vaginal opening and the anus or between the scrotum and the anus in a male. It is rich in nerve endings. During labour, many physicians make a routine perineal incision, called an **episiotomy** which protects the vagina from tearing.

FEMALE GENITAL MUTILATION

Clitoridectomies: the surgical removal of the clitoris. This is a form of female genital mutilation. It occurs in some groups in Egypt and Sudan as an unchallenged social custom. It is a rite of initiation into womanhood in may of these predominantly Islamic cultures. Often performed as a puberty ritual in late childhood or early adolescence. Typical young woman does not see herself as a victim.

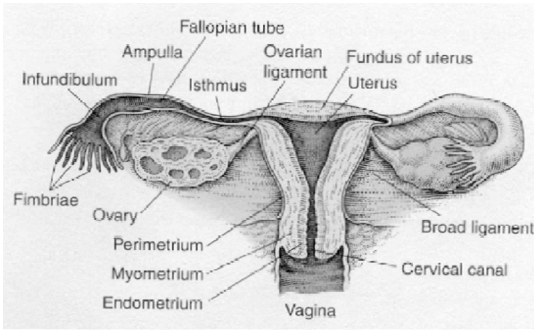
STRUCTURES THAT UNDERLIE EXTERNAL SEX ORGANS

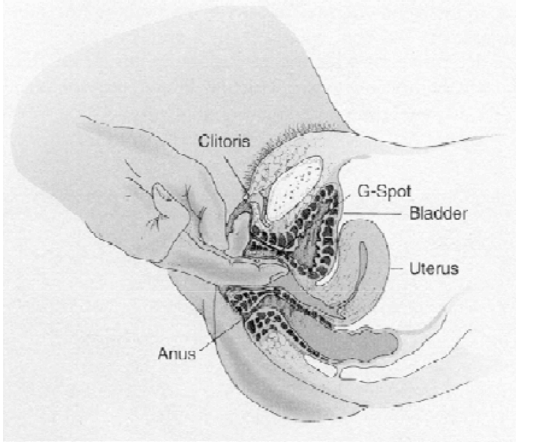
Clitoral crura: anatomic structures resembling legs that attach the clitoris to the pubic bone. They are wing-shaped.
Vestibular bulbs: are attached to the clitoris at the top and extend downward along the sides of the vaginal opening. Blood congests them during sexual arousal, swelling the vulva and lengthening the vagina.
Bartholin's glands: glands that lie just inside the minor lips and secrete fluid just before orgasm. They lie just inside the minor lips, on each side of the vaginal opening.
Pubococcygeus muscle: the muscle that encircles the entrance to the vagina. They contract automatically or involuntarily during orgasm and toning them may contribute to increased sensation during sexual activity. These are referred to as Kegal exercises.

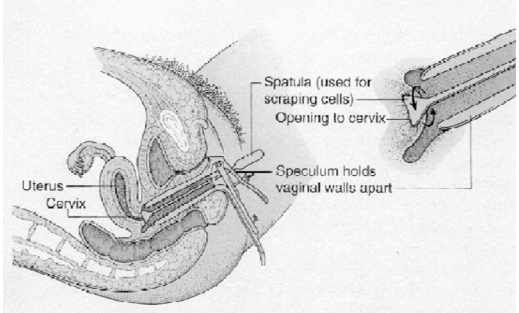
THE INTERNAL FEMALE SEX ORGANS

Vagina: the tubular female sex organ that contains the penis during sexual intercourse and through which a baby is born. It extends back and upward from vaginal opening. The inner two-thirds insensitive to touch. Vaginal walls secrete substances that help maintain the vagina's normal acidity.
Vaginitis: vaginal inflammation whether caused by infection, birth control pills, antibiotics, allergic reaction, chemical irritation or lowered resistance due to fatigue or poor diet. The following suggestions may help prevent vaginitis:

- Wash your vulva and anus regularly with mild soap
- Wear cotton not nylon underwear
- Avoid pants that are tight at the crotch
- Be certain your sex partners are well washed
- Use condoms, they reduce the spread of infection
- Use a sterile, water-soluble gel if lube is needed for intercourse, do not use Vaseline
- Avoid intercourse that's painful or abrasive to the vagina
- Avoid diets high in sugar and refined carbs because the alter the vagina's normal acidity
- If you are prone to vaginal infections it may help to douche occasionally with plain water
- Watch your general health, a poor diet and insufficient rest will reduce your resistance to infection



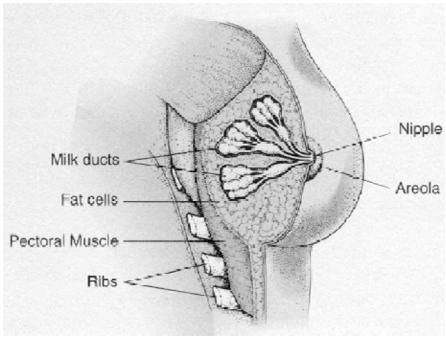




Grafenberg "G" spot: it is theorized that the G spot can be stimulated by fingers or by intercourse in the rear-entry or the female-superior position. It is a bean shaped area in the anterior (front) wall of the vagina. It is believed to lie about 2.5-5cm from the vaginal entrance and to consist of a soft mass of tissue that swells from the size of a dime to a loonie when stimulated. Stimulation may lead to female ejaculation.
Cervix: the lower end of the uterus. Contributes to the chemical balances of the vagina. The opening in the middle of the cervix is called the **os**, is typically about the width of the straw, although it expands to permit passage of a baby from the uterus to the vagina during childbirth. Sperm passes from the vagina to the uterus through the cervical canal.
Uterus: the hollow, muscular, pear-shaped organ in which a fertilized ovum implants and develops until birth.
Radiotherapy: treatment of a disease by x-rays or by emissions from a radioactive substance. This method is used to treat cervical cancer if detected early. Cervical cancer can be prevented if precancerous changes are detected by a Pap test.
Pap test: examination of a sample of cervical cells for cervical cancer and other abnormalities. It involves the smearing of a sample of cervical cells on a slide to screen. It is recommended that women should have Pap rests every one to three years depending on their previous test results.

Ovum: egg cell which once fertilized implants and develops in the uterus until birth.
Endometrium: the innermost layer of the uterus. The uterus has three layers, the endometrium (richly supplied with blood vessels and glands).
Endometriosis: a condition caused by the growth of endometrial tissue in the abdominal cavity, or elsewhere outside the uterus, and characterized by menstrual pain.
Hysterectomy: surgical removal of the uterus which may be performed when women develop cancer of the uterus, ovaries, or cervix or have other diseases that cause pain or excessive uterine bleeding.
Complete hysterectomy: 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.
Fallopian tubes: tubes that extend from the upper uterus toward the ovaries, conducting ova to the uterus. Uterine tubes are about 10cm in length.
Ectopic pregnancy: a pregnancy in which the fertilized ovum implants outside the uterus, usually in the fallopian tubes.
Ovaries: almond-shaped organs that produce ova and the hormones estrogen and progesterone. These hormones are part of the endocrine system.
Estrogen: a generic term for sex hormones (including: estradiol, estriol, estrone and others) or synthetic compounds that promote the development of female sex characteristics and regulate the menstrual cycle.
Progesterone: a steroid hormone that stimulates proliferation of the endometrium and is involved in regulation of the menstrual cycle. Progesterone is secreted by the corpus luteum or prepared synthetically.
Follicle: a capsule within an ovary containing an ovum.

THE FEMALE BREASTS



Secondary sex characteristics: traits that distinguish women from men but are not directly involved in reproduction. An example of this is **breasts.**
Mammary glands: milk-secreting glands. Each breast contains 15-20 clusters of mammary glands.
Areola: the dark ring on the breast that encircles the nipple. Darkens during pregnancy and remains darker after delivery.
Breast Cancer: is the second leading cause of cancer-related death among Canadian women.
Cysts: saclike structures filled with fluid or diseased material.
Benign: doing little or no harm.
Malignant: lethal; causing or likely to cause death.
Mammography: a special type of x-ray test that detects cancerous lumps in the breast. It allows the detection and treatment of tiny, highly curable cancers before they can be felt by touch.
Lumpectomy: surgical removal of a (usually cancerous) lump from the breast. This process spares the breast.
Mastectomy: surgical removal of all or part of the breast. Many women who have mastectomies have surgical breast implants to replace their missing tissue.

THE MENSTRUAL CYCLE

Menstruation: cyclical bleeding that stems from the shedding of endometrium. Human cycle averages 28 days in length.
Ovulation: the process by which a mature ovarian follicle ruptures and releases an ovum. Normally the ovum reaches maturity and is released by an ovary during ovulation.
Corpus luteum: an ovarian follicle that has released an ovum. The corpus luteum remains in existence only if pregnancy begins. It functions as an endocrine gland, producing large amounts of progesterone and estrogen.
Endocrine gland: a gland that secretes a hormone directly into the blood, rather than through a duct. Examples include the thyroid, adrenal, and pituitary glands, as well as the ovaries and the testes.
Menarche: the first menstrual period. Ovulation may not occur in every menstrual cycle. Anovulatory (without ovulation) occurs most commonly in the few years after the first period and again in the years prior to menopause.
Hypothalamus: a bundle of neural cell bodies involved in regulating body temperature, motivation, and emotion. It's located near the centre of the brain.
Pituitary gland: the gland that secretes growth hormone, prolactin, oxytocin, and other hormones.
Hormones: a substance secreted by an endocrine gland to regulate various body functions.

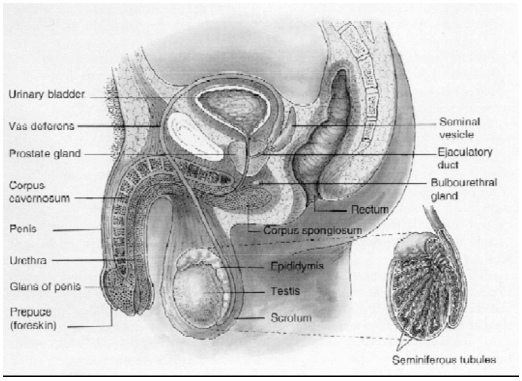
PHASES OF THE MENSTRUAL CYCLE

1. **The Proliferative Phase:** the first phase of the menstrual cycle, which begins with the end of menstruation and lasts about 9 or 10 days. During this phase, the endometrium proliferates.
2. **The Ovulatory Phase:** the second stage of the menstrual cycle. This is when a follicle ruptures and releases a mature ovum. **Graafian follicles** are the mature ovarian follicles that rupture to discharge an ovum. Identical twins develop when one fertilized ovum divides into two separate zygotes. Ovulation is set into motion when estrogen reaches a critical level.
3. **The Secretory Phase:** the third phase of the menstrual cycle, following the ovulatory phase. Also referred to as the luteal phase, after the corpus luteum, which begins to secrete large amounts of progesterone and estrogen after ovulation. Levels of progesterone and estrogen peak at around the 20^{th} or 21^{st} day of an average cycle.

4. **The Menstrual Phase:** the fourth phase of the menstrual cycle, when the endometrium is sloughed off in menstrual flow. This occurs when estrogen and progesterone levels decline to the point where they can no longer sustain the uterine lining, and the lining disintegrates.

Testosterone: the male sex hormone that fosters development of male sex characteristics and is connected with the sex drive. Male and females also produce sex hormones characteristic of the other sex, but relatively in smaller amounts.
Tampon: a cylindrical plug of cotton that's inserted into the vagina and left in place to absorb the menstrual fluid.
Menopause: the cessation of menstruation. It commonly occurs between the ages of 46 and 50 and lasts for about two years, thought it may begin at any time between the ages of 35 and 60.
Perimenopause: the years leading up to menopause, between the beginning of the climacteric and the cessation of menstruation. It is usually characterized by 3-11 months of **amenorrhea** (lack of menstruation).
Climacteric: a long-term process, including menopause, that involves the gradual decline in the reproductive capacity of the ovaries.
Hormone Replacement Therapy (HRT): post-menopausal replacement of naturally occurring estrogen or estrogen and progesterone with synthetic (sometimes natural) equivalents.
Dysmenorrhea: pain or discomfort during menstruation.
Primary dysmenorrhea: menstrual pain or discomfort in the absence of known organic problems.
Secondary dysmenorrhea: menstrual pain or discomfort caused by identified organic problems.
Prostaglandins: hormones that cause muscle fibres in the uterine wall to contract, as during labour.
Mastalgoa: a swelling of the breasts that sometimes causes premenstrual discomfort.
Amenorrhea: absence of menstruation.
Primary amenorrhea: absence of menstruation in a woman who has never menstruated.
Secondary amenorrhea: absence of menstruation in a woman who has previously menstruated.
Anorexia nervosa: a psychological disorder characterized by a desire to lose weight by refusing to eat.
Premenstrual syndrome (PMS): a combination of physical and psychological symptoms (such as anxiety, depression, irritability, weight gain from fluid retention, and abdominal discomfort) that regularly afflicts many women during the 4-6 day interval that precedes their menses each month.

MALE ANATOMY AND PHYSIOLOGY
THE EXTERNAL MALE SEX ORGANS
Phallic symbols: images of the penis that are usually suggestive of generative power.
Testes: the male sex glands, suspended in the scrotum. They produce sperm cells and male sex hormones (androgens) and produce mature germ cells. Testes usually range between 2.5 and 4.5cm in length. The left testicle usually hangs lower.



Penis: the male organ of sexual intercourse. It is a conduit for urine. It contains no bones or muscles.
Corpora cavernosa: two cylinders of 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.
Frenulum: the sensitive strip of tissue that connects the underside of the penile glans to the shaft.
Root: the base of the penis, which extends into the pelvis.
Shaft: the body of the penis which expands as a result of vasocongestion.
Foreskin: the loose skin that covers the penile glands in an uncircumcised male. It is also referred to as the prepuce.
Circumcision: surgical removal of the foreskin of the penis. About 17% of Canadian male babies are circumcised. It lessens the risk of UTIs and may impact sexual sensations.
Phimosis: an abnormal condition in which the foreskin is so tight it cannot be withdrawn from the glans.
Scrotum: the pouch of loose skin that contains the testes.
Spermatic cord: the cord that suspends a testicle within the scrotum and contains a vas deferens, blood vessels, nerves, and the cremaster muscle.
Vas deferens: a tube that conducts sperm from the testicle to the ejaculatory duct of the penis. The cylindrical tube is about 40cm long.
Cremaster muscle: the muscle that raises and lowers the testicle in response to temperature change and sexual stimulation.
Germ cell: a cell from which a new organism develops.
Sperm: the male germ cell, which fertilizes the ovum. It takes 72 days for testes to manufacture a mature sperm cell. Each sperm cell is 0.0005cm long.
Spermatozoa: mature male germ cells, which fertilize the ova.
Androgens: the male sex hormones.
Testosterone: a male steroid sex hormone.
Secondary sex characteristics: traits that distinguish the genders but are not directly involved in reproduction.
Seminigerous tubule: a tiny winding, sperm-producing tube located within the lobe of the testis.
Spermatogenesis: the process by which sperm cells are produced and developed.
Epididymis: a tube that lies against the back wall of the testicle and serves as a storage facility for the sperm.
Vasectomy: a sterilization operation in which the vas deferentia are severed.

Seminal vesicle: a small gland that lies behind the bladder and secretes a fluid that combines with sperm in the ejaculatory duct.
Ejaculatory duct: a duct formed by the convergence of a vas deferens and a seminal vesicle. Sperm travels via the ejaculatory duct through the prostate gland and into the urethra.
Andropause: the so called male menopause.
Potent: capable of sexual erection and orgasm.
Human growth hormone (HGH): a hormone that helps maintain muscle strength and that may help prevent fat buildup.

THE INTERNAL MALE SEX ORGANS
Prostate gland: the gland that lies beneath the bladder and secretes prostatic fluid, which gives semen its characteristic odour and texture. It contains muscle fibres and glandular tissue. It is approximately the size and shape of a chestnut.
Cowper's gland: a structure that lies below the prostate and empties its secretions into the urethra during sexual arousal.
Seminal vesicles: small glands that are 5cm long. Lie behind bladder and open into ejaculatory ducts.
Semen: the whitish fluid that constitutes the ejaculate, consisting of sperm and secretions from the seminal vesicles, prostate gland and Cowper's gland. Contains water, mucus, sugar, acids and bases. Typical ejaculate contains 200-400 million sperm cells and ranges from 3-5mm in volume.
Urologist: a physician who specializes in the diagnosis and treatment of diseases of the urogenital system.
Urethritis: an inflammation of the bladder or urethra.
Cryptorchidism: a condition in which at least one of the testicles fails to descent from the abdomen into the scrotum.
Benign prostatic hyperplasia (BPH): enlargement of the prostate gland, due to hormonal changes associated with aging. It's characterized by urinary frequency, urgency and difficulty starting the urine flow.
Prostate cancer: 1/7 men will develop prostate cancer mostly after the age 70 and 1/27 will die from it.
Prostatitis: inflammation of the prostate gland.

MALE SEXUAL FUNCTIONS
Erection: the enlargement and stiffening of the penis as a consequence of its engorgement with blood.
Performance anxiety: Feelings of dread and foreboding in connection with sexual activity.
Sacrum: the thick, triangular bone located near the bottom of the spinal column.
Autonomic nervous system (ANS): the division of the nervous system that regulates automatic bodily processes, such as heartbeat, pupil dilation, respiration and digestion.
Somatic nervous system: the division of the nervous system that regulates voluntary movements, such as wiggling a toe or waving an arm.
Sympathetic nervous system: the branch of the ANS most active during emotional responses that draw on the body's reserves of energy, such as fear and anxiety. The sympathetic ANS largely controls ejaculation.
Parasympathetic nervous system: the branch of the ANS most active during processes that restore the body's reserves of energy, such as digestion. The parasympathetic ANS largely controls erection.
Premature ejaculation: a sexual dysfunction in which the male persistently ejaculates too early to afford the couple adequate sexual gratification.
Peyronie's Disease: an abnormal condition characterized by an excessive curvature of the penis which can make erection painful.
Priapism: persistent and painful erection of the penis.
Orgasm: the climax of sexual excitement.
Paraplegic: a person with sensory and motor paralysis of the lower half of the body.
Emission stage: the first phase of ejaculation, which involves contractions of the prostate gland, the seminal vesicles and the upper part of the vas deferens.
Ampulla: a sec or dilated part of a tube or canal.
Urethral bulb: the small tube that makes up the prostatic part of the urethral tract. It balloons out as muscles close at either end, trapping semen prior to ejaculation.
Expulsion stage: the second stage of ejaculation, during which muscles at the base of the penis and elsewhere contract rhythmically, forcefully expelling semen and generally providing pleasurable sensations.
Retrograde ejaculation: ejaculation in which the ejaculate empties into the bladder.
Spinal reflexes and sexual response:

1. A man's penis is stimulated
2. The nerve impulse travels from site of touch to lower part (sacral area) of spinal cord
3. Nerve impulse travels back to penis
4. Erection occurs

chapter 12: sexuality across the life span & sexual-health education

Development of Childhood Sexuality, 0 to 12 Years of Age

Age (years)	Common characteristics and behaviours	Learning domains	Developmental outcomes
Infancy (0-2)	• Explores own body, including genitals • Displays spontaneous reflective sexual response (ejaculation, lubrication) • Enjoys touch from caregivers • Enjoys nudity	• Learns correct names for body parts, including genitals • Learns to differentiate between male and female • Learns to experience pleasure from touch (cuddling, nonsexual touching)	• Develops capacity to trust caregivers • Develops capacity to experience sensory (touch) pleasure • Begins to distinguish between males and females • Begins to develop sense of autonomy • Begins first social / play interactions with peers
Early childhood (2-5)	• Engages in occasional masturbation focused on soothing nor arousal • Engages in consensual exploration of same aged playmates' bodies in curiosity focused manner • Enjoys nudity • Uses slang terms for bodily functions	• Learns basics of reproduction • Learns basic rules of privacy • Learns your body belongs to you • Learns difference between appropriate and inappropriate touching	• Develops ability to identify self as male or female • Begins to understand basics of human reproduction • Understands concept of privacy related to nudity and sexuality
Middle childhood (5-8)	• Engages in curiosity based body exploration with same sex and opposite sex playmates • Engages in occasional masturbation (may begin to focus on pleasure) • Uses slang words to describe body parts and sexual behaviours • May have crushes	• Acquires basic understanding of human reproduction • Acquires preparatory understanding of basic physical changes associated with puberty • Acquires understanding of basic disjunction between heterosexuality and homosexuality	• Has well established sense of gender identity (male or female) • May show early signs of puberty (breast development) • Understand terminology for body parts (penis, vagina) • Develops basic understanding of sexual orientation (hetero, homo, bi)
Preadolescence (9-12)	• May masturbate more regularly, with a sexual focus • Experiences more frequent crushes, which can develop into relationships • May begin partnered sexual activity (rare) • Becomes more curious about sexuality • Becomes interested in sexually oriented media	• Acquires reasonably complete knowledge of physical and psychological aspects of puberty • Acquires basic knowledge of concepts of delaying first intercourse and contraception / safer sex • Learns social skills related to rights and responsibilities in relationships • Learns media literacy skills, to understand and evaluate sexual imagery and messages	• Exhibits physical and psychological changes associated with puberty • Understands basic rights and responsibilities related to sexuality and relationships

ADOLESCENT SEXUALITY

There are 4 main developmental tasks of adolescent sexuality:

1. Adapt to the physical and emotional changes of puberty
2. Accept yourself as a sexual being
3. Explore romantic and sexual relationships
4. Learn to protect your sexual health

Masturbation is a major sexual outlet in adolescence. Boys are more likely to masturbate than girls. Most adolescents experiment with sexual touching. Experience of touching below the waist increases with age – about 75% by grade 11.

Oral Sex and Vaginal Intercourse Experience Among Male and Female Teens in the US, 2002

Age	Male gave oral sex	Female gave oral sex	Male received oral sex	Female received oral sex	Male experienced intercourse	Female experienced intercourse
15-17	28.3%	30.4%	39.1%	38.0%	36.2%	36.4%
18-19	52.4%	62.8%	66.0%	66.6%	64.8%	72.3%

Percentage of 15-19 Year Old Canadians Who Have Had Sexual Intercourse, 1996-2005

	1996-1997	2003	2005
15-17	32%	30%	29%
18-19	70%	68%	65%
Male	43%	46%	43%
Female	51%	45%	43%

PUBERTY

Puberty: the stage of development when reproduction first becomes possible. Puberty begins with the appearance of secondary sex characteristics and ends when the long bones make no further gains in length.
Secondary sex characteristics: physical characteristics that differentiate males from females, but not directly involved in reproduction. Examples include bodily distribution of hair and fat, development of muscle mass, and deepening of the voice.
Primary sex characteristics: physical characteristics that differentiate males and females and are directly involved in reproduction. These are the sex organs.
Critical fat hypothesis: the view that a girl must reach a certain body weight to trigger pubertal changes such as menarche.
Nocturnal emission: involuntary ejaculation of seminal fluid while asleep.
Larynx: a structure of muscle and cartilage that lies at the upper end of the trachea and contains the vocal chords. It is also called the voice box.

ADULT SEXUALITY

Adults tend to seek more long-term, complete relationships (marriage is primary)

- Passion – how the relationship begins
- Friendship – important for satisfying relationship
- Communication – direct about likes and dislikes
- Sexual health – no less important in adulthood

RELATIONSHIPS

Serial monogamy: a pattern of becoming involved in one exclusive relationship after another, as opposed to engaging in multiple sexual relationships at the same time.
Celibacy: complete sexual abstinence. The term is sometimes used to describe the state of being unmarried, especially for people who take vows to remain single.
Cohabitation: the state whereby two people live together as a couple but are not legally married. 84% of Canadians approve of cohabitation.
Common-law relationship: a relationship in which two people live together as a couple but are not legally married. The term can refer to both opposite and same sex couples. Some jurisdictions recognize a common-law relationship as marriage.
Marriage: found in all human societies, most common lifestyle in Canada – ¾ of Canadians will marry in their 30s.
Same-sex marriage: in 2002 the term marriage was redefined to include same-sex couples. In 2005 same-sex couples were allowed to marry. In 2006 same sex common law partners increased by 11% over 5 years.
Divorce: 37.9% of marriages that took place in 2004 is expected to end in divorce. Divorce rate peaked in 1987 in response to changes to the divorce act in 1985 which made it easier to obtain a divorce. Most likely to occur after 3-4 years of marriage.
Monogamy: marriage to one person.
Polygamy: simultaneous marriage to more than one person.
Polygyny: a form of marriage in which a man is married to more than one woman at the same time.
Polyandry: a form of marriage in which a woman is married to one man at the same time.
Homogamy: the practice of marrying someone who's similar to yourself in social background and standing.
Extramarital sex: sexual relations between a married person and someone other than his or her spouse.
Conventional adultery: extramarital sex that's kept hidden from one's spouse.
Consensual adultery: extramarital sex that's engaged in openly, with the knowledge and consent of one's spouse.
Swinging: a form of consensual adultery in which both spouses share extramarital sexual experiences. This is also referred to as mate swapping.
Comarital sex: swinging, or mate swapping.
Polyamory: any form of open relationship that allows for consensual sexual and/or emotional interactions with more than one partner.

SENIOR SEXUALITY

CHANGES IN SEXUAL AROUSAL ASSOCIATED WITH AGING

Changes in the Female	Changes in the Male
Reduced myotonia (muscle tension)	Longer time to erection and orgasm
Reduced vaginal lubrication	Need for more direct stimulation for erection and orgasm
Reduced elasticity of the vaginal walls Smaller increases in breast size during sexual arousal	Less semen emitted during ejaculation
Reduced intensity of muscle spasms at orgasm	Erections may be less firm
	Testicles may not elevate as high into the scrotum
	Less intense orgasmic contractions
	Lessened feeling of a need to ejaculate during sex
	Longer refractory period

PATTERNS OF SEXUAL ACTIVITY

- Sexual relationships decline with age.
- 73% of those aged 57-64, 53% of those aged 65-74 and 26% of those aged 75-85 reported having sex with partners during the previous year.
- The average frequency of sex for those who were sexually active was 2-3 times a month. Women were less likely than men to have sexual relations because more women than men are widowed.
- People in good health were twice as likely as those in poor health to be sexually active.
- Half of those who were sexually active had one or more sexual problems, yet most had not discussed these problems with doctors after turning 50.
- 14% of the men used Viagra or other supplement to improve their sexual functioning.
- Only a minority (13% of men and 35% of women) felt that sex was not all that important.

chapter 4: sexual arousal and response

THE SENSES AND SEXUAL AROUSAL

Sight: visual cues can be sexual turn-ons. Men appear to be more responsive to visual stimuli than women.
Smell: plays a lesser role in governing sexual arousal in humans than in lower mammals.
Taste: some people are sexually aroused by the taste of genital secretions.
Pheromones: chemical substances that are secreted externally information to, or produce specific responses in, other members of the same species. They are odorless chemicals that many animals detect through a sixth sense – the vomeronasal organ (VNO).
Menstrual synchrony: exposure to other women's sweat can modify a women's menstrual cycle.
Erogenous zones: parts of the body that are especially sensitive to tactile sexual stimulation.
Primary erogenous zones: erogenous zones that are particularly sensitive because they are richly endowed with nerve endings.
Secondary erogenous zones: parts of the body that become erotically sensitized through experience.

APHRODISIACS, ANAPHRODISIACS, AND PSYCHOACTIVE DRUGS

Placebo effect: perception that consumption of a substance (i.e. medication) results in an effect (i.e. relief of a headache) even though the substance does not contain properties (i.e. active ingredients that reduce pain) that cause the effect to occur. A person who consumes a supposed aphrodisiac and feels sexually aroused may attribute the turn-on to the effects of the substance, when in reality it has no direct physiological effect on sexual desire or arousal.

Aphrodisiac: any drug or other agent that's sexually arousing or that increases sexual desire. In some societies, genital secretions are considered aphrodisiacs.

Anaprodisiac: a drug or other agent whose effects are antagonistic to sexual arousal or sexual desire. It indirectly dampens sexual arousal.

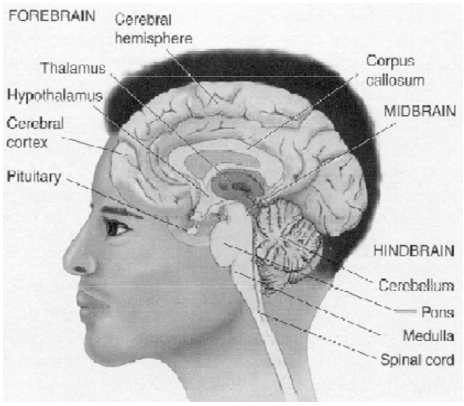
Antiandrogen: a drug that reduces the levels of androgen in the blood system. They have been used in the treatment of deviant behaviour patterns, such as sexual violence and adult sexual interest in children, with some promising results.

Alcohol: small amounts of alcohol can induce feelings of well-being, but large amounts curb sexual response. It can lower sexual inhibitions and induce feeling of euphoria. Appears to impair ability to weigh information and can lead us to ascribe our behaviour to the effects to alcohol rather than ourselves.

Hallucinogens: strong hallucinogens like LSD have been reported to enhance sexual response while there is no evidence of marijuana directly stimulating sexual response.

Stimulants: such as amphetamines (speed, uppers…) are reputed to heighten arousal and sensation of orgasm. These drugs typically activate the central nervous system, which can lead to sexual arousal. Also elevates mood, perhaps sexual arousal is heightened by general elation.

SEXUAL RESPONSE, THE BRAIN AND SEXUAL BEHAVIOUR



Cerebral cortex: the wrinkled surface area (gray matter) of the cerebrum (main part of the brain). Cells fire when we experience sexual thoughts, images, wishes and fantasies.

Limbic system: a group of structures active in memory, motivation, and emotion. These structures form a fringe along the inner edge of the cerebrum.

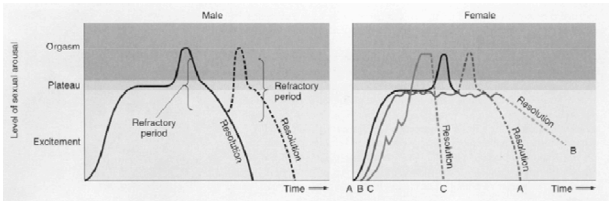
Hormone: a substance, secreted by an endocrine gland that regulates various body functions.

Secondary sex characteristics: physical traits that differentiate males from females, but are not directly involved in reproduction.

Transsexual: a person with a gender-identity disorder, who feels that he or she is really a member of the other gender, and trapped in a body of the wrong gender.

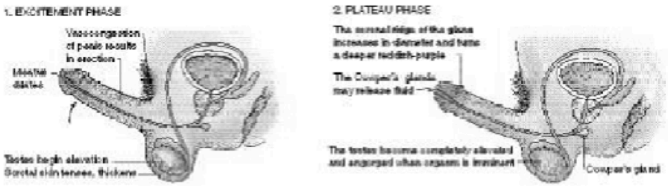
Hypogonadism: a condition marked by abnormally low levels of testosterone production. OCCURS IN MALES.

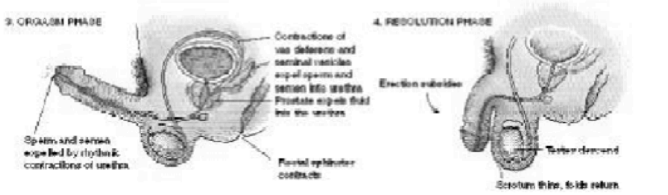
Ovariectomies: surgical removal of the ovaries. OCCURS IN FEMALES.



FACTORS INFLUENCING AROUSAL

- Arousal among men and women could be enhanced by partner's positive characteristics, varied sex, and anticipation of sexual encounters.
- Arousal was inhibited by a partner's self-consciousness, a lack of balance in giving and receiving sex, and worries about various issues.
- Women more aroused than men by partner's positive characteristics, feeling emotionally connected, and hormones.
- Men were more aroused by specific sexual stimuli.
- Women were more inhibited than men by possible sexual violence and exploitation and concern about sexual performance.

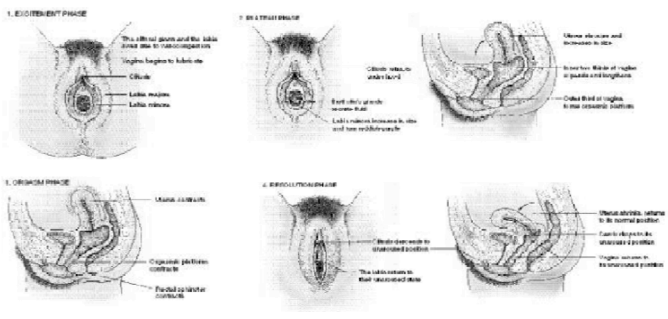




MODELS OF SEXUAL RESPONSE

Sexual response cycle: masters and Johnson's model of sexual response, which consists of four phases.

1. **Excitement phase:** the first phase of the sexual response cycle, characterized by erection in the male, vaginal lubrication in the female and muscle tension and increased heart rate in both the male and female.
2. **Plateau phase:** the second phase of the sexual response cycle, characterized by increased vasocongestion, muscle tension, heart rate, and blood pressure, in preparation for orgasm. In women vasocongestion swells the tissues of the outer 1/3 of the vagina, contracting the opening.



3. **Orgasmic phase:** ejaculation occurs in man and woman. In the male, consists of 2 stages of muscular contraction. Sensations of pleasure tend to be related to strength of contractions and amount of seminal fluid. First 3-4 are most intense and occur at 0.8 second intervals; 2-4 more occur at a slower pace. In the female, orgasm is comprised of 3-15 contractions of the pelvic muscles that surround the vaginal barrel. In both genders, muscles throughout the body spasm, blood pressure and heart rate peak, and respiration increases to 40 breaths per minute.
4. **Resolution phase:** the fourth phase of the sexual response cycle, during which the body gradually returns to its pre-aroused state. Both men and women may feel relaxed and satiated.

Vasocongestion: swelling of the genital tissues with blood, which causes erection of the penis and engorgement of the area surrounding the vaginal opening.
Myotonia: muscle tension.
Sex flush: a reddish rash that appears on the chest or breasts late in the excitement phase of the sexual response cycle.
Orgasmic platform: thickening of the walls of the outer 1/3 of the vagina (due to vasocongestion) during the plateau phase of the sexual response cycle.
Sex skin: the reddened skin of the labia minora during the plateau phase.
Refractory period: the time following an orgasm when an individual no longer responds to sexual stimulation.
Kaplan's 3 stages of sexual response: based on clinical work, a 3 stage model for desire and sexual response:

1. Desire
2. Excitement
3. Orgasm

Basson's intimacy model of female sexual response: an intimacy model of female sexual response, especially relevant for women in long-term relationships:

- Process may not always begin with desire
- Women may feel aroused for intimacy reasons
- Arousal may precede desire
- Arousal may not lead to orgasm

THE ENIGMATIC ORGASM

Multiple orgasms: one or more additional orgasms following the first, occurring within a short period of time and before the body has returned to its pre-plateau level of arousal. Women can maintain a high level of arousal and experience orgasms in rapid succession because they do not have a refractory period. Women have multiple kinds of orgasms:

- **Clitoral orgasm:** achieved through direct clitoral stimulation such as masturbation.
- **Vaginal orgasm:** an orgasm achieved through deep penile thrusting during intercourse.
- **Vulval orgasm:** orgasm involving vulval contractions.
- **Uterine orgasm:** orgasm in response to deep thrusting against the cervix.
- **Blended orgasm:** combines features of the vulval and uterine orgasms. It involves both an involuntary breath-holding response and contractions of the pelvic muscles.

SEXUALITY AND DISABILITIES

Multiple Sclerosis (MS): a chronic, unpredictable disease that affects the nervous system. The tissue called myelin, which surrounds and protects nerve cells, disintegrates, leaving scar tissue in its place. MS impairs sexual functioning.
Cerebral Palsy: a muscular disorder caused by damage to the central nervous system, usually before or during birth, and characterized by spastic paralysis. It does not generally impair sexual interest, capacity for orgasm or fertility.
Spinal-cord injuries: people who suffer physical disability as a result of traumatic injury or physical illness must learn to cope with their limitations, but adjust to a world designed for able-bodied people. The effect of spinal-cord injury on sexual response depends on the injury's site and severity.
Sensory disabilities: blindness, deafness, etc. do not directly affect genital responsiveness. Sexuality may be affected in the ability to understand a partner's anatomy.
Arthritis: a progressive disease characterized by inflammation and pain in the joints. It may make it difficult or painful to participate in sexual activity.

chapter 13: sexual dysfunction

TYPES OF SEXUAL DYSFUNCTION

Sexual dysfunction: a persistent or recurrent difficulty with a lack of sexual desire or arousal, or difficulty reaching orgasm. Sexual dysfunctions are classified as lifelong/acquired (following periods of unproblematic functioning) or generalized (occur in all situations) / situational (only in some situations). There are four categories of sexual dysfunction:

1. **Sexual-desire disorders:** these involve lack of interest in sex or aversion to sexual contact.
2. **Sexual-arousal disorders:** in men, these involve persistent difficulty in obtaining or sustaining erections sufficient to engage in satisfactory sexual activity. In women, they typically involve insufficient lubrication.
3. **Orgasmic disorders:** these involve persistent problems reaching orgasm, or reaching orgasm more quickly that the individuals would like. Women are more likely to encounter difficulties having orgasms, and men are more likely to reach orgasm too quickly (rapid ejaculation).

4. **Sexual-pain disorders:** both men and women may suffer from dyspareunia (pain during sex). Women may experience vaginismus or involuntary contraction of the muscles that surround the vaginal barrel, preventing or making penetration painful.

Dyspareunia: a sexual dysfunction characterized by persistent or recurrent pain during sexual activity.
Vaginismus: a sexual dysfunction characterized by involuntary contraction of the muscles surrounding the vaginal barrel, preventing or making penetration painful.
Canadian contraception study: about ½ of women reported at least one of low sexual desire (43%), painful intercourse (15% or lack of orgasm during intercourse (24%). 40-80 year old Canadian men and women found 23% of men experienced rapid ejaculation and 16% had problems with erection. 40-88 year old Canadian men found 49% of men experienced some form of erectile dysfunction.

SEXUAL DESIRE DISORDERS
Sexual desire disorders: result in a lack of sexual desire or aversion to sexual contact, more common among women than men. Discrepancies in desire are more common in heterosexual couples. Sexual arousal and response may not be impacted. Lack of desire is only considered a dysfunction if the person finds his or her level of desire distressing.
Hypoactive sexual desire disorder: little or no sexual interest or desire. One of the most commonly diagnose sexual dysfunctions.
Sexual aversion disorder: finds sex disgusting, aversive and avoids all genital contact. Histories of erectile problems can cause sexual aversion in men. Histories of sexual trauma often figure largely in cases of sexual aversion, particularly among women.

SEXUAL AROUSAL DISORDERS – CAUSES AND TREATMENTS
Sexual arousal disorders: failure to achieve or sustain the erections or lubrication necessary to facilitate sexual activity. Lack the subjective feelings of sexual pleasure and excitement that normally accompany sexual arousal.
Male erectile disorder: sexual arousal disorder in the male. It's characterized by persistent difficulty in achieving or maintaining an erection sufficient to allow completion of sexual activity. In most cases, the failure is limited to sexual activity with partners or with some partners and not others (situational). Some men can attain erections much not sustain them. Incidence increases with age. Treatments include: oral medications, hormone treatment, vascular surgery, penile implants, or vacuum pump.
Performance anxiety: anxiety concerning one's ability to perform behaviours, especially behaviours that may be evaluated by other people.
Female arousal disorder: women may encounter persistent difficulties becoming sexually excited or sufficiently lubricated in response to sexual stimulation. Can be lifelong or develop after period of normal functioning. May be pervasive, but most occur in specific situations. Causes are usually psychological (depression, relationship problems…) or biological (diabetes, heart disease…) Treatments include: sex education, coping with cognitive interference, working on relationship problems, artificial lubricant, testosterone skin patches, or Viagra.
Female anorgasmic disorder: women who are unable to reach orgasm, through any means. Or have difficulty reaching orgasm after what would usually be adequate sexual stimulation. This is more common among women than men. A woman who has orgasms through masturbation but not intercourse does not have female orgasmic disorder. Treatments include: addressing negative attitude about sex, Masters and Johnson's couples oriented approach or individual masturbation.
Male anorgasmic disorder: also referred to as delayed ejaculation, retarded ejaculation, and ejaculatory incompetence. May be lifelong or acquired, generalized or situational. Very few men have never ejaculated – in most cases the disorder is limited to intercourse. Can be caused by physical factors (MS or neurological damage) or psychological factors (performance anxiety, sexual guilt or hostility toward partner. Treatments include: increasing sexual stimulation, reducing performance anxiety, or sensate focus exercises.
Rapid ejaculation (RE): a sexual dysfunction in which ejaculation occurs with minimal stimulation, and before the man desires it. It is also called premature ejaculation. Degree of rapidity varies, most men ejaculate just before or after penetration. Treatment can include sensate-focus exercises, squeeze technique (the tip of the penis is squeezed to temporarily prevent ejaculation), or stop-start method (stimulate (manually or through intercourse) until the man is about to ejaculate, stop until arousal subsides, then resume stimulation).

SEXUAL-PAIN DISORDERS – CAUSES AND TREATMENTS
Dyspareunia: painful intercourse or persistent pain associated with any stimulation of the vaginal area. Painful intercourse is less common in men, generally associated with a genital infection. It is one of the most common sexual dysfunctions and a common complaint of women seeking gynecological services. Location of pain may vary. Can be caused by physical factors (inadequate lubrication, vaginal infections, STIs, allergic reactions to spermicide or latex, endometriosis, general hypersensitivity to pain) or psychological factors (unresolved guilt, anxiety about sex, sexual trauma…) Treatment includes: medical intervention to treat underlying physical problems which may cause pain, cognitive-behaviour therapy or surgery.
Vaginismus: an involuntary contraction of the pelvic muscles that surround the outer 1/3 of the vaginal barrel, resulting in pain. Avoidance of penetration seems to be the key factor differentiating vaginismus from dyspareunia. Vagismus occurs reflexively during attempts at vaginal penetration making entry of the penis, fingers, or a dildo difficult or impossible. Some believe it is caused by a fear of penetration, rather than by physical injury or defect. Can be caused by psychological factors (trauma or botched abortion resulting in fear of penetration) or physical factors (cause or effect of dyspareunia). Treatments can include: behavioural exercises in which plastic vaginal dilators of increasing size are inserted to help relax the musculature or psychological treatment for sexual trauma may be needed if this is the root cause.
Vulvodynia: a gynecological condition characterized by vulval pain, particularly a chronic burning sensation, irritation and soreness.
Vulvar vestibulitis: pain that can be experienced both through sexual and nonsexual contact at the entrance of the vagina.

ORIGINS OF SEXUAL DYSFUNCTION

Biopsychosocial model: an approach to explaining dysfunction that looks at the interactions of biological, psychological and sociocultural factors.

Biological factors: physical changes associated with aging, prescription and illegal drugs/alcohol use, medical conditions/health problems.

Hypogonadism: an endocrine disorder that reduces the output of testosterone.

Tumescence: erection; swelling.

Cultural influences: children reared in sexually repressive cultural or home environments may learn to respond to sex with feelings of anxiety and shame, rather than anticipation and pleasure.

Psychosexual trauma: women and men who were sexually victimized in childhood are more likely to have trouble becoming sexually aroused.

Emotional factors: pleasurable, fulfilling sexual activity with a partner typically involves allowing yourself to let go emotionally, at least to some extent.

Myths and misinformation: many people grow up badly misinformed about sexuality.

Ineffective sexual techniques: people who lack information about sexuality, and particularly about sexual response, are more likely to be unaware of what techniques are sexually pleasurable for themselves and their partners.

Boredom and routine: it's common for couples to fall into narrow sexual routines, in which the timing and sequence of sexual activity follow constant, familiar patterns.

Lack of sexual communication: partners who don't communicate their sexual preferences or experiment with new techniques may find themselves losing interest.

Performance anxiety: plays an important role in sexual dysfunctions.

TREATMENTS FOR SEXUAL DYSFUNCTIONS

Sex therapy: a collective term for behavioural models for treating sexual dysfunctions. Sex therapy aims to modify dysfunctional cognitions (beliefs and attitudes) and behaviours as directly and as quickly as possible. Biological treatments can include Viagra for erectile dysfunction.

PLISSIT model: used by many therapies to address the sexual concerns of their clients. This model allows health professionals and their clients to differentiate between sexual problems that can be resolved through basic education and counseling and problems that require intensive or specialized sex therapy. The PLISSIT model consists of 4 escalating levels:

- **Permission (P):** at the first level, the therapist gives the client permission to talk about sexuality and personal concerns. The therapist often asks exploratory questions, to bring out the relevant issues and put the client at ease.
- **Limited information (LI):** some sexual problems may be rooted in myths and misinformation about sexuality. Providing a limited amount of correct information about sexual functioning is often a key step in resolving a problem.
- **Specific suggestions (SS):** once the basic nature of a sexual problem is identified, the therapist provides suggestions to help resolve it. The client may be encouraged to read books about sexual enhancement, or watch instructional videos. With a basic understanding of the client's sexual issues, the therapist may also make specific suggestions for incorporating specific sexual techniques, or suggest way the couples can refocus their sexual interaction.
- **Intensive therapy (IT):** if the first three elves of therapy are unsuccessful in solving the problem, a more intensive form for sex therapy may be required. At this point, a therapist who doesn't specialize in sex therapy will refer the client to someone with advanced training in treating sexual dysfunction.

Senate-focus exercises (the Masters-Johnson Approach): exercises in which sexual partners take turns giving and receiving pleasurable stimulation in non-genital areas.

Sexuality technique: a method for treating premature ejaculation. The tip of the penis is squeezed, to temporarily prevent ejaculation.

chapter 6: attraction and love

ATTRACTION

Attraction-similarity hypothesis: the concept that people tend to develop romantic relationships with those whose levels of attractiveness are similar to their own. It has been found that people in committed relationships are likely to be similar to their partners in terms of attitudes and cultural attributes. Our partners tend to resemble us in race and ethnicity, age, level of education, and religion. 95% of Canadians choose partners from their own racial backgrounds.

Propinquity: proximity, the reason why the great majority of us have partners from our own backgrounds. Women place greater weight on similar attitudes, men on physical attractiveness. We tend to assume people we find attractive to share our attitudes. Similarity may be important in determining initial attraction; compatibility appears to be a stronger predictor of maintaining an intimate relationship.

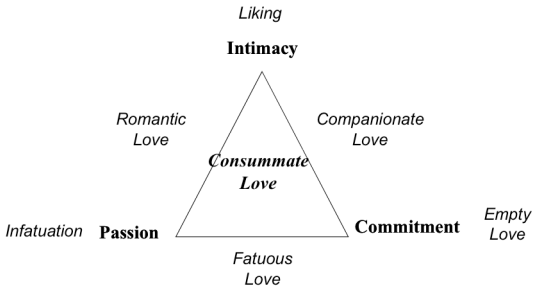
Reciprocity: mutual exchange. When we feel admired and complimented, we tend to return these feelings and behaviours. Reciprocity is a potent determinant of attraction. May enable couples to become happy with one another. Can stoke neutral or mild feelings into robust, affirmative feelings of attraction.

Physical attractiveness: is a major determinant of interpersonal and sexual attractiveness. Some contend it is the key factor in consideration of partners for dates, sex and long-term relationships. Importance is accentuated by the "what is beautiful is good" effect. Is beauty in the eye of the beholder? What is considered attractive varies by culture, women consider taller men to be more attractive, thinness is values in North American culture and the hourglass figure is popular in Canada and in most other cultures (this varies by sexual orientation however). How beautiful we find a partner is likely to be enhanced by traits such as familiarity, liking, respect, and shared values and goals. Gender role orientation and expectations affect perceptions of attractiveness. Women's judgments of themselves are closely related to how men perceived them. In selecting a long-term partner: women place relatively greater emphasis than men on

vocational status, earning potential, expressiveness, kindness, consideration, dependability, fondness for children, while men give relatively greater consideration to youth, physical attractiveness, cooking ability, and frugality. Women rate attractiveness as more important in choosing a casual sex partner. In a spouse: men valued only one characteristic more highly than women did: good looking. Women, more than men, values such traits as: manages money well, is well educated and intelligent and shares your religion. Critics suggest that gender differences in mate preferences are maintained by male-dominated social structures. As cultures develop higher levels of gender equality, male and female standards of attractiveness will gradually change. Some of these changes are occurring already.It was determined that women who were more open to short-term sexual relationships would be more likely to prefer highly masculine male faces and bodies. Women associate higher levels of masculinity with healthier genes. Men want mates to be younger and women prefer mates to be older. Gay and heterosexual men generally found younger partners more sexually appealing than lesbian and heterosexual women. Gay men preferred the youngest partners, lesbian women preferred the oldest. Physical closeness has always been a factor in interpersonal attraction. With the internet, proximity is not necessary. On-screen, the cues that might spark attraction or interest are different than in person. Sometimes relationships develop faster online. Online flirting can build unrealistic expectations of relationships.
Love: our culture idealizes the concept of romantic love. People who feel loved have better health that those who do not. About ½ of adult Canadians report that they are satisfied with the amount of love in their lives.

LOVE
Storge (STORE-gay): loving attachment and nonsexual affection. This is the type of emotion that binds parents to children.
Agape (AH-gah-pay): selfless love. This kind of love is similar to generosity and charity.
Philia (FEEL-yuh): love between friends. This kind of love is based on liking and respect, rather than sexual desire.
Eros: the kind of love that's closest to our modern-day concept of passion.
Infatuation: a state of intense absorption in or focus on another person, usually accompanied by sexual desire, elation, and general physiological arousal or excitement. Infatuation can also be referred to as passion. Usually accompanied by sexual desire, elation, general physiological arousal or excitement, passion. Difficult to distinguish love from infatuation in the first month or two of a relationship. As partners begin to view each other more realistically, they are better able to determine if a relationship should continue. Infatuation is based on intense feelings of passion, not attachment and caring. Infatuation can lead to a more lasting love relationship, but isn't a necessary precursor. Sometimes one partner experiences infatuation and the other does not.
Romantic love: love characterized by feelings of passion and intimacy. Romantic love as represented by fairy tales, has been idealized in Western culture. In adolescence, strong sexual arousal and idealized images of the objects of our desire lead us to label our feelings "love". Being "in love" ennobles sexual attraction and sexual arousal. Women more often are expected to justify their sexual experiences by involving "love". Most people in Canada believe romantic love is a prerequisite for marriage. About ½ of Canadians believe in love at first sight. When fulfilled, romantic love is usually a source of deep fulfillment and ecstasy. When unrequited, it can lead to emptiness, anxiety and despair.

CONTEMPORARY MODELS OF LOVE
Biological mechanisms: some researchers focus on the bodily changes that occur when we experience feelings of romantic love. i.e. neural pathways, brain chemistry.
Love as appraisal of arousal: romantic love is the state of intense physiological arousal and the cognitive appraisal of that arousal as love. i.e. sweaty palms, racing heart attributed as love. The perception of falling in love requires: state of arousal in connection with love object, cultural setting which idealizes romantic love, attribution of arousal to feelings of love.
Styles of love (6): romantic love (eros), game-playing love (ludus), friendship (storge, philia), logival love (pragma), possessive, excited love (mania) and selfless love (agape).
Sternberg's triangular theory of love: there are three components of love, **intimacy** (the experience of warmth toward another person that arises from feelings of closeness, bondedness and connectedness, include the desire to give and receive emotional support and to share one's innermost thoughts), **passion** (an intense romantic or sexual desire for another person accompanied by physiological arousal) and **commitment** (dedication to maintaining the relationship through good times and bad.) Various combinations of the three components of love characterize six different types of love relationships.



- Liking = intimacy alone
- Empty love = commitment alone
- Infatuation = passion alone
- Romantic love = intimacy + passion
- Companionate love = intimacy + commitment
- Fatuous love = passion + commitment
- Consummate love = intimacy + commitment + passion

chapter 7: relationships, intimacy, and communication

THE ABC(DE)s OF ROMANTIC RELATIONSHIPS
Social exchange theory: the view that a relationship's development reflects the unfolding of social exchanges – that is, the rewards and costs of maintaining the relationship, as opposed to those of ending it. During each stage, positive factors sway the partners toward maintaining and enhancing their relationship. Negative factors incline them toward letting it deteriorate and end.
ABCDE method: Levinger's view, which approaches romantic relationships in terms of five stages: attraction, building, continuation, deterioration, and ending (or termination).

- **Attraction:** occurs when two people become aware of and find one another appealing or enticing. We may find ourselves attracted to an enchanting person across a crowded room, in a nearby office, or in a new class. We may meet others through blind dates, introductions by mutual friends, computer matchups, or by accident.
- **Building:** building a relationship follows initial attraction. Factors that motivate us to build a relationship include similarity in level of physical attraction, similarity in attitudes and interests, and a generally positive evaluation of the partner. Factors that may deter us from trying to build a relationship include lack of physical appeal, dissimilarity in attitudes, and a mutually negative evaluation.
- **Continuation:** once a basic level of attachment and intimacy has been established, a relationship typically enters a stage of continuation, during which established patterns of interaction remain relatively stable. While these patterns often continue, they do not remain entirely static. Within this stage, a relationship will mature and evolve as time passes and circumstances change. A relationship in the continuation stage that does not balance the stability of established patterns of intimacy and communication with the need for ongoing adaptation and development may enter a stage of deterioration.
- **Deterioration:** a relationship begins to deteriorate when it becomes less rewarding than it was. A couple can respond to deterioration actively or passively. Active means of response include doing something that may enhance the relationship. Passive methods of response include merely waiting for something to happen, doing little or nothing. The couple can sit back and wait for the relationship to improve on its own or to deteriorate to the point where it ends. It's irrational to assume good relationships require no investment of time and effort. No two people are matched perfectly. When problems arise, it's better to work to resolve them than to act as though they do not exist and hope they will just disappear.
- **Ending:** according to social-exchange theory, relationships draw to a close when the partners find little satisfaction in the affiliation, when the barriers to leaving the relationship are low, and especially when alternative partners are available. Problems with jealousy and communication and common reasons for ending a relationship. Various factors can save a deteriorating relationship for example people who continue to find some source of satisfaction, are committed to maintaining the relationship, or believe they will eventually be able to overcome their problems are more likely to invest what they must to prevent the collapse.

Online dating: most online dating sites cater to niche markets and can be costly. pof.com is free and open to all, and offers only the basics yet it is the most popular dating site in Canada. Revenue comes from google ads, and because of low operating costs, largely funnel to Marjus Frind who runs the site. While most men and women find it acceptable to communicate with a potential date online or via texting, the preferred way of asking someone out is still in person or over the phone. Rapid self-disclosure seems to be the norm in cyberspace. Cyberspace allows for anonymity and enables people to control what they want to reveal. Sexual self-disclosure is seen on many blog sites.

Self-disclosure: the revelation of personal-perhaps intimate-information. Opening up is central to building an intimate relationship. There must be a careful balance of enough but not too much information. Women are only slightly more revealing about themselves than men. Individuals who communicate more about their sexual likes and dislikes report higher sexual satisfaction. For women, disclosing about nonsexual issues was more associated with sexual satisfaction than sexual issues. Least disclosed topics tend to be masturbation and sexual thoughts. Culture definitely influences sexual self-discosure.

Sexting: refers to the sending of sexually explicit messages from one mobile phone to another. Sexting has garnered much media attention. No Canadian research on prevalence has been conducted. May break Canadian child pornography laws.

Small talk: a superficial kind of conversation that allows exchange of information but stresses breadth of topic coverage rather than in-depth discussion. In the early stage of building a relationship, we typically look for common ground in the form of overlapping attitudes and interests, and we check out our feelings of attraction. The opening line is one kind of small talk. Some opening lines include verbal salutes (good morning), personal inquiries (how are you?), compliments (I like your outfit), references to mutual surroundings (great apartment), references to people or events outside the immediate setting (how do you like the weather we have been having?), references to the other person's behaviour (I see you out on this track every morning) and references to your own behaviour or your own (hi, my name is…) Early exchanges are likely to include name, occupation, marital status and hometown. Relationship progression requires the exchange of information. Disclosing too much may make others feel uncomfortable. More common now for women to initiate contact. Direct opening lines that signal interest are rated most effective by men and women.

Sexual initiation: initiating sex is stereotypically considered a mans role. Most initiation involves some verbal initiation with indirect initiation more common than direct initiation. Women report using a number of strategies to influence their partners to have sex, if they are reluctant.

Commitment: studies show that men are more reluctant than women to make relationship commitments. Cohabitation (and having free access to sex may be a disincentive to commit. Boredom can deteriorate a relationship, but it may not end it as people consider it a tradeoff for true love and companionship. Factors leading to endings include fighting, inequity, jealousy and general dissatisfaction.

Jealousy: present in all cultures, but more common in cultures with stronger machismo traditions and where men view women's infidelities as threats to their honour. Found in all genders and sexual orientations. Aroused when we think our relationships are threatened by rivals. Can lead to loss of affection, feelings of insecurity and rejection, anxiety, loss of self-esteem and mistrust of our partners and potential rivals. Can lead to depression, abuse, suicide or murder. Milder forms not necessarily destructive. Feelings of possessiveness can subject relationships to stress. ¾ of participants in a UofG study reported that they or their partners had former romantic or sexual partners as facebook friends. 92% said their partners had facebook friends they did not know. Correspondence or seeing photos of these individuals triggered feelings of jealousy, especially among those already jealous. Time spent on facebook increased jealousy. Males are more upset by sexual infidelity. Jealous has been shaped by natural selection as a way of assuring males that their female partners' offspring are their own. Females are more upset by emotional infidelity. Mates who stray may not continue to provide resources to facilitate child-rearing. This gender difference disappears when our partners are unfaithful with members of the same sex. Jealousy

increases when individuals attribute their partners infidelity to internal causes. When infidelity is attributed to external causes (alcohol use or social pressures), less jealousy is reported.
Sexual consent: UofG study found that most do not ask explicitly for sex. About half consent to sex by not saying no. A slight majority prefer for consent to be verbalized but a significant minority would rather assume it until a partner indicates otherwise. Follow-up study found consent is often not considered necessary to obtain in longer term relationships.
Breaking up: difficult for the person terminating the relationship and the one being let go. Anxious people experience more difficulty. Emotionally secure people seek social support. Insecure individuals more likely to turn to alcohol and drugs. Stalking can occur following a break up. Jealousy, abusiveness, and physical violence in relationships are key predictors.
Intimacy: feelings of closeness and connectedness, marked by sharing of one's innermost thoughts and feelings. A key ingredient in a passionate relationship. Sexual and emotional intimacy are not always connected. Honesty is a key component (but not oversharing). Intimacy fosters health and well-being.
Mutual cyclical growth: the view that your need for your partner promotes commitment, which promotes acts that enhance the relationship, and that these acts build trust, increasing your partner's commitment to the relationship. This model includes five stages:

1. The feeling that you need your partner promotes your commitment to and dependence on the relationship.
2. Your commitment to the relationship encourages you to do things that are good for the relationship.
3. Your partner sees your pro-relationship acts.
4. Your partner's perception of your pro-relationship acts enhances his or her trust in you and in the relationship.
5. Your partner's feelings of trust increase his or her willingness to depend on the relationship.

Heterosexual and LGB relationships: few differences in factors which predict satisfaction in relationships or the deterioration and ending of a relationship. One difference: gay and lesbian couples tend to distribute household chores more equally. For women, sexual and relationship satisfaction are connected. Because heterosexual relationships are more likely to have family support and are less likely to be stigmatized by society, they tend to be more stable. LGB relationships tend to have issues requiring special sensitivity toward these commonly stigmatized subpopulations:

- LGB identity development, and its effect on the couple's functioning.
- Parenting, and its impact on the couple.
- LGB individuals as members of families.
- The kinds of stressors that affect individuals who are underrepresented in the groups and LGB members of religious groups.
- Legal issues and their impact on the couple.
- Workplace issues, and their impact on the couple.

Communication skills: clear communication can take the guesswork out of relationships. People may be uncomfortable discussing sexual topics, fearing they will offend their partners or incur negative reactions. Higher sexual self-esteem associated with communicating sexual desires to a partner. Individuals who feel more positive about their sexuality and who have had more partners are more confident bringing up a new activity. There are obstacles to sexual communication: considering sex talk to be vulgar or inappropriate or harboring irrational believes about relationships and sex. To get started, you must: admit it is difficult to talk about sex, pick a time when you are rested and relaxed, pick a place where you have privacy and ask permission to raise an issue. In order to communicate sexual needs, you must: ask questions to draw the other person out, use self-disclosure to invite reciprocation, grant the other person permission to say something which might upset you, provide information, accentuate the positive, use verbal cues and use nonverbal cues. 46% of Canadians report that they are very comfortable asking their sexual partners to try something new or different in their sexual relationships. 17% say they are not comfortable. Those who are 50 and older are least comfortable with this. Listening to your partner effectively can help a relationship. Some listening effectively mechanisms include:

- Active listening
- Paraphrasing
- Using reinforcement
- Valuing your partner even when you disagree

chapter 5: gender identity and gender roles

Gender: the physiological state of being female or male, as influenced by cultural concepts of gender-appropriate behaviour. Gender is distinct from anatomic sex, which is based on the physical differences between females and males.
Gender typing: the process by which children acquire behaviours deemed appropriate for sex.

PRENATAL SEXUAL DIFFERENTIATION

Sexual differentiation: the process by which males and females develop distinct reproductive anatomy.
Chromosome: a rod like structure found in the nucleus of every living cell. It carries the genetic code, in the form of genes. When a sperm fertilizes an ovum, 23 chromosomes from the male parent normally combines with 23 chromosomes from the female parent. The 23rd chromosome is the sex chromosome. Ovum carries the x sex chromosome while sperm can carry either x or y chromosome.
Zygote: a fertilized ovum (egg cell).
Embryo: the stage of prenatal development that begins with implantation of a fertilized ovum in the uterus and concludes with development of the major organ systems at about two months after conception. After fertilization, the zygote divides repeatedly. During the first 6 weeks, embryonic structures of both sexes develop along similar lines. At the 7th week, the genetic code (xx or xy) begins to assert itself. If Y chromosome is absent, ovaries begin to differentiate.
Androgens: male sex hormones. Without androgens we would all develop female external reproductive organs.
Testosterone: the male sex hormone that fosters development of male sex characteristics and is connected with the sex drive.

Descent of the testes and ovaries: by 10 weeks after conception, testes and ovaries have descended. 4 months after conception, testes descend into the scrotal sac. Cryptorchidism is a condition in which one of the testes fails to descend. The inguinal canal is a fetal canal that connects the scrotum to the testes, allowing the latter to descend.
Klinefelter's syndrome: a disorder in which a male has an extra x sex chromosome (an xxy pattern rather than an xy pattern). Affects 1 in 500 males. Males fail to develop appropriate secondary sex characteristics and fail to produce sperm. They tend to have mild mental retardation.
Turner's syndrome: a disorder in which a female has just one x sex chromosome. It affects 1 in 2500 females causing them to not naturally undergo puberty. If treated with hormones, it can spur the development of secondary sex characteristics.

GENDER IDENTITY
Gender identity: one's view of oneself as being male or female.
Sex (gender) assignment: the labeling of a newborn as male or female. This reflects a child's anatomic sex. This usually occurs at birth.
Intersexual: a person who possesses the gonads of one gender and external genitalia that are ambiguous or typical of the other gender. An intersexual is also referred to as a pseudohermaphrodite.
Hermaphrodites: an individual who possesses both ovarian and testicular tissue. The person usually assumes gender identity and gender role assigned at birth.
Congenital adrenal hyperplasia: a form of intersexualism in which a genetic female has internal female sexual structures and masculinized external genitals. Girls with CAH showed more interest in masculine typed toys, more likely to have boys as friends and to want masculine typed careers.
Androgen insensitivity syndrome: a form of intersexualism in which a genetic male is prenatally insensitive to androgens. As a result, his genitals do not become normally masculinized.
Dominican Republic syndrome: a form of intersexualism in which a genetic enzyme disorder prevents testosterone from masculinizing the external genitalia. First documented in a group of 18 affected boys in 2 rural villages. Boys resembled girls and were reared as females. At puberty, secondary sex characteristics were developed and 17 shifted to masculine gender identity.
Intersexuality: all of the different syndromes characterized by some abnormality or anomaly in physical sex differentiation.
Gender Identity Disorder (GID): is a very controversial diagnosis. Some researchers question the validity of GID, arguing that the diagnosis pathologizes transgendered persons. Cross-cultural research suggests that in some cultures, cross-gender behaviour is an unproblematic variation, not a mental disorder. Distress felt by North American children may be result of hostile and discriminating attitudes.
Transsexualism: a condition in which an individual strongly desires to be and to live as a member of the other sex. The American Psychiatric Association calls this "gender identity disorder". Many transsexuals undergo hormone treatments and surgery to create the appearance of the external genitals typical of the other sex. This can be done more precisely for male to female transsexuals than for female to male transsexuals.
Transgenderism: a synonym for transsexualism. It is also an activist movement seeking rights and pride for transgendered individuals. For many in the transgender movement the label transgendered encompasses not only transsexual and transgendered people but also cross-dressers or transvestites, drag queens, drag kings, intersexed individuals, and anyone who is unconventionally gendered (who identifies or behaves in a manner that runs counter to expected societal norms for the gender assigned at birth. Some researchers contend that men who seek to become women fall into other categories like homosexual transsexual (extremely feminine men who aren't fully satisfied by sexual activity with other men) and autogynephilic (men who are sexually stimulated by fantasies that their bodies are female). These conceptualizations are highly controversial. Homosexual transsexuals usually show cross-gender preferences in play and dress during early childhood. Female to male transsexuals appear to have an easier time adjusting than male to female transsexuals. It may be easier for a female transsexual to wear man's clothes and pass for a man than the reverse.
Gender dysphoria: a sense of incongruity between your anatomic sex and your gender identity.
Phalloplasty: surgical creation of an artificial penis.
Sex reassignment: health professionals conduct careful evaluations to determine that people seeking reassignments are competent to make such decisions and have thought through the consequences. It involves a lifetime of hormone treatments. Surgery is cosmetic and cannot construct internal genitals or gonads. Most reports of transsexuals' postoperative adjustments are positive. Most are no longer gender-dysphoric and most will function well sexually, psychologically and socially. Adjustment is most favorable for female to male transsexuals. In 1966, Bruce Reimer, one of a pair of identical twins lost much of his penis as a result of a circumcision accident. At the time it was believed that gender identity was sufficiently malleable that the boy could undergo sex reassignment surgery and be successfully reared as a girl. By age 14, she was told of the accident and the process of sex reassignment she decided to pursue life as a male. As an adult he recalled he had never felt comfortable as a girl and committed suicide in 2004 as the age of 38.
Third gender (sex): refers to people who are considered neither women nor men. May represent an intermediate state between man and woman, a state of being both man and woman or a state of being neither man or woman. Examples include the ladyboys of Thailand, the two=spirits of North America and the Hijras of South-Central Asia.

Identity Development Stages in Female to Male Transsexualism

Development Stage	**Some Characteristics**	**Some Actions Taken**
Abiding anxiety	Unfocussed gender and sex discomfort	Preference of masculine activities and companionship
Identity confusion	First doubts about suitability of assigned gender and sex	Reactive gender and sex conforming activities or preference for masculine activities and companionship
Identity comparison	Seeking ad weighing alternative female identities	Adoption of mannish lesbian identity, secret identity as a man and a male
Discovery	Learning that female to male transsexualism exists	Accidental contact with information about transsexualism

Identity confusion	First doubts about the authenticity of own transsexualism	Seeking more information about transsexualism
Identity comparison	Testing transsexual identity using transsexual reference group	Start to disidentify as women and females, start to identify as a transsexual
Identity tolerance	Identify as probably transsexual	Increasingly disidentify as women and females
Delay	Waiting for changed circumstances and looking for confirmation of transsexual identity	Seeking more information about transsexualism, reality testing in intimate relationships and against further information about transsexualism
Identity acceptance	Transsexual identity established	Tell others about transsexual identity
Delay	Transsexual identity deepens and final disidentify as women and females occurs – anticipatory socialization as men	Learning how to do gender and sex reassignments, saving money and organizing a support system
Transition	Changing genders, between sexes	Gender and sex reassignment
Identity acceptance	Identities established as transsexual men	Successful passing as men and as males
Integration	Transsexuality mostly invisible	Stigma management
Identity Pride	Publicly transsexual	Transsexual advocacy and activism

GENDER ROELS, STEREOTYPES AND SEXISM

Stereotype: a fixed, conventional idea about a group of people.
Gender roles: complex clusters of ways males and females are expected to behave.
Sexism: the prejudgment that a person will possess certain traits because of gender.
Gender types: the process by which a child acquires behaviours deemed appropriate for his or her gender.
Gender roles and aggression: in most studies, males have been found to behave more aggressively than females. Aggression seems to have increased among girls in recent years. Bullying in both genders in elementary school is highly predictive of aggression in later dating relationships.

GENDER TYPING

Biological perspectives: tend to focus on the roles of genetic and prenatal influences.

- **Evolutionary perspective:** men's role as hunters and warriors and women's roles as caregivers and gatherers are carried forward in our genes.
- **Prenatal brain organization:** prenatal sex hormones may masculinize or feminize the brain by creating predispositions which are consistent with gender role stereotypes.
- **Psychoanalytic theory (Freud):** gender typing is explained in terms of identification. Appropriate gender typing requires boys to come to identify with their fathers and girls their mothers. Oedipus complex is a conflict of the phallic stage in which the boy wishes to possess his mother sexually and perceives his father as a rival for her love. This is similar in girls and it is called the electra complex.
- **Social cognitive theory:** explains gender typed behaviour in terms of processes such as observational learning, identification and socialization. Socialization is the process of guiding people into socially acceptable behaviour patterns using information, rewards and punishment. Parents and schools are key agents of socialization.
- **Cognitive development theory:** children play an active role in gender typing through the formation of schemas about gender. Schema is a concept or way of interpreting experience or processing information. Gender stability is the concept that people retain their genders for a lifetime (achieved by the age of 4 or 5). Gender constancy is the concept that people's genders do not change, even if they alter their dress or behaviour, achieved by age 7 or 8. Children are motivated to behave in gender appropriate ways once they have established the concepts of gender stability and gender constancy.
- **Gender schema theory:** children develop gender schemas as a means of organizing their perceptions of the world. Gender schema is a cluster of mental representations about male and female physical qualities, behaviours and personality traits. Gender gains prominence as an organizing construct because of society's emphasis on it.

GENDER ROLES AND SEXUAL BEHAVIOUR

Gender roles: gender roles affect sexual behaviour. Children learn at an early age that men usually approach women and initiate sexual encounters, whereas women serve as the gatekeepers in romantic relationships. Embedded in the larger stereotype that men are sexually aggressive and women are sexually passive. Men are expected to have a higher number of sexual partners.
Gender sexual stereotypes: men should determine the course of sexual activity, men should satisfy partners sexually, but not ask their partners about their preferences because they are natural sexual experts, men are easy to arouse sexually, women do not share men's natural interest in sex, a woman discovers her sexuality when a man ignites her sexual flame, women do not enjoy sex as much as men, and women who express their sexual desires are sluts.
Attitude and behaviour differences: an assumption is that gender differences in sexual attitudes and behaviours are quite large. A meta-analysis found differences in general sexual permissiveness were relatively small and decreasing over time. Larger differences are related to masturbation and the use of sexually explicit materials. There is greater variation within gender than between.
The sexual double standard: many men and women perceive a sexual double standard, women may be harsher judges of women's behaviour than men, men are perceived to have a greater sexual freedom than women, despite the perception of a double standard, most endorse a single standard, and some endorse a reverse double standard.
Highly sexual women: some women consider themselves highly sexual where they think about sex a lot, enjoy fantasizing about sex, are willing to try almost everything, confident about their sexual abilities and enjoy masturbation.

PSYCHOLOGICAL ANDROGENY

Psychological androgeny: a state characterized by possession of both stereotypical masculine traits and stereotypical feminine traits. May lead to an individual being bale to meet the demands of various situations and to better express their desires and talents. May be more comfortable with their sexuality – can draw upon boarder repertoires of sexual behaviour.

chapter 9: sexual orientation

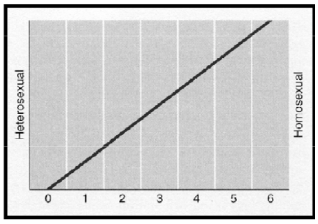
GETTING ORIENTED TO SEXUAL ORIENTATION

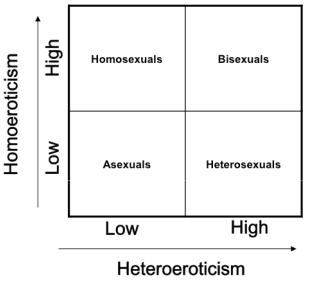
Sexual orientation: refers to a person's erotic attraction to and interest in developing romantic relationships with members of one sex or the other. **Heterosexual orientation:** an erotic attraction to members of the other sex. Also referred to as "straight". **Homosexual orientation:** an erotic attraction to members of your own anatomic sex. Homosexual men are often referred to as gay males while homosexual women are often called lesbians. Gay males and lesbians may also be collectively referred to as gays, gay people or homosexuals. When heterosexuals think about homosexuals they often focus on sexual aspects of relationships; the relationships of homosexuals (like heterosexuals) involve more than just sex. Only a small amount of time is in heterosexual and homosexual relationships is spent on sex. More basic to gay or lesbian sexual orientation is the formation of one's own sex. **Bisexual orientation:** a sexual attraction and an interest in forming romantic relationships with both males and females.

Biphobia: negative attitudes and feelings toward bisexual people, including intolerance, hatred and fear.

Asexuality: people who have a low sexual attraction for both sexes.

CLASSIFYING SEXUAL ORIENTATION





Heteroerotic: having an erotic nature and involving members of the opposite sex. Gay males and lesbians may experience this interest.

Homoerotic: having an erotic nature and involving members of one's own sex. Heterosexual people may have occasional interests.

Sexual response: Chivers and Bailey (2005) noted that male heterosexuals responded genitally only to female stimuli while gay males showed the reverse pattern. The women both hetero and homosexual were more likely to be aroused by both male and female stimuli. Attraction to people of the others sex and attraction to people of the same sex may thus not always be mutually exclusive. People may have various degrees of sexual interest in, and sexual experience with, people of either sex. Boundaries between homosexual and heterosexual orientations are sometimes blurry.

Kinsey continuum: conceived a 7-point heterosexual-homosexual continuum that classifies people according to their sexual behaviour and the magnitude of their attraction to members of their own gender. It was reported that sexual behaviour patterns can change, somewhat dramatically. Sexual experiences or feelings involving people of the same sex are common, especially in adolescence and don't necessarily mean these individuals will engage in sexual activity exclusively with people of their own sex in adulthood. Bisexuality represented a midpoint (3) between exclusively heterosexual (0) and exclusively homosexual (6) orientation. Bisexuals are high in both dimensions while asexuals are low in both dimensions.

PERSPECTIVES ON GAY AND LESBIAN SEXUAL ORIENTATIONS

Historical and Religious Perspectives: Greeks only accepted male-male sexual behaviour. Jews and Christians have traditionally referred to male-male sexual activity as a sin of Sodom. Nowadays being gay is no longer a sin and many churches offer marriage to gay couples. The UN believes that people should not be punished for the sexual orientations. Some countries sill harshly punish people convicted of engaging in homosexual acts.

Cross-Cultural Perspectives: male-male sexual behaviours have been practiced in many preliterate societies. Sexual activity between males is sometimes limited to rites that mark boys' initiation into manhood. In some preliterate societies, semen is believed to boost strength and virility. Older males thus transmit semen to younger males through oral or anal sexual activities. Sambian culture expects young males to perform fellatio on older men to drink the semen but by age 19 they are expected to enter only male-female relationships. Lesbian and gay orientations are rejected by many ethnic minority groups in Canada. Lesbians and gay men typically find more of a sense of belonging in the gay community than in their ethnic communities.

Cross-Species Perspectives: biologists have observed male-males and female-female sexual behaviour in at least 450 animal species in every part of the world. Displays of dominance and submissiveness seem sexual but it is difficult to infer sexual motivation.

Biological Perspectives: focuses on the possible roles of evolution, genetics and hormonal influence in shaping sexual orientation. The Evolutionary Perspective: male-male and female-female sexual behaviours drive from individual selection for reciprocal altruism. Strong male-male and female-female alliances have advantages for group survival, in that they bind group members together emotionally. There is a significant increase in fecundity among women related to homosexuals in the maternal line, but not among women related to homosexuals in the paternal line. This suggests that genetic factors link to the X sex chromosome that might influence homosexual orientation in males are not eliminated by natural selection because they also increase fecundity in female carriers. Women related to gay males apparently bear more children, compensating for the lesser likelihood that homosexuals will reproduce. Genetics and Sexual Orientation: there is considerable evidence that gay and lesbian sexual orientations run in families. Twin studies shed light on the possible role of heredity. **Monozygotic twins** or identical twins are siblings who develop from the same fertilized ovum (they share 100% of their heredity) while **Dizygotic twins** or fraternal twins are siblings who develop from different fertilized ova (they share 50% of their heredity). Thus, if a gay or lesbian sexual orientation were transmitted genetically, it would be found about twice as often among identical twins as among fraternal twins born to gay and lesbian people. Because MZ and DZ twins who are reared together share similar environmental influences, differences in the degree of concordance for a give trait between MZ and DZ twins are further indicative of

genetic origins. Hormonal Influences and Sexual Orientation: sex hormones strongly influence the mating behaviours of other species. Testosterone is essential to male sexual differentiation and levels of testosterone. Testosterone appears to have an **activating effect** (influence sex drive levels) in adulthood. It affects the intensity of desire but not the preference for partners of one sex or another. Brain Structure and Sexual Orientation: researchers have found a structural difference between the brains of heterosexuals and homosexuals. There are similarities between brains of gay men and heterosexual women. In lesbians and heterosexual men, the right hemisphere of the brain was larger than the left. The amygdala's functioning was similar for lesbians and heterosexual men. And it was similar for gay men and heterosexual women. This suggests that brain organization differs by sexual orientation as well as by gender, which further suggests that biology predisposes a person to be homo or heterosexual. Birth Order and Sexual Orientation: the odds of being gay increase in proportion to the number of his older brothers. This relationship has not been found among females. Biology and Sexual Orientation: sexual orientation is somewhat influenced by biological factors. They play a key role at birth. Genetic factors are another important influence. The differences in brain structure indicated a biological influence.

Psychological Perspectives: psychoanalytic theory and learning theory are two major social psychological approaches to understanding the origins of sexual orientation. Psychoanalytic Views: Freud believed that children entered the world open to all forms of sexual stimulation. Through proper resolution of the Oedipus complex, a boy will forsake his incestuous desire for his mother and come to identify with his father. As a result, he'll eventually transfer his erotic attraction from his mother to a more appropriate female partner. A girl through proper resolution of her Electra complex, will identify with her mother and seek erotic stimulation from men when she becomes sexually mature. In Freud's views, a gay or lesbian sexual orientation results from the failure to successfully resolve the Oedipus complex by identifying with the parent of the same sex. Freud believed that the mechanism of unresolved **castration anxiety** where a man feels that his genitals will be removed, plays a role in gay male orientation. The boy unconsciously fears that his father will rival for his mother's love and will retaliate by removing the organ the boy has come to associate with sexual pleasure. His fear causes him to suppress his sexual desire for his mother and to identify with the potential aggressor – his father. The boy thus overcomes his castration anxiety and is headed on the path to heterosexuality. Freud believed that little girls become envious of boys' penises because they lack their own. This concept is called **penis envy.** Jealously leads the little girl to resent her mother, whom she blames for the anatomic deficiency and to turn from her mother to her father as a sexual object. Learning Theory: agrees with Freud that early experiences play important roles in the development of sexual orientation. They focus on the role of reinforcement of early patterns to sexual behaviour. We generally repeat pleasurable activities and discontinue painful ones. Gender Nonconformity: not behaving in a way that is consistent with the gender-role stereotype associated with one's anatomic sex in a given culture. Gay males tend to be somewhat feminine and lesbians tend to be somewhat masculine, but there is a good deal of variation in between each group. A **butch** is a lesbian who assumes a traditional masculine gender role while a **femme** is a lesbian who assumes a traditional feminine gender role.

CURRENT ATTITUDES

Canada: has a far greater acceptance of equal rights for gay people today than at other times in history, can be attributed to exposure of gay individuals. Most Canadians accept same sex marriage. EGALE has lobbied for changes to the Charter of Rights and Freedoms and the Canadian Human Rights Act.

Homophobia: a cluster of negative feelings and attitudes toward gay, lesbian and bisexual people, including intolerance, hatred and fear. It takes on many forms including: using derogatory names (queer, faggot, dyke), telling disparaging queer jokes, barring gay people from housing, employment, and social opportunities, taunting (verbal abuse) and **gay bashing** (physical abuse, sometimes lethal). Homophobia may be due to a fear of one's own gay identity and a desire to maintain gender roles. Despite many strides, Canada still remains a hostile and damaging environment for LGBTQ youth.

Heterosexism: heterosexual bias – tendency of society to view the world in heterosexual terms. This perspective devalues other kinds of relationships. Lesbians and gay men are often as concerned about heterosexism as homophobia, because it is so pervasive in society.

SELF-ACCEPTANCE AND COMING OUT

Given the stigma historically associated with homosexuality, it is not surprising that some gay, lesbian and bisexual people have a hard time recognizing and accepting their sexual orientation, Sexual minority youth growing up in hostile environments have extra challenges. There is often a 10 year gap between initial attraction to members of one's own sex, and disclosure of one's orientation to others. Males are more likely to engage in same-sex sexual activity before they identify as gay. Females are more likely to label themselves as lesbian before pursuing relationships. Younger cohorts tend to come out earlier than older. Accepting identity can be sudden or gradual. Some believe coming out involves a series of well-defined stages; others disagree. Disclosure is fraught with risks. Negative reactions are often anticipated from family members, but family reactions vary. Parents report initial reactions are highly emotional, involving shock, denial, guilt and shame.

GAY AND LESBIAN ADJUSTMENT

LGB youth were more likely to have experienced physical and sexual abuse, harassment in school, and discrimination in the community. They were more likely to have run away from home at least once during the previous year. They were more likely to be sexually experienced. They were more likely to have been pregnant or gotten someone pregnant. They were more likely to have reported emotional stress suicidal thoughts and suicide attempts. They were less likely to participate in sports and physical activities. They were more likely to spend time on the computer. They felt less cared about by parents and less connected to their families. They felt less connected to school (lesbian and bisexual females). Homosexuals and bisexuals were twice as likely as heterosexuals to attempt suicide. They are more likely to be diagnosed with depression, anxiety, and dependence on alcohol and other substances. Most gay males and lesbians are well adjusted, particularly if they have accepted their orientation and are open about it. Most who are in close relationships are satisfied with the quality of them. Children raised in gay and lesbian parenting:

- Develop typical gender identities and roles

- Develop typical peer relationships
- Exhibit normal emotional and behavioural development
- Have fewer issues regarding their sexual identity than children raised in heterosexual families
- Are no more likely to grow up gay or lesbian than children raised in heterosexual families

chapter 8: sexual techniques and behavioural patterns

SOLITARY SEXUAL BEHAVIOUR

Sexual fantasy: almost any mental imagery that is sexually arousing or erotic to the individual. Sexual fantasies can occur because an individual wants them to (during masturbation) or they can happen simultaneously, without conscious effort. It can range from a brief, erotic mental picture lasting a few seconds to a lengthy, highly explicit scenario. They can be experienced as either positive or negative, or both. Unmarried women are more likely to fantasize about current partners than married women. Men are more likely to fantasize about forcing women into sexual activity. Women are more likely to fantasize about being forced – though this does not mean either gender really wants to participate in this activity. LGB who were in relationships were more likely to fantasize about common activities with their partners. **Theoretical perspectives**: evolutionary theorists conjecture that women are more likely than men to fantasize about familiar lovers, because female reproductive success in ancestral times was more likely to depend on emotionally close, protective relationships with reliable partners. Women can bear and rear relatively few children, therefore have a relatively greater genetic investment than men in each reproductive opportunity. Men on the other hand can enhance their reproductive success by having intercourse with high numbers of sexual partners. Men are therefore more likely to have fantasies about casual sex with different partners. There is a tendency for women's sexual fantasies to be more romantic than men's, and the greater tendency for men's fantasies to involve new sexual partners.
Sexual dreams: appear to be more common among university students. Most rated the dreams to be as pleasurable as having intercourse. Most common activities were kissing and sex. Most dreamed about behaviours they had engaged in with their partners.
Masturbation in history: in the Judeo-Christian tradition, sexual self-stimulation has been strongly condemned as sinful. Sexual desire was associated with sin and all non-procreative sex was sinful. These views carried into the medical profession in the 18th century and the doctors translated sin into disease and advised parents to take measures to prevent their children from masturbating. In the mid 19th century, it was suggested that parents bandaged or caged their children's genitals or tie their hands. Some of the contraptions designed were barbarous.
Masturbation today: it can be indicated that most people, including many married people, masturbate at some time. The incidence of masturbation is generally greater among men than women. Masturbation occurs least occasionally for 18-59 year olds. 40-59 year old women masturbated more often than female teenagers. Masturbation tends to increase with education, the more you know about masturbation, the most you participate. Online masturbation is now common. 83.3% of men and 30.8% of women had looked at sexually explicit online videos or photos. ¾ of those men and women reported masturbating while watching this. 11.1% of men and 1.7% of women indicated they had masturbated while looking at strangers on webcams.
Male masturbation techniques: techniques vary widely; most men report that they masturbate by manual manipulation of the penis. Men tend to grip the penile shaft with one hand, jerking it up and down in a milking motion. Some men move the whole hand up and down the penis while others just use two fingers. They usually shift from a gentler rubbing action during the flaccid or semi-erect state of arousal to a more vigorous milking motion once full erection takes place. At orgasm, he will most likely grip the shaft tightly, avoiding glans. Lubricant may be used (soapsuds, lotions, etc.)
Female masturbation techniques: techniques vary widely; most women masturbate by massaging the mons, labia minora, and clitoral region with circular or back-and-forth motions. They also may straddle the clitoris with their fingers, stroking the shaft rather than the glans. She may pull or tug on vaginal lips, while some women massage other sensitive areas like the breasts or nipples. Some use dildos or vibrators and others masturbate during baths.

SEXUAL BEHAVIOUR WITH OTEHRS

Foreplay: consists of various forms of sexual activity that occur prior to penetrative sex, such as cuddling, kissing, petting and oral-genital contact. The pattern and duration of foreplay vary widely within and across cultures. It is important because most couples aren't ready for penetrative sex without first building arousal and sexual response. Sex therapists often encourage couples to consider foreplay activities as activities for their own sake, rather than as activities which must least to penetration. Men and women are similar in terms of how long they want foreplay to last. Women underestimated how much foreplay their partner wanted. Men were accurate in estimating how much time their partners wanted to spend on foreplay.
Tantric sex: a type of lovemaking that emphasizes prolonged foreplay. It is based on Eastern spiritual philosophies that promote the integration of the mind and the body. It focuses on the sexual union as a spiritual connection that leads to heightened sexual pleasure and ecstasy. It includes deep breathing, slowed sexual interaction, and delayed ejaculation.
Kissing: almost universal in our culture, but it's not known in some societies in Africa. Kissing is now practiced in japan, because of the influence of western culture, but it was previously unknown there. In Indonesia, people bring their faces close enough to smell each other's perfume and feel the warmth of each other's skin, this practice has been dubbed "rubbing noses". In some preliterate societies, kissing consists of sucking each other's lips and tongue and allowing saliva to pass from one mouth to the other. Simple kissing is when partners keep their mouths closed, which may develop into caresses of the lips with the tongue, or nibbling of the lower lip. Deep kissing or French kissing or soul kissing is when the partners part their lips and insert their tongues into each other's mouths. It may be simply an affectionate gesture without erotic significance.
Touching: commonly a form of foreplay. Caressing erogenous zones with the hands or other parts of the body can be highly arousing. Women prefer stimulation around the clitoris rather than on the sensitive glans; often not manual penetration. Men typically like their partners to directly strong their genitals early in sexual interaction. Women prefer partners to caress their genitals later.

Breast stimulation: men are more likely to stimulate women's breasts than to enjoy having their own breasts fondled, even though the breasts (especially the nipples), are erotically sensitive in both sexes. Most (but not all) women enjoy having their breasts stimulated, and some women are capable of achieving orgasm from breast stimulation. Generally women prefer several minutes of body contact and gentle caresses before intense breast stimulation. In gay males, they stimulate their partner's nipples more than heterosexual women do. Gay male couples tend to engage in sexual activities such as kissing, hugging, petting, mutual masturbation, fellatio, and anal intercourse.
Oral-genital sex: like **fellatio,** the oral stimulation of the male genitals, is often referred to as blowjob, sucking, sucking off, and giving head. Oral stimulation of the female genitals is called **cunnilingus**, is often referred to as eating out, or going down on her. If orgasm is reached, a partner may be concerned about tasting or swallowing the ejaculate. Oral sex is not risk free – contact with the genitals of an infected partner, even if you do not contact semen may transmit the infection. The popularity has increased since the 1940s and 50s. it was first seen as a way of arousing the couple, particularly the women, prior to sex. It is now an accepted means of pleasure on its own. Recently, anxiety among parents has increased due to media reports of oral sex parties among youth. For most age groups, women are only slightly less likely to report receiving oral sex than giving it. It is more common than previously though among those in their 40s, 50s and 60s. Oral sex experience related to level of education. It is a common activity among university women and gay and bisexual men. Not everyone likes oral sex: some choose to abstain, some do not enjoy giving or receiving, some object on grounds of cleanliness, some are concerned or embarrassed about direct views of private body parts, some prefer not to taste or swallow semen and some worry about whether oral sex is accepted by their religion or culture.
Oral sex techniques: in terms of fellatio, the act of sucking is not necessarily arousing, it is the up and down movements of the penis in the partner's mouth and the licking of the penis that are the most stimulating. Gentle licking of the scrotum may also be arousing. The mouth is stimulating to the penis because like the vagina, it contains warm, moist mucous membranes. Muscle of the mouth and jaw can create varied pressure and movements. Erection may be stimulated by gently pulling the penis with the mouth and simultaneously providing manual stimulation. Some people may gag during fellatio, a reflex triggered by pressure of the penis against the back of the tongue or against the throat. It can be avoided by grasping the shaft of the penis with one hand and controlling the depth of penetration. It is less likely to occur if the partner giving fellatio is on top, rather than below, and if there's verbal communication about how deep the man should penetrate. It may also be overcome by allowing gradually deeper penetration over successive occasions, while keeping the throat muscles relaxed. Be careful to never touch the penis with the teeth. In terms of cunnilingus, a woman can be highly aroused by her partner's tongue, because it's soft, warm and well lubricated. The partner may begin by kissing and licking the woman's abdomen and inner thighs, gradually nearing the vulva. Gentle tugging or sucking of the labia minora can be stimulating, but the partner should take care not to bite. Many women enjoy the licking of the clitoral region and other desire sucking of the clitoris itself. The tongue may also be inserted into the vagina where the woman may be most receptive. Many women find it the best means for orgasm since it is so stimulating.
69: mutual simultaneous oral-genital stimulation. It may be practiced side by side or with one partner on top of the other. Partners often alternate positions. It can be positive because both partners are stimulated at the same time, but may be challenging if partners are not the same size. It deprives each other of focusing on receiving pleasure.
Intercourse techniques: in sexual intercourse, the penis is inserted into the vagina. It can take place in many positions as long as the genitals are aligned so the vagina contains the penis. In addition to varying positions, couples vary the depth and rate of thrusting and the sources of additional stimulation. There are 5 most common positions:

1. **Male Superior Position (man on top):** also called the missionary position. The partners face each other and the man lies above the woman, supporting himself on his hands and knees. Movement is easier for man, so he largely directs the activity. It may be pleasurable for the woman to guide the penis into the vagina. Because the couple faces each other, it is easier to kiss. Woman can stroke the man's body, buttocks or scrotum. It makes it difficult for the man to caress partner (clitoris in particular).
2. **Female Superior Position (female on top):** partners face each other while the woman straddles the man from above controlling the angle of penetration and the depth of thrusting. Some women lie, some sit, most vary their positions. Women may feel in charge and can guarantee that she receives adequate clitoral stimulation thus facilitating orgasm.
3. **Lateral Entry Position (side entry):** man and woman lie side by side, facing each other. It allows each partner relatively free movement and easy access to each other. It isn't physically taxing. It is an excellent position for prolonged coitus, older couples, couples who are fatigues or with pregnant women.
4. **Rear Entry Position (doggie style):** man faces the woman's back. The many may enjoy viewing and pressing his abdomen against his partner's buttocks. Man can reach around to provide extra stimulation of the breasts or buttocks. The woman can reach behind to stroke testicles. Some couples feel uncomfortable with this position because of animal mating patterns, impersonality or perceived male dominance.
5. **Anal Sex:** can be practiced by male-female and male-male couples. It involves the insertion of the penis into the rectum. The rectum is rich with nerve endings and highly sensitive to stimulation. Both men and women may achieve orgasm through anal sex. Penetrating male is usually the partner behind. The rectum produces no natural lubrication so artificial lubricants are advised. A finger in the rectum during orgasm can heighten sensation. Approximately ¼ men and 1/5 women reported engaging in anal sex in their lifetimes (10% over the last year). It is more common among gay males than heterosexual couples. Not all gay men enjoy or practice anal sex. Those who do, often alternate between being the insertive and receptive partner. Some individuals engage in fisting (insertion of hand or fist into the vagina or rectum). This carries a risk of infection and injury. Some couples kiss or lick anus during foreplay (anilingus). This carries a serious health risk because microorganisms which cause intestinal diseases and various STIs can be spread. STIs and HIV are spread through anal sex when small tears in the rectal tissues allow microbes to enter the recipient's bloodstream. Couples having anal sex should use condoms.

GAY AND LESBIAN SEXUAL BEHAVIOUR

Most gay and bisexual men report that the most common activities included deep tongue kissing, oral sex without condoms and mutual masturbation. Anal sex without condoms were more common among regular partners than casual ones. Sexual techniques practiced by lesbians vary and includes kissing, manual and oral stimulation of the breasts and genitals. Many couples engage in genital apposition (rubbing genitals together rhythmically).

FEELING ABOUT SEXUAL BEHAVIOUR

The fact that people engage in certain behaviours does not mean that they feel positively about them. Women rate themselves as more comfortable than men with less sexually explicit behaviours (cuddling, hugging, dancing). Men were more comfortable than women with fellatio, anal sex, woman on top sex and rear entry vaginal intercourse.

chapter 15: sexual variations

NORMAL VERSUS DEVIANT SEXUAL BEHAVIOUR

Deviant sexual behaviour: something that falls outside a statistical norm can be considered abnormal. Something can be considered deviant because it deviates from the norm. Another approach to assessing whether a behaviour is normal is to determine how closely it adheres to the accepted norms of society. A third approach is to determine whether a sexual behaviour is normal focuses on harm – for the individuals involved for others and for society. In this approach, a sexual behaviour is considered abnormal if it causes stress, anxiety or unhappiness for the individual who engages in it, or if it's non-consensual or it harms someone else.

THE PARAPHILIAS

Paraphilias: involve sexual arousal in response to unusual stimuli such as children or other non-consenting individuals (watching unsuspecting people, or exposing his/her genitals to them), nonhuman objects (shoes, leather, rubber, undergarments), or pain or humiliation. It is a diagnostic category used by the American Psychiatric Association to describe this atypical pattern of sexual arousal / behaviour that becomes problematic in the eyes of the individual or society. The urges are recurrent and either acted on or distressing to the individual who experiences them. Paraphilias varies in severity. In some cases, people can function sexually in the absence of the unusual stimuli, seldom if ever acting on their deviant urges. In other cases, people resort to paraphilic behaviour only in times of stress. In more extreme forms, individuals repeatedly engage in paraphilic behaviour and may become preoccupied with thoughts and fantasies about these experiences. They may be unable to become sexually aroused without fantasizing about or being in the presence of the paraphilic stimuli. Some paraphilias are generally harmless and victimless (people with fetishes). Clinicians consider paraphilias to be a mental disorder. Milder forms of these behaviours may be practiced by individuals and not considered harmful. Some believe that paraphilias should not be considered a sexual disorder. Sexual behaviours are strongly influenced by political values. It is possible to learn to express interests in healthier ways. There is little research on female paraphiliacs.

Fetishism: an inanimate object elicits sexual arousal. Articles of clothing and materials made of rubber, leather, silk or fur, are among the more common fetishistic objects. Leather boots and high-heeled shoes are especially popular.

Partialism: a fetishism related paraphilia in which sexual arousal is exaggeratedly associated with a particular body part such as feet, breasts or buttocks.

Transvestism: a paraphilia in which a person repeatedly cross-dresses to achieve sexual arousal or gratification, or is troubled by persistent, recurring urges to cross-dress. Clothing or object is only sexually alluring when wearing it. Transvestites are mostly male (gay or heterosexual). Many transvestites have masculine gender identities and do not see to change their anatomic sex. Transsexuals usually cross-dress because they are uncomfortable with the attire associated with members of their anatomic sex and wish to be members of the other sex. Origins are largely unknown but has been associated with separation from parents, same-sex sexual experiences, use of pornography, high rates of masturbation and other paraphilias. The individual may use a single item or a whole outfit.

Exhibitionism: a paraphilia characterized by persistent, powerful urges and sexual fantasies that involve exposing one's genitals to unsuspecting strangers. The exhibitionist achieves sexual arousal or gratification from this behaviour. Typical exhibitionist is thought to be male, young, lonely or in an unhappy male-female relationship and sexually repressed. Many are single and find it hard to relate to women. May attempt to assert masculinity to express hostility towards women. May be shy, passive, lack sexual and social skills. The urge to flash usually occurs between the ages of 13 and 16. How to respond to an exhibitionist: stay calm, do not display shock or fear, could advise individual seek professional help and report the incident to the police.

Telephone scatologia: a paraphilia characterized by the making of obscene phone calls. Males become sexually aroused by shocking their victims. Females are motivated by rage rather than sexual excitement. Typical obscene phone caller is a socially inadequate heterosexual male who has difficulty forming relationships with women. How to respond to an obscene phone caller: remain calm, do not reveal shock or fright, hang up or advise the caller to seek professional help and request an unlisted number or call trace.

Voyeurism: a paraphilia characterized by strong, repetitive urges and sexual fantasies related to observing unsuspecting strangers who are naked, disrobing, or engaged in sexual relations. Voyeur becomes aroused by watching and does not seek to participate. More common among men and usually begins before age 15. It may include masturbation during or after. Normal voyeurism – most people would watch someone undress if they would not get caught. Fewer women (40%) than men (70%) said they would watch a couple have sex.

Sexual masochist: a person who becomes sexually aroused by experiencing pain or humiliation inflicted by a sexual partner. May act on or be distressed by persistent urges and sexual fantasies involving the desire to be restrained, spanked, whipped, flogged, humiliated or made to suffer in some way in order to achieve sexual excitement. Pain must be a part of an elaborate sexual ritual.

Sexual masochism: a paraphilia characterized by the desire or need for pain or humiliation to enhance sexual arousal and attain gratification. An example of this is bondage. It is the most common paraphilia among women. Association of sexual arousal with mildly painful stimuli is actually quite common. Pain increases overall bodily arousal which may enhance sexual excitement. When desire for

pain for the purposes of sexual arousal overshadows other sources of sexual stimulation, or when masochistic experience causes physical or psychological harm it is considered abnormal.
Sexual sadist: a person who becomes sexually aroused by inflicting pain or humiliation on a sexual partner.
Hypoxyphilia: a practice in which a person seeks to enhance sexual arousal, usually during masturbation by depriving himself of oxygen. This is also known as auto-erotic asphyxia. Miscalculation can result in death by suffocation or strangulation.
Sexual sadism: a paraphilia characterized by the desire to inflict pain or humiliation on others in order to enhance sexual arousal and attain gratification. Sexual sadist acts on urges or finds them distressing. Some hurt or humiliate willing partners, a small minority stalk and attach non-consenting victims.
Sado-masochism (S&M): a mutually gratifying sexual interaction between consenting partners, in which sexual arousal is associated with inflicting and receiving pain or humiliation. Most encounters are time limited and are often built around particular themes involving role play. Both the dominant person and the submissive person agree ahead of time on the rules, and usually choose a safe word that the submissive person will say to stop a particular action if it exceeds his or her limits. In a small minority of relationships, referred to as 24/7 S&M slavery, that participants attempt to live full time in owner-slave relationships. Variation in bondage and discipline (B&D) which involves restraining and punishing a submissive partner physically or verbally. S&M becomes pathological when the fantasies are acted on in ways that become destructive, dangerous or distressing to either partner. There is a negative stereotype that people who engage in S&M behaviours are mentally disturbed. There is no evidence that people involved in S&M have greater difficulty than others in establishing intimate relationships. There is no evidence that engaging in S&M is distressing or dysfunctional.
Frotteurism: a paraphilia characterized by recurrent, powerful sexual urges and fantasies that involve rubbing against or touching a non-consenting person. It has been reported exclusively among males. It mostly takes place in crowded places and is often fleeting so it goes unnoticed. The man fantasizes about consenting relationships.
Toucherism: a practice related to frotteurism, characterized by the persistent urge to fondle non-consenting strangers.
Zoophilia: a paraphilia involving persistent or repeated sexual urges and fantasies that involve sexual contact with animals. Actual contact with an animal is known as bestiality.
Necrophilia: a paraphilia characterized by a desire for sexual activity with corpses. Regular necrophilia is when an individual has sex with a deceased person. Necrophilic homicide is when an individual commits murder to obtain a corpse for sexual purposes. Necrophilic fantasy is when an individual fantasizes about sex with a corpse. Some necrophiliacs get jobs where they have access to corpses. The primary motivation appears to be desire to completely possess an unresisting and non-rejecting partner.
Klismaphilia: a paraphilia in which sexual arousal is derived from the use of enemas.
Coprophilia: a paraphilia in which sexual arousal is attained in connection with feces.
Urophilia: a paraphilia in which sexual arousal is associated with urine.

THEORETICAL PERSPECTIVES
Biological perspectives: studies appear to confirm that many paraphiliacs have higher than normal sex drives. Most recent studies use an electroencephalograph (EEG) to investigate electrical responses in the brain among paraphiliacs and control subjects. It is noted that there are brain differences between subjects with paraphilia vs. those who do not.
Psychoanalytic perspectives: suggests that paraphilias are psychological defenses, usually against unresolved castration anxieties dating to the Oedipus complex.
Cognitive behavioural perspectives: fetishes and other paraphilias are learned via association, punishment or observational learning.
Sociological perspectives: focuses on the effects of the group and society on individual and group behaviour. For example S&M provide the opportunity to reserves customary power relationships between males and females and social classes.
Integrated perspective: paraphilias may have complex biopsychosocial origins. Paraphilias can be traced to lovemaps which form in childhood.

TREATMENT TO PARAPHILIAS
Issues involving treatment: many people do not want to seek treatment. Health care providers may encounter ethical problems when asked to persuade sex offenders to change their behaviours. Health care provides realize that they are generally unsuccessful in treating resistant clients. Sex offenders typically claim that they cannot control their impulses.
Psychotherapy: resolves unconscious conflicts that are believed to originate in childhood and to give rise to pathological problems such as paraphilias in adulthood. The aim is to bring unconscious conflicts (Oedipal conflicts) into conscious awareness so they can be worked through.
Cognitive behaviour therapy: systematic application of the principles of learning in order to modify a problem behaviour.
Systematic desensitization: a method for terminating the connection between a stimulus (like a fetishistic object) and an inappropriate response (sexual arousal to the paraphilic stimulus). The individual practices muscle relaxation in the presence of a series of increasingly arousing stimuli, until he/she learns to remain relaxed and not sexually aroused in their presence.
Aversion therapy: a method for terminating an undesirable sexual behaviour. It is repeatedly paired with an aversive stimulus such as electric shock, until the person develops a conditioned aversion to the stimulus.
Covert sensitization: a form of aversion therapy in which thoughts about engaging in undesirable behaviours are repeatedly paired with imagined aversive stimuli.
Social skills training: a method of behaviour therapy that relies on coaching and practice to build social skills.
Medical approaches: no drug or surgical technique eliminates paraphilic ideas while leaving other cognitive functions intact. Antidepressants or anti-androgen drugs can be used to reduce the sex drive by lowering the level of testosterone. This is a from of chemical castration. Surgical castration is also another method. Antiandrogens in conjunction with psychological treatment can help some people. There is a 6 level schema for treatment for mild to severe cases:

1. Cognitive behavioural treatment
2. SSRIs
3. SSRIs and a small dose of androgens
4. Antiandrogens or hormonal treatment
5. Antiandrogens or hormonal treatment by injection
6. High doses of an Antiandrogen or LHRH administered by a therapist

Orgasmic reconditioning: a method for strengthening the connection between sexual arousal and an appropriate sexual stimulus (such as a fantasy about an adult of the other gender). In involves repeatedly paring the desired stimulus with orgasm.

SEXUAL ADDICTION, COMPULSIVE SEXUAL BEHAVIOUR, AND HYPERSEXUALITY

Sexual addiction: similar to other addictions such as alcohol, drug and gambling addictions. A sex addict engages in sexual behaviour to relieve anxiety, but typically does not achieve a high level of gratification. The addict feels bad about the behaviour but is unable to control or resist it. A sexual addict experiences withdrawal symptoms and treatment is similar to other addictions.

Compulsive sexual behaviour: sexual behaviour that is frequent enough to interfere with a person's ability to carry on with his or her daily life is best seen as an OCD vs. a sexual addiction. It is characterized by recurrent, sexually arousing fantasies that the individual is unable to get out of his or her mind and intense sexual urges that when acted upon, temporarily relieve anxiety. Excessively frequent, out of control sexual behaviour is not an indication that an individual is addicted to sex.

Hypersexuality: similar to the criteria commonly described for sex addiction and compulsive sexual behaviour. It is being considered for inclusion in the DSM-5. The proposed diagnostic criteria are:

- Time consumed by the sexual fantasies or behaviours interferes with other important activities and obligations.
- The person repetitively engages in the sexual fantasies or behaviours in response to mood states such as anxiety or depression.
- Frequency and intensity of the sexual fantasies or behaviours causes clinically significant personal distress.
- The sexual fantasies or behaviours are not due to medication or drug abuse.
- The person has been unable to reduce the frequency of the sexual fantasies or behaviours.

chapter 11: contraception and abortion

People have been devising mean of contraception since they became aware to the relationship between penile-vaginal intercourse and contraception. Greek and Roman women placed absorbent materials within their vaginas to absorb semen. Sheaths worn over the penis as decorative covers can be traced to ancient Egypt (1350 BCE). The Italians first described sheaths of linen in European writings in 1564. The term **condom** was not used to describe the penile sheath until the 18th century. At that time, sheaths of animal intestines became a popular mean of preventing STIs and pregnancy. Condoms made of rubber were first introduced shortly after 1843. Many other methods were used in the 19th century like withdrawal, vaginal sponges and douching.

CONTRACEPTION IN CANADA

Contraceptive use among Canadian women: out of a survey of 2751 women who had penile-vaginal intercourse over the past year, although none were trying to get pregnant, only 410 (14.9%) used no contraception. Most women rely on male condoms and oral contraceptives for birth control. 54.3% used condoms and 43.7% used oral contraceptives. Withdrawal is the third most popular method, used by 11.6% of the women.

Birth control history in Canada: birth control was legal until the 19th century when laws were introduced forbidding both birth control and abortion. It was illegal to provide information about bitch control because contraceptives were associated with loose morals and prostitution. The use of **artificial contraception** (contraception that applies a human-made device) is still opposed by many religious groups like the Roman Catholic Church, yet there are many liberal attitudes toward contraception.

Contraceptive use among Canadian teens: ¼ of students in grade 10 had experienced sexual intercourse. The contraceptive methods used most often by theses sexually experienced youth at last intercourse were condoms (males 47% and females 40%) and birth control pills (males 25% and females 33%). Withdrawal was the third most common method (males 8% and females 14%). Condom use during last intercourse increased between 1992 and 2003 (from 64% to 75% among males and from 53% to 64% among females). As teenagers get older and form longer term relationships, they switch from condoms to the pill.

METHODS OF CONTRACEPTION

Oral contraceptives (the pill): an oral contraceptive is contraceptive that consists of sex hormones and is swallowed. There are many kinds of birth control pills, varying in hormone types and dosages. Birth control pills fall into two major categories:

1. **Combination pills:** contain a synthetic form of the hormone estrogen and progesterone. The synthetic form of progesterone is called progestin. Most combination pills provide a steady dose of synthetic estrogen and progesterone. Other combination pills called **multiphasic pills** vary the dosages of these hormones across the menstrual cycle, reducing the overall dosages and possible side effects women are exposed to.
2. **Minipills:** contain only synthetic progesterone (progestin) but no estrogen.

- **How does the pill work?** Women cannot conceive when they are already pregnant, because their bodies suppress maturation of egg follicles and ovulation. The combination pill fools the brain into thinking the woman is already pregnant, so no additional ova mature or are released. If ovulation does not take place then a woman cannot become pregnant. In a normal menstrual cycle, low estrogen levels during and just after the menstrual phase stimulates maturation of the ovarian follicles. The estrogen in the combination pill inhibits FSH production so follicles do not mature. The progestin inhibits the pituitary's secretion of luteinizing hormone (LH) which would otherwise lead to ovulation. The woman continues to have menstrual periods, but there is no unfertilized ova to be sloughed off in the menstrual flow. The combination pill is taken for 21 days of the typical 28 day cycle and then for 7 days, the woman takes no pill or she takes an inert placebo pill. The sudden drop in hormone levels causes the

endometrium to disintegrate and menstruation to follow three or four days after the last pill is taken. The progestin increases the thickness and acidity of the cervical mucus thus becoming a more resistant barrier to sperm and inhibits development of the endometrium. This would stop any sort of fertilization or implantation. The minipills contain progestin and are taken daily throughout the menstrual cycle, even during menstruation. They act in two ways: they thicken the cervical mucus to impede the passage of sperm through the cervix, and they render the inner lining of the uterus less receptive to a fertilized egg. Thus even if the woman does conceive, the fertilized egg will pass from her body rather than implanting.

- **Effectiveness of the pill?** When used consistently and correctly, the failure rate of the birth control pill is very low (0.5% or less) depending on the type of pill. Under typical use, the failure rate increases to 3%. Failures can occur when women forget to take the pill for two days or more and do not use backup methods when they first go on the pill, or switch from one brand to another. The World Health Organization suggests that if a woman misses a pill she should take one as soon as possible then continue taking one each day. If she misses 3 or more combination pills in a row, she should use condoms or abstain from sex until she has taken pills for 7 days in a row.
- **Reversibility?** A woman may temporarily experience reduced fertility after discontinuing the pill, but their use is not associated with permanent infertility. Nearly all women begin ovulating regularly within 3 months of suspending use.
- **Advantages and disadvantages?**

Advantages	Disadvantages
Nearly 100% effective when used properly.	Confers no protection against STIs.
Does not interfere with spontaneity or sensation.	May reduce the effectiveness of antibiotics.
Reduces the risk of PID, benign ovarian cysts and breast growths.	Must plan to use it several weeks before becoming sexually active.
Regularizes menstrual cycles.	Not advised for women with various health concerns (hypertension, diabetes, migraines, headaches, blood clots) or smokers.
Reduces premenstrual cramping and discomfort.	May have side effects (nausea, weight gain, depression).
May be helpful in treating iron-deficiency anemia and facial acne.	
Reduces some forms of cancer.	

- **Emergency contraception?** The morning after pill is taken after unprotected intercourse or when contraception fails. In Canada, the two types are Plan B and Yuzpe regimen. Plan B has fewer side effects and is more effective. It is not an abortion pill because it will no end an established pregnancy. It is available without prescription on customer-accessible shelves. It works by preventing the joining of the sperm and the egg. It prevents a fertilized egg from attaching to the uterine wall. It is most effective when taken within 72 hours (should be taken as soon as possible) after unprotected sex. Nausea is a side effect and can last a day or two. Pregnancy rates of 1-3% among women using Plan B.

The Contraceptive Patch: delivers estrogen and progestin to prevent ovulation and implantation. Ortho Evra has been available in Canada since 2004. The patch is thin and measures about 5cm. It can be worn on the abdomen, buttocks, upper arm or upper torso but not breasts. The patch contains a weeks worth of hormones, which is gradually released into the bloodstream. The patch is worn weekly for 3 weeks and then the 4th week is patch-free to allow for menstrual bleeding. When used correctly it is more than 99% effective. Advantages: women who use it do not need to think about daily contraception. The patch does not interrupt sex. Disadvantages: side effects and potential hazards are similar to those of the pill.

The Vaginal Ring: relatively new method in Canada called the Nuva Ring. It delivers estrogen and progestin through the skin. It is inserted in the vagina and worn for three consecutive weeks followed by one ring-free week. At the end of this week, the woman inserts another ring. The ring is left in place during sex and can be reinserted if it slips our. Most mend and women do not notice it during sex. It is as effective as the birth control pill. Advantages: may be helpful if the women has a hard time remembering to take a pill everyday. Disadvantages: research needed to determine the long-term side effects.

Injectable Contraception: Depo-Provera is an injectable hormone solution available by prescription. It is 99.7% effective. It is administered by a needle in the arm or buttocks every 12 weeks, preventing pregnancy for 12 weeks. Advantages: highly effective, permits spontaneous sex, remains effective without taking it everyday. Disadvantages: it has similar side effect to other hormonal contraceptives (like vaginal bleeding, headaches, weight gain, irregular menstrual cycles…), prolonged use is associated with bone loss, ovulation may take a few months to return, not recommended for women with health concerns (like breast or uterine cancers, elevated blood pressure…)

Intrauterine Devices (IUDs): small object inserted into the uterus by a doctor or nurse practitioner and left in place. It is used by less than 5% of sexually active women of reproductive age in Canada. There are two main devices and system available in Canada: copper IUDs (Flexi-T and Nova-T) and Levonorgestrel-releasing IUD system (Mirena). It works by preventing sperm from fertilizing the eff and prevents fertilized eggs from implanting in the uterus. It is about 99% effective for up to 5 years. About 9/10 former IUD users who wish to become pregnant do so within a year. Advantages; highly effective and relatively maintenance free. Disadvantages: most common side effects include excessive menstrual cramping, irregular bleeding between periods and heavier than usual bleeding. It has a risk of pelvic inflammatory disease (PID) and results in a greater risk for ectopic pregnancy. Women with pelvic infections, or risk factors for PID should not use this method.

The Diaphragm: shallow cup or dome made of thin latex rubber. The rim is a flexible metal ring covered with rubber. It comes in different sizes for a precise fit. It is available by prescription and must be fitted by a health care practitioner. It works by forming a barrier against sperm when placed over the cervical opening with spermicide inside. The woman must insert and leave it in place for at least 6 hours after intercourse. If used correctly and consistently, the failure rate is 6% and in typical use the failure rate the first year is 18%. Advantages: fairly effective when used correctly, use as needed as opposed to taking a pill everyday. Disadvantages: high pregnancy rate associated with typical use. Need to insert before intercourse so it may be disruptive.

The Cervical Cap: small (thimble sized) dome-shaped rubber cap which comes in different sizes. It must be fitted by a health care professional. It is meant to fit snugly over the cervix and is intended to be used with spermicide. It is inserted before sex and left in for at least 8 hours after. Failure rate in typical use is high (185 in women who have not born children and 36% in women who have).

Disadvantages: some women find the cap uncomfortable, side effects include: UTIs and allergic reactions or sensitivities to the rubber or the spermicide.

Spermicides: coat the cervical opening, blocking the passage of sperm and killing sperm by chemical action. It comes in different forms: jellies, creams, suppositories and aerosol foams. Suppositories must be inserted 15 minutes before sex to allow time to dissolve and left in for several hours after intercourse. Effectiveness for typical use, first year failure rate for spermicides used alone is 21%. When used correctly and consistently it is 6%. All are more effective when combined with other methods (condom). Disadvantages: may cause vaginal or penile irritation, some find the taste unpleasant.

The Contraceptive Sponge: soft and disposable device that provides a barrier with built-in spermicide. It does not need to be fitted and can be inserted in the vagina several hours before intercourse and it absorbs sperm. 1/20 people are mildly irritated by the spermicide and it is currently unavailable in Canadian pharmacies.

The Male Condom: sheaths made of latex, polyurethane and intestinal membranes of lambs (which do not provide protection against some STIs). Many have nipples or reservoirs to catch semen and prevent bursting during ejaculation. It comes in different sizes. Though condoms protect against STIs, may use it for protection from pregnancy.

- **How it works:** it serves as a barrier, preventing the passage of sperm and disease carrying microorganisms from the man to his partner. It helps to prevent infected vaginal fluids and microorganisms from entering the man's urethral opening or penetrating through small cracks in the skin of the penis.
- **How it is used:** the condom is rolled onto the penis once erection is achieved, before contact between the penis and the vagina (or effectiveness is sharply reduced).
- **Effectiveness:** the failure rate with typical use is 12% and drops dramatically if used correctly and consistently and with a spermicide. You must use a condom every time you have intercourse so it is effective. It must be handled carefully avoiding sharp objects. Place the condom on before it contacts the vulva. If you are uncircumcised, pull back the foreskin before putting the condom on. If you are using spermicide, put it inside the tip of the condom before putting the condom on. If you are using a condom without a reservoir tip, leave a little space (about 1cm) at the end of the condom to hold the semen. Unroll the condom to the base of the penis and ensure that adequate lubrication is present during intercourse (only water-based). If the condom breaks, put on a new one immediately and use more spermicide. After ejaculation, withdraw the penis while it is still erect and hold the rim of the condom firmly as you withdraw. Do not store the condom in a pocket or glove compartment of car. Do not use a condom more than once. Do not use a condom after its expiration date. Never use a condom that is sticky, gummy, discoloured or brittle, or showing other signs of deterioration. Never use a condom if the sealed packet containing it is damaged, cracked or brittle. Do not open the sealed package until you are ready to use the condom.
- **Advantages and Disadvantages?**

Advantages	Disadvantages
Unparalleled protection against STIs.	Some people have allergic reactions to the spermicide.
Both partners can share in putting it on, making it an erotic part of lovemaking rather than an intrusion.	Some people are allergic to latex.
Use of textured or ultra thin condoms can increase sensitivity.	Condoms also sometimes slip off, break or tear.
	May make sex less spontaneous.
	Some men experience erectile difficulties using condoms.

The Female Condom: a polyurethane sheath that is used to line the vagina during intercourse. It is held in place by a flexible plastic ring and provides a secure but flexible shield that barricades against sperm but allows the penis to move freely within the vagina during sex. It can be inserted up to 8 hours before sex, but should be removed immediately following. A new one must be used for each act of intercourse. During testing trials, pregnancy rate was estimated to range between 21%-26% thought it was estimated to be as low as 5% among cautious users. Many women complain it is bulky and difficult to insert. It costs several times more than the male condom.

Douching: many couples believe that if a woman douches (rinses the vagina by inserting a liquid and allowing it to drain out) after intercourse, she won't become pregnant. Douching is ineffective because sperm move beyond the range of the douche seconds after ejaculation. Regular douching can alter the natural chemistry of the vagina.

Withdrawal: the man removes his penis before ejaculating. First year failure rate among typical users is 20%. There are several reasons for failure: man may not withdraw in time, some ejaculate may still fall on the vaginal lips, a man may not be aware that he has begun to ejaculate and active sperm may be present in pre-ejaculatory secretions.

Fertility Awareness Methods (rhythm methods): rely on awareness of a woman's menstrual cycle. Intercourse is avoided on days when conception is most likely to occur.

- **How do they work?** They are used to predict the likelihood of conception. They are mirror images of the methods couples use to increase their chances of conceiving.
- **The calendar method:** a fertility awareness method of contraception that relies on predicting ovulation by tracking menstrual cycles, typically for 10 to 12 months and assuming that ovulation occurs 14 days before menstruation.
- **The basal-body temperature (BBT) method:** a fertility awareness method of contraception that relies on predicting ovulation by tracking the woman's temperature during the course of the menstrual cycle.
- **The cervical mucus (ovulation) method:** a fertility awareness method of contraception that relies on predicting ovulation by tracking the viscosity of cervical mucus. There are peak days during the menstrual cycle when a woman is most likely to be fertile.
- **Ovulation prediction kits:** tallow women to test their urine every day for the presence of LH. LH levels surge about 12-24 hours before ovulation.
- **Effectiveness:** the estimated first year failure rate is 20%.
- **Advantages and disadvantages:** Advantages: appeal to people who want to avoid artificial means, no side effects and is inexpensive (except for ovulation prediction kits). Disadvantages: low reliability and requires abstaining from sex.

Sterilization: surgical procedures that render people incapable of reproduction without affecting sexual activity. Most effective form of contraception with the exception of abstinence. The prospect arouses strong feelings and often involves a profound change in self-concept.

- **Male sterilization:** a **vasectomy** is the surgical method of male sterilization in which each vas deferens is cut and tied back or cauterized to prevent sperm from reaching the urethra. It is carried out in a doctor's office under local anesthesia in about 15-20 minutes. It does not diminish sex drive, sensations, or function. There have been few serious complications reported. Minor complications can occur like inflammation and swelling and are not uncommon. Reversibility is a complicated practice (procedure called vasovasotomy) with success rates ranging from 16-79%. In this procedure, the cut or cauterized ends are sewn back together.
- **Female sterilization:** a **tubal sterilization / ligation** is when the fallopian tubes are surgically blocked to prevent meeting of sperm and ova. It is the most common method of female sterilization. There are two main procedures, and two alternative options:
    1. **Minilaparotomy:** a kind of tubal sterilization in which a small incision is made in the abdomen to provide access to the fallopian tubes.
    2. **Laparoscopy:** a procedure used for tubal sterilization where a laparoscope is inserted through a small incision just below the navel and used to cauterize, cut or clamp the fallopian tubes.
    3. **Culpotomy:** is a kind of tubal sterilization in which the fallopian tubes are approached through an incision in the back wall of the vagina.
    4. **Hysterectomy:** surgical removal of the uterus. This procedure is not appropriate as a method of sterilization.
    - Neither of the first two methods disrupt sex drive or sexual response. The menstrual cycle is undisturbed and unfertilized eggs are reabsorbed by the body. It is highly effective in preventing pregnancy (0.4% failure rate). It should be considered irreversible (43%-88% of reversals are successful).
- **Advantages and disadvantages:** Advantages: effectiveness and permanence. Disadvantages: permanence (if a couple changes their mind, greater risks of complications than with male sterilization and no protection against STIs.

Selecting a method of contraception: when selecting a contraception method, you must consider the following factors: convenience, moral acceptability, cost, ability to share responsibility, safety, reversibility, protection against STIs and effectiveness. The ideal contraceptive does not seem to exist. However new advances are coming. It appears many women are uncomfortable with the idea of a male contraceptive pill. However a major breakthrough was announced in 2008 when researchers discovered a gene which when removed stopped ovulation in mice. This gene may be useful for treating infertility as well as for contraception.

Abortion: an **induced abortion** is the purposeful termination of a pregnancy before the embryo or fetus is capable of sustaining independent life. Perhaps more divisive that any other social issue. It is rarely used as a primary means of birth control. The reasons for abortion include psychological factors and external circumstances. The moral question of when life begins arises. Attitudes have varies across cultures and eras. Right-to-life or Pro-life movement assert that human life begins at conception and views abortion as murder of an unborn child. Some in the movement would permit abortion to save the mother's life or when pregnancy results from rape or incest. Pro-choice movement contends that abortion is a matter of personal choice. Most Canadians believe abortion is acceptable under certain circumstances. Abortion was illegal in Canada until 1969. The struggle between pro-life groups and pro-choice groups has been contentious and sometimes violent. Dr. Morgentaler, the leader of the pro-choice movement in Canada has been challenging the law since 1969 by establishing private abortion clinics. He was awarded the Order of Canada in 2008 for his commitment to increased health-care opportunities for women and his efforts to influence public policy. The Supreme Court of Canada ruled against a man trying to stop his former girlfriend from having an abortion, stating that the law does not recognize a father's right to do so. Despite these legal decisions, access to abortions are limited, often available only in urban centres. PEI offers no abortion services and some provinces restrict women's access to abortions at public hospitals and refuse to pay for abortions performed at private clinics. Women may experience a range of negative emotions, including fear, anger, guilt and ambivalence. Reactions depend on various factors including the strength of social support and their relationship with their parents. The sooner the abortion occurs, the less stressful it is. There is more distress post-abortion associated with: having a difficult time reaching a decision, blaming the pregnancy on their own character, having a lower coping ability and having less social support. In a survey of 882 women, the majority were satisfied with their decision to have an abortion and would make the same decision again. Many experienced more benefits than harm. There are three methods of abortion:

1. **Vacuum aspiration:** removal of uterine contents via suction. It is relatively painless and inexpensive and can be used during the first trimester.
2. **Dilation and Evacuation (D&E):** removal of the uterine contents via a suction tube and forceps. The uterine wall may be scraped to ensure that the lining has been fully removed. Used most often in the second trimester.
3. **Abortion drugs:** RU-486 (not yet approved for sale in Canada) induces early abortion by blocking the effects of progesterone, the hormone that stimulates proliferation of the endometrium and allows implantation of the fertilized ovum.

chapter 14: sexually transmitted infections

Sexually transmitted infection (STI): an infection that is passed on from one person to another through sexual contact. Some STIs such as HIV can also be transmitted in other ways.

STIs in Canada: Human papillomavirus (HPV) and genital herpes (herpes simplex virus, HSV) are the most common (but not reportable). Chlamydia is the most common reportable STI. Gonorrhea is less common than chlamydia but has increased in the last decade. The number of syphilis cases is small but still rising. The rate of chlamydia, gonorrhea and syphilis are increasing among young people faster than among 40-59 year olds.

BACTERIAL INFECTIONS

Bacteria: a class of single-celled microorganisms that have no chlorophyll and can give rise to many illnesses.

Chlamydia: the most common bacterial STI in Canada. It is caused by *Chlamydia trachomatis* bacterium. It is transmitted through sexual intercourse (vaginal or anal). It can cause an eye infection if the eyes are touched after handling genitals of infected partner. Oral sex with infected partner can infect the throat. Up to 50% of men and 70% of women have no symptoms. Men experience non-specific urethritis (NSU) which presents as a thin, whitish discharge from the penis, burning or other pain during urination, soreness of the scrotum and feeling of heaviness in the testes. Women experience inflammation of the urethra or cervix (burning during urination, genital irritation, mild vaginal discharge. Untreated infections can damage the reproductive systems of women and men. It can be diagnosed by a cervical or urethral smear in women and swabs being inserted through the penile opening and fluid being extracted for analysis in men. Antibiotics other than penicillin are highly effective for treatment. Treatment of partners is essential to prevent reinfection. Regular chlamydia screening is recommended for sexually active women.
Gonorrhea: tis the second most common bacterial STI in Canada. It is caused by the *Neisseria gonorrhoeae* bacterium. Transmission requires a warm, moist environment, because outside of the body it dies within a minute. Unprotected vaginal sex is less likely to be spread from vaginal discharge than penile. Unprotected oral sex is less likely to spread from cunnilingus than fellatio. Anal sex, oral sex, or anal sexual activities are methods of transmission. It can spread from a mother to her newborn during delivery. It is rarely transmitted through contact with a moist, warm towel or sheet immediately after it has been used by an infected person. Most men have symptoms within 2-5 days and consists of discharge, inflamed urethra, and a burning sensation while urinating. 30-40% of men have swelling and tenderness in lymph glands of groin. 80% of women have no symptoms in the early sages of the infection. Others have cervicitis, discharge, and burning during urination. Untreated infections can damage the reproductive systems of women (PID) and epididymitis in men, leading to infertility. **Pelvic Inflammatory Disease (PID)** is the inflammation of the pelvic region in women, possibly including the cervix, uterus, fallopian tubes, abdominal cavity and ovaries. Symptoms are abdominal pain, tenderness, nausea fever, and irregular menstrual cycles. The condition may lead to infertility. When diagnosed and treated early, gonorrhea can clear up rapidly, more than 90% of the time. Clinical inspection of the genitals by a physician is necessary for diagnosis, to culture and examine the genital discharge. Antibiotics are used to treat gonorrhea and because gonorrhea and chlamydia often co-occur, people infected with gonorrhea are usually treated with another antibiotic for chlamydia.
Syphilis: is an STI caused by the *Treponema pallidum* bacterium. It may progress through several stages of development, often from a chancre to a skin rash to damage to the cardiovascular or central nervous system. It is transmitted through vaginal or anal intercourse or oral-genital or oral-anal contact with an infected person. It is usually transmitted when open lesions of an infected partner come into contact with the mucus membrane of the other. It can be contracted by touching an infectious chancre sore or ulcer. It can be transmitted from mother to fetus through the placenta and congenital syphilis can be present at birth. There are four stages of symptoms:

1. **Primary stage:** two to four weeks after contact, a painless chancre appears at infection site.
2. **Secondary stage:** a few weeks to a few months later skin rash develops that eventually darkens and bursts, oozing a discharge. Sores in the mouth, swelling in the joints, sore throat, headaches, fever (some may assume that they have the flu).
3. **Latent stage:** symptoms disappear and infection lies dormant for 1-40 years. Spirochetes continue to multiply and burrow into the circulatory system, central nervous system and bones.
4. **Tertiary stage:** a large ulcer may form on the skin, muscle tissue, digestive organs, lungs, liver, and other organs – though these can be treated. Serious damage can be done if the infection attacks the central nervous or cardiovascular system and can be fatal.

- It can be diagnosed in the primary stage by a clinical exam. Spirochetes are quite visible in fluid draw from the chancre. Blood tests are not definitive until the second stage. Penicillin is the treatment of choice. Sex partners or infected persons should be evaluated.

VAGINAL INFECTIONS

Vaginitis: any type of vaginal infection or inflammation. Genital irritation, itching or burning during urination and odorous discharge are most common. It is caused by bacteria the reside in the vagina or from sexually transmitted organisms.
Bacterial Vaginosa (BV): usually caused by overgrowth of the *Gardnerella vaginalis* bacterium. It is transmitted through sexual contact. Infected women often have no symptoms but a thin, foul-smelling discharge may be present. Diagnosis requires culturing the bacterium. It increases the risk of other gynecological infections. Reoccurrences are very common and oral / topical treatments are effective.
Candidiasis: caused by a yeast-like fungus, changes in the vaginal environment allows the fungus to overgrow. It can result from antibiotics, birth control pills, IUDs, pregnancy and diabetes, nylon underwear, or tight clothing. It can be passed back and forth between partners, oral sex, anal sex, or by women sharing a washcloth. It produces soreness, inflammation and intense itching around the vulva accompanied by a thick white, curd-like vaginal discharge. Yeast infections can occur in the mouths of men and women and in the penis of men. Most men have no symptoms, but can develop NGU or genital thrush accompanied by itching and burning during urination, or reddening of the penis. About 75% of women will have at least one episode in their lives. 50% of women have recurrent infections. Treatments include vaginal suppositories or creams.
Trichomoniasis: caused by the protozoan *Trichomonas vaginalis* (a single celled parasite). It is the most common parasitic STI. It facilitates the transmission of HIV and is linked to the development of tubal adhesions which can result in infertility. It is almost always sexually transmitted. It can live for several hours on moist surfaces outside of the body (towels, washcloths, bedclothes) and can be picked up from toilet seat but the penis of vulva has to directly touch it. Women experience a burning or itching in the vulva, mild pain during urination or intercourse and an odorous foamy, whitish to yellowish green discharge, though women can also have no symptoms. Men are usually symptom free although it can cause NGU and a slight penile discharge, tingling or itching in the urethral tract. Diagnosis can be made by microscopic examination of a smear of vaginal fluid. Examination of cultures grown from the vaginal smear is more reliable however. When both partners are treated simultaneously, the success rate approaches 100%.

VIRAL INFECTIONS

Viruses: tiny particles of DNA surrounded by protein coatings. They are incapable of reproducing on their own but when they invade a body cell, they can use the cell to spin off new viral particles that spread to other cells.

HIV and AIDS: a sexually transmitted virus that destroys white blood cells in the immune system, leaving the body vulnerable to life threatening diseases. HIV is the virus that causes acquired immunodeficiency syndrome (AIDS). AIDS is a condition caused by HIV and characterized by the destruction of the immune system by stripping the body of its ability to fend off life-threatening diseases. AIDS is considered fatal, though many people now live with HIV/AIDS for many years with powerful antiviral medications. For people living in industrialized nations like Canada, HIV/AIDS may become a chronic but manageable condition like diabetes. In other nations without access to medications, HIV/AIDS may remain a death sentence. From 1985 (when HIV testing began) through 2008, 67422 people in Canada were diagnosed with HIV. The number of new cases peaked in 1993 and since then has declined. An estimated 2300 to 4300 new cases occurred in 2008. It is estimated that 65000 people were living with HIV (including AIDS) in 2008. It is estimated that 169000 were unaware that they were infected. The number of cases in women have risen and the number of cases in MSM have decreased. A number of aboriginal people living with HIV has increased in recent years. A significant portion of heterosexual HIV infections originated in countries with high HIV prevalence rates. Infection drug use accounts for 14% of new infections. Some HIV terms - **The immune system:** the complex of mechanisms the body uses to protect itself from disease causing agents such as pathogens. It is the body's first line of defense against disease causing organisms. It produces leukocytes which engage in microscopic warfare, undertaking search and destroy missions. **Pathogens:** an agent, especially a microorganism that can cause disease. **Leukocytes:** white blood cells that are essential to the body's defenses against infection. They recognize foreign agents by their antigens because the body reacts to their presents by developing antibodies. **Antibody:** a specialized protein that attaches itself to a foreign body, inactivates it and marks it for destruction. **Opportunistic disease:** a disease that takes hold only when the immune system is weakened and unable to fend them off. **Sepropositive:** having a pathogen or antibodies to that pathogen in the bloodstream. **Seronegative:** lacking a pathogen or antibodies to that pathogen in the bloodstream.

- **HIV infection:** spikes known as gp120 spikes) on the surfaces of HIV allow it to bind to sites on the cells in the immune system. HIV uses the cells it invades to spin off copies of itself. HIV directly attacks the immune system by invading a type of lymphocyte called CD4 cell or helper T cell (the quarterback of the immune system). By attacking and disabling CD4 cells, HIV disables the cells which the body relies on to fight infections. The blood normally contains about 1000 CD4 cells per mm. People remain healthy as long as this level is maintained. As number of CD4 cells decrease with HIV infection, symptoms generally increase. A person is most vulnerable to opportunistic infection when their CD4 levels fall below 200.
- **HIV progression:** shortly after infection, the person may experience mild, flu-like symptoms. These usually disappear in a few weeks. People generally look ad act well and may unwittingly pass the virus to others. Most people remain symptom free for years. Some enter a symptomatic phase which is marked by chronically swollen lymph nodes, intermittent weight loss, fever, fatigues and diarrhea. The beginning of full blown AIDS is often marked by swollen lymph nodes, fatigue, fever, night sweats, diarrhea and weight loss that cannot be attributed to diet or exercise. AIDS is connected with the appearance of opportunistic diseases like Kaposi's sarcoma (a form of cancer), taxoplasmosis of the brain and herpes simplex with chronic ulcers. About 10% of people with HIV have wasting syndrome (unintentional loss of more than 10% of body weight). As AIDS progresses, the person grown thinner and more fatigued. She/he becomes unable to perform ordinary life functions and falls prey to opportunistic infections. If left untreated, AIDS nearly always results in death within a few years.
- **HIV transmission:** transmitted by contaminated blood, semen, vaginal secretions and breast milk. The first three may enter the body though vaingal, anal or oral-genital intercourse with an infected partner. HIV can enter the body through tiny cutes or sores in the mucosal lining of the vagina, the rectum or even the mouth. HIV can be spread by sharing needles, from mother to fetus during pregnancy, childbirth (most likely) or breastfeeding. Male-female transmission through vaginal intercourse is twice as likely as female-male transmission. Male-female and male-male anal intercourse are especially risky because of easy tearing.
- **HIV/AIDS diagnosis:** most widely used test is the enzyme-linked immunosorbent assay (ELISA). ELISA is performed on blood, saliva, or urine, detects HIV antibodies (can take up to 3 weeks). A seropositive test means that antibodies have been found. Presence of the virus can be confirmed by more expensive tests such as the western blot or the immunfluorescene assay. HIV tests are not considered accurate until three months following the person's last exposure to the virus. Rapid testing (1 minute) is not available in Ontario.
- **HIV/AIDS treatment:** there is not safe, effective vaccine for HIV. Protease inhibitors target the protease enzyme, blocking HIV replication. A combination of antiviral drugs ahs become the standard for HIV and AIDS. Highly Active Antiretroviral Therapy (HAART) uses a protease inhibitor with a combination of other antiretroviral agents. There are many side effects like depression and it is very expensive. It can reduce HIV to levels which are undetectable by ordinary means.
- **HIV/AIDS prevention:** HAART reduces the levels of the virus in the body and decreases the likelihood of transmission. Circumcision may reduce risk of infection. Education and access to condoms is a huge prevention method!

Herpes (HSV): chronic, remains in the body for life. 60% of people are asymptomatic (but still transmissible). Recurrent outbreaks are associated with stress. Herpes Simples Virus type 1 (HSV-1) causes oral herpes, cold sores or fever blisters on lips or in the mouth. It can be transferred to the genitals via oral-genital contact. Genital herpes is caused by Herpes Simplex Virus type 2 (HSV-2). It presents as painful, shallow sores and blisters on the genitals. It can be transferred to the mouth through oral-genital contact.

- **Herpes transmission:** through oral, anal or vaginal sexual activity. The virus can survive on toilet seats and other objects where they can be picked up by direct contact. Oral herpes is easily contracted by sharing a cup, kissing, or sharing towels. Genital herpes is generally spread sexually and can be spread from one part of the body to another (i.e. ocular herpes). It is most contagious during active flare ups but can be spread at other times. Passage through the birth canal of infected mothers can harm or kill the babies.

- **Herpes symptoms:** genital lesions or sores appear 6-8 days after infection (reddish, painful bumps or papules). Papules turn into groups of small blisters that are filled with fluid containing viral particles. These fill with pus, burst and become extremely painful, shallow ulcers surrounded by red rings. Blisters crust over and heal within1-3 weeks. Internal sores in the vagina or on the cervix may take 10 days longer than external sores to heal. Other symptoms may include headaches and muscle aches, swollen lymph glands, fever, burning urination and vaginal discharge. Although symptoms disappear, the virus does not. The virus burrows into the nerve cells at the base of the spine and may lie dormant for years or a lifetime. Reoccurrences are related to infections, stress, fatigue, depression, exposure to the sun and hormonal changes.
- **Herpes diagnosis and treatment:** it is first diagnosed by clinical inspection of herpetic sores or ulcers in the mouth or on the genitals. Fluid is cultured to detect growth of the virus. Antiviral drugs can relieve pain, speed healing and reduce duration of viral shedding. It can reduce the severity of the initial episode and if taken regularly, can reduce the frequency and duration of outbreaks. Warm baths, loose clothing, aspirin and cold compresses may relieve pain during flare ups.
- **Coping with genital herpes:** psychological impact can be more distressing than physical effects. Most people learn to cope with the infection and with adjustments, are able to establish and maintain satisfying intimate relationships. Some are helped by support groups and having a caring and trusting partner is important.

Viral Hepatitis: an inflammation of the liver. The major types are A, B, C and D. Most people have no symptoms, but when people do, they may have jaundice, loss of appetite, abdominal discomfort, whitish bowel movements, feelings of weakness and nausea or tea-coloured urine. Hepatitis A is transmitted through contact with infected fecal matter in contaminated food or water, or by oral contact with fecal matter. Hepatitis B is transmitted through anal, vaginal or oral intercourse with an infected partner, transfusion with contaminated blood supplies, sharing of contaminated needles or syringes and contact with contaminated saliva, menstrual blood, nasal mucus, or semen. Sharing razors, toothbrushes and other personal articles with an infected person can also transmit hepatitis B. Hepatitis C and D can be transmitted sexually or through contact with contaminated blood. Hepatitis D can only occur if hepatitis B is present. People can transmit the viruses even if they are unaware that they have the disease. Hepatitis is diagnosed by testing blood samples for the presence of hepatitis antigens and antibodies. Bed rest and fluids are generally recommended until the acute stage of the virus passes. A vaccine protects against hepatitis B and D.

Human Papilloma Virus (HPV): most common viral STI – approximately 70% of Canadians will have at least one HPV infection in their lifetimes. Most infections are asymptomatic and harmless. In 90% of cases, the body clears the infection within two years. There are many different strains of HPV. Types 6 and 11 cause genital warts and types 16 and 18 lead to cervical cancer.

- **HPV transmission:** vaginal and anal intercourse are the most common ways to contract it. Oral sex and other types of skin-to-skin contact can transmit HPV. It is so common it is difficult to prevent. Abstinence is the most effective way; condoms do not eliminate risk entirely because the virus can be spread by skin-to-skin contact of areas not covered by the condom. People with active warts should avoid sexual contact until the warts are removed that the area has healed.
- **HPV symptoms:** genital warts can be hard and yellow-grey when they form on dry skin, or they can take on a pink, soft, cauliflower like appearance in moist areas. They can occur on external and internal genetalia. They can also occur outside of the genital area – such as on lips, eyelids, or nipples, around the anus and in the rectum. The incubation period for genital warts can be a few weeks to more than a year.
- **HPV treatment:** crytherapy (freezing the warts with liquid nitrogen), alcohol based pedophyllin solution, gel or cream, burning off warts with electrodes and removing them with a laser or conventional surgery are methods of treatment.
- **Vaccine:** all provinces and territories in Canada have implemented publicly funded school programs to lower cervical risk for women, but acceptance of the vaccine has not been universal. Cervical cancer is relatively rare in Canada and it is detectable with regular pap rests.

ECTOPARASITIC INFESTATIONS

Ectoparasites: live on the outer surface of animals. They are larger than the agents which cause other STIs. Sexual contact should be avoided until infestation is eliminated.

Pediculosis (*Pthirus pubic*) (crabs): infestation by pubic lice that is spread sexually and via contact with objects. It can survive for 24 hours without a human host. It may deposit eggs that take up to 7 days to hatch in bedding and towels. Fingers can also transmit the lice from genitals to other parts of the body. Itching is the most common symptom and it can be effectively treated with medication.

Scabies: infestation caused by tiny mites. They may be transmitted through sexual contact or contact with infested fabrics. They burrow into the genital area causing itching and discomfort. They create reddish lines from burrowing, sores, welts and blisters on the skin. Diagnosis can be made from skin scrapings. It is most often found out the hands and wrists, can also be found on the genitals, buttocks, armpits and feet. It can be effectively treated with medication. Sex partners and others in close bodily contact should also be treated. Clothing and bed linens should be dry cleaned or washed and dried on hot cycle.

STI EPIDEMIOLOGY: BIOLOGICAL, PSYCHOLOGICAL AND SOCIAL FACTORS

Biological factors: multiple means of transmission, lifelong infections, asymptomatic cases, increased vulnerability from some STIs to others, gender, and lack of vaccines and cures.

Psychological factors: perceived low risk, lack of communication, psychological obstacles to condom use (love, trust, embarrassment about purchasing, decreased pleasure or spontaneity) and alcohol and drug use.

Social factors: gender inequality, sexual orientation, group marginalization, province or territory, culture, social capital, and societal attitudes.

APPLIED KNOWLEDGE

Reducing your risks: be knowledgeable, be abstinent, use latex condoms, limit your number of sexual partners, get tested for STIs and HIV avoid nonsexual risk behaviours, get regular medical checkups, engage in lower risk sexual behaviours, make your own sexual health plan, talk to your parents about sexual health, and talk to your physician if you suspect you have been exposed.

chapter 16: sexual coercion

SEXUAL ASSAULT

Sexual assault: non-consensual bodily contact for a sexual purpose. It has replaced rape as the term used in the Canadian legal system. There is no statue of limitations for persecution of sexual assault. A central issue is whether or not consent has been given (a person has to be capable of giving consent). Sexual assault has three levels:

1. **Level 1:** any form of sexual activity forced on another person, or non-consensual bodily contact for a sexual purpose. Touching, kissing, and oral, vaginal and anal sex are considered level 1. Minor physical injury can occur or even no physical injury at all. Conviction is punishable up to 10 years in prison.
2. **Level 2:** sexual assault in which a perpetrator uses or threatens to use a weapon, threatens the victim's friends or family members, causes bodily harm to a third party, or commits the assault with another person. Conviction is punishable up to 14 years in prison.
3. **Level 3:** a sexual assault that wounds, maims or disfigures the victim, or endangers the victim's life. Conviction is punishable by up to life in prison.

Sexual assault and Canadian law: considers sexual assault an act of power and dominance, rather than an act of sex. It is gender-neutral with regard to sexual assault. It allows for sexual assault to be committed against one's spouse. It allows for consent to be given to some activities but not to others.

Incidence of sexual assault: in Canada in 2009, the Uniform Crime Reporting Survey (UCR) indicates that almost 21,000 sexual offences were reported to the police and more than 95% of them were level 1 offences. Rates of sexual assault have declined since 1993. This reflects a decline in the number of level 1 assaults reported to the police as level 2 and level 3 rates have remained stable. These date reveal that there is a large difference between the number of sexual assaults reported to the police and those that actually take place. Researchers estimate that 1/10 sexual assaults in Canada is reported to the police. False allegations are rare. Rising incidence of drug-facilitated sexual assaults.

Female sexual offenders: researchers estimate that women are responsible for 4-5% of all sexual offenses. Little is known about female sex offenders. They are less likely than males to use force. They are less likely than males to deny actions. Many have been physically or sexually abused as children. About ½ acted on tandem with male offenders. One sub-type is called the "teacher/lover".

Types of sexual assault: there are many different types of sexual assault:

1. **Stranger sexual assault:** sexual assault committed by an assailant previously unknown to the person. Assailants select a target who seems vulnerable and seeks out a safe time and place to attack. It accounts for 18% of incidents reported in 2007.
2. **Acquaintance sexual assault:** sexual assault by an acquaintance of the person who is assaulted. It is more common, but less likely to be reported than stranger assaults.
3. **Date sexual assault:** common form of acquaintance sexual assault. More likely to occur if the couple has been drinking and parks in the man's car or goes to his home. Man tends to perceive his partner's willingness to return home with him as a sign of sexual interest. Some men interpret resistance as being coy. It can be challenging for the courts to determine if consent was given in cases of established relationships. If a woman says no and a man forcibly violates her, she has been assaulted.
4. **Gang sexual assault:** exercise of power appears to be the major motive behind gang sexual assaults. Some attackers may be expressing anger against women. Sexual assaults involving groups of attackers tend to be more vicious than individual assaults. Relatively few survivors of gang assaults reported the attacks to police or sought support from rape crisis centres.
5. **Sexual assault against males:** 1/5 university men reported being coerced into sex in the previous year. Most sexual assaults against men are committed by other men. Most attackers are heterosexual. Motives include domination, control, revenge, retaliation, sadism, degradation, and status/affiliation. It can also be a part of sports hazing rituals. Media has recently reported many cases of men in positions of authority assaulting boys. Male survivors tend to suffer greater physical injury than female survivors. Males are more often attacked by multiple assailants held captive longer, and are more reluctant to report the assaults. Male survivors may experience traumatic effects similar to those suffered by female survivors.
6. **Sexual assault against gay and bisexual males:** one study found that 14% has been forced or coerced into having sex before the age of 14. Half of the reported incidents involved forced receptive anal intercourse. Men who had been sexually coerced has lower rates of suicide and higher rates of depression, they were more likely to abuse alcohol and have attempted suicide.
7. **Partner or marital sexual assault:** probably more common than date rape because a relationship has already been established. A traditional man may believe it is a woman's duty to satisfy his sexual needs, even when she is not interested. The type of assault often goes unreported. Victims may not recognize it as assault. Victims may fear that others won't believe them. Motives include domination and degradation. Often occurs within a pattern of violence and physical intimidation. Victims may fear physical injury and death as much as victims stranger assault do. Long-term effects are similar to those of stranger assaults (fear, depression, sexual dysfunction). Women usually have to live with her assailant and may fear what will happen if she reports the attack.

The complexity of sexual assault: the issue of sexual consent is central as it has been defined and conceptualized in many ways. Can it be given under duress? Must it be given verbally? How do people actually ask for and give consent? Is it a clear yes or no? Most men and women give consent indirectly.

Social attitudes and myths: women say no when they mean yes, women like men who are forceful and pushy, women dress in a way that invites assault, women want to be assaulted… Myths create a climate which legitimizes sexual assault. Gender, gender roles, ethnicity and

endorsement of other social attitudes are associated with acceptance of these myths. Young men may come to view dates not as chances to get to know their partners, but as opportunities for sexual conquest. There is a link between sexual behaviour and sports. It is proposed to have roots in evolutionary history when men were forced to compete for limited sexual resources.

The date-rape drug: Rohyphol (also called roofies) is easily slipped into the drinks of women. It lowers inhibitions, lessons the ability to resist sexual assault and causes blackouts. To avoid being roofied, be wary about accepting drinks from strangers, do not put your drink down and leave it, if you think you have been a victim, notify police.

Sexually coercive males: not all men are equally likely to act in sexually aggressive ways. Researchers seek out factors which predict which men are more likely to be sexually coercive like anti-social personalities, long histories of violent behaviour, and/or violence and sexual arousal become connected. Other associated characteristics can include: more aroused by portrayals of rape, more likely to come from families with alcohol problems, more likely to abuse alcohol and more likely to have experienced childhood sexual abuse, pornography during childhood and deviant sexual fantasies during childhood and adolescence. Research is biased because it usually only includes offenders.

Male vs. female victims of sexual coercion: Hartwick et al. (2007) found that the main difference between male and female victims was that the women were more likely to have experienced coerced kissing and fondling (rates of intercourse almost the same). Men and strangers were more likely to be coerced through intoxication; women and relationship partners through pressure and guilt.

Adjustment of sexual assault survivors: the experience is terrifying, victims may fear for their lives and feel helpless. In the days and weeks following, many survivors are in crisis and experience insomnia, crying, eating problems, menstrual irregularities. They become withdrawn, sullen and mistrustful and may experience guilt and shame. Emotional distress tends to peak about three weeks after the assault and tends to remain high for a month or two before abating. Many survivors have more lasting problems like feeling powerless to affect their own fates, encountering problems at work, impaired relationships with partners and sexual problems. Many do not report the assaults to the police for fear of retaliation, social stigma, worrying others won't believe them, feeling it's hopeless to bring charges against the perpetrator, have concern about negative publicity and fear emotional distress if the case goes to trial.

If you are sexually assaulted: do not change anything about your body, strongly consider reporting the incident, ask a relative or friend to take you to the hospital, seek help in an assertive way, question health professionals about health risks and treatments, and consider calling a sexual-assault hotline.

Psychological disorders resulting from sexual assault: anxiety disorders and depression, alcohol and substance abuse, lower self-esteem, **PTSD** (a type of stress reaction brought on by a traumatic event characterized by flashbacks of the experience in the forms of dreams or intrusive recollections, a sense of emotional numbing or restricted range of feelings, and heightened body arousal).

Treatment of sexual assault survivors: there is a two stage process – 1) helping the victim through the crisis after the attack and 2) fostering long-term adjustment. Psychotherapy can help to deal with emotional consequences, avoid self-blame, improve self-esteem, validate experiences, establish or maintain loving relationships, and mobilize social support.

Preventing sexual assault: total elimination would require massive changes in cultural attitudes and socialization practices. Education can reduce its incidence. Until basic cultural attitudes which support sexual assault change, women must take a number of precautions. This is not the same as blaming the victim, the assailant is always responsible for the assault.

Confronting the attacker: should you fight, flee or plead? Some women have thwarted attacks by pleading and crying, screaming may ward off some attacks. Self-defense training may help you fend off the assailant. There is no single strategy that is likely to be helpful in all situations.

Lowering your risk of sexual assault: taking precautions such as these may lower your risk of being assaulted – establish signals with other women, list yourself in phonebook/mailbox by initials only, use deadbolt locks, keep doorways and entries well lit, keep keys handy when approaching car or front door, avoid deserted areas, do not allow strange men into your home without checking their credentials, check the back seat of your car before getting in and do not give rides to hitchhikers. Some tips for avoiding sexual assault on a date – communicate your sexual limits in advance, meet a new date at a public place, or in your own car, state your refusal definitely, become aware of your fears, pay attention to your vibes, be especially cautious in a new environment, do not let an ex into your place if you do not feel good about him.

COERCIVE VERBAL PRESSURE TACTICS

Verbal sexual coercion: persistent verbal pressure or the use of seduction lines to manipulate a person into sexual activity. There is a wide spectrum of persuasion, which not all would consider coercive. It is used more often than physical coercion. Tactics include: using alcohol and drugs to loosen a partner's reluctance to have sex, using obligations, expectations and guilt, and exploiting emotional and economic vulnerabilities. Continual arguments and verbal pressure are the most common tactics along with the use of alcohol or drugs. Women and individuals in a same-sex relationship also use verbal coercion.

SEXUAL ABUSE OF CHILDREN

Children who are sexually assaulted often suffer social and emotional problems that impair development and persist into adulthood. Data from 2007 UCR indicates that more than half of all victims that year were under 18, 25% were under 12, and most (81%) of those under 18 were female. Sexual abuse of children ranges from exhibitionism, kissing, fondling, and sexual touching to oral, anal and vaginal intercourse. Sexual contact between an adult and child is abusive even if the child is willing because children are legally incapable of consenting to sexual activity. Voluntary contact between children of similar ages is not sexual abuse. In Canada, it is against the law for any adult or teenager to engage in any type of sexual activity with a child under the age of 14. The exception is activity between someone at least 12 and someone who is less than two years older. It is against the law for a person in a position of trust or authority to have any sexual contact, consensual or not, with a person under 18. Also, the same goes for an adult using the internet to lure a person he or she believes is under 18 for the purpose of committing a sexual assault, or to entice a child believed to be under 14 into sexual relations. In

2008, the Canadian Parliament raised the legal age of consent from 14-16 to protect adolescents in that age group from adult sexual exploitation. This was challenged as discriminatory toward gay males because it is illegal to engage in anal sex with someone under 18.
Patterns of abuse: children from stable middle-class families appear to be at lower risk than children from poorer, less cohesive families. Most children know their attackers. The decision to report the abuse largely depends on the relationship between the abuser and the person ho discovers the abuse. It is typically the child who initially trusts the abuser and physical force is seldom necessary. Most children are abused only once and those abused by family members are more likely to suffer repeated acts of abuse. Genital fondling is the most common type of abuse. Abused children rarely report abuse because they fear retaliation or worry that they will be blamed. Adults may notice changes in the child or a doctor may see signs during a physical exam. There is a overwhelming majority of males who abuse children and they are mostly adults, but some adolescents. Male adolescents are more likely to have been abused themselves. The number of female abusers may be greater than in the past. Some Canadians travel to developing countries to have sex with children, in part because there is a lesser chance of being prosecuted there, this is called **sex tourism**. In 1997, the Canadian government changed the criminal code to allow prosecution of Canadians who sexually abuse children while out of the country. A 2002 amendment allows prosecution in Canada even without agreement of other countries.
Pedophilia: a paraphilia that features sexual attraction to children. It involves sexually arousing fantasies, urges, or behaviours that involve sexual activity with a prepubescent child. A clinical diagnosis is given when a person acts on or is distressed by these pedophilic urges. It has been estimated that up to 5% of men have sexual fantasies or sexual contact with prepubescent children. Pedophiles are almost exclusively male, not always only attracted to children, may never have any contact with children, may only abuse children they are related to, or not, and may limit interest to looking at or undressing children, whereas others fondle them or masturbate in their presence, and others coerce them into oral, anal or vaginal sex. They often have personality disorders, are often emotionally unstable, disagreeable, angry, impulsive and mistrustful, often have grown up in families with insecure attachment experiences, and may lack social skills to develop relationships with adult women. Pedophiles often see children as sexual beings who want to have sex with adults. They believe that sex does not harm children, and that it may be beneficial. They think that they are so important that they are entitled to have sex with whomever they want. Pedophilia is associated with having a head injury before the age of 6, having older brothers, school failure by one or more years and subsequent enrollment in special education, lower levels of intelligence and brain differences. Children are often manipulated by pedophiles who say that they want to: show them something, teach them something, and do something with them that they will like. Some pedophiles seek to gain the child's affection and then discourage them from disclosing using gifts and threats.
Incest: sexual relations between individuals who are so closely related that sexual relations are prohibited and punishable by law. There are three types of incest: father-daughter incest, brother-sister incest and mother-son incest. Family factors include: general family disruption, spousal abuse, alcoholic or physically abusive parents, stressful events in the father's life, uneven power relationships between spouses, and generations of abuse history.
Effects of sexual abuse of children: short and long term psychological complaints (anger, depression, anxiety, eating disorders), acting out behaviour, PTSD, externalization of boys, internalization of girls and late adolescence and early adulthood difficulties.
Treatment of child sexual abuse survivors: psychotherapy in adulthood is often the first chance for survivors to confront pain, anger and misplaced guilt. Group and individual therapy can be helpful. There is individual therapy for the mother, child, and father, group therapy for the younger child, marital therapy for parents and family therapy.
Helping children avoid sexual abuse: prevention programs help children understand what sexual abuse is and how to avoid it. It recognizes the differences between good and bad touch and how to prepare children to handle actual encounters with molesters. Children can't always prevent the abuse but can be encouraged to tell someone about it. Teachers and helping professional are required to report suspected abuse, and need to be taught to recognize signs.

TREATMENT OF PERPETRATORS

Treatment: reforming the individual. Recent programs were more successful that those prior to 1980. Programs can encourage offenders to take responsibility for their actions. They teach more effective coping skills and use reconditioning strategies to enhance appropriate sexual interests and reduce deviant ones. They help to better integrate offenders into the community and helps them to avoid reoffending by meeting their intimacy and relationship needs. Surgical castration and anti-androgen drugs are other methods of treatment. In 2004, Canadian government established a sex offender registry. Many do not register and the list is not up to date. Public notification programs have been criticized for increasing stress on offender and thus the potential for reoffending.

SEXUAL HARASSMENT

Sexual harassment: deliberate or repeated unsolicited and unwelcome comments, gestures, or physical contact of a sexual nature. It is forbidden by federal and provincial human rights legislation. It may include: verbal harassment, verbal abuse, leering or ogling, brushing against a person's body, etc. It is most common to stare, make jokes and remarks about women or about the respondents themselves.
Minority groups: ethnic minority women may feel less free to report harassment to the authorities. Minority women do not perceive the term sexual harassment to fully capture the racial aspects of the behaviours. Minority women experience more harassment than white women (double jeopardy).
Workplaces: sexual harassment includes any behaviour of a sexual nature that interferes with an individual's work performance or creates a hostile, intimidating or offensive work environment. Most severe type involves an employer or supervisor who makes sexual demands a condition of employment. Harassers can be employers, supervisors, co-workers or clients. Employers can be held responsible for their own actions, and actions of their employees. There are few people who experience sexual harassment in the workplace who actually report it. Some workplaces ban consensual sexual contact between employees. Despite this, many intimate relationships begin in the workplace.
Campuses: one study indicated that 9% of female and 2% of male graduate students experienced sexual harassment. It is most common for the sexual harassment to be a sexist remark or a sexual comment. Female students on campus

have been harassed by male professors and instructors and other students. Most forms involve unequal power relationships and most instances are not reported.
Schools: in one study of 1213 students in grades 6-8, boys were more likely to report perpetration, both genders were equally likely to report victimization and the three behaviours most experienced were: homophobic name calling, sexual comments or jokes and flashing/mooning. Boys perpetrated more same-sex harassment while girls dealt with more cross-sex harassment. Research on older adolescents suggest sexual taunts and advances have become more common. Girls were more likely to report becoming upset by sexual harassment behaviours than boys. Most students responded passively to the harassment; hardly anyone told a teacher or filed a complaint. A large scale study suggests that gay, lesbian and bisexual students experience more physical and sexual abuse than heterosexuals do. This is attributed to the stigma attached to LGB orientations. There is a considerable concern today about websites that spread sexual rumors about students. This is typically about boys being gay and girls being a slut. There is an issue about circulating nude photos. Teachers have also been sexually harassed on websites.
Resisting sexual harassment: responsibility for sexual harassment rests with the perpetrator and with the organization that permits the harassment to take place. If it is happening to you, you should: convey a professional attitude, discourage harassing behaviour, avoid being alone with the harasser, maintain a record, file a complaint or seek legal remedies, talk with or write a letter to the harasser and seek support.

chapter 17: commercial sex

PROSTITUTION

Prostitution: the sale of sexual activity for money or goods of value. It is often called the world's oldest profession. In recent years, "sex worker" has replaced "prostitute" as the preferred term for a person who engages in sexual activity in exchange for monetary compensation. The term underscores the economic and labour aspects of the work.
Prostitution laws in Canada: while prostitution itself is legal, almost all the activities involved with it are illegal, specifically: transporting or directing another person to a common bawdy house, keeping, being an inmate of, being found without lawful excuse in, or allowing a place to be used for the purposes of a common bawdy house and procuring and living off of the avails of prostitution. Several Canadian cities have attempted to regulate prostitution by licensing escorts and escort agencies. When escorts and agencies were first given licenses there was the hope that they would be treated as a legitimate business. In reality, escorts felt the police treated their business as undesirable. In 1983, a special committee appointed by the Canadian Minster of Justice recommended that prostitution offenses be removed from the Criminal Code. Instead the federal government brought it more restrictive legislation making it illegal to communicate with or stop a person in a public place to negotiate sexual services for payment. This was challenged under the Charter of Rights and Freedoms, but upheld by the Supreme Court. Police and politicians have been particularly concerned about teen prostitution. Parliament has significantly increased penalties for clients who attempt to obtain sexual services from someone under the age of 18. Police in Canada often use the strategy of entrapment to obtain convictions against prostitutes and their clients. Police are less likely to entrap those who engage in homosexual prostitution. However, the gay and lesbian communities face the possibility of arrest for other kinds of sexual activities. There have been attempts over the years to legalize prostitution and they have been resisted by government leaders. Additional challenges have related to mandating safer working conditions for sex workers. Sex work has been viewed as a degrading activity which no one would willingly engage in – leading to a focus on sexual exploitation of children and human trafficking. In 2007, a small group of lawyers and sex workers launched constitutional challenges to three sections of the prostitution laws:

1. The provision against communication for the purpose of prostitution, because it prevents sex workers from screening potentially violent clients.
2. The provision against bawdy houses because it prohibits sex workers from working in an indoor environment, which is safer than working on the streets.
3. The provision against living off the avails of prostitution, because it is too broad, and it prevents sex workers from hiring security personnel, such as escorts, who would in turn hire drivers for the prostitutes.

Canadian attitudes: a 2009 Angus Reid poll found most Canadians would like to see Canada's prostitution laws modified. 50% thought some aspects should be decriminalized, 25% thought prostitution should be prohibited entirely, 16% thought laws should remain the same and 8% were not sure what they thought.
Female sex workers: are usually classified according to the setting where they work.

- **Street-based workers** solicit customers in the street, they are the lowest in the sex work hierarchy, they comprise of about 20% of all sex workers, they typically earn less and incur more risk and they work in the open so they are more likely to be arrested. Some work to support pimps and pimps tend to acts as a lover, father, companion and master. They often live lives of sex, violence, disease and substance abuse. Many feel powerless to control their own fates. Many die young from drug abuse, disease, suicide, and physical abuse. Those who survive become less marketable with age. Hotel workers have slightly higher status and better working conditions.
- **Brothel workers** occupy a middle position in the hierarchy of sex workers and work in brothels or massage parlours.
- **Massage parlour works** work in massage parlours that serve as fronts for sex work. Clients pay fees for standard massages and tip the workers for sexual extras. To avoid massage parlour regulations, some owners have obtained licenses claiming that they were holistic health centres or aromatherapy centres. Most massage parlours that offer sexual services limit them to masturbation of the client. Most do not offer oral sex or penetration in an attempt to avoid prosecution.
- **Escorts** post ads in telephone directories and newspaper personals to attract conventioners and businessmen. Services provide masseuses or masseurs to hotel rooms. Escort services typically offer sexual services. Sex workers who work for escort services usually come from middle-class backgrounds and are well-educated.
- **Call girls** are sex workers who arrange their sexual contacts by telephone. They occupy the highest rung on the social ladder of female sex work. They are the most attractive, best educated, charge the most and work on their own (without pimps). They serve

as companions and sex partners. Many receive clients in their apartments or make outcalls to clients' homes and hotels. They may insist on seeing a client's business car or learning his home telephone number before making contact. They may investigate that the person is who he purports to be.

Advocacy for sex workers: sex work can be a dangerous, highly stigmatized occupation. There is a meaningful progress towards improving safety and working conditions that will likely depend on the Supreme Court of Canada's decision on the constitutional challenge against existing laws. Beyond decriminalization, the safety and well-being of sex workers can be improved through policies that focus on occupational health and safety, access to essential rights and services. A number of organizations provide support services to sex workers across Canada.

Intentional human trafficking: a major global enterprise. The trafficking of girls and women is the industry's major component. Because it is illegal and underground, it is difficult to obtain accurate information about the number of girls and women trafficked to Canada. Girls and women have been trafficked from Eastern Europe, Asia and Africa, usually by an organized crime group. Women and girls are lured by the promise of a better life. They arrive in Canada after false promises of a legal job; coerced into sex work to repay the trafficker for her travel costs. Trafficker keeps her working the sex trade by withholding her passport, isolating her from the wider community, confining her with force and threatening her with violence.

Entry into sex work: many factors are associated with sex work. Poverty and sexual and/or physical abuse are a common background in many sex workers. Research in this area has focused on street workers and may not accurately reflect characteristics of other categories of sex workers. Some voluntarily ender the business and do not see themselves as victims.

Male customers of female sex workers: referred to as johns or tricks. They represent all socioeconomic and racial groups. One study found johns were similar to men who are not customers of sex workers. They had an average age of 38, more than half were married or in a serious relationship and on average had used services of a sex worker 19 times. Most Canadian studies of client sex workers have used samples from john schools. These samples are biased as they consist of men who were arrested for soliciting streetwalkers. Most patrons are occasional johns (like travelling salesmen or military personnel). Habitual johns use sex workers as their primary or exclusive sexual outlet. Some johns use sex workers to meet their psychological or sexual needs as they are unable to meet them otherwise. Others may have a Madonna-whore complex which is a rigid stereotypic of women as either sinners or saints. In Canada there is a stigma attached to paying for sex. Motives for buying sex include: sex without negotiation, sex without emotional commitment, sex for eroticism and variety, prostitution as a social outlet, sex away from home and difficulty of attracting a partner. In return for attending the day-long school, men with no previous criminal records who are charged with communicating for the purpose of prostitution can have their charges erased from court record if they attend a john school. Here they listed to streetwalkers talk about the negative effects of the sex trade, lectures on STIs, etc. Men are expected to provide donations to help support the programs.

Male sex workers: include male-male and male-female activities. Male sex workers who service female clients (gigolos) are rare. Beach boys in developing countries make money from their relations with women tourists. There is an overwhelming majority of service gay men. They are sometimes called "hustlers", a many who engages in sex work with male customers. Patrons of hustlers are sometimes called scores. Many male sex workers come from families troubled by conflict, alcoholism, and physical and sexual abuse. They may be gay, bisexual or heterosexual. Compared to female street-based sex workers, male street-based sex workers: do no work for pimps, were more likely to have another source of income, see fewer clients per week, spend more time with each client, more likely to kiss, and less likely to experience sexual and physical assault and robbery. There are various kinds of male sex workers: strippers, kent boys, call boys, punks, drag prostitutes, and brothel prostitutes. Male sex work tends to be an adolescent enterprise. Younger men can set higher fees, limits on what they will and will not do, and turn more tricks. Men who pay for sex with men fall into three categories:

1. Men who keep their sexual desire for men hidden
2. Men who wanted to have sex with younger men
3. Men who couldn't attract regular partners

STIs and sex work: in one study 1/3 of both male and female sex workers reported that they had had STIs in the previous two years. Most sex workers report very high condom use with clients, less so with men who were not.

Stripping: a kind of sex work, though men and women who work in strip clubs typically refer to themselves as dancers. Some limit their sexual activity to dancing and taking off their clothes while others do lap or table dances, making contact with customers as they dance. Some strip clubs have private shows and VIP areas where strippers can be alone with clients. Most strippers do so on a part-time, temporary basis.

SEXUALLY EXPLICIT MATERIAL (SEM)

SEM: is found nearly everywhere in magazines, DVD rentals, internet, cable/satellite, phones and mp3 players. It is typically used to enhance sexual arousal, often as a masturbation aid. It may also be used by couples during sex.

Pornography: written, visual, or audiotaped material that is sexually explicit and produced to elicit or enhance sexual arousal. It has a negative connotation today and is typically associated with SEM that is violent and/or degrading.

Prurient: tending to excite lust and lewd.

Erotica: SEM that does not involve violence of degradation of women, it may be as sexually explicit as porn.

Obscenity: SEM that offends community standards.

Perspectives on pornography: it is obscenity based that offends community standards. Conservatives believe that it is a threat to the traditional values of society while liberals believe that in the absence of clear harm, the government should not restrict access to SEM. The anti-pornography feminist approach, portrays women as objects intended to provide pleasure to men and presents women in dehumanized degrading ways. Pro-pornography feminist approach is that SEM can promote gender equality.

Canadian law and SEM: Canadian obscenity laws provide the legal framework for outlawing the dissemination of porn. It relies on offending people or violating community standards. The Supreme court has been strongly influenced by the anti-pornography feminist approach. All materials that come into Canada can be confiscated by the Canadian Border Services Agency if they are deemed to violate

Canada's obscenity laws. Stores can be charged for selling materials that are defined as obscene under the criminal code. Legal efforts to regulate SEM in Canada have been thwarted by easy access on the internet.

Child pornography: Canadians almost universally view child pornography as obscene and harmful. It is illegal to sell child porn as well as possess anything that depicts people under the age of 18 engaging in real or simulated sexual behaviour. Visual representations (for sexual purposes) of sex organs for people who are under 18 and written materials and pictures that advocate having sex with under aged individuals are also forbidden. The law allows exemption from prosecution if the material has artistic merit or an educational, scientific or medical purpose. In 2001, exceptions to include private materials and SEM created by children and adolescents that are meant to be kept strictly private and only for personal use.

Employers and SEM: many Canadian employers have policies which forbid the viewing of SEM in the workplace. Some use filtering software or screen email messages for offensive content. Some employees have lost their jobs for looking at internet SEM at work.

The internet and SEM: Canadians increasingly use the internet to look at SEM. Studies of university students suggest that many young men and women are using the internet to look at sexual images and videos. Many find it arousing, have learned new techniques from it, and masturbated while online. The rates and frequency are typically higher among men than women. Many Canadians are exposed to unsolicited SEM through email messages and pop-ups. Males are more likely to respond positively to these than females. On secondlife.com, avatars can engage in virtual sex with other avatars.

Gender differences in response to SEM: researchers have found both men and women are physiologically aroused by SEM. Women are more likely than men to express negative feelings about SEM. Most erotic visual materials are produced by men, for men. Many women find SEM a turn off or disgusting, especially if it depicts women in unflattering roles. Many Canadian women are more comfortable today with posing in topless or nude photos. Many Canadian couples are using digital cameras to create home made SEM for private consumption.

Cybersex addiction: it appears that 1/3 of internet visits involve sexually oriented websites, chat rooms and news groups. Accessibility and anonymity of sex on the internet is fuelling what some health professionals call cybersex addiction. Many spend hours a day masturbating to pornographic images or having online sex via char rooms or web cams. Especially vulnerable people may be those who have been suppressed and limited all of their lives and who suddenly find an infinite supply of sexual possibilities. Online viewing that begins as harmless recreation can become all-consuming. Cybersex compulsives may ignore their partners and children and risk their jobs.

Sexual coercion and SEM: The Fraser committee concluded that available evidence does not suggest that porn leads to violent crime, sexual abuse of children, and the disintegration of communities and society. There have been few differences found between men incarcerated for sex offenses and nonsexual offenses. Research suggests that it is the violence in violent SEM, not the explicit sex that potentially affects or reinforces the attitudes and behaviours of sex offenders. There is little evidence to suggest that SEM causes aggression since men who are predisposed to sexual aggression are more likely to view violent SEM and therefore will likely show the strongest effects. Nonviolent SEM does not appear to affect men's attitudes towards women's right and roles in society. Exposure of 6 weeks to casual sex SEM films was associated with greater acceptance of premarital and extramarital sex and simultaneous sexual relationships with multiple partners. Prolonged exposure to SEM may foster dissatisfaction with physical appearance and sexual performance of one's intimate partners. it may also contribute to unrealistic expectations about sexual functioning. Most research of SEM has come from harm-based approaches, serves on only men and considers women as victims. An increased amount of SEM is produced by women, for women and couples. This indicated that many women are willing consumers.