Exam III: Study Notes

Lecture 1: Understanding and Promoting Sexual and Reproductive Health (With Special Focus on STI)

Psychology 2075 Survey Results:
–Personally purchased condoms: Men more than women
–Access to condoms in place of residence: Men more than women
–Used male or female condoms in the past six months: Women more than men
–Latex during oral sex: very low

–Sexual "debut" in early teenage years, long-term partners in late 20's: time period susceptible to STI infection (15-25 highest)
–Sex leads to…Pleasure, Babies, and Infection

Sexually Transmitted Infections: STI rather than STD because STD implies symptomatic, while STI encompasses infections that are asymptomatic
–**Bacterial Infection**s are treatable (i.e. chlamydia, gonorrhoea)
–**Viral Infection**s are chronic but manageable (i.e. HSV, HPV, HIV)

Understanding the Problem: Psychological determinants of sexual and reproductive health risk and prevention:
–**INFORMATION** and **MOTIVATION** and **BEHAVIOURAL SKILLS** lead to SEXUAL ACTIVITY and REPRODUCTIVE HEALTH RISK AND PREVENTION PRACTICES
–Must have all three (IMB) to lead to healthy behaviour)
–Information and Motivation must be coupled with **Behavioural Skills** to produce Reproductive Health Behaviour

INFORMATION and Health Behaviour:
–Reproductive health education involves information that is irrelevant, incomprehensible, fear generating, sexist (males taught they are unmanageable beings, clitoris is often left out of discussion), and sometimes dangerous (i.e. MacLean's magazine disproving HPV vaccination)

Public Health and Primary Care: What we say versus what we get:
–"Have fewer partners": Always need STI protection unless both partners have only had sexual relations with each other ever
–"Get to know your partner": Most STI are asymptomatic (Plus 40% of people will lie in order to have sex)
–"Oral contraception to prevent pregnancy is enough": Does not prevent against STI's

Oral contraceptive onset = condom use offset presented by Canadian National Survey
–More partners with condom use=less likely to attain an STI than less partners and solely using oral contraception

MOTIVATION and Health Behaviour:
–Emotions: Erotophobia vs. Erotophilia
–Mechanisms of social control that condition a degree of sexual restraint, anxiety, or guilt causing erotophobia
–Many people are relaxed enough to have sex, but too uptight to plan and talk about protection
–Attitudes: based on sex and socio-romantic behaviour
–Social Norms: condom use is not yet a normative part of standard sexual script

BEHAVIOURAL SKILLS and Health Behaviour:
–Necessary to know how to implement behaviour

–Often sexual consent is assumed/conveyed through body language rather than verbalized (not safe practice of sex)

Reproductive Health Behaviour Sequence (same sequence, different methods for STI/HIV prevention, contraception, and HPV vaccination):
–Self-acceptance of sexuality
–Creating personal sexual and reproductive health agenda
–Bringing up, negotiating prevention or enhancement, existing an unsafe situation
–Public prevention or enhancement acts
–Consistent practice of prevention or enhancement, self- and partner-reinforcement
–Shifting preventative and enhancement scripts (from abstinence to protected and rewarding intercourse)

Testing the IMB Model:
–STI/HIV Preventative behaviour in University student sample, and in gay male sample, urban minority high school males and females, netherlands adult homosexual males, low-income African American females, low income white females, etc.
–GO BACK OVER THIS SECTION OF THE POWERPOINT, VERY CONFUSING

Solving the Problem: Changing the IMB Model and Promoting Health Behaviour Change
–Information and Motivation and Behavioural Skills lead to Reproductive Health Behaviour
Phase I: Elicitation (collecting information)
–Elicitation of population specific levels of prevention
Phase II: Intervention
–Design and Implementation of targeted interventions, to address prevention IMB and behaviour
Phase III: Evaluation:
–Evaluation of intervention impact on prevention IMB and Behaviour
–Changing Information and promoting reproductive health
–Changing Motivation and promoting reproductive health
–Timing is everything: prevention methods should be presented prior to sexual activity begins (easier to teach than to change people)
–Changing emotions: At Western: “Can we talk?”
–Changing attitudes: Using funny advertisements promoting condom use
–Changing norms: Walking through the entire reproductive health behaviour sequence

Sexually Transmitted Infections:
–The worried well (tested after questionable sexual activity)
–The blissfully unaware
–The infected
–The affected (relationship crisis, chronic carriage)

Chlamydia:
–Canadian Prevelance: **Highest prevalence of any reportable STI in Canada**
–Young heterosexual females and males aged 20-24=highest incident rate
–Routes of transmission: **Penis in vagina, or penis in anus intercourse** are most common, oral sexual contacts may transmit the infection as well
–Highest rates for youth 15-24, increasing prevalence over the years
–Symptoms: Most often **asymptomatic** or present minimal sympotoms such as **clear discharge** from vagina, penis, or anus. Urinary symptoms such as **burning or itching and vaginal bleeding after intercourse** (for women)
–Diagnosis through **cervical swab, urethral swab, or urine sample**
–Consequences: May spread to uterus and fallopian tubes and cause **pelvic inflammatory disease** (PID), which can cause pain with or without intercourse. Consequences to male reproductive tract are generally less severe.
Treatment:

–**Oral antibiotics**: medication is free for infected persons in most Canadian jurisdictions
–**Partner notification** is essential
–Prevented by the proper use of male or female **condoms**
–Consequences of STI transmission on relationships

Gonorrhea:
–8/10 people do not know they have it
–Prevalence is **highest among Canadian men who have sex with men**, and tourists who have had sex while travelling abroad. Prevalence rising among heterosexual men and women (but still considerably less prevalent than chlamydia)
–Routes of Transmission: **Penis in vagina, or penis in anus intercourse** are most common, but through oral interactions are possible as well
–Symptoms: More frequently symptomatic, **burning on urination and greater quantity of genital discharge of a pus-like yellowish to greenish discharge**
–Frequently asymptomatic in women
–Diagnosis: **Cervical swab, urethral swab, urine sample**
–Consequences: May spread to uterus and fallopian tubes and cause **PID**, consequences to male reproductive tract generally less severe
–Treatment: **oral antibiotics**, or medication in the form of a **single injection** if present in the anus or pharynx or if PID occurs
–Prevention: Proper use of male or female **condoms**

Syphilis:
–Canadian prevalence: **not common in general population**, **greater risk among men who have sex with men**, people who had sexual contact while travelling abroad in high syphilis prevalence areas, some geographic areas of Canada where outbreaks occur periodically
–Routes of transmission: **Penis in vagina, or penis in anus intercourse** ore most common, also through **oral sex and injection drug use, and transmission from infected mother to infant during pregnancy/childbirth**
–Symptoms: Appears at different **stages of progression**, initially includes single or multiple **painless ulcerations** (ulcerations will clear but infection is still present and must be treated otherwise it will progress to widespread organ and neurological damage)
–**Syphilis lesions**: damage to the organs or tissue
–Treatment: **Injected penicillin**, partner notification is critical (synergy between syphilis and all genital ulcerative diseases and HIV infection)
–Prevention: Proper use of male or female **condoms**

Herpes (HSV: Herpes Simplex Virus):
–Prevalence: **1/3 of Canadians may be affected** by either HSV type 1 or type 2 in the anogenital area
–Routes of transmission: **penis-vagina, penis-anus, and oral genital sexual contacts. Infants can be infected by mother or caretakers** (many people transmitting virus are asymptomatic)
–Increased prevalence of oral sex confused two types of herpes (oral and anogenital)
–Symptoms: **Lesions** typically present on both sides of anogenital area when first infected, outbreaks reoccur after initial outbreak. Local symptoms such as **numbness and pins and needles will occur prior to reoccurrence by 12-36 hours, red patch of skin will be covered by small watery or pus-filled bubbles that will crust over** (outbreaks can last for several days, and blistery lesions reoccur only on one side)
–Diagnosis: **Swabbing lesions**, preferably before they crust, and performing a **viral identification test**
–Treatment: **oral antiviral treatment** can limit the length of an initial herpes outbreak. For patients with frequently reoccurring lesions there are significant psychological, social and sexual consequences
–**Keeping lesions clean and dry and using an over-the-counter antibiotic preparation** can lessen local symptoms

HPV (Human Papilloma Virus):
–ALL sexual activities pose risk for HPV infection
–Vaginal, oral, and digital contact (fingering)
–Smoking increases risk of vulnerability
–High Risk capable of causing cancer
–Low Risk capable of causing cauliflower-like anogenital warts (types 6 and 11)
–Can get rid of the warts, not the HPV
–Many people spontaneously clear it, some progress to warts and must be treated, some will get an abnormal pap-smear

HPV infection is exceedingly prevalent
–Sellors et al.: Age specific prevalence: Affects 24% of women aged 20-24 (1 in 4 chance of acquiring HPV): Representative Series of 995 Ontario Women
–Richardson et al.: Montreal Univeristy Women: Probability of HPV infection during 36 month follow up: Acquisition of HPV (HR and LR) when HPV- at enrolment is high
–Winer et al.: University women's risk of HPV infection with FIRST sexual partner

Richardson et al.: Natural History of HPV Infection in Montreal University Women:
–Women followed for 24 months at 6 month intervals
–New LR HPV acquisition rate was 13.4% at one year, and 23.7% at two years
–New HR HPV acquisition rate was 12.7 at one year and 29% at two years
–HPV 16 had highest baseline rate of infection (7%), and highest rate of acquisition (12% at 24 months), and longest duration of infection (18.3 months)

–HPV infection generally spontaneously clears, but low risk strains of the virus cause genital warts while high risk trains can cause cervical cancer
–HPV infection is getting scarier (transforming as time goes on): Cervical dysplasias, colposcopies, genital warts, and HPV+ oropharyngeal cancer (incidence of cancer within men and women are similar)

HPV related Head and Neck Cancer: The new STI
–HPV in HNC biopsies in Sweden: upward trend since 1970's (similar to the trend in Canada)

HPV infection can impair quality of life
–Anogenital warts health quality of life: Pain, anxiety, and depression remain elevated for duration of wart episode
–Levels of anxiety return to normal levels after approximately four months (initial spike dissipates over time)

HPV Infection Impacts:
–Feel worse about current, past, and future sexual parters and relations
–Reduced sexual desire, sexual frequency, sexual arousal, and orgasm
–Prevention through vaccine: Gardasil most common in Canada (prevents type 6, 11, 17, and 18–quadrivalent vaccine)
–Nanovalent vaccine prevents 9 strains of the virus
–Despite what textbook says, there is no age limit for getting the virus, both men and women should get it

Partner notification is complex:
–Parnter can be a source of support or conflict
–According to Canadian STI guidelines, patients are encouraged to inform sex partner(s) of infection but partner notification is not demonstrated as effective in prevention

–Condoms are somewhat helpful in preventing infection

–HPV infection is vaccine preventable
–Rates of uptake in school based programs in most provinces are 70%-80% but in Ontario 50%-60% (perhaps because of multiculturalism)
–Rates of uptake in Psych 2075 are 60% of women and 5-10% of men
–Personal attitudes (belief profile) and social norms (perceived social support) affect men and women's motivation to get vaccinated
–Correlation between poor motivation, negative perceived social support and NOT getting vaccinated
–HPV vaccination is not particularly controversial: it is safe, effective, necessary, and recommended

"The Brave New World" : HPV Infection in the HPV DNA era
–HPV DNA testing: positive=cytology test: positive=colposcopy
–Testing: netative=repeat HPV DNA test at five year intervals
–Recommend HPV vaccination, catch up is free for women born after 1994, parental insurance coverage for women and men

How to be reasonable sexual:
–Think about sex
–Learn about sex
–Talk about sex
–Talk to your health care provider
–Contraception
–STI screening and testing
–Get vaccinated (Hepatitis B, HPV)
–Get pap tests
–Get STI screening or testing
–Be aware of limits of STI screening or testing
–Consider seeking help when there is an abnormality or issue
–Criminal Law with sex and HIV: obligation to inform partner prior to sexual contact if HIV+ and possibility of transferring infection is present
–Screening refers to offering testing to individuals with no symptoms
–Testing is targeted test for specific illness
–STI tests for chlamydia, possibly syphilis and ghonorrhea, HIV and NOT for herpes or HPV
Lecture 2: Understanding and Promoting Sexual and Reproductive Health (With Special Focus on HIV/AIDS):

HIV/AIDS: The Ultimate STI
–Transmitted by most pleasurable human activity
–Transmitted by behaviour required for species survival
–Keeps host healthy and infectious for years (5-10 years)

–**1981**: GRIDS (Gay Related Immune Deficiency aka AIDS) "**discovered**" by CDC clerk
–**1984 HIV** (the virus that causes AIDS) was **discovered** and an antibody test became available
–**1910-1950 crossover from primate** simian immunodeficiency virus to humans (People in Africa were butchering bush meat for consumption)
–Went unnoticed because of early epidemic in Africa: the "skinny disease"
–**SILENT SPREAD**
–1982: The New York Times communicated the cause of the disease was unknown, "no evidence that the disease is spread from person to person"

–Transmitted through the exchange of bodily fluids (semen, vaginal secretions, blood, tissue)
–Sexual behaviour, sharing drug injection paraphernalia, unscreened blood transfusion and tissue transplantation, and occupational exposure, breastfeeding, childbirth

–HIV infects immune cells that ordinarily fight infection

–Once infected cells are activated they work to create ne viruses instead of doing the job they are supposed to do
–Many helper T-cells are destroyed in the HIV replication process
–HIV infection progresses to immune system destruction, opportunistic infection, AIDS related death within 5-10 years
–People do not die of HIV; they die of AIDS

–HIV transmission is a function of the infected individual's viral load and access to the uninfected individual's bloodstream
    –First 3-4 weeks of infection viral load is at an ultimate high
    –Latency period of 5-10 years: not as infectious (lower viral load)
    –Last few years: constitutional symptoms, opportunistic virus, death

–NO Risk: Kissing, Hand-Genital Sex
–LOW Risk, but not no risk: Oral Sex
–HIGH Risk: unprotected penile-vaginal intercourse, and unprotected penile-anal intercourse

Psych 2075 Results:
–VERY low percent of people use condoms during oral sex
–Condoms during Penis in vagina sex: males=63.5%, females=55.8%
–Condoms during anal sex: males=54.9%, females=33.7%

1981-1996: Fear Therapeutic Impotence, and Death
–Fifteen year period where everyone was dying from the disease (AIDS quilt as a memorial effort)
–1993-1995: peak for diagnosis, death, and infections
    –1995: Anti-retroviral therapy: more people living with HIV infection, lower number of new infections
    –CANADA: between 1990-1996: highest number of AIDS related death

–Kieth Haring: Artist promoting HIV awareness (silence=death, ignorance=fear)
–Ryan White expelled from school in 1986, he was a haemophiliac and infected that way

1996: Vancouver AIDS Conference: Era of Highly Active Antiretroviral Therapy
1996-2016: Era of Antiretroviral Therapy
    –Struggle to make ARV drugs available to AIDS epidemic epicenters
    –Patent of the drug makes it more expensive and less attainable
    –Focus on adherence to mediation and avoidance of multidrug resistance
–ARV Therapy: An individual health victory and a public health challenge
    –HIV undergoes very rapid, error-prone replication
    –Critical importance of early, multidrug intervention (otherwise the virus will build an immunity to the drugs)
    –Critical importance of adherence to therapy, viral load, viral escape
    –Number of people living with HIV has increased due to ARV Therapy

2016: Current State of Epidemic:
–Almost 37 million people living with HIV
    –25.8 million living in Sub-Saharan Africa
–HIV is a disease of social disorganization and poverty: occurs when societies undergo change and crumble, when people are involved in lots of sex work and drug use
–Around 2 million new infections, and 1.2 million deaths in 2014
–Canada as of 2016:
    –80, 469 Canadians living with HIV
    –36, 424 Canadians have died of AIDS
    –25% of Canadians living with HIV are unaware (cause of many new infections)
    –Around 2000 Canadians acquire HIV each year (slowly declining)

–24% of incident HIV infections are women
–People living with HIV from endemic countries and Aboriginal peoples living with HIV are over-represented among Canadians living with HIV infection
–Prevalence increasing (people with the disease)
–Incidence decreasing (likelihood of contracting the disease)
–Increasingly common for non-endemic heterosexuals to contract the disease

Treatment as Prevention:
–"Biomedical tsunami" Focus on treatment as prevention
–Relative de-emphasis of safer sex, safer needle use, maintenance of behaviour change
–Biomedical interventions are fundamentally behavioural interventions
–Test and treat
–Pre-exposure prophylaxis
–Anti-retroviral therapy
–Microbicides
–Treatment as prevention
–Circumcision

The Limits of Treatment as Prevention:
–People fail to adhere to medication intake, and develop viral loads without detection
–Only one set of antiretroviral drugs in Africa, therefore eople may become immune to them but it is all they have access to
–Ongoing viral detectability
–Ongoing risky sex
–HIV Unaware: Treatment as prevention is only one, valuable, part of the picture
–Let's not forget where this came from: SEX, and unsafe sex at that
–Syphilis epidemic among HIV positive people due to the management of their HIV infections and therefore less cautious about barrier methods
–The "Road to Hell" was paved with reliance on single prevention approaches
–Focus on uninfected people with low risk behaviour, while should be focusing on all people (including prevention from the standpoint of an infected person)
–Next step: Continue to practice safer sex

Highly Active Retroviral Prevention (HARP)
–Behavioural Change + Biomedical Strategies + Treatment/Antiretroviral/STI/Antiviral + Social Justice and Human Rights
–MULTIPLE methods of prevention are necessary for proper prevention

INFORMATION–MOTIVATION–BEHAVIOURAL SKILLS MODEL of HIV Risk and HIV Preventive Behaviour
–HIV Prevention information + HIV Prevention motivation = HIV Prevention Behavioural Skills = HIV Preventive Behaviour
–HIV Prevention Behaviour Sequence:
–Self Acceptance of Sexuality
–Learning relevant information about HIV
–Bringing up, Negotiating Prevention, or Exiting an unsafe situation
–Public prevention acts (buying condoms, seeking HIV testing)
–Consistent practice of prevention and self- and partner- reinforcement
–Shifting preventative scripts (from abstinence to HIV testing and protected intercourse)

HIV Preventive Behaviour in University Students, in Gay Males, in Inner City Minority male and female adolescents, Puerto Rican HIV+ patients
–WHAT DOES THIS STUFF MEAN

Solving the Problem: Changing Information, Motivation, Behavioural Skills, and Promoting HIV Prevention Behaviour

–INFORMATION + MOTIVATION + BEHAVIOURAL SKILLS = HIV PREVENTION BEHAVIOUR CHANGE
–Phase 1: Elicitation of population specific levels of HIV prevention IMB and Behaviour
–Phase 2: Intervention: Design and implementation of targeted interventions, to address HIV Prevention IMB and Behaviour
–Phase 3: Evaluation of intervention impact on HIV prevention IMB and Behaviour

HIV Prevention Education in a US University Student Population
–Residence based intervention in TV rooms: 3 x 2hr work shops
    –Information slide show, motivation video, behavioural skills video

"People Like Us": Motivating AIDS Preventive Behaviour in the 1980's and 1990's
    –Always a fatal untreatable condition
    –Universal belief that AIDS was threat to homosexual, promiscuous, drug using people
    –Documentary mobilized Festinger's social comparison theory to motivate HIV prevention
–Intervention and History (AIDS 1981-1996)

Sex, Condoms, and Videotape: Behavioural script coaching video
–Modeling HIV Prevention Behavioural Skills
–HIV Prevention Behaviour Sequence
–Significant increase in condom acquisition, condom discussion, and condom use in intervention (vs. control) condition at two-month follow-up.
    –Existing couples were more or less impervious to the prevention intervention

HIV Prevention Education in Inner City US High Schools
–Existing teachers, 4 or 5 classes, 2$/student
–Stakes are high: safer sex behavioural skills modeling in the Inner City context
–HIV Prevention Education Increases High School Student HIV Preventive Behaviour at One Year Follow-up
    –Significant increase in condom use among High School Students after HIV Prevention Education programs

Third Rail in HIV Prevention: Prevention with Positives
–Steady level of incident HIV cases
–All incident cases begin with prevalent cases
–Highest intervention priority should be on HIV+ persons capable of infecting others

AIDS Exceptionalism: Departures from standard practice that stress individual rights over public health
–Refusal to close high-risk venues
–Resistance to HIV testing
–Resistance of treatment of mother to child infection
–Scrupulous avoidance of prevention focus on HIV+ persons

Liberal Values and HIV Research: AIDS Exceptionalism
–Liberal Values:
    –Non-judgemental
    –Avoid more absolutes
    –Focus on relieving individual's distress
    –Avoid addressing individual responsibility, seen as "victim blaming"
–HIV patients already living with a terrible stigma
–HIV patients already living with a terrible disease
–HIV clinicians and researchers are compassionate and tolerant
–AIDS physicians and scientists
    –50% Jewish
    –40% Gay/Lesbian

–30% Female
–Activist and passionate
–HIV prevention research developed in a social context of demonization, fear, and stigma
–HIV prevention researchers exquisitely aware of the need to avoid further stigmatizing and further blaming the victim
–AIDS Exceptionalism:
–Early HIV: "Don't get tested, there is nothing you can do"
–Middle HIV: "It is up to others to protect themselves"
–Late HIV: "Testosterone, Viagra to ameliorate the suffering of the afflicted!"
–AIDS Exceptionalism focuses solely on prevention through HIV- persons

AIDS Exceptionalism Redux (Revival):
HIV Prevention research for HIV+ persons is nearly nonexistent 25 years in to the epidemic
–Semaan (2002) profile of HIV prevention trials
–HIV+ persons not the focus of ANY of the 99 studies
–Johnson (2002) meta-analysis of HIV prevention trials
–ONE study of prevention for HIV+ persons
–Albarracin (2005) meta-analysis of HIV prevention trials
–Only 22/354 intervention groups even provided information about the HIV infection status of participants
–Only 58/898 published intervention studies focus on prevention for HIV+ persons

The Delay in prevention research directed at HIV+ persons was brought on by…
–Prejudice, Fear, Victim Blame (homophobia, fear of contagion, just world beliefs)
–Empathy, Tolerance, Altruism (Self-selected professionals wish to avoid further harm to victim)
–Public Health and Prevention Research (attempts to undertake sound public health practice and prevention research)
–Instrumentally sensitivity to incentives (Political pressure, research funding, driving HIV underground)
–Resistance to change (Motivated cognition, cognitive consistency, normative influence, reactance)

–Changing the Nature of HIV Epidemic (Antiretroviral therapy makes widespread HIV testing and prevention for positives the emphathetic and rational course of action)
–Decline of HIV Exceptionalism (normalized public health policy prevention research priorities)
–Public Health and Prevention Research (Attempts to undertake sound public health practice and prevention research

Options in America: The Options Project (IMB Model intervention to promote safer sex among HIV-Infected Individuals)
–Teaching HIV care physicians to have HIV prevention conversations with HIV+ patients
–Baseline HIV Transmission Risk: 52/489 HIV+ men and women engaged in 1072 unprotected vaginal or anal sex acts with 197 HIV- or HIV unknown partners within THREE MONTHS TIME
–Motivational Interviewing:
–Importance ratings: how important is condom use to you?
–Confidence ratings: how confident are you in your abilities to always use a condom?
–Decreasing unprotected events after intervention effects on unprotected vaginal/anal/oral penetrative events across 18 months

Life Windows: An IMB Skills model intervention to promote antiretroviral adherence among HIV-Infected individuals
–Highly personalized and interactive software program
–Assesses each participants specific barriers to adherence then provides them with a tailored list of strategies and interventions to work on
–Life Windows sessions take approximately one hour to complete

–Participants interact with Life Windows on an ongoing basis at each clinical care visit

Options in South Africa: IMB Model-based intervention in 16 HIV Care settings in Kwazulu Natal
–18% HIV prevalence ages 18-49
–1.8% HIV incidence each year
–N~2000 HIV+ patients
–100% on antiretroviral
–25% detectable viral load

Elicitation Research: HIV- Infected South Africans in Kwazulu Natal:
–Information, motivation, and behavioural skills gabs
–Motivation critical to HIV prevention among men
–Behavioural skills critical to HIV prevention among women
–Social norms for child bearing critical for all

Existing lay counsellors implemented brief IMB focused intervention with MI Methods during routine clinical care on ongoing basis
–Low tech
–Low cost
–Designed to be implemented
–Intervention never ends

Izindlela ZokuphilaL: Options for Health: Participant Characteristics
–N=1890, 16 clinics
–1050 women, 840 men
–Age Median=37, range from 18-78
–27% married
–60% unmarried cohabitating
–72% unemployed
–2/3 rural
–High rates of sexual activity (~80% in the past four weeks)
–High rates of unprotected sex (~50%-60%)
–Depression (~25%)
–Problem Drinking (1/4 of men, low percent of women)
–Around 2 years on ARV's
–Detectable viral load in 25%

Baseline Risky Sexual Behaviour:
–Within sexually active sample of people living with HIV on Antiretroviral Therapy…
–581 HIV+ participants reported a total of 2, 222 unprotected sex acts with a total of 681 HIV- or HIV? Partners during the past FOUR WEEKS
–87% retention after 18 months
–Interventions were feasible and implemented with high levels of fidelity

Intervention Outcome Analysis:
–Significantly reduced sexual risk behaviour among South AFRICAN PLWH on ART
–Proportion of Izindlela Zokuphila patients engaging in recent unprotected sex decreased from 52% at baseline to 19% at the 18 month follow up
–Patients engaging in unprotected sex with HIV-/HIV? Persons decreased from 32% to 7% at 18 month follow up

Lecture 3: Erotica, Pornography, and Behaviour: A Critical Review

–Everything is photographically represented today–no matter how perverse or frightful: Ivan Bloch (invented term sexology)

–Sexually explicit imagery facilitates the adoption of new technologies
–It is "everywhere"
–Porn is an $8 billion industry / year
–Americans spend $13 billion / year on pornography
–It is "dangerous"
–Said that both violent and nonviolent pornography affects both aggressive attitudes and behaviours (Malamuth)

Psychological theories point to possible negative effects of pornography:
–Observational learning theory: acquiring potential patterns of behaviour
–Social learning theory: acquiring potential patterns for behaviour and expectations of consequences of behaviour
–Classical conditioning: conditioning arousal to new sexual cues (such as violence)
–Script theory: learning new sexual scripts

Defining Pornography:
–Legal definitions of obscenity: "any publication, the dominant characteristic of which is the undue exploitation of sex"
–In practice, it boils down to arguments concerning harm to individuals or society
–Child Pornography in the Criminal Code of Canada: Any person under 18, or depicted as under the age of 18, engaging in sexual activity or shows their genitals for sexual purpose (unless the material has artistic merit, educational, scientific, or medical purpose) is guilty of an indictable offense
–Emotional definitions of obscenity: Conditioned erotic stimuli leads to Affective responses and evaluative responses
–Feelings towards sex (erotophobia/Erotophilia) affect the labelling of images as pornographic or not
–Consequences of labelling porn: sexual behaviour changes

Sexually Explicit Material:
–Pornography: Sexually explicit material that portrays and endorses sexual coercion or sexual violence
–Erotica: Sexually explicit material that portrays and endorses consensual sexual activity

Effects of EROTICA on behaviour:
–Leads to small, short-term, non-novel, increases in sexual behaviour (US President's commission)
–Long term exposure to erotica: (Mann)
–66 Married couples view erotica weekly, slight increase in amount of sexual intercourse between couples per night
–Erotica increases non-novel behaviour: Nothing "new" in the bedroom after erotica exposure

Gender differences in arousal response to erotica:
–Men report higher levels of arousal to such portrayals than women
–In reality: women and men often do not differ in response to erotic stimuli
–Between both genders the casual sex theme was most stimulating (rather than the love theme and the lust theme)
–"Category Specificity":
–Subjective Sexual Arousal:
–Women: FM, then FF, then MM
–Men: FF, then FM
–Genital Sexual Arousal:
–Women: Nonhuman, then FF, FM, MM
–Men: MM, then FM, then FF
–Women are less category-specific than men when it comes to genital arousal (they get we easier than men get hard)

Gender differences in affective response to erotica:
–Men have a greater positive affect and a lower negative affect than women

Gender Differences Summarized:
–Arousal: Inconsistent gender differences
–Affect: Females may have less positive and more negative affect responses than men
–Category Specific: Females are category specific for subjective arousal and category nonspecific for genital arousal; males are category specific for both subjective and genital arousal

PLISSIT: Model for sex therapy with four levels
–Permission
–Limited information
–Specific suggestions
–Intensive therapy

Effects of Pornography on Behaviour:
–Violent pornography and aggression against women:
–Porn as MODEL: teaches normative behaviour with little countervailing information
–Porn as DISINHIBITOR: you can get away with it
–Porn as INCENTIVE: violence against women "works" for men and for women as it becomes arousing
–Monkey see, monkey do (but we must remember that the monkey has a brain!)

Violent Pornography and Sexual Fantasy:
–Malamuth Study:
–Men exposed to images of rape
–Asked whether or not the women would have enjoyed being raped (23% yes women would be aroused, 11% no women would be disgusted)
–Mean shock delivered to female after watching movies (either neutral, erotic, or pornographic (both aggressive, one positive one negative outcome with woman)
–Men who watched the aggressive porn with a positive outcome has the highest rates of shocking the female victim regardless of whether or not they were angry or non-angry males

R. V. Wagner, 1985: By social psychological testimony the court is convinced that social harm does result from repeated exposure to obscene films
–Limit on freedom of expression due to justification of link between societal and individual harm to violent pornography

Problems with the connection between pornography and aggression:
–Believes the worst about sex, and the worst about men
–Critical data are ignored
–Fraser Committee: Establishes that the information and research found on the link between porn and aggression is chaotic and inadequate and no consistent body of research information has been established: 1985
–Prevalence of violent pornography is low (Less than 1% of pornography)
–Inverse / no relation between sexual assault rates and the legalization of pornography
–Few violent sexual acts in XXX videos: 80% of videos contain NONE
–Perpetrators of violent sexual acts are often females (around half are female perpetrators)
–Legalization of pornography and decline/no change in sex crime rates in Denmark, and Germany
–Japan: Has the highest rate of "rape" pornography, but the lowest rate of sexual offences
–Politics hijacks science when it filters the studies published and used!

–Sex criminals' experience with erotica and pornography: an inverse relationship?

–Percent of "normals" who have been exposed to pornographic imagery is higher than that of "rapists" who have been exposed to pornographic imagery
–Percent of control group that regularly use porn and prefer S&M content higher than that of offenders

–Relationship of pornography and sexual violence: negative evidence
–Rejection of Sexual Violence as a function of self-regulated exposure to X-rated videotapes: Men who were consistent renters of X-rated video tapes were more likely to be in support of laws against sexual assault

Does pornography cause men to fantasize about rape? (Fisher, redoing Berkowitz study)
–0% rape fantasies after exposure to neutral, erotic, and pornographic (both positive and negative) films
–Steady acceptance/un-acceptance of rape myth across the board, regardless of the type of film shown (erotic, neutral, pornographic positive/negative)
–Steady positive attitudes to women across the board, regardless of film shown
–Re-doing the shock experiment: 84% chose to walk away and not administer shocks (16% had the intention to before hand)

Meta-analytic critique:
–Limitations within the data due to the source of experimental laboratory situations

Sex, Guys, and Cyberspace
–Internet pornography is a different story, more worrisome
–ACCESSIBLE: To most Canadians (men, women, boys, and girls), no age barriers or age inaccessibility, at home, school, library, Internet café's
–AFFORDABLE: Low or no cost, sexually explicit material samples so profusely available, there is no need to purchase pornography (yet it is still an $8 billion dollar industry)
–ANONYMOUS: from user's perspective it is anonymous, mostly accessed while alone
–INDIVIDUALLY TAILORED: an individual's inclinations can tailor the selection of sexually explicit materials specifically selected to arouse and reinforce sexual appetites (for better or for worse)

–1997 computer game to test feminist assertion about pornography
–Assessment of ATWS (attitudes towards women's rights and responsibilities scale), RMAS (rape myth attitude scale), Aggr (aggressiveness)
–Support for women's rights high, rape myths low, aggression low
–No connection between ability to objectify women's imagery and aggression/degradation of women

The Empire Strikes Back?: the Confluence Model:
–Men who read sexual magazines had 5 antisocial background factors, self-reported aggression against women
–High sex drive predicts confluence effects of antisocial tendencies on antiwoman aggression and replaced

Internet Pornography and Sexual Assault USA, 1995-2005:
–Period of exponential increase in internet sexuality accompanied by decrease in sexual assault
Pornography Research Conclusion: 2009
–The findings are highly consistent across experiemental and nonexperiemental studies: pornography use can be a risk factor for sexually aggressive outcomes, principally for men who are high on other risk factors and who use pornography frequently
–Malamuth: If you have a strong pre-existing aggressive anti-woman inclinations pornography will synergistically drive you to sexual aggression against women
–Not necessarily the case that if you watch lots of porn you will become violent against women

–Evidence for a causal relationship between exposure to porn and sexual aggression are slim and may have been exaggerated by politicians, pressure groups, and some social scientists… the debate has focused on violent pornography but evidence of any negative effects is inconsistent and violent pornography is comparatively rare in the real world. Victimization rates for rape in the US demonstrate an inverse relationship between pornography consumption and rape rates
–It is concluded that it is time to discard the hypothesis that pornography contributes to sexual assault

Pornography is pervasive:
–Revenue of $13 billion in USA
–$93 billion world wide
–80% of porn users do not even pay for their access
–244 million pages of pornography sited in the USA
–28,000 searches for porn PER SECOND
–Pervasiveness is increasing each year

Existing Supportive Evidence
–Pornography reduces:
    –Attractiveness of partner
    –Commitment to partner
    –Love for partner
    –Sexual satisfaction
    –Relationship satisfaction
    –Acceptance of monogamy
–Convergent evidence:
    –Correlational studies
    –Logitudinal studies
    –Experimental studies

Allbright Study:
–Shows more positive effects than negative effects on relationship
    –Sex more often, more open to trying, easier to talk, view together to arouse

–Divorce rates decreased as Internet pornography increased

Have we learned anything?
–Criticism of individual studies:
    –Correlational
    –Logitudinal (tiny effect sizes)
    –Experimental
–General primary focus solely on negative outcomes
–Top-down, close ended research
–Overarching issue
    –Maybe negative evaluations of sex and relationships are good effects
    –Pornography as an aspirational medium

Aim of Current Study:
–Identify spontaneously reported positive, negative, and neutral effects of pornography from a broad sample
–Bottom-up, open ended research
–“No Positive effects”: 34 references
–“No Negative effects”: 621 references
–“No effects”: never assessed before

Positive effects:

–Easier communication about sex
–Acceptable alternative outlet that reduces sexual pressure and burden on my partner
–Increases positive affect
–Increases sexual arousal
–Increases intimacy
–Improves sexual skills
–Strengthens sexual confidence
–Supports sexual autonomy

Negative effects:
–Creates unrealistic expectations
–Caused relationship dissolution

Conclusions:
–Pornography consumers and their partners report a broad range of perceived effects of pornography on relationships (some have been investigated in large scale quantitative research, and some may not)
–Potential negative effects of pornography use on relationships have received vastly more extensive coverage than positive effects
–Quantitative work in this area should move beyond constrained array of pornography impacts currently investigated to examine the impact of porn use on the full range of specific elicited positive and negative relationship outcomes

–Erotica and pornography will have effects that are limited by the individual's learning history, internal restraints, and expectancies for reward or punishment
–For individuals who lack internal restraint and realistic sense of reward and punishment, it is the individual, not the sexual stimulus that is of concern

Censorship?:
– Antisocial, antidemocratic
–Reinforces erotophobia
–Ineffective
–Once we accept in censorship of disliked opinion it will be used against dislike minorities

Bill C-54 on Obscenity:
–Would have instituted severe censorship in Canada
    –Reverse onus: you must prove your innocence

Educational Immunization:
–Immunizes to reject the lie of pornography
–Potentially effective and generalized effects
–Does not reinforce erotophobia
–Models democratic solution to social problem

Commercial Sex Work: Providing Sexual Services for Money
–Griffith Study: Reasons for becoming a pornography actress:
    –Money
    –Enjoyment of sex
    –Attention
–What acresses like about the industry:
    –Money
    –People
    –Sex
    –Freedom/Independence
    –Attention

–What actors dislike about the industry:
- –People
- –STI Risks
- –Exploitation

Prostitution:
–Street prostitution
–Massage parlors
–Call in (brothels)
–Call out (escort)
–Males (hustlers)
–Risk are a function of work venue (where it takes place determines the riskiness of the situation)

Commercial Sex work:
–Pimp:
- –Manager and possibly relationship partner of a sex worker
- –Commercial sex workers much more likely to practice safer sex with clients than with pimp

–Madam:
- –A women who manages an in-call or out-call service

–Internet is the new market-place
–Sex trafficking:
- –Recruiting, controlling, exploiting sex workers (or immigrants or others) by threat or force

Law concerning prostitution in Canada struck down by Supreme Court in 2003:
–Buying and selling sex in Canada was not illegal per se:
- –Communicating in public to sell sex was illegal
- –Keeping a common bawdy-house (a place where prostitution takes place) was illegal
- –Living off of the avails of prostitution was illegal
- –Supreme court struck down as "threatening sex worker's rights to life, liberty, and security of the person"

–Very inconsistent enforcement
- –Commercial sex workers prosecuted much more than clients
- –Female sex workers prosecuted more than male sex workers
- –Street workers prosecuted more than anyone else

Canada's New Prostitution Law:
–Purchasing sexual services is now a crime
–Advertisting the sale of sexual services is now a crime
–Critique: Criminalizing advertising and criminalizing purchase of sexual services will drive prostitution further out of view and further endanger the safety of sex workers in Canada

The Career of a Sex Worker:
–Why a woman enters the profession:
- –Economics
- –Acquaintance
- –Drug addiction
- –Force or coercion

–Apprenticeship:
- –Learn skills of profession

–Mid-career:
- –May transition to managing other sex workers or move to a different venue (street to bar, in-call to out-call)

–Squaring up:
- –Leaving the life

Customers:
–Use of prostitution has dramatically declined in the past 50 years
–"Johns": Term that sex workers use to refer to their customers
–50% of clients are occasional and 50% are repeat Johns
–49% of clients in one study had a spouse or regular partner

Transgender Sex Workers:
–Mainly serve male clients
–"Genetic males" who may life full-time as a women
–Similar to female sex workers: spend little time with each client
–Similar to male sex workers: few reported never enjoying sexual activities
–Offer oral sex and excuses
–More than half never told customer they were male

Lecture 4: Sexual Coercion
–Never assume consent, the absence of a yes is a no

Campus Sexual Violence Elimination Act (SaVE Act)
–At all universities with US funding
–Campus based extra-judicial tribunal, decision, punishment by variably trained personnel
–"Preponderance of evidence (51%)
–More approachable for alleged victim, less fair for alleged accused?
–"Academic death penalty"
–28 Harvard Law school professors open letter in Harvard Crimson: the tribunal "lacks the most basic elements of fairness and due process"

"Rape" in the Criminal Code of Canada prior to 1983:
–"A male commits rape when he has sexual intercourse with a female who is not his wife"
    –Gendered form of sexual assault (no provisions for male victim, or female assailant)
    –Sexual intercourse as the only basis for sexual assault
    –Leaves wives unprotected from sexual assault by their husbands
    –Victims past history could be put on trial
    –Complaints had to be made immediately after the attack

"Sexual Assault" in the Criminal Code of Canada as Amended 1983:
–Sexual Assault in three tiers
–Gender-neutral
–Prosecution of spousal assault
–Consent must be clearly established
    –Must come from individual, not from abuse of trust or power, may be withdrawn after initial consent
–"Rape shield laws" protect victim from exposure of past sexual history in court
–Current criticism: "sexual assault" as diminishing violation and impact of the act, desire to reintroduce "rape" as emotive term

Sexual Assault from the Layperson's Perspective: the "Match and Motivation" Model:
–Muhlenhard posits that perceiving and labelling an event as "rape" depends on two factors:
    –"Match": Does an event match an individual's operational definition of rape or sexual assault?
        –Did I know the perpertrator? Was physical force involved? Was I somehow complicit? Did I resist?
    –"Motivation": What will labeling or reporting the event cost me?
        –Do I want to maintain the relationship?
        –Will I have to distrust all men?
        –What will happen to me if I label it as "rape"?

–What are the costs of reporting the event?

–Special deterrent to male's labeling or reporting of sexual assault (no match, very negative motivation: double deviant, "not male enough" and "assaulted"

–128/1862 University women asked, reported that they had coercered sexual intercourse

–58/128 women who reported an event that objectively was sexual assault, did not label it as such but labeled it: a normal sexual experience, a bad sexual experience, a miscommunication, a "mistake on my part" or a "mistake on the other person's part"

Is Rape a Sex Crime?

–Feminist inspired redefinition of rape:

–Rape is an assault, not a sexual crime

–Rape is an expression of male power and control over women

–Rape is a mechanism whereby all men control all women whether they are discretely victims or not

–Does this possibly confuse the experience of the victim with the motivation of the rapist?

–Victim experience is of assault, not sex

–Rapist motivation may be many things: sexual, paraphilic (sexual saditistic), sociopathological (rapist obeys no social rules), or indeed an expression of male rage, power, and domination

Incidence and Prevalence of Sexual Assault: Victimization Data

–Impact of Sampling: Representative?

–Impact of Methodology: Victimization rates or reported rates? (Victimization rates)

–Impact of definition: Unwanted…touching…insertion

–Sexual assault involved unwanted sexual contact that could include touching of a sexual nature, oral sex, sexual intercourse, anal sex, or sexual penetration with a finger or object

Incidence of Sexual Assault per 1000 in Canada: Victimization Data for 1999, 2004, 2009

–Physical assault reported four times more than sexual assault

–Higher rates of sexual assault for women, between the ages of 15-24, who are single, and generate less than $20, 000 per year, and vast majority are of aboriginal descent

–2009: Rate of sexual assault 2x higher for females than males

–Majority of reports involved tier one sexual assaults, without the use of threats or physical violence (which were about 20% of the sexual assaults)

–More likely to involve offenders who were known to their victims (more than robberies and physical assaults)—In over half (51% the assailants were friends, acquaintances or neighbours of the victim)

Prevalence of Spousal Sexual Assault in Canada: Victimization Data:

–Statistics Canada (1993) violence against women victimazation survey reported that 8% of Canadian women have ever been sexually assaulted by a current or former spouse

–Statistics Canada (2004) victimization survey reported that 3% of women had been sexually assaulted by a former spouse or common-law partner in the past 12 months

–Centers for Disease Control (2004) report a strong association between male non-sexual violence (battering) and male violence

Prevalence of Sexual Assault: Ontario University Student Study

–Online study of male and female students at the University of Guelph

–Unwanted sex activity before age 14 with person > 5 years older

–Men: 24.2%, Women: 23.2%

–Coercered sexual activity of varying degrees

–Men: 38.8%, Women 47.9%

–Coercion strategies:

–Guilt and Intoxication

Ideas about male rape victims are where ideas about female rape victims were about 50 years ago:
–He's making this up
–Most men would enjoy this sort of thing
–No man can get raped if he really doesn't want to
–Must remember: child abuse, date sexual assault, prison sexual assault

Sexual assault in prison:
–Ever pressured or forced sex:
    –Men: 21%, Women: 19%

Psychological Impact of Sexual Assault:
–Victims may be emotionally controlled, or emotionally expressive
–Severe emotional reactions after an assault which reach a peak at three weeks after the assault and stay high for the next month are a common pattern
–Gradual improvement in emotional state 2-3 months after
–After 3 months women (men) who were assaulted still report more fear, anxiety, sexual problems, and problems with self-esteem
–Some women (men) experience post traumatic stress disorder
    –Reliving event
    –Emotional numbing
    –Hyperarousal
    –Somatic symptoms
–Self blame
–PTSD is more likely in women who have received negative reactions to their distress and who lack support
–Spouse or partner of victim may be profoundly affected
–Post-traumatic growth/positive life changes
    –New research indicates that even following such traumatic events sexual assault victims may emerge with a sense of greater sympathy for others, a greater belief in themselves, and a greater sense of purpose in life

Causes of Sexual Assault Against Women: Four Major Views of What Causes SA:
–Victim-precipitated: "asking for it": Old ideas die hard!
–Psychopathology of rapist: a psychologically disturbed man commits rape
–Feminist: link between gender role and power
–Social disorganization: community cannot enforce its norms against crime

Psychopathology of Rapists: Paraphilic Rape?
–Not all sex-offenders are proclivitily inclined to rape: it is a mixed group

Feminist Analysis of Causes of Rape: Traditional Gender Role, Male Power in Society Make Rape Happen
–Marxist feminist hypothesis: areas where women's absolute status is high will have lower rape rates compared to areas where women's absolute status is low
–Radial and liberal feminist hypothesis: In areas where gender equality is high, rape rates will be lower than in areas with less gender equality
–Alternative radial feminist hypothesis: Areas where gender equality is high will have higher rape rates than areas where gender equality is low
–Socialist feminist hypothesis: Both women's absolute status and gender equality will significantly influence rape rates
–In US cities in 2000 where women have higher incomes, higher percentages of university degrees, higher labor force participation, and higher occupational status, rape rates are LOWER
    –When women are doing well, rate of rape drops

–In US cities in 2000 where gender equality is higher, rape rates are higher, indicating a backlash phenomenon
–When women and men are doing equally well, rate of rape INCREASES

–Social Disorganization and Sexual Assault: Communities Cannot Enforce Norms

Other Causes of Sexual Assault:
–Cultural values: unattached women (without fathers, husbands, or brothers) are acceptable victims
–Sexual scripts: she came to my apartment so she consented
–Peer group: that's how it works in my gang
–Characteristics of the situation: alcohol, drugs
–Miscommunication: can men and women have platonic friendships
–Masculinity norms and men's attitudes

Date Rape Drugs: Four Major Types
–Alcohol
–Rohypnol: "roofie" "roachie"
–Causes victim to sleep and not remember what happened the next day
–GBH "G" "easy lay"
–Causes similar effects to alcohol but also hallucinations and loss of consciousness if mixed with alcohol
–Ketamine "Special K"
–Causes combination of amnesia and hallucinations

Preventing Sexual Assault:
–Socialize boys and girls differently
–Avoid high-risk situations
–Alcohol, set sexual limits, trust your gut feelings, be forceful and firm, clarify consent clearly, do not give mixed messages, decide early if you would like intercourse, do not do anything just to avoid unpleasantness, be aware that alcohol and drugs are often related, be careful inviting or going home with someone

Sexual Exploitation of Children: Canadian Legal Definitions
–Sexual statutes relate to sexual exploitation of children, under the age of 14:
–Sexual assault
–Sexual interference
–Invitation to sexual touching
–Sexual exploitation
–Sexual exploitation of a person with a disability
–The age of consent is 16
–If an individual is under 14 he/she cannot consent to sexual activity
–Once can consent at 14 or 15 but only if the partner is less than five years older than the individual
–Different forms of consent apply to different ages and age couplings
–Age of consent for anal intercourse is 18, higher than that of vaginal intercourse, although Supreme Court has ruled this law even though it discriminates against gay youth

Sexual Harassment at Work:
–A type of sexual discrimination
–Sexual harassment defined as: unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when submission is made a term or condition of an individual's employment or academic advancement or decisions about a position, or when it creates a hostile environment
–Four types of harassment:
–Earnest harassment

–Hostile harassment
–Paternalistic-ambivalent harassment
–Competitive-ambivalent harassment

Sexual Harassment: It depends how you ask!
–Subjective Sexual Harassment: Harassed by a professor or instructor of a university student: 4.3%
–VERSUS: Objective sexual harassment: up to 56.5%

Sex between professionals and patients:
–Unethical
–Potential for emotional damage
–Some provinces define any sexual behaviour between professionals and patients as abuse/misconduct

Lecture 5: Part 1: Preventing Sexual Violence and Sexual Harassment on Campus

Upstander: People that get involved with helping others in need
–See Something, Do Something: We all have the power to act out against sexual assault and sexual violence

The Bystander Effect:
–You do not act unless you see others acting, you follow what people do
–The more people that are around, the less likely someone is to act
–10% of people will always help, 10% of people will never help, but 80% of people are affected by the bystander effect

Bystanders vs. Upstanders
–Don't notice an emergency // Notice the problem
–Don't interpret the situation as an emergency // Identify the problem
–Don't feel responsible for intervening // Feel motivated and capable of finding a solution
–Don't know how to help // Possess skills for action
–Don't feel safe intervening // Act

Sexual Assault:
–Any form of sexual contact without voluntary consent
–Kissing, fondling, sexual intercourse (vaginal or anal) and oral sex are all examples of sexual assault if they occur thought voluntary consent

Consent is…
–Voluntary, sober, enthusiastic, continual, active, honest, non-coerced
–Never assumed or implied, not silence or the absence of "no"
–Cannot be given if someone is incapacitated by alcohol or drugs or is unconscious
–Can't be obtained through threats or coercion
–Can be revoked at any time
–Cannot be obtained if the perpetrator abuses a position of trust, power, or authority

What is Rape Culture?
–Climate or culture that trivializes experience of sexual violence
–Victim blaming or survivor shaming
–Putting the onus on the victim contributes to rape culture

Intervention as possibly being either direct, or indirect

Responding to a Disclosure:

–Believe the survivor, listen and be supportive
–Never blame the survivor
–Provide a private, safe place for the survivor and offer emotional support
–Do not ask questions about the details of the assault
–Provide information and link survivors to resources, let them have control over any decisions

Part 2: Sexual Harassment and Sexual Violence: The Western University Perspective
–Not tolerated at Western

Bill 132: Anti-sexual violence bill introduced by Ontario government
–To help survivors of violence, and to promote safety, and to prioritize sexual violence issues
–All universities will be mandated to have sexual violence "laws" in place
–Enhance employer law with sexual violence

Legal Framework: (Canada-wide)
–Criminal Code of Canada: Governs criminal matters including:
–Sexual assault with or without a weapon
–Uttering threats
–Criminal harassment
–Forcible confinement
–Human trafficking

Legal Framework: (Ontario-wide)
–Occupational Health and Safety Act
–This legislation governs workplace relationships
–Ontario employees are entitled to workplaces free from violence and harassment
–"Workplace bullying" or "personal harassment"
–While, legislatively Western is only required to provide protection to employees in the workplace with respect to harassment, through its policies, Western extends protection from personal harassment to students as well

Personal Harassment:
–Vexatious comment or conduct that is known or ought to be reasonable known to be unwelcome
–Often referred to as bullying type behaviour

Ontario Human Rights Code:
–Every Ontarian has a right to be free from discrimination in employment, while receiving services and in arranging accommodation
–"Protected grounds" on which discrimination and harassment are prohibited
–Race, ancestry, place of origin, colour, ethnic origin, citizenship, creed
–Sex, sexual orientation, gender identity, gender expression
–Age, marital status, family status, or disability

What is "Discrimination"?
–Any form of unequal treatment based on the grounds listed in the Human Rights Code
–Intentional or unintentional
–A rule may appear neutral on its face but may inadvertently discriminate against certain groups
–Human rights is not about intent, it is about the individual on the other end of the discrimination
–Know the difference between discrimination and what is NOT discrimination

What is Harassment?
–A course of vexatious comments or conduct that is known (or ought to be reasonable known) to be unwelcome
–Personal harassment, sexual harassment, gender-based harassment

Sexual Harassment:
–Unwelcome comment or conduct of a sexual nature that detrimentally affects the academic environment (or the work environment) or leads to adverse consequences for the person being harassed
–Often not about sexual desire or sexual interest at all, often about abuse of economic and social power
–Can be related to sex, sexual orientation, gender identity, or gender expression

Gender-Based Harassment:
–A form of sexual harassment
–Defined as "any behaviour that polices and reinforces traditional heterosexual gender norms"
–Gender based harassment is not generally motivated by sexual interest but is usually based on hostility
–Often an attempt to make a person feel unwelcome in their environment
–Example: being made fun of for being a male nurse

"Sexual Violence" As defined by Western's Anti-Sexual Violence Policy
–Includes all defintions within Ontario Human rights Code, the Occupational Health and Safety Act, and the Canadian Criminal Code
–Any violence, physical or psychological carried out through sexual means or by targeting sexuality
–Sexual violence includes: Sexual abuse, sexual assault or rape, sexual harassment, stalking, indecent or sexualized exposure, degrading sexual imagery, voyeurism, cyber harassment, trafficking or sexual exploitation

Equity and Human Rights Services address issues of "discrimination" and "harassment" at Western.

Part 3: Indian Residential Schools
–Typical Story of a Residential School: Donald
    –Abuse (physical, verbal, and sexual), cultural assimilation
    –Forced to secrecy about sexual abuse
    –Effects followed him later in life (alcoholism, abuse to family)

What happened historically?
–Who: Indian Residential Schools were created under the Indian Act and governed by the Department of Indian Affairs run by the Catholic, Anglican, and United Churches
–When: Schools in existence from 1876-1996
–Why: Goal of the legislation was cultural assimilarion
–What happened: Corporal punishment was used on students
–In total 130 residential schools, approx.. 150,000 students forced to attend
    –Approx. 80,000 currently alive today

Law of Commission Canada:
–Suggest the federal government and the churches violated The United Nations Convention on Genocide in that the intent of the IRS system was "to destroy a national, ethnic, racial or religious group by deliberately inflicting upon the group conditions of life calculated to bring about its physical destruction in whole or in part

Legal Process Surroundign Sexual abuse at Indian Residential Schools:
–Class Action Litigation Law suit: allows a large number of people who have common legal interests to sue as a group
–For uniformity on the decisions, saves time and effort in the legal world

Correct legal process:
–Sexual Assault

–Criminal Law (focus is on perpetrator, not about compensation for victim)
–Civil Law (focus is on compensation, not on guilt of perpetrator)
–Individual action
–Class action
–Individual Assessment Process ("IAP")

Procedural Legal Hurdles:
–2002, initially trial judge did not certify; 2004 Ontario Court of Appeal certified the class action
–2005 retired Supreme Court Justice Frank Lacobucci appointed to negotiate a lasting resolution with all parties resulting in the IAP

Legal Framework of Compensation for Abuse:
1) Acts of Sexual Abuse: measures how bad each child's abuse was
2) Consequential Harm: measures how it affected them later in life
3) Aggravating Factors: measures the other factors of their abuse
4) Future Care: measures how much money they should get for future care
5) Loss of Opportunity: how much money they should get from lost opportunity

Post Traumatic Stress Disorder:
–Part of consequential harm
–Commonly diagnosed in the Independent Assessment Process
–The person is exposed to a traumatic event involving actual or threatened death, serious injury or sexual violence
–There was intense fear, horror, or helplessness
–Traumatic event is consistently re-experienced
–Avoidance of stimuli associated with the trauma

Could receive UP to $250,000
Compare that to John Doe v. O'Dell, Roman Catholic Church et al.: Class action law suit CONSIDERABLY less compensation

Individual Action vs. The IAP
–Adversarial process vs. inquisitorial process
–Cross examination vs. no cross examination and lawyering behind the scenes
–Facing the alleged abuser vs. rarely if any witnesses
–Court room vs. hotel

Where are we now in Canada?
–The residential school experience is belived to be attached to inconsistent employment histories, criminal offending, substance use, poor parenting skills, and higher rates of suicide in Indian adults
–"Institutional dependency mentality": ongoing discomfort with responsibility of everyday life and lack of self-confidence in dealing with white people

The TRC (Truth and Reconciliation Commision of Canada)
–Commision that hears Indian Residential School survivors histories of sexual abuse by church and government actors
–Goal: to clarify historical abuses and avoid revisionism
–Invovled first nations, inuit, metis, IRS students, their faminiles, and communities, former school employees, government people of Canada
–Calls to action in areas such as child welfare, education, preservation and promotion of aboriginal language, health, justice, professional training, church apologies
–To allow healing and to allow survivors to move on
–Not a legal process and goes well beyond what a court process can achieve
–Psychological benefits to acknowledging the wrongs of the federal government