HIV/AIDS Reference Library for Nurses

TEACHING MODULES
FOR BASIC EDUCATION
IN HUMAN SEXUALITY

volume 7

These modules are designed
for use by teachers

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1995
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2. Sex behaviour.
I. Series

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Nurses and other health care workers are often required to help people overcome problems related to sexual matters. Maintenance of good health does not always protect people from sexual problems. Professionals may be faced with questions about family planning, fertility regulation methods and pregnancy or concerns about sexual functioning. Clients may have sexually transmitted diseases or be at risk of contracting them. In particular, human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS) cause great concern about sexual practices.

To be effective, those providing health services must understand their own feelings and be comfortable talking about sexual matters. It is important to be able to understand and help clients whose sexual preference, culture or lifestyle differs significantly from their own. A good rapport depends on the health care worker's professional ability to create a comfortable atmosphere and have a non-judgemental discussion with the client. Health care workers are best able to help people with sexual problems if they are knowledgeable about, and comfortable with, the topic of human sexuality.

Instructors are faced with the challenge of teaching student health care workers about human sexuality. This can be difficult because sexuality is a taboo subject in many cultures. Students may not be aware of how their own ability to give help or care to others is affected by these taboos. For example, in many cultures, people do not talk openly about sexuality or about sexual practices prevailing in their communities.

The use of the Teaching Modules for Basic Education in Human Sexuality may help health care workers to deal more confidently with sensitive sexual issues. The modules may also improve their communication and counselling skills to better perform their role as community educators and motivators in a variety of fields such as family planning, sexually transmitted disease and HIV / AIDS.
These teaching modules are designed to enable teachers of students in the field of health services to discuss human sexuality with confidence. They are specifically designed to help health care professionals examine their attitudes, feelings and beliefs about sexuality and give an opportunity to experience talking out loud about different aspects of sexuality. When using these modules the teachers should have greater confidence and comfort in teaching sexual history taking and counselling about sexuality.

This booklet is not meant to be a replacement for courses on human reproduction, birth control, fertility, family values or sexual responsibility. All these topics can be adequately covered in other classes. The influence of religion and spirituality on sexuality have not been exhaustively covered in these teaching modules, since our aim is to present the clinical view of sexuality and not the moral aspects. The modules will help teachers of health care professionals become comfortable teaching their students about sexuality.

S.T. Han, MD, Ph. D.
Regional Director
The original *Teaching Modules for Basic Nursing and Midwifery Education in the Prevention and Control of HIV Infection*, developed in 1988, have been successfully adapted, implemented and well evaluated in Member States in several WHO Regions.

As more and more feedback was received from those who had used this material, WHO Global Programme on AIDS decided in 1992 to rewrite and update all of the modules. Discussions took place with nurses and nursing educationalists in several countries in the WHO Regions, especially in the United Republic of Tanzania (and Zanzibar), India and Thailand. As a result of these discussions and, as technical and scientific knowledge increased, the modules were re-developed by nursing educationalists at the Riverside College of Health Studies (North West Thames Regional Health Authority AIDS Education Unit) in London.

December 1995
ACKNOWLEDGEMENTS

Funds for this publication were provided by the United Nations Population Fund Office for the South Pacific. Their contribution is gratefully acknowledged.

The HIV/AIDS Reference Library for Nurses series has benefited from the expertise and dedication of many nurse researchers, writers, educators and administrators who developed much of the material, as well as consultants and participants to several WHO Western Pacific Regional workshops in 1988 and 1989.

The WHO Regional Office for the Western Pacific HIV/AIDS Reference Library for Nurses was the result of efforts by nurses in the Western Pacific Region and other health care workers around the world in their attempt to stop the spread of HIV infection through the improvement of their understanding of the problem, its control and management.

It is our hope that these books will contribute to nursing services throughout the Western Pacific Region in the prevention and control of AIDS.
INTRODUCTION

Human sexuality and sexual health

Sexuality is an important aspect of the human personality and is inextricably woven into the fabric of human existence. There are few people for whom sex has not been important at some time. Sexuality is a quality of being human; it is a powerful and purposeful aspect of human nature and it is an important dimension of our humanness.

Sexuality is more than just overt sexual behaviour; it spans and underlies the complete range of human experience and contributes to our lives, and to the lives of our clients, in many ways. A healthy or positively developed sense of sexuality:

- enables many people, through children, to establish a link with the future;
- provides a means of physical release and sexual pleasure;
- binds people together;
- allows us to communicate subtle, gentle, or intense feelings;
- provides a sense of self-worth when sexual experiences are positive;
- and is also one of those factors that builds an individual's identity.
Defining sexual health is as difficult as defining the concept of health itself. The concept of sexual health, used in these modules, stresses that sexual health is not just about the issue of sexually transmitted diseases. Concepts important in defining sexual health often include characteristics, such as the need for and the importance of: having a knowledge about sexual phenomena and a positive body image; having a self-awareness about one's attitude to sex and an appreciation of one's feelings about sexuality. It also includes having a well-developed, usable value system that provides input for sexual decision-making and having the ability to create effective relationships with members of both sexes. And finally, most definitions would stress the importance of having some degree of emotional comfort, interdependence, and stability with respect to the sexual activities in which they participate.

The following definition of sexual health is presented as a step towards a definition of sexual health.

Sexual health is the integration of the emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love.

...thus the notion of sexual health implies a positive approach to human sexuality, and the purpose of sexual health care should be the enhancement of life and personal relationships and not merely the counselling and care related to procreation or sexually transmitted diseases.¹

Nurses often ask, quite rightly: "Why do health care professionals need to be concerned with sexual health?" The answer is because nursing has traditionally been concerned with the total person. Nursing has a holistic view of clients, and, as sexuality is a basic human need, it is an essential focal point of nursing care. The promotion of sexual health is a legitimate role for the nurse.2

Unfortunately, the exploration of sexual health in many pre- and post-registration nursing education programmes is frequently inadequate. Teachers of nursing are often unprepared and unskilled in promoting learning experiences focused on human sexuality and sexual health. Consequently, nurses are often uncomfortable with both their own sexuality and that of their clients. For most nurses, the sexual needs, problems or concerns of their clients are anxiety-producing, embarrassing and uncomfortable topics that are best left alone and ignored.

The continuing demand by nurses for teaching support within the arena of human sexuality confirms the need to provide health care professionals opportunity to discuss and explore areas of human behaviour which were ignored during their formal educational preparation. This failure to incorporate and integrate human sexuality into nursing curricula is not unique to any country. In most parts of the world, where all forms of sexually transmitted diseases, including HIV infection, continue to exist as an important threat to health and well being, AIDS training has, for the first time, legitimized teaching and learning focused on human sexuality. Training needs analysis consistently demonstrates that an area of intense need is to provide a safe environment in which to legitimize teaching and learning opportunities focusing on human sexuality. This is true in Europe and North America and has also been found to be true in Africa and India. Here is the paradox; where the need is greatest, the smaller are available learning resources. These teaching modules attempt to help meet this need for reliable, accurate and adaptable teaching materials, which can be made sensitive to the culture in which they are being used.

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2 Fogel CI, Lauver D. Sexual health promotion, Philadelphia, USA, W. B. Saunders, 1990
Teaching modules for basic education in human sexuality

These teaching modules were originally conceived and developed by the World Health Organization Regional Office for the Western Pacific (WPRO) in 1992 as an important part of their HIV/AIDS Reference Library for Nurses. In 1994, they were partly re-written and updated on behalf of the WHO Regional Office for the Western Pacific by educational specialists at the Centre for Sexual Health and HIV Studies, in the School of Health and Science at Thames Valley University, London.
MODULE 1
CONCEPTS OF HUMAN SEXUALITY AND SEXUAL HEALTH

General objective
On completion of this module, the student will have constructed a definition of human sexuality and a concept of sexual health and will have reflected on how this affects their nursing practice.

Learning outcomes
On completion of this module, the student will be able to:

- identify the different components of 'human sexuality';
- describe what human sexuality means to them;
- outline the different aspects of 'sexual health' and formulate a definition;
- discuss barriers to sexual health and describe the role of the health care provider in promoting sexual health.
Learning activities

Human sexuality

Introduction

Throughout this course, the term "human sexuality" will often be used, yet, human sexuality is difficult to define. The different aspects of sexuality are so varied and numerous that it is impossible to put them all together in one universally acceptable concept. In most societies, talking and thinking about human sexuality is taboo, making it even harder to define. It is important for each individual to formulate what sexuality means to themselves.

Learning exercise 1

Write your own definition of human sexuality:

Compare your definition with the person nearest to you.
Suggested teaching activity following learning exercise 1: After the students have had a brief discussion in pairs, introduce the following material to the students:

Human sexuality has been defined by the World Health Organization in the following manner:

While recognizing that it is difficult to arrive at a universally acceptable definition of the totality of human sexuality, the following definition of sexual health is presented as a step in this direction:

Sexual health is the integration of the somatic, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love.

...thus the notion of sexual health implies a positive approach to human sexuality, and the purpose of sexual health care should be the enhancement of life and personal relationships and not merely the counselling and care related to procreation or sexually transmitted diseases.¹

Sexuality is a part of a person which cannot be removed and looked at separately from all other parts.

¹ Source: (see Introduction).
Suggested teaching activity to introduce learning exercise 2: Lead a full-group discussion on the components of human sexuality. On a flipchart or overhead transparency, list the major items identified by students. Your flipchart or OHP transparency might look like the box below.

<table>
<thead>
<tr>
<th>Human sexuality includes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>desires</td>
</tr>
<tr>
<td>feelings</td>
</tr>
<tr>
<td>acts</td>
</tr>
<tr>
<td>values</td>
</tr>
<tr>
<td>attitudes</td>
</tr>
</tbody>
</table>

It involves:
- biological aspects
- psychological aspects
- social aspects

It is clear that healthy human sexuality is more than just sexual acts or reproduction. It is not "good" or "bad", or "right" or "wrong" but a part of each person which deserves understanding and attention.

**Learning exercise 2**

Divide into small groups and ask students to discuss their definitions of human sexuality and compare these with the WHO definition. Have students ask the following questions:

- Is there more to sexuality than sex acts?
- What else makes up human sexuality?
• Are there things from your experience/culture/society which are left out of the World Health Organization definitions?

• What would you add or take away from the definitions of sexuality?

**Suggested teaching activity following learning exercise 2:** Write down on a flip chart or OHP transparency all the different ideas and try to develop one definition of human sexuality from your group to present to the whole class. When this definition has been agreed, write it down on a flip chart or a large piece of paper and put on the wall of the classroom. You will need to refer back to this material in later modules. It is possible that this definition of human sexuality will change as students progress through further modules of the course.

**Sexual health**

**Introduction**

What is sexual health? The World Health Organization promotes the concept of Sexual Health. It is seen as a basic need and a human right.

**Learning exercise 3**

In small groups, have students discuss understanding of the term "sexual health". Ask them to write down on a piece of large paper what they as a group feel are the important elements of a definition of sexual health.
Suggested teaching activity following learning exercise 3: Have a student from each group describe their definition of sexual health. Then, introduce the following material:

WHO describes sexual health as part of one's mental and physical health and is seen as an important aspect of "health for all by the year 2000". It is defined as: "the integration of the somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love".² So, sexual health involves a healthy body, healthy emotions, a healthy mind and a healthy society. Sexual health has different definitions in different societies.

Ask the students to compare their definition of sexual health with the WHO definition and agree the important components of what you and they mean by the term "sexual health", List these on a large piece of paper or OHP transparency, which might look like the box below.

![Sexual health is:]

- A capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic.
- Freedom from fear, shame, guilt, false beliefs and other psychological factors inhibiting sexual response and impairing sexual relationships.
- Freedom from organic disorders, diseases and deficiencies that interfere with sexual and reproductive functions.

So it is clear that to obtain sexual health, a person must:

- be able to say yes or no to sexual encounters and respect a partner's wishes.
- have proper information about sex.
- be physically well and free from sexually transmitted diseases.

All of these require communication skills, i.e. being able to talk about and negotiate sexual activity.

Keep this list of the components of "sexual health" on a large piece of paper on the wall, next to the definition of "human sexuality", as you will continue to refer to it in later modules. Like the definition of human sexuality, it is likely that the groups' definition of sexual health will change later as students explore further modules of the course.

**What are the barriers to sexual health?**

*Introduction*

There may be many barriers to individuals achieving sexual health as we have just defined it.

*Learning exercise 4*

In two groups, ask the students to discuss and identify possible barriers to sexual health and to list them on a large piece of paper. After 20 minutes, reform the group and lead a full group discussion, listing, on a OHP transparency or
large piece of paper all of the potential barriers perceived by the students. These might include the following:

- **Myths, taboos and attitudes**
  These are responsible for much sexual inhibition and unhappiness and are a barrier to talking about sex. Some remain useful, but those which no longer serve any rational purpose cause unnecessary guilt and anxiety.

- **The idea that sex is only for reproduction**
  This denies sexual acts as pleasure-producing and sees sex as only fulfilling biological needs. It also negates expressions of closeness and love between people through simple acts of intimacy.

- **Strictly defined sex roles (male and female) and sexuality**
  Often the ways people are expected to behave in society leads to problems with sexuality as it suggests conformity is limited to a few options only.

- **Denial of sexuality in childhood**
  The way in which sexual behaviour in children is treated can either help develop sexual health or give rise to guilt and shame about sex.

- **Access to health care**
  Access to health prevention and care facilities may be limited by distance, cost, etc. and so prevention, diagnosis and treatment may be delayed or not available.
How can health care providers promote sexual health?

Introduction

The goal of sexual health care is the enhancement of life and personal relationships. Health care professionals can contribute to sexual health care in many ways. The first requirement is to break the conspiracy of silence and encourage clients to talk about their problems.

Learning exercise 5

In small groups, ask the students to discuss how health care providers can incorporate the issues of sexual health in their own practice and to identify professional opportunities in clinical practice for doing this. Ask them to identify their own educational needs in order to feel confident in discussing sexual health with clients and discuss the practicalities of meeting these needs.

In a large group feedback session, summarize the information provided by the students and elaborate as needed. The teacher will need to explore with the group the acceptability of introducing the topic of sexual health with clients in various settings. For sexual health to be of real value in practice, there is a paramount need to make it relevant and acceptable to clients.
MODULE 2
HUMAN SEXUALITY AND ITS DEVELOPMENT

General objective

On completion of this module, the student will have examined various aspects of life and development which contribute to the sexual dimensions of the human personality, and will be able to identify ways in which to share this information with others.

There are numerous exercises in this module which you may like to adapt and use for your students. In order to prepare facilitation of the various issues that many of these exercises may raise, it is advisable that the teacher attempt these in advance.

Learning outcomes

After completing this module, the student will have:

- examined important issues in human sexual development;
- explored barriers to the attainment of full sexual development; and
- an appreciation for the importance of human sex and sexuality in the holistic understanding of self and others
Learning activities

Introduction

Sex, sexualities, sexual health, sexual development: all this talk about SEX! Some people think that there is too much emphasis on sex and sexuality, others think it is a private affair which does not need talking about, and others, that sex is a taboo area surrounded in fears, myths, and prejudice. Yet people of all walks of life are becoming increasingly aware of the major role sex and sexuality play within the life of both the individual and society. Sexuality is not only intricately bound up with being who you are, and I am, but is inseparable from us as human beings: unique, individual persons. In this module, we will look at aspects of sex and sexuality in history, cultures, and the health care setting, and the reasons why we actually need to be addressing the issues now. There are numerous exercises which are intended to assist the teacher in background preparation.

An understanding of human sex, sexuality, and related development, needs to be completely holistic, looking at the human person in the totality of his/her being, including, at least, elements from these four dimensions:

- **physical nature**: genetic origins; hormonal influences; gender; biological differences between male and female; physiological changes which take place both through erotic arousal and throughout each year or phase of the person's life, etc.;

- **psychological nature**: how the person "feels" with themselves and others; their acceptance of sex and sexuality as an intricate part of their lives; the ability to express themselves humanly, sexually and genitaly in a way which enhances their being and is not detrimental to others; gender identity in the interrelation between maleness and femaleness, etc.;
• **aesthetic nature**: how they view sex and sexuality within their philosophy and meaning of life; appreciation of self and others; beauty; creativity; morality and ethics; culture; spiritual dimensions; religious influences; striving for personal goals and developments, etc.;

• **relationship with self and others**: love; friendship; lust; tenderness; desire; compassion; appreciation; eroticism; physicality and genitality; aloneness with self and relation with others (and society); unique gender expression of masculinity and femininity, etc.

These four dimensions of life are just one way of looking at human sexual development, but it is not the only way, neither are the contents under each heading the last word on what each area of life contains.

**Learning exercise 1. Lesson planning**

In preparing your "Lesson Plan", reflect on the Introduction above and list some ways in which you might approach these four areas of life, relating to sexuality, in a culturally acceptable way for your own students or clients.

**Talking about sex and sexuality: past influences**

By the end of the last century, many books written on the subject of morality had sections on sex and sexuality written in Latin, so that the masses, i.e. ordinary people, would not understand what was being said. The word "vulgar", frequently used to refer to sex and "swear" words, literally means "used by the common people": the "people's native language" as opposed to the more sophisticated and elite Latin vulgaris. In your own society, there are probably many ways in which sex and sexuality have been hidden away from most people too, through influences of politics, economics, religious belief, and even the "medicalization" of sexual words and practices.
Learning exercise 2. Try listing a few ways here, with what you think are the possible consequences:

<table>
<thead>
<tr>
<th>Ways in which sex and sexuality have been hidden in your society</th>
<th>Some of the possible consequences on individuals and society as a whole</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. “using terminology which is hard to understand, and not in everyday language”</td>
<td>can make patients/clients feel dirty, vulgar, inferior or even studied, if they do not use the accepted “medicalized” terminology</td>
</tr>
</tbody>
</table>

Note: This exercise can be carried out with students, to assist them in gaining an awareness of the important role language can have in erecting barriers to care.
The world of health care has frequently fallen into the trap which contributes to sex and sexuality being treated as a taboo subject. One of the primary ways of doing this includes describing sexual development in terms of anatomy and physiology of the reproductive system or organs. Immediately this presupposes that sex is primarily, or even exclusively, for reproduction. Yet "from the cradle to the grave", many people have sex; either with themselves (e.g. masturbation, touching the vagina or anus, playing with erogenous zones such as nipples, and fantasizing about sex) or with others, often for reasons other than for having babies.

Another way of treating sex and sexuality in a taboo way in the health care setting is to medicalize, or pathologize, the subject. This gives rise to such terms as "unnatural", "perverted", "kinky", "sick", and even "sinful". This implies that there is a definable, or scientifically provable "norm" in many cultures, against which everything else is pathologically deviated. The consequences can lead to a "them and us" situation, which is dangerous and unhelpful, as our clients do not always conform to that particular image. This is compounded by barriers between "them and us", like uniforms, white coats, sitting behind desks, and using Greek or Latin terminology, when the rest of society uses more familiar terms (sometimes deemed "vulgar"). One way some health care workers try to be a little more informal is to use euphemisms, like "making love", or referring to the genitals in childlike terms like __________________ (N.B. Teachers can insert local euphemisms here). But euphemisms are notoriously bad for being misunderstood between people; they should be avoided. One final point on language is that we need to learn to be comfortable using a range of words and terminology, finding a balance between being accurate and understandable, to both carer and client. It is also important to avoid being derogatory, offensive or patronizing.
Anatomy and physiology

It is important that we know a good deal about human development, from the anatomy and physiology of various "systems" through to psychosocial influences. One of the main reasons is that our clients or patients may come to us, as the "experts", to help diagnose what they perceive as a problem. Figures 2.1 and 2.2 are diagrams of the male and female sex organs. The diagrams contain accepted anatomical terms for parts of the organs. You may find it interesting to think of as many other names you know for these parts of the body, and then try a similar exercise with a group of students. Such exercises are beneficial in that participants can actually learn the technical language for parts of the body, and also explore terms they may either use themselves, or hear their clients using. Some of these terms may be "loaded", in that they evoke various emotions, such as laughter, through to anger or disgust. Working through these emotions, to a satisfactory conclusion, will enhance a more rounded approach to learning.

Although it is important to have an understanding of the physical and physiological responses during sexual development and stimulation, it is equally important not to get bogged down with it, otherwise the whole subject becomes too clinical. Beware of spending too much time on the physiology of sex, laden with medical terms and concepts, thereby missing the psychological and sociocultural dimensions of the subject.

There are many arguments supporting placing greater emphasis on sex and sexuality to improve the individual's overall well-being and development. Important reasons for talking about sex and sexuality include knowledge of the risk of acquired serious sexually transmitted diseases, e.g. AIDS. However, it is important to talk of sex and sexuality for its own sake, as a most important part of human life and development, not only from a disease perspective.
Figure 2.1 The male genital tract
Figure 2.2 The female external genitalia
Psychological approaches to sex and sexuality

The way you are as a sexual being has been influenced by genetics, physical attributes, stages of growth and psychological development, and by what you have learned about sex from your parents, school teachers, peers, magazines, jokes, religion, the media, and so on. Each of these can have positive, neutral or negative influences on sexual development. For example, it is usual for young children to explore their bodies and to become genitally aroused at certain sensations or practices, but the development can be inhibited if they are made to feel dirty, naughty, evil or sick about such things. This can happen from infancy to about the age of six. After that, some parents breath a sigh of relief and think it is all over for a while; this is the period between the ages of around six years old to puberty. Freudian psychologists have traditionally called this time sexual "latency". However, more socially orientated psychologists would see this as a time when the emphasis on sexuality is more to do with friendship and closeness, or social intimacy, prior to the emergence of the more fully active genital period of adolescence. Adolescence is a time when many people feel confused, both adolescents and their parents. It is a time when many parents still wish to protect their children, especially from the influences of the big bad world", but it also the period when the adolescent and young adult can physically procreate, and, in many countries get married, live away from the family home, join the armed forces, and later on, to vote. On the one hand, many are still treated like children; but society expects them to accept more changes here than at any other period of their lives. After the onset of increased genital awareness and activity (puberty and adolescence), many psychologists describe the next stage as a move to fuller maturity through combining the genital, social and affective dimensions of their sexual being in adulthood.
Learning exercise 3

A common practice of young children is rubbing or stroking the genitals, which may develop into masturbation; after puberty, this has the potential of leading to orgasm.

Ask the students to form into small groups and discuss the following question. Make sure that each group knows that they need to identify one group member to report back to the full class at the end of the exercise.

Question: What other names do you know for masturbation?

Which of these names would you feel comfortable using while discussing masturbation with:

your parents:
  why?

young children:
  why?

your patients/clients:
  why?
Some of the age-old myths around masturbation claim that it makes people go blind or insane. Obviously the latter is easy to disprove, but it is surprising how many people who wear spectacles feel embarrassed when they are reminded of such myths from their childhood years. Old myths tend to have a knack at hanging around and making people feel just that little bit guilty, especially about the taboo subject of sex. Adults frequently find the thought of children being sexually aroused (e.g. masturbating) or inquisitive difficult to accept, and may handle the situation with parental disapproval. However, there is more of a case to say that many adults have problems with accepting the sexual nature of children's lives, than to say that children have an unhealthy interest in sexual matters.

Another huge area surrounded with myth and suspicion is menstruation, having periods. On a physiological level, menstruation is part and parcel of being an adult woman between puberty and the menopause. Having monthly periods can be understood by referring to the various texts on the hormonal cycles within a woman's body. For some women, however, menstruation may be more than just hormonal changes leading to the shedding of blood. Some women experience considerable physical and psychological problems with menstruation: pain, discomfort, inconvenience, headaches, mood changes, etc. Added to this, some cultures insist that menstruating married women are not allowed to share the same bed as their husband. In other cultures, men will actually avoid touching a woman, just in case she is having a period. Think of the number of jokes or nasty stories that may be told about menstruation. They frequently lead to further discrimination, myths and inaccuracies. So much negative attention has been paid to menstruation, through the various ages and cultures, that some women look forward to the day when it will stop (the menopause). Yet the trouble does not cease there! Menopause brings physiological changes to the woman's health and makeup, as well as psychosocial issues. Many societies, with their over-emphasis on childbearing aspects of sex, treat post-menopausal women as though sex and sexuality is no longer important for them. This can have major implications for women, on their self-image, self-esteem, on their relations with others, and on the expectations placed on them by society and culture.
Learning exercise 4

Ask the students to re-form their small groups and discuss what they consider to be sexual needs of a post menopausal woman. After about 10 minutes, ask the groups to report back to the class and list their responses on a large sheet of paper (e.g. flipchart).

Sex and society

Throughout the ages, in various parts of the world, individual society's approach to sex and sexuality have often been less than positive, supportive or helpful. In some societies, individuals are not encouraged or allowed to talk about sex and there may be legal penalties for doing so. This is contrasted in other societies where sex may seem readily available to all, and is used in many other ways, e.g. using pretty models to sell products from hair shampoo, through cars, and even to bars of chocolate! Consequently, the messages about sex can say much to the individual about what is or is not acceptable. These images may give some of the following impressions:

- sex is only for married couples;
- sex is for having babies;
- too much sex is bad for you/leads to promiscuity, being a prostitute;
- penis + vagina is the only "normal" form of sex (i.e. non-penetration, oral or anal sex are abnormal, wrong, or perverted: punishable by law in some societies. Likewise, sex by oneself is often frowned upon or thought "selfish", as is non-procreative sex, e.g. using certain forms of contraception, sex between people of the same sex, or sex with postmenopausal women);
- sex is for the good looking (when was the last time you saw a product being advertised using someone considered to be ugly, spotty, old or too fat/thin?);
- sex is with one partner for life;
• sex before or outside of marriage is wrong; and
• sex is only for the young and able-bodied.

Learning exercise 5

In small groups, ask the students to discuss, some of the messages which they take from the various media campaigns in their own country and culture. Ask each group to nominate one student to report back to the whole class. After 10-15 minutes, ask each group to report back and summarize the perceived media messages on a large piece of paper (flip chart) or an overhead projector (OHP) transparency.

Why all this talk about sex and sexuality in the health care setting?

There are various, important, reasons why sex and sexuality need to be discussed in the health care setting, such as:

• the fact that being human includes being sexual. Sex and sexuality are therefore important parts of our nature. They therefore deserve to be treated with the respect and understanding we show to other aspects of human life and development.

• secondly, that many societies are seeing an increase in the way sex and sexuality are being talked about or treated. Even twenty years ago, many countries would not have featured sexuality in newspapers, films, television, selling "beauty products", etc. In many ways sex is now something of a fashionable commodity. However, in saying this, only certain forms of sex or sexual beings are given this positive attention; people who do not conform to this mythical sexual norm are somehow excluded, e.g. people with physical and mental disabilities, people of different age groups, those who want sex for reasons other than for having babies, people of the same sex, adolescents.
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- sex and sexuality have long been a taboo for everyone except heterosexual men. Some people would say that this has a lot to do with stereotyping, roles, power-relations, women's rights and pleasure, etc. Making sex education available to all may be frightening to some people and cultures, because it may go against these strongly held, usually patriarchal, norms.

- for some people, sex is now being linked to a viral infection which has the possibility of leading to death (uniting those two great taboos: sex and death). As health care workers interested in health promotion, there is a need to help our clients to be fully informed and empowered to make their own choices in life. This will mean helping those who are not infected with HIV to remain uninfected and helping those who are infected to make the healthiest choices for their own life, including sex and sexual expression.

- finally, many national and international organizations; including the World Health Organization, are already at the forefront in encouraging people to explore issues of sex and sexuality as their personal right, contributing to the holistic development of the whole being, not just parts of it.

To understand sex and sexuality beneficially we need to look at ways in which the message can become "sex positive". Negative ways of teaching sex include the use of fear tactics, such as telling clients to stop having penetrative intercourse, otherwise they might become infected with HIV. Consider how you would feel or react to a similar command!

This is atypical "sex-negative" statement. Personally, you might react to it by saying, "Don't tell me what I can and can't do!", or "I'll do what I want to do, thank you very much!" Not everyone likes being told what they can and can't do. If that is the way we talk about sex, then many people will simply rebel against the message, to the point that they might disregard important pieces of information. Health psychologists have proved that fear is not a sufficient or lasting tool to be used in encouraging behaviour change as reflected by the large number of people who continue to smoke tobacco or drink alcohol to levels which are detrimental to their health. Neither is knowledge alone sufficient to change people's behaviour. Being "sex positive", in the way we communicate about sex, helps people to develop and affirm their sexuality and facilitates their ability to explore health-orientated options in their sexual activities.
Learning exercise 6

In small groups ask the students to discuss examples of common sex-negative messages in their own culture and communities. Ask them to write out five sex-negative messages and then attempt to rephrase each of these as sex-positive messages. Ask each group to nominate one student to report back to the whole class and, at that time, summarise their reports on a large piece of paper (flip chart) or an OHP transparency.

Important aspects of human sexual development

Sex and sexuality are intricately bound to each of us, as human beings. For many people, their only source of learning about sexual development comes from sources which have a particular bias or interest, or at least, from sources which fail to be sex positive.

Learning exercise 7

In small groups ask the students to discuss examples of messages they have received about "sexual development" from the following sources:

- politicians
- society's main religion(s) or religious leaders
- police or legal system
- former schooling (as a child)
- parents
Then, ask each student to complete the following exercise:

"If you were to model yourself around the messages you have received from the above, where do you think you would be on a line continuum of being sex positive or sex negative?"

<table>
<thead>
<tr>
<th>sex positive</th>
<th>neutral</th>
<th>sex negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 4 3 2 1 0 1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

"Where do you believe you actually are on such a continuum, at this moment in your life?"

<table>
<thead>
<tr>
<th>sex positive</th>
<th>neutral</th>
<th>sex negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 4 3 2 1 0 1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: There are no right or wrong answers here, just different positions for different people.
"How does your actual place on the continuum help or hinder you in discussing sexual development with: (a) your colleagues? (b) your clients/patients?"

By participating in this exercise, it is possible for an individual to gain some insight into their own approach to sexual development, which can inform or help in their future development, e.g. in highlighting strengths, and also possible areas where further exploration and/or development may be helpful. This is a healthy place to be in, seeing that we all continue to grow and develop throughout life.

One image that people might have concerning sexual development and the law is to do with the language sometimes used of people who commit "sexual offences". There is a tendency in many societies to describe such people, or their 'offences', as being less than human, like wild animals or beasts. But that is something we are not. For each and every one of us, sex and sexuality is that of human beings, many of whom are striving throughout life to integrate their sexual expressions into the whole of their being. Sexual development, or lack of it, can only ever be human. Understanding this goes along way in ensuring that we will try, at least, to understand people who are at a different point to ourselves in their expression of sexuality.

Being "sex positive" does not mean that we have to say that "anything goes". There is a need for individuals and societies to set boundaries beyond which individuals ought not to go, but these would be better if they started from a point of reference such as "never to have sex with someone who cannot or will not give their full, informed consent", rather than using one section of society and its regular sexual practices to be seen as "the norm", or the only genuine expression of human sexual relation, and all else as illegal or wrong.

Human sexual development can, therefore, be seen as having various influences throughout the life span of the person. This may be enhanced by other aspects of personal growth, such as a healthy self-love and appreciation, self-esteem and self-respect, with an increasing awareness of the unique contribution each person has to make, both to their own lives and those of others. Freud's concepts of psychosexual development were very much from a biological point of view, and in particular, of a married, heterosexual, early twentieth century
Jewish man, living in central Europe. In his approach to sexuality, he divided a child's early years into periods of sexual development, such as the oral, anal, and phallic/genital stages.

Other psychologists started from a different position to Freud; they looked at various social and personal dimensions of human growth and development which can influence sexual development. Freud's emphasis was mainly on pleasure or gratification, as a stress reducing activity in life. Between the end of the phallic stage to puberty (about 6-11 years), he spoke of sexual 'latency', mentioned above. Freud saw very little evidence of genital activity during this period. With the onset of puberty, the adolescent was seen, in some ways, to reach the peak of their genital expression. From this, it might appear that there is a downhill slide for the rest of life. Such an approach would fail to appreciate the maturity that comes later in life. Even though a genital expression of sex may be less frequent or less vigorous between a person of 60 and a 16 year old, nevertheless, it still has its important place to play in the development of the whole person. Freud seems to be the classical psychologist known by millions, even if only through the "Freudian slip", or the fact that he had something to say about sex.

Other important psychologists included Alfred Adler, Viktor Frankl and Abraham Maslow. Their treatment of sex and sexuality was also from a middle-class, male, heterosexual point of view. Details such as this should be taken into consideration if sexual development is also to be viewed from the female, homosexual and bisexual points of view. Adler's starting point was that as individuals (e.g. as children), we are incomplete of ourselves. There is therefore a striving for completeness, wholeness, and of healthy power (not being inferior). For him, sexual identity was, by necessity, something which involved another; the social dimensions are critical. The other, in this case, can be a whole range of people, from the child's parents and the close bonding that may take place there, to "best friends" at school, usually of the same sex. After this period, Adler describes progress through to the genital expression of the social person, in what was for him, the dyadic relationship of a man and woman, leading to the possibility of offspring.
A different point of view was that of another psychologist, Viktor Frankl. After spending some time as a prisoner (in concentration camps) during the Second World War, Frankl's over-riding concern was for meaning to life. To Frankl, a person's life development was threefold: personal achievement or fulfilment; appreciation of the other, especially the good in the other; and through the experience of suffering. Growth was seen to come out of suffering which was unavoidable (not suffering which one can remove).

The final psychologist to be mentioned here, on the theme of sexual development, is A.H. Maslow. His pyramid of "self-actualization", Maslow's Hierarchy of Needs (Figure 2.3) is possibly world famous in the concepts of human development and health. For Maslow, the aim of all human beings is to become self-actualized. In the lifelong striving for self-actualization, an individual can integrate both genital and affective sexual needs within the fulfilment of their total being.

Human sexuality in its entirety is therefore constituted by at least these four areas:

- the somatic or physical and physiological developments and responses in sex and sexuality;
- the psychological emphases of people such as Freud and Maslow;
- the aesthetic or life-meaning perspectives of theorists like Frankl;
- and the relational or social views of people like Adler.

Encompassing each of these aspects is Maslow's Hierarchy of Needs, which begins with more basic, physical needs, and can develop into the expression of fully actualized human persons.
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Figure 2.3 based on Maslow's Hierarchy of human needs^1

Learning exercise 8

In small groups, ask the students to discuss examples of some of the major influences on sex and sexuality in their own country and culture. This may include issues such as, customs, rituals, the role of sex, major religious influences, important historical events such as natural or human disasters, wars, etc.

Ask the students to explore some of the ways in which these influences may contribute to, or hinder, the development of sex and sexuality in the health care setting.

The above exercise facilitates various groups of Students to gain an understanding of the differences in approach and attitudes to sex and sexuality experienced by their patients/clients.

What's love got to do with it?

Not everyone needs to know the anatomy and physiology of the brain to be able to think! Likewise, we do not have to know all the theories, concepts and details that go to make up human sexuality and sex to be able to function as a sexual human being. An important focus of human sexuality is the relationship between sex and love.

In many cultures there appears to be a stereotypical "ideal" about sex that it is something to be shared between two people who love each other, who are in a lifelong union together, and possibly with an aim of "the procreation and education" of children. However, not everyone will genuinely fulfil all of these criteria. Consider, for example, the number of people who are in "arranged marriages", "marriages of convenience", or coerced marriages.
In addition, there are the issues of personal freedom to consent to sex each and every time, a freedom that is not always available to many people. Consequently, although sex and love do go together, they don't always, nor on every occasion, and many people actually chose to separate the two. Lust or sexual desire is undoubtedly important to many people. There is nothing wrong or abnormal in wanting to have sexual relations with others; problems often arise when people pursue their desires in ways unacceptable to the other or society.

It would seem that no one theory can claim to be the only, or definitive, theory of human sexual development; it is probably more helpful to be both eclectic and integrative. Being eclectic means identifying all of the positive contributions to the topic, from various sources, which you can then integrate to make a personal definition and philosophy of your own. This will have to take account of some of the main stages of human life and development.

**Sexual identification**

Another important aspect of defining human sexuality are the concepts of female, male, femaleness, maleness, femininity, masculinity. These are not only formed by biological determinants (such as genes), but also through the individual's response to interactions with others around him/her, whether this be from the parents or local family, through peers, friends, the media, or society at large.

**Learning exercise 9**

Ask the students to write out their own definition of "Sexuality", without using the words "sex" or "sexual". After about 7-10 minutes, ask them to join into small groups (usually of about 4-6 people), and take about 20 minutes to come out with a group definition, which they can then present back to the whole class. The group definitions should include elements from each person's individual definitions, and should not exclude anyone within their group. If a group finds it hard to be all-inclusive, (and consequently, are excluding someone in their approach), then they must work towards a compromise acceptable to all.
Other considerations around sex and sexuality

Stereotyping of gender roles and expectations can be seen to have mostly negative consequences in the healthy development of sexuality. In many societies, such sex roles are little more than the "flexing of muscles", or the imbalance in power-sharing relationships between the sexes and sexualities. This is seen in the extreme in what some cultures may call the "macho man" image, which is often little more than an excuse to portray some as the ideal or norm, usually to the detriment of others, be they women, younger or older men, unmarried men, or people with less physical strength or ability. This can certainly have a detrimental effect in the health care setting, for example, in derogatory attitudes towards female nurses, as though they are meant to be merely men's assistants, submissive and obedient to them; also towards men in nursing, implying that they are not "real" men (i.e. by "doing a woman's job").

Such attitudes of prejudice are often formed in the early years of a person's life, and may be compounded by society's attitudes throughout life.

One author has suggested an alternative viewpoint: "people of whatever biological sex should be free to behave and live as they want with regard to gender roles and sexual preferences. The only limit that needs to exist is that their freedom, equality and self-expression does not oppress, exploit or harm others in the way that present social arrangements do in different ways for both women and men. We would then live in a much more healthy society and be more healthy as individuals".

Another point to be mentioned in sexual development is that not all people wish to express their sexuality procreatively. This may be seen as taboo in many societies but most people would probably agree that not everyone has sex simply for making babies. The other side of this statement is that there are many people who do have sex to have children, but who, for one reason or another, are unable to. This is sometimes perceived as a disgrace and reflects negatively on their masculinity or femininity. Impaired or reduced physical performance, e.g. through anything from physical disabilities to loss of sexual functioning through the side effects of certain drugs, may also be perceived as a disgrace or stigma. For men, there may be feelings of loss of "manhood"
or masculinity if they can not have children (especially a boy), whilst for women, they may have the added burden of having their sexuality constantly linked to that of children, i.e. "women and children". This can heighten feelings of being unfeminine or lacking in the maternal instinct in women who choose a career before, or in place of, having children. Other resentments that can develop for women concern their perceived or actual loss of body image, e.g. changed body shape and stretch marks (striae gravidarum) caused by the effects of pregnancy and having children.

Many of these problems are heightened with the over-emphasis on the importance of the sexual orgasm, both male and female. Again certain stereotypical norms seem to say one thing, when many people’s experience is quite different. This can lead to feelings of inferiority and of not being quite normal or natural.

Within the area of sexual development, discussion has frequently focused on the issue of nature or nurture, which has frequently led to the term of "sexual preference". More will be said on this in Module 4.

Know yourself

A major developmental imperative throughout the ages, and in various cultures, has been to know oneself. In the realm of sexuality, especially for health care workers, this will involve at least three major aspects:

- knowing oneself intimately, and to an extent whereby one can relate comfortably with others;

- overcoming embarrassment about sex and sexuality, so as to be able to effectively communicate on the subject with others;

- identifying and demolishing barriers which may stand in the way of fruitful human, sexual development. (This final point is covered in this section, Know yourself, and in the following sections, Talking about sex, and Sex and sexuality in the health care setting).
Most of what has been discussed and experienced earlier in this Module will have helped you to identify ways in which both you and others develop as human sexual beings. We have looked at ways in which sex and sexuality are frequently talked about in today's societies and at the ways in which this may be done positively, negatively, or in a derogatory manner.

Our ability to relate to other people, whether affectively or genitally, will be enhanced if we first learn to relate to ourselves positively and creatively. This means that a healthy self-love and appreciation helps us to develop our full potential, and from the fullness of our development and personhood, we can share this positive outlook with others.

Knowing oneself also means knowing some of the more painful aspects of life, or those incidents or moments which can still make us feel the hurt. Growing through these, instead of suffering them, will enable us not only to develop ourselves, but be better equipped in dealing with the hurt of others. If we shut ourselves off to things we dislike, disagree with, or which cause feelings of discomfort and pain, then we will miss the opportunity to mature through the experience, and will find it an obstacle, or "stumbling block", each time we are confronted with similar situations in our relations with others.

**Talking about sex**

Sex is probably one of the topics most frequently spoken about in the daily lives of people in many societies. It is spoken about seriously, intellectually, academically, in jokes, through the media, and by people both in and out of satisfying sexual relationships. It is one topic that can provoke many different emotions in people, depending on the context, the understanding, the meaning, and the reason for talking about it. Some people still believe that 'ignorance is bliss', i.e. what you don't know won't hurt you. This is often an approach to young people and children, believing that their age of "childlike innocence" should not be shattered by the reality of adult life. However, in today's world, where many young people are talking about sex, and others are sexually active, it may be more helpful for adults to serve as role models, communicating on sex and sexuality honestly, effectively, without prejudice, fear or discrimination. This would facilitate younger people to approach their sexual development more
empowered to take responsibilities for themselves. All people, but especially those younger persons with an evolving sexuality, need accurate information and skills in talking about and negotiating sexual activities. This is important in enabling them to develop satisfying sexual relationships and to avoid much of the unhappiness and health risks (e.g. sexually transmitted diseases, including HIV infection, unwanted pregnancies) often associated with inaccurate information, an inability to talk about sex and a lack of decision-making skills.

Talking about sex and sexuality has to be honest, respecting the other person where they are at, and, at the same time, being true to ourselves. If, for example, a health care worker has an unresolved sexual hurt, then they may not be the best person to deal with a client's problems brought about through perpetrating a similar hurt in others. Health care professionals have a responsibility to care for themselves, as well as their clients, and in this situation, to explore alternative avenues of help such as referral to other colleagues or a specialist in the given field.

Learning to enjoy being oneself, including one's approach to sex and sexuality, will enable the individual to be more at ease in talking about the subject with others. Obviously there will be times, discussing sex or sexuality, when one feels highly embarrassed, and this is a common experience. Yet one of the best ways for overcoming embarrassment is through laughter. Learning to laugh with our clients, and not at them, will also lighten what could be a tense situation. Clients who spend time laughing with their carers, for example, are far more likely to learn from them, be able to trust them, and most importantly, look forward to coming back to them, than if they were to have such an embarrassing time that they actually dread a repeat session!

Learning to enjoy oneself, including sexual relationships and activities, is also a vehicle for healing past hurts from various developmental stages of many people's lives. It is through such hurts in life that we all experience, in one way or another, that we are enable to grow and mature, rather than wilt or become embittered.
Human sex and sexual development is central to health care, as one way or another, all the people we care for, work with and relate to, are sexual beings. Once we realize this, and once they realize it about ourselves, too, the easier it will be for everyone to relate on matters of sexual development.

We have explored the importance which sexual development plays in a person's life, and the need to avoid pre-judging people, or trying to make them follow our own particular brand of morals or beliefs. In the health care setting, clients expect equal treatment from us and, as professionals, they sometimes expect us to know something about everything! A huge demand for us to try to live up to. However, we need to be honest with ourselves and our clients, and admit that there are some things we do not know, but which we can possibly find out. In treating people equally, we must avoid the trap of making presumptions, e.g. that all people have the same sexual needs, that everyone is heterosexual and presumed married. These types of pre-judgements may be counter-productive in approaching people with differing sexual roles, orientations and aspirations. Equally detrimental to care is the popular myth that older people, especially post-

"Despite the tidal wave of sex talk, present-day attitudes to sex still leave a lot to be desired. The advance during this century of academic and specialist knowledge about physical and psychological aspects of sexuality has not been matched by similar progress in personal, social, religious, legal, and public attitudes."

Anthony Grey
menopausal women, do not want or have sex. The misinformation and negative attitudes around older people having sex is an area which is compounded by lack of understanding in the health care setting, and which reinforces the ideas that non-procreative sex is somehow not an essential part of life (and therefore can or should be given up).

Learning exercise 10

In small groups, ask the students to discuss some ways in which health care professionals might presume or pre-judge the sexual needs of:

- a ten year old client;
- a fifteen year old client (female);
- a nineteen year old client (male);
- a forty-one year old female client; and
- a seventy-nine year old male client.

After 15-20 minutes, ask each group to report back to the whole class and then summarise the salient points of their discussion.

In the health care setting, there may be a variety of ways in which people seek help for problems related to their sexuality and/or sexual activities. Guilt is frequently the basis of numerous problems because of the way sex has been treated in many societies in the past, by the State, politicians, legal system, religious leaders. Consequently, many people with sexually-related problem may refrain from seeking help. Often they feel their sexuality or sexual activities are sinful and consequently, their problems are a punishment. This is especially true of people with HIV infection who have acquired it through sex or injecting drug use.
Dealing with sexual issues in the health care setting often means building a rapport with the client (or colleague) which shows that you will not be pre-judging them, that you will not be condemning them, and that you will try, in as much as you can, to have a positive regard for them. This is not always easy as our own past history can often be a hindrance to an honest acceptance of the person we are actually dealing with.

**Conclusion**

Sex and sexuality have been portrayed in this module as a completely 'natural' and important element of human life and development. Throughout life, sex and sexuality form an intricate relationship with all other parts of human maturity: physical, psychological, aesthetic and sociorelational. Affective sexuality helps meet the intimacy needs of each person, while genital sexuality by itself contains elements of physical desire which may have negative connotations for some. However, both these aspects of sexuality need to be expressed humanly by the person. In many areas of life, people often try to learn by their mistakes, and frequently share this knowledge with others, so that they do not make similar errors. This is, however, often uncommon in the arena of sexuality, where people may often feel ashamed, embarrassed or guilty in discussing sexual problems. Moving into the twenty-first century health care workers have an opportunity to help facilitate an understanding of the development of human sexuality and promote sexual health.
MODULE 3
SEXUAL ACTIVITIES

General objective

On completion of this module the student will have an understanding of the different kinds of sexual activities in which people engage and be able to discuss these without conveying judgement or embarrassment.

Learning outcomes

On completion of this module, the student will be able to:

• name and define several sexual activities by both their medical names, and the street names used in their community; and

• discuss these activities, in relation to safer sex, with other members of the class.

Learning activities

Introduction

In order to become comfortable taking sexual histories, it is important to have some knowledge about the kinds of sexual activities which people engage in. In this module, students will be given the opportunity to become comfortable talking about specific sexual activities. Sexual activity is a normal part of everyday life and most people, during their lifetime, will have experience of sex; either with themselves or, with another.
Learning exercise 1. Exploring barriers to talking about sexual activities

This exercise is to help explore and identify potential barriers which health care providers may encounter in discussing sexual activities with their clients and patients.

Divide the group into four and give each group a large piece of paper and a marker pen. Ask them to consider the barriers to talking to clients and patients about sexual activities under the following four headings: Personal, Professional, Religious and Social.

After approximately 20 minutes, ask each group to elect a spokesperson to feedback their findings to the rest of the group. When all the groups have fed back, discuss with the group common issues which have been identified. Categorizes those barriers which (1) seem impossible to overcome and (2) others, e.g. embarrassment, ignorance, which could be addressed. This then sets the “agenda” for the following exercises.

Learning exercise 2. Who does what?

This exercise is designed to help students discuss the various sexual activities of people with varying sexual preferences.

Have the students reassemble into four small groups. Each group should have a large piece of paper and some marking pens. Each of the four papers should have a large heading for one of the four sexual preferences (heterosexual, bisexual, lesbian, male homosexual). Each group is then given one of the papers. All the group members should then suggest sexual activities which might be performed by someone with this sexual preference (e.g. a heterosexual might have vaginal intercourse, a lesbian might have oral-vaginal sex). After five minutes, the papers are rotated so that each group has a different one. The
process is repeated until each group has added activities to each paper. The students should try to think openly about what activities are possible in different relationships. The papers are then compared in the front of the class to see who does what.

At the feedback, (1) check that everyone know the meaning of the activities described, e.g., there might be a "street" name which is more familiar to some of the students; (2) ask the group if they see any similarities in activities across the groups. There is often an assumption that an activity is only performed by one particular group when, in fact, it is commonplace, e.g., anal intercourse occurs in both homosexual and heterosexual relationships; (3) stress that although many sexual activities are shared across all groups, when dealing with individuals one should never assume anything about their sexual life.

Learning exercise 3. Safety first

This exercise will facilitate students in defining sexual activities in terms of safety in relation to HIV transmission.

It will be useful if the teacher reviews the ways in which HIV is transmitted (see Box 3.1), stressing that sexual activity is the most common way in which people are exposed to this virus.

Ensure that the lists which the students made in learning exercise 2 include the following: kissing, cuddling, fantasy, masturbation, cunnilingus, fellatio, anal intercourse, anilingus, vaginal intercourse, massage, frottage, using sex toys, and massage. If these items were not identified, ask the group to define them and give any "street" names for them that might be more familiar to themselves or clients.

Redistribute the lists which the students made in learning exercise 2, one to each group and ask them to consider each activity in terms of the potential risk of HIV transmission. Ask them to classify each activity on their list as either (a) high risk, (b) low risk and (c) no risk and to be able to justify their decision, based on the known means of transmission.
HIV can be transmitted:

- Sexually, through intercourse or through contact with infected blood, semen, or cervical and vaginal fluids. This is the most frequent mode of transmission and HIV can be transmitted from any infected person to his or her sexual partner (man to woman, woman to man, man to man and, but less likely, woman to woman).

- During transfusion of, or inoculation with, blood or blood products infected with HIV.

- Using injecting or skin-piercing equipment contaminated with HIV.

- From a mother infected with HIV to her child during pregnancy, during labour, or following birth as a result of breast-feeding.

HIV cannot be transmitted by:

- coughing or sneezing
- handshakes
- insect bites
- work or school contacts
- touching or hugging
- using toilets
- water or food
- using telephones
- kissing
- swimming pools
- public baths
- sharing cups, glasses, plates and other eating and drinking utensils

Box 3.1 Transmission of HIV
On completion of this task, invite each group to discuss one activity in turn on their list and describe how they categorized it, and why. Allow for comparisons to be made across the groups and encourage discussion where differences occur.

Once the lists are exhausted, ask the group to consider how a "high risk" activity could be made a "low risk" or "no risk" activity. For example, unprotected vaginal intercourse is a high risk activity but could be made a low risk activity by correctly using condoms. Agree a final list and display this on the wall of the classroom.

**Learning exercise 4. Using condoms correctly**

This exercise will provide an opportunity for students to practice teaching clients the correct way of using condoms.

For this exercise, each student will need to be provided with a condom. In addition, there needs to be a model of a male penis (for the teacher to demonstrate correct condom use) and a selection of appropriately sized and shaped objects for students to use in their practice teaching sessions. Finally, distribute a copy of the material in Box 3.2 to each student.

This activity is likely to cause embarrassment and laughter. It should be a “fun” activity but, at the same time, participants need to recognize their role as health educators and the importance of giving accurate information in an effective and acceptable way in which clients can understand it.

Start by demonstrating the stages included in safe condom use (Box 3.2), using an anatomical model, a vegetable or fruit, other objects. At the end of the demonstration, answer any questions and then divide the group into pairs and ask them to demonstrate condom use to each other; one acting as teacher and the other as the learner. They should have Box 3.2 readily available to prompt them. When both have had the opportunity to teach each other, finish the session with a general discussion on how easy or difficult they found this exercise and to identify potential opportunities in clinical practice when they might engage in this health education activity.
Box 3.2 Safe Condom Use

- Always use a new condom. Condoms should only be used once.
- Store condoms in a safe place where they cannot be damaged by heat or moisture.
- When taking the condom out of its wrapper, be careful not to damage it.
- The condom can only be put onto an erect penis and should be put on before there is any penetration.
- Before putting the condom on, squeeze the first centimetre of the closed end to remove trapped air which would place a strain on the condom during intercourse.
- Hold the condom over the tip of the penis and unroll it carefully as far as it will go. If the condom is the wrong way round it will not unroll. If this happens, the condom should be reversed and carefully rolled down the shaft of the penis.
- Ensure that the partner is relaxed and sufficiently aroused for penetration to be comfortable. Forced or dry sex is a common cause of condom breakage.
- If additional lubrication is needed it should never be oil-based or greasy because that weakens the rubber of the condom.
- After ejaculation, the base of the condom should be gripped firmly and the penis should be withdrawn.
- Dispose of the used condom safely.
Summary points

- Sex is fun and sexual activities are spread widely across the sexually active population;
- Some sexual activities are more likely to transmit HIV than are others;
- As health educators, nurses and other health care providers need to encourage people to practise safer sex by adopting "no risk" or "low risk" activities.
MODULE 4
HOMOSEXUALITY AND BISEXUALITY

General objective

On completion of this module, the student will have explored dimensions of human sexuality relating to issues around same-sex sex, identifying ways of improving health care delivery for people with related sexual needs.

Learning outcomes

On completion of this module, the student will have:

- considered some of the more frequent expressions of human sexuality;
- examined ways in which the health care environment may be detrimental to a holistic appreciation of particular individuals; and
- identified strategies for improving the care and understanding of people with various sexuality needs.

Learning activities

Introduction

Module 2 looked at various ways in which human sexuality develops. From this, and based on the reality of human life throughout the ages and cultures, it can be seen that presuming "human sexuality = heterosexuality" is flawed.
Module 2 also looked at the relevance of sexual development to the life of the individual, and the ways in which certain issues, such as fear, prejudice, ignorance and discrimination, can alienate the person not only from aspects of their own society's life, but also, psychologically, within themselves. Such alienation, by society and within the individual, can have major implications in the health care setting. Issues such as these contribute to the reason for devoting a whole Module to aspects of homosexuality and bisexuality.

The facts of life

Throughout the ages the combinations of partners have included all types of relations: men having sex with women, or men, or men and women; and women having sex with men or women, or men and women (see Figures 4.1 and 4.2). Universal evidence of these phenomena show that such a variety of relationships may be experienced by individuals exclusively, e.g. that a man or woman only ever has a sexual partner of the same or opposite sex, giving rise to the terms "heterosexual" and "homosexual", and that other individuals have sexual relationships with members of the opposite and the same sex. Some of these have an equal emphasis on same-sex / opposite-sex relations, others show a predominance over one or the other, (e.g. a married man who appears predominantly heterosexual, but who occasionally has sex with other men) give rise to the term "bisexual".

Most societies and cultures throughout the world have evidence of this plurisexual combination of partners. Various cultures have prized the fact that some of its citizens have had different types of sexual relations. Some societies even boast of great achievements made by people whose sexual orientations have been different and varied. There are stories of armies of all-male lovers, who fought battles with unimaginable determination (so as to protect their lovers, who were fighting alongside them); there are also the great literary, artistic and musical achievements by people who had sexual partners of the same sex. Some of these great people included philosophers, characters in various religious scriptures, painters and sculptors, many of whom have famous works continuing to adorn some of the world's historic palaces and centres of religious pilgrimage. Some of these famous people's personal sex lives are common knowledge, others are merely hinted at or possibly purposely hidden.
Figure 4.1 Range of possible partnership constellations for women

Figure 4.2 Range of possible partnership constellations for men
Alongside the wealth of positive contributions made to the world's life and culture by people able to express themselves sexually with members of the same, the opposite, or both sexes, were people who for one reason or another disapproved of, and subsequently outlawed, such expressions. The consequences of requiring sexual conformity in a society leads to restricting human sexuality to one primary mode only, that of male-female relations, usually with the explicit command to procreate. There are so many ways in which anything which deviates from this is considered to be unnatural, perverted, sinful, demonic, insane, or criminal. For people who do not consider themselves to be of the Male + Female = Having Babies equation, there are two main choices: 1) be open and honest about themselves, and risk facing the wrath of their society, family, culture, legal system, politics, religions, health care professionals, etc., or 2) keep their behaviours totally hidden and secret. The hidden nature of many people's (sexual) lives leads them to behave with two different fronts: their public face and their private one. In public, they may be seen to conform to the society's required norms, but in private, their practices may be very different. Even historians have contributed to a conspiracy of silence, when they have written about famous homosexual and bisexual men and women from all angles of their life, except their sexuality.

This brings us to the present time where we now have such titles as those coined in the 19th century: "heterosexual", "homosexual" and "bisexual". The background to these terms shows a very rich, but sometimes exceptionally sad, picture of life, which includes: human development, sex, love, politics, relationships, hostilities, persecutions, fears and discrimination. In caring for homosexual and bisexual people, it is worth remembering that while some individuals or societies have an honest and open approach to human sexual development, others may still experience misunderstanding and discrimination, which has continued throughout the ages.

Working with people who self-identify as being "homosexual" or "bisexual" may therefore challenge the learner to reassess her/his own prior assumptions on the subject, and certainly make note of any actions or behaviours on their part, which may be indicative of ignorance, prejudice or discrimination.
Learning exercise 1

Students can be asked to make a list of famous people throughout the ages, from their society, whom they know, or believe, to have had homosexual or bisexual relations:

Then to list some of the positive contributions they made to life,

and some of the ways in which they may have been persecuted or discriminated against.

Participating in such an exercise can give the student an opportunity to look at the wider environment (a sociological perspective) of the subject, rather than just in medical isolation.
A variety of sexual expressions – as ancient as humanity

Principal words describing the various sexual expressions are combinations of Greek and Latin nouns and adjectives:

- sexualis (Latin) = sexuality
- homos (Greek) = the same Note: not homo (Latin) for 'man'
- heteros (Greek) = the opposite
- bi- (Latin) = (a prefix for) two (of something)

Module 2 highlighted the fact that there is no shortage of theories about human sexuality and its development. Some schools of thought claim that within each individual person, there are elements of various aspects attributed to both male and female, as sexual beings; likewise, the capacity to relate to people of the same sex, the opposite sex, and both sexes. Since sexuality is an intricate part of being human, and given that most people relate to members of the same sex, the opposite sex, and therefore, both sexes, most humans are bisexual in the broadest sense of the word. This does not mean that we all want sex with people of both sexes, neither does it deny the existence of heterosexuality or homosexuality, but for a person to be 100% either heterosexual or homosexual could mean that their relations with others is inhibited. Two different diagrams may highlight this point.

Notice how Figures 4.3 and 4.4, while both attempting to shed light onto human sexual experience, may give a very different picture of the final result. Figure 4.3 starts with a human sexual being’s ability to relate to others of the same and opposite sex. Problems arise when a person is so totally fixated at one end of
Based on Goergen (1974), p. 82

**Figure 4.3 The sexuality continuum**

<table>
<thead>
<tr>
<th>exclusively heterosexual with no homosexual</th>
<th>predominantly heterosexual but more than incidentally homosexual</th>
<th>predominantly homosexual but more than incidentally heterosexual</th>
<th>exclusively homosexual with no heterosexual</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>

**Figure 4.4 Kinsey’s sexual classification system**
the scale or the other, that relating to other people is somehow hindered. Kinsey's Scale (Figure 4.4) gives a different message in that it is numerically ordered. This can unintentionally give the impression that position "0" is the norm, or starting point, against which all else is to be judged. Implications of misunderstanding such data can lead to problems in the health care setting, such as categorising people into neatly defined boxes, or groups, and then pre-judging what people are thought to be like. Indeed, many psychoanalytical theories claimed that to be a fully mature adult sexual being, the individual must achieve a fully functional heterosexual status. Numerous psychoanalysts are questioning the reliability of former (often inadequate) studies, which led to such erroneous conclusions.

Looking at homosexuality and bisexuality in the histories of many cultures, religions and races, can prove to be a most enlightening exercise in discovering the ways in which health carers, of all professions, have contributed or colluded with often discriminatory approaches, to people whose sexualities seem to differ from that of the majority.

**Homosexuality and bisexuality as concepts**

It is worth labouring the above points to show that there are no easy ways of simply putting human persons into "pigeon holes", or boxes with labels on, so that others can make judgements about them. Take for example the concepts of the male homosexual person:

**Male homosexuals** - or men who have same-sex sexual partners - may include:

* men who have sex with men incorporating any male who has - or has had - genital contact with another male, even if only as a minor part of their total sexual lives;
- men who self-identify as belonging to a homosexual culture, politically or socially, e.g. by attending certain bars, cinemas, clubs, or organizations. These men frequently call themselves "gay" men, and their homosexual sociopolitical environment the "gay scene". Many gay men object to the term "homosexual" as being clinical and derogatory, and imposed by others outside of the community, that is, it is seen as a medicalization or pathologizing of human experience;

- men who cannot be open about their sexual orientation, but have sex with other men in secrecy or anonymously e.g. in other towns or private places;

- men who live with their wives / girl friends, but have occasional genital interactions with other men; many may not call these activities "sex", as sex, to them, may mean penetrative intercourse with a woman;

- men who live in all-male environments, e.g. armed forces, prisons, schools, or religious institutions, who mayor may not choose to have sex with men if women were equally available;

- men who identify as being heterosexual, but have sex with men for financial reasons e.g. sex industry workers, prostitutes, "rent boys, hustlers", and some transvestites and transsexuals;

- men who are experimenting with different forms of sex;

- men who identify as wanting sexual relations with men and women i.e. bisexuals;

- men who have sex with men who are dressed as women e.g. such as transvestites or transsexuals;

- men who have sex with men as part of their culture of maturing and growing up e.g. initiation ceremonies of certain peoples;

- men in erotic places or situations who wish to have sexual contact to "relieve" themselves: but would not identify as being homosexual or bisexual;
• **men wishing to have sexual relations with another person other than the woman they intend to marry**: some cultures has more prohibitions against a man having sex with his intended partner for marriage, than it does if he were to have sex with another man;

• **men who self-identify as "queer"**: part of a growing group of politically and socially aware "gay men", who use the term "queer" of themselves, by way of diffusing its negative connotations when used in a derogatory (homophobic) fashion by non-gay men or women. (This argument also extends to some ethnic groups using terms such as "nigger" of themselves, so as to counteract its power as a racist, abusive, term);

• **men who rape other men** e.g. as part of a "machismo" degradation of other men, such as in times of war, conflict, in prisons, or just everyday life in the 20th century;

and so the list could go on.

*Learning exercise 2*

Students can add to such lists from their own knowledge and experience of their particular country or culture.

Making lists like these may also include fathers, brothers, boy-friends, husbands, and sons, as men-who-have-sex-with-men. This shows the diversity of human sexual expression in people who possibly do not self-identify as being homosexual, bisexual or gay. Such lists frequently contain more people than societies generally like admitting to!
Learning exercise 3

At this point, try making a similar list of women-who-have-sex-with-women. This list may include:

- female homosexuals: many dislike this term for the reasons above, and because it is erroneously thought, by some, that the prefix "homo" refers to the Latin noun "man".

- lesbians: originally from the ancient Greek all-female island called Lesbos, presided over by Saphos, hence "Saphic" referring to lesbians / lesbianism;

- gay women

- dyke (or dike), the term is of uncertain origin, but usually has the same political meaning as that attached to the reclaimed word "queer" (see above);

Here, the list sometimes stops. Try adding your own terms.
Some of the terms discovered in such exercises may seem derogatory. Added to this list, of course, are mothers, sisters, aunts, and girl-friends. Frequently lesbians are totally missed out of discussions on human sexuality, either because societies expect the majority of women to marry (and have children), therefore, it is not culturally acceptable to have non-married women, or, the society may shut its eyes to the presence of lesbians, pretending that they do not exist. This was the case with Queen Victoria (1819-1901) during the passing of laws against male homosexuals in Britain. Victoria would hear nothing about lesbians or lesbianism, as she simply could not imagine that women did that sort of thing! One of the major tasks lesbians face in many societies, is, first of all, to have their very existence recognized.

Causes

Medicine and health care specialities have always excelled at being able to find various causes for specific illnesses. It is no surprise to find that with the pathologizing of sex and sexuality throughout the ages, homosexuality and bisexuality have also been treated in such away. There are many people who try to look for a cause for homosexuality, with such questions as: Is there a difference in the shape or size of the brain? Are there such things as gay genes? or Is it caused by psychosocial influences on the developing child, in such a way as to "pervert" the so-called "normal" development (i.e. heterosexuality)? A cause for homosexuality or bisexuality may never be found, but we have to ask ourselves some very serious questions. Firstly, does homosexuality or bisexuality have to be considered as a pathology? If not, then why are scientists looking for a cause for homosexuality and bisexuality, but not heterosexuality? The presumption is that heterosexuality is the normal, natural expression of human sexuality. Psychosocial questions on cause look to certain influences, or events, in an infant's life that are thought to predispose to homosexuality or bisexuality. But this does not explain the fact that siblings, even twins, brought up by the same parents, may grow up to have different sexual orientations (e.g. one heterosexual, another homosexual). The approaches to causation are often referred to as the "nature/nurture" arguments.
Looking for a cause for homosexuality can lead some people to an experience of guilt; for example, parents might ask: "Where did I/we go wrong?"; "Was the father too distant / the mother too close to their child?" Such guilt may also be expressed as blame: of the parent(s), child, society, up-bringing, and so on.

Questions as these are bound to be asked; they frequently contain emotions that can alienate people within themselves, and within their own family or social networks. Talking about finding a cause for homosexuality or bisexuality is about as useful as wanting to find the cause of why some people will develop to be innately artistic, or political, or hardworking. The dangers could lead to discrimination, the re-pathologizing of sexual orientation, and even the elimination of such potential people in future generations through abortion.

**Therapies**

History shows that many societies have tried to "cure" homosexuals of their orientation, be it through religious exorcism, counselling, aversion (behavioural) therapies including electroconvulsive therapy (ECT), or imprisonment and exile. Many research studies now show that homosexual and bisexual people have no more pathologies than their heterosexual counterparts. What may be a problem, however, is managing the discrimination and abuse that is frequently levelled at them from various sources within their society. Therapies, such as counselling, can help a person to discover who they really are, and to explore ways of managing their lives to their fullest potential. For example, if a person believes that they are homosexual, but that having same-sex sex bring them persecution from others, then counselling could help them explore all of the viable options open to them, and to look at the best way for them to develop as a fully functioning human being.
Counselling, as a therapy, may also help individuals who have low self-esteem, especially if this means that they have poor assertion skills. Such issues could be relevant for negotiating safer sex. Counselling may also assist people exploring ways in which they wish to express their lives, to develop or enhance relationships, to cope with pressures and guilts inflicted by external and internal sources, to grow to appreciate themselves, to be enabled to relate well with others. Specific issues related to coming to terms with one's sexual orientation include:

- "coming out" i.e. self-identifying and being open to others about being homosexual or bisexual;
- coming out and moving on from specific relationships, e.g. when a married person realizes that s/he is homosexual and wishes to leave husband or wife (and family) to live a homosexual life-style. This possibly includes moving from the local community to another one, e.g. to a large city;
- managing relationships in one's given society;
- special legal issues;
- bereavements and losses, such as moving on from relationships with people who cannot accept one's sexuality, such as parents, siblings, or former friends and colleagues;
- self-awareness and esteem;
- employment issues;
- spiritual and religious beliefs and practices; and
- cultural rules and expectations (and penalties if they are broken).

These are just some of the specific issues that may be relevant to homosexual or bisexual people. The challenge for the health care professional is to help facilitate the client's growth and development into the real person that they wish to be, and not to treat their sexual orientation as a genetic or mental aberration, which, once diagnosed, can be treated and cured.
Language and culture

Language and terminology in a given culture is another important issue. For example, to talk of sexual "orientation" is a positive way to refer to a person's direction in life, especially regarding their affectionate and genital expression of sex. Sexual "preference" gives the impression that a person simply chooses one thing over and above another. This erroneously implies that they could likewise change their choice, if they so desired. The term deviation has been used with regards to same-sex sex; again, suggesting that there is a definable "norm", from which a person chooses to deviate. Finally, there has been wide use of the terms perversion (and pervert), and inversion (and invert). Such terms imply illness, whether psychological or moral, and of the person being not quite normal or natural.

Using negative terms in health care theories has given credence to ideas that perverts, deviants, queers and so on, are somehow less than human. This has led many societies and religions to legitimize persecution of homosexual and bisexual people. This persecution has been particularly widespread in Judeo-Christian cultures (especially Roman Catholicism and fundamental Protestantism) and more orthodox Islamic countries, but is noticeably absent from most forms of Buddhism. This persecution leads to the development of sheer hate for homosexual people, which may be institutionalized in law, as well as at work and home, causing much personal pain and suffering. This discrimination, or homophobia, is more like the blind hatred in racism and sexism, rather than psychological phobic conditions such as agoraphobia or claustrophobia.

After centuries of persecution, many homosexual people now ascribe to a gay liberation movement, which seeks to rid society of prejudice and discrimination. Gay liberation is a concept built on ideas of the human person specific to one culture, and may be alien to parts of the world where same-sex practices are viewed differently. For example, some ancient Pacific cultures continue to see male homosexual practices as part of growing up, and of becoming asexually active, reproductive, man. Some Islamic cultures, whilst "turning a blind eye" to acts which happen in total privacy, may fear notions such as Gay Liberation and consider them to originate from "demonic" influences of "Western
imperialist decadence". Likewise, in various Catholic cultures, where condoms are specifically forbidden as contraceptives, the Church may find that where homosexual people feel excluded from the faith community (because of their orientation and the fact that they are sexually active), there may be strong grounds for the State legislature to allow the free availability of condoms as prevention against the spread of disease, e.g. HIV, given the fact that two men having sex would not be able to have a baby, anyway.

Many people still imagine that in homosexual relations, one person "plays the man's part", while the other "plays the woman". This stereotypical view, from a heterosexual perspective, is on the practices of two people physiologically different from 1-man-plus-1-woman. Considering the great variety of sexual practices which can be experienced by both men and women, and human imagination being what it is, very few homosexual people would feel proscribed to follow a male/female role model. Various societies, cultures and religions tend to deal a more severe punishment to homosexual men perceived as being effeminate, or the receptive partner in anal intercourse, for supposedly "degrading" manhood, or masculinity, to the level of women who, in many cultures have been treated as "second-best" to, or lower than, men. While an attitude towards women having sex with women is that what they really need is a good man! This shows that there are still many ancient taboos and practices influencing the treatment of homosexual people in today's societies.

One final note on religions: some religious people who condemn same-sex sex as being a sin would probably ascribe to the view that infections such as HIV are a sign of God's punishment on people breaking religious laws. Health carers believing this, and acting on such a belief, may attempt to get homosexuals or bisexuals to repent of their way of life or face the consequences: be this HIV, AIDS or "eternal punishment". If your health care services are trying to respect all people equally, then such an imposition of a religious view on a client/patient, would be incompatible with respecting their own autonomy, whatever one's own personal beliefs. Many people would agree that the vulnerability attached to being ill should not be capitalized upon for winning converts to a particular way of life or belief.
Learning exercise 4

Using separate sheets of flipchart paper, write the words Bisexual Women, Bisexual Men, Heterosexual Women, Heterosexual Men, Homosexual Women, Homosexual Men, one on each flipchart. Then, ask students to write any words they have heard (even if they do not understand them) in two columns on each paper. One column says "What are they called", and refers to names used for the particular group of people, the second column says "What do they do sexually?" and looks at all the sexual practices ascribed to the group.

As teacher, it is important that you feel comfortable in facilitating such a session, as strong feelings or emotions may come out.

The exercise usually shows how five of the groups usually have far more derogatory terms than one other group (heterosexual men). Also, for sexual practices, the non-heterosexual groups usually attract the more exotic forms of sex, especially practices perceived as being somehow deviant or strange. However, the outcome is that anyone, in any group, can participate in the various sexual acts. The one exclusive act to heterosexual sex is penetrative intercourse / encirclement.

Plenty of time should be given to facilitate the expression of feelings around this exercise. It is also a very useful exercise to explore issues such as prejudice, discrimination, misinformation, broadening knowledge of sexual practices, identifying risky and safer sex practices, and identifying ways in which prejudice and misinformation may hinder the carer-client relationship.

Problems in the health care setting

This module, continuing on from Module 2, has looked at some of the various issues involved with same-sex sex. Hopefully, the learner will have expanded much of this general overview with examples from their own culture and society. The exercises have aimed at facilitating the learner's reflection on issues of homosexuality and bisexuality within the gamut of human sexual experience, in a way which has enabled them to identify areas detrimental to the holistic care of clients and the education of other learners.
Learning exercise 5

With students in groups of about 4-5, ask them to brainstorm on what they now consider to be the special, or characteristic, health care needs of:

- a man who self-identifies as being gay / homosexual;
- a woman who self-identifies as being lesbian / homosexual / gay;
- a woman who identifies as being heterosexual and married, while at the same time is having a secret sexual relationship with another woman; and
- a man who identifies as being heterosexual and married, while at the same time is having a secret sexual relationship with another man.

Specific problems in the health care setting care therefore be seen to include:

- lack of genuine understanding of people who have sex with partners of the same, as well as, in some cases, the opposite, sex;
- discriminatory practices against people identified as being homosexual or bisexual, e.g. from the legal system, religions and cultures, and the pathologizing of their conditions by certain health care professions;
- the frequent attempts at making homosexual and bisexual people seem invisible e.g. presuming that everyone is heterosexual; giving different rights and treatment to people who conform to a society's expected "norms";
- blaming homosexual men, and bisexual men and women, for the spread of HIV, and conversely, many heterosexuals believing that they are not at risk from infection because they are not homosexual or bisexual;
- various counselling needs for people who have experienced forms of discrimination and persecution;
• attitudes of health care staff which may be hostile or detrimental to the holistic care of clients/patients; and

• equal access to adequate health care services, and those which are specifically designed to meet the individual's presenting health care needs or deficits.

Incorporating sex-positive views of human development in the light of the wider environment of life, culture, society, religion and health care, are not always easy. There have been centuries of negativity towards sex and sexualities, which have resulted in the subjects being pathologized in the health care world. The challenge for the future will be enhanced by a more open and honest approach to people and practices which may differ greatly from those of the carer, and the society in which they live and work.
MODULE 5
TAKING A
SEXUAL HISTORY

General objective

On completion of this module the student will be able to take a sexual history from a person of either sex in a manner that is comfortable for both themselves and the client.

Learning outcomes

After completing this module, the student will be able to:

• ensure a comfortable and private setting for confidential history taking; and
• ask questions about sexuality in a sensitive, non-judgemental manner.

Learning activities

Introduction

Taking a sexual history is increasingly seen as an important skill for a healthcare professional to have. There are many reasons why this is so. AIDS is becoming more prevalent in every part of the world. Screening clients for risky sexual practices has become increasingly important. There is more general awareness of sexuality in most societies than there used to be. Televisions, films and magazines have brought sex out into the open. As a result, more people are concerned about sexual performance and sexual health than ever before. Clients may be more likely to ask questions about sexuality.
Although there is more acknowledgement that sexuality is a vital aspect of health, many health care professionals feel unskilled in communicating with clients about their sexual histories. Research in some countries among doctors identified the following three factors as reasons for their difficulties in taking sexual histories: embarrassment; a belief that sexual history is not relevant to the client's complaint; and a feeling of not being adequately trained for the task. These findings may relate to your own country and culture.

This module is designed to address these issues and equip health care providers with the skills and sensitivity needed to undertake this task in a comfortable and non-judgemental way.

### Why, when, and where is it appropriate to take a sexual history?

*Learning exercise 1*

Divide into three smaller groups and ask students to discuss the following questions:

- the reasons for taking a sexual history;
- when it would be appropriate to take a sexual history; and
- where it would be appropriate to take a sexual history.

Allow 15-20 minutes for this discussion and then ask each group to designate a student to report back to the full group. During the full group discussion, summarize on a large piece of paper or an overhead projector transparency (OHP) the responses from each of the three groups.

These discussions will highlight many of the central issues about sexual history taking. It is crucial that students feel confident that they understand the reasons for taking a sexual history and that they are convinced by them.
• Reasons they identify are likely to include the following:

• The main means available to prevent the spread of HIV is through health education;

• Talking to clients about sexuality may enable them to clarify misunderstandings and anxieties and change risky behaviours;

• Education about condom use and other safer sex practices may prevent the transmission of other sexually transmitted diseases;

• Unplanned pregnancies might be prevented;

• Genito-urinary problems may be identified;

• Psychosexual problems and concerns may be revealed;

• Through sensitive sexual history taking clients may be able to discuss problems they have, related to many different aspects of sexuality. It may give them the opportunity they have wanted, but have felt too embarrassed to ask for themselves, related to a wide variety of sexual concerns they have; and

• Appropriate referrals and information could be given that may otherwise have been missed, yet is of vital concern to the client.

It would be appropriate and legitimate to take a sexual history in more settings than many health care providers initially realize.

There is an argument for normalizing discussions about sex with our clients and not being unduly selective about whom we assume to be at risk from HIV, or indeed other sexually transmitted diseases or related problems. Virtually all health care providers have some remit to provide health education.¹

A sexual history is automatically taken in a genito-urinary medicine (GUM), family planning or abortion clinic. It could also usefully be taken in a travel clinic and when medication is given that may affect sexual performance, or when someone presents with vague symptoms that may conceal the underlying sexual problem. A sexual history should always be taken as part of initial screening, along with the medical and social history, as this places it centrally on the agenda as part of general health care.

The amount of detail that may be relevant will vary. A full history is automatically regarded as relevant in genito-urinary medicine departments or in family planning services. It may be more difficult, however, for people who have had a stroke to raise worries they have. Through the health care providers raising the matter first, they may receive help they felt too inhibited to ask for. By acknowledging sexuality as apart of holistic health care, and an important aspect of people's lives, much can be done to increase sexual health. A sexual history is an important component in building a complete picture of a client.

"When" and "where" also implies questions about the timing and setting of the history taking. The client and the health care provider must be comfortable and free from interruptions. Privacy and confidentiality are essential. Whatever the specific environment, the health care provider should aim to ensure as much privacy and safety as possible. A room with a closed door is best. It is essential to allocate sufficient time to allow for full answers and adequate time to respond to the information given. It is important not to leave the client half way through disclosing potentially painful and deeply personal details. Also, if the health care provider is distracted by competing demands, s/he will not be able to listen sensitively. If the health care provider knows s/he has only a limited amount of time available it is best to tell the client how much time they have and, if necessary, make another appointment.

Eventually, health care providers should feel able to discuss their client's sexual history with them at the initial meeting. In order to do this they must be sure of their reasons for taking a sexual history and confident of their own ability to respond in a non-judgemental manner. They must, therefore, be aware of their own sexuality and attitudes and values. Through exploring their own difficulties in talking openly about themselves they will be much more sensitive to what they are asking of clients.
Developing sensitivity

Learning exercise 2

This exercise is a kind of guided fantasy and sufficient time must be allowed between each question to allow the student ample time to imagine the situation and enter into their feelings and bodily experience while exploring the fantasy.

In a quiet classroom, ask the students to close their eyes and relax. Then take them through the following steps:

Imagine that you have been asked by a health care provider to give a full and detailed sexual history. You need to describe your sexual experiences in detail, including your sensations and emotions. How do you react to being asked to do this? Be aware of what happens in your body as well as in your mind.

Think of the other people in this room and of other health care providers you know. Who would it be easy and who would it be difficult to talk to about your sexual experiences and feelings? What is it about these people that helps or hinders disclosing this material? Would the gender, age, sexual orientation, religious or ethnic background make a difference and what would that difference be? What would you censor (i.e. not tell) and why? What would you need to know from the health care provider that might help to put you at ease?

Following this exercise, allow sufficient time for the students to slowly open their eyes and re-orientate to the reality of the classroom.

This exercise helps the students to appreciate how they might feel if they were the client. Their ability to empathize and be sensitive to others will develop through this identification. Learning will only take place if the exercise is processed thoroughly afterwards so that the relevant learning is made explicit. It is essential in setting up the exercise that students are not told whether they will be expected to tell each other the content of their histories or not afterwards as this will help them to enter into the feelings aroused more fully. In fact, they will not be expected to discuss the content of their histories but will focus on their thoughts and feelings about imagining being placed in that situation.
Doing this exercise can also highlight very directly the vulnerability clients may feel when asked about their sexual history. However, it is important to note that many will feel fine about it and be happy to answer questions. Additionally, this exercise can provoke a range of feelings, from resistance, anger and fear, to excitement and curiosity. It is precisely this anticipation of the potential strength and negativity of the feelings aroused that create anxiety for the health care provider when asked to take a sexual history. The need to be able to contain and feel comfortable with strong emotional responses is demonstrated in this way.

Through an exploration of what they would have censored, they will become aware of how much judgements by others are feared. Whether the censored material contains information that is about "sinful" and "guilty" pleasure, or is about things that feel too shameful and painful, it will be apparent that we expect others to make hostile judgements about us. What we imagine others will think about our sexual life (e.g. will they think it uninteresting and boring or strange and unusual?) will affect how truthful we are. The vital importance of being as open and non-judgemental as possible will, consequently, be manifestly obvious.

Afterwards, it is useful to have the students reflect on what they considered relevant to their own sexual histories and what they omitted as irrelevant. Does this reveal assumptions about what constitutes sexual experiences? In safer sex work, we often talk of broadening our whole understanding of sexual pleasure, yet how many people thought mainly of sexual experiences as those involving penetrative sex?

Questions of interpretation become obvious and therefore the importance of clarity in communication is revealed. Some people will think of sexual experience in a very narrow way while others may interpret it very broadly. Reflecting on this will help health care providers to be alert to the way apparently straightforward questions can be misleading. For example, when we ask how many sexual partners someone has had, it is possible that someone will regard a relationship that involved only kissing as a sexual relationship.
The difficulties in describing sex satisfactorily are also made apparent. Our vocabulary for talking about our sexual experiences is very limited, as other modules will have made clear. This is particularly so when we are trying to describe sensations and emotions.

Who we talk to also affects what we feel able to say. By asking students to reflect on whether the gender, age, sexual orientation, religious or ethnic background of the professionals they imagined talking to would make a difference they will become more sensitive to how these factors might get in the way of good communication. Although it is not possible to ensure someone has the "perfect match", it can help us to identify assumptions that are being made and often we can then set someone's mind at rest. For example, a woman who is a member of a religious faith which proscribes sexual activity outside of marriage may assume she is going to be judged harshly if she talks to another person with the same religious background and this could lead to a useful discussion about how she herself feels about her religion. It is important to note here that not everyone will react in the same way. What may be a barrier for one person may be much desired by another. One man may only feel comfortable talking to another man and another man may only feel comfortable talking to a woman. What is necessary is not to make sweeping assumptions but to be alert to picking up clues to discomfort.

Body language can give us these clues to awkwardness and embarrassment, not only in our clients but in ourselves. Being uncomfortable is understandable and does not mean that the interview should stop. Often laughing together and acknowledging the awkwardness can be enough to help both client and health care provider. Fears of being judged or thought silly are often at the heart of these reactions and highlights, yet again, the importance of being non-judgemental. Awareness of our own values and judgements paradoxically helps us to be non-judgemental to others.

As should by now be apparent, taking a sexual history may bring up very strong reactions and developing sensitivity is vital. It is precisely because health care providers fear these potential responses that they are anxious about taking sexual histories. Health care providers feel anxious that by asking intimate and personal questions clients will feel hostile and become aggressive. They may also feel that they will not be able to cope as clients become very distressed.
and talk about past or present sexual abuse, rape or painful sexual problems. Arguments about the necessity of sexual history taking will receive only token commitment unless these fears are discussed and ways of approaching them are explored.

This exercise will have, hopefully, raised these fears so that they can be discussed and ways of dealing with sensitive material explored.

**Boundaries**

Clarity about the importance of maintaining boundaries is an essential aspect of taking a sexual history. It is necessary to know what you feel comfortable and uncomfortable discussing and what your limits and boundaries are.

**Learning exercise 3**

Prior to this exercise, it may be useful for students to review the material in Modules 2 and 3. In small groups, brainstorm different expressions of sexuality. Write each of these on cards then each take a turn to place them on a continuum from very comfortable discussing to very uncomfortable discussing. The list in the box below gives examples but it is better for each group to generate their own as different cultures may come up with very different issues.

<table>
<thead>
<tr>
<th>male homosexuality</th>
<th>masturbation</th>
</tr>
</thead>
<tbody>
<tr>
<td>group sex</td>
<td>paedophilia</td>
</tr>
<tr>
<td>anal intercourse</td>
<td>female homosexuality</td>
</tr>
<tr>
<td>bisexuality</td>
<td>sexual abuse of children</td>
</tr>
<tr>
<td>visiting prostitutes</td>
<td>rape</td>
</tr>
<tr>
<td>oral sex</td>
<td>incest</td>
</tr>
</tbody>
</table>
Encourage the groups to talk about the issues that arise as they place each card. How would they feel about talking to someone about any of these? Which would be difficult and why? The more honestly they can explore how they might feel and what they would do if clients disclosed any of these activities the more they will feel prepared if issues are disclosed when taking a sexual history that present personal problems for them. Through this they will learn about their limits and can discuss how they could respond appropriately, and refer on skilfully, when they feel out of their depth.

Out of this exercise further training needs may become apparent so that they can extend the range they feel comfortable with and also learn more about how to deal with clients who become aggressive, distressed or traumatized. Regular supervision and peer support can help health care providers develop these skills. It is not necessary for them to be able to personally help everyone; that is not their task. What they can improve is their skill at referring a client to the appropriate place and increase their ability to offer initial support. Their role is to listen with as much sensitivity as possible. Often that is all that is needed. The client may not feel ready to get further help and that needs to be respected.

**Ethical and legal boundaries**

Boundaries also refers to the ethical and legal framework health care providers are working within. Confidentiality, for instance, is usually regarded as a pre-requisite for honest and frank discussions around sexuality. In order to feel secure, clients will need to know who will have access to written notes, how detailed these notes will be and what are the limits to confidentiality.

**Learning exercise 4**

Health care providers should find out the legal and ethical framework of the institution they are working within and should familiarize themselves with the laws relating to sexuality that apply to them.
Teaching modules for basic education in human sexuality

The laws relating to sexuality vary so enormously that it is not possible to discuss these here. It is important that once students know their ethical and legal code of practice they then think through how they would respond to problematic ethical issues. Ethical and legal issues can look deceptively clear-cut when, in practice, they can be complex and upsetting.

Learning exercise 5

Once you have a thorough understanding of your own ethical and legal guidelines, discuss in groups possible scenarios where you would feel obliged to take action and work out (a) what you would do and (b) how you would feel about doing this. The following examples are included to give some starting points.

- A 15 year old boy tells you he is selling sex for money.
- A 17 year old girl tells you she was sexually abused by her uncle for years and never told anyone. He does not abuse her now.
- A 24 year old woman tells you that a colleague of yours has been sexually harassing her on the ward.
- A 30 year old man tells you he likes to have sex with 12 year old boys. He assures you he would never have sex with the boys unless they consented.
- A 45 year old woman reveals extensive injuries which she tells you is the result of the sado-masochist sex she enjoys.

Discuss these fully so that you have a better idea about how you would act and how you would feel about this. It is not necessary to reach a consensus. By their very nature ethical issues present dilemmas which have no right answers. Report back to the full group and share problems and solutions.
Language

Issues related to language will have been raised in other modules but it is worth some re-examination in this context as health care providers must be able to discuss sex with clients clearly and simply.

Learning exercise 6

In small groups, each person must explain a sexual practice to the others. The others should pretend they do not understand and should keep asking questions until they feel satisfied with the explanation.

This exercise gives rise to much laughter and embarrassment but students become much better at describing sex much more simply and directly. It becomes apparent how ambiguous and imprecise language related to sex can be and how open therefore to misunderstandings. Assumptions that clients know what we are talking about are revealed and health care providers develop greater sensitivity to potential miscommunications.

Questioning

Learning exercise 7

In pairs, have each student ask the other closed questions, and then open questions, about a general topic that is non-threatening, such as holidays, shopping or television. They could also experiment with asking the questions in different tones of voice, e.g. offhand, indifferent, overly curious.

Closed questions lead to a one word, phrase or yes/no answer whereas open questions invite further explorations.

Afterwards each pair should explore the effect on them of being asked closed or open questions and how the tone adopted affected them.
It is not that closed questions are wrong. In certain instances they are essential. When someone requests the morning-after pill, very specific answers are required. But often, more open questions lead to greater exploration and depth and are felt as less invasive and threatening. They encourage more personal disclosure and help to develop a relationship where the client feels there is going to be space for them to be listened to. The invitation to talk and be listened to sensitively by an interested but non-intrusive health care provider may enable clients to open up about areas of concern they have never before felt able to.

**Assumptions**

*Learning exercise 8*

In small groups, discuss your assumptions about the sexual beliefs, values and practices of the following "people" in the box below.

<table>
<thead>
<tr>
<th>married woman</th>
<th>married man</th>
</tr>
</thead>
<tbody>
<tr>
<td>catholic priest</td>
<td>thirteen year old girl</td>
</tr>
<tr>
<td>fifteen year old boy</td>
<td>transvestite</td>
</tr>
<tr>
<td>lesbian</td>
<td>bisexual man</td>
</tr>
<tr>
<td>sixty six year old woman</td>
<td>homosexual man</td>
</tr>
<tr>
<td>a man in prison</td>
<td>unmarried women</td>
</tr>
</tbody>
</table>

It is important to realize that we all make assumptions. What we need to explore is how these assumptions might influence the way we would take asexual history. Would we feel able to keep to a standard set of questions for all these people and if we changed the questions we asked each person might we miss relevant information? Explore these issues in the group. Ask yourselves how each of these people might respond to being asked to give a sexual history.
Sexual history

Initial screening

Whether the screening history is part of a full medical history, or asked alone, the practitioner should start with an explanation to put the patient at ease (see previous section). Have models, diagrams and pictures ready and proceed in a confident manner.

The purpose of a screening interview is simply to find out whether or not the patient has any sexual problems or concerns, and to open the topic of sexuality for exploration. The screening questions may lead to more complete histories.

The following questions, or variations of these will give a good basic start to a sexual history.

1. "Are you sexually active?"
   [If no:] "When were you last sexually active?"
   [If a time is given: Go on to question 2.]
   Also: "Is this satisfactory?"
   Explore
   [If never:] "Is this satisfactory?"
   [If no:] Explore
   [If yes:] Ask about future plans
   [If yes:] Go to question 2.

2. Do you have any discomfort or difficulties in your sexual activities?
   [If yes:] Do these bother you?
   [If yes:] Explore
   [If no:] Go to question 3.
3. How many sexual partners have you had?
   [If one or none:] Go to question 4
   [If more than one:] "How many? When?"
   Then go on to question 4.

4. "Do you have any pain in or discharge from your sexual parts (genitals)?"
   [If no:] Go to question 5.
   [If yes:] Get a history, then go to question 5.

5. "Do you have any sores on or itching of your sexual parts (genitals)?"
   [If yes:] Get history

6. "Have you ever had a sexually transmitted disease?"
   [If yes:] Get history

The answers to these questions will not provide a complete sexual history but will give patients permission to talk about any problems related to sex that may have been concerning them. Some answers may alert you to problems which can be explored more thoroughly later.

Learning exercise 9

Discuss these questions and reflect upon your responses to them. Bear the following considerations in mind as you think of how you might feel about using them.

It is a good idea to start from the easiest questions as these are likely to be felt as less intrusive. Move gradually to the more sensitive and private areas. By structuring the interview in this way it is possible for the health care provider to note the responses of the client and alter their own responses accordingly.
It is important to note that expressions of discomfort or anger should not necessarily lead the health care provider to stop the interview. Sometimes, of course, that would be appropriate, but if the information is essential it may be vital to continue as sensitively and flexibly as possible. Questions as to the importance of the sexual history will be crucial considerations here. It is essential at all times that the health care providers feel clear about the reasons for taking the history and the legitimacy of each of their questions. The more certain they are that it is a legitimate and worthwhile aspect of general health care the more confident they will be and the more able to convince the client and explain their reasons. Most clients respond to this. If the health care providers are not convinced themselves of the legitimacy of their questions they are unlikely to get a positive response.

Each question needs to be looked at in turn and the health care provider needs to know why it is being asked. One way of explaining the legitimacy of the questions is through the use to which the information can be put. For instance, knowing a woman has had penetrative anal as well as vaginal intercourse will inform physical examinations and safer sex advice.

The questions should not make assumptions about the gender of the partner or about the sexual practices taking place. Similarly, questions such as “How many times a week do you have sexual intercourse?” may lead to anxieties about appearing "normal" and inhibit truthful answering. The terms used in the questions should be ones the health care providers feel comfortable with and they should feel sufficiently familiar with them to explain them to a client.

It is worth developing guidelines that you feel comfortable with. These need not be rigidly adhered to but provide a useful structure so that it is clear when health care providers expect to take a sexual history, what they will ask, who they will ask and where. This places sexual history taking firmly on the agenda as a routine aspect of general health care for everyone. It also provides a memory aid so that all the relevant information will be included every time.
Taking a "complete" sexual history

All the considerations noted above apply. In taking a more complete history, the context will be relevant and will change the focus and purpose of the questions.

Women are more likely to be in situations where sexual histories are seen as appropriate, for instance, while attending a family planning service. Opportunities for discussions with men need to be explored.

The following questions by Ross, adopted for (a) women and (b) men, are provided for you to examine. Use these as starting points to develop guidelines related to what is relevant and appropriate in your setting.

Women

It is relatively easy to start a sexual history with women because taking a menstrual and obstetric history is a good starting point, and can be easily recognized as an essential part of a medical history. There are ways of asking the questions, however, which may elicit more information and open the door to freer talking about sexual matters. Here are some suggested questions for a menstrual history:

1. "How old were you when your periods started?"
2. "How well prepared were you for the start of your periods?"
3. "How did your parents talk to you about your periods?"
4. "How did they act about sexual matters?"
5. "Can you remember how you felt when your periods started?"
6. "Have you ever had any difficulties with your periods?"
7. "If you are still having periods, how regular are they?"
8. "If you are not still having periods, can you tell me what happened before they finally stopped?"
It is then usually natural and comfortable to move on to asking about the obstetric history. These questions are useful:

1. "How many times have you been pregnant?"
2. "Can you tell me what happened with each pregnancy?"

It is then easier to move on to a history of sexual intercourse:

1. "Tell me what happened the first time you had sexual intercourse."
2. "How did you feel about it at the time?"
3. "What was your physical response like? Orgasm?"
4. "Tell me about your experiences after that."
5. "What happened the first time you masturbated?"

The answers to these questions can then lead to more exploration of sexuality. The patient may say the first time was with her husband after their wedding. Or she may tell you that she has never had sexual intercourse and prefers to have sex with other women, or that her first sex was with a male relative who forced himself on her. Be prepared for many different kinds of answers, and open to exploring these answers more deeply. You might then move on to questions on the current sexual relationship for those who are sexually active with one partner:

1. "How did you meet your current partner?"
2. "What happened physically between you in the early stages of the relationship?"
3. "What happened when you first had sexual intercourse with this partner?"
   Emotional and sexual responses? Contraception?
   Situation? Who decided to have intercourse?"
4. "What sort of person is your partner?"
5. "How is the relationship going?"

Once again, the answers to these questions can lead to many areas for deeper exploration. For those with multiple sexual partners, the following questions on sexual behaviours are valuable. They should also come next for those with one partner:

1. "Tell me about you current pattern of sexual activities? Partners, emotional involvement"
2. "About how often do you have sexual intercourse or have sex with a partner? Does this suit you? Your partners?"
3. "About how often do you reach climax (have an orgasm, come) when making love? If you do not climax, do you fake it? What are your reasons for that?"
4. "Do you have any problems with lubrication?"
5. "What form of contraception (birth control) do you use? Is it satisfactory to you and your partners? Do you need to use birth control?"
6. "What protection against sexually transmitted diseases do you use?"
7. "Have you had any problems getting pregnant? Have you investigated this further?"
8. "How often do you masturbate?"
9. "What other kinds of sexual activities do you engage in?"
10. "What is your level of satisfaction with your current sexual activities?"
Obviously not every question is appropriate for every patient. For instance, for a patient who is lesbian and never has sex with men, the questions about intercourse and birth control would not be necessary. These questions should be adapted for each person on an individual basis.

When sexual problems are brought up, they should be thoroughly explored within the limits of the practitioner's ability and comfort. Sometimes giving limited information and permission is all a patient needs. When more is needed, the patient should be referred to the appropriate specialist when possible.

Finally, ask the patient if there is anything of concern to her which has not been discussed. Does she have any more questions? Then be sure she knows she can come back or call if she has further concerns or questions.

Men

It may be more difficult to start a sexual history with a man, since there is no easy topic to begin with like menstruation. Beginning with a short preface and the basic screening history is always safe. Then it will be more comfortable to go on to explore early sexual history:

1. "What did you learn about sex in your early family life?"
2. "How did your parents express affection to you? To each other?"
3. "What did you learn about sex in school?"
4. "How did you feel about discussing sexual matters with your parents?"
5. "Tell me about the first time you had a wet dream (nocturnal emission). Your reaction. Your parents reaction."
6. "Tell me about the first time you masturbated."
7. "When was the first time you had sexual activities with a partner? What feelings did you have? How did your partner react?"
When the earlier sexual history has been explored, further intercourse history can be pursued. The questions are the same as for women. Then you can move on to questions on current sexual relationships and sexual behaviours:

1. "About how often do you have sexual activities with a partner? How does that suit you? Your partner(s)?"
2. "Do you ever have sex with other men? How often? How do you feel about it?"
3. "Do you have any problems getting or maintaining an erection? For how long? How does your partner react? What is the situation? How do you feel about it?"
4. "After you insert your penis, how long does it take before you ejaculate (come, have an orgasm)? Is this satisfactory to you? To your partner?"
5. "How do you think your partner(s) feels about sexual intercourse? Foreplay? Orgasm?"
6. "What form of birth control (contraception) do you use? Is this satisfactory to you? Your partner(s)?"
7. "What do you use to prevent sexually transmitted diseases?"
8. "How often do you masturbate?"
9. "What other kinds of sexual activities do you engage in?"
10. "What sort of person is your partner?"
11. "When you are having any sexual difficulties, how do you respond? How does your partner respond?"
These questions must be adapted for each individual. It is important to be sensitive to your patient's reactions to these questions. If he seems particularly uncomfortable, it may be helpful to repeat the preface, explaining that sexual history is important to overall health care. It also may be helpful to reassure the patient that many men have sexual problems, most people are uncomfortable talking about sex, or it is perfectly appropriate to talk about any sexual concerns he may have to you at this time.

This history may uncover sexual dysfunction. Remember that erectile dysfunction and premature ejaculation are quite common. General relationship problems may also be brought up. Often patients may only need limited information or permission in order to deal effectively with their problems. If the problems are extensive, or if you are not experienced or comfortable with your ability to help, it is good to know where to refer him for help.

*What happens next?*

When you have taken a sexual history, it is important to have already considered how you are going to record the information and who will have access to it. The confidentiality of the information is essential and the limits to this need to be clarified.

If problems are revealed, which cannot be dealt with by the health care provider-s/he must know places to refer the client to and how the referral is made. Health care providers need to build up a knowledge of local agencies that could be of help.
How to respond

The "PLISSIT Model for Sexual Health Intervention" is included here as it is a useful and easy to use guide for responding to clients when you have taken a sexual history.

The PLISSIT Model for Sexual Health Intervention

The letters of the PLISSIT model stand for:

- Permission to talk about, think about and enjoy sex;
- Limited
- Information
- Specific
- Suggestions
- Intensive
- Therapy
This model offers four levels of sexual health counselling; it encourages nurses to intervene at the level at which they feel comfortable. The four levels are described as follows:

- **Give Permission.** Convey to the client or relatives that you are willing to discuss sexual thoughts and feelings. You might ask: "Have you experienced, or do you expect to experience, a problem with sexual functioning because of your condition?"

- **Offer Limited Information** on the implications of, for example, being pregnant, having cancer or being prescribed a particular medication.

- **Make Specific Suggestions.** Provide specific instructions that facilitate positive sexual functioning, such as coital positions for women with arthritis.

- **Provide Intensive Therapy.** Clients needing this type of approach should be referred to nurses with advanced knowledge of sex therapy, or to specialist therapists. Surgical interventions, such as penile implant, may be necessary in some cases.

**Learning exercise 10**

In small groups, generate examples of possible sexual histories. Use the PLISSIT model to help you to work out how you might respond appropriately.

Doing this with both "easy" and "difficult" clients will build confidence that the health care providers can deal skilfully with clients needs. The usefulness of taking a sexual history will also be reinforced through the accumulated evidence of its potential benefits to clients.
Summary points

Upon completion of this module, students should check through the following questions in the box below to evaluate their ability to take a sexual history in a confident, sensitive and non-judgemental manner:

- Who would you take a sexual history from?
- When would you take a sexual history?
- What reasons would you give for taking a sexual history?
- Do you feel able to communicate effectively about sex?
- Are you aware of the ethical and legal boundaries and how these would affect you?
- Do you have specific guidelines that you feel confident you could use?
- Do you know where you will record the information given, who has access to it and how the information would be used?
- Do you know local referral agencies able to offer more specialist help?
- Do you know your own boundaries and limitations?

Finally, students should consider whether they require further information and/or training and how they could go about getting needs identified here met.
<table>
<thead>
<tr>
<th><strong>GLOSSARY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abortion</strong></td>
</tr>
<tr>
<td><strong>Adolescence</strong></td>
</tr>
<tr>
<td><strong>Adultery</strong></td>
</tr>
<tr>
<td><strong>AIDS</strong></td>
</tr>
<tr>
<td><strong>Amenorrhoea</strong></td>
</tr>
<tr>
<td><strong>Ampulla</strong></td>
</tr>
<tr>
<td><strong>Anilingus</strong></td>
</tr>
<tr>
<td><strong>Anaphrodisiac</strong></td>
</tr>
<tr>
<td><strong>Androgens</strong></td>
</tr>
</tbody>
</table>
### Anti-androgens
Drugs that inhibit the action of androgens.

### Aphrodisiac
A substance that arouses sexual desire.

### Areola
The dark circle surrounding the nipple.

### Artificial insemination
Introduction of semen into the vagina or uterus to induce conception, using means other than sexual intercourse. AID is artificial insemination by a donor; AIH is by the husband/partner.

### Bartholin's glands
Two small glands just inside the vaginal opening.

### Bartholin's cyst
Cyst on Bartholin's gland (can become infected and painful).

### Bisexual
Frequently refers to a person who is attracted to (and has sex with) persons of both sexes.

### Brothel
A place where sex workers work.

### Candida albicans
A fungus or yeast normally present in the vagina. Excessive amounts cause vaginal irritation.

### Castration
Removal of the testes or ovaries.

### Cavernous bodies
Areas of erectile tissue in the penis and clitoris that engorge with blood during sexual arousal.

### Celibacy
Literally meaning being single, i.e. not married. It implies that the celibate person does not have sexual relations with another. A person may be celibate for various reasons, including: religious faith and practice (e.g. nuns, monks and priests of certain religions); separation from a partner; not having met the 'right' person yet; or through fear of sex or contracting sexually transmitted diseases. Some of these reasons may be perceived to be positive contributions towards the individual's life, others (such as fear), may be detrimental to the sexual and psychological health.

### Cervix
The neck of the uterus.

### Chancre
A sore that develops at the site of infection with syphilis.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chastity</td>
<td>Literally, remaining sexually pure, in thought, word and deed. Chastity is often seen to be a religious virtue. Abstention from sexual activity.</td>
</tr>
<tr>
<td>Cilia</td>
<td>Hair-like Structures that line the inside of various body Structures, including the fallopian tubes and vas deferens.</td>
</tr>
<tr>
<td>Circumcision</td>
<td>Removal of the foreskin in the male (see also Female genital mutilation).</td>
</tr>
<tr>
<td>Clitoral hood</td>
<td>The skin at the junction of the labia minora that protects the clitoris.</td>
</tr>
<tr>
<td>Clitoris</td>
<td>A highly sensitive organ in the vulva that heightens sexual response.</td>
</tr>
<tr>
<td>Cohabitation</td>
<td>Literally, living with another person; usually implying a sexual relationship (with or) without marriage.</td>
</tr>
<tr>
<td>Coitus</td>
<td>Latin for penetrative intercourse (usually penis-Vagina)</td>
</tr>
<tr>
<td>Coitus interruptus</td>
<td>A Latin term which usually refers to a man with drawing his penis from a woman's vagina prior to ejaculation, usually as a form of contraception. However, coitus interruptus is an exceptionally, unreliable form of contraception (as the man may be oozing semen and sperm throughout most of the sexual encounter); it also means that STDs and HIV can be passed this way; it can cause pelvic congestion in the woman, and it is frequently found to be psychologically unsatisfactory for both partners. Coitus interruptus is described in the Book of Genesis in the Hebrew Scriptures/Christian Old Testament as performed by a man called Onan, hence &quot;onanism&quot;, which is now inaccurately applied to masturbation.</td>
</tr>
<tr>
<td>Condom</td>
<td>See Prophylactic.</td>
</tr>
<tr>
<td>Contraception</td>
<td>Prevention of conception using techniques, devices or drugs.</td>
</tr>
<tr>
<td>Term</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Corpora cavernosa</td>
<td>See Cavernous bodies</td>
</tr>
<tr>
<td>Corpus spongiosum</td>
<td>See Spongy body</td>
</tr>
<tr>
<td>Corpus luteum</td>
<td>Yellowish body found in the ovary after rupture of a Graafian follicle. The corpus luteum secretes progesterone to prepare the uterine lining for implantation of the fertilized ovum.</td>
</tr>
<tr>
<td>Cowper's glands</td>
<td>Two pea-sized glands that secrete an alkaline fluid into the urethra during sexual arousal in the male.</td>
</tr>
<tr>
<td>Cremaster muscle</td>
<td>A thin layer of muscle along the spermatic cord that lifts the testicles when contracted.</td>
</tr>
<tr>
<td>Cremasteric reflex</td>
<td>Involuntary contraction of the cremaster muscle caused by stroking the inner thigh.</td>
</tr>
<tr>
<td>Crura</td>
<td>The connections between the cavernous bodies and the pubic bones.</td>
</tr>
<tr>
<td>Culture</td>
<td>Behavioural and psychological characteristics shared by a particular society.</td>
</tr>
<tr>
<td>Cunnilingus</td>
<td>Licking or tonguing the clitoris and vulva. (Also called oral sex, and has many local names).</td>
</tr>
<tr>
<td>Cystitis</td>
<td>Inflammation of the bladder or urethra characterized by discomfort during urination.</td>
</tr>
<tr>
<td>Dental dam</td>
<td>A small square of latex rubber (or substitute, such as a condom split open, or plastic food-wrap) put over the clitoris and labia, or anus, for oro-genital/ oro-anal licking (see anilingus and cunnilingus ).</td>
</tr>
<tr>
<td>Date rape</td>
<td>A term gaining increasing recognition in legal circles, signifying the non-consensual penetrative intercourse (vaginal or anal) by a person or persons known to the victim (e.g. someone 'dating' or 'courting' the person raped).</td>
</tr>
<tr>
<td>Differentiation</td>
<td>The development of male or female sex organs in the fetus.</td>
</tr>
<tr>
<td>Digital sex/contact</td>
<td>Sex play involving fingers or toes. These may be inserted into the vagina, anus or mouth for sexual stimulation.</td>
</tr>
</tbody>
</table>
Dildo A phallic (penis-like) object, usually used for sexual stimulation by inserting it into the vagina or rectum. Dildoes are frequently made to look like real penises (even if the size is somewhat exaggerated!). Similarly, a vibrator is a phallic object with batteries and a motor, to give motorized stimulation to the recipient. Substitutes are found by using all sorts of similar-shaped objects (e.g. bananas, courgettes/ zucchini, and cucumbers), or those with obvious dangers, such as glass bottles, other breakable objects, or objects which might get lost inside (especially the rectum).

Douche Washing out the vagina or rectum, with clear water or a particular solution, usually for reasons of hygiene and before or after intercourse/ encirclement. This procedure is now thought to be detrimental to sexual health for a few reasons: it alters the pH balance of the vagina, thus predisposing the woman to certain STDs; if done rectally, it changes the natural flora of the bowel, again, predisposing to certain STDs; and it may cause slight trauma to otherwise intact mucosa.

Ductus deferens See Vas deferens

Dysmenorrhea Pain or discomfort associated with menstruation.

Dyspareunia Pain or discomfort during intercourse.

Ejaculation Expulsion of semen out of the penis.

Ejaculatory ducts Two short ducts in the prostate gland.

Ejaculatory inhibition Inability of a male to ejaculate inside the vagina.

Emission phase The first stage of male orgasm in which seminal fluid collects in the urethral bulb.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encirclement</td>
<td>Vaginal (or anal) encirclement of a penis; emphasizing the role of the active participant in what is called ‘penetrative intercourse’ when the active partner is the male insertor.</td>
</tr>
<tr>
<td>Endocrine system</td>
<td>System of glands that secrete hormones directly into the bloodstream.</td>
</tr>
<tr>
<td>Endometrium</td>
<td>The mucous membrane that lines the uterus. Epididymis Structure attached to each testis that stores sperm. Erectile inhibition Inability of a man to achieve erection in response to sexual stimulation.</td>
</tr>
<tr>
<td>Erection</td>
<td>Increase in size of the penis or clitoris due to engorgement with blood.</td>
</tr>
<tr>
<td>Erogenous zones</td>
<td>Areas of the body that respond to sexual stimulation.</td>
</tr>
<tr>
<td>Estrogen</td>
<td>A class of hormones responsible for the development of secondary sex characteristics and regulation of the menstrual cycle in females, and the inhibition of spermatogenesis in males.</td>
</tr>
<tr>
<td>Estrogen replacement therapy (ERT)</td>
<td>Supplementary estrogen given to alleviate the symptoms of menopause.</td>
</tr>
<tr>
<td>Excitement phase</td>
<td>Masters and Johnson’s term(^1) for the first phase of the sexual response cycle, marked by engorgement of sexual organs and raised muscle tension, heart rate, and blood pressure.</td>
</tr>
<tr>
<td>Exhibitionism</td>
<td>The sexual meaning of this word refers to the act of exposing one’s genitals to another, for sexual excitement and gratification.</td>
</tr>
<tr>
<td>Fallopian tubes</td>
<td>Two tubes that extend from the uterus to the ovaries.</td>
</tr>
</tbody>
</table>

\(^1\) Masters WH and Johnson YE. *Human sexual response.* Bantam, 1981.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fellatio</td>
<td>A Latin term for sucking or licking a penis (also called &quot;oro-genital stimulation&quot; and has many local names).</td>
</tr>
<tr>
<td>Female genital</td>
<td>Includes removal of the clitoris (clitoridectomy); removal of the clitoris and labia minora; and removal of the clitoris, labia minora and inside surfaces of the labia majora (infibulation). Sometimes incorrectly referred to as female circumcision.</td>
</tr>
<tr>
<td>mutilation</td>
<td></td>
</tr>
<tr>
<td>Fetishism</td>
<td>Extreme sexual interest in an inanimate object or a part of the body.</td>
</tr>
<tr>
<td>Fimbriae</td>
<td>Fringe-like ends of the fallopian tubes which collect the released ovum.</td>
</tr>
<tr>
<td>Follicle</td>
<td>Stimulating hormone (FSH) -a pituitary hormone that stimulates the development of ovarian follicles in the female and sperm production in the male.</td>
</tr>
<tr>
<td>Forceps</td>
<td>Instruments used to assist delivery when the baby is at risk, for instance after prolonged second-stage labour.</td>
</tr>
<tr>
<td>Foreplay</td>
<td>The concept that all sexual contact (oral, manual or mechanical) prior to penetrative intercourse/encirclement is simply a means-to-an-end, i.e. leading up to penetration/encirclement.</td>
</tr>
<tr>
<td>Foreskin</td>
<td>Skin that covers the penile or clitoral glans.</td>
</tr>
<tr>
<td>Fornication</td>
<td>Pejorative term for coitus between unmarried people.</td>
</tr>
<tr>
<td>Fourchette</td>
<td>Skin fold at the posterior of the vaginal vestibule.</td>
</tr>
<tr>
<td>Frenulum</td>
<td>See Frenum</td>
</tr>
<tr>
<td>Frenum</td>
<td>A thin, highly sensitive fold of skin that connects the foreskin to the underside of the penile glans.</td>
</tr>
<tr>
<td>Frottage</td>
<td>Rubbing one’s genitals against another person (body rubbing) for sexual gratification. This may be either consensual, or non-consensual, e.g. when someone rubs their genitals against another person in a crowded place, such as a bus or train.</td>
</tr>
<tr>
<td>Term</td>
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</tr>
<tr>
<td><strong>Fundus</strong></td>
<td>The top portion of the uterus.</td>
</tr>
<tr>
<td><strong>Gay</strong></td>
<td>An old term for a homosexual (usually male) who identifies with an open gay culture or 'scene' (female homosexuals frequently prefer the term lesbian). This term has been popularized in many parts of the world since the late 1960s, often used with gay liberation, gay rights, and gay lifestyle (bars, holiday resorts, restaurants, etc.)</td>
</tr>
<tr>
<td><strong>Genital herpes</strong></td>
<td>A viral infection in the genito-anal region caused by the herpes simplex virus (HSV) type 2. The virus can lay dormant for periods of time (even years), erupting sporadically into tiny blistering lesions which can exude infectious viral particles. (Note: HSV 1 is the virus which usually causes oral herpes, often called the 'cold sore'; this common condition is not usually considered to be sexually related).</td>
</tr>
<tr>
<td><strong>Genitals</strong></td>
<td>Or genitalia: the sex organs.</td>
</tr>
<tr>
<td><strong>Gender identity</strong></td>
<td>Perception of oneself as either male or female.</td>
</tr>
<tr>
<td><strong>Genital tubercle</strong></td>
<td>The part of a fetus that develops into the external genitals. It is undifferentiated prior to six weeks of age.</td>
</tr>
<tr>
<td><strong>Gigolo</strong></td>
<td>Male sex worker who services women.</td>
</tr>
<tr>
<td><strong>Glans</strong></td>
<td>The highly sensitive head of the penis or clitoris.</td>
</tr>
<tr>
<td><strong>Gonads</strong></td>
<td>Testes or ovaries.</td>
</tr>
<tr>
<td><strong>Gonadotropin-releasing factors</strong></td>
<td>Substances produced by the hypothalamus that stimulate the pituitary to produce gonadotropins. Gonadotropins Pituitary hormones that influence the gonads.</td>
</tr>
<tr>
<td><strong>Gonorrhea</strong></td>
<td>A sexually transmitted disease that initially inflames the mucous membranes of the reproductive system. Graafian follicle A cyst in the ovary that contains a maturing ovum.</td>
</tr>
<tr>
<td><strong>Group sex</strong></td>
<td>Having sex with more than one person at a time, or at least in the company of others (e.g. an orgy).</td>
</tr>
</tbody>
</table>
GUM
Genito-urinary medicine; the branch of health care which includes caring for people with sexual health needs, such as sexually transmitted diseases, including HIV infection and disease.

Gynaecology
The health care speciality for caring for specific issues related to women’s sexual and/or reproductive health.

Hennaphroditism
Presence of biological characteristics of both sexes.

Herpes
See Genital herpes.

Heterophobia
A compound from the Greek words meaning "a fear of the opposite (sex)" (see also: misogyny)

Heterosexism/heterosexual
Usually means favouring heterosexuality or heterosexuals, and implies an element of homophobia.

Heterosexual
A person sexually attracted to members of the opposite sex.

HIV
Human immunodeficiency virus. This term was adopted in mid-1986 as the name for the virus which causes AIDS. It distinguishes the virus causing AIDS from other retroviruses and indicates an independent species. The virus previously was referred to as HTLV-III (Human T Cell Lymphotropic Virus, Type Three) LAV (Lymphadenopathy Associated Virus), and ARV (AIDS-related retrovirus). It renders the human immune system deficient and unable to resist opportunistic infections and the development of cancers.

Homophobia
A compound from the Greek words meaning "a fear of the same (sex)"; usually used to imply hatred and abuse (e.g. so-called "Queer" bashing) of homosexual people. Homophobia may be found in derogatory remarks towards homosexual people, as well as in institutionalised discrimination and other forms of unequal treatment and discrimination.
<table>
<thead>
<tr>
<th>Term</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Homosexual</td>
<td>A person sexually attracted to members of the same sex.</td>
</tr>
<tr>
<td>Hormones</td>
<td>Chemical substances produced in various parts of the body that influence specific target organs.</td>
</tr>
<tr>
<td>Human chorionic gonadotropin (HCG)</td>
<td>A hormone that helps to maintain the initial stage of pregnancy by increasing progesterone secretion by the ovary.</td>
</tr>
<tr>
<td>Hustlers</td>
<td>A term referring to male sex industry workers or sex workers. It may imply that the 'hustler' has sexual relations with men or women, and its meaning may change in different countries or cultures. In some countries, the term 'rent boy' is used.</td>
</tr>
<tr>
<td>Hymen</td>
<td>The membrane that partially or completely covers the vaginal opening. It is sometimes torn or broken when a virgin girl or woman has her first penetrative intercourse/encirclement, but can also be done on inserting objects into the vagina such as tampons, and spontaneously upon strenuous exercises etc. The virgo intacta (intact virgin) is often highly sought after and prized in many cultures, hence, some 'vaginal' virgins may have other forms of sex (e.g. oral, anal or manual) so as not to have vaginal intercourse before their wedding. This has major implications for understanding safer sex and sexual practices; also, with such wide use of tampons for menstruation, the absence of the hymen cannot be taken as proof that the woman has &quot;lost her virginity&quot; (i.e. had vaginal penetrative intercourse with a man).</td>
</tr>
<tr>
<td>Hypothalamus</td>
<td>The part of the brain that regulates several processes, including the reproductive functions.</td>
</tr>
<tr>
<td>Hypothalamic-releasing factors</td>
<td>Chemicals secreted by the hypothalamus that stimulate hormone production in the pituitary.</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>The surgical removal of the uterus.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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</tr>
<tr>
<td>Imperforate hymen</td>
<td>A hymen that completely seals the vaginal opening.</td>
</tr>
<tr>
<td>Impotence</td>
<td>See Erectile inhibition.</td>
</tr>
<tr>
<td>Incest</td>
<td>Sexual relations (usually including penetrative intercourse) with members of one’s own family, either those too close for a legal marriage (e.g. father and daughter; brother and sister; ‘close’ blood cousin, etc.) or, less frequently, relatives of the same sex. This raises major issues about such relationships, frequently centring around the sexual abuse of one of the participants.</td>
</tr>
<tr>
<td>Inguinal canal</td>
<td>The canal in the groin through which the testicles descend to the scrotum during fetal development.</td>
</tr>
<tr>
<td>Interstitial cells</td>
<td>Testosterone-producing cells located between the seminiferous tubules.</td>
</tr>
<tr>
<td>Interstitial-cell-stimulating-(ICSH)</td>
<td>A hormone secreted by the pituitary gland that stimulates testosterone production in the interstitial hormone cells.</td>
</tr>
<tr>
<td>Introitus</td>
<td>The opening to the vagina.</td>
</tr>
<tr>
<td>Intromission</td>
<td>Insertion of the penis into the vagina.</td>
</tr>
<tr>
<td>Kegel exercises</td>
<td>Exercises that strengthen the muscles underneath the external genitalia.</td>
</tr>
<tr>
<td>Labia majora</td>
<td>The outer lips of the vulva.</td>
</tr>
<tr>
<td>Labia minora</td>
<td>The inner lips of the vulva.</td>
</tr>
<tr>
<td>Lactobaccili</td>
<td>Bacteria normally present in a healthy vagina.</td>
</tr>
<tr>
<td>Lesbian</td>
<td>Female who has sex with another/other female(s). The word is originally from the island of Lesbos, where the whole community comprised women. The ancient leader of this all-women community was Saphos.</td>
</tr>
<tr>
<td>Leucorrhoea</td>
<td>A vaginal discharge characteristic of several infections.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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</tr>
<tr>
<td>Leydig's cells</td>
<td>See Interstitial cells.</td>
</tr>
<tr>
<td>Libido</td>
<td>Sexual motivation.</td>
</tr>
<tr>
<td>Limbic system</td>
<td>A subcortical brain system that influences sexual behavior.</td>
</tr>
<tr>
<td>Luteinizing hormone (LH)</td>
<td>Pituitary hormone that stimulates ovulation in the female and production of androgens in the male (where it is known as ISCH).</td>
</tr>
<tr>
<td>Male rape</td>
<td>A term signifying non-consensual anal penetration of one man by another/others. Such a practice has often been denied any legal recognition, although there are now advances in the law in many countries, to actually recognize it for what it is.</td>
</tr>
<tr>
<td>Masturbation</td>
<td>Stroking and manually stimulating the clitoris, in the woman, or penis, in the man, usually to the point of orgasm or ejaculation. There are many local, often derogatory, terms for it.</td>
</tr>
<tr>
<td>Menarche</td>
<td>See menstruation.</td>
</tr>
<tr>
<td>Menopause</td>
<td>See menstruation.</td>
</tr>
<tr>
<td>Menstruation</td>
<td>The periodic discharge (usually of a cyclic nature, e.g. every 3-4 weeks) of the non-pregnant uterine lining, in the form of blood passing via the vagina. It starts in girls about 9 years old in some cultures, though is frequently a few years later in others (e.g. with the full onset of puberty in the early teens). Its commencement is called the menarche; it finishes with the menopause frequently in the woman's later 30s through to early 50s, or with surgical removal of the ovaries and/or uterus.</td>
</tr>
<tr>
<td>Midwife</td>
<td>A trained birth attendant.</td>
</tr>
<tr>
<td>Misogyny</td>
<td>From the Greek, meaning to hate women, hence: a misogynist.</td>
</tr>
<tr>
<td>Mittleschmerz</td>
<td>Abdominal pain that sometimes accompanies ovulation.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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</tr>
<tr>
<td>Moniliasis</td>
<td>See Candida albicans.</td>
</tr>
<tr>
<td>Mons veneris</td>
<td>Cushion of fat over the pubic bone above the vulva.</td>
</tr>
<tr>
<td>MSM</td>
<td>A recent term coined to describe men-who-have-sex-with-men (hence, the alternative: MWHSWM) who may not describe themselves with other titles such as gay, homosexual or bisexual.</td>
</tr>
<tr>
<td>Mucosa</td>
<td>Moist membranes that line certain parts of the body, such as the penile urethra, vagina and mouth. (AKA mucous membranes.)</td>
</tr>
<tr>
<td>Multigravida</td>
<td>Referring to a female who has been pregnant on more than one occasion (irrespective of how the pregnancy continued or was ended).</td>
</tr>
<tr>
<td>Multiple orgasms</td>
<td>Several orgasms occurring within a short time.</td>
</tr>
<tr>
<td>Multiparous</td>
<td>Referring to a female who has given birth on more than one occasion.</td>
</tr>
<tr>
<td>Myotonia</td>
<td>Muscle tension.</td>
</tr>
<tr>
<td>Negative-feedback mechanism</td>
<td>The interaction between endocrine glands and their target organs and cells that regulates hormone production.</td>
</tr>
<tr>
<td>Neisseria gonorrhoeae</td>
<td>The bacteria that cause gonorrhea infections.</td>
</tr>
<tr>
<td>Nocturnal emission</td>
<td>Ejaculation during sleep, a &quot;wet dream&quot;.</td>
</tr>
<tr>
<td>Oral sex</td>
<td>Stimulation of the penis or vulva with the mouth. See also fellatio and cunnilingus.</td>
</tr>
<tr>
<td>Orchidectomy</td>
<td>The surgical removal of the testes.</td>
</tr>
<tr>
<td>Orgasm</td>
<td>Muscular contractions of the pelvic floor that occur at the peak of sexual arousal.</td>
</tr>
<tr>
<td>Orgasm phase</td>
<td>Masters and Johnson's term for the third phase of the sexual response cycle, during which orgasm occurs.</td>
</tr>
<tr>
<td>Os</td>
<td>The opening in the cervix.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
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</tr>
<tr>
<td>Ovaries</td>
<td>Pair of organs that produce ova and sex hormones in the female.</td>
</tr>
<tr>
<td>Ovulation</td>
<td>The rupture of a Graafian follicle to release mature ovum.</td>
</tr>
<tr>
<td>Ovum</td>
<td>The female reproductive cell.</td>
</tr>
<tr>
<td>Paedophilia</td>
<td>From the Greek meaning to love children. In current use, it usually refers to people who have sex with children.</td>
</tr>
<tr>
<td>Pelvic inflammatory disease (PID)</td>
<td>An infection in the uterus and surrounding area.</td>
</tr>
<tr>
<td>Penis</td>
<td>External male sexual organ.</td>
</tr>
<tr>
<td>Perineum</td>
<td>The area between the vagina or scrotum and anus.</td>
</tr>
<tr>
<td>Petting</td>
<td>Sexual contact excluding coitus.</td>
</tr>
<tr>
<td>Pheromones</td>
<td>Odours produced by the body that can affect sexual activity. In humans, the exact mechanism is not yet clearly understood.</td>
</tr>
<tr>
<td>Piercing</td>
<td>Usually refers to the adornment of the body with jewelry through pierced skin, e.g. rings in the ears and nose. It may also refer to piercing the skin (for the insertion of jewelry or other objects) as part of a person's sex life, e.g. rings through other parts of the body, including the nipples and genitalia.</td>
</tr>
<tr>
<td>Pimp</td>
<td>One who is paid to procure business for sex workers.</td>
</tr>
<tr>
<td>Pituitary gland</td>
<td>A gland located in the brain that secretes hormones which affect other endocrine glands.</td>
</tr>
<tr>
<td>Plateau phase</td>
<td>Masters and Johnson's term for the second phase of the sexual response cycle in which muscle tension, heart rate, blood pressure, and vasocongestion increase.</td>
</tr>
<tr>
<td>Pornography</td>
<td>Visual and written materials of an explicit sexual nature.</td>
</tr>
<tr>
<td>Postpartum period</td>
<td>The first few weeks after childbirth.</td>
</tr>
</tbody>
</table>
**Premarital sex**
Coitus before marriage.

**Premature ejaculation**
Ejaculation that occurs so quickly that sexual pleasure is impaired.

**Preorgasmic**
Never having experienced orgasm.

**Prepuce**
See Foreskin.

**Preputial glands**
Small glands located in the penile foreskin that produce a lubricating fluid.

**Priapism**
Prolonged and uncomfortable penile erection.

**Primagravida**
Refers to a female who has been pregnant only once.

**Primary erectile inhibition**
Inability of a man to achieve an erection with a partner.

**Primiparous**
Refers to a female who has given birth on one occasion only.

**Progesterone**
Hormone secreted by the corpus luteum and placenta responsible for the changes in the endometrium during pregnancy and the menstrual cycle.

**Prophylactic**
Something which 'prevents' an undesired outcome, e.g. in health terms, a prophylactic (medicine) prevents infection or disease; in sexual terms, may refer to the prevention of pregnancy (e.g. antispermicides, contraceptive pill, etc.) and/or STD, e.g. contraceptives such as the male or female condom. The condom is also called a preservativo, a 'preservative'.

**Prostatectomy**
Surgical removal of the prostate.

**Prostate gland**
A gland at the junction of the bladder and urethra that produces most of the seminal fluid released during ejaculation.

**Prostatitis**
Inflammation of the prostate.

**Prostitute**
Sex worker.

**Prostitution**
Selling sexual services.
### Teaching modules for basic education in human sexuality

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Puberty</td>
<td>The age at which the reproductive organs mature and secondary sex characteristics appear.</td>
</tr>
<tr>
<td>Pubic lice</td>
<td>Pediculosis (or phthirus) pubis are one of two species of lice which can affect humans (pediculosis humanus = body lice proper). Pubic lice are spread primarily through close bodily contact during sex. There may be rare occasions when they are found in the eyebrows, too.</td>
</tr>
<tr>
<td>Rape</td>
<td>Non-consensual sexual intercourse under actual or threatened force.</td>
</tr>
<tr>
<td>Rape trauma syndrome</td>
<td>Emotional problems suffered by people who have been raped.</td>
</tr>
<tr>
<td>Rapid ejaculation</td>
<td>See Premature ejaculation.</td>
</tr>
<tr>
<td>Refractory period</td>
<td>The time following male orgasm before another orgasm can occur.</td>
</tr>
<tr>
<td>Resolution phase</td>
<td>Masters and Johnson's term for the fourth phase of the sexual response cycle, or return to the non-excited state.</td>
</tr>
<tr>
<td>Retrograde ejaculation</td>
<td>Expulsion of semen into the bladder.</td>
</tr>
<tr>
<td>Rhythm method</td>
<td>A contraceptive method based on calendar estimation of fertile days.</td>
</tr>
<tr>
<td>Rugae</td>
<td>The folds of the vagina.</td>
</tr>
<tr>
<td>Sadomasochism (S and M)</td>
<td>The giving (sadism) or receiving (masochism) of physical or psychological pain to attain sexual satisfaction.</td>
</tr>
<tr>
<td>Scrotum</td>
<td>The pouch of skin that encloses the testes.</td>
</tr>
<tr>
<td>Secondary erectile inhibition</td>
<td>Impotence in a man who has previously experienced erections.</td>
</tr>
<tr>
<td>Secondary erogenous zones</td>
<td>Areas of the body that are conditioned to be erotically sensitive.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>Secondary nonorgasmic</strong></td>
<td>Woman who can experience orgasm through masturbation but not with a partner.</td>
</tr>
<tr>
<td><strong>Secondary orgasmic dysfunction</strong></td>
<td>Kaplan’s label² for a woman who no longer experiences orgasm.</td>
</tr>
<tr>
<td><strong>Secondary sex characteristics</strong></td>
<td>Non-genital physical characteristics that develop during sexual maturation, such as body hair, breasts, and deepened voice.</td>
</tr>
<tr>
<td><strong>Semen</strong></td>
<td>The ejaculate, which is comprised of sperm, and fluids from the seminal vesicles and prostate and Cowper’s glands.</td>
</tr>
<tr>
<td><strong>Seminal fluid</strong></td>
<td>See Semen.</td>
</tr>
<tr>
<td><strong>Seminal vesicles</strong></td>
<td>Two small glands situated on either side of the prostate gland that store sperm prior to ejaculation and produce some of the seminal fluid.</td>
</tr>
<tr>
<td><strong>Seminiferous tubules</strong></td>
<td>Sperm-producing structures in the testes.</td>
</tr>
<tr>
<td><strong>Sensate focus</strong></td>
<td>A form of sexual therapy that enhances sexual pleasure and reduces performance pressure through a process of touching and communication.</td>
</tr>
<tr>
<td><strong>Sexual anaesthesia</strong></td>
<td>Lack of pleasure from sexual stimulation.</td>
</tr>
<tr>
<td><strong>Sexual apathy</strong></td>
<td>Lack of sexual motivation.</td>
</tr>
<tr>
<td><strong>Sexual health</strong></td>
<td>The integration of the somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love.</td>
</tr>
<tr>
<td><strong>Sexually transmitted diseases (STD)</strong></td>
<td>Diseases that are transmitted through sexual activity.</td>
</tr>
</tbody>
</table>

### Sodomy
Usually a derogatory term for anal penetrative intercourse (whether man-to-woman or man-to-man). In some countries, this term is accepted as the legal terminology for anal intercourse. The term's origins stem from the Hebrew Scriptures/Christian Old Testament's references to the inhospitality shown to guests in a certain town. (Sodom), but which has traditionally been interpreted in many cultures as the aggressive town leaders wanting to humiliate the visiting strangers by raping them. Buggery is another term, often used in a derogatory fashion, for the same act of anal penetration, originating from the violent rape of conquered soldiers by certain tribes in medieval Bulgaria (Europe).

### Spermatic cord
A cord attached to the testicle that contains the vas deferens, blood vessels, nerves, and cremasteric muscle fibres.

### Spermatogenesis
Sperm production.

### Spermicide
Chemical substance that kills sperm.

### Spongy body
Erectile tissue in the male that surrounds the urethra and extends from a bulb at the base of the penis to the glans.

### Spontaneous abortion
See Miscarriage.

### Squeeze technique
A technique for treating premature ejaculation by squeezing the penis at the base of the glans.

### Statutory rape
Sexual intercourse with a person below the legal age of consent.

### Swinging
An interchange of sexual partners or spouses for the purpose of sex, e.g. "wife" or "husband swapping".

### Syphilis
A sexually transmitted disease caused by *Treponema pallidum* or *Spirochaeta pallida*. 
<table>
<thead>
<tr>
<th>Glossary</th>
<th>Definition</th>
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<tbody>
<tr>
<td><strong>Target organs</strong></td>
<td>Organs and cells that are influenced by hormones.</td>
</tr>
<tr>
<td><strong>Testis</strong></td>
<td>Male gonad, also known as the testicle. Normally a pair are located in the scrotum. They produce sperm and hormones.</td>
</tr>
<tr>
<td><strong>Testosterone</strong></td>
<td>A hormone produced by the testes.</td>
</tr>
<tr>
<td><strong>Transsexual</strong></td>
<td>A person whose psychological gender identity is opposite to their biological sex.</td>
</tr>
<tr>
<td><strong>Transvestism</strong></td>
<td>Wearing clothing of the opposite sex for sexual gratification.</td>
</tr>
<tr>
<td><strong>Trichomoniasis</strong></td>
<td>A form of vaginitis caused by a single-celled protozoan called <em>Trichomonas vaginalis</em>.</td>
</tr>
<tr>
<td><strong>Tyson's glands</strong></td>
<td>Small glands on either side of the frenum.</td>
</tr>
<tr>
<td><strong>Urethra</strong></td>
<td>The tube which conducts urine out of the body in males and females, and through which the ejaculate passes in males.</td>
</tr>
<tr>
<td><strong>Urethral bulb</strong></td>
<td>The portion of the urethra between the urethral sphincters in the male.</td>
</tr>
<tr>
<td><strong>Urethral sphincter</strong></td>
<td>Muscle that surrounds and closes the urethra.</td>
</tr>
<tr>
<td><strong>Urology</strong></td>
<td>The medical speciality concerned with the urinary system.</td>
</tr>
<tr>
<td><strong>Uterus</strong></td>
<td>The organ in the female pelvis where the fetus develops.</td>
</tr>
<tr>
<td><strong>Vagina</strong></td>
<td>The canal that connects the cervix to the opening of the vulva.</td>
</tr>
<tr>
<td><strong>Vaginismus</strong></td>
<td>Involuntary spasms of the muscles of the vagina.</td>
</tr>
<tr>
<td><strong>Vaginitis</strong></td>
<td>Inflammation of the vaginal walls.</td>
</tr>
<tr>
<td><strong>Vasa deferentia</strong></td>
<td>Two tubes that transport sperm from the testes to the urethra (vas deferens -singular).</td>
</tr>
<tr>
<td><strong>Vasectomy</strong></td>
<td>Male sterilization by removal of sections from each vas deferens.</td>
</tr>
<tr>
<td><strong>Vasocongestion</strong></td>
<td>The engorgement of blood vessels.</td>
</tr>
</tbody>
</table>
Teaching modules for basic education in human sexuality

**Venereal disease**
Diseases transmitted by sexual contact.

**Vestibular bulbs**
Two areas of erectile tissue inside the vaginal opening that become engorged with blood during sexual arousal.

**Vestibule of the vagina**
The area between the labia minora.

**Virgin**
A person who has not experienced sexual intercourse.

**Voyeurism**
Literally, obtaining sexual gratification by observing other people's sexual behaviours, with or without their consent, e.g. being sexually aroused and stimulating oneself whilst looking at pornography; being with other people as they have sex, but not physically interacting with them (simply watching and possibly masturbating oneself), or peeping at (spying on) people having sex, who are unaware of the voyeur's presence or actions, hence, an invasion of privacy.

**Vulva**
The external female genitalia, including the mons veneris, labia majora, labia minora, clitoris, and urinary and vaginal openings.

**Water sports**
A popular term in sexual slang for playing with urine, e.g. urinating over one's sexual partner. To some people, it can also mean a man urinating inside his partner's vagina or rectum (this would be indicative of unprotected intercourse).

**Withdrawal**
See coitus interruptus.

**Wolffian ducts**
The parts of the embryo that develop into the male reproductive structures.
FURTHER READING


