Promoting Sexual Health and Responsible Sexual Behavior:

A Universal Curriculum for Health Professionals

CESH
The Center of Excellence for Sexual Health
At Morehouse School of Medicine

The Satcher Health Leadership Institute
at Morehouse School of Medicine
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Attribution

CESH is dedicated to leadership in student learning regarding sexual health and its dimensions of public health. CESH is also dedicated to developing scholarly materials that enhance the education of health professionals. CESH is happy to freely distribute this curriculum for use in health professions. In order to track adoption of this curriculum for health professionals’ education, we ask for acknowledgment of this curriculum through the use of a ‘Thank You’ letter that should be sent via email anytime this curriculum or any component within is adopted for use. We strongly encourage you to send a letter acknowledging the use of any materials in your student curriculum so that CESH can maintain a relationship with those who use this curriculum.

The following includes:

- A list of recommended details to include in the ‘Thank You’ letters.
- A short letter template.

LIST OF DETAILS

- Name of creator
- Type of material
- Title of material
- Type of attendees (students, physicians, etc.)
- Number of attendees
- Date of use or dates for recurring use
- Institution where it is being used
- Name of those using the material
- Feedback (if appropriate)

TEMPLATE

[Date]

Dear Center of Excellence for Sexual Health,

I am sending this letter in order to thank you for allowing us to use your curriculum, Promoting Sexual Health and Responsible Sexual Behavior: A Universal Curriculum for Health Professionals for the purpose of teaching [type of attendees] at [institution] on [date]. The number of attendees was [number].

Thank you for sharing your scholarship with our institution!
Sincerely,

[Your name and title]
Acknowledgements

CESH is informed and guided by discussions of the National Advisory Council on Sexual Health, a diverse group of national leaders in the area of sexual health. It was through their input that this project was identified, and we are grateful for the dedication of these individuals to CESH and to the sexual health of all persons.

We also acknowledge the 2008-2009 CESH Community Leadership in Sexual Health Scholars’ Program at MSM for additional implementation opportunities and preliminary evaluation of components of this curriculum.

We acknowledge the MSM Curriculum Review Committee: David Levine, M.D., F.A.A.P., Associate Professor of Clinical Pediatrics; Martha Elks, M.D., Ph.D., Chair, Department of Medical Education; Marlene MacLeish, Ed.D., Research Professor of Medical Education; Janice Herbert-Carter, M.D., M.G.A., F.A.C.P., Associate Professor of Family Medicine; Shawn Garrison, Ph.D., Director, Department of Counseling Services; Eve Higginbotham, M.D., Dean and Senior Vice President for Academic Affairs, Morehouse School of Medicine, for their review of this curriculum in the vetting process.

We acknowledge the overall direction of David Satcher, M.D., Ph.D., 16th Surgeon General of the United States and Director of the Satcher Health Leadership Institute at Morehouse School of Medicine (SHLI/MSM). This project was made possible through answering Dr. Satcher’s Call to Action to Promote Sexual Health and Responsible Sexual Behavior (2001). We also acknowledge John Maupin, D.D.S., M.B.A, 5th President of Morehouse School of Medicine, for his support of the Center of Excellence for Sexual Health and the Satcher Health Leadership Institute.

Finally, we gratefully acknowledge the financial support of the Ford Foundation, who answered Dr. Satcher’s Call to Action with a generous grant that supported and nurtured the founding and development of CESH at Morehouse School of Medicine.
Dear Colleagues,

As noted in my *Surgeon General’s Call to Action to Promote Sexual Health and Responsible Sexual Behavior (2001)*, physicians, nurses, pharmacists and other health care professionals, often the first point of contact for individuals with sexual health concerns or problems, can have great influence on the sexual health and behavior of their patients. Yet, both adolescents and adults frequently perceive that health care providers are uncomfortable when discussing sexuality and often lack adequate communication skills on this topic. Health care professionals need more and better sexuality and sexual health education in order to capitalize on opportunities to promote sexual health.

In answer to this identified need, The Center of Excellence for Sexual Health (CESH) of the Satcher Health Leadership Institute at Morehouse School of Medicine (SHLI/MSM) in Atlanta, Georgia is pleased to offer the enclosed sexual health curriculum for health professionals for your consideration, adoption, adaptation and augmentation. In addition, CESH offers our assistance in your deliberation and implementation of this sexual health curriculum for the training of future generations of leaders in the provision and promotion of sexual health and responsible sexual behavior.

This curriculum was built upon recommendations put forth by our National Advisory Council on Sexual Health, a group of thought leaders who represent very diverse perspectives and value systems. Selective lesson plans have been incorporated into Morehouse School of Medicine’s Fundamentals of Medicine I, III, intensive fourth-year sexual health elective, and Grand Rounds in Obstetrics and Gynecology as well as Psychiatry. The curriculum has also been piloted in our CESH Scholars’ Program. This curriculum is rooted in cultural competence with patients from diverse communities and inclusive of the experience of persons with disabilities and chronic conditions. It is also sensitive and responsive to the importance and diversity of the religious communities of our nation.

Curriculum leaders in health professions education have long sought effective curriculum models and materials for use in augmenting sexual health education. The comprehensive integration of sexual health into public health and physician and health professional education has been elusive. This curriculum is intended to address that integration.

The next generations of physicians and health professionals must also be leaders in their communities. They must be able to speak to the importance of cultural and social conditions that directly affect individual health and public health. Sexuality and sexual health is an essential part of that conversation. This curriculum recognizes those future leadership roles.

If you determine that we can be of assistance in the use, adaptation and augmentation of this curriculum model to meet your educational goals, please contact us. We stand ready to provide assistance in advancing this important aspect of public health education for future generations of health professionals.

Cordially,

David Satcher, M.D., Ph.D.
Director - Satcher Health Leadership Institute
Center of Excellence on Health Disparities
Poussaint-Satcher-Cosby Chair in Mental Health
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16th Surgeon General of the United States
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**About Us**

In 2001, Dr. David Satcher, 16th U.S. Surgeon General, issued the *Call to Action to Promote Sexual Health and Responsible Sexual Behavior*, the first governmental recognition that public health includes sexual health. In 2004, as director of the National Center for Primary Care at Morehouse School of Medicine, Satcher initiated a sexual health program. In 2006, as Interim President of Morehouse School of Medicine (MSM), he founded the Center of Excellence for Sexual Health (CESH). Upon leaving the Office of the President of MSM, Satcher founded the Satcher Health Leadership Institute (SHLI), of which CESH is a part.

The mission of CESH is to raise the level of national dialogue on human sexuality, sexual health, and well-being in a sustained, informed, honest, mature, and respectful way and to link it to actions that reflect scientific evidence and deeply held beliefs. The first Center of Excellence for Sexual Health in the United States, CESH seeks to strengthen public health through promotion of national public discussion of sexual health issues, provide forums and assistance to leaders of divergent viewpoints in building agreements on controversial issues of public health policy regarding sexual health, and provide education to improve the sexual health of the American people.

The themes to guide our program development include:

1. **Consensus-building**: Consensus-building among leaders of diverse viewpoints for effective sexual health policy and services;
2. **Student Learning**: Leadership in student learning regarding sexual health and its dimensions of public health;
3. **Community Education**: Replicable models in healthcare professions and institutions for improving nationwide public health education about sexual health;
4. **Disparity Reduction Initiatives**: Services to improve equal access to national sexual health understanding and services and to reduce the disparities in health services for minority communities.

CESH is housed in SHLI at MSM in Atlanta. MSM is a leader among the Historically Black Colleges and Universities in America. CESH provides unique cultural leadership for the United States through its understanding of minority communities.
Introduction

The CESH curriculum, *Promoting Sexual Health and Responsible Sexual Behavior: A Universal Curriculum for Health Professionals*, grew out of a vision generated by our National Advisory Council on Sexual Health (NAC). The vision is that all health professionals will graduate from their programs with knowledge of sexuality issues and the ability to: open discussion with patients or clients* about sexuality issues with sensitivity to cultural and religious issues; provide advice for managing sexual health; detail for patients (at appropriate ages) the physically and emotionally healthiest options to choose regarding sexual behavior; describe the risks and benefits of alternative courses of action for sexual health, and; answer patients’ questions comfortably and without judgment. The vision will be reached by developing educational materials for and providing assistance to health professions education. It will also influence credentialing and licensing bodies to establish a sexual health assessment and consultation as a normative component of medical practice and health care delivery.

CESH’s NAC provided their input on the following:

1. **Significant Problem Area:** Health profession education leaders and teachers face a significant challenge in providing effective sexual health education. There is a need for a common understanding of the scope and components of a sexual health curriculum, including outcome goals, outcome indicators and teaching methods.

2. **Best Practices:** A “best practices” sexual health curriculum model for health professional training and continuing education does not exist, and there is a need for one.

3. **Scope:** The scope of professionals to whom the sexual curriculum is addressed should be broad and include, but not be limited to, practicing physicians, medical students, residents, nurses, nurse practitioners, physician’s assistants, counselors, social workers, marriage and family therapists, pastoral counselors and occupational therapists.

4. **Continuing Education:** Continuing education in sexual health should be offered to augment professional training.

5. **Innovation:** There is a lack of use of innovative teaching models for dealing effectively with sexual health training for health professionals, and there is a need for such.

6. **Research:** There is significant deficiency in, and therefore a need for more effectiveness data regarding sexual health curricula for professional training and continuing education for health professionals.

7. **Value and Concern for Diversity:** There is a spectrum of values and levels of concern among professional education leaders regarding the scope, outcome goals, outcome indicators, content, duration and management of teaching about sexual health in health professional training and continuing education. Hence, there is a need for sensitivity to these matters when rolling out a new curriculum.

8. **Integration:** There is a particular challenge with regard to available hours in integrating sexual health education permanently and sufficiently into the larger

* Patients in this curriculum refers to both patients and clients
professional training curriculum framework for health professionals that needs to be addressed strategically.

9. **Teacher Dependency:** There is an historic problem of institutional continuity regarding instruction in sexual health education and an unsound dependency on unique, particular teachers in providing this instruction. There is a need for embedding the sexual health instruction within the larger health curricular framework in order to reduce reliance on singular teachers.

The net result of the NAC discussions was the recommendation to develop a comprehensive model sexual health curriculum for health professional training for consideration by health professions education leaders.

The vision, goal, and recommendations of the NAC are certainly not new, but their input on the current state of affairs reflects an ongoing dilemma. In 1974, The World Health Organization (WHO) published *The Teaching of Human Sexuality in Schools for Health Professionals*, which outlined new roles for health practitioners along with the training needs and suggestions for the educational program and curriculum planning, development and implementation. The WHO (1974) publication detailed the dilemma as follows:

In relation to human sexuality as a health entity, the role of medicine has been far from clear. To a large extent the health professions have avoided involvement by the simple expedient of providing no sex education at the professional level in medical and nursing schools. Consequently, the physician and the nurse often lack essential knowledge and, naturally enough, prefer not to become involved in a branch of medicine in which they find themselves personally embarrassed and professionally incompetent (p. 11).

Prior to the 1974 WHO report, significant work was made in the field thanks to the efforts of giants like Dr. Harold Lief. As early as 1963, Lief published a paper on what medical schools teach about sex (Lief, 1963). In 1960 there were only three medical schools in the U.S. providing sexual health education. By 1974, 106 schools included programs that offered some type of sexual health course. This remarkable growth was the result of the work of the Center for the Study of Sex Education in Medicine (CSSEM) founded in 1968. In 1978, one of the first published works on what can be and what must be taught in the medical school core curriculum (Stayton, 1978) was included in the seminal book *Sex Education for the Health Professional: A Curriculum Guide* (Rosenzweig and Pearsall, 1978). This work focused on the importance of addressing the personal attitudes, values, and feelings of the educator, as well as those of the health professional.

While we have made significant gains in the United States since 1974 with the majority of medical schools (54.1 percent) providing three to 10 hours of sexuality education and 32.5 percent providing more than 10 hours (Solursh, et al., 2003), indications from experts in the field like the members of the CESH NAC and from patients (Marwick, 1999) is that practicing physicians and other health professionals are not adequately prepared. Hence, the ultimate aim, “to provide universal training in human sexuality for all health practitioners” (WHO, 1974, p. 31) has yet to be fulfilled. The development of an updated curriculum for health professionals is long overdue.
Overview

Need

As noted in the Surgeon General’s Call to Action to Promote Sexual Health and Responsible Sexual Behavior (2001) (Call to Action), physicians, nurses, pharmacists and other health care professionals, often the first point of contact for individuals with sexual health concerns or problems, can have great influence on the sexual health and behavior of their patients. Yet, both adolescents and adults frequently perceive that health care providers are uncomfortable when discussing sexuality and often lack adequate communication skills on this topic. Health care professionals need more and better sexual health education in order to capitalize on opportunities to promote sexual health.

Despite the education that is currently being offered in the various places and settings reviewed below, overall promotion of sexual health is spotty. Because sexual health encompasses the many aspects of sexuality, including biological, psychological, social, emotional, and spiritual, promotion of sexual health requires a coordinated effort among health care providers, health educators, and clergy. The literature attributes this spotty coverage of sexual health care to lack of comfort and lack of adequate skills in providing sexuality education and counseling among health professionals. The list of barriers contributing to avoidance or non-involvement of professionals in promoting sexual health is long and includes the following (Brassell & Zapf, 1988; Ducharme & Gill, 1990; Krueger, 1991; Novak & Mitchell, 1988; Rosen 2006):

- inadequate knowledge of the subject matter
- discomfort in discussing sexual concerns or details
- commonly held myths regarding sexuality
- lack of skills
- personal values conflicts
- assuming someone else is covering it
- lack of time

Lack of comfort and lack of adequate skills in addressing sexual concerns is understandable based on reviews of sexuality education programs for health professionals (Weerakoon, 1992; Solursh, 2003; Parish & Clayton, 2007). The target population, timing and duration, aims and objectives, and evaluation methods, when provided, vary considerably. Sexuality education for health professionals may or may not focus on building comfort and skills.

A survey of North American medical schools indicated that 83.2 percent of human sexuality education classes for physicians used a lecture format; a multidisciplinary team was responsible for the education in 63.4 percent of the schools, psychiatry was the discipline most frequently involved, teaching in 75.3 percent of the medical schools; 37.7 percent of the medical schools provided less than six hours, 29.6 percent provided six to 10 hours, 17.4 percent provided 11 to 19 hours and 15.3 percent provided 20 or more hours – less than a third of these courses were required and even fewer teach medical students how to take a detailed sexual history (Solursh, 2003). About half of the survey respondents did not offer continuing medical education courses in sexuality. A large majority (94.1 percent) included causes of sexual dysfunction in the curriculum, its treatment (85.2 percent), altered sexual identification (79.2 percent) and issues of sexuality in illness or disability (69.3 percent). Other topics covered by some medical schools included sexually transmitted diseases, infertility, sexual abuse, and sex across the lifespan. The North American survey indicated that American medical schools appear
to stress the knowledge component of sexuality and secondarily that of skills to address sexual issues. Canadian schools appear to have a somewhat more balanced approach that includes an equal amount of exploring attitudes and beliefs. Only 42.6 percent of schools offered clinical programs, which included a focus on treating patients with sexual problems and dysfunctions, and 55.5 percent provided supervision in dealing with sexual issues to students in their clerkships.

Although biased toward erectile dysfunction, a more comprehensive approach to sexual health in medical school curricula was advanced by Pfizer, Inc., in 2003, subsequent to their introduction of Viagra in the marketplace (Ferrara et al., 2003; Kingsberg et al., 2003; Solursh et al., 2003; McGarvey et al., 2003). A one-time award of $100,000 that was to be used over the course of two years was granted to seven medical schools ($700,000 in total) to stimulate the advancement of a multidisciplinary approach to sexual health that focused on attitude change, behavior change, and knowledge acquisition. The seven grantees were: Case Western Reserve University School of Medicine; Dartmouth-Hitchcock Medical Center; MCP Hahnemann University Institute for Women’s Health; Mount Sinai School of Medicine; University of Massachusetts Medical School; New Jersey Medical School; and University of Virginia Health Sciences Center. The materials developed under these grants were published at [www.pfizersexualhealth.com](http://www.pfizersexualhealth.com) around 2003. Two of these grantees published papers about their programs in a free supplement of the *International Journal of Impotence Research*, made possible through commercial sponsors including Bayer Healthcare, Lilly ICOS, LLC, and Pfizer, Inc.

Despite many attempts at providing sexual health education for health professionals, Parish and Clayton (2007) sum up its current state from a global perspective:

> In all countries, medical students, house staff, and practicing physicians currently receive variable, nonstandardized, or inadequate training in sexual history taking and sexual medicine assessment and treatment. There remain significant physician–patient barriers to discussing sexual issues; and patients feel that their physicians are reluctant, disinterested, or unskilled in sexual problem management. There is a knowledge gap between developments in sexual medicine and the clinical skills of practicing physicians (p.259).

Interdisciplinary and multidisciplinary educational programs are needed more than ever for health professionals in today’s atmosphere where communication and cooperative care is required to meet the holistic needs of patients.

**Review of Existing Programs**

“[I]t must be stated very emphatically that a knowledge of reproduction and contraception does not of itself provide the training needed to deal with sexual problems” (WHO, 1974, p. 26).

As part of the process of developing *Promoting Sexual Health and Responsible Sexual Behavior: A Universal Curriculum for Health Professionals* we reviewed medical school sexual health curricula, both published and unpublished, syllabi, and course outlines. We are indebted to the Medical Institute for sharing with us course descriptions and syllabi they obtained in their Centers for Disease Control and Prevention (CDC)-funded survey of sexual education in medical schools (Malhotra, Khurshid, Hendricks, & Mann, 2008). With some exceptions like the weeklong program offered at the University of Medicine and Dentistry of New Jersey (UMDNJ) Robert Wood Johnson Medical School (Leiblum, 2001), and specific programs in human
sexuality (i.e., University of Minnesota Program in Human Sexuality intensive elective, Widener University’s Human Sexuality Program, and MSM’s sexuality elective), our review revealed, not surprisingly, a narrow focus on reproductive health with an emphasis on disease and dysfunction.

We also looked beyond medical schools to curricula, syllabi, and course outlines that apply to audiences across the lifespan as well as across professional disciplines. The list of other material reviewed included curricula for health professionals, sexuality degree program curricula, curricula for parents, kindergarten to 12 (K-12) curricula, faith-based curricula, and HIV prevention curricula. The list of other curricula in Appendix 1 details those most pertinent to the development of this curriculum. Outside of K-12 and faith-based curricula for youth and targeted HIV prevention and reproductive health curricula, a readily published and easily available comprehensive curriculum for health professionals in training or for continuing education of health professionals was absent.

**Rationale**

Promoting Sexual Health and Responsible Sexual Behavior: A Universal Curriculum for Health Professionals fills an identified educational gap among health professionals. The curriculum is intended for people who are interested in improving their ability to talk about sexuality, and who would like to be able to relay accurate information and specific suggestions for promoting and improving sexual health. The limitations in much of the existing sexuality education for health professionals (Weerakoon, 1992) – vaguely stated aims and objectives that are not written in operational terms, absence of needs assessments, and lack of clear program evaluations – were addressed by this project. This curriculum begins to meet the needs expressed by health professionals for more sexuality education and training.

Based on the limited success of the cadre of shorter offerings to translate into meaningful practice outcomes and considering the range of sexuality education to be covered using the interactive and experiential methods described, CESH designed this 40-hour plus curriculum to achieve cognitive, affective, and behavioral goals. The CESH faculty and staff have a collective experience of over 100 years in sexual health education, with terminal degrees in medicine, public health, human sexuality education, sexology, theology, nursing, women’s studies, and adult education. The CESH team used the Delphi method (Linstone and Turoff, 1975) based on reaching a consensus among experts after a series of independent contributions, sharing the contributions, reflecting on the contributions, and making revisions to arrive at 18 universal topics and related objectives. Universal topics are considered essential to all aspects of promoting sexual health and responsible sexual behavior regardless of core discipline or specialty. The Delphi method is especially useful in areas where precise scientific laws have not been established yet, which unfortunately is the current state of sexual health education for health professionals. Schools that are already covering one or more of the universal topics or that cannot adopt the curriculum in its entirety can pick and chose from the 18 universal topic modules to broaden their sexual health offerings.

The curriculum was developed by CESH then vetted through a voluntary group of physicians and medical educators at MSM and the members of CESH’s NAC who represent a wider range of stakeholders. This curriculum is being offered as a work-in-process to be further enhanced through its implementation into various health professions programs and the feedback we receive.

The 18 universal topics covered in this curriculum include: 1) Sexuality Language & Communication; 2) Models of Sexuality; 3) Values, Attitudes & Beliefs; 4) Sexuality across the

Introductions and language are needed to establish peer relationships and a working dialogue. Establishing a common language, a common understanding of sexuality, an awareness of the range of values, attitudes, and beliefs around sexual issues that exist even among participants, and sexuality as a developmental and lifelong process forms the foundation which all other topics can be built upon. Both sexual anatomy and physiology and sexual response cycles are taught from a healthy standpoint. Participants learn about unimpaired function, response, and expression and what is in the range of responsible sexual behavior before delving into other states. Once health is understood, students move to learning about sexual challenges, problems and concerns.

The 18-topic program provides an opportunity for participants to gain the knowledge, comfort, and skills necessary to understand and manage the sexual health care of patients, and to promote sexual health with the communities they serve. This model program is designed to be adaptable to many settings and to serve as the foundation for more targeted education based on the health professional’s core specialty. The overall aim is to develop a nation of well-trained health professionals who promote sexual health and responsible sexual behavior.

Goals

Promoting Sexual Health and Responsible Sexual Behavior: A Universal Curriculum for Health Professionals was developed with the following goals in mind. Graduates of this program should:

- be able to articulate their own values, attitudes and feelings about sexuality;
- acknowledge, respect and affirm the sexual values, attitudes and feelings of others;
- understand their target population’s primary sexual concerns;
- cultivate the communication skills necessary to provide a supportive environment;
- effectively assess their patient or client’s sexual health status;
- provide advice for managing sexual health
- relay relevant, accurate, and unbiased sexual information;
- be knowledgeable of the many sexual options available across the lifespan;
- be familiar with the range of resources available in sexual health.

Objectives

Each lesson plan contains objectives to address the three domains in learning: affective (emotions), cognitive (knowledge), and behavioral (behaviors). These three domains of learning are routinely referred to as knowledge, skills and attitudes in U.S. medical education. The affective objectives are geared toward promoting a positive attitude toward sexual health and responsible sexual behaviors. Exercises serve to promote group building and comfort, and to
provide permission for further exploration of sexual topics. The cognitive objectives are aimed at building a knowledge base for participants to draw on when needed to provide limited information and specific suggestions. The behavioral objectives are aimed at developing skills in conducting focused behavioral sexuality assessments and to accurately relay information and specific suggestions.

**Relevance**

Sexual health, as expressed in the working definition of sexual health published on the World Health Organization’s website, is greater than the absence of disease:

> Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled ([http://www.who.int/reproductive-health/gender/sexualhealth.html](http://www.who.int/reproductive-health/gender/sexualhealth.html)).

Sexual health includes how people feel about themselves as loveable and capable partners, establishing and maintaining intimate relationships, freedom from stigma, discrimination, sexual abuse, coercion and violence, and the ability to enjoy sexual pleasure and satisfaction. With a broad definition of sexual health in mind, CESH set out to develop a sexual health curriculum for health professionals that is reflective of the multiple dimensions that contribute to being a sexually healthy and responsible person.

**Target Audience**

Because of the universal, foundational nature of this curriculum, the scope of professionals to whom the curriculum is addressed is broad and includes but is not limited to the following:

- Medical students
- Residents
- Physicians in practice
- Public health students
- Nurses
- Nurse practitioners
- Midwives
- Physician’s assistants
- Psychologists
- Social workers
- Marriage and family therapists
- Clergy
- Rehabilitation specialties including physical therapists, occupational therapists, and recreation therapists
- Health education specialists
Theoretical Underpinnings

The lesson plans are based on adult learning theory and problem-based learning, and are for the most part interactive and experiential (Cross, 1981; Neutens & Skonie-Hardin, 1994; Silberman, 1998). While knowledge-based competencies can be achieved through reading and lectures, developing comfort with the subject matter, increasing awareness of personal biases, increasing acceptance and understanding of the diversity of sexual expression, and developing skills in talking with others about sexual issues is most readily achieved through active engagement with other learners.

The active approach to training involves a commitment to learning by doing (Silberman, 1998). Research on adult learners suggests that participants must be actively engaged during a training program. Without group participation, they will forget or fail to apply what they are taught, as well as be bored by the material presented. In addition, many of the objectives target attitudes and skills. Experiential learning approaches help participants to become more aware of their feelings and reactions to certain issues and new ideas. In addition, they allow participants to practice and refine new skills and procedures.

Theoretically, teaching health professionals how to communicate about sex and sexuality will help them overcome some of the barriers or obstacles in communicating with their patients described earlier and lead to change. Caffarella (2002) wrote about three kinds of likely change: individual change, organizational change, and community and societal change. In order to bring about change, while incorporating the varying learning styles, Promoting Sexual Health and Responsible Sexual Behavior: A Universal Curriculum for Health Professionals incorporates a variety of teaching methods and adheres to Silberman’s (1998) eight qualities for active training:

1. moderate level of content
2. balance between affective, behavior and cognitive learning
3. variety of approaches
4. opportunities for group participation
5. utilization of participants’ expertise
6. recycling earlier learned concepts and skills
7. real-life problem solving
8. allowance for future planning (pp. 13-15).

The activities allow for values reflection, open discussion, question asking, role modeling, role-playing, and skill practicing. Adults are given the chance to not only learn from the teacher, but from their peers as well. While the educational sessions are designed for them to achieve personal growth, the primary goal is for them to be able to communicate about sexuality. The actual change occurs when the participants bridge the classroom learning with real life experience.

Assumptions

- We are all sexual beings throughout the lifespan
- We all have our own values, attitudes and feelings about sexual activities and behaviors
- Science and deeply held beliefs are not mutually exclusive
- The majority of health professional students have received little sexuality education in high school or undergraduate school beyond mandated classes focusing on STDs or abstinence
• Sexuality education for health professionals who work in various settings will increase the likelihood that the promotion of sexual health and responsible sexual behavior will be provided when needed

Values
• Sexual health knowledge
• Medical accuracy
• Cultural competency
• Religious diversity
• Sexual rights
• Sexual pleasure

Educational Methods
As noted, the educational methods employed are highly interactive and experiential. The methods used in this course fall within three general categories: affective methods, behavioral methods, and cognitive methods. Affective methods help students get in touch with their feelings and values; behavioral methods help students build skills and empower positive action; cognitive methods help students learn to give and gather information (Hedgepeth & Helmich, 1996). These education methods facilitate the obtainment of knowledge, skill, and attitude objectives.

Specific types of affective methods that are incorporated into the curriculum include small and large group discussion, values clarification and instructional media including sexually explicit video and sexually explicit slides. Other available methods include “fish bowl” (group observation of a role-play), interviews, stories, focus writing and guided imagery. Specific types of behavioral methods used in the curriculum include case studies and problem solving. Others available methods include role-play, simulations and “real-life” homework. Specific types of cognitive methods used are brainstorming, guest/resource speakers, display of models and objects, videos, reading and research. Others available methods include presentations, anonymous questions and task groups (Hedgepeth & Helmich, 1996; Bruess & Greenberg, 1988; Cook, Kirby, Wilson & Alter, 1984; Morrison & Underhill-Price, 1974). Many of the specific methods incorporate all three of the major methods.

Large group discussion
Discussion in a large group allows for open exchange of ideas in which the entire group may benefit, as opposed to the small group setting where only a few members may benefit. More opportunities are available for peer interaction and knowledge exchange.

Small group discussion (aka “buzz groups”)
“Small groups give participants an opportunity to discuss ideas and ask questions in greater detail than is possible in a large-group format. Group movement also accommodates the diverse personal learning styles of your participants, many of whom may feel more comfortable speaking in a small group than they do when all of the participants are together” (Silberman, 1998, pp. 269-270). Small groups of learners – also known as “buzz groups” – can be organized to encourage increased opportunity for verbalization, more independent learning, and differing points of view (Bruess & Greenberg, 1988). They are most appropriately used when an open ended topic is being discussed. When adequate discussion has occurred, the instructor has two
options. The learning experience can end or each group to report to the others. It may not be necessary for each group to know what the other groups concluded. When the topic is a personal one that the learners feel comfortable discussing with only a few people they know well, it is inadvisable to broaden the discussion beyond the small group. However, should you want each group to report to the others, you can have a recorder give a brief report to the larger group or turn in a brief written report which can be copied and given to the other groups.

**Brainstorming**
When a range of ideas needs to be generated, brainstorming is an effective method (Cook et al., 1984). This instructional strategy requests learners to supply any and all ideas that come to mind relative to the issue that is being discussed (Bruess et al., 1994, p. 232). The ideas are recorded but not evaluated until enough ideas have been generated. At that point, each idea is considered. After these and other ideas are listed, the instructor will direct the learners to focus on each idea and decide whether or not to keep it on the list. Brainstorming can be a good way to find out where the group is, including how much students know.

**Sentence completion**
A good adjunct to small group discussions is the sentence completion technique (Bruess & Greenberg, 1988). All this requires is that learners write endings for incomplete sentences and be prepared to discuss these sentences in their small groups. These sentences are open-ended; there is no one correct answer. They provide excellent motivation for small group discussions.

**Values clarification**
Values clarification activities are designed to help learners identify their values (Bruess & Greenberg, 1988). Such exercises are not designed to develop any particular set of values but rather to help learners identify the values they already possess so they can decide for themselves whether or not to keep them and how to behave more consistently with them. As with many other types of student-oriented instructional strategies, the discussion following the exercise is the most important aspect of the activity.

**Case studies**
One way to present content is to place it within a story. A case study is a story, usually accompanied by discussion questions, that can be analyzed and from which learning can occur (Bruess & Greenberg, 1988).

**Problem solving**
“During problem solving, learners consider a difficult, confusing situation, one with potential negative consequences, and break it into manageable pieces for the purpose of finding a solution or making a decision” (Hedgepeth et al., 1996, p. 202). Problem solving helps learners critically think about sexuality topics and devise solutions to apply as they encounter problems in their lives.

**Instructional media**
Students today are accustomed to getting information from the visual media. They enjoy audiovisuals – whether music, films, or short video clips – and are usually eager to express their own attitudes and feelings about the issues presented (Bruess & Greenberg, 1988).
Audiovisuals
“[G]ood videos skillfully incorporated in a series of activities can expose individuals vicariously to a wider range of values, cultures, behaviors, dilemmas, and choices than might be available in the group. . . videos allow safe introspective time. They may be appropriate for introducing subjects that groups have difficulty discussing” (Hedgepeth et al., 1996, p. 155). Like the models, videos help learners relate to the real-life experience.

Display of models and charts
“Many excellent models of sexual and reproductive anatomy are available to sexuality educators and are useful if only because many people learn visually. Others need visual input to enhance aural understanding” (Hedgepeth et al., 1996, p. 151). It is important to combine experiential and academic learning because everyone experiences sexuality. Teaching with models that are close to the real-life experience helps learners apply the information in the actual experience.

Short lectures or verbal presentations
A short, informal presentation can be an effective way to impart information that students do not already have. During factual presentations, teachers should maintain two-way communication by asking questions and encouraging participants to ask questions or comment on the material (Cook et al., 1984). Lectures should focus on a small amount of content limited to about 20 minutes at a time (Gunter, Estes, & Schwab, 1999). Lecture is a way to capture students’ attention and focus them in on the content at hand.

Guest/resource speakers
“Since the sexuality educator cannot be expected to be an expert in all sexuality-related content areas, the use of guest speakers can add a valuable dimension to a sexuality education program” (Bruess et al., 1994, p. 237). Guest speakers not only give a different perspective, but they also allow the instructor time to prepare for the next lesson.

Gaming
“Gaming is an instructional experience that is fun for the learner, has rules and regulations governing it, and has a goal toward which the learners are striving. . .Since games are enjoyable to play, they often result in a level of learner involvement and interest that cannot be achieved in any other way” (Bruess et al., 1994, p. 233).

The varieties of methods used are necessary to maximize and optimize learning in a population with varying learning styles. Also, Silberman (1998) noted the following statistics for learning retention rates based on the methods used:

<table>
<thead>
<tr>
<th>Method</th>
<th>Retention Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lecture</td>
<td>5 percent</td>
</tr>
<tr>
<td>Reading</td>
<td>10 percent</td>
</tr>
<tr>
<td>Audiovisuals</td>
<td>20 percent</td>
</tr>
<tr>
<td>Demonstration</td>
<td>30 percent</td>
</tr>
<tr>
<td>Discussion</td>
<td>50 percent</td>
</tr>
<tr>
<td>Practice by doing</td>
<td>75 percent</td>
</tr>
<tr>
<td>Teaching others</td>
<td>90 percent (p.2).</td>
</tr>
</tbody>
</table>

Promoting Sexual Health and Responsible Sexual Behavior

CESH
SHLI/MSM
12
Instructional Materials
In addition to materials like handouts, videos, slides, samples, general supplies and materials, and audiovisual equipment listed in Table 1 on pages 18 – 21, each lesson has a list of required or core and recommended readings to augment the required materials.

Instructor Qualities/Recommended Trainings

“Apart from their experience and knowledge of the subject, teachers will require training in educational methodology. Since much of what is taught is emotionally charged and must be taken on trust by the student, whoever deals with the subject should be a person who inspires confidence in the students and is able to deal with all the types of question which human sexuality provokes” (WHO, 1974, p. 24).

Comfort and communication have been the cornerstones for teaching about human sexuality. The instructor must be comfortable communicating about sexuality in order to set students at ease in working with an often difficult and highly sensitive aspect of life. Establishing trust not only with the students, but also amongst the students is one way to create safety in learning about sexuality. Hedgepeth et al. (1996) offered some of the following tips for launching a good sexuality class:

1. Share your credentials for teaching sexuality.
2. Tell students why you think it is important for everyone to learn about sexuality.
3. Demonstrate your comfort with hearing sexual slang, translating it into correct terminology.
4. Demonstrate, if possible, that you cannot be shocked easily by student revelations or comments.
5. Express your anticipation of and sensitivity to student discomfort with sexuality or with certain topics.

It is important that the instructor has examined her/his values, beliefs, attitudes, and biases about sexuality prior to teaching this course. “In order to function competently, the health professional needs to be keenly aware of his or her own attitudes, feelings, and judgments surrounding all areas of sex, and must have a basic body of knowledge as well as skills for treating sexual concerns of the patient or client” (Stayton, 1978, p. 51). Ideally, an instructor will have participated in a SAR (Sexual Attitude Reassessment seminar), prior to teaching human sexuality. The 2004 Standards for SARs of the American Association of Sex Educators, Counselors and Therapists (AASECT) describes the SAR as a process-oriented, structured group experience to promote participants’ awareness of their attitudes and values related to sexuality, and to assist them in understanding how these attitudes and values affect them professionally and personally. Information on the availability of SARs in your area can be found at http://www.aasect.org.

“Research conducted at the University of Pennsylvania School of Medicine, through the Center for the Study of Sex Education and Medicine, revealed that medical students who participated in the implosion model were significantly more comfortable in confronting sexual issues in patients than those who saw no films” (Stayton, 1998, p.28). Some have argued that the use of explicit sexual material may, in fact, have a detrimental effect, resulting in some students’ developing more rigid and inflexible attitudes towards some aspects of sexual behavior, such as homosexuality (Stayton, 1998). However, the vast majority of studies do not support this view. Stayton (1998) notes that “alternative methods of desensitization…without the use of explicit
films” are available for environments that do not support or allow the use of sexually explicit media. Alternative methods “include the use of fantasy, experiential exercises, and guided imagery followed by discussion” (Stayton, 1998, p.28). Knowing where one stands on sexuality issues allows the instructor to attempt remaining neutral in order to avoid alienating students who do not share the same ideas.

**Sensitivity**

Attention to sensitivity must be paid when teaching about sexuality. Many factors affect the responses evoked in a sexuality course. “Because of the personally sensitive topics and diverse value perspectives within a sexuality education class, emotions sometimes run high, and personal boundaries are more easily violated” (Hedgepeth et al., 1996, p. 45). It is important that the instructor and students create a safe and supportive environment where open, respectful learning can occur. The instructor may begin establishing safety through the use of language. Brueck et al. (1994) said, “Helping learners to be more comfortable with sexual terms is a responsibility of the sexuality educator. One way of achieving this end is to teach the correct, socially acceptable terminology” (p. 216). Not only do instructors need to be conscious of the language they use, but they also need to help students become language conscious. The use of exclusive, power laden language may ostracize students and prevent them from learning. Three suggested strategies for establishing safety, support and sensitivity in the sexuality education classroom are establishing ground rules, making use of a “parking lot” and making available a question box are three strategies for establishing safety, support and sensitivity in the sexuality education classroom. The key to maintaining safety, support, and sensitivity is to regularly use the ground rules, ‘parking lot’, and ‘question box’. While establishing them serves as a beginning, the instructor should refer students to these three areas throughout the course, especially if problems arise.

**Ground Rules**

“Ground rules are a set of agreements, or explicit group norms, about how a group will operate to protect both individual and group rights” (Hedgepeth et al., 1996, p. 44). Ground rules are established by the group and the facilitator in order to provide a safe environment. The ground rules should include: establishing and maintaining confidentiality; allowing the right to ‘pass’; avoiding generalizations and using ‘I’ statements instead; balancing open sharing of personal experience; respecting privacy; encouraging full participation; maintaining the integrity of every contribution; acknowledging and accepting expression of feelings; and, respecting differences. When ground rules are followed, safety is increased; group process problems are prevented; and, interpersonal conflicts are minimized (Hedgepeth et al., 1996).

**Parking Lot**

A ‘parking lot’ is a piece of paper labeled ‘parking lot’. As students bring up topics that cannot be addressed at that exact moment, the topics get listed on the ‘parking lot’ for later discussion. The ‘parking lot’ serves as a reminder to the facilitator to come back and address the topics listed. Sensitivity is maintained because the topic is not discarded, but addressed at a more appropriate time. Stopping during the middle of a lesson to address an off the topic question can distract from the lesson. Coming back to the question at a break allows the instructor to completely address the question without making the student feel discounted.
Question Box

A ‘question box’ is a box specifically used for students to anonymously put questions in as they arise. For those students who may feel uncomfortable asking questions out loud, they can still receive an answer to their questions without feeling uncomfortable by placing the questions in the ‘question box’. The instructor should establish time in class where the questions in the ‘question box’ will be answered.

With regard to sensitivity, some of the lessons include required and recommended videos. Some of the videos recommended in lessons in this curriculum are sexually explicit and require extra time for processing students’ affective/emotional responses in addition to the time you would allow for processing the knowledge focused content. An instructor should never show a sexually explicit video – or any video – to a group without screening it first and leaving adequate time for processing (a general guideline is to allow two minutes of processing for every one minute of explicit content). The inclusion of recommended videos could substantially increase the estimated time required for that particular lesson. Recommended and even required videos that are easily and affordably accessible in the public domain can be assigned as homework in order to leave more time in class for interaction and discussion. Watching a sexually explicit film in any setting should be a voluntary decision based on informed consent. The facilitator must make the potential viewer aware of both the sexually explicit nature of the film and the setting in which it will be shown.

Time Required

“There is no stage in the training of the health professional at which teaching in this area would not be appropriate. It can begin in the first year, and it can be usefully included in refresher courses for health workers fully engaged in the practice of their profession” (WHO, 1974, p. 23). Ideally this curriculum would be taught over a typical semester in a university setting to give participants time to do the assigned reading in advance and to process their class experience afterwards. However, the lessons can be condensed into a two to three week intensive offering or delivered over several years of a program. Each lesson plan can be conducted in two-and-one-half to three-hour blocks of time; however, there is the option to augment the lessons with more media and more interactive activities if the luxury of time allows. Conversely, the instructor can adapt a lesson to relay the most essential elements in a shorter period if time does not allow otherwise. The instructor may exercise flexibility with the sequencing based on the teaching modalities used and the class’s progression through the course.

Class Composition

Class composition will vary based on the particular target audience and where you reach them. Familiarity with the various teaching methods described will help you create opportunities for small group discussions, even when teaching a large seminar of over 100 students. Many of the lessons require small group work, while others use large group discussion. Smaller numbers of students allow for deeper discussions and more processing of the content areas. Since the content in this course often evokes a variety of responses and emotions, it is essential to have the time to process.
Evaluation

Clear and comprehensive program evaluation procedures are also included in the curriculum. Evaluation of the lessons can be accomplished in a variety of ways both qualitatively and quantitatively: observation of discussions, written reactions, group interactions, generation of ideas, and formal testing are a few examples. We have generated three evaluation questions at the end of each lesson which can be used for discussion and/or formal testing and evaluation. A comprehensive list of the evaluation questions is also provided at the end of the curriculum in Appendix 2. You may email CESH at cesh@msm.edu to request answers. CESH will be happy to assist you.

Evaluations can occur on many levels throughout the course. Hedgepeth et al. (1996) stated:

Evaluation of learner progress provides feedback to the student and also further crystallizes concepts, facts, attitudes, and skills as they are reviewed and practiced during evaluation processes. Evaluation of the success of the lesson indicates what should take place in future lessons and allows student input into the progression of their sexuality education (p. 119).

Participants can be assessed in the following ways: through attendance and participation in class, the quality of the completed assignments, and observations.

Evaluation options

Attendance and participation: Students can be evaluated on attendance and participation by the number of times they are present in class, their contributions to the class, and the completion of their assignments. Since the lessons are interactive based on both experiential and academic learning, it is important that participants attend class. Giving them credit for their attendance and participation serves as a motivator for them to attend and participate.

Journal completion: Students can be evaluated on completion of periodic journal assignments. Not only does this reflect their participation in completing the assignment, but it also demonstrates that they read, or at least skimmed, the assigned readings. Journals are not only great tools for assessing learning and receiving feedback, but they are also great tools for students to explore their values, beliefs, and attitudes. Some students may use the journals as a forum for asking questions that they were uncomfortable asking in class.

Quality of discussion: By listening to the quality of the students’ discussions, the instructor can evaluate what learning has occurred and what is still needed. Listening allows the instructor to evaluate the accuracy of the information students are transmitting. If the students are quiet, the instructor may need to explore the reason behind the silence and assess what further teaching is needed.

Objective measures that make use of simulations, online cases or standardized patients in objective standardized clinical exams can also be used.

Conclusion

While it is our hope that schools will adopt this curriculum and cover all 18 universal topics in the depth we described, we recognize the challenges and practical logistics of adding substantial hours, which could easily amount to a full course, to an overall medical school or university curriculum. We trust that educators will review the purpose, rationale, objectives, procedures, required readings, and videos where appropriate and tailor the lessons to their own time constraints.
We hope you will be champions and advocates for the inclusion of the full array of sexual health topics covered in this universal curriculum for health professionals. For information about technical assistance for implementing this curriculum into your program, please contact CESH at cesh@msm.edu or (404) 756-5044.
Promoting Sexual Health and Responsible Sexual Behavior

**Instructional Materials**

Table 1 lists the materials needed for each lesson and where to obtain them. We recommend allowing ample time to obtain the materials that are not provided with this curriculum such as the required texts, copyrighted articles, and films. The source “Curriculum” in the table below is used to indicate materials such as handouts and discussion guides that are included. The source “Classroom” in the table below indicates standard classroom materials like a computer, Internet connection, projector and screen, TV and DVD player, newsprint and markers. Most materials that need to be obtained can be easily found through an Internet search. Suggested places to purchase materials listed in the table does not imply endorsement by CESH.

**Table 1: Instructional Materials**

<table>
<thead>
<tr>
<th>Lessons</th>
<th>Materials</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Sexuality Language &amp; Communication</strong></td>
<td>See Learning about Our Bodies: Language lesson</td>
<td>Our Whole Lives: Sexuality Education for Grades 10-12 (pp. 25-28)</td>
</tr>
<tr>
<td></td>
<td>TV and VCR</td>
<td>Classroom</td>
</tr>
<tr>
<td></td>
<td><strong>2. Models of Sexuality</strong></td>
<td></td>
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<tr>
<td></td>
<td>Handouts:</td>
<td></td>
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<tr>
<td></td>
<td>• Interplay of Self-Concept, Self-Identity, Sexual-Self, and Trauma / Illness</td>
<td><a href="http://her.oxfordjournals.org/cgi/reprint/17/1/43">http://her.oxfordjournals.org/cgi/reprint/17/1/43</a></td>
</tr>
<tr>
<td></td>
<td>• Sexual Health Model</td>
<td><a href="http://www.vch.ca/teensexualhealth/training_teen/HS_healthy_sexuality_mapping.htm#flower">http://www.vch.ca/teensexualhealth/training_teen/HS_healthy_sexuality_mapping.htm#flower</a></td>
</tr>
<tr>
<td></td>
<td>• Healthy Sexuality Flower Map</td>
<td><a href="http://www.advocatesforyouth.org/lessonplans/circlesofsexuality3.htm">http://www.advocatesforyouth.org/lessonplans/circlesofsexuality3.htm</a></td>
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<tr>
<td></td>
<td>• Circles of Sexuality</td>
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<td>• Parental Education Circles Model</td>
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<td>• ISIS Wheel of Sexual Experience</td>
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<td></td>
<td>• Models of Sexual Experience</td>
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<td></td>
<td>Models of Sexuality Power Point</td>
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<tr>
<td></td>
<td>Computer, projector, LCD screen</td>
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<tr>
<td></td>
<td>Intake/Sexual Assessment Screen</td>
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<td>Sex History Questionnaire</td>
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<td></td>
<td>Instructors</td>
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<td></td>
<td><strong>3. Values, Attitudes &amp; Beliefs</strong></td>
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<tr>
<td></td>
<td>Sexuality Knowledge, Attitudes, and Beliefs Pre-Test/Post-Test</td>
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<tr>
<td></td>
<td>See Sexuality and Values lesson</td>
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<tr>
<td></td>
<td><strong>4. Sexuality Across the Lifespan</strong></td>
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<tr>
<td></td>
<td>Newsprint and markers</td>
<td></td>
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<tr>
<td>Lessons</td>
<td>Materials</td>
<td>Source</td>
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<tr>
<td>----------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>5. Sexual Anatomy, Physiology &amp; Response Cycles</td>
<td>Green and purple male and female anatomy and physiology cards</td>
<td>Curriculum</td>
</tr>
<tr>
<td></td>
<td>Flip charts of male and female reproductive anatomy</td>
<td><a href="http://www.anatomywarehouse.com/Basic-Female-Pelvis-Section-Model-724">http://www.anatomywarehouse.com/Basic-Female-Pelvis-Section-Model-724</a></td>
</tr>
<tr>
<td></td>
<td><em>Men’s Health and Women’s Health pamphlets</em></td>
<td><a href="http://pub.etr.org/SearchCategoryResult.aspx?ID=0&amp;format=F&amp;language=1&amp;keyword=ReproductiveAnatomy&amp;searchType=All%20Keywords">http://pub.etr.org/SearchCategoryResult.aspx?ID=0&amp;format=F&amp;language=1&amp;keyword=ReproductiveAnatomy&amp;searchType=All%20Keywords</a></td>
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<tr>
<td></td>
<td><em>Film: Inside the Living Body</em></td>
<td><a href="http://pub.etr.org/ProductDetails.aspx?id=350000&amp;prodid=S104">http://pub.etr.org/ProductDetails.aspx?id=350000&amp;prodid=S104</a></td>
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<tr>
<td></td>
<td>Power Point</td>
<td>Curriculum</td>
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<tr>
<td></td>
<td>TV, DVD player, computer, LCD projector, screen, tape</td>
<td>Classroom</td>
</tr>
<tr>
<td>6. Gender &amp; Gender Variation</td>
<td>Handout: Gender Terminology List</td>
<td>Curriculum</td>
</tr>
</tbody>
</table>
|                                              | *Film: Changing Sexes: Female to Male*                                   | [http://www.amazon.com/Changing-Sexes---Female-Male/dp/B000MFQ1HE/ref=sr_1_2?ie=UTF8&
s=dvd&asid=1241047527&sr=8-2](http://www.amazon.com/Changing-Sexes---Female-Male/dp/B000MFQ1HE/ref=sr_1_2?ie=UTF8&s=dvd&asid=1241047527&sr=8-2) |
<p>|                                              | <em>Film: Is it a Boy or a Girl?</em>                                           | <a href="http://www.isna.org/videos/boy_or_girl">http://www.isna.org/videos/boy_or_girl</a>                |
|                                              | Computer with Internet access, LCD projector, screen, TV and DVD player  | Classroom                                                                                        |
| 7. Sexual Orientation, Identity &amp; Behavior   | Newsprint and markers, TV, DVD player, computer with Internet access, speakers, LCD projector, screen |                                                                                                  |
|                                              | <em>Handouts:</em>                                                               |                                                                                                  |
|                                              | • The Kinsey Scale                                                       | <a href="http://www2.huberlin.de/sexology/GESUND/ARCHIV/GIF2/KINS.GIF">http://www2.huberlin.de/sexology/GESUND/ARCHIV/GIF2/KINS.GIF</a> |
|                                              | • Cass Model of Homosexual Identity Development                          | Curriculum                                                                                        |
|                                              | • The Klein Sexual Orientation Grid                                      | <a href="http://www.bisexual.org/kleingrid.html">http://www.bisexual.org/kleingrid.html</a> |</p>
<table>
<thead>
<tr>
<th>Lessons</th>
<th>Materials</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>8. Relationships &amp; Love</strong></td>
<td>Computer with Internet access, LCD projector, screen, newsprint and markers</td>
<td>Classroom</td>
</tr>
<tr>
<td><strong>See Power and Responsibility lesson</strong></td>
<td></td>
<td><em>Our Whole Lives: Sexuality Education for Grades 10-12 (pp.185-187)</em></td>
</tr>
<tr>
<td><strong>9. Sexual Function, Problems &amp; Concerns</strong></td>
<td>Index cards, newsprint, markers, computer, LCD projector, screen</td>
<td>Classroom</td>
</tr>
<tr>
<td><strong>Sexual Function, Problems &amp; Concerns Power Point</strong></td>
<td></td>
<td><em>Curriculum</em></td>
</tr>
<tr>
<td><strong>10. Disabilities &amp; Chronic Conditions</strong></td>
<td>Disabilities &amp; Chronic Conditions Power Point TV, DVD player, computer, LCD projector, screen</td>
<td>Classroom</td>
</tr>
<tr>
<td><strong>Film: Sexuality Reborn</strong></td>
<td></td>
<td>Kessler Institute for Rehabilitation, Inc. (973) 243-6812</td>
</tr>
<tr>
<td><strong>Guidelines and discussion guide for video Sexuality Reborn</strong></td>
<td></td>
<td><em>Curriculum</em></td>
</tr>
<tr>
<td><strong>11. Fertility, Pregnancy &amp; Contraception</strong></td>
<td>See Becoming a Parent: Conception, Pregnancy, and Birth lesson</td>
<td><em>Our Whole Lives: Sexuality Education for Grades 10-12 (pp. 119-126)</em></td>
</tr>
<tr>
<td>**Computer with Internet access, speakers, LCD projector, screen,</td>
<td></td>
<td>Classroom</td>
</tr>
<tr>
<td><strong>markers, newsprint or chalk/white board, TV and DVD player</strong></td>
<td></td>
<td><a href="http://shop.nationalgeographic.com/product/2692.html">http://shop.nationalgeographic.com/product/2692.html</a></td>
</tr>
<tr>
<td><strong>Film: In the Womb</strong></td>
<td></td>
<td><em>Curriculum</em></td>
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<tr>
<td><strong>Handouts</strong></td>
<td><strong>Contraception Fact Sheet</strong></td>
<td><strong><a href="http://physed.sjsd.net/BC_Kits_Stdrd___Dlxe.pdf">http://physed.sjsd.net/BC_Kits_Stdrd___Dlxe.pdf</a></strong> or similar Internet search for “contraception**</td>
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<tr>
<td></td>
<td><strong>NFP chart</strong></td>
<td>**teaching kit”</td>
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<tr>
<td><strong>Contraceptive teaching kit</strong></td>
<td>(includes samples of birth control pills, patch, ring, Depo Provera vial, copper and Mirena</td>
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<tr>
<td><strong>Intrauterine Devices, Plan B, Today sponge, male and female condoms</strong></td>
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<tr>
<td>**and penis model, diaphragm and cervical cap, male and female</td>
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<tr>
<td><strong>sterilization diagrams, abstinence/Natural Family Planning</strong></td>
<td></td>
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<tr>
<td><strong>charts/thermometers/ovulation kits)</strong></td>
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<tr>
<td><strong>Contraception Jeopardy answers</strong></td>
<td></td>
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<tr>
<td><strong>12. Infertility</strong></td>
<td>Computer with Internet access and speakers, LCD projector, screen</td>
<td>Classroom</td>
</tr>
<tr>
<td></td>
<td>Film: Private Dicks: Men Exposed</td>
<td><a href="http://www.amazon.com/Private-Dicks-Exposed-Alan-Abel/dp/B000E1NWTW">http://www.amazon.com/Private-Dicks-Exposed-Alan-Abel/dp/B000E1NWTW</a></td>
</tr>
<tr>
<td></td>
<td>TV and DVD player, newsprint and markers</td>
<td>Classroom</td>
</tr>
<tr>
<td>Lessons</td>
<td>Materials</td>
<td>Source</td>
</tr>
<tr>
<td>---------</td>
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</tr>
<tr>
<td><strong>15. Culture &amp; Religion</strong></td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
I. Sexuality Language & Communication

Time Required
2 hours

Purpose
To explore the language of sexuality; to become comfortable discussing sexuality issues

Rationale
Communicating about sexuality can be difficult. It is essential to be able to communicate about sexuality professionally and personally for overall well-being. This interactive lesson allows participants to practice using language to increase comfort in discussing aspects of sexuality.

Objectives
- To generalize the affective aspects of different words
- To explain the ways that language use reflects attitudes
- To create a list of words for use with children, friends and/or partners, colleagues, patients
- To appraise which words are comfortable to use and which words cause discomfort
- To describe how the meaning of words can change based on the context they are used in

Materials

Procedure
2. Show film What Kids Want to Know about Sex and Growing Up. (60 minutes)
3. Facilitate a discussion around the following questions (15 minutes):
   - What forces and institutions make open communication about sexuality difficult?
   - What has hindered you from talking comfortably about sex and sexuality personally and professionally? What has helped you?
   - How have differences in age, race, culture, gender, professional position, and sexual orientation affected your ability to communicate in general and about sexuality?

Evaluation Questions
Instructors please email cesh@msm.edu to request answers.

1. The language used for communicating about sexuality changes based on the audience.
   A. True
   B. False
2. Which audiences do we need to be prepared to communicate with when it comes to sexuality issues?
   A. Adults
   B. Children
   C. Colleagues
   D. Partners
   E. Friends
   F. All of the above

3. Which of the following are barriers to communicating about sexuality?
   A. Personal discomfort with sexuality language
   B. A history of positive sexuality education
   C. Feeling ashamed or embarrassed about sexuality
   D. A & C
   E. All of the above
   F. F. None of the above

Required Readings

Recommended Readings

Film
2. **Models of Sexuality**

**Time Required**
2 hours

**Purpose**
To conceptualize sexuality; to explain the differences between sex, sexual health, and sexuality; and to identify all the aspects of sexuality

**Rationale**
Before one can begin teaching or counseling in sexuality, s/he must have an understanding of what sexuality is and how it differs from ‘sex’ and ‘sexual health’. This is a foundational lecture designed to help participants develop a definition of sexuality that they will continue to build upon throughout their careers as health professionals.

**Objectives**
- Compare and contrast a variety of sexuality models
- Compose a definition of sexual health that synthesizes sexuality from a biopsychosocial and spiritual perspective
- Use the definition of sexual health to guide sexual history taking with patients

**Materials**
- Handouts of the models:
  - Interplay of Self-concept, Self-identity, Sexual-Self, and Trauma/Illness (Roth Bayer, 2004)
  - Sexual Health Model (Robinson et al., 2002)
  - Healthy Sexuality Flower Map (BCCDC, 2003)
  - Circles of Sexuality (Advocates for Youth, 1995)
  - Parental Education Circles Model (National Consensus Process on Sexual Health & Responsible Sexual Behavior, 2006)
  - ISIS Wheel of Sexual Experience (Ogden, 2008)
  - Models of Sexual Experience (Timmers, 1976)
- **Models of Sexuality** Power Point slides, computer, LCD projector and screen
- **Intake/Sexual Assessment Screen**

**Procedure**
1. Tell the participants that the purpose of this lecture is to conceptualize sexuality and look at various models of sexuality
2. Give participants copies of the models for review during and after the presentation
3. Show the **Models of Sexuality** Power Point slides. As you are going through the slides, ask the participants the questions on the slides. Process each slide and ask the participants what they observe about the definitions and models presented
4. Refer participants to the Sex History Questionnaire and Intake/Sexual Assessment Screen to review asking questions about sexuality

**Evaluation Questions**

*Instructors please email cesh@msm.edu to request answers.*

1. Which of the following is not one of the Circles of Sexuality?
   A. Intimacy
   B. Masturbation
   C. Sexual Identity
   D. Sexualization

2. Which of the sexuality models depicts the environmental impact on sexuality?
   A. Sexual Health Model
   B. Healthy Sexuality Flower Map
   C. Circles of Sexuality
   D. Parental Education Circles Model

3. Which of the sexuality models was developed for HIV Prevention?
   A. Sexual Health Model
   B. Healthy Sexuality Flower Map
   C. Circles of Sexuality
   D. Parental Education Circles Model

**Required Readings**

- Healthy Sexuality Flower Map [http://www.vch.ca/teensexualhealth/training_teens/HS_healthy_sexuality_mapping.htm#flower](http://www.vch.ca/teensexualhealth/training_teens/HS_healthy_sexuality_mapping.htm#flower)
- Advocates for Youth (Circles of Sexuality) [http://www.advocatesforyouth.org/lessonplans/circlesofsexuality3.htm](http://www.advocatesforyouth.org/lessonplans/circlesofsexuality3.htm)

**Recommended Readings**

- Gomes, M. (n.d.). Intake/Sexual Assessment Screen. AASECT listserv/professional communication. Freely accessible, email drgomes@wilsh.us or cesh@msm.edu for access.
Defining ‘Sex’

How do you define sex?

- Biological characteristics that define humans as female or male
- Also can mean “sexual activity”
Defining ‘Sexual Health’

How do you define ‘sexual health’?

World Health Organization

Purpose of sexual health care:

- Enhancement of life and personal relationships not merely counseling and care related to procreation or sexually transmitted diseases (HIV/AIDS).

Sexual health

- Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

- 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. Fundamental to this concept are the right to sexual information and the right to pleasure.

Defining ‘Sexuality’

How do you define ‘sexuality’?
Defining ‘Sexuality’

- Central aspect of being human throughout life
- Encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction
- Experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships.
- Influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.

Defining Self-concept

“Self-concept is a composite of thoughts, values, and feelings that one has for one’s physical and personal self at any given time, formed from interactions with the environment and with other people, and directing one’s behavior” (LeMone, 1991, p. 129).

Defining Self-identity

“Self-identity is defined as a life story which is socially constructed and constantly being revised throughout the life span, and which provides a sense of continuity despite change” (Dien, 2000, p. 1).
Defining Sexual-self

- Sexual-self is a deep aspect of the total person beginning in utero and continuing until death and is comprised of sexual identity, body-image, sexual orientation, sex role, and sexual aspects of oneself that guides sexual behavior.


Interplay of Self-concept, Self-identity, Sexual-Self, and Trauma/Illness (Roth Bayer, 2004)

Models of Human Sexuality

How do you conceptualize human sexuality?
**Parental Education Circles Model**


**ISIS Wheel of Sexual Experience**

(Ogden, 2006)

**Models of Sexual Experience**

(Timmer, 1976)
Comparing and Contrasting Models

What similarities do you see between the models?

What differences do you see between the models?

Applying the Models to Practice

How do the Human Sexuality Models effect the way you interact and treat patients?

References

References

- Roth Bayer, C (2005). Nurses’ perceptions of the sexuality of pediatric, critical care patients. Presentation at the American Association of Sex Educators, Counselors and Therapists Conference. Portland, OR.

MOREHOUSE SCHOOL OF MEDICINE

Models of Sexuality

Promoting Sexual Health and Responsible Sexual Behavior: A Universal Curriculum for Health Professionals

Center of Excellence for Sexual Health
Satcher Health Leadership Institute
Morehouse School of Medicine
Interplay of Self-concept, Self-identity, Sexual-Self, and Trauma/Illness

From Roth Bayer, C (2004). Nurses’ perceptions of the sexuality of pediatric, critical care patients. Used with permission
3. Values, Attitudes & Beliefs

Time Required
2½ hours

Purpose
To have basic factual knowledge about sexuality; to be comfortable with open discussion of sexuality issues; to understand your values

Rationale
Everyone has values, attitudes, and beliefs, especially about sexuality issues. It is essential to understand not only one’s values, but also how they are shaped and developed. This lesson allows the participant to not only explore her/his own values, but also gain an understanding of values different from his/her own.

Objectives
• To explore personal values, beliefs, and attitudes pertaining to sexuality
• To compare and contrast controversial perspectives
• To clarify areas of agreement and disagreement on controversial issues

Materials
• Sexuality Knowledge, Attitudes, and Beliefs Pre-Test/Post-Test
• See Kimball, RS (2000). “Sexuality and Values” (pp. 15-23) in Our Whole Lives: Sexuality Education for Adults.

Procedure
1. Develop a Sexuality Knowledge, Attitudes, and Beliefs test based on the sexuality content you will cover in your course. (examples of sexuality knowledge, attitudes, and beliefs tests can be found in: Davis, C. et al. (Eds). (1998). Handbook of sexuality-related measures. Thousand Oaks, CA: SAGE Publications, Inc.) This should be done prior to the day of the session.
2. Administer the test at the beginning of this session and instruct the participants that the same test will be administered at the completion of the course as a post-test. (30 minutes)
3. Collect the test and keep it on file for comparison at the end of the course.
**Evaluation Questions**

*Instructors please email cesh@msm.edu to request answers.*

1. Which of the following influence one’s sexuality values, attitudes, and beliefs?
   - A. Culture
   - B. Religion
   - C. Education
   - D. A & C only
   - E. A, B, & C

2. Sexuality values, attitudes, and beliefs may change over time?
   - A. True
   - B. False

3. When encountering someone whose sexuality values differ from yours, you should do which of the following:
   - A. Ignore the person’s values and exert that your values are the only correct values.
   - B. Respect the person’s values and engage in a discussion to understand them further.
   - C. Judge the person based on stereotypes.
   - D. A & C only

**Required Readings**


**Recommended Readings**

4. **Sexuality Across the Lifespan**

**Time Required**
1 hour

**Purpose**
To illustrate the concept that people are sexual beings from birth to death

**Rationale**
People often misunderstand the term “sexuality” to mean strictly the physical aspects of coitus. Before we can begin talking about the extensive role sexuality plays in someone’s life and in the provision of sexual health care, participants must understand the full spectrum of human sexuality. This activity provides a fun, interesting way for participants to think about sexuality and how its expression changes at different stages of life. This activity also allows participants to explore their own assumptions and attitudes about sexual expression at different ages and how these assumptions may affect them personally and professionally.

**Objectives**
- Explain at least three ways a person can express his/her sexuality at each of eight stages of the life cycle
- Identify personal attitudes, values, and beliefs about various forms of sexual expression by individuals at each stage of the life cycle
- Appraise comfort levels with various forms of sexual expression by individuals at each stage of the life cycle
- Compose a holistic definition of sexuality that recognizes a broad range of aspects, including: biological, physiological, psychological, social, relational and spiritual

**Materials**
- Newsprint and markers

**Procedure**
1. Hang up eight newsprint sheets around the room, each with one of the following life stages written at the top: in utero, infant (ages 0 to 2), young child (Ages 3-11), adolescent (Ages 12 to 19), young adult (Ages 20-39), middle adult (Ages 40-64), older adult (Ages 65 and beyond), end of life (relative to know fatal condition).
2. Break up participants into groups and have each group start at one stage of the life cycle. Hand out markers to participants and ask participants to brainstorm as many developmental milestones and as many ways possible for a person to express his or her sexuality at that particular stage of life. Ask them to consider biological, psychological, social, religious, and legal influences at each stage. Have them list everything on the newsprint.
3. After about 3-4 minutes have participants move clockwise to the next stage and do the same for that one. Continue to rotate the groups until all have visited each of the stages, adding to the lists of previous groups or putting check marks next to items on the list they agree with.
Facilitators make suggestions of sexual expressions that may have been left out. For example, if spiritual items are lacking, ask if a Confirmation or Bar Mitzvah could be considered a form of sexual expression.

4. Process: Go through each stage and have a participant read off the list. Discuss the following questions:
   - What do you notice?
   - What are the similarities among the stages?
   - What are the differences among the stages?
   - Is it possible that some items listed may also be expressed at an earlier or later stage in life?
   - What senses are involved in sexual expression? (Even if all 5 senses have not been included, encourage participants to think of ways that sexuality can be expressed with each of the senses: touch, taste, hearing, smell, and sight).
   - How was it for you to see all these ages as sexual?

5. After discussion, have the group try to come up with a definition of sexuality. Encourage participants to derive a definition that incorporates biological, physiological, psychological, social, emotional, spiritual, and relational aspects of sexuality. What do we gain by a broader definition? How does sexuality affect our self-esteem?
   - Alternative if pressed for time: Hand out a definition of sexuality and then ask how it fits or does not fit the areas that came up in the exercise.

6. Optional: Give each group newsprint and markers and ask participants to draw the center of sexuality using the definition. Allow approximately 5 minutes. If you want to begin a discussion about gender, you can assign individual groups to draw the center of male, of female, and of human sexuality.
   - Have participants post their drawings and interpret them for the rest of the group.
   - Did people draw genitals, brains, hearts, toes, angels? Process with regard to a holistic definition of sexuality. What is the relationship between centrality and holism?

**Evaluation Questions**

Instructors please email cesh@msm.edu to request answers

1. It is perfectly normal for a child of three or four years of age to engage in sex play with members of their own sex.
   - A. True
   - B. False

2. All of the following are typically considered as rites of passage in adolescents except:
   - A. First masturbation
   - B. Getting your driver’s license
   - C. Confirmation
   - D. Going to the prom
   - E. Starting your period
3. Which of the following would you expect to see in both young and older adults?
   A. Use of online dating sites
   B. Experimenting sexually with members of the same sex
   C. Getting married
   D. Unprotected sexual intercourse
   E. All of the above
   F. A and C

**Required Readings**


**Recommended Readings**


**Recommended Films**


* Portions of this lesson adapted with permission from *Providing Comprehensive Sexual Health Care in Spinal Cord Injury Rehabilitation* © 1997 by Mitchell S. Tepper
5. Sexual Anatomy, Physiology & Response Cycles

Time Required
2-4 hours (4 hours if showing the whole movie)

Purpose
To use sexuality language to communicate about the sexual anatomy and physiology, and to conceptualize the variation in sexual response cycles

Rationale
Participants are rarely given the opportunity to discuss sexual anatomy and physiology. Just because they may have the anatomy does not mean they know its name or its functions. This lesson allows participants to interactively process the female and male sexual anatomy while discussing the functions. Then, they apply that knowledge to a discussion and critique of several models of human sexual response cycles.

Objectives
- To correctly identify the specific male and female sexual anatomical parts and their functions
- To identify similarities and differences in the female and male sexual anatomy
- To describe and critique the following models of sexual response: Moll, Reich, Masters and Johnson, Kaplan, Zilbergeld and Ellison, Reed, Whipple, Basson

Materials
- Green cards with each male part on one and the function on another
- Purple cards with each female part on one and the function on another
- Tape
- Plastic models of the male and female reproductive anatomy
- Flip charts of male and female reproductive anatomy
- Men’s Health and Women’s Health pamphlets
- Film: Inside the Living Body (2007)
- Human Sexual Response Cycles Power Point, computer, LCD projector, screen
- TV, DVD player, computer, LCD projector, screen

Procedure
1. Stand flip charts up around the room
2. Put plastic models out for viewing and handling
3. Have tape already torn for posting the cards around the room
4. Explain that this lesson is on the sexual/reproductive anatomy and physiology or ‘the parts and their functions’. Break the students up into groups of 3-4.
5. Give each group a stack of cards with the anatomy on one and the physiology on the other. Make sure the cards are mixed up so the group has to think about which part matches which function. Tell the groups to discuss the parts and functions and match them up.
6. When the groups have matched all their parts and functions, have one person from the group come up and tape their matching cards on the board at the front of the room. All the purple cards will go on one side and all the green cards will go on the other side.

7. Once all the parts are taped to the board and the students are all seated, go through each part and ask the class if they agree with the function that it is matched with. If they agree, have a volunteer show the class on the model or chart where the part is located. If they do not agree, find the correct function amongst the rest of the cards, correct the match and then have the volunteer demonstrate the location.

8. Go through all the parts and functions with different volunteers demonstrating on the models/chart each time.

9. Discuss what similarities and differences the group noticed between the male and female sexual anatomy and physiology.

10. After all the discussion is complete, ask if there are any questions about the anatomy and physiology.

11. Hand out the pamphlets on Women’s Health and Men’s Health.

12. Show the film Inside the Living Body (95 minutes)

13. When the film is complete, ask the participants their reactions to the film. Ask them if their conceptualization of body systems and sexuality changed at all while viewing the film. Emphasize how each body system plays a role in one’s sexuality.

14. Transition from anatomy and physiology to sexual response. Break out into small groups of males and females; have them describe the typical male or female sexual response cycles from beginning to end. Have the women comment on the men’s descriptions and the men on the women’s.

15. Show the Human Sexual Response Cycles Power Point slides.

16. Compare groups’ descriptions of male and female sexual response from before the review and ask the participants what they observe about the similarities and differences among the cycles presented, as well as critiques of the cycles

**Evaluation Questions**

_Instructors please email cesh@msm.edu to request answers._

1. What is the largest sexual organ in/on the body?
   A. Brain
   B. Skeleton
   C. Skin
   D. Heart

2. Which organ systems are involved in one’s sexual response?
   A. Circulatory System
   B. Nervous System
   C. Respiratory System
   D. Reproductive System
   E. All of the above

3. Women and men have the same sexual response cycles.
   A. True
   B. False
Required Readings


Recommended Readings


Film

Describe Sexual Response Cycle

- Describe the typical able-bodied female and male sexual response cycle from beginning to end in as much detail as possible.
**Moll’s Sexual Response Cycle** (1909)
- Onset of voluptuousness
- Equable voluptuous sensation
- Voluptuous acme
- Sudden decline

**Reich’s Sexual Response Cycle** (1927)
- Mechanical tension
- Bioelectric charge
- Bioelectric discharge
- Mechanical relaxation

**Masters & Johnson Human Sexual Response Cycle**
- The Excitement Phase
- The Plateau Phase
- Orgasm
- Resolution
The Excitement Phase

**MALE**
- Erection
- Testes Rise
- Scrotal skin changes
- Pulse, blood pressure, respiration

**FEMALE**
- Vaginal lubrication
- Labial engorgement
- Clitoral erection
- Vaginal expansion
- Rising of uterus
- Pulse, blood pressure, respiration

The Plateau Phase

**MALE**
- Testes rise further
- Cowper’s glands emission
- Pulse, blood pressure, respiration

**FEMALE**
- Orgasmic platform
- Color deepens
- Swelling of labia
- Uterus rises further
- Clitoral changes
- Pulse, blood pressure, respiration
**Orgasm**

**MALE**
- Muscular contractions
- Emission phase: buildup of fluids in prostate
- Propulsion phase: ejaculation of semen
- Dramatic changes in pulse, blood pressure, respiration

**FEMALE**
- Muscular contractions
- Uterus may rise markedly
- Basin below uterus attains greatest size
- Dramatic changes in pulse, blood pressure, respiration

**Resolution**

**MALE**
- Penis declines partially
- Penis, testes, scrotum regain non-stimulated appearance
- Pulse, blood pressure, respiration rates drop
- Possible restimulation
- Perspiration

**FEMALE**
- Vulva, breasts, other organs return to non-stimulated condition
- Pulse, blood pressure, respiration rates drop
- Possible restimulation
- Perspiration

**Helen Kaplan and Desire**

- Tri-phasic model
  - Desire
  - Vascongestion of the genitals
  - Reflex muscular contractions of orgasm
- Inhibited and hypoactive sexual desire
Erotic Stimulus Pathway

The Erotic Stimulus Pathway Model of David Reed

Sexual Response Cycles Compared

Erotic Stimulus Pathway of Reed compared with Masters and Johnson’s HSRC, and Kaplan’s Triphasic Model

Zilbergeld and Ellison Sexual Response Cycle (1980)

- Interest (desire)
- Arousal
- Physiological readiness (erection, vaginal lubrication)
- Orgasm
- Satisfaction (one’s evaluation of how one feels)
Basson’s Sexual Response Cycle

What systems are responsible for healthy sexual functioning?
**Cardiovascular System**
- Heart
- Blood
- Arteries
- Veins

**Respiratory System**
- Nasal Cavity
- Bronchi
- Lungs
- Diaphragm

**Muscular and Skeletal Systems**
Endocrine System

- Hypothalamus
- Pituitary Gland (Hypophysis)
- Adrenal Gland
- Ovaries
- Testes

Reproductive System

Nervous System

- Brain
- Spinal Cord
- Peripheral Nerves
  - 12 pairs of cranial nerves
  - Autonomic System
    - Sympathetic division
    - Parasympathetic division
  - Somatic System
Sensory Organs

- Ears
- Eyes
- Fingernails
- Mammaries
- Nose
- Skin & Hair
- Tongue

References

### Male Anatomy and Physiology

<table>
<thead>
<tr>
<th>Anatomical Part (front of card)</th>
<th>Anatomical Description (back of card)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corona</td>
<td>The rim of the penile glans</td>
</tr>
<tr>
<td>Cowper’s Gland (Bulbourethral glands)</td>
<td>Produces a slippery, mucus-like substance that appears in droplet form at the tip of the penis at the beginning of sexual arousal</td>
</tr>
<tr>
<td>Ejaculatory Ducts</td>
<td>Two ducts located in the prostate gland</td>
</tr>
<tr>
<td>Epididymis</td>
<td>The structure along the back of each testicle in which sperm maturation occurs</td>
</tr>
<tr>
<td>Foreskin</td>
<td>A covering over the penile glans</td>
</tr>
<tr>
<td>Frenulum</td>
<td>A highly sensitive, thin strip that connects the glans to the shaft on the underside of the penis</td>
</tr>
<tr>
<td>Penis</td>
<td>The male sex organ made up of the internal root, external shaft, and the glans</td>
</tr>
<tr>
<td>Prostate Gland</td>
<td>Located at the base of the bladder, this gland produces 30% of the seminal fluid</td>
</tr>
<tr>
<td>Scrotum</td>
<td>The pouch that holds the testicles</td>
</tr>
<tr>
<td>Seminal Vesicles</td>
<td>These small glands secrete a major portion of the seminal fluids</td>
</tr>
<tr>
<td>Seminiferous Tubules</td>
<td>Thin, coiled structures in the testicles in which sperms are produced</td>
</tr>
<tr>
<td>Sperm</td>
<td>The reproductive male cell</td>
</tr>
<tr>
<td>Spermatic Cord</td>
<td>This cord contains the vas deferens, blood vessels, nerves, and cremasteric muscle fibers</td>
</tr>
<tr>
<td>Spongy Body (Corpus Spongiosum)</td>
<td>This chamber runs along the underside of the penis and becomes engorged during sexual arousal</td>
</tr>
<tr>
<td>Testes</td>
<td>They sit inside the scrotum and produce sperm and sex hormones</td>
</tr>
<tr>
<td>Urethra</td>
<td>The tube that carries urine from the bladder to the outside of the body</td>
</tr>
<tr>
<td>Vas Deferens</td>
<td>A sperm-carrying tube that begins at the testicle and ends at the urethra</td>
</tr>
</tbody>
</table>
### Female Anatomy & Physiology

<table>
<thead>
<tr>
<th>Anatomical Part (front of card)</th>
<th>Anatomical Description (back of card)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bartholin’s Glands</td>
<td>One on each side of the vaginal opening, which produce a few drops of fluid just prior to orgasm</td>
</tr>
<tr>
<td>Cervix</td>
<td>The small end of the uterus located at the back of the vagina</td>
</tr>
<tr>
<td>Clitoris</td>
<td>The only purpose of this structure is sexual pleasure</td>
</tr>
<tr>
<td>Fallopian Tubes</td>
<td>Two tubes extending from the uterus where the oval and sperm travel</td>
</tr>
<tr>
<td>Fimbriae</td>
<td>Fingerlike projections at the end of the fallopian tubes into which the ovum enters</td>
</tr>
<tr>
<td>Grafenberg (G-spot) Spot</td>
<td>Glands and ducts felt through the anterior wall of the vagina; some women may ejaculate from stimulation to this area</td>
</tr>
<tr>
<td>Introitus</td>
<td>The lower part of the vagina</td>
</tr>
<tr>
<td>Labia Majora</td>
<td>The outer lips</td>
</tr>
<tr>
<td>Labia Minora</td>
<td>The inner lips</td>
</tr>
<tr>
<td>Ova/Eggs</td>
<td>The female reproductive cells</td>
</tr>
<tr>
<td>Ovaries</td>
<td>Almond-shaped organs that produce ova and sex hormones</td>
</tr>
<tr>
<td>Perineum</td>
<td>The area between the vagina and the anus</td>
</tr>
<tr>
<td>Urethra</td>
<td>The tube that carries urine from the bladder to the outside of the body</td>
</tr>
<tr>
<td>Uterus</td>
<td>A pear-shaped organ in the pelvis where the fetus develops</td>
</tr>
<tr>
<td>Vestibular Bulbs</td>
<td>One on each side of the vagina that engorge with blood during sexual arousal</td>
</tr>
<tr>
<td>Vestibule</td>
<td>The opening to the vagina</td>
</tr>
</tbody>
</table>

* Portions of this lesson adapted with permission from *Human Sexuality Education for the Community College Student* © 2003 by Carey L. Roth and from *Providing Comprehensive Sexual Health Care in Spinal Cord Injury Rehabilitation* © 1997 by Mitchell S. Tepper.
6. Gender & Gender Variation

Time Required
2 hours + film viewing time prior

Purpose
To understand the difference between sex and gender and familiarize the learner with the concepts and lived experiences of people who are transgender, transsexual and intersex

Rationale
It is important to understand why sex and gender roles influence how we see ourselves and others, particularly those who appear, live and behave beyond the constraints of “traditional” binary gender roles (i.e. male/masculine and female/feminine). This lesson will analyze and deconstruct ideas of gender, conceptualize how changing concepts of gender have affected our society and introduce the concepts of transgender, transsexual and intersexuality as genders that are neither male nor female.

Objectives
- Define gender, transgender, transsexual and intersex
- Describe the difference between sex and gender, and transgendered, transsexual and intersex
- Analyze prescriptive socialized gender roles
- Discuss the rationale and health implications or gender assignment surgery for intersex newborns and infants in the United States

Materials
- Handout: Gender Terminology List
- Computer with Internet access, LCD projector, screen
- Films: Changing Sexes: Female to Male, The “John/Joan Case”: The Boy They Tried to Make Into a Girl and Is it a Boy or a Girl?
- TV and DVD player

Procedure
1. Prior to the lesson, participants should view the film Changing Sexes: Female to Male
2. Discuss the following questions about gender:
   - What is gender?
   - What is the difference between sex and gender?
   - List normative gender roles for boys and men; for girls and women
   - How is gender identity formed?
   - How do your personal ideas of male/masculine and female/feminine gender roles differ from what you see as “traditional” gender roles for men and women?
3. Discuss the following questions about the assigned reading “A Fabulous Child’s Story” (remind the group that this is a work of fiction!)
   - What are your general reactions from this story?
   - What are some of the messages Gould is trying to convey in this story?
How did the parents’ gender roles deviate from prescribed gender roles as they raised X?

What did the Other Children learn about themselves?

While this is a work of fiction, what do you think the realities would be if a child were being raised without gender? What effects would this reality have on the child? Other children? The parents? The community?

4. Distribute the handout “Gender Terminology List” to the group and give them several minutes to read through the definitions.

Challenge the group to use the pronouns “hir” instead of “him” and “her” and “ze” or “sie” instead of “he” and “she” from the Gender Terminology List for the remainder of the class.

5. Then show the film *The “John/Joan Case”: The Boy They Tried to Make Into a Girl* available at [http://www.videosift.com/video/The-Story-of-David-Reimer-JohnJoan](http://www.videosift.com/video/The-Story-of-David-Reimer-JohnJoan), and facilitate a discussion around the following questions to frame the issue of gender variation:

- Is gender identity biologically or socially determined?
- Who or what most influenced your gender identity and in what ways?

6. Participants were responsible for viewing *Changing Sexes: Female to Male* prior to this class meeting. Facilitate a discussion of the film around the following questions:

- What were your general reactions to and specific personal challenges in viewing this film?
- What did this film teach you about transsexuality/transgenderism?
- What particular challenges did you see in the film around the relationships the transsexuals had with:
  - Themselves
  - Their friends and family?
  - Their careers?
  - Their communities?

7. As a group, view the film *Is it a Boy or a Girl?* and facilitate a discussion around the following questions:

- What were your general reactions to and specific personal challenges in viewing this film?
- What did this film teach you about intersexuality?
- What are your feelings around sex assignment surgery for intersex babies and children? Is it helpful or harmful to the child and parents?
- The article from the UK Intersex Association [http://www.ukia.co.uk/diamond/ped_eth.htm](http://www.ukia.co.uk/diamond/ped_eth.htm) compares surgical correction of ambiguous genitals to surgical correction of a cleft palate. Is this a fair comparison? Is it the same or comparable to correct a deformed face as to correct deformed genitals when there are no other health problems?
**Evaluation Questions**

*Instructors please email cesh@msm.edu to request answers.*

1. What influences prenatal sex differentiation?
   - A. Chromosomes
   - B. Testosterone
   - C. Maternal nutrition
   - D. Both A and B
   - E. All of the above

2. Approximately how many live births are believed to be intersex?
   - A. 1 in 150
   - B. 1 in 2,000
   - C. 1 in 10,500
   - D. 1 in 150,000

3. What condition is present when one’s sex assignment does not match one’s gender identity?
   - A. Androgyny
   - B. Intersex
   - C. Asexuality
   - D. Transgender

**Required Readings**

- The UK Intersex Association. “Pediatric Ethics and the Surgical Assignment of Sex.” [http://www.ukia.co.uk/diamond/ped_eth.htm](http://www.ukia.co.uk/diamond/ped_eth.htm)
- Intersex Society of North America [http://www.isna.org](http://www.isna.org)
- The World Professional Association for Transgender Health [http://www.wpath.org](http://www.wpath.org)

**Recommended Readings**

- Harry Benjamin International Gender Dysphoria Association (2001). *Standards Of Care For Gender Identity Disorders, Sixth Version* (PDF available through CESH or [http://www.wpath.org](http://www.wpath.org)).

Films
• Miller, NJ and Soiseth, TV (Executive Producers) (2002). Changing Sexes: Female to Male [Film]. United States of America: Discovery Channel. (Viewing required prior to class meeting)
• The “John/Joan Case”: The Boy They Tried to Make Into a Girl
Gender Terms:
Words We Speak,
Words We Tweak

The following glossary of terms and definitions helps provide a common language for discussing gender identity and transgender issues. The glossary incorporates vocabulary from various sources and will continue to evolve as dialogue on gender, trans, intersex, queer, same-gender loving and LGB issues evolves. Recognizing the importance of clarity in communication on issues related to gender and sexuality, we encourage frank discussion and shared understanding regarding the language used to talk about these issues.

Each person has the right to define their gender for themselves. To question one’s gender identity, and explore or play with gender expression is healthy, normal, and something to be celebrated. We believe no one should feel obligated to unquestioningly accept the gender identity assigned to them. We encourage everyone to use vocabulary and terms that feel right for your experiences.

This glossary was created by T. Aaron Hans, with support from Melisa S. L Casumbal, Ken Carl, Alicia Schmidt, and NYAC. These terms reference and draw on the groundbreaking work of many trans scholars and activists, who we thank and acknowledge: Kate Bornstein, James Davis-Rosenthal, Dallas Denny, the former American Educational Gender Information Services, James Green, Shadow Marion, Leslie Feinberg, Nancy Nangeroni, Kiki Whillock, Riki Anne Wilchins, Female to Male International, and Gary Bowen. Thank you for inspiring so many.
ADDITIONAL PRONOUNS: Pronouns such as “ze,” “hir,” and “per,” which do not denote rigid masculinity or femininity. Coined by trans activists and scholars, such gender-bending pronouns emerged (and may continue to emerge) in opposition to, and in recognition of, the insufficiency of gender-specific pronouns (i.e., him, her, his, hers, she, and he) to refer to trans and gender-variant people. (See also ZE, HIR, PER.)

ANDROGYNY (ALSO ANDROGYNOUS): A person who expresses and/or presents merged culturally/socially defined feminine and masculine characteristics, or mainly neutral characteristics. May or may not express dual gender identity.

ASSIGNED GENDER: The declaration by doctors of what one’s gender is based upon what one’s genitalia appear to be. One is then expected to grow up and exist within a certain set of gender roles “appropriate” to one’s assigned gender. (See also GENDER [SEX] ASSIGNMENT).

BI-GENDER: A person who identifies as both or some combination of the two culturally prevalent genders. A bi-gender individual may shift their gender identity and/or expression from one gender to another, or a combination of genders, in ways that make sense to them — such shifting may occur on an hourly, daily, monthly, or yearly basis.

BINARY GENDER SYSTEM: A culturally/socially defined code of acceptable behaviors which teach that there are men and women, who are masculine and feminine, and that there is nothing outside of this system. Most popular discussion on gender assumes a binary gender system. Discussion of trans issues and identities, however, challenges a binary gender system and forces us to think of gender within a multi-gender system.

BINDING: The practice of wrapping or taping in order to compress the chest or “breast tissue” so that one can pass as a man. This is done with extremely tight bras, elastic bandages, and other methods.

BIPHOBIA: The irrational fear of people perceived as bisexual. Biphobia also includes refuting the existence of bisexuality by promoting the belief that every individual is either homosexual or heterosexual.

BISEXUAL (BI): An individual who is emotionally, spiritually, physically, and/or sexually attracted to those of either gender (clinical term). Within bisexual communities, many find themselves attracted to multiple gender expressions and gender identities, and actively oppose a binary gender system.

CREATE YOUR OWN LANGUAGE!
TRANSPHOBIA (ALSO GENDERPHOBIA): The irrational fear of those who are perceived to break or blur stereotypical gender roles. Expressed as negative feelings, attitudes, actions, and institutional discrimination. Often directed at those perceived as expressing or presenting their gender in a transgressive way, defying stereotypical gender norms, or who are perceived to exhibit non-heterosexual characteristics—regardless of individuals' actual gender identity or sexual orientation. (See also HOMOPHOBIA.)

TRANSSENSUAL: An individual who is emotionally, spiritually, physically, and/or sexually attracted to those of any trans-identified genders or a specific trans-identified gender.

TRANSSEXUAL: An individual who experiences intense, persistent, long-term discomfort with their body and self-image due to the belief that their assigned gender is inappropriate. This individual may then take steps to adapt or change their body, gender role and gender expression in order to achieve congruence with their gender identity, (what they believe their true gender to be). Such steps may include cross-living, hormone use, surgery, and/or other body modification. Taking such steps may or may not lead to a feeling of harmony or congruence between a person's body and gender identity. After transitioning and surgery some transsexuals who are living full-time identify only as a man or a woman. (See also F2M/FTM/MALE-TO-MALE, M2F/MTF/FEMALE-TO-MALE, PRE-OPERATIVE, POST-OPERATIVE, NON-OPERATIVE)

TUCK: The technique of hiding male genitals.

TWO-SPRIT: A term used by some indigenous/First Nation/Native American people to describe the experience of being, in Euro-American-centric terms, lesbian, gay, bisexual, or transgender. For a lengthy discussion on the use of this term, refer to Gary Boven's article, "Transgendered Native Americans" (1996), available through The American Boyz (contact information via their website at: http://www.amboyz.org/articles/native.html).

WOMAN: A term referring to someone who identifies as such, who may often exhibit feminine or female characteristics (see FEMALE and FEMALE). Popularly understood within a binary gender system to refer to someone who is female-bodied.

ZE: (pronounced "zee"). Used in place of "she/he," a pronoun coined by trans activists to refer to individuals who identify as existing/presenting outside of a binary gender system and its rigid delineations of "male" and "female." (See also ADDITIONAL PRONOUNS.)

BOTTOM SURGERY: Surgery "below the waist," to create either a vagina (for a male-to-female, or MTF), or a penis and testicles (for a female-to-male, or FTM). Factors people consider in deciding whether or not to have bottom surgery include: degree of desire or need, expense, physical health, age, and access to medical care and information. There are risks and complications associated with these surgical procedures, which should be discussed with medical professionals. Such risks and complications are also a factor in individuals' decision-making regarding these surgeries.

BOYDYKE: A female-bodied person who intentionally or non-intentionally expresses and/or presents culturally/stereotypically masculine, particularly boisy, characteristics. (See also DYKE.) Also, one who enjoys being perceived as a young male (See PASSING).

BUTCH: This term can be used to identify any person who expresses and/or presents culturally/stereotypically masculine characteristics. A person, who self-identifies, mainly with the stereotypically masculine and at a gender characteristic spectrum. Within lesbian, bisexual women's, and trans communities, a female-bodied person who self-identifies as butch and understands the intricacies of, and exhibits, a masculine spirit. ("Butch" is not, however, a term used by lesbian, bisexual women's and trans communities exclusively.)

BUTCH QUEEN: A masculine gay man.

CAMP (ALSO CAMPY): A culturally specific play on gender, sexuality, and heterosexual norms that occurs within the LGBT community.

COMING OUT: The process of becoming aware of, understanding, and accepting the sexual orientation, gender identity, and/or gender expression of oneself, one's family member(s), one's partner(s), or one's friend(s). Also, the ongoing process of decision-making about the level of openness a person feels in disclosing such information about oneself or one's family member(s), partner(s), or friend(s) to others. (See also IN THE CLOSET.)

CROSS-DRESSING (ALSO TRANSVESTITE, TRANSVESTITISM): A person who, on occasion, wears the clothing considered typical for another gender, but who does not desire to change their gender. Reasons for cross-dressing can range from a need to express a feminine or masculine side to attainment of erotic/sexual/fetish gratification. Cross-dressers can be of any sexual orientation; the majority of cross-dressers tend to identify as heterosexual/straight. For more information regarding cross-dressing, contact Cross Dressers International (CDI).
CROSS-LIVING: Cross-dressing full-time (also referred to as 24/7), and living as the gender that one believes oneself to be.

DRAB: Acronym for “Dressed as a Boy.”

DRAG (ALSO DRAG KING, DRAG QUEEN, FEMALE/MALE IMPERSONATOR): Wearing the clothing of another gender, often involving the presentation of exaggerated, stereotypical gender characteristics. Individuals may identify as Drag Kings (male in drag) or Drag Queens (male in drag). Drag often refers to dressing for functional purposes such as entertainment/performance or social gatherings. Drag has held a significant place in LGBT history and community. Can also be an acronym for “Dressed as a Girl.”


DYKE (ALSO FEMME DYKE, BUTCH DYKE, BI DYKE): A person who identifies as a woman, and who is emotionally, spiritually, physically, and/or sexually attracted primarily to women. This term is reclaimed or appropriated in a positive way by many types of people for the purpose of self-identification, and can be political. “Dyke” has been historically used in a pejorative way, to ridicule and label lesbians who were/are perceived to express or present stereotypically masculine characteristics.

EFFEMINATE: A term used to identify a person (usually male) who expresses, and/or presents, culturally/stereotypically feminine characteristics. Often used in a pejorative way, due to sexism.

F2M, FTM, FEMALE TO MALE, FEMALE TOWARDS MALE: A term used to identify a person who was assigned a female gender at birth or is female-bodied, and who identifies as male, lives as a man, or identifies as masculine. Some use this as an identifier to let others know where on the spectrum they come from and the direction they might be headed. Others in the community use the signifier MTF, male-to-male, to affirm their belief that their assigned gender was inaccurate.

THIRD GENDER: A term used to describe people who feel they are other than male or female, or a combination of both.

TOP SURGERY: Surgery “above the waist,” usually breast augmentation for MTFs and breast reduction for FTM. Factors people consider in deciding whether or not to have bottom surgery include: degree of desire or need, expense, physical health, age, and access to medical care and information. There are risks and complications associated with these surgical procedures, which should be discussed with medical professionals. Such risks and complications are also a factor in individuals’ decision-making regarding these surgeries.

TRANS (ALSO TRANSGENDER): A term used to describe those who transgress social gender norms; often used as an umbrella term to mean those who defy rigid, binary gender constructions, and who express or present a breaking and/or blurring of culturally prevalent/stereotypical gender roles. The term trans includes but is not limited to transsexuals, intersex individuals, bi-genders, no-genders, androgynes, cross-dressers, gender-benders, feminine men, masculine women, shape shifters, transvestites, and sometimes Two-Spirit people. Transfolk, transperson, transpeople and transnaries are other more casual terms used to refer to people who identify as trans or gender variant.

TRANSGENDER COMMUNITY (ALSO GENDER COMMUNITY): A loose association of individuals and organizations who transgress gender norms in a variety of ways and perform advocacy and education on trans issues and trans liberation. Celebrating a recently born self-awareness, this community is growing fast across all lines. The central ethic of this community is unconditional acceptance of individual exercise of freedoms around gender, sexual identity and orientation.

TRANSGENDERIST: An individual who chooses to cross-live full time, but who chooses not to have SRS/GRS. Such individuals may or may not take hormones. For many individuals, self-identification and self-expression alone (through cross-living or other methods of gender expression) achieve harmony or congruency between one’s body and one’s gender identity. Such individuals may thus feel no need for surgical reconstruction.

TRANSITION: The period during which a transgender person (usually transsexual) begins to live a new life as their true gender. Can include the period of full-time living (see REAL LIFE TEST) required before gender reassignment surgery. After transitioning and surgery some transsexuals who are living full-time identify only as a man or as a woman.
SECONDARY SEX CHARACTERISTICS: Physical characteristics that emerge with the onset of puberty, including but not limited to: facial and body hair growth, muscle development, voice changes, breast development, and the ability to reproduce.

SELF-DEFINED GENDER: A gender identity that one chooses for oneself without regard for limitations imposed by social norms or a binary gender system. May or may not be fixed, may evolve and change. Often determined as a result of an individual's questioning and exploring gender issues, examination of gender roles, and through a process of self-discovery.

SEX: 1. A term used historically and within the medical field to identify genetic/biological/hormonal/physical characteristics, including genitalia, which are used to classify an individual as female, male, or intersex. 2. (Also SEXUALITY, SEXUAL BEHAVIOR) Activity engaged in by oneself, with another or others to express attractions and/or arousal.

SEXUAL ORIENTATION: A continuum of affectional, erotic, fantasy, or sexual arousal toward an individual of the same gender, the opposite gender, or other genders. Terms used to identify sexual orientation include: gay, lesbian, bisexual, pansexual, transsexual, straight, heterosexual, homosexual, same-gender loving, two-spirit, dyke, taq, queer, women who have sex with women, men who have sex with men, and asexual. People experience sexuality in three ways: sexual orientation, how one experiences attractions; behavior, or how one acts based upon such attractions; and self-identification, or how one chooses to define or identify oneself.

SHAPE SHIFTER (ALSO METAMORPH): A term used by some people (who choose not to identify as transsexuals) to express their belief they are not changing their gender, but changing their body to reflect their inner feelings and gender identity.

STANDARDS OF CARE: A set of minimum guidelines formulated by the Harry Benjamin International Gender Dysphoria Association, Inc. (HBIGDA) for care of transsexual individuals. Provides requirements for consumers and service providers. For a copy of the standards of care, contact HBIGDA (contact www.hbigma.org).

STRAIGHT (ALSO HETEROSEXUAL, HET): A term used to describe a person who is emotionally, spiritually, physically, and/or sexually attracted primarily to members of the opposite gender. A person who accepts their opposite gender attraction and who identifies as straight or het.

FAG (FAGGOT): A person who identifies as a man, and who is emotionally, spiritually, physically, and/or sexually attracted primarily to men. This term is reclaimd or appropriated in a positive way by many types of people for the purpose of self-identification, and can be political. "Fag" has been historically used in a pejorative way, to ridicule and label gay men who were/are perceived to express or present stereotypically feminine characteristics. This term is becoming more gender neutral; therefore, one does not have to be a man to identify as a fag (i.e., a person who identifies as a "faggy" dyke).

FEMALE: A medical label used to signify a "human sex," the biological designation based on genitalia (a vagina and clitoris). Can also be a socio-political term, used by an individual to label their gender identity.

FEMALE-BODIED: A term used to recognize a person who was assigned a female gender at birth, or who had/had a female body with some variation of genitalia, chromosomes and phenotype as those of a female. Trans or gender variant people who are female-bodied may or may not choose hormonal, surgical and/or other body modification to create a "more female" body. Someone who is female-bodied cannot, however, have a male body in the same way someone born male, with some variation of genitalia, chromosomes and phenotype as those of a male.

FEMININE: An often ambiguous term that refers to self-expression, performance, actions, behaviors, dress, grooming, adornment and speech popularly associated with someone who is female-bodied within a binary gender system. People of all genders can self-identify as feminine or as having feminine characteristics.

FEMME: This term can be used to identify any person who expresses and/or presents culturally/stereotypically feminine characteristics. A person, who self-identifies, mainly with the stereotypically feminine end of a gender characteristic spectrum. Within lesbian, bisexual women's, and trans communities, a person who self-identifies as femme and understands the intricacies of, and exhibits, a feminine spirit. ("Femme" is not, however, a term used by lesbian, bisexual women's, and trans communities exclusively.)

FEMME QUEEN: A feminine gay man, who may or may not cross-dress, do drag, or be trans-identified.

FULL-TIME: Living 24/7; living all the time as the gender with which one self-identifies.
GAY: A person (who usually identifies as a man) who is emotionally, spiritually, physically, and/or sexually attracted primarily to members of the same gender. Someone who accepts their same-gender attraction and identifies as gay.

GENDER: A social construct based on a group of emotional and psychological characteristics that classify an individual as feminine, masculine, androgynous, or other. Gender can be understood to have several components, including GENDER IDENTITY, ASSIGNED GENDER, and GENDER ROLE.

GENDER (SEX) ASSIGNMENT: The process by which doctors determine what one’s gender is, based upon what one’s genitalia appear to be. One is then expected to grow up and exist within a certain set of gender roles “appropriate” to one’s assigned gender. (See also ASSIGNED GENDER.)

GENDER-BENDER (ALSO GENDER-BLENDER, GENDER FUCK): A person who merges characteristics of any gender in subtle ways or intentionally faults blurred stereotypical gender norms for the purpose of shocking others, without concern for passing.

GENDER DYSPHORIA: An intense, continuous discomfort resulting from an individual’s belief in the inappropriateness of their assigned gender at birth and resulting gender role expectations. Also, a clinical psychological diagnosis, which many in transgender communities are offended by, but is often required in order to receive medical services such as hormones and surgery.

GENDER EXPRESSION: Any way in which an individual chooses to present or explain their gender. The self-expression, performance, actions, behavior, dress, grooming, adornment, and speech of individuals according to culturally proscribed norms associated with gender within a binary gender system (i.e., female and male, feminine and masculine). Also refers to self-expression, performance, actions, behavior, dress, grooming, and speech of individuals in ways which do not conform to gender within a binary gender system, and do not follow culturally proscribed notions of man/male and woman/female or masculine and feminine.

GENDER IDENTITY: The inner sense of being man/male, woman/female, both, neither, butch, femme, two-spirit, multi-gender, bi-gender or another configuration of gender. Gender identity usually matches one’s physical anatomy, but sometimes does not. Gender identity includes one’s sense of self, the image that one presents to the world, and how one is perceived by the world.

POST-OP (Abbreviated for POST-OPERATIVE): A term used to describe transgender, transsexual, or gender variant individuals who have attained gender reassignment surgery, and/or other surgeries to change secondary sex characteristics.

PRE-OP (Abbreviated for PRE-OPERATIVE): A term used to describe transgender, transsexual, or gender variant individuals who have not attained gender reassignment surgery, but who desire to and are seeking that as an option. Such individuals may or may not currently be cross-living full time; may or may not undergo hormone therapy; and may or may not be seeking surgery to change secondary sex characteristics, but who may look at this as an option for the future.

PRESENTATION: The totality of one’s appearance, including attire, voice, behavior, body language, etc.

PRIMARY SEX CHARACTERISTICS: Identifiers such as genitalia, body fat distribution, and hair growth patterns that are commonly used to assign or label someone’s gender as male or female within a binary gender system.

QUEER: Historically and currently used as a slur targeting those perceived to transgress “norms” of sexual orientation and/or gender expression. In the 1980’s and 1990’s, “queer” was increasingly reclaimed and popularized by some LGBT communities as a positive term of self-identification. More recently, this term has been used to identify trans, bisexual, lesbian, intersex, gay, and heterosexual individuals who are progressive sexual and gender outlaws in some way or another.

REAL LIFE TEST (Also LIFE TEST): A period of time required of individuals seeking gender reassignment surgery during which they must live full-time expressing and presenting the gender in which they identify. Many doctors require a Real Life Test of two or more years before advancing to surgery.

SAME GENDER LOVING: In the spirit of self-naming, and of ethnic/sexual pride, the term “same-gender-loving” (SGL) was introduced to fortify the lives and illuminate the voices of black and African-American homosexual and bisexual people of color; to provide a powerful identity not marginalized by “racism” in the gay community or “homophobic” attitudes in society. Adapted from the following website – www.samegenderloving.net.
**MASCULINE:** An often ambiguous term that refers to self-expression, performance, actions, behaviors, dress, grooming, adornment, and speech popularly associated with someone who is male-bodied within a binary gender system. People of all genders can self-identify as masculine or as having masculine characteristics.

**MULTI-GENDER:** A term used to describe a person who identifies with all genders at some level, and may perform gender in a variety of ways.

**NO-GENDER (ALSO NON-GENDER):** A term used to describe a person who identifies as neither of the two genders existing within a binary gender system. A no-gender person may “live outside of” gender, and play with various types of gender or anti-gender expression.

**NON-OP (Abbreviated for NON-OPERATIVE):** A term used to describe transgender, transsexual or gender variant individuals who have not attained and may not desire to attain gender reassignment surgery. Such individuals may or may not take hormones. For many individuals, self-identification and self-expression alone (through cross-living or other methods of gender expression) achieve harmony or congruence between one's body and one's gender identity. Such individuals may feel no need for surgical reconstruction.

**OPPRESSION:** A system of exploitation, and imbalance of power and control, in which one social group benefits over another. Oppressed groups are often made to feel invisible, devalued, disempowered, unimportant, and “abnormal,” and are systematically denied legal rights and economic, political, and cultural access and privilege given to and maintained by groups with greater power within an oppressive system.

**PACKING:** The act of creating a visual, physical, and tangible form of a penis in one's pants. This can be done using a variety of techniques and materials, including socks, gel-filled condoms, prosthetic dicks and dildos.

**PANSEXUAL (ALSO OMNISEXUAL):** A person who is emotionally, spiritually, physically, and/or sexually attracted to those of any gender or physical makeup.

**PASSING:** The ability to present oneself as any gender other than that assigned at birth, and be accepted as such.

**PER:** (pronounced “pur”) Abbreviated form of the word “person.” Like HIR, used in place of “him” or “her.” A pronoun coined by trans activists to refer to individuals who identify as existing/presenting outside of a binary gender system and its rigid delineations of “male” and “female.”

**GENDER OPPRESSION:** The verbal, physical, and emotional violence and legal discrimination against people who do not conform to socially acceptable gender roles. (Genderism is sometimes being used to describe this)

**GENDERQUEER:** A term which is used by some people who may or may not fit on the spectrum of trans, or be labeled as trans, but who identify their gender and sexual orientation to be outside of the binary gender system, or culturally proscribed gender roles.

**GENDER REASSIGNMENT SURGERY-GRS (ALSO SEX REASSIGNMENT SURGERY-SRS):** Permanent surgical refashioning of genitalia to resemble the genitalia of the desired gender. Sought to attain congruence between one's body and one's gender identity.

**GENDER ROLE:** The social expectation of how an individual should act, think and feel, based upon one's assigned gender. The social expectation that an individual must be defined as man or woman. Gender role includes behavior characterized as feminine or masculine according to culturally prevalent or stereotypic standards.

**GENETIC:** A term often used to refer to the gender assigned at birth. Also used to refer to the discussion of the chromosomal makeup of an individual.

**GETTING READ (ALSO CLOCK, TO BE CLOCKED):** Being detected as a person who is “cross-dressed,” or is not living in their “assigned gender.”

**HETEROSEXUAL:** An individual who is emotionally, spiritually, physically, and/or sexually attracted primarily to those of the opposite gender (clinical term).

**HIR:** (pronounced “her”) Used in place of “him/her,” a pronoun coined by trans activists to refer to individuals who identify as existing/presenting outside of a binary gender system and its rigid delineations of “male” and “female.”

**HOMOPHOBIA:** The irrational fear of love, affection, and erotic behavior between people of the same gender. Expressed as negative feelings, attitudes, actions, and institutional discrimination against those perceived as non-heterosexuals. Often directed at those perceived as expressing or presenting stereotypically non-heterosexual characteristics and/or blurred gender roles, regardless of individuals' actual sexual orientation or gender identity. (See also TRANSPHOBIA)
HOMOSEXUAL: An individual who is emotionally, spiritually, physically, and/or sexually attracted primarily to those of the same gender (clinical term). A term often viewed as negative, overly clinical, or disempowering by many members of LGBT communities.

HORMONE THERAPY (ALSO HORMONE REPLACEMENT THERAPY, HRT, HORMONAL SEX REASSIGNMENT): Administration of hormones to affect the development of secondary sex characteristics of the opposite gender than that one was assigned; this is a process, possibly lifelong, of taking hormones to change the internal body chemistry. Female-to-males (FTMs) use androgens such as testosterone, and male-to-females (MFTs) use estrogen and progesterone. Hormone therapy is safest when administered by a medical professional, and after discussion of potential health risks. Some effects of prolonged hormone use are irreversible.

IDENTITY: How one views, labels, or chooses to identify oneself.

IN THE CLOSET: Not disclosing (See COMING OUT), or being secretive about, the sexual orientation and/or gender identity of oneself or one’s family member(s), child or children, sibling(s), or friend(s).

INTERNALIZED HOMOPHOBIA (ALSO INTERNALIZED TRANSPHOBIA): The belief that same-gender sexual orientation and/or transgressive, non-conforming gender identity is inferior to heterosexual orientation and/or traditional masculine or feminine gender identity. The internalization of negative messages, feelings about oneself and one’s group, and beliefs about how one should be treated, which often results in self-hate and difficulty with self-acceptance. Also, an irrational fear of deviating from stereotypical gender roles.

INTERSEX (ALSO HERMAPHRODITE): A person born with anatomy or physiology which differs from cultural ideals of male and female. Intersexuates may be born with “ambiguous genitalia,” and/or experience hormone production levels that vary from those of culturally “ideal” female and male. Intersexuates may be born with “full or partial” internal genitalia, and/or “full or partial” external genitalia. Intersexual genitalia may “look nearly” female, with a very large clitoris, or they may look “nearly male,” with a very small penis. They may be truly “right in the middle,” with a phallus that can be considered either a large clitoris or a small penis; with a structure that might be a split, empty scrotum, or outer labia; with a small vagina that opens into the urethra rather than into the perineum.

Intersexuates are typically assigned a single gender at birth, and often undergo surgery on their genitals in infancy to force a more culturally acceptable gendered appearance — one which “matches” their assigned gender. Many intersex people who undergo such surgery in infancy later report feeling a sense of loss of an essential aspect of themselves.

Examples of the medical diagnoses used for intersexuates include: adrenal hyperplasia (CAH); ambiguous genitalia; androgen insensitivity, full or partial (AIS/PAIS); clitoromegaly; early genital surgery; hypospadias; Klinefelter’s; microphallus; and testicular feminization. For more information regarding intersexuality, contact the Intersex Society of North America (ISNA), via their website www.isna.org.

LESBIAN: A person who identifies as a woman, who is emotionally, spiritually, physically, and/or sexually attracted primarily to members of the same gender. Someone who accepts her same gender attraction and identifies as a lesbian.

M2F, MTF, MALE TO FEMALE, MALE TOWARDS FEMALE: A term used to identify a person assigned a male gender at birth or is male-bodied, and who identifies as a female, lives as a woman, or identifies as feminine. Some use this as an identifier to let others know where on the spectrum they come from and the direction they might be headed. Others in the community use the signifier FT, female-to-female, to affirm their belief that their assigned gender was inaccurate.

MALE: A medical label used to signify a “human sex,” the biological designation based on genitalia (a penis and testicles). Can also be a socio-political term, used by an individual to label their gender identity.

MALE-BODIED: A term used to recognize a person who was assigned a male gender at birth, or who has/had a male body with some variation of genitalia, chromosomes and phenotype as those of a male. Trans or gender variant people who are male-bodied may or may not choose hormonal, surgical, and/or other body modification to create a “more female body.” Someone who is male-bodied can never, however, have a female body in the same way as someone born female, with some variation of genitalia, chromosomes and phenotype as those of a female.

MAN: A term referring to someone who identifies as such, who may often exhibit masculine or male characteristics (see MASCULINE and MALE). Popularly understood within a binary gender system to refer to someone who is male-bodied.
7. Sexual Orientation, Identity & Behavior*

Time Required
2 hours

Purpose
To develop an understanding of the concept of sexual orientation and for the special needs gay/lesbian/bisexual people who live in a “heterosexist” culture

Rationale
Many people struggle with understanding different sexual orientations and carry their own prejudices toward people who are gay, lesbian and bisexual. This lesson will introduce the learners to models of sexual orientation that lie on a continuum, rather than binary classifications and explore the roots of same-sex orientation on bio-physiological and social levels.

Objectives
- Define sexual orientation and heterosexism
- Differentiate between sexual orientation and sexual identity
- Rate and define each of the levels on the Kinsey scale and compare and contrast them with other orientation scales

Materials
- Computer with Internet access, speakers, LCD projector, screen
- Newsprint and markers
- Handout: The Kinsey Scale
- Handout: Gender/Sexual Identity Development
- Handout: Cass Model of Homosexual Identity Development
- Handout: The Klein Sexual Orientation Grid
- Handout: The Heterosexual Questionnaire
- Film: Gray Matters
- Film: Setting them Straight
- TV and DVD player

Procedure
   - What is “normal” when considering sexual orientation?
   - Discuss the differences between sexual orientation, sexual identity and sexual behavior
2. Show segment from Gray Matters (DVD chapters 20 and 21) and discuss the following questions:
   - List several barriers possibly faced when disclosing one’s orientation (make sure privilege – assumption of heterosexuality, validation of relationships, lifestyle,
sexual orientation, etc. – is covered for straight and discrimination/loss of relationships is covered for GLBT)

- Discuss the advantages to living an openly gay, lesbian or bisexual life. What might one find fulfilling and life-affirming when she or he is “out”?

5. Distribute the Gender/Sexual Identity Development Handout and the Kinsey Scale and give the group several minutes to read through the definitions on the handout and the Kinsey Scale. Note: When introducing scales frame them as theories about sexual orientation and not as models that problematize homosexuality

- Ask a volunteer to read the definition for sexual orientation out loud (p.2, handout). Ask students what that definition means to them.

6. Write the following on newsprint:

- Orientation: how one experiences attractions
- Behavior: what one does
- Identity: how one defines who they are

- Ask the group to brainstorm examples of orientation, behavior, and identity to demonstrate scoring on the Kinsey Scale.

7. Distribute the Cass Model of Homosexual Identity Development and Klein Sexual Orientation Grid handouts and give the group about 10 minutes to study the handouts

- Ask the group to critique the Cass and Klein models, both alone and in comparison to the Kinsey Scale

- What are the strengths and shortcomings of all three models of orientation?
- How might you conceptualize a model or scale of sexual orientation?

8. Show the film Setting them Straight

- Pause the film at 5:24 and ask the group what they think is going to happen, discuss for a moment, then finish the film

- Discuss the following questions:
  - What are your general reactions to the film?
  - What stereotypes exist pertaining to sexual orientation?
  - How can stereotypes be overcome? (i.e. how many assumed that ‘Jack’ was gay with straight parents as opposed to straight with gay parents? Why was that assumption made?)

9. The Heterosexual Questionnaire Note: Instructor should be prepared for potential strong emotional reactions from the group while completing the questionnaire and during the discussion. Do not get defensive, but allow students to process and express emotion.

- Explain that you will be passing out a questionnaire for the students to fill out. Tell them that they will have 15 minutes to work through the questions. Ask them to please remain quiet throughout the questionnaire and hold questions for processing at the end.

- At the end of the 15 minutes discuss the following questions:
  - What are your reactions to this activity?
  - How did the questionnaire make you feel?
  - What is heterosexism?

- Allow students to express their feelings about the activity.

10. Conclude by asking how this activity could be applied to other populations.
Evaluation Questions
Instructors please email cesh@msm.edu to request answers.

1. Which model conceptualizes movement through subsequent levels of sexual identity formation?
   A. Kinsey
   B. Whipple
   C. Cass
   D. Klein

2. What term describes how one experiences attractions?
   A. Sexual behavior
   B. Sexual identity
   C. Sexual fetish
   D. Sexual orientation

3. An individual who has equal heterosexual and homosexual experiences would place where on the Kinsey Scale?
   A. 0
   B. 2
   C. 3
   D. 6

Required Readings

Recommended Readings

Films

* Portions of this lesson adapted with permission from Human Sexuality Education for the Community College Student © 2003 by Carey L. Roth
COMING OUT is a life-long process of exploring one’s sexual orientation and Gay / Lesbian identity and sharing it with family, friends, co-workers and the world. COMING OUT is one of the most significant developmental processes in the lives of Gay and Lesbian people. Coming Out is short for the phrase “coming out of the closet.” Coming Out means recognizing, accepting, expressing and sharing one’s sexual orientation with oneself and others.

<table>
<thead>
<tr>
<th>1</th>
<th>IDENTITY CONFUSION: Personalization of information regarding sexuality.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o Recognizes thought / behaviors as homosexual, usually finds this unacceptable</td>
</tr>
<tr>
<td></td>
<td>o Redefines meaning of behaviors</td>
</tr>
<tr>
<td></td>
<td>o Seeks information on homosexuality</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>2</th>
<th>IDENTITY COMPARISON: Accepts possibility s/he might be homosexual.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o Feels positive about being different, exhibits this in ways beyond orientation</td>
</tr>
<tr>
<td></td>
<td>o Accepts behavior as homosexual, rejects homosexual identity</td>
</tr>
<tr>
<td></td>
<td>o Accepts identity but inhibits behavior (ex: heterosexual marriage / anonymous sex)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3</th>
<th>IDENTITY TOLERANCE: Accepts probability of being homosexual, recognizes sexual / social / emotional needs of being homosexual.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o Seeks out meeting other Gay / Lesbian people through groups, bars, etc.</td>
</tr>
<tr>
<td></td>
<td>o Personal experience builds sense of community, positively and negatively</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>4</th>
<th>IDENTITY ACCEPTANCE: Accepts (vs. tolerates) homosexual self – image and has increased contact with Gay / Lesbian subculture and less with heterosexuals.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o Increased anger toward anti-gay society</td>
</tr>
<tr>
<td></td>
<td>o Greater self – acceptance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5</th>
<th>IDENTITY PRIDE: Immersed in Gay / Lesbian subculture, less interaction with heterosexuals. Views world divided as “gay” or “not gay”.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o Confrontation with heterosexual establishment</td>
</tr>
<tr>
<td></td>
<td>o Disclosure to family, co – workers</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>6</th>
<th>IDENTITY SYNTHESIS: Gay / Lesbian identity integrated with other aspects.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o Recognizes supportive heterosexual others</td>
</tr>
<tr>
<td></td>
<td>o Sexual identity still important but not primary factor in relationships with others</td>
</tr>
</tbody>
</table>

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8. **Relationships & Love**

**Time Required**
2 hours

**Purpose**
To conceptualize the role of love in sexuality; to experience power differentials in a non-threatening way; to discuss the mechanics of relationships

**Rationale**
Love and relationships are complex and sometimes controversial phenomena. This lesson allows participants to analyze love as well as relationships in order to enhance their professional and personal lives.

**Objectives**
- To formulate a definition of love
- To assess the power dynamics present in various relationships
- To differentiate healthy relationships from unhealthy relationships

**Materials**
- Computer with Internet connection and LCD projector
- Newsprint and markers
- Video clips from Helen Fisher’s work ([www.helenfisher.com](http://www.helenfisher.com), click on ‘media’, click on ‘5th clip’ under the video section; then, click on ‘NYTimes.com April 10 2007’ under the video section)

**Procedure**
1. Show the Helen Fisher clips.
2. Process the clips with the group asking what their reactions are to Fisher’s types of love: Lust, Romantic Attraction, Attachment.
3. Ask the group the following questions:
   - How do you define love?
   - What role does love play in relationships?
   - What impact does love have on intimacy?
5. Ask the group the following questions and record their responses on newsprint and hang in the room.
   - What is a relationship?
   - What makes a good/healthy relationship?
   - What are signs of an unhealthy relationship?
   - Name the various kinds of relationships.

7. Conclude by asking the following questions:
   - Does each stakeholder have to have equal power in order for a relationship to be successful?
   - How does power affect the relationship dynamics?
   - Are there connections between love and power?

Evaluation Questions
Instructors please email cesh@msm.edu to request answers.

1. Which of the following is not one of Chapman’s Love Languages?
   - A. Attachment
   - B. Quality Time
   - C. Physical Touch
   - D. Acts of Service

2. Sex drive or libido refers to which of Fisher’s core systems?
   - A. Romantic Attraction
   - B. Lust
   - C. Attachment
   - D. None of the above

3. What characteristics are generally present in unhealthy relationships?
   - A. Abuse
   - B. Coercion
   - C. Communication
   - D. A & B only

Required Readings

Recommended Readings
- Helen Fisher’s website www.helenfisher.com
- David Schnarch’s website www.passionatemarriage.com

Film
Video clips from Helen Fisher’s work (www.helenfisher.com, click on ‘media’, click on ‘5th clip’ under the video section; then, click on ‘NYTimes.com April 10 2007’ under the video section)
9.  **Sexual Function, Problems & Concerns** *

**Time Required**
2 hours

**Purpose**
To provide a broad overview of sexual difficulties and dysfunctions, known etiologies, and treatment options by building upon the concepts and critiques of the different human sexual response cycles

**Rationale**
Constructs of human sexual response inform our definitions of sexual function and dysfunction, and hence our diagnosis and approach to treatment of sexual problems. Health professionals need to have knowledge of sexual response and function as well as difficulties and dysfunctions in order to be able to proactively elicit a comprehensive sexual health history. Furthermore, actual sexual dysfunctions may point to underlying medical issues that have yet to be diagnosed. This lesson draws upon the sexual response cycles by applying the concepts to the identification, diagnosis, treatment and management of various sexual disorders and dysfunctions.

**Objectives**
- Compose a definition of orgasm that is not dependent on brain-genital nerve connection
- Identify factors that can effect sexual response and expression
- Recognize the signs and symptoms of all the female and male dysfunctions
- Provide permission, limited information, and specific suggestions to a standardized patient based on sexual interview and assessment
- To describe treatment options for the various sexual dysfunctions

**Materials**
- Index cards
- Newsprint and markers
- *Sexual Function & Dysfunction* Power Point
- Computer, LCD projector, screen

**Procedure**
1. Start the Power Point presentation with the orgasm activity. Distribute index cards to participants and instruct them to take 3-5 minutes to write a definition of orgasm based on their current level of knowledge.
2. Divide the group into groups of 4-6 people and give each group a sheet of newsprint. Instruct the groups to take another 5 minutes to compare each member’s definition of orgasm, come to an agreement on a joint definition and write their group’s definition on a piece of newsprint.
3. Take another 5 minutes as a class to look at the definitions generated. How are they similar? How are they different?
4. Show slides of different definitions of orgasm and discussion questions comparing different definitions and group’s definitions.
5. Proceed with the Power Point presentation by having the group think about the theory and research on human sexual response with this framework of orgasm in mind.

6. Review the sexual response cycles and discuss pleasure and review the staircase and circle model on the next slides (see lessons on Models of Sexuality and Sexual Anatomy, Physiology & Response Cycles)
   - According to Timmers (1976), there are two commonly held views. “The most common view is goal-directed, which is analogous to climbing a flight of stairs. The first step is touch, the next step kissing, the next steps are caressing, then vagina/penis contact, which leads to intercourse and orgasm. There is a goal that both or one partner has in mind, and that goal is orgasm. If the sexual experience does not lead to the achievement of that goal, then they do not feel good about all that they have experienced (Whipple, 1987).
   - The alternative view is pleasure directed, which can be conceptualized as a circle, with each expression on the circle considered an end in itself. Whether the experience is kissing, oral sex, holding, etc., each is an end in itself and each is satisfying to the couple. There is no need to have this form of expression lead to anything else. If one person in a couple is goal directed and one is pleasure directed, problems may occur if they do not realize their goals or do not communicate their goals to their partner (Whipple, 1987).

7. With this pleasure oriented approach in mind, proceed to the discussion of sexual dysfunction
   - Discussion points: One problem with presenting patterns and models is that people are tempted to measure themselves against them (Ladas, Whipple & Perry, 1982). If their own responses don’t generally match one of these patterns, they may conclude that there is something wrong with them, ignoring the fact that there are wide variations from one person to the next and for one person from one sexual episodes to the next.
   - Masters and Johnson (1966) described physiological effects of sexual stimulation on both men and women – increase in heart rate, respiration and blood pressure, a noticeable “sex flush” in the chest, neck, face and ears, nipple erection and an increase in breast size and muscle tension throughout the body. At orgasm, all physiological responses peak followed by a rapid release of muscular tension and return to pre-excitement levels for physiological measures.
   - Helen Singer-Kaplan’s model of sexual response model built on Masters and Johnson with the addition of desire. Kaplan believes that the further away from orgasm the sexual problem is the more difficult the sexual problem is to treat. This led to a whole area of sexual therapy concerning inhibited sexual desire.
     - Ask participants what might inhibit sexual desire. Possible answers: Stress, fatigue, anxiety, depression, pain, age, fear, medication and recreational drugs, negative past experiences, power and control issues in a relationship, loss of interest in a partner, low self-image, hormonal influences, injury and disability.
   - David Reed’s model of sexual response focuses more on the psychosocial aspects of human sexual response of the four stages of seduction, sensation, surrender and reflection.
8. Continue through the slides on the different sexual dysfunctions – low desire, arousal disorders, pain, orgasmic disorders, normal changes with aging, erectile and ejaculation dysfunction, medications and comorbidities
9. Conclude with the PLISSIT activity and case examples

Evaluation Questions

Instructors please email cesh@msm.edu to request answers.

1. Orgasm is possible even in someone with a complete transection of their spinal cord
   A. True
   B. False
2. Your 25-year-old patient or patient reveals that she is not sexually satisfied because her husband has problems with erections. What sexual dysfunction might the husband be dealing with?
   A. Erectile dysfunction
   B. Premature ejaculation
   C. Hypoactive Sexual Desire Disorder
   D. Any of the above
3. One of the most common approaches to addressing sexual problems used by health professionals is:
   A. Sensate focus
   B. Cognitive-behavioral therapy
   C. PLISSIT Model
   D. Psychosexual therapy

Required Readings

- [http://www.fsd-alert.org](http://www.fsd-alert.org)

Recommended Readings


**Recommended Film**

* Portions of this lesson adapted with permission from *Providing Comprehensive Sexual Health Care in Spinal Cord Injury Rehabilitation* © 1997 by Mitchell S. Tepper
Orgasm Exercise

- On your index card write a definition of orgasm based on your current level of knowledge.
- Compare definitions and come to an agreement on a group definition. Write that definition on the peace of newsprint provided.

Orgasm

(Money et al., 1991)

- It occurs simultaneously in the brain/mind and the pelvic genitalia.
- Irrespective of the locus of onset, the occurrence of orgasm is contingent upon reciprocal intercommunication between neural networks in the brain, above, and the genitalia below.
- Phenomenologically it fails to survive mutual disconnection of the brain and the pelvic genitalia by severance of the spinal cord. However, it is able to survive even extensive trauma at either location.
Other Definitions

- Orgasm is an explosive discharge of [pelvic] neuromuscular tension (Kinsey et al., 1953)
- Orgasm is a peak intensity of excitation generated by: (a) afferent and re-afferent stimulation from visceral and/or somatic sensory receptors activated exogenously and/or endogenously, and/or (b) higher-order cognitive processes, followed by a release and resolution (decrease) of excitation. By this definition, orgasm is characteristic of, but not restricted to the genital system. (Komisaruk, Beyer-Flores & Whipple, 2006)
- An orgasm is what a woman says is an orgasm! (Whipple, 1991).

Compare Definitions of Orgasm

- How do the definitions compare to each other?
- How do our definitions compare to those in published literature?
Reed’s Erotic Stimulus Pathway
(as cited in Stayton, 1989)

The Erotic Stimulus Pathway Model of David Reed

Sexual Response Cycles Compared

Erotic Stimulus Pathway of Reed compared with Masters and Johnson’s HSRC, and Kaplan’s Triphasic Model
Basson's Sexual Response Cycle (2001)

- Willingness to become excited
- Sexual activity with appropriate contact
- Physiological and biological processing
- Orgasm or sexual satisfaction
- Appendixes: Sexual intimacy, healing of negative effects from sexual assault
- Non-sexual reward; emotional intimacy, well-being, lack of negative effects from sexual distress
- Sexual and responsive sexual desire

Sexual Pleasure and Orgasm

- Related phenomenon
- Often conflated
- Focus on the goal of orgasm
- Ignore the process
  - Warmth, affirmation of sexual esteem, shared intimacy, connection
- Orgasm reinforces in the learning of sexual behavior (Bancroft, 1989)
Pleasure

- State of consciousness
- Experienced through senses
- Perceived through cognitive processes
- Influenced by attitudes, beliefs, knowledge, and lived experiences

Attitudes Toward Pleasure

- Sexual pleasure as a lesser good
- Sexual pleasure as a sin
- Sexual pleasure as a sickness
- Sexual pleasure as a perversion
- Sexual pleasure as natural, healthy
- The orgasm imperative

Pleasure As an Affirmation of Life

- Motivating factor
- Pleasure bond
- Sexual self-esteem
- Relationships, connectedness
- Antidote to pain, harmful cultural messages
Sexual Dysfunction

- What is sexual dysfunction?
- Name and describe some sexual dysfunctions.
- What causes sexual dysfunction?
  - Physical
  - Psychological
- How is sexual dysfunction treated?

Sexual Dysfunction

There are wide variations in sexual response, experience and pleasure from one person to the next.

One problem with presenting patterns and models is that people are tempted to measure themselves against them (Ladas, Whipple & Perry, 1982).

If their own responses don’t generally match one of these patterns, they may conclude that there is something wrong with them.
**General Definition of Sexual Dysfunction**

- Any aspect of your sexual response that causes you or your partner dissatisfaction or distress

---


- Sexual Desire Disorders
  - Hypoactive sexual desire disorder
  - Sexual aversion disorder
- Sexual Arousal Disorders
  - Male erectile disorder
  - Female sexual arousal disorder
- Orgasmic Disorders
  - Female orgasmic disorder
  - Male orgasmic disorder
  - Premature ejaculation
- Sexual Pain Disorders
  - Dyspareunia
  - Vaginismus

*See Strong, et al. (2008), p. 469*

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- Lifelong or primary
- Acquired or secondary
- Generalized
- Situational
- Secondary to a medical condition
Comorbidity of Sexual Dysfunction

- Comorbidity is common
- Need to clarify with the patient:
  - Lifelong vs. acquired;
  - Situational vs. generalized;
  - Contextual factors
    - Past (upbringing/losses/traumas/interpersonal relationships/cultural & religious restrictions)
    - Current (partner sexual dysfunction, inadequate stimulation, unsatisfactory emotional contexts)
    - Medical (conditions, psychiatric conditions, medications, substance abuse)
- Degree of distress—mild, moderate, or marked.

The New View Classification of Women's Sexual Problems

- Sexual problems due to socio-cultural, political, or economic factors
- Sexual problems relating to partner and relationship
- Sexual problems due to psychological factors
- Sexual problems due to medical factors

Due to Socio-Cultural, Political, or Economic Factors

- Ignorance and anxiety due to inadequate sex education, lack of access to health services, or other social constraints:
  - Lack of vocabulary to describe subjective or physical experience
  - Lack of information about human sexual biology and life-stage changes
  - Inadequate access to information and services for contraception and abortion, STD prevention and treatment, sexual trauma, and domestic violence
- Sexual avoidance or distress due to perceived inability to meet cultural norms regarding correct or ideal sexuality, including:
  - Anxiety or shame about one's body, sexual attractiveness, or sexual responses
  - Confusion or shame about one's sexual orientation or identity, or about sexual fantasies and desires
- Inhibitions due to conflict between the sexual norms of one's subculture or culture of origin and those of the dominant culture
- Lack of interest, fatigue, or lack of time due to family and work obligations
**Relating to Partner & Relationship**

- Inhibition, avoidance, or distress arising from betrayal, dislike, or fear of partner, partner’s abuse or couple's unequal power, or arising from partner's negative patterns of communication
- Discrepancies in desire for sexual activity or in preferences for various sexual activities
- Ignorance or inhibition about communicating preferences or initiating, pacing, or shaping sexual activities
- Loss of sexual interest and reciprocity as a result of conflicts over commonplace issues such as money, schedules, or relatives, or resulting from traumatic experiences, e.g., infertility or the death of a child
- Inhibitions in arousal or spontaneity due to partner's health status or sexual problems

**Due to Psychological Factors**

- Sexual aversion, mistrust, or inhibition of sexual pleasure due to:
  - Past experiences of physical, sexual, or emotional abuse
  - General personality problems with attachment, rejection, cooperation, or entitlement
  - Depression or anxiety
- Sexual inhibition due to fear of sexual acts or their possible consequences, e.g., pain during intercourse, pregnancy, sexually transmitted disease, loss of partner, loss of reputation

**Due to Medical Factors**

- Pain or lack of physical response during sexual activity despite a supportive and safe interpersonal situation, adequate sexual knowledge, and positive sexual attitudes.
- Such problems can arise from:
  - Numerous local or systemic medical conditions affecting neurological, neurovascular, circulatory, endocrine or other systems of the body
  - Pregnancy, sexually transmitted diseases, or other sex-related conditions
  - Side effects of many drugs, medications, or medical treatments
Low/No Sexual Desire or Interest

**Puzzle Pieces**

**Individual factors**
- Hormonal issues
- Medication side effects
- Illness, chronic conditions
- Body image concerns
- Aging-related concerns
- Depression
- Substance abuse
- Sexual trauma
- Fear of loss of control
- Fear of pregnancy

**Relationship Factors**
- Lack of attraction to a partner
- Anger in the relationship and other marital conflicts
- Partner’s poor sexual skills
- Fear of closeness/vulnerability/intimacy
- Passive-aggressive solution to power imbalance

---

**Treatment of Desire/Interest Disorders**

- Multidisciplinary/biopsychosocial approach
- Education on women’s sexual response
- Cognitive Behavioral Therapy (CBT)
- Sensate Focus
- Review of current medication with possible changes to comparable medications with less sexual side effects (particularly with antidepressants)
- Testosterone, DHEA, Estrogen, Tibolone, Bupropion????

---

**Treatment of Arousal Disorders**

- Know/find out how you get aroused
- Relaxation, anxiety reduction
- Know/find out how your partner gets aroused
- Multidisciplinary/biopsychosocial approach
- Education on women’s sexual response
- Cognitive Behavioral Therapy (CBT)
- Sensate Focus
- Review of current medication with possible changes to comparable medications with less sexual side effects (particularly with antidepressants)
- Testosterone, DHEA, Estrogen, Tibolone, Bupropion????
- Zestrat???
- Eros-CTD (clitoral therapy device) to increase blood flow to the clitoris
**Testosterone**

- Measure blood levels first
- Oral
- Sublingual
- Injections
- Skin Patch
- Topical Cream
- For women the only FDA approved testosterone is for hot flashes (Estratest)
- **Side effects**: (dependent on dosage and way of administration)
  - oily skin/acne, weight gain, risk of liver and heart disease, hair loss, deep voice, clitoral hypertrophy, high cholesterol

---

**Sexual Pain Problems**

- **Causes:**
  - Vulvodynia (NVA)  
  - Vulvar Vestibulitis Syndrome
  - Vaginal atrophy
  - Adhesions
  - Depression
  - Alcohol or drug abuse
  - Past sexual trauma
  - Medication side effects
  - Illness, Chronic conditions
  - Age-related concerns
- **14%** of women report pain during intercourse
- **Situational**
- **Acquired**
- **Lifelong**
- **Multifactoral**

---

**When Sex Causes Pain**

- Schedule sexual activities when your symptoms are least problematic;
- Take pain-controlling or antispasmodic medications prior to sexual activity;
- Experiment with sexual positions and activities that minimize painful intercourse;
- Have your partner stimulate your genitals orally;
- Tell your partner exactly what feels good and what is painful;
- Spend time engaged in other sexual, erotic, and intimate activities that do not involve intercourse or orgasm.
Treatment Options

- **1st step:** Thorough gynecological exam with focus on treatable skin conditions or infections
- Conservative treatment (sitz bath, lubrication, anesthetic creams)
- Elavil
- Physical therapy of pelvic floor muscles
- Biofeedback
- Acupuncture
- Surgery

Causes of Orgasmic Problems

<table>
<thead>
<tr>
<th>Individual factors</th>
<th>Relationship Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Hormonal issues</td>
<td>- Lack of attraction to a partner</td>
</tr>
<tr>
<td>- Medication side effects</td>
<td>- Anger in the relationship and other marital conflicts</td>
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<tr>
<td>- Illness, chronic conditions</td>
<td>- Partner’s poor sexual skills</td>
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<td>- Body image concerns</td>
<td>- Fear of closeness/vulnerability/intimacy</td>
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<tr>
<td>- Aging-related concerns</td>
<td>- Passive-aggressive solution to power imbalance</td>
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<tr>
<td>- Depression</td>
<td>- Environmental factors</td>
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<td>- Substance abuse</td>
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<td>- Sexual trauma</td>
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<td>- Fear of loss of control</td>
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<td>- Nerve damage</td>
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<td>- Pain</td>
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Treatment of Orgasmic Disorders

- Directed masturbation program (lifelong disorder)
- Relationship therapy (situational disorder)
- Education about sexual function and response
- Anxiety reduction techniques
- DHEA (hormonal), Zestra?????

(No pharmacological agents are recommended for treatment)
Being Sexually Successful

I think of a couple as sexually successful

- When they create mutual erotic pleasure,
- To whatever level and in whatever form they desire
- On any particular occasion,
- So that each ends up feeling good about herself or himself and the other,
- Experiencing a good time and enhancing their relationship.

- Carol Rinkleib Ellison, author of Women’s Sexualities (2000)

Normal Changes With Aging: Men

- Mental & direct physical stimulation required
- Erections become less strong (ED is not a normal change; get a physical exam)
- Erections do not last as long
- Longer time between two erections and ejaculations
- Less volume and force of ejaculate
- Less sensation associate with orgasm
- Reduced size of testicles

Normal Changes With Aging: Women

- Reduced vaginal elasticity
- Reduced lubrication
- Making the mucous lining of the vagina susceptible to irritation, minor injury and infection
- Reduced thickness of the vaginal wall
- Normally thick and cushiony – thins out
- Less engorgement during sexual arousal
- Less sensation with orgasm
- Actual size of vagina and uterus shrink
**Atrophic Vaginitis**

- Inflammation of vaginal tissue as a result of atrophy (deterioration) of the tissue.
- The top layer of cells is often lost entirely, exposing the layer below, which is more easily traumatized and more vulnerable to inflammation or infection.
- Vaginal secretions also decline, which can make intercourse painful.
- Vaginal itching, burning, frequent urination, or vaginal discharge may occur.

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**Atrophic Vaginitis Treatment**

- Topical estrogen creams or tablets
- Estrogen releasing vaginal ring (Estring), lasts 3 months
- Oral estrogen (HRT)
- Vaginal lubricants (Astroglide, KY-jelly, Lubrin, etc. applied before and during sexual activity)
- Replens (applied daily or at other regular intervals independent of sexual activity)
- Prevention: Sexual activity may help preserve the vaginal epithelium, presumably by increasing the blood flow.

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**When Sexual Difficulties May Be Symptoms Of Other Factors**

- Depression
- Alcohol or drug abuse
- Past sexual trauma
- Medication side effects
- Work on underlying issues and sexual problems may improve
Antidepressant Medications

- Antidepressants that increase serotonin stimulation of 5HT2, including the tricyclics, SSRIs, and MAOIs, have been implicated in ED, inhibited desire and orgasm, and impaired ejaculation.
- Antidepressants that antagonize or block serotonin stimulation of 5HT2, like serzone (nafazadone), desyrel (trazadone), and remeron (mirtazapine), cause essentially no sexual dysfunction.
- Antidepressants that have no serotonin effect, like bupropion (wellbutrin) which only inhibits norepinephrine and dopamine reuptake, also do not cause sexual dysfunction.

Antihypertensive Medications

- Most antihypertensives have been associated with some erectile impairment, but diuretics seem to have relatively little effect on erectile function.
- The calcium channel blockers and ACE inhibitors are associated with a low incidence of erectile dysfunction.

Prevention – What Can We Do To Stay Sexually Healthy?

It is never too early and never too late to:

- Start talking to your children about sex and help them develop into sexually healthy adults.
- Maintain physical health through regular exercise and a healthy diet.
- Stop Smoking.
PLISSIT (Annon, 1976)

- **Permission**: ask and give
- **Limited Information**: don’t overwhelm
- **Specific Suggestions**: give focused suggestions that can easily be done on the patient’s time
- **Intensive Therapy**: refer to a sex therapist as needed (www.aasect.org has a listing of educators, counselors, and therapists around the world)

General Tips

- Everybody needs love and affection.
- **Hug, kiss, embrace** each other. Do not hold back these gestures in fear of triggering sexual feelings.
- **Be open** with each other.
- **Talk about problems** as they appear.
- **Go to the health practitioner together**. It will be easier to absorb all information, and you can give each other support.
- Erectile dysfunction can have psychological and/or physical causes. Various treatment options exist.
- Have a positive attitude.

Broaching the Subject

- **Use open-ended questions**
- Allow time to respond to questions
- Let the patient tell the story without interruption
- Verbally acknowledge the patient’s concerns
- Normalize/legitimize the patient’s questions and/or concerns
- Avoid judgmental and/or shaming remarks
Areas to Focus on in Counseling or Therapy

- Masturbation experiences
- Sexual experiences with partner(s) or lack of opportunities
- Fantasy or lack of fantasy with distracting thoughts
- Feelings about diminished sensation, no orgasm, no ejaculation
- Beliefs about sexual potential and future

PLISSIT Practice Cases

1. What else do you need to know? (i.e., questions to ask in history)
2. Possible diagnoses?
3. Possible causes?
4. Actions to take? (i.e., possible treatments/referrals)
5. Specific challenges for you as a health care provider?

Case #1

- A 23-year-old school teacher comes in with her husband of eight months because intercourse was attempted on many occasions but had never actually occurred (either during her marriage or before). She reports experiencing vaginal discomfort when intercourse is attempted and he says he cannot get his penis into her vagina. Both she and her husband were born into families that emigrated from India and had known each other since childhood. Both families are putting pressure on the couple to have children and no one else knows of their inability to have intercourse. She says she is terrified of pain and expects to experience pain with anything entering her vagina (or going out, hence also her fear of childbirth). Her dread of pain is so strong that she cries out when he gets near her vulva (a reaction that makes him progressively less enthused about making attempts at intercourse).
Case #2

- A 33-year-old man has diabetes and hypertension and has had his right amputated above the knee. He presents with erectile dysfunction, delayed ejaculation, orgasmic disorder and diminished sensation. He has prescriptions for Nifedipine-CR and Enduron, which he believes to be contributing to his problems attaining an erection, maintaining an erection, and a loss of penile sensitivity leading to an inability to ejaculate and orgasm.

Case #3

- A 35-year-old woman has had severe pelvic pain, for more than 5 years, since having been pregnant and having had a child. When she has sex with her partner, it hurts a lot, both during the moments and also during a rather long period afterwards (days). When she has a lot of pain she starts to hate sex and have feelings of asexuality. She asks what to do in her relationship when she can't make love this way.

Case #4

- A 26-year-old woman with arthritis, hip pain and chronic low back pain has had trouble lately with a certain position she likes and is unable to flex her hip a certain way without pain.
Case #5

- A 52-year old woman is accompanied by her husband in a therapy setting. She suffers from hypertension and pain associated with Fibromyalgia and says she does not feel like a sexual person anymore. When the therapist asks the woman about affection and family relationships, the husband chimes in, "Sex is close to non-existent due to my wife's chronic pain, what suggestions do you have for us?" His wife gives you permission to address his question.

References


References

References

10. Disabilities & Chronic Conditions *

Time Required
2-3 hours

Purpose
To detail the likely effects of various disabilities and chronic conditions on sexual health using spinal cord injury as a basis

Rationale
Disabilities and chronic conditions may have direct, indirect, or treatment effects on sexual response and expression. Healthcare providers need to have a basic understanding of these possible effects so that they are prepared to explore these issues with their patients. Note: while this lesson focuses primarily on physical disability – specifically spinal cord injury – sexual health considerations of those with intellectual and developmental disabilities must also be emphasized.

Objectives
- Identify common beliefs and attitudes about the sexuality of people with disabilities
- Predict the likely direct and indirect effects of system level impairment and major categories of disability and chronic conditions on sexual response and expression
- Elicit information about changes in sexual function, response, or expression since onset of disability or chronic condition
- Relate the range of sexual activities available to patients with disabilities or chronic conditions and their partner(s) based on abilities

Materials
- Disabilities & Chronic Conditions Power Point, computer and LCD projector
- Film: Sexuality Reborn
- TV and DVD player
- Guidelines and discussion guide to Sexuality Reborn

Procedure
Show Disabilities & Chronic Conditions Power Point slides and facilitate discussion around material presented
1. Review systems the contribute to sexual response and expression from lessons on Sexual Anatomy, Physiology & Response Cycles and Sexual Function & Dysfunction
2. Present the possible effects of acquired disabilities like spinal cord injury (SCI) on sexual response cycles.
   - SCI potentially affects every aspect of sexuality from sexual function, to body image and self-esteem.
   - SCI impairs messages from the brain to other parts of the body.
   - SCIs are grossly classified as complete and incomplete. Complete injuries result in loss of motor function and sensory function below the neurological level of injury. Incomplete injuries result in partial loss of motor or sensory function below the level of injury (i.e. the segment of the spinal cord that is damaged)
Levels of injury range from cervical or neck, thoracic or chest, lumbar or lower back, to sacral or lowest segment of the back or spine.

Motor impairments resulting from SCI may include inability to move legs, arms, hands, abdomen, or any other motor function below the level of injury. Sensory impairments may include the inability to sense light touch, sharp and dull pin pricks, and hot and cold. Ability to control bowel and bladder function is also often impaired.

3. Accompanying other functional changes resulting from acquired disabilities are changes in sexual functioning.

- Some type of change in sexual function is experienced by roughly 80-90% of people with SCI.
- In addition, many people with SCI must deal with changes in their body appearance because of atrophy, loss of muscle tone, use of urinary appliances, use of wheelchairs, braces or crutches.
- Ability to carry out established life roles may also be affected. All of these areas need to be considered when thinking about comprehensive sexual health care.

4. Review likely changes in genital function associated with level and completeness of neurological impairment.

- Changes in genital sexual function are closely correlated with the level of injury. Current research demonstrates that innervation is more complex than has been recognized. However, we do know that neurogenic erectile dysfunction or changes in lubrication in women often result from lesion or disorder.
- Generally it is believed that complete spinal cord injuries above T10 result in loss of psychogenic sexual responses or sexual responses mediated by the brain and carried via the hypogastric nerve.
- It is also believed that complete injuries in the sacral area will result in loss of reflexogenic sexual responses or sexual responses resulting from direct or indirect stimulation to the genital area.
- For men with SCI above T10, erections are likely to result from direct stimulation to the penis but are not likely to result from sexual thoughts. In women with complete SCI above T10, erection of the clitoris and lubrication of the vagina is likely to result from direct stimulation to the vulva but is not likely from sexual thoughts.
- For both men and women with injuries between L2 and S2, it is believed that both psychogenic and reflexogenic responses are likely, however they are not likely to be coordinated. In men, seminal emission often accompanies intense arousal in men with lesions below L2.
- The literature does not tell us about injuries between T10 and L2 or between S2 and S4. There is not enough specific information to accurately predict the degree of sexual functioning when impairment is in this area or when impairment is incomplete. We need to rely on our ability to talk with people about their sexual function and assess abilities based on the person’s self reports.
- Sexual function and assess abilities based on the person’s self reports.
5. Options if someone wants to have genital sex…
   - Options for men:
     - Erection requires increased blood flow to the penis and restricted blood flow out of the penis.
     - The stuffing technique is an option for men at any level. For men who experience reflex erection from direct or indirect stimulation of the penis, stuffing the penis into the vagina or anus while your partner uses their muscles to stimulate the penis may cause erection and help maintain it. Often both partners are satisfied with this sexual activity whether an erection is attained or maintained or not.
     - Use of a constriction device (rubber or silicone ring or adjustable leather strap) can help men who have no problem attaining an erection but have difficulty maintaining it. It is safest to get a prescription for a custom fitted device from a urologist so they can thoroughly review the proper use of the product. A proper fit that allows some blood flow is important to avoid bruising the penis and damaging erectile tissue inside the penis. These devices are also available “over the counter” and marketed as “cock rings.” The two biggest concerns are skin integrity and adequate blood flow. The use of plenty of water-based lubricant is necessary to avoid skin breakdown when applying and removing the device. Even with a good fit, the device should not be left on more than 30 minutes or permanent damage to the penis may occur.
     - Vacuum erection devices have been successful with men who have difficulty attaining an erection. A cylinder is placed over the penis and a mechanical or electrical pump is used to create a vacuum and draw blood into the penis. Then a constriction device is used to trap the blood in the penis. Vacuum devices are available through a prescription from a doctor or urologist or over-the-counter.
     - Prescription oral medications such as Viagra, Levitra or Cialis. Over-the-counter “male enhancement supplements” have not been evaluated for safety and are not recommended.
     - Delivering medication directly into the shaft of the penis using a small syringe has also been effective with men who have difficulty attaining an erection. The quality of erection attained using this method is sometimes preferred to erections maintained with a constriction device. However, some men are initially uncomfortable with the thought of injecting medication or anything else into their penis. Risks of this method include bruising, scarring at the injection site, and priapism (an erection that lasts for many hours). This method, sometimes referred to as Pharmacological Erection Program (PEP), is available only through a prescription from a doctor or urologist.
     - Medicated Urethral Suppository for Erections (MUSE)
     - Surgical implants permanently alter the erectile tissue in the penis, carry higher risks than other methods mentioned, and therefore should be the option of last resort. Implants involve surgically inserting semi-rigid rods or inflatable tubes in the shaft of the penis. This procedure involves all the
risks of surgery plus the added risk of long term infection, erosion of the
device through the skin, and malfunction and replacement of the device.
This device is only available through urologists.

- Options for women: lubrication and positioning.
  - For women, a main consideration is proper lubrication. If there is lack of
    sensation and/or inadequate lubrication in the vagina, and in all cases of
    anal intercourse, a water or silicone-based lubricant should be used.
    Vaseline or other petroleum based products increase the chance of
    infection and will deteriorate and reduce the effectiveness of latex
    condoms. Use of lubrication applies whether inserting a penis, a vibrator,
    or any other object into the vagina or rectum.

6. Physical management for sexual activity might be needed for both men and women.
7. Proper bowel and bladder management including management of catheters and ostomies,
   management of pain and spasticity, help with positioning, and working around ventilators
   are possible considerations.
8. Avoiding intense genital or anal stimulation when you have a full bowel will help avoid
   an unscheduled bowel movement during sexual activity.
9. Emptying your bladder before sexual activity will help avoid voiding during sex.
10. Keep some protective sheets (blue pads or chunks), a towel, and a urinal nearby if you are
    concerned about your bowel or bladder.
11. Both men and women with indwelling catheters can leave the catheter in during
    intercourse. The catheter can be folded along the penis and held in place with a condom
    or tape. For women, the condom can be taped to the lower abdomen.
12. Plenty of water based lubricant should be used when having intercourse and leaving the
    catheter in place.
13. Disabilities and chronic conditions do not protect from sexually transmitted diseases or
    HIV/AIDS. The use of condoms for all types of intercourse is highly recommended to
    substantially reduce the risk of transmitting infections.
14. If someone wants to have a baby...
   - For women:
     - Spinal cord injuries do not physiologically interfere with a woman’s
       ability to conceive. Although menstruation (periods) may stop for six to
       eight months after injury, it is still possible to get pregnant. Regular
       menstrual cycles will come back in time.
     - Carrying a baby to term involves similar risks to any pregnancy. However
       there is increased risk of bladder infection, pressure sores, hypertension,
       and, automatic dysreflexia (episodes of highly elevated blood pressure,
       major headaches, sweating, flushed facial skin, goosebumps, nasal
       congestion, and intense nervousness and anxiety). All these risks are
       manageable with a knowledgeable physician.
     - Balancing and transferring during pregnancy may also present an
       increased challenge.
     - With regard to delivery, women can deliver vaginally despite lack of
       voluntary muscle control. Breast feeding is still a viable option although
       adaptive equipment such as a sling or harness to help hold the baby may
       be necessary.
For men:

- Some men may face difficulty ejaculating and poor sperm quality
- For men who have difficulty with ejaculation, the two most commonly used procedures for retrieving sperm for use in insemination procedures are vibratory stimulation and electroejaculation stimulation (EES). Direct aspiration of the sperm from the vas deferens and other high-tech procedures are also available.
- Little can be done to improve sperm quality at this time. Low volume, greater percentage of deformed sperm, and low motility still create a challenge for conception. An evaluation of sperm quality is the best way to determine the possibility of having a baby.
- There are advanced procedures to deliver sperm directly into the ovum (egg).
- Men with should ask their doctor for a referral to a fertility clinic that specializes in SCI if they are interested in having a baby.

Adoption is also a viable option for parenting.

15. If someone wants to be an active parent...

- Occupational therapists can help with choosing adaptive equipment like accessible cribs, changing tables, carrying slings, etc.
- Giving love, support, and direction and finding mutual ways to have fun together.

16. If someone does not want to have a baby...

- All options are available to couples interested in contraception. However a few carry increased risks or may present some physical difficulty using. Women should consult a health care professional familiar with SCI to help them choose the best method.
  - The intrauterine device or IUD presents decreased ability to self-monitor for perforated uterus or infection for women with loss of sensation.
  - Diaphragms may present a problem with insertion, and atrophy in the muscles surrounding the vagina may create a problem with fit and decrease the efficacy of this method. A partner can assist in inserting the diaphragm if both are comfortable with the situation.
  - Oral contraceptives (hormonal methods such as the pill) were once believed to present increased risk of deep vein thrombosis (blood clots) for women with SCI. However, this is questionable with newer oral contraceptives.
  - The male condom is still one of the easiest and safest methods of contraception and it helps prevent the transmission of infections. Men with limited hand function may have difficulty putting on a condom. Once again, a partner can help if they have adequate hand function and are comfortable.

17. We cannot restore sensation....

- However, there are commonly used techniques to help increase awareness to areas of our body where sensation is still intact and where we may be open to sexual stimulation.
- Three options for increasing sexual communication and sexual pleasure are: sensate focus exercises (Masters and Johnson, 1970), pleasure mapping (Stubbs,
1988), and charting personal extragenital (areas besides your genitals that may bring sexual pleasure) matrix (Whipple and Ogden, 1989).

- Sensate focus, pleasure mapping, and charting extragenital matrix are all ways to explore various parts of the body including the head, hair, face, ears and neck; chest, breasts, nipples, abdomen; back, buttocks, arms, underarms, hands, fingers, legs, feet, and toes.
- Exploration can include using different kinds of touch with the hands like stroking, rubbing, squeezing; different kinds of touch with the mouth like kissing, sucking, nipping; incorporating lotions, oils, and powders, feathers, silk, or even a vibrator.
- It is best to set time aside to explore a certain portion of the body, say from the shoulders up. During that time focus on stimulation to the chosen area without any plans of moving to any other areas or of having sexual intercourse.
- These exercises place the emphasis on intimacy and pleasure versus the goal of performance and orgasm. These exercises are not specific to people with disabilities and chronic conditions. Everybody has the potential for sexual growth through these activities. Sexual pleasure adds to quality of life for everybody, including people with disabilities and chronic conditions.

18. Sexual pleasure is still possible...
- It is of importance to note the self-reported incidence of orgasm in people with SCI is consistently around 50%. As mentioned earlier, reports of orgasm have not been strongly associated with level or completeness of the SCI.
- Many people report an area of hyper-sensitivity above the level of injury that when stimulated results in sexual arousal and sometimes orgasm.
- Other people report having orgasm as the result of stimulation of the ears, neck, breasts, or through fantasy. Orgasm in people with SCI usually requires a much longer period of stimulation than before injury.
- It is also important to note that the majority of people with SCI report sexual satisfaction even if they do not experience orgasm.

19. Recommended if time allows and instructor is versed in the use of sexually explicit media: Show Sexuality Reborn film and facilitate discussion using guidelines and discussion guide

**Evaluation Questions**

Instructors please email cesh@msm.edu to request answers.

1. Rebecca is a 28-year-old female with a SCI at T9. She is 1 year post injury and pregnant for the first time. Chances are more likely Rebecca will have what type of delivery?
   A. Premature
   B. Vaginal
   C. Cesarean
   D. High-risk
   E. Dangerous
2. Bill has a SCI and reports a bit of swelling in his penis when having sex with his partner followed by emission of a few drops of semen. Bill’s report suggests which of the following nerve pathways is still intact?
   A. Vagas
   B. Hypogastric
   C. Pelvic
   D. Pudendal
   E. Sciatic

3. Men and women who report an impairment in an activity of daily living or the need for an assistive device to walk more than three blocks (men and women with disabilities) are more likely than men and women without disabilities to think of themselves as homosexual or bisexual.
   A. True
   B. False

**Required Readings**

**Recommended Readings**

**Film**

1. Tell participants that portions of this video are sexually explicit. Give people permission to close their eyes or leave the room, but stress that you prefer they close their eyes because there is a lot of rich dialogue.

2. Explain to participants that sexually explicit media has both a cognitive and affective component. Explicit scenes not only convey information but evoke emotional responses. Ask viewers to pay attention to the feelings the film generates for them personally.

3. Show film (48 minutes).

4. Open up group discussion by inviting participants to share some of their feelings and reactions to the video. Suggest the following topics: What came up for you first? Other feelings? What surprised you in your own reaction? How was it watching this in this room? etc. The participants may want to move to professional application quickly and avoid the personal. Ask them to consider, “What's going on for me right now?”

5. So what? Move discussion to topic of sex and disability, and the range of sexual activities and behaviors that are available to people with disabilities. Sex with such a physical impairment might emphasize pleasuring and intimacy more than performance and be less goal-oriented toward orgasm than traditional models of sex.

6. Now what? How can we use what we learned in our roles as health professionals? What were some common questions and concerns expressed in the film and the ways people compensated for changes in sexual function?

7. Have participants respond to one of the following to help close the discussion:
   - I am still not clear about...
   - The thing I think I’ll remember most about the video is.....
   - The sex in this film can be best described by the following words.....
   - The attitudes in this film can be best described by the following words...

8. Other specific questions that can be posed as discussion starters:
   According to Joe, “life does not revolve around being able to have an orgasm or reach orgasm.” For Joe, being able to bring his partner to orgasm boosts his self-esteem, gives him satisfaction and makes him happy. According to Mark, “When it comes to the ‘big O’... an orgasm is really in your mind.”
   - Is an orgasm really in your mind?
   - As a person with a spinal cord injury, is that all you can expect now?

   How about when Terry says there are still certain parts of Joe’s body where she’s able to get him aroused such as his nipples and his neck. When she touches these places, she can feel the tension in him and she knows he’s not just doing this to make her happy. He’s feeling something too. So he’s getting some sexual pleasure out of this physical pleasure, other than
just what he is giving. So it’s not like he’s just going through the motions and feeling nothing.
  o How do we explain this?
  o What are some of the ways you can find out which areas of the body are most receptive to sexual stimulation?
  o What is the difference between an orgasm resulting from stimulating an ear versus an orgasm resulting from stimulating genitals?
  o Is an orgasm that results from something other than genital stimulation any less real than an orgasm that results from genital stimulation?
  o Why does Mark experience orgasm while Steve does not?
  o What are some well known erogenous zones?
  o How would someone go about exploring their body to find out what areas and sensations turn them on?
  o How did it feel watching this couple engage in mutual oral genital pleasuring?
  o What are society’s general feelings toward genitals?
  o What are some of the stories that you have heard about masturbation?
  o Why do you think there are so many myths and jokes about masturbation?
  o How comfortable would you be providing people with specific sexual suggestions?

Dr. Alexander used the word impotence when he was talking about erectile dysfunction.
  o What’s the difference? What’s in a name?

As the film got more explicit:
  o What feelings were you aware of in yourself?
  o Were their any “turn-offs” for you in this film? Any “turn-ons”?
  o What was your comfort level with the explicit sexual scenes?

* Portions of this lesson adapted with permission from Providing Comprehensive Sexual Health Care in Spinal Cord Injury Rehabilitation © 1997 by Mitchell S. Tepper
Disabilities & Chronic Conditions

Promoting Sexual Health and Responsible Sexual Behavior: A Universal Curriculum for Health Professionals

Center of Excellence for Sexual Health
Satcher Health Leadership Institute
Morehouse School of Medicine

Background Information

- 1 in 5 (54 million) Americans have disabilities
  (U.S. Census, 2008)
- Largest and poorest minority group
  (Disability Funders Network, n.d.)
- Pervasive cultural constructs
  - Childlike
  - Asexual
  - Not interested in sexual pleasure
  - Not acceptable candidates for reproduction
- Invisible in the media
  - White, heterosexual, young, single, non-disabled

2004 N.O.D./Harris Survey Documents
Trends Impacting 54 Million Americans

- Only 35 percent of people with disabilities reported being employed full or part time, compared to 78 percent of those who do not have disabilities.
- Three times as many live in poverty with annual household incomes below $15,000 (26 percent versus 9 percent).
- People with disabilities remain twice as likely to drop out of high school (21 percent versus 10 percent).
- They are twice as likely to have inadequate transportation (31 percent versus 13 percent), and a much higher percentage go without needed health care (18 percent versus 7 percent).
- People with disabilities are less likely to socialize, eat out, or attend religious services than their non-disabled counterparts.
- Life satisfaction for people with disabilities also trails, with only 34 percent saying they are very satisfied compared to 61 percent of those without disabilities.
Definitions – ADA

- Americans with Disabilities Act (1990) definition of disability
  - Physical or mental impairment
  - Limits one or more major activities
  - Has a record or history of an impairment
  - Regarded as having an impairment

International Classification of Functioning, Disability and Health

- WHO (1980)
  - Impairment (differences in body/mind structure)
  - Disability (functional limitations)
  - Handicap (disadvantages experienced because of the impairment or disability)

- WHO (1991)
  - Body functions and structure
  - Activities (related to tasks and actions by an individual) and participation (involvement in a life situation)
  - Additional information on severity and environmental factors

Disability Groups by Types

- Physical
- Developmental
- Sensory
- Cognitive
- Psychiatric
- Learning
- Environmental (emerging population)
- Weight related (emerging population)
Call To Action on People with Disabilities
(2005)

- Sexuality and sexual needs often ignored
- PWD too often exploited and abused
- Serious underutilization of existing assistance developed for vulnerable populations
- Additional materials and programs needed
- Further research needed

Summary of 2002-2003 NSFG:
Compared to people without disabilities, people with disabilities are . . .

- More likely to have been forced
  - 33% : 15% women heterosexual vaginal intercourse
  - 5% : 2% men forced by another male to have oral or anal sex against your will
- More likely to have had ≥10 lifetime partners
- More likely to have had same sex experiences
  - Women 17% : 10%
  - Men 9% : 6%
- More likely to have an STI
  - Women with disabilities; 13% : 9%
  - Women who have been raped, 24% : 17%
  - the effects are independent

Models of Disability

- Moral (1700s-mid 1800s)
  - Disability as a sin
  - Selected to have a disability
- Medical (mid-1800s)
  - Dwells within the individual
  - Find a cure to be "normal"
- Minority or social model (early 1900s, reemerged in the early 1970’s)
  - Disability as social construction
  - Problem within the environment
A historical view of the disability experience

- Emphasis on medical concerns
  - 70%-90% institutionalized
- Move towards social issues
  - Sexuality as a topic of great importance
- Current knowledge
  - 54 million Americans with disabilities
  - Largest and poorest minority group

Growing Political Demand from Minority Groups to be Represented as Fully Sexual Beings

- [http://www.bentvoices.org/bentvoices/encounters.htm](http://www.bentvoices.org/bentvoices/encounters.htm)
- “Dearth of empowering, positive, sexy images of disabled people”
- United We Sit
- Emphasize solidarity with other disabled people and to challenge the norms.
  - Normalized for non-disabled

Intimate Encounters by Belinda Mason-Lovering

- Neglect of the pleasurable aspects of sex has been reinforced by the greater cultural assumption that people with disabilities are asexual
- "Sexuality is often the source of our deepest oppression; it is also often the source of our deepest pain." (Finger, 1992)
- "It's time to publicize our sexual oppression." (Waxman, 1996)

Effects of Disability or Illness on Sexual Response and Expression (Bancroft, 1989)

- The direct physical effects of the condition
- The psychological effects of the condition
- The effects of treatment on sexuality

Direct Physical Effects

- Impaired genital function
- Bowel and bladder incontinence
- Difficulty with movement and positioning
Psychological Effects
- Cognitive Genital Dissociation
- Sexual Disenfranchisement
- Decreased Sexual Self-esteem

Treatment Effects
- Scarring
- Wheelchairs, braces, leg bags
- Pharmacological side effects

Primary, Secondary, Tertiary
Disabilities: Effects on Sexual Function

- **Primary:**
  - Occurs as a result of neurological changes that directly affect sexual feelings and/or sexual response.

- **Secondary:**
  - Physical changes, which affect the sexual response indirectly.

- **Tertiary:**
  - Psychological, emotional, social, and cultural aspects that impact sexuality.

Primary Effects of MS

- Altered or impaired genital sensation, including numbness, pain, burning, or discomfort (M/F)
- Decreased libido (M/F)
- Difficulty achieving or maintaining an erection (M)
- Decreased vaginal lubrication (F)
- Decreased frequency and/or force of ejaculation (M)
- Decreased frequency and/or intensity of orgasm (M/F)

Secondary Effects of MS

- Fatigue
- Muscle tightness, spasms
- Weakness
- Bladder and bowel dysfunction
- Incoordination
- Difficulty with mobility
- Side effects of medication
- Cognitive difficulties
- Numbness, pain, burning, or discomfort in non-genital areas of the body
**Tertiary Effects of MS**

- Negative changes in self-image, mood, or body-image
- Depression and anger
- Feeling less sexy or attractive
- Feeling less masculine or feminine
- Feeling less confident about one's sexuality
- Fear of being rejected sexually
- Worries about sexually satisfying one's partner
- Difficulty communicating with one's partner
- Feelings of dependency

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**Innervation of the Genitals**

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**Hypogastric Plexus: T10 to L2 (Female)**

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Hypogastric Plexus: T10 to L2 (Male)

- Carries Psychogenic Messages

Sacral Plexus (Female)

- Pelvic Nerves - S2 to S4
- Responsible for Reflexogenic Responses
- Lubrication

Sacral Plexus (Female)

- Pudendal Nerves - S3 to S4
- Sensory Messages
- Voluntary Control of PC Muscles
Sacral Plexus (Male) Pelvic Nerves -S2 to S4 Responsible for Reflexogenic Responses -erection

Sacral Plexus (Male) Pudendal Nerves -S3 to S4 Sensory Messages Voluntary Control of PC Muscles

Between L2 and S2 (Male) Psychogenic Reflexogenic Not Coordinated
Problems of Sex and Disability Most Commonly Seen in Office Practice

- Interference with habitual sexual behavior by a relatively minor disability (arthritis, asthma), or by side-effects of medication;
- Convalescence from coronary heart disease;
- Sequelae of common surgical procedures (mastectomy, prostatectomy).

Habitual Sexual Behavior

- “The pattern to which the patient has become accustomed – even a change of venue can disrupt the relaxation necessary for sexual function in some people. The pattern may cover rigid and mistaken beliefs about normality – patients who say they "cannot have intercourse" may mean only that it is no longer possible in the male-superior position....In all of these common presentations, counseling is the major part of therapy, and involves sexual education” (Comfort, 1978, p. 8).
Common Disabilities or Chronic Conditions Impacting Sexuality

- HIV/AIDS
- Amputation
- Arthritis
- Asthma
- Back injury
- Cerebral Palsy
- Diabetes
- Heart disease
- Hearing impairment
- Hypertension
- Mastectomy
- Multiple Sclerosis
- Prostatectomy
- Spinal cord injury
- Stroke
- Traumatic brain injury
- Vision impairment

Process of Sexual Self-Discovery

- The ability to experience pleasure and orgasm with acquired disability is the culmination of a process of sexual self-discovery after injury that is reflective of sexual discovery before injury within the larger sexual culture and includes reestablishing a sexual relationship with oneself and others in the context of a changed body, changed life, and changed interpersonal relationships. (Tepper, 2005)

Emergent Themes

- Experience of Pleasure
- Masturbation
- Communication
- Emotional response
- Physical response
- Improved sexual esteem
- Partner

Experience of Disability

- Mind, body, spirit
- Pain and catheterization
- Bending thoughts
- Need to be with
- Partner for sexual interaction
- Having Sex
- Friends

Trusted partner

Don't ask, don't tell

Need to be with a partner for peak experiences

What was learned before injury

Having Sex

Printed Material

Favor

Partner

Improved Sexual Esteem

Emotional Response

Physical Response

Communication

Mind, Body, Spirit

Experience of Disability

Masturbation

Experience of Pleasure

Emergent Themes

(Tepper, 2001)
**Connectedness**

- Overwhelmingly a relationship with a sexual partner defined the peak sexual experience
- Trusted sexual partner was the pathway to pleasure and orgasm

**The Real Accessibility Issue**

- What are we doing it all for?
- Full inclusion means access to pleasure
- Establishing and/or maintaining sexual relationships

**Comprehensive Sexual Health Care**

- Addresses sexuality from a biopsychosocial and spiritual perspective
- Uses an interdisciplinary team approach
- Is incorporated into the overall health care
- Patients have services readily available to access as needed
Eliciting a Sexual History
Barriers and Bridges

Barriers: Gaps in Coverage
- Belief that someone else is doing the job
- Inadequate knowledge of the subject matter
- Discomfort with sexuality and disability
- Personal values conflicts

Additional Barriers to Providing Sexual Healthcare
- Time
- Age
- Gender
- Orientation
- Behavioral issues
- Readiness
Guidelines for Readiness (Tepper, 1997)

- Institutional Readiness
- Staff Readiness
- Early Assessments
- Peer Supports
- Individual Readiness
- Outpatient Follow-up

Bridges to Comprehensive Sexual Health Care

- Making an institutional commitment
- Continuing education and training
- Routinely including sexual assessments
- Providing privacy, permission, patience
- Capitalizing on teachable moments
- Tailoring the depth of the discussion

Assessment, Counseling, And Education

- Clarifying the sexual concerns
- Assess present and past sexual functioning
  - response, interest, activities, behaviors, fertility, sexual self-view
- Explore values and beliefs
- Normalize and validate concerns
- Provide support to client and family
- Providing information and specific suggestions
Areas to Focus on in Counseling or Therapy

- Masturbation experiences
- Sexual experiences with partner(s) or lack of opportunities
- Fantasy or lack of fantasy with distracting thoughts
- Feelings about diminished sensation, no orgasm, no ejaculation
- Beliefs about sexual potential and future

Educational and Therapeutic Interventions

- Address misinformation and misguided beliefs
- Incorporate behavioral exercises

Comprehensive Sexual Health Care (Tepper, 1997)

- Addresses sexuality from a biopsychosocial and spiritual perspective
- Uses an interdisciplinary team approach
- Is incorporated into the overall treatment plan
- Patients have services readily available to access as needed
Questions & Ready Responses

Can I still have sex?

Will I still be able to get an erection?
Will I still respond the same?

Will I still be able to have kids?

What's the point of still having sex if I can't feel anything?
Can I still please my partner?

How am I going to be able to have sex with this catheter in me?

Will my partner be able to please me?
How can I have sex when I don't feel sexy?

How will I be able to attract a partner?

I never looked at anyone in a wheelchair before, why would anyone look at me?
References

11. **Fertility, Pregnancy & Contraception**

*Time Required*
5-7 hours

*Purpose*
To understand the complexities of the female and male systems with regard to fertility; to understand the physiological processes of conception, pregnancy, and birth; to determine factors affecting sexuality during pregnancy and the post partum period; to gain familiarity with the different available contraceptive methods

*Rationale*
Partners’ sexuality is impacted by pregnancy and childbirth. This lesson encourages participants to think about the biological, psychological, and emotional aspects of pregnancy and childbirth. This lesson also helps participants understand the basic mechanics of male and female fertility in order to understand pregnancy and childbirth. Planning, spacing, and avoiding pregnancy is also an important aspect of sexual health, fertility, and pregnancy. Learning the best available methods to accomplish effective family planning is important in order to provide comprehensive and accurate information about contraception.

*Objectives*
- To review the physiologic and emotional mechanics of fertility
- To identify developmental milestones throughout pregnancy in the correct order
- To reflect on factors affecting sexuality during pregnancy and the post partum period
- To compare and contrast contraceptive methods and their advantages and disadvantages
- To name non-contraceptive health benefits associated with contraceptive methods

*Materials*
- See ‘Becoming a Parent: Conception, Pregnancy, and Birth’ in *Our Whole Lives Grades 10-12* Curriculum, pages 119-126
- Computer with Internet access, Speakers, LCD projector, screen
- Internet link: [http://www.fertilitylifelines.com/fertilityhealth/biology/naturalcycle.jsp](http://www.fertilitylifelines.com/fertilityhealth/biology/naturalcycle.jsp)
- Film: *In the Womb*
- TV and DVD player
- Handout: “Contraception Fact Sheet”
- Handout: “NFP chart”
- Contraceptive teaching kit
- Contraception Jeopardy answers, markers, newsprint or chalk/white board

*Procedure*
**Fertility (1 hour)**
1. Process the readings (Strong et al. chapters on male and female anatomy and physiology) and website ([http://www.fertilitylifelines.com/](http://www.fertilitylifelines.com/)) by asking:
   - What did you learn from the readings and the website?
   - What was new information and what did you already know?
3. Process the lives of the sperm and eggs as seen in the animation clip.
4. Conclude by asking participants for definitions of fertility.

**Pregnancy (2-4 hours if showing the film)**

2. Show the film *In the Womb* (2005) 89 minutes
3. Discuss the following questions:
   - If you or your partner became pregnant today, what would you do? Where would you go in order to receive support for your decision?
   - If you or your partner were to have a child, where and how would you prefer to deliver the baby? Who would you want present? What steps would you be willing to take in order to ensure your wishes were granted?
   - At what age/stage of life do you feel it is appropriate to become pregnant?
   - Who should be allowed to become parents? Who should not be allowed to become parents?
   - What activities would you suggest partners do to keep communication open about sexuality during and after pregnancy?
   - How is sexuality impacted by pregnancy both for the pregnant woman and her partner(s) during the prenatal and postnatal periods?

**Contraception (2 hours)**

1. Before this portion of the class, arrange the contraceptives on a table to show to the class and pass around when each is being discussed.
2. Have the group discuss the following questions:
   - Why is it important to learn about contraception?
   - Why do we need contraception?
   - What factors should one consider when choosing a method?
3. Hand out copies of the Contraception Fact Sheet to the group. Allow group to read it for several minutes and orientate them to the layout and format.
4. Lecture is organized as follows
   a. Hormonal methods – birth control pills (oral contraceptives), Ortho Evra® patch, NuvaRing®, Depo-Provera®, Implanon® and Plan B®
   b. Intra-uterine devices (IUDs)
   c. Natural methods – Abstinence, fertility awareness, withdrawal
   d. Barrier methods – Male and female condoms, sponge, diaphragm and cervical cap
   e. Surgical methods – Male and female sterilization
4. Teach and describe each of the methods. Use the *Contraception Fact Sheet* as a guide, but do not read straight from it. As each method is taught, pass the sample around the group for participants to see. Highlight the following:
   - Birth control pills
     - Combined pills contain estrogen and progestin. Progestin-only pills (aka “mini-pills”) do not contain estrogen
- Combined pills are typically packaged in packs of 28 pills – 21 “active” pills (containing hormones) followed by 7 “inactive” pills (containing no hormones). Some newer pills may have lower levels of hormones or other ingredients like iron in the “inactive” pills
- Combined pills are monophasic (all active pills have the same dose of hormones), biphasic or triphasic (hormone doses change throughout the active cycle)
- Newer “continuous cycle” pills are designed for a longer “active” phase in which women will have fewer periods throughout the year. Women have also used monophasic pills for continuous cycling by skipping the “inactive” pills and continuing into the next pack of “active” pills, although this is not FDA approved
- Take one pill at the same time every day. There is a window of about +/- 3 hours for combined pills, but no margin of error for progestin-only pills. Use may be initiated at any time during the menstrual cycle once the prescription is filled. In the very first cycle of pill use, a backup method (abstinence, condoms, sponge) must be used for the first seven days before the pills have taken full contraceptive effect.
- Noncontraceptive benefits of birth control pills include decreased risk for ovarian and endometrial cancer, regular periods, reduction in menstrual blood loss, reduction in menstrual cramps, treatment of endometriosis
  - Ortho Evra® patch
    - One patch worn each week for three weeks, followed by one patch-free week for menstruation. The patch delivers 20 micrograms estrogen, 150 micrograms progestin daily through the skin directly into the bloodstream. Use may be initiated at any time during the menstrual cycle once the prescription is filled. In the very first cycle of patch use, a backup method (abstinence, condoms, sponge) must be used for the first seven days before the patch has taken full contraceptive effect.
    - Patch may be worn on the upper arm (bicep), shoulder blade, hip or buttock, never to be worn on the breasts.
    - Skin irritation and discoloration are commonly reported side effects
    - The patch should not be removed mid-week. If it becomes detached the user should replace as soon as she discovers it has detached. User should wear the patch on a different location week to week.
    - Patch users may wear one patch weekly and not take a “patch-free” week for continuous cycling, although this is not FDA-approved.
    - While the dose of hormones is the same as many birth control pills, because the hormones are delivered straight through the skin and into the blood (versus metabolizing through the system as with ingestion of pills), users are exposed to about 60% more estrogen. This may be a contraindication for women who are sensitive to estrogen, and may increase the risk for blood clots, which can be fatal. The FDA has placed a warning on the package of the patch, but currently has no plans to remove the patch from market.
o NuvaRing®
  ▪ Flexible polymer ring worn vaginally for 21 days (15 micrograms estrogen, 120 micrograms progestin delivered daily), followed by 7 days ring-free for menstruation.
  ▪ Use must be initiated in the first five days of menstrual bleeding. Providers can instruct patients on how to insert and remove the ring. In the very first cycle of ring use, a backup method (abstinence, condoms, sponge) must be used for the first seven days before the ring has taken full contraceptive effect.
  ▪ The ring may be used for continuous cycling by replacing it on Day 21 immediately after the prior ring is removed, although this is not FDA approved
  ▪ Not recommended for women who are not comfortable touching their genitals/vagina
  ▪ The ring has the lowest estrogen dose of any combined method and may be a good option for women who are less tolerant of estrogen

o Depo-Provera®
  ▪ A progestin-only injection administered by a provider every 11-13 weeks – 150 mg progestin per injection
  ▪ As with most progestin-only methods, amenorrhea (no period) is common. Other side effects include severe mood swings and weight gain
  ▪ Recommended use in adolescents for only 2-3 years because reduced estrogen in body inhibits bone mineral formation, lasting effects on bone demineralization related to use are unknown. Users should supplement calcium, eat calcium-rich foods (dairy products, dark leafy green vegetables) and engage in weight-bearing exercise
  ▪ Users may experience a delay in return to baseline fertility for up to a year after discontinuing the method

o Implanon®
  ▪ FDA-approved in 2006
  ▪ Single-rod, 4 cm long, implanted beneath the skin of the upper inner arm for daily progestin release for 3 years
  ▪ Suppresses ovulation, thickens cervical mucus, thins and atrophies endometrium
  ▪ Women may experience irregular menstrual bleeding or amenorrhea

o Plan B®/emergency contraception
  ▪ Available to women and men 17 years and older without a prescription, women under 17 require a prescription
  ▪ Plan B® may be taken up to 120 hours (5 days) after unprotected intercourse (condom broke or was not used, several pills skipped, ONE progestin-only pill skipped, forced sex occurred, etc) – the sooner, the better. Both Plan B® pills may be taken together. The woman will begin to menstruate in about 7 days and her cycle will re-start from that point.
  ▪ If the woman using Plan B® uses birth control pills as her regular method and has skipped several pills, she should resume regular pill use the day after she takes Plan B®.
Plan B works three ways to prevent unintended pregnancy: 1) Prevents ovulation if it has not already occurred; 2) changes motility of the uterus and Fallopian tubes to prevent fertilization if it has not already occurred; 3) prevents implantation of a fertilized egg in the uterine wall

Plan B® is not the “abortion pill” – it will not prevent pregnancy if a fertilized egg has implanted into the uterine lining, however, this may not be consistent with some providers’ or patients’ deeply held beliefs

Plan B® will not affect a woman’s ability to become pregnant in the future (planned or unintended)

Plan B® should not be used as a primary method – it is costlier (up to $70/dose), it only works for isolated incidents of unprotected intercourse, it is not as effective as other primary methods, it does not protect against STDs, and it interrupts and re-starts the menstrual cycle

Copper IUDs may also be inserted within 5 days after unprotected intercourse for emergency contraception and continue for highly effective, long-term contraception, though for EC this method is more costly, more invasive and less effective than Plan B®

Many regular birth control pills may also be taken in certain combinations to produce the same effect as Plan B®

IUDs (intra-uterine device, also called intra-uterine system or IUS or intrauterine contraceptives or IUC)

- Used by 85-100 million women worldwide but only ½-1% of women in the U.S. who use contraception. IUDs were widely used in the 1960s and 1970s but fell out of favor when a number of women died from complications from one product – the Dalkon shield® – in the 1970s. Though product manufacturing was immediately ceased and the IUDs available now are known to be safe, many women in the U.S. still fear IUDs.

- Used more often by parous women (have given birth) but not contraindicated for nulliparous women (have not given birth). Insertion takes place in doctor’s office and takes about 20 minutes.

- Copper T (Paragard®) IUD contains no hormones and does not change menstrual timing, though some women may experience increased menstrual cramping and bleeding. The copper creates a sterile environment and acts as a highly effective spermicide, preventing fertilization and implantation. Can be left in place up to 10 years.

- Mirena® (progestin) IUD releases progestin daily and prevents ovulation in about 50% of women using it, fertilization and implantation. Women using Mirena® report up to 90% reduction in menstrual blood loss but many experience menstrual irregularity and amenorrhea.

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* The “abortion pill” is RU-486, sold under the brand name Mifepristone® and is taken by women who are less than 6 weeks pregnant as a means of terminating an existing, known pregnancy. Plan B® has no effect on existing pregnancies.
Abstinence

- For pregnancy prevention, abstinence means avoiding any genital-to-genital contact or hand-to-genital contact that could result in semen coming into contact with the vagina.
- It is the surest way to avoid pregnancy or STD infection.
- Discuss the following questions:
  1. How can partners negotiate abstinence?
  2. What are some refusal skills and strategies one can use if one wants to abstain?
  3. Should young people be convinced to abstain as long as possible?
  4. What are the advantages and disadvantages to abstinence as an individual behavior choice and a public health strategy?
  5. How can one remain committed to abstinence, or re-commit if one has been sexually active in the past?
  6. What other sexual behaviors and practices can one engage in that will not carry risk for pregnancy?

Natural Family Planning (hand out NFP chart)

- When used correctly, consistently, NFP can be highly effective to avoid pregnancy and fertility awareness methods can also help plan pregnancy. Multiple natural methods can be used concurrently, or barrier methods can be used in conjunction to increase effectiveness if trying to avoid pregnancy.
- Calendar Method (NaPro Method): To determine fertile days, record the number of days in each menstrual cycle for 6-12 months. Subtract 18 from the number of days in the shortest cycle and subtract 11 from the number of days in the longest cycle minus 11 days. For example, if a woman recorded her cycles for 12 months, and the longest cycle was 31 days and her shortest cycle was 27 days, then in any given cycle her fertile days would be days 9-20 (27-18=9; 31-11=20). Couple should abstain or use a backup method (i.e. condoms) during fertile days if not trying to conceive; have intercourse during those days if trying to conceive.
- Standard Days Method: Use color-coded beads like CycleBeads® (www.CycleBeads.com) that indicate generally when to have or avoid intercourse to plan or avoid pregnancy. Can be used by women whose cycles are normally 28-33 days and does not require at least 6 months of cycle tracking.
- Cervical Mucus Ovulation Detection Method (Billings Method): Woman checks with her fingers or a tissue the amount, color and consistency of mucus on the cervix for changes at different points in the menstrual cycle. Post-ovulation and post-menstrual, there is little to no mucus; fertile pre- and immediately post-ovulation, mucus is cloudy and sticky; ovulation mucus is clear, wet, stretchy and sticky but slippery.
- Two Day Method: If the woman did not notice vaginal secretions or cervical mucus today or yesterday then she is less likely to become pregnant if she has intercourse.
Promoting Sexual Health and Responsible Sexual Behavior

- Basal Body Temperature Method (refer to handout): Woman takes her temperature before getting up in the morning. Body temperature will drop 0.2-0.4°F just before ovulation then rise 0.4-0.8°F around ovulation. To avoid pregnancy, the woman abstains from her first day of menstrual bleeding through 3 days of consistent rise in temperature.
- Post-Ovulation Method: To avoid pregnancy, a woman abstains from the first day of menstrual bleeding and may only resume having unprotected intercourse after all signs of ovulation have subsided (thin, slippery cervical mucus, consistently elevated basal body temperature)
- Lactational Amenorrhea Method: At least 90 percent of the infant’s nutrition must be from breastfeeding, the mother is less than 6 months postpartum and menstruation AND ovulation have not resumed; It may be difficult to determine when ovulation resumes because a woman may ovulate and not menstruate; In addition to being a contraceptive, LAM encourages breastfeeding, which is beneficial to both mother and baby and promotes bonding between mother and baby. Many hospitals and birth centers offer counseling on LAM
- Withdrawal: During intercourse the man withdraws his penis from the vagina prior to any ejaculation. Pre-ejaculatory fluid is usually present, which is a lubricant produced by the Cowper’s gland that facilitates the passage of semen during ejaculation, and this fluid produced does not contain any sperm. Some sperm however may be mixed in the fluid if any is still in the man’s urethra from a prior ejaculation.

- Male and female condoms
  - Using a penis model, demonstrate how to properly put on and take off a male condom (you may invite volunteers to participate in this activity):
    1. Squeeze the condom to the side of the package and carefully open from the corner
    2. Determine which way the condom rolls before putting it on the penis
    3. Roll the condom down to the base of the erect penis
    4. During intercourse, check periodically that the condom is in place and intact
    5. After ejaculation hold the base of the condom and withdraw the penis
    6. Firmly but gently pull the condom off the penis from the base
    7. Wrap the condom in tissue and throw it in the trash (do not flush it down the toilet)
  - Show the group what the female condom (FC®) looks like. It covers external skin and offers slightly better STD protection from those passed through skin-to-skin transmission. The female condom is inserted by squeezing the inner ring and inserting it into the vagina. During intercourse, the penis must be carefully kept inside FC®. They are only intended for single use. After ejaculation, remove the penis, twist the outer ring closed and pull FC® out of the vagina.
Water and silicone-based lubricants are safe for use with latex condoms, oil-based lubricants are not – they will deteriorate latex in less than a minute. Examples of oils include cooking oils like olive oil, vegetable oil, canola oil, Crisco®, ointments, massage oils, and vaginal yeast infection treatments.

- **Today® Sponge**
  - Available through the mid-1990s and pulled from the market because production was ceased due to facilities not being up to code (nothing wrong with the product itself) and re-introduced in 2006, though currently not widely available
  - Over-the-counter barrier method that blocks sperm, absorbs sperm, kills sperm (contains spermicide)
  - To use, open package, wet sponge with tap water, squeeze to activate spermicide, fold in half and insert in the vagina so that the dimpled side covers the cervix and the string is on the bottom. The sponge can be inserted several hours before intercourse and may be used for multiple acts of intercourse in 24 hours with no need to re-apply anything. It must be left in place 6 hours after last intercourse and no more than 30 hours (risk of toxic shock, urinary tract infections, yeast infections)
  - **Do not use** during menstruation, cumbersome to insert and remove, good non-hormonal barrier alternative to condoms (though does not protect from STDs and HIV), higher failure rates especially in parous women

- **Diaphragm and cervical cap with spermicide**
  - Barrier methods that must be fitted by a provider. Providers can also counsel patients in their office on how to use them. To use, rim the device with spermicide gel and fill the dome partially with spermicide and insert vaginally to cover the cervix (spermicide is the active mechanism for contraception – the diaphragm and cap are devices that hold spermicide in place). Both can be left in place for multiple acts of intercourse with no re-application necessary. Diaphragm can be left in place up to 24 hours, cap up to 48 hours. Both must be left in place 6 hours after last intercourse.
  - Nonoxynol-9 warning: Nonoxynol-9 is the only spermicide available in the U.S. and has been found to irritate sensitive skin and actually increase the risk of HIV/STD infection if exposed. Women at high risk for HIV/STDs should not use contraceptives containing Nonoxynol-9
  - Diaphragm and cervical cap can also increase UTI and yeast infection risk

- **Male and Female Sterilization**
  - Female sterilization (tubal ligation) is the most commonly used method in the US and worldwide; male sterilization (vasectomy) is less expensive, less invasive and more effective than tubal ligation
  - Patients should plan on sterilization procedures being permanent and irreversible. Depending on the method, reversibility may be possible but are not guaranteed to restore fertility
  - Tubal ligation has no effect on menstrual cycles (removal of uterus and ovaries in hysterectomy will cease menstrual cycles); vasectomy have no effect on sexual function in men
Methods of tubal ligation include removal and sealing off portions of the Fallopian tubes (bipolar cautery, modified Pomeroy, modified Parkland), application of removable bands or clips (silastic band, Hulka-Clemens clip, Filshie clip – highest potential for reversibility, but also for failure), fimbriectomy (removal and sealing end of tube near ovary) and excision and burial of Fallopian tube into uterine muscles (Irving, Uchida – lowest potential for reversibility)

Essure® is the newest method of female sterilization – insertion of a coil into each Fallopian tube that causes permanent scarring and irreversible blockage

Vasectomy is a short, outpatient procedure in which a small incision is made to the scrotum and a portion of each vas deferens is removed and tied or cauterized off. It is not immediately effective – only effective after ~20 ejaculations or sperm count=0

5. Play Contraception Jeopardy. See game board with answers and daily doubles – instructors please email cesh@msm.edu for questions. Draw a table of 5 columns, 6 rows on newsprint or a chalk/white board and fill in categories and point values. Rules:

- Emphasize that the activity is just a game! Some participants may get very competitive.
- Divide the large group into two teams and instruct each group to choose a sexy team name. Choose one participant to serve as a Judge/Scorekeeper.
- Emphasize with the group that no external resources are allowed. Instruct them to put away all books, notes, websites, etc.
- Toss a coin to determine which team picks the first category and point value. When a clue is read, the judge/scorekeeper will cross out or erase that block from the game board.
- When the answer is read, either team may “buzz” in by raising hands. Any member of the team may raise her/his hand if s/he thinks s/he knows the answer (question). Participants may not raise their hands until answer is read entirely. The judge/scorekeeper determines who raises hand first.
- Teams may confer no more than 5 seconds or they lose the turn and the clue is asked to the other team.
- All answers must be in the form of a question (ex. Who is…; What is…; etc).
- Points are earned for correct answers, deducted for incorrect answers. The scorekeeper is responsible for tracking the correct and incorrect responses and tallying the points.
- If one team answers incorrectly, the other team may try to answer (except in “daily double” questions).

**Evaluation Questions**

Instructors please email cesh@msm.edu to request answers.

1. How long does the ova/egg survive in the woman’s body after ovulation?
   - A. 24 hours
   - B. 48 hours
   - C. 72 hours
   - D. 96 hours
2. At what point is it generally safe to engage in sexual intercourse in the postpartum period?
   A. Immediately after delivery
   B. 3 weeks after delivery
   C. 6 weeks after delivery
   D. None of the above

3. Which of the following contraceptive methods does not involve hormonal manipulation?
   A. Abstinence
   B. Birth control pills
   C. Condoms
   D. A & C only
   E. A, B, & C

Required Readings

Recommended Readings
• [http://www.managingcontraception.com](http://www.managingcontraception.com)

Films
• [http://www.fertilitylifelines.com/fertilityhealth/biology/naturalcycle.jsp](http://www.fertilitylifelines.com/fertilityhealth/biology/naturalcycle.jsp)
• National Geographic. (2005). *In the Womb*. Produced by Pioneer Film and TV Productions Limited.
## Contraception Jeopardy

<table>
<thead>
<tr>
<th>Point</th>
<th>Category</th>
<th>Question</th>
<th>Answer</th>
<th>Trivia</th>
<th>This or That?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>200</strong></td>
<td><strong>Hormones</strong></td>
<td>A: These two hormones are in combined pills, the patch and the ring.</td>
<td>A: These two methods protect against both pregnancy and sexually transmitted diseases.</td>
<td>A: People allergic to this material should use a polyurethane alternative.</td>
<td>A: This is a smaller barrier method compared to a similar method, the diaphragm.</td>
</tr>
<tr>
<td><strong>(Daily Double)</strong></td>
<td><strong>Methods</strong></td>
<td>A: This hormone, found in hormonal contraceptives, is believed to benefit bone mineral density.</td>
<td>A: This is the brand name of emergency contraceptive pills.</td>
<td>A: This contraceptive may cause skin irritation or discoloration.</td>
<td>A: This method is similar to, but offers <em>slightly</em> better STI protection than male condoms.</td>
</tr>
<tr>
<td><strong>400</strong></td>
<td><strong>Side Effects</strong></td>
<td>A: These two methods protect against both pregnancy and sexually transmitted diseases.</td>
<td>A: This hormone primarily responsible for libido and it is not found in any contraceptives.</td>
<td>A: This is the brand name of emergency contraceptive pills.</td>
<td>A: Cassanova is said to have used this citrus fruit as cervical caps.</td>
</tr>
<tr>
<td><strong>600</strong></td>
<td><strong>Trivia</strong></td>
<td>A: People allergic to this material should use a polyurethane alternative.</td>
<td>A: This is the most commonly used method both in the United States and worldwide.</td>
<td>A: The first birth control pill was introduced in this year.</td>
<td>A: Female sterilization is called <em>tubal ligation</em>. Male sterilization is called this.</td>
</tr>
<tr>
<td><strong>800</strong></td>
<td><strong>This or That?</strong></td>
<td>A: This is the brand name of emergency contraceptive pills.</td>
<td>A: Lubricants made of this substance cannot be used with latex condoms.</td>
<td>A: Due to elevated risks for blood clots, women using hormonal contraceptives should avoid doing this.</td>
<td>A: “Mini pills” do not contain this hormone, whereas combined pills do.</td>
</tr>
<tr>
<td><strong>1000</strong></td>
<td><strong>A: This combined hormone delivers 15 micrograms of estrogen daily, the lowest dose of any combined method.</strong></td>
<td>A: This is the brand name of the female condom.</td>
<td>A: Use of these barrier methods may increase a woman’s risk for developing yeast infections and urinary tract infections.</td>
<td>A: This method was first invented in 1564 and is used 5 billion times every year.</td>
<td>A: This non-hormonal method is effective for 10 years, whereas its progestin-only counterpart is effective for five years.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Method</th>
<th>How it Works</th>
<th>How to Use It</th>
<th>Advantages*</th>
<th>Disadvantages*</th>
<th>Availability</th>
<th>Cost</th>
<th>Failure %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Control Pill (Combined oral contraceptives, progestin-only pill “mini-pill”)</td>
<td>Pills suppress ovulation, thickens cervical mucus, thins endometrium</td>
<td>Take one pill at the same time everyday</td>
<td>Less menstrual bleeding, cramps, acne, anemia. Regulate cycles. Decreased risk of some cancers.</td>
<td>Increased spotting in first cycles, lowers sex drive, mood changes, weight gain, nausea, breast tenderness, risks in smokers &gt;35</td>
<td>Prescription only: pharmacies, women’s clinics</td>
<td>$30-$35 per cycle</td>
<td>Typical: 8% Perfect: 0.3%</td>
</tr>
<tr>
<td>Ortho Evra® Birth Control Patch</td>
<td>Adhesive patch suppresses ovulation, thickens cervical mucus, thins endometrium</td>
<td>Wear 1 patch/week for 3 weeks, then 1 week patch-free</td>
<td>Easier to use than pills, stays put in water and sweat. Regulate cycle. Similar health benefits as pills.</td>
<td>Similar as pills. Can irritate or discolor skin. Less effective in women &gt;198 lbs. Increased risk for blood clots.</td>
<td>Prescription only: pharmacies, women’s clinics</td>
<td>$30-$35 per cycle</td>
<td>Typical: 8% Perfect: 0.3%</td>
</tr>
<tr>
<td>NuvaRing®</td>
<td>Vaginal ring suppresses ovulation, thickens cervical mucus, thins endometrium</td>
<td>Wear ring for 21 days, then 7 days ring-free. Left in place for intercourse.</td>
<td>Less spotting than pills/patch, lowest dose of any hormonal method. Regulate cycle. Most women cannot feel ring in vagina. Similar health benefits as pills.</td>
<td>Spotting after ring-free week, may dislike inserting and removing ring from vagina</td>
<td>Prescription only: pharmacies, women’s clinics</td>
<td>$30-$35 per cycle</td>
<td>Typical: 8% Perfect: 0.3%</td>
</tr>
<tr>
<td>Injection: Depo-Provera® Progestin only</td>
<td>Suppresses ovulation, thickens cervical mucus, thins endometrium</td>
<td>Injected into arm or buttocks every 11-13 weeks</td>
<td>Less menstrual bleeding, cramps, anemia. Amenorrhea (no period) common. Decreased risk of some cancers.</td>
<td>Irregular bleeding, weight gain, lowers sex drive, amenorrhea, depression, mood changes</td>
<td>Prescription only: injected by provider only</td>
<td>~$60/ injection</td>
<td>Typical: 3% Perfect: 0.3%</td>
</tr>
<tr>
<td>Intra-Uterine Device (IUD: copper or progestin)</td>
<td>Kills sperm (copper), inhibits sperm and tubal motility. Progestin IUD suppresses ovulation, thickens cervical mucus, thins endometrium</td>
<td>Provider inserts IUD into uterus, left in place 5 yrs. (progestin), 10 yrs. (copper)</td>
<td>“Reversible sterilization.” Decreased risk of some cancers. Amenorrhea (progestin). Nothing to remember daily/weekly/monthly. Most cost-effective, long-term contraception.</td>
<td>Insertion and removal cause short-term cramping. More menstrual blood loss (copper), amenorrhea (progestin). Expulsion (rare). High initial cost</td>
<td>Inserted and removed by provider only, usually after birth or abortion</td>
<td>$300-$500</td>
<td>Typical: 0.8% (C); 0.1% (P) Perfect: 0.6% (C); 0.1% (P)</td>
</tr>
<tr>
<td>Emergency Contraception (EC): Plan B®, Copper IUD</td>
<td>Prevents pregnancy after unprotected sex: prevents ovulation (Plan B®), fertilization, implantation</td>
<td>Plan B® taken, IUD inserted ASAP, within 120 hours (5 days) after sex.</td>
<td>Decreases number of abortions and unintended and teen pregnancies. IUD effective long-term contraception.</td>
<td>Spotting or disrupted cycle (usually returns to normal in one cycle), nausea (Plan B®), cramping (IUD)</td>
<td>1-888-NOT-2-LATE <a href="http://www.not-2-late.com">www.not-2-late.com</a> OTC &gt;18 yrs</td>
<td>Plan B® $35-$70 IUD $300-$500</td>
<td>Typical: 11%-25% Perfect: 1%</td>
</tr>
<tr>
<td>Male Condom</td>
<td>Latex or polyurethane sheath worn over penis stops sperm from entering vagina</td>
<td>Before sexual contact, roll condom from tip to base of erect penis. Remove after ejaculation</td>
<td>Only used at time of intercourse (nothing to remember daily), sex is less messy. STI PROTECTION (gonorrhea, chlamydia, HIV)</td>
<td>Less protection from herpes, HPV, syphilis (only protects covered skin). Possible latex allergies. Disrupts sex. Use with EC or another contraceptive.</td>
<td>Drug stores, pharmacies, clinics, other retail stores</td>
<td>Latex: &lt;$1 each Polyurethane: $1-$3 each</td>
<td>Typical: 15% Perfect: 2%</td>
</tr>
<tr>
<td>Female Condom</td>
<td>Polyurethane sac worn in vagina, held in place by flexible inner ring, stops sperm from entering vagina</td>
<td>Before sexual contact, insert closed end, open end hangs out of vagina. Remove after ejaculation</td>
<td>Good method for women whose partners will not use male condoms. STI PROTECTION (gonorrhea, chlamydia, HIV; herpes, HPV, syphilis if skin is covered)</td>
<td>May dislike inserting condom in vagina, limited availability in stores, makes noise during sex, must be held in place carefully during sex.</td>
<td>Drug stores, pharmacies, women’s clinics, online</td>
<td>$1-$3 each</td>
<td>Typical: 21% Perfect: 5%</td>
</tr>
</tbody>
</table>

*Advantages and Disadvantages: Not all individuals who use a particular method of contraception will experience all of the listed advantages and disadvantages.
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<th>Failure %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Today® Sponge</td>
<td>Polyurethens sponge with spermicide kills sperm, absorbs semen, and blocks sperm from entering uterus</td>
<td>Before sexual contact, wash hands, wet sponge, squeeze until sudsy, fold sponge and insert in vagina, dimple covers cervix.</td>
<td>Good non-hormonal barrier alternative to condoms, can be inserted hours before sex and left in place for multiple sex acts, up to 24 hours</td>
<td>May dislike inserting sponge in vagina. Must be left in place 6 hours after last sex act, but not &gt;30 hours. Spermicide can irritate vaginal tissue. Use with EC or another contraceptive.</td>
<td>Drug stores, pharmacies, online</td>
<td>$3 each</td>
<td>Typical: 14%-27%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NO STI PROTECTION</td>
<td></td>
<td></td>
<td>Perfect: 9%-21%</td>
</tr>
<tr>
<td>Diaphragm or Cervical Cap with Spermicide</td>
<td>Rubber device filled with spermicide covers cervix to block sperm from entering uterus</td>
<td>Before sexual contact, fill with spermicide gel and place in vagina, covering cervix</td>
<td>Can be left in place 24 (diaphragm) or 48 (cap) hours for multiple sex acts, absorbs sperm, kills semen, and blocks sperm from entering uterus</td>
<td>May dislike inserting and removing object from vagina, less effective in women who have given birth</td>
<td>Pharmacies, clinics. Must be fitted by provider.</td>
<td>$25-$50 + cost of Dr. visit and spermicide</td>
<td>Typical: 16%-32%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NO HIV PROTECTION</td>
<td></td>
<td></td>
<td>Perfect: 6%-9%</td>
</tr>
<tr>
<td>Male Sterilization (vasectomy)</td>
<td>No sperm in semen, therefore sperm cannot enter vagina</td>
<td>Outpatient procedure removes and ties or burns part of vas deferens</td>
<td>Safer, less expensive, more effective than female sterilization. Permanent. No risk of sexual dysfunction.</td>
<td>Not immediately effective (use backup method), regret (rare), not easily reversed.</td>
<td>Procedure performed at clinic only</td>
<td>$300-$1000</td>
<td>Typical: 0.15%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NO STI PROTECTION</td>
<td></td>
<td></td>
<td>Perfect: 0.1%</td>
</tr>
<tr>
<td>Female Sterilization</td>
<td>Stops egg passage through Fallopian tube to prevent fertilization</td>
<td>Outpatient procedure removes, ties, or burns or blocks off part of Fallopian tube</td>
<td>Permanent, highly effective, lowers risk of ovarian cancer, no permanent menstral changes</td>
<td>Not easily reversed, increased risk of ectopic pregnancy if method fails, regret (more common in younger women)</td>
<td>Procedure performed at clinic only</td>
<td>$1000-$2500</td>
<td>Typical/ Perfect: 0.5%-3.7% depending on method</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>Fewer or no sperm enter vagina</td>
<td>Before any ejaculation (including pre-ejaculation), man removes penis from woman’s vagina</td>
<td>Involves man in contraception, no other method needed for use</td>
<td>NO HIV PROTECTION</td>
<td>Procedure performed at clinic only</td>
<td>N/A</td>
<td>NONE Typical: 27%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NO STI PROTECTION</td>
<td></td>
<td></td>
<td>Perfect: 4%</td>
</tr>
<tr>
<td>Natural Family Planning</td>
<td>Periodic abstinence: No sexual contact on woman’s fertile days</td>
<td>Woman tracks cycle timing and checks cervical mucus, basal body temperature, hormonal surge</td>
<td>Woman learns about her body, good if religion restricts contraception, works well for planning pregnancy</td>
<td>Difficult to use for irregular cycles, careful record-keeping, sperm live 3-5 days inside uterus.</td>
<td>Procedure performed at clinic only</td>
<td>N/A</td>
<td>NONE Typical: 25%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NO STI PROTECTION</td>
<td></td>
<td></td>
<td>Perfect: 1%-9%</td>
</tr>
<tr>
<td>Lactational Amenorrhea Method (LAM) (Breastfeeding)</td>
<td>Woman exclusively breastfeeding, not ovulating or menstruating, &lt;6 months post-partum</td>
<td>Suckling produces prolactin and inhibits estrogen to suppress ovulation</td>
<td>Beneficial to infant, decreased risk of some cancers, post-partum weight loss</td>
<td>Unpredictable return of fertility, less effective &gt;6 months, HIV+ women may infect infant, breast discomfort from breastfeeding</td>
<td>Procedure performed at clinic only</td>
<td>N/A</td>
<td>NONE Typical: 2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NO STI PROTECTION</td>
<td></td>
<td></td>
<td>Perfect: 0.5%</td>
</tr>
<tr>
<td>Abstinence</td>
<td>No sperm enters vagina, preventing fertilization</td>
<td>Avoid any genital or hand-to-genital contact so semen does not come into contact with vagina</td>
<td>Can improve communication and negotiation skills, can improve self-image</td>
<td>Must rely on backup method if any sexual contact may occur. Both partners must agree to abstain</td>
<td>N/A</td>
<td>NONE</td>
<td>Typical: unknown</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>STI PROTECTION</td>
<td></td>
<td></td>
<td>Perfect: 0%</td>
</tr>
</tbody>
</table>


12. **Infertility**

**Time Required**
2 hours

**Purpose**
To gain an understanding of the comprehensive nature of infertility and infertility treatment

**Rationale**
More and more people are wanting to have children in spite of infertility problems. Infertility and infertility treatments are cutting edge, complex topics that raise biological, psychological, legal, political, ethical, moral, and cultural concerns. This activity allows participants to gain an understanding of the complexities associated with infertility.

**Objectives**
- To identify factors affecting fertility
- To compare and contrast infertility treatment options
- To explore the emotional implications of infertility with patients and their partner(s)

**Materials**
- Computer with Internet access and speakers, LCD projector, screen

**Procedure**
1. Introduce the topic of infertility
2. Have the participants watch Frederick Sengstacke II, MD (MSM OB/GYN Professor) presentation “Current and Future Advances in the Treatment of Human Infertility: Trends, Techniques, Challenges, and Controversies” at the link below
   - [http://av01.msm.edu/mediasite/Viewer/Viewers/Viewer240TR.aspx?mode=Default&peid=721b3be8-0725-46fd-9f7a-9b212ceb969d&pid=0b72a36f-ef7-40f1-8623-f0ce75e212f9&playerType=Port25#](http://av01.msm.edu/mediasite/Viewer/Viewers/Viewer240TR.aspx?mode=Default&peid=721b3be8-0725-46fd-9f7a-9b212ceb969d&pid=0b72a36f-ef7-40f1-8623-f0ce75e212f9&playerType=Port25#)
3. When the presentation is complete, engage the group in a discussion of the presentation. Ask the following questions.
   - What new information did you learn from this presentation about causes of infertility, infertility treatments, and disparities related to infertility?
   - How might you incorporate this information into your personal choices and decisions around pregnancy and parenthood? How might you incorporate this information when counseling patients?
   - What are some of the biological, psychological, legal, political, ethical, moral, and cultural concerns you identified from the presentation? Can you think of any that were not mentioned in the presentation?

**Evaluation Questions**
Instructors please email cesh@msm.edu to request answers.
1. Women experience a higher rate of infertility than men.
   - A. True
   - B. False
2. Which of the following are used to treat infertility?
   A. Surgery
   B. Gamete Intra Fallopian Transfer (GIFT)
   C. Intrauterine Insemination (IUI)
   D. Ovulation Induction Agents
   E. All of the above

3. What is the average cost of one cycle of In vitro Fertilization (IVF)?
   A. $100-$500
   B. $5,000-$9,000
   C. $10,000-$15,000
   D. $25,000-$30,000

Required Readings


Recommended Readings

- American Society for Reproductive Medicine website: [www.asrm.org](http://www.asrm.org)
- Society for Assisted Reproductive Technology website: [www.sart.org](http://www.sart.org)
13. **Body Image, Self Esteem & Sexual Self Esteem**

**Time Required**
2½ hours

**Purpose**
To analyze what factors contribute to healthy and unhealthy body image and positive and negative self esteem and how body image and self esteem influence sexual decision-making.

**Rationale**
Popular images in the media, while not the only factor, significantly contribute to how one sees her or his body and positive or negative outcomes associated with body image. Body image, also while not the only factor, contributes to one’s overall self esteem and feelings of self-worth, particularly attractiveness and sexual self esteem. Ideals of beauty are constrained in a dominant and highly unattainable standard. This lesson will examine factors that influence body image, but broadening the concept of beauty to a multicultural framework.

**Objectives**
- Define body image, self esteem, sexual self esteem
- Describe how various socio/environmental factors can contribute to positive/negative body image
- Describe the relationship between body image, self esteem and sexual self esteem and sexual decision-making

**Materials**
- Films: *Reviving Ophelia* and *Private Dicks: Men Exposed*
- TV and DVD player
- Newsprint and markers

**Procedure**
1. Have the group discuss and conceptualize working definitions for body image and self esteem and record the definitions on newsprint
   - How do one’s body image and self esteem influence one another?
   - Thinking about biological, physical, cognitive and sexual development through different stages in the lifespan and related experiences, how is body image formed and how does it change?
   - How does an individual’s body image and self esteem influence her or his sexuality and sexual health?
2. Discuss and conceptualize a working definition for sexual self esteem and record the definition on newsprint
   - What are some of the health consequences related to body image (think about physical, mental and sexual health), thinking both positively and negatively?
3. Show the group the film *Reviving Ophelia* (38 minutes) and facilitate a discussion around the following questions
   - What were your general reactions to the film? Did anything come as a surprise to you? What made you feel hopeful? Concerned?
○ How is femininity both helpful and harmful in influencing girls’ and women’s self-esteem and sexuality?

4. Recommended if time permits and instructor is versed in the use of sexually explicit media: Show the group the film *Private Dicks* (55 minutes) and facilitate a discussion around the following questions:

○ What were your general reactions to the film? Did anything come as a surprise to you? What made you feel hopeful? Concerned?
○ At what age do you think boys typically first start to develop body image issues? What factors contribute to these feelings?
○ Why is penis size such an important factor in men’s body image and self esteem?
○ How is masculinity both helpful and harmful in influencing boys’ and men’s self esteem and sexuality?

**Evaluation Questions**

_Instructors please email cesh@msm.edu to request answers._

1. What psychiatric disorder is characterized by cycles of excessive calorie intake followed by compensatory behaviors to rid one’s body of the calories?
   - A. Binge eating disorder
   - B. Anorexia nervosa
   - C. Compulsive eating
   - D. Bulimia nervosa

2. What percentage of patients with eating disorders are women?
   - A. 50%
   - B. 70%
   - C. 85%
   - D. 90%

3. One’s level of regard for and confidence in capacity to experience sexuality in a satisfying and enjoyable way is:
   - A. Sexual self-esteem
   - B. Sexual self-schema
   - C. Bodiosexuality
   - D. Sexual disposition

**Required Readings**

Recommended Readings


Films

14. Media & the Internet

Time Required
2 hours + film viewing time prior

Purpose
To highlight the power of the media to influence sexual feelings, attitudes, values, and behaviors; to apply real-life media examples and discussion to student learning; to expose learners to the various ways that people use the Internet, ranging from the search for sexual health information to finding outlets for sexual expression and sites for entertainment; to stimulate thinking about how the Internet can be used to promote sexual health and responsible sexual behavior; to review potential risks associated with online sexual behaviors

Rationale
The media is saturated with sexual messages, both overt and covert. However, the implications are rarely discussed. While most of us in the field of sexual health have used the Internet for personal and professional reasons, not everyone has taken an opportunity to explore web-based resources beyond their immediate needs. Furthermore, depending on our area of expertise or specialization, we may not have considered asking our students or patients about their use of the Internet as it relates to their sexual health. This lesson allows the participants to find real-life sexuality examples in the media and on the Internet, think critically about media messages and Internet content, and be able to deconstruct and construct messages in a way the lay public can understand.

Objectives
- Describe the strategies the media uses to influence sexual feelings, attitudes, values, and behaviors.
- To deconstruct sexual messages in media and explain them to others.
- Explain what is meant by the “AAA engine” as it relates to the Internet.
- Describe 3 positive and 3 negative aspects of the Internet
- Develop a list of useful sites for their population

Materials
- TV and DVD player
- Films: Shrek and Killing Us Softly 3
- Computer with Internet access
- Media & the Internet Power Point

Procedure
1. Participants should have watched the film Shrek (2001) before this lesson
2. View the film Killing Us Softly 3.
   - Start a discussion by asking viewers to what extent they agree or disagree with the assertions made in the video with regard to the impact of the media on women.
   - Ask viewers in what ways do they think the media impacts boys and men.
o You may also facilitate a discussion around media and sexuality using selected discussion questions on pp. 12-14 of the Study Guide (see Recommended Readings).

3. Review the components of media literacy and how they apply to sexual messages in the media.

4. Guide participants in deconstructing the sexual messages in Shrek film
   o Ask participants how they would respond to parents who asked them, “What’s the matter with Shrek?”

5. Have each student share a recent, favorite or memorable film, episode of a TV show, song, or video game that would serve as another striking example of incorporating stereotypic or harmful sexual messages

6. Have each student share a recent, favorite or memorable film, episode of a TV show, song, or video game that would serve as a resource for a balanced portrayal of sexuality

7. Discuss the assignment of creating a SecondLife profile.
   o What was your experience with SecondLife?

8. Brainstorm the ways people use the Internet for sex and sexual health related reason – The list will typically include searching for health information, finding like-minded communities, shopping, dating, cybersex, and personal expression

9. Show the Media & the Internet Power Point slides
   o Describe what is meant by the AAA Engine and why it drives sex online
   o Have participants recommend sites that they think represent these various spaces well
   o Take the class on a virtual tour of the suggested sites and discuss the following questions
     ▪ How would you evaluate the quality of the sites we visited?
     ▪ What other sites are there in this space that you know of?
     ▪ If you were designing a site to serve your specific population of interest, what would it look like?
     ▪ What are the helpful and the risky aspects of this medium?

10. Other questions for discussion:
    o What other forms of media are we exposed to and how do they influence sexual health?
    o What are some of the different stereotypes based on gender, orientation, race, ethnicity, and ability?
    o How would your characterize each?
    o Discuss the effect of media messages on boys and men, girls and women.
Evaluation Questions

Instructors please email cesh@msm.edu to request answers.

1. The Center for Media Literacy’s five core concepts include:
   A. All media messages are constructed
   B. Media messages are constructed using a creative language with its own rules
   C. Different people experience the same media message differently
   D. Media have embedded values and points of view
   E. Media is neither positive or negative
   F. Most media messages are organized to gain profit and/or power
   G. A through E
   H. B through F
   I. A through F excluding E

2. The acronym, “AAA,” and the term AAA engine stands for:
   A. Anonymous, Affordable, Accurate
   B. Accessible, Attractive, Affordabile
   C. Access, Anonymity, Affordability
   D. Access, Anonymity, Asexual

3. .org sites are inherently more accurate and less biased than .com sites.
   A. True
   B. False

Required Readings

- Create an account in SecondLife.com if you do not have one and navigate to Sexual Health SIM

Recommended Readings

- http://www.tvturnoff.org
- PEW Internet and American Life http://www.pewinternet.org/
- http://www.sexualhealth.com/
- http://sexuality.about.com/
Films

Outline

- Why the World Wide Web
- What is e-learning
- What is sexy from an e-learning perspective
- Evolution of the Internet
- Media Literacy
- Leading lay and professional resources
- Who’s online and what are they doing
- Innovative programs

Why the World Wide Web for Sexual Health?

- The Triple A Engine
  - Accessibility
  - Anonymity
  - Affordability
- Private medium
- Unparalleled access
- Untapped potential - sexuality counseling
e-Learning

- Formal and informal education and information-sharing that uses digital technology
  - Internet-based learning, Information and Communication Technology (ICT), Virtual Knowledge Communities (VKCs)
- Available any time, at the learner’s convenience
- Can bridge distances and conserve resources
- More easily updated than traditional textbooks
- Open communication channels between teacher and learner
- Enable people to access knowledge content they otherwise would not have been exposed to

e-Learning (continued)

- User-friendly
- Affordable
- Individualized
- Interactive
- Collaborative
- Online education fosters life-long learning and personal and career development

What is Sexy?

- "What is beautiful?"
- "What is male?"
- "A Dream... naked Brain!"

---
Sexy = Attractive

- What people find sexy or attractive varies based on interests and learning styles
  - Reading text
  - Looking at images
  - Sending messages (e-mail, IM, text)
  - Live chats
  - Watching videos
  - Playing games
  - Participating in surveys
  - Using interactive tools

Using Sexual Information to Address Sexual Insecurities

- Am I normal….
- I am to be married – will my history of masturbation make me weak?
- I had sex with someone the other day and now I have a rash:....
- Can I still have sex now that I am disabled?
- What does sex reassignment surgery entail?
- Could I get pregnant if....
- Does this mean I’m gay?

The Evolution of Sexuality Information on the Internet: From Static to Dynamic

- Text-based content over the Internet
  - Alt groups (alternative to news groups) and distributed bulletin board system (BBS)
- Repurposing offline content for the World Wide Web
- Asking and answering questions
- Educational videos
- Diagnostic tools
- SMS/Text messaging
- Social networking
- Gaming
The Internet as a Source of Sexuality Education for the Lay Public

- What kind of sites are available
- How they came into being
- What they provide
- How to assess quality

Media Literacy – Judging Reliability

- Go to the websites* pictured on the following slides and ask:
  - What is the source of the information?
  - Universities, hospitals, clinics, government agencies, scientific journals, pharmaceutical companies, nutriceutical companies, sex toy site, etc.)
  - User generated vs. credentialed expert?
  - How timely or current is the content?
- What other ways can reliability be assessed?

*List of selected resources does not imply endorsement by The Center of Excellence for Sexual Health.
Sexuality Professional Organizations Listservs*

- American Association of Sexuality Educators, Counselors and Therapists (www.aasect.org)
- The Society for the Scientific Study of Sexuality (www.sexscience.org)
- International Society for the Study of Women's Sexual Health (www.isswh.org)
- Association of Sexuality Educators and Trainers (Active Listserv)

*List of selected resources does not imply endorsement by The Center of Excellence for Sexual Health.
Who is using the Internet?

Internet Users in the World
by Geographic Regions

TOP 25 COUNTRIES WITH HIGHEST NUMBER OF INTERNET USERS

Source: Internet World Stats - www.internetworldstats.com/stats.htm
Statistical inaccuracies are ±1,566,370 1989 for March 31, 2008
What research has been conducted on who is using the internet to obtain sexuality information?

Who's Online?

74% of all adults in the U.S. use the Internet (135 million)

<table>
<thead>
<tr>
<th>Age</th>
<th>Percent in age group who use the Internet</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 – 29</td>
<td>87%</td>
</tr>
<tr>
<td>30 – 49</td>
<td>82%</td>
</tr>
<tr>
<td>50 – 64</td>
<td>72%</td>
</tr>
<tr>
<td>65+</td>
<td>41%</td>
</tr>
</tbody>
</table>

Pew Internet & American Life Project (2009)

Who's Online?

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Percent in group who use the Internet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian/White</td>
<td>77%</td>
</tr>
<tr>
<td>African American/Black</td>
<td>64%</td>
</tr>
<tr>
<td>English-speaking Latinos(as)</td>
<td>58%</td>
</tr>
</tbody>
</table>

Pew Internet & American Life Project (2009)
**Who's Online?**

<table>
<thead>
<tr>
<th>Annual Income</th>
<th>Percent in group who use the Internet</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; $30,000</td>
<td>57%</td>
</tr>
<tr>
<td>$30,000 – 49,999</td>
<td>77%</td>
</tr>
<tr>
<td>$50,000 – 74,999</td>
<td>90%</td>
</tr>
<tr>
<td>&gt; $75,000</td>
<td>94%</td>
</tr>
</tbody>
</table>

Pew Internet & American Life Project (2009)

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**What research has been done about sexuality information on the Internet?**

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**What Are Adults Doing Online?**

- Have Searched for Health Information
- Have Searched for Sexual Health Information
- Singles looking for partners have done at least one dating-related activity online
- Have Visited an Adult Website
- Have Gone to a Dating Website
- Have Downloaded or Shared Adult Content

Pew Internet & American Life Project (2009)
What Are Youth Doing Online?

- Parents that believe Internet use is good for their children.
- More than half of American families with teenagers use Internet filters.
- Out of 7 youth have never received an unwanted sexual solicitation online.
- Youth who reported unwanted exposures to sexual materials online.

Pew Internet & American Life Project (2009)

What Are Youth Doing Online?

- 87% of ALL Teens aged 12 to 17 use the Internet.
- Half of ALL Teens create content (blog, webpage, artwork, photography, stories, videos).
- Search for information about a health topic that's hard to talk about: drug use, sexual health, etc.

Pew Internet & American Life Project (2009)

Innovative Programs*

- InSpot (www.isis-inc.org)
- SexInfo (www.isis-inc.org)
- Gaming (www.SecondLife.com)

*List of selected resources does not imply endorsement by The Center of Excellence for Sexual Health.
**Personalization – the Internet 'Holy Grail'**

- Providing general information in a ‘data dump’ format is not enough anymore
- Web sites are seeking to move from providers of general information and products to personalized offerings to improve user experience
- Technology can be the differentiator
- Automation of personalization

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**Advantages of integrating the Internet into the delivery of sexual health care**

- Privacy
- Reliable evidence based information
  - Medical and Clinical Advisory Board
  - Consumer Advisory Board
- Food for thought/ways of understanding issue
- Practical self-help exercises/instruction
- Resources
- Personalized report
- Facilitate discussing sexual problems with healthcare providers

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**Sexual Health Continuing Education and Research Resources**

- Medscape
- Centers for Disease Control and Prevention
- American Social Health Association
- Planned Parenthood
- The Alexander Foundation for Women’s Health
- The Electronic Journal of Human Sexuality

*List of selected resources does not imply endorsement by The Center of Excellence for Sexual Health.
References

Media & the Internet

Promoting Sexual Health and Responsible Sexual Behavior: A Universal Curriculum for Health Professionals

Center of Excellence for Sexual Health
Satcher Health Leadership Institute
Morehouse School of Medicine
15. Culture & Religion

Time Required
2 hours

Purpose
To review the range of cultural and religious influences on sexual health

Rationale
Cultural and religious foundations of sexual health serve to shape the ways which people and governments make important and sometimes critical sexual health decisions. Health professionals and leaders in sexual health need to have a full appreciation of the influence that culture and religion have on sexual health and illness.

Objectives
• To state how cultural, religious, ethical, and moral views of sexuality shape attitudes toward caring for the physical, emotional, psychological and spiritual health in the United States
• To appraise the influence of culture, religion, ethics, beliefs, morals and practices on patient or personal perceptions of sexual health as well as sexual mores and expression

Procedure
1. At least one week prior to class, assign chapters from Sexual Health, Vol. III: Moral and Cultural Foundations to individual students or groups based on the class size. Have them find a related source from the International encyclopedia of sexuality. Have each student or group present a synopsis and critique of their assigned readings
2. Review CRASH Model (Rust, et al., 2006):
   Consider: Culture
   Respect
   Assess, Affirm
   Sensitivity, Self-Awareness
   Humility
3. Have participants discuss how CRASH can be applied to the provision of sexual health care and education with special emphasis on “sexual minorities.”
4. Other questions for discussion:
   o Who or what defines what is moral?
   o What is the relationship between culture and religion? Religion and morals?
   o Why is it important to consider various cultural and religious perspectives in the provision of sexual health care?
   o Is it possible to discuss culture and religion without stereotyping?
Evaluation Questions

Instructors please email cesh@msm.edu to request answers.

1. Culture is to sexual orientation as:
   A. Judaism is to Christianity
   B. African-American is to Native American
   C. Morality is to religion

2. Humility can compensate for a lack of knowledge about a specific culture and/or stereotyping based on culture when taking a sexual history.
   A. True
   B. False

3. What plays a bigger role in shaping our sexual value system?
   A. Race and ethnicity
   B. Cultural background
   C. The media
   D. Secular and religious constructs of morality
   E. It depends

Required Readings

- http://www.cultureandmediainstitute.org/

Recommended Readings

16. Behaviors, Practices & Expressions

Time Required
3 hours

Purpose
To familiarize the learner with various sexual behaviors and expressions of sexuality and to develop an understanding of less common sexual practices

Rationale
Regardless of one’s sexual identity and/or orientation, sexual behaviors, practices and expressions are part of the innate sexual part of one’s humanity. Whether one express her or himself in more “traditional” or “vanilla” ways sexually, or participates in atypical or less common sexual practices, the human sexuality professional should be familiar with the entire range of sexual behaviors and practices that humans as sexual beings have available to us to safely and positively express our sexuality. This lesson reviews sexual behaviors, practices and expressions from least sensitive to most sensitive.

Objectives
- To describe the range of sexual behaviors from holding hands to intercourse
- To differentiate between paraphilias and “atypical” sexual practices
- To analyze health outcomes attributable to healthy, positive sexual expression

Materials
- Sample collection of massagers (vibrators), sex toys, heighteners and lubricants
- Newsprint, markers
- Computer with Internet access and LCD projector, screen
- Handout: The Paraphilias
- Film: Power and Love: Powerplay in Relationships
- TV and DVD player

Procedure
1. Write down on newsprint “If you can think of it, someone has done it” and tell the group to keep this statement in mind during this lesson
2. Ask the group to discuss what is “normal” sexual behavior?
3. After the group discusses this question, conclude by writing the definition of normal sexual behavior from the World Association for Sexual Health (WAS): anything among consenting adults, out of sight and sound of unwilling observers, without any coercion, and that is not harmful to any participants, should be considered normal whether or not I would like to participate and proceed to deconstruct the definition.
4. As a group, compose working definition of “sexual expression” and write it on newsprint
   o Have the group brainstorm a list of all sexual practices and behaviors they can think of and write them down on another sheet of newsprint. Think of both “traditional” and “atypical” practices
**Prompt:** Think of ways people express themselves sexually in romantic, sexual and platonic relationships with people of all genders (i.e. hugging or kissing a friend or family member or flirting with strangers in a romantic or non-romantic context, electronic forms of sexual expression like cybersex, webcam, “sexting” and other social networking)

- Re-group list into solo, partnered and platonic (non-romantic) practices (you may want to use another sheet of newsprint or mark the groups on the existing list with symbols for each group), keeping in mind that many may overlap
  - Solo practices may include (but not limited to) fantasy, autoeroticism (videos, books, etc), crossdressing, cybersex and masturbation
  - Partnered practices may include (but not limited to) “pleasuring” (nongenital touching and caressing, not for sexual stimulation), hand-holding, kissing, oral sex, “dry humping”, intercourse, swinging (recreational sex outside of a committed relationship with one partner, with the partner’s full knowledge and permission), BDSM, group sex
  - Platonic practices may include (but not limited to) hugging, “peck” kisses, spooning or cuddling

5. Distribute the paraphilias handout and give the group 10 minutes to read through them
   - Ask students what their reactions are to reading the definitions listed on the handout.
   - What does a paraphile look like?
   - Do paraphilias require sex therapy to “correct” the behavior?
   - How should paraphiles be treated (i.e. socially, therapeutically)?

6. Transition to use of sex toys
   - Explain how selected toys are used for sexual stimulation, describe differences in shape, size and texture
   - Give the group the opportunity to feel the consistency of different lubricants
     - Water-based, silicone-based safe for use with latex condoms (oil-based lubricant will destroy a latex condom)
     - Silicone-based lubricant not recommended for use with silicone toys (lubricant may damage the toy)
   - Review safety and hygiene when using toys, including cleaning and sharing carefully and use of condoms with sex toys
   - As a group, analyze the website [http://book22.com](http://book22.com)

7. Distribute the Clinician’s Guide to S/M Terminology handout and give the group 10 minutes to read through and discuss the handout.

8. Show the group Power and Love: Powerplay in Relationships film. *Note: This film may be difficult for some to view. Give the group permission to look away from the film if they are not comfortable, but to listen to the dialogue in the film.*
   - Review “safe, sane, consensual” in BDSM play and explain the concept that the “submissive” is really the person in control the entire time
   - Ask the group about their reactions to the film and to the idea of BDSM
   - How are the roles of “top/dominant” and “bottom/submissive” empowering for the individuals occupying the roles?
   - What can be problematic about BDSM as a practice within a relationship and acceptance of BDSM in the greater community?
Optional: Invite a guest speaker who is a member of the “kink” community to talk to the group about the language, practices and culture of BDSM.
8. Ask the group for any final reflections or insights gained from this lesson

Evaluation Questions
Instructors please email cesh@msm.edu to request answers.
1. The majority of paraphilias are believed to occur equally among males and females.
   A. True
   B. False
2. What three tenets must be present in order for BDSM to be sexually healthy?
   A. Spontaneous, reciprocal, monogamous
   B. Safe, sane, consensual
   C. Heterosexual, androcentric, hygienic
   D. Predetermined, frequent, submissive
3. Recreational sex outside of a committed relationship with one partner, with the partner’s full knowledge and permission is referred to as:
   A. Polyamory
   B. Gerontophilia
   C. Bisexuality
   D. Swinging

Required Readings

Recommended Readings

Films
The Paraphilias

An erotosexual condition of being recurrently responsive to, and obsessively dependent on, an unusual or unacceptable stimulus, perceptual or in fantasy, in order to have a state of erotic arousal initiated or maintained, and in order to achieve or facilitate orgasm. The majority of paraphilias are believed to occur significantly more frequently in males than females.

**Acrotomophilia:** The condition of being dependent on the appearance or fantasy of one’s partner as an amputee in order to obtain erotic arousal and facilitate or achieve orgasm.

**Apotemnophilia:** The condition of being dependent on being an amputee, or fantasizing oneself as an amputee, in order to obtain erotic arousal and facilitate or achieve orgasm. It is accomplished by obsessional scheming to get one or more limbs amputated.

**Asphyxiophilia** (or **autoasphyxiophilia**): The rare condition in which a person, usually an adolescent male, is dependent on partial asphyxiation, as by hanging, or by restaging of it in fantasy, in order to obtain erotic arousal and facilitate or achieve orgasm. Death may inadvertently result. Some victims have been found cross-dressed.

**Autoassassinatophilia:** The condition of being dependent on the masochistic staging of one’s own murder in order to obtain erotosexual arousal and facilitate or achieve orgasm.

**Coprophilia:** The condition of being responsive to, or dependent on, the smell or taste of feces for erotic arousal and facilitate or achieve orgasm. It may involve also the sight and sound of a person defecating (aka “scat clubs”).

**Ephebophilia:** The condition in which an adult is responsive to and dependent on the actuality or imagery of erotic/sexual activity with a pubertal child or adolescent boy or girl in order to obtain erotic arousal and facilitate or achieve orgasm. An ephebophilic may be of either sex. Ephebophilic activity may be replayed in fantasy during masturbation or copulation with an older partner.

**Exhibitionism:** The condition of being responsive to, or dependent on the surprise, debasement, shock, or outcry of a stranger (usually female), unexpectedly exposed to the sight of the penis, in order to obtain one’s erotic arousal and facilitate or achieve orgasm.

**Fetishism:** The condition in which a person is dependent on a talisman or fetish object, substance or part of the body in order to obtain erotic arousal and facilitate or achieve orgasm (e.g. foot fetish).

**Frotteurism:** The condition in which a person is dependent on rubbing against and feeling the genital or other region of the body of a stranger, especially in a tightly packed crowd, in order to obtain erotic arousal and facilitate or achieve orgasm.
**Gerontophilia:** The condition in which a young man is responsive to and dependent on erotic/sexual activity with a much older female partner in order to obtain erotic arousal and facilitate or achieve orgasm.

**Kleptophilia:** The condition in which a person is dependent on carrying out or fantasizing the stealing of something in order to obtain erotic arousal and facilitate or achieve orgasm.

**Klismaphilia:** The condition in which a person is dependent on being given an enema, or in the restaging of it in fantasy in order to obtain erotic arousal and facilitate or achieve orgasm.

**Lust Murderism (homicidophilia):** The very rare condition in which a person is dependent on sadistic homicide of the partner, or the restaging of it in fantasy, in order to obtain erotic arousal and facilitate or achieve orgasm. Recorded cases are either heterosexual or homosexual, but not bisexual.

**Masochism:** The condition of being responsive to or dependent on being the recipient of punishment and humiliation in order to obtain erotic arousal and facilitate or achieve orgasm.

**Mysophilia:** The condition in which a person is dependent on something soiled or filthy, for example, sweaty underwear or used menstrual pads, in order to obtain erotic arousal and facilitate or achieve orgasm.

**Narratophilia:** The condition of being responsive to, or dependent on reading or listening to erotic narratives in order to obtain erotic arousal and facilitate or achieve orgasm.

**Necrophilia:** The condition of being responsive to, or dependent on sexual activity with a cadaver in order to obtain erotic arousal and facilitate or achieve orgasm. In necrophilia, there is an obsession with death.

**Pedophilia:** The condition in which an adult is responsive to or dependent on the imagery or actuality of erotic/sexual activity with a prepubertal or early pubertal boy or girl, in order to obtain erotic arousal and facilitate or achieve orgasm. A pedophiliac may be a male or a female.

**Pictophilia:** The condition of being responsive to or dependent on erotic pictures in order to obtain erotic arousal and facilitate or achieve orgasm.

**Raptophilia (or rapism):** The condition in which a person is dependent on the terrified resistance of a nonconsenting stranger, under conditions of unexpected assault and threats of further violence, in order to obtain erotic arousal and facilitate or achieve orgasm. True rape is not the same as the coercive imposition of coitus on an acquaintance or spouse.

**Sadism:** The condition of being responsive to or dependent on punishing or humiliating one’s partner in order to obtain erotic arousal and facilitate or achieve orgasm.
**Scoptophilia:** The condition in which a person is dependent on looking at sexual organs and watching their coital performance in order to obtain erotic arousal and facilitate or achieve orgasm. It is not the surreptitious, as in voyeurism.

**Somnophilia:** The condition in which a person is dependent on intruding upon and fondling a partner who is a stranger asleep, or fantasying doing so, in order to obtain erotic arousal and facilitate or achieve orgasm.

**Telephone scatophilia:** The condition in which a person talks sexually on the telephone in a manner that he expects will be offensive or shocking to a female listener who does not know him. He is dependent on this maneuver to obtain erotic arousal and facilitate or achieve orgasm.

**Triolism ("cuckhold"):** The condition in which a person is dependent on being the third member of a sexual partnership, or on fantasying being so, in order to obtain erotic arousal and facilitate or achieve orgasm. Typically, a husband arranges that his wife has another male partner, so that he can fantasy her in the role of a whore, without which he cannot become aroused.

**Urophilia ("watersports"):** The condition of being responsive to or dependent on the smell or taste of urine, or the sight and sound of someone urinating, in order to obtain erotic arousal and facilitate or achieve orgasm.

**Voyeurism:** The condition of being responsive to, or dependent on, the risk of being apprehended while illicitly peering at an individual (usually female) or a couple undressing or engaged in sexual activity, in order to obtain erotic arousal and facilitate or achieve orgasm. A voyeur is also known as a peeping Tom.

**Zoophilia ("bestiality"):** The condition of being responsive to or depending on sexual activity with an animal in order to obtain erotic arousal and facilitate or achieve orgasm; also known as bestiality. Sexual contact (oral or genital) with an animal may occur sporadically in the course of human development without leading to long-term zoophilia.
A CLINICIAN'S GUIDE TO S/M TERMINOLOGY
The American Academy of Clinical Sexologists

Clinical success with leather, sadomasochistic, patients will be facilitated by understanding and using the jargon commonly utilized by this sexual minority.

While DSM III-R classifies all sexual masochism (302.83) and sexual sadism (302.84) as sexual disorders in the subclass of paraphilias, the clinical sexologists generally will not see S/M practitioners where both adult partners are engaged in consensual sadomasochistic practices.

Often the presenting problem is that one of the partners in a relationship does not share the other's interest in this form of sexual activity and consequently feels sexually excluded and fearful of being injured or injuring the partner if agreeing to engage in these activities.

It is important that a person seek out like minded individuals who will engage in "safe, sane and consensual" sexual play.

Abrasion – sex play that includes rubbing, scraping or shaving the skin with various rough materials. i.e., brushes, graters, loofah sponge.

Age play – partners assume roles of another age or generation. i.e., babies, teenagers, grandparents.

Amputation – (apotemnophilia) sexual arousal about having parts of the body cut away. i.e, castration.

Animals – assuming the role of an animal. i.e., eating from a dog bowl; being taken for a walk on a leash.

Ash – sexual arousal by cigar smokers, cigar smoke, cigar ashes.

Ass play – sexual stimulation of the anus, buttocks.

B/D – bondage and discipline.

Bi bottom – assumes the submissive role with both men and women in sexual activities.

Bi top – assumes the dominant role with both men and women in sexual activities.

Blood sports – sexual pleasure derived from cutting or abrading the skin or being cut or abraded to produce a flow of blood.

Bottom – (sexual masochist) the submissive partner; used mainly by gays.

Boy – (sexual masochist) the submissive bottom/slave in a gay S/M relationship. Also used by S/M lesbians in the same context.

Branding – any permanent marking of the skin caused by burning.

Breath control – (hypoxophilia) sexual arousal by oxygen deprivation by use of noose, ligature, plastic bag, oxygen mask, etc.
Butt plug — an insertive anal device, often sized and shaped like an erect penis.

CBT — (cock ball torture) male genital play that may include pressure, pinching, flagellation, pulling and piercing that causes sexual pain in the male genitals.

Captivity — a sexual fantasy of being held a prisoner or inmate slave. Can include the use of jail cells, cages and containers.

Catheterization — the use of medical catheters or sounds for sexual pleasure.

Chestmen — gay men who are sexually aroused by the sight and touching of other men with hairy chests.

Clothes pins — used as torture clips on the nipples, penis, balls, chest, vulva and clitoris. Rapid application and removal produces sharpest pain.

Cotton sissy — a derisive term for a gay male who goes to leather bars in non-leather clothing. Also called a twinkie.

Cunt torture — female genitorture by slapping, hitting or pinching using clips, clothes pins, whips, electricity, etc. on the female genitalia.

Cut — circumcised.

Cutting — a blood sport involving the use of knives, scalpels, razor blades to cut and draw blood.

Daddy — (sexual sadist) the dominant master/top partner in a gay relationship. Also, used by S/M lesbians in the same context.

Dildo — a sexual toy in the shape of an erect penis often made of flexible plastic materials.

Discipline — obedience training of the submissive; consequence of infractions of orders established by the partners.

Dominant — (sexual sadist) the top, master or mistress in the relationship. The term dominant is used more frequently by heterosexuals with top being the more common term of gays.

Dominatrix — (Domina) a female dominant. Use of courtesy titles, countess, mistress, lady, marquesa, goddess, princess, is a common practice of these dominant women.

Domination — the practice of controlling the submissive bottom by physical, verbal or psychological means.

Edge play — any S/M activity that carries the sexual fantasy to dangerous, extreme and uncharted practices.

Elastrator — pliers adapted to place rubber rings on the nipples of either men or women, originally designed to castrate animals.

Electricity — sexually arousing play that utilizes either static or ac/dc electrical current for enhancement or torture.

Enema — (klimaphilia) a sexual arousal by the sensation of fullness and sensual pleasure of warm water going in the rectum.

FFA — abbreviation and code for Fist Fuckers of America.

Fist fucking — inserting the hand and forearm into the anus (brachiorectal) or vagina (brachiovaginal).

Fetishism — the use of non living objects for sexual excitement and/or orgasm. The most common fetishes are leather, rubber, latex underwear of either sex, shoes, etc. Does not
include transvestic fetishism. In clinical terms, a foot fetish is a contradiction as DSM III-R includes only non-living objects as fetishes.

Flagellation – a variety of sexually arousing practices that utilize paddles, hands, whips, canes, floggers, rods, crops, etc., to strike, whip, spank, paddle, cane the submissive bottom on the back, genitalia, buttocks, arms, legs, etc.

Flogger – short handled whip of ten or more flat, fairly wide tails. Usually made of doe-skin.

French/active – (Fr/A) – to perform fellatio.

French/passive – (Fr/P) – to be felledated.

Genitorture – sexual stimulation of male and/or female genitals by hitting, striking, squeezing, clamping, binding, etc.

Golden showers – (urophilia) – sexual arousal by being urinated upon or urinating on another person.

Goddess – courtesy title for a female dominant.

Greek/active – (Gr/A) – insertive partner during anal intercourse.

Greek/passive – (Gr/P) – receptive partner during anal intercourse.

Handballing – synonym for fisting.

Hankie codes – the bandana color and choice of rear pocket is used by gay and lesbian S/M practitioners to indicate top/dominant (left rear pocket) or bottom/submissive (right rear pocket): the most common hankie colors are:

<table>
<thead>
<tr>
<th>Color</th>
<th>Left pocket</th>
<th>Right pocket</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>heavy S/M dominant</td>
<td>heavy S/M submissive</td>
</tr>
<tr>
<td>Red</td>
<td>fist fucker</td>
<td>fist fuckee</td>
</tr>
<tr>
<td>Grey</td>
<td>performs bondage</td>
<td>receives bondage</td>
</tr>
<tr>
<td>Dark Blue</td>
<td>insertor - anal intercourse</td>
<td>receptor – anal intercourse</td>
</tr>
<tr>
<td>Light Blue</td>
<td>receives fellatio</td>
<td>gives fellatio</td>
</tr>
<tr>
<td>Yellow</td>
<td>urinates</td>
<td>receives urination</td>
</tr>
</tbody>
</table>
Hot wax – the dripping of hot wax from a burning candle onto the submissive’s body.

Humiliation – sexual activity whereby the top/dominant shames, embarrasses, ridicules the submissive.

Infantilism – (autonepiophilia) – sexual arousal is dependent upon an adult impersonating a baby in diapers and being treated as such by the partner. Being sexually aroused by an adult role playing a baby in diapers is nepiophilia.

J/O – an abbreviation for jack-off (masturbation).

Keys – keys hanging from the belt indicate S/M roles, i.e., left-dominant; right-submissive. Mostly used by gays in bars to facilitate sexual decision making.

Kink – all sexual practices that involve more activity than just oral, anal or vaginal play, i.e., S/M bondage, urination, fisting, etc.

Latex – a sexual fetish that includes wearing latex or rubber clothing.

Leatherman – any male with an interest in leather and/or S/M sexual activities.

Leatherwoman – any female with an interest in leather and/or S/M sexual activities.

Master – a courtesy title for a male dominant.

Mistress – a courtesy title for a female dominant.

Mummification – a form of bondage in which the submissive is wrapped in plastic wrap, bandages, etc. The result resembles an Egyptian mummy.

Negotiation – The discussion, prior to beginning, between the dominant/top and the submissive/bottom regarding what is expected, what the limits are and the establishment of a safe word to end the scene. This stage ensures that the session will be safe, sane and consensual.

Nipple play – stimulation of the nipples by fingers or clamping devices.

Pervertibles – common articles that can be adapted for use as a sex toy, i.e., chapsticks, brushes, paint stirrers, rope, candles, plastic wrap, toothbrushes, clothes pins, etc.

Piercing – the temporary or permanent placing of objects through the surface of the skin. The most common piercing areas are the ears, nipples, penis, clitoris, labia, etc.

Player – one who engages in leather S/M practices.

Playroom – the place or space set aside for S/M leather sexual activities. Also call the dungeon.

Pushing bottom – an oxymoron for domineering submissives who want to control the scene and activity.

Rimmer – anyone that performs analingus.

Rimming – (analingus) licking the anus.

Raunch – a sexual interest in urine, feces and other bodily excretions.

Rubber – a fetishistic interest in rubber clothes and objects made of rubber.

Safe, sane and consensual – The National Leather Association’s credo for standards of S/M practices.
Safe word – a word or signal established during safe, sane and consensual negotiations that when exercised, immediately terminates the activity. Usually a word not associated with sexual activity such as pineapple, automobile, etc. Sometimes the safe word is “safeword.”

Scat – (coprophilia) – a paraphilia that involves being smeared with or ingesting feces.

Scene – any leather S/M activity, encounter or interaction that has been agreed upon in advance. Can also generically refer to the entire leather community.

Session – another name for play scene.

Sir – most commonly used address by the submissive to the dominant male.

Slave – the submissive in the scene. May be a permanent lifestyle or temporary role of minutes, hours or days.

Submissive – (sexual masochist)- the partner that relinquishes control to the other partner. Used more frequently in the heterosexual S/M community.

Switch – a person that alternates between dominant and submissive roles.

Tit torture – all nipple play.

Top – the dominant partner; used more by gays than heterosexuals.

Toy – any object or equipment that is used during an S/M session, i.e., belts, vibrators, paddles, clamps, brushes, clothes, pens, whips, canes, etc.

Twinkie – a derisive term for non-S/M gay males who go to leather bars in non-leather clothing.

Ultra violet wand – an electrical device developed in the 1920’s to stimulate hair growth. The gas-filled glass wand produces a series of electrical discharges that mix with oxygen in the air and cause violet sparks when touched on the body.

Uncut – uncircumcised.

Uniforms – a fetish for wearing or being attracted to those wearing uniforms, i.e., military, police, nurses, physicians.

Vanilla sex – sexual encounters that do not involve S/M components.

VA – (verbal abuse) – the use of harsh, sometimes obscene language to humiliate the partner in the scene.

Water sports – (urophilia) – sexual arousal by being urinated upon or urinating on another person.

Wrapping – an S/M practice whereby some part or the whole body of the submissive is securely bound and tied in a symbolic act of complete submission.
17. **Sexually Transmitted Diseases, HIV & AIDS**

**Time Required**
2 hours

**Purpose**
To discuss the scope and risk factors for STDs and HIV; to identify ways that STDs and HIV are transmitted; to gain an understanding of the biopsychosocial perspective of HIV and AIDS

**Rationale**
Sexually transmitted diseases (STDs), HIV and AIDS are a reality in all ages and populations. This activity allows participants to understand the mechanics of transmission, screening, and treatment, the emotional impact, and how to protect oneself at the same time. This activity also challenges participants to research available resources for persons with STDs and HIV/AIDS. It should be noted that STDs are also often referred to as sexually transmitted infections or STIs. The public health community has been engaged in ongoing dialogue regarding this terminology, particularly when considering that many STDs have no outwardly discernable symptoms. Language and communication about sexuality are fundamental and ongoing dialogue is encouraged.

**Objectives**
- To discuss the scope and risk factors for STDs and HIV/AIDS
- Participate in a simulated spread of an infectious disease and analyze the results to determine the origin of the “disease”
- Interpret information from the film *The Lost Children of Rockdale County* through a series of written questions and answers
- To identify HIV screening and diagnosing mechanisms, and treatment options
- To role play communication strategies for HIV/AIDS prevention

**Materials**
- A Glance at the HIV/AIDS Epidemic (CDC Fact Sheet)
- Guest lecturer with a personal story about HIV/AIDS

**Procedure**
1. See *The Lost Children of Rockdale County Teacher’s Guide*, Lesson 3: Epidemic
2. Have the participants complete the ‘Sex and the Internet’ FAQs on HIV/AIDS section on page 585 of the text.
   - Process what they learned from the activity.
3. Have the guest lecturer present his/her story in relation to HIV and AIDS.
   - Allow time for the participants to ask the guest speaker questions.
   - Ask the participants if they have been impacted by HIV and AIDS through family and friends. What have they learned through these experiences?
   - Refer to pages 526-527 of the assigned chapter for a chart of the STDs
5. Finish processing by asking the ‘Questions for Discussion’ on page 585 of the text.

Other questions for discussion:
- What local city, county or state health department services are available?
- Are there any private or not-for-profit agencies that focus on communicable diseases?
- How accessible are these agencies or groups to their target populations?

**Evaluation**

_Instructors, please email cesh@msm.edu to request answers._

1. As of 2009, what is the estimated disease burden of HIV worldwide?
   A. 26 million
   B. 33 million
   C. 57 million
   D. 81 million

2. Use of spermicides can decrease risk for STD and HIV infection.
   A. True
   B. False

3. According to CDC, the surest way to prevent the spread of STDs and HIV is to:
   A. Abstain from sexual intercourse
   B. Use male condoms
   C. Use microbicides
   D. Get tested every 6 months

**Required Readings**

**Recommended Readings**
- http://www.pbs.org/wgbh/pages/frontline/shows/georgia/
- http://www.aids.org/
- http://www.aids.gov/

**Film**
- Demme, J, Saxon, E, Goetzman, G, Utt, K, and Zea, K (Producers) and Demme, J (Director) (1993). _Philadelphia_ [Motion picture]. United States of America: Sony Pictures. [Recommended Film]
**HIV/AIDS DIAGNOSES**

At the end of 2003, an estimated 1,039,000 to 1,185,000 persons in the United States were living with HIV/AIDS [1].* In 2005, 37,331 cases of HIV/AIDS in adults, adolescents, and children were diagnosed in the 33 states with long-term, confidential name-based HIV reporting [2]. CDC has estimated that approximately 40,000 persons in the United States become infected with HIV each year [3].

**By Transmission Category**

In 2005, the largest estimated proportion of HIV/AIDS diagnoses were for men who have sex with men (MSM), followed by adults and adolescents infected through heterosexual contact.

**Transmission categories of adults and adolescents with HIV/AIDS diagnosed during 2005**

*The term HIV/AIDS refers to 3 categories of diagnoses collectively: (1) a diagnosis of HIV infection (not AIDS), (2) a diagnosis of HIV infection with a later diagnosis of AIDS, and (3) concurrent diagnoses of HIV infection and AIDS.*

**By Sex**

In 2005, almost three quarters of HIV/AIDS diagnoses were for male adolescents and adults.

**Sex of adults and adolescents with HIV/AIDS diagnosed during 2005**

*Note. Based on data from 33 states with long-term, confidential name-based HIV reporting.*

**By Race/Ethnicity**

In 2005, blacks (including African Americans), who make up approximately 13% of the US population, accounted for almost half of the estimated number of HIV/AIDS cases diagnosed.

**Race/ethnicity of persons (including children) with HIV/AIDS diagnosed during 2005**

*Note. Based on data from 33 states with long-term, confidential name-based HIV reporting.*
TRENDS IN AIDS DIAGNOSES AND DEATHS

During the mid-to-late 1990s, advances in treatment slowed the progression of HIV infection to AIDS and led to dramatic decreases in deaths among persons with AIDS. The number of deaths of persons with AIDS fluctuated from 2001 through 2005, but the number of AIDS cases diagnosed during that same period increased [2]. The reasons for the increase in the number of AIDS diagnoses are unclear but may be due to increased emphasis on testing; the fact that more people are living with HIV and thus are experiencing the development of AIDS; and technical issues in the statistical process used in estimating the number of AIDS diagnoses.

Better treatments have also led to an increase in the number of persons in the 50 states and the District of Columbia (D.C.) who are living with AIDS. From 2001 through 2005, the estimated number of persons in the 50 states and D.C. living with AIDS increased from 331,482 to 421,873—an increase of 27% [2].

Estimated numbers of AIDS diagnoses, deaths, and persons living with AIDS, 2001–2005

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>AIDS diagnoses</td>
<td>38,079</td>
<td>38,408</td>
<td>39,666</td>
<td>39,524</td>
<td>40,608</td>
<td>952,629</td>
</tr>
<tr>
<td>Deaths of persons with AIDS</td>
<td>16,980</td>
<td>16,641</td>
<td>17,404</td>
<td>17,453</td>
<td>16,316</td>
<td>530,756</td>
</tr>
<tr>
<td>Persons living with AIDS</td>
<td>331,482</td>
<td>353,249</td>
<td>375,511</td>
<td>397,582</td>
<td>421,873</td>
<td>NA</td>
</tr>
</tbody>
</table>

NA, not applicable (the values given for each year are cumulative).

REFERENCES


For more information . . .

CDC HIV/AIDS
http://www.cdc.gov/hiv
CDC HIV/AIDS resources

CDCINFO
1-800-232-4636
Information about personal risk and where to get an HIV test

CDC National HIV Testing Resources
http://www.hivtest.org
Location of HIV testing sites

CDC National Prevention Information Network (NPIN)
1-800-458-5231
http://www.cdcnpin.org
CDC resources, technical assistance, and publications

AIDSInfo
1-800-448-0440
http://www.aidsinfo.nih.gov
Resources on HIV/AIDS treatment and clinical trials
18. **Sexual Abuse, Violence & Harassment**

**Time Required**
2 hours

**Purpose**
To further develop understanding of different forms of “sexual victimization” and how these problems are originated and perpetuated

**Rationale**
Sexual abuse, violence and harassment affects everyone. Some people have experienced it themselves, have known someone who has experienced it, has been a perpetrator of it, and virtually everyone can potentially have this experience. The public health problem of sexual abuse, violence and harassment may attach a “victim” or “potential victim,” or “perpetrator” or “potential perpetrator” component to men’s and women’s sexuality. These problems also do not exist in a vacuum or exclusively perpetrated by one gender or sexual orientation.

**Objectives**
- To explain the differences amongst the various types of sexual abuse and violence
- Define and describe the different stages in the “cycle of domestic violence”
- To evaluate the range of physical and emotional effects related to sexual abuse and violence
- To describe treatment options for the various types of sexual abuse/violence/harassment

**Materials**
- Films: *Disclosure* and *Playing the Game 2*
- TV and DVD player
- *Playing the Game 2* Facilitator’s Guide
- Newsprint and markers

**Procedure**
Preface all discussions to avoid victim-blaming. If possible, try to avoid gender and orientation-specific language when talking about perpetrators and victims/survivors.

**Definition of terms**
1. Have the group conceptualize working definitions of *sexual harassment, rape* (including date and stranger rape), *incest, intimate partner violence* (definitions may or may not be consistent with state law definitions) and write down the definitions on newsprint
2. What other forms of sexual abuse and violence exist that may not fall into the categories defined? (may include obscene phone calls, stalking, certain paraphilias like exhibitionism and frotteurism)

**Sexual harassment**
1. Show a clip from *Disclosure* (DVD chapters 9-13, about 11 minutes)
2. Have the group keep the following questions in mind while viewing the clip (you may prepare a handout with the questions to give to the group for note-taking):
• What type of sexual victimization occurred?
• What feelings might the victim have experienced?
• How might the victim cope with those feelings?
• Could the victimization have been prevented?

3. What differentiates between sexual harassment and flirting or other sexual conversation or behaviors that would not be considered harassment?

4. What relationship might sexual harassment have to homophobia?

**Intimate partner violence**

1. Draw the “cycle of violence” and ask the class to describe characteristics of the stages – see illustration on page 106
2. What contributes to the propensity to begin continue to abuse one’s partner?
3. What factors influence an individual experiencing intimate partner violence to remain in the relationship?
4. Why are social structures (i.e. family, community (especially in racial/ethnic and sexual minority communities), law enforcement, social services) reluctant to intervene to provide safety and coping for those experiencing intimate partner violence?

**Rape**

1. Show the *Playing the Game* 2 DVD and follow the Facilitator’s Guide for a guided group discussion on the film.

*Optional* Guest lecturer:

Instead of the film activities, invite a professional from the community (researcher, advocate, therapist) to talk to the group about sexual violence, abuse and harassment, including incidence, prevalence, laws/policy, and resources. Allow ample time for questions from the group and remind the group to maintain confidentiality.

**Other questions for discussion:**

- How do certain prejudices (i.e. racism, sexism, homophobia) contribute to the problem and perpetuation of sexual violence, abuse and harassment?
- What additional challenges arise for gay men and lesbians who experience sexual harassmens, intimate partner violence and rape?
- Who is responsible for preventing and/or ending sexual harassment, rape, and intimate partner violence?
- Evaluate language around the labels *victim* and *survivor* when describing one who has experienced sexual violence, abuse or harassment.

**Evaluation**

*Instructors, please email cesh@msm.edu to request answers.*

1. Approximately what percentage of rapes are perpetrated by strangers?
   - A. 11%
   - B. 27%
   - C. 65%
   - D. 80%
2. Which is not a phase in the cycle of intimate partner violence?
   A. Tension-building
   B. Honeymoon
   C. Acute incident
   D. Resolution

3. Women do not perpetrate rape, sexual harassment or intimate partner violence.
   A. True
   B. False

**Required Readings**

**Recommended Readings**
- Rape, Abuse and Incest National Network (RAINN) [http://www.rainn.org](http://www.rainn.org)
- Men Can Stop Rape [http://www.mencanstoprape.org](http://www.mencanstoprape.org)
- Men Stopping Violence [http://www.menstoppingviolence.org](http://www.menstoppingviolence.org)
- Male Survivor [http://www.malesurvivor.org](http://www.malesurvivor.org)

**Films**
PLAYING THE GAME 2

Facilitator’s Guide

Dr. Robin Sawyer
University of Maryland

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Introduction

When I produced the first version of *Playing the Game* in 1991, date rape had received a great deal of publicity, particularly in the decade that preceded the production. The research of Mary Koss in the mid-eighties had scared to death the nation’s college and university administrators, where statistics like 1 in 4 college women sexually assaulted and 1 in 15 raped, had resulted in the initiation of numerous campus sexual assault programs across the United States. High profile date rape cases like the William Kennedy Smith (Senator Edward Kennedy’s nephew) trial in 1991, and boxer Mike Tyson’s conviction for date rape in 1992 served to reinforce the wide extent of this issue and the need for social reform. Some 15 years have passed since these incidents garnered national attention and campus programming became entrenched, but as the French say, “Plus ça change, plus c'est la même chose” … the more things change, the more they stay the same! Cases of sexual assault and date rape have continued to plague our culture, particularly on college campuses. Athletes in particular have continued to feature prominently in sexual assault cases, and in 2003 Kobe Bryant replaced Mike Tyson as the poster child for date rape. Yet no-one could have anticipated the firestorm of controversy that a Duke University lacrosse party would create in 2006 where three team members were accused of raping a young woman who had been stripping at the party. The Duke students were later acquitted, but not before the team had lost its season, Duke University was dragged through the mud, labeled as racist and elitist, and the three young men and their accuser had their lives scrutinized, choking beneath the constant media barrage.

Without doubt, we still need to consider the issue of date rape, particularly as it occurs on a college campus. I travel and speak extensively, and I continue to hear the same old outdated, inaccurate sentiments about this issue, from men and women alike:

- She shouldn’t have gone to his room, what did she expect?
- I know she was drunk, but so was the guy … why should he get punished?
- It’s not rape because she didn’t actually say “no.”
- It couldn’t be rape because the girl was too ugly.
- A guy can’t be expected just to turn off once he gets to a certain point.
- She was all over him at the party … of course she wanted it.
- Girls all play that hard to get thing … they really want sex.
- She didn’t put up much of a struggle … how could that be rape?

The majority of rape prevention education continues to be aimed at women, and yet in reality, surely it’s the male of the species who needs to change the most? The point is we can continue to ostracize the male and write him off as a hopeless case, or we could include him in the conversation. I have long believed, *if men are the problem then we MUST make them part of the solution*, or nothing will ever really change. *Playing the Game 2* is an effort to take an honest, constructive, and balanced approach to two of the problems integral to date rape, alcohol abuse and inability to communicate effectively about sex. By representing an all too often ignored male perspective on these issues, I by no means intend to excuse or legitimize rape or sexual assault. Rape is clearly wrong under any circumstances and at any time. However, such a position on its own is not enough to change individual behavior and this program seeks to
explore the extremely sensitive and sometimes explosive norms and attitudes of male and female sexual expression. Isolated parts of the film should not be taken out of context, but rather viewed as part of a program designed to promote frank and honest discussion.

I hope that you find the DVD to be a useful educational tool in your efforts to reduce the incidence of sexual assault and date rape. As with most complicated problems, there is no single panacea or approach that will ever “fix” the problem. *Playing the Game 2* is an attempt to create a dialogue between young men and women that might play a small role in reducing sexual assault.

Robin G. Sawyer, Ph.D.
University of Maryland
Use of the DVD

- The DVD has been designed as a stimulus for a constructive and meaningful discussion about sexuality and communication, and date rape. The DVD contains material that is intended to elicit strong emotional response and viewers must be given an opportunity to discuss their reactions. To that end, it is strongly recommended that Playing the Game 2 should not be shown without some form of follow-up processing.

- The DVD is essentially open-ended in nature in an effort to challenge the audience to actively participate in processing what they have seen. The story should be viewed in its entirety before beginning discussion.

- Ideally, discussion following the film is greatly enhanced by having an audience of both men and women. This allows for a more balanced discussion about the issues, and affords many men and women the opportunity to hear opposite gender perspectives about sexuality and communication.

- Groups of about 20-30 individuals, equally represented by both genders would be the ideal size. However, larger groups could still participate as long as the facilitator feels that he or she could adequately control the discussion in this larger format. Also, using the DVD with single-sex groups is also possible as long as the facilitator acknowledges and represents the perspective of the missing gender.
Suggested Discussion Points

Are there major differences between Jenn’s and Chris’s versions in relation to behavior at the party?

Chris’s perception clearly leads him to believe that Jenn is extremely interested in him, and that she reciprocates his advances. Chris’s description of Jenn being “all over me” reflects his perception that she’s very interested in hooking up, and by his definition, sexual intercourse is a definite possibility. In Jenn’s version, she definitely seems interested in Chris, is animated in conversation, receptive to his flirting, and even kisses him back. So, in effect, the versions don’t appear to be that different … it’s the subjective perception of what the interactions mean that becomes the issue, and ultimately the big problem.

How about the dancing?

Dancing today is interesting, to say the least! Grinding, freaking, whatever you want to call it entails a great deal of physical contact, especially genital. What does this highly sexualized form of dancing mean … if anything? Do men and women both feel that it’s just dancing and no assumptions should be drawn? Will Jenn and Chris both think similarly about the dancing or will there be a difference in perception? There’s no definitive answer here, but it’s worth discussing.

When Chris invites Jenn back to his room, what does this actually mean? Does Chris expect sex to occur? What does it mean when Jenn says “Yes?” Does this mean to Chris that Jenn’s up for sex?

These are all important questions that are difficult to answer. Many men in situations like this believe that there is at least an opportunity for sex to occur, and in many ways social expectations would probably pressure men to at least make some type of sexual advance. Women’s responses could range from an assumption that sex would definitely occur, to a more innocent belief that this was simply a means to continue the evening…. And, by the way, what does “sex” mean? Maybe Chris or Jenn might want to fool around a little, but maybe not have intercourse, to use the formal term… and how do you communicate that? Ideally, these are questions that individuals consider before they end up in a potentially dangerous situation, and without getting so drunk that they are unable to make informed decisions.

What type of communication occurs in Chris’s room?

In Jenn’s flashback, Chris seems much more physically aggressive. He pushes Jenn back on the bed and physically holds her down. Jenn is clearly less receptive. Verbally, Jenn tells Chris to stop and says “No” on several occasions. In Chris’s flashback, Jenn lays back on the bed without physical pressure, and seems very responsive to Chris’s advances. Jenn never actually says the word “No” but she voices her uncertainty about having sex. Jenn continues to make out with Chris as she asks him to slow down and tells him that she’s not sure that this is what she wants.
What are the major perception differences that we see in the bedroom scenes?

Chris’s perception is of a woman who really wants to have sex but who is going through the motions of protecting her reputation by not appearing too eager. Jenn’s sees herself as a woman who likes Chris a lot but is very clear that sexual intercourse is not an option, and although she is happy to fool around for a while, Jenn is not prepared for intercourse.

Imagine you’re on a jury. Based on what you’ve seen in Jenn’s version of what occurred (disregard what you’ve seen in Chris’s version), do you feel that Chris raped Jenn?

This version is really a “no-brainer” given that Jenn explicitly says “No” to sex, she asks Chris to stop, but he continues and has intercourse. Also the fact that Jenn seems pretty drunk, in many states this factor alone would predict a guilty verdict. Most audience participants will agree that Chris is guilty in this version.

Imagine you’re on a jury. Based on what you’ve seen in Chris’s version of what occurred (disregard what you’ve seen in Jenn’s version), do you feel that Chris raped Jenn?

This is where the real discussion will begin! A large majority of both men and women will not feel that the events depicted in Chris’s version constitute rape. Jenn was all over Chris; she went to his room; she lay back on the bed; Chris didn’t force her to do anything; Chris never hit Jenn; she never actually said “No”; Jenn may have been drunk, but Chris was drunk too; Jenn was still making out with Chris while she was talking to him; Jenn was looking to hook up with Chris all night – what’s the big deal?

The bottom line is this … most college students and young adults do not understand the legal definition for what constitutes date rape. The gold standard today is basically verbal consent. Regardless of the fact that Jenn voluntarily went to Chris’s room, lay down on his bed, made out with him, may have been completely naked, Chris needs to receive verbal consent before penetration. Now, this may sound ridiculous to many people, but the reality is, in situations where sex is completely consensual, verbal consent is pretty much irrelevant. BUT in cases like Chris’s version, where one person is hesitating, demonstrating and describing uncertainty, then the need to verbally clarify what the hesitant person wants is essential. As mentioned earlier, if the woman is too drunk to be able to provide verbal consent, then the male will likely be found guilty anyway.

Males in particular often get very angry at this part of the program. Here’s the harsh reality – no-one’s asking them to like what the law says, or even agree with it, but at the end of the day, it is the law and both men and women need to be aware of the legal parameters of date rape.

Do the characters of Ron and Brittany provide a different perspective concerning sexuality and communication?

In talking about these issues, we must be careful not to sexually stereotype individuals. There are men like Ron who do not subscribe to the more traditional male views, just as there are
women like Brittany who would feel that Jenn’s plight was, to some extent, self-induced. If these issues are to be addressed honestly, we must challenge sexual stereotypes that depict all men as terrible villains and all women as helpless victims.

**And what about Jake’s character? How typical is he of undergraduate college men?**

Jake’s character is the archetypical, chauvinistic male who subscribes to most of the male-perpetuated concepts about women and sex. His character may not be very sympathetic, but his attitudes need to be heard, especially by young women. It’s difficult to assess how common are such attitudes today, but suffice it to say that they are common enough to create problems. Certainly, Jake’s theory about how women gradually give in to a man’s advances is a theory that is frequently held by many men.

**What role does alcohol play in date rape and sexual assault?**

Alcohol is without doubt the drug of choice on nearly all college campuses. Taken at low levels alcohol tends to provide young people with more confidence to be able to communicate in social settings. Unfortunately, alcohol actually confuses the interpretation of signals and consumed in large quantities, removes much of an individual’s ability to control his or her behavior, and also be responsive to a partner’s wishes. Over many years in this field, I have hardly ever seen a date rape incident that didn’t involve alcohol use, usually by both individuals concerned.

**What can men and women do to reduce the incidence of date rape?**

This may seem politically incorrect, but I firmly believe that both men and women have responsibilities in this area. Men have the responsibility to not make assumptions about whether or not a woman might have sex with him, based on previous contact, conversation, dancing, kissing, touching or agreeing to go to his room. Men also have the responsibility to listen to what a woman says and take it at face value … assume “No” does mean just that, and hesitation or doubt on behalf of a man’s partner needs to be clarified before a man goes any further.

Women have the responsibility to clearly communicate their intentions and desires in an assertive manner, particularly when asked to go to a guy’s room. Women who are fooling around but then stop because they don’t want to have intercourse, should probably not go back to making out, unless they are absolutely certain their partner understands their limits, as this tends to buy into the male sexual script described by Jake in the film.
TIPS FOR

Men

❖ Think about and acknowledge your sexual limits. Believe in your right to set those limits and if you’re not sure what’s going on, stop and talk about it. It’s OK not to “score.”

❖ Being turned down for sex is not a rejection of you personally. Women who say “No” to sex are not rejecting the person; they are expressing their desire not to participate in a single act.

❖ Accept the woman’s decision. “No” does mean just that in an overwhelming number of occasions… it’s not a woman’s way of playing hard to get. Don’t read other meanings into the answer … even based on past experience with this or other women. Don’t continue after “No” … if you’re so certain the woman doesn’t mean it, simply stop and ask … then respect the decision.

❖ Don’t assume that if the woman dresses in a very sexy manner and flirts a great deal that she wants to have sex with you … maybe, maybe not.

❖ Don’t assume because a woman comes to your room she wants to have sex with you … maybe, maybe not.

❖ Don’t believe your own hype that when you get so aroused you can’t stop yourself … you may not be able to control your desire, but your actions and behaviors are well within your control.

❖ Don’t drink to the point where you have no idea what you’re doing. You could put yourself in a dangerous situation, and although alcohol might be an excuse in your own mind, such a defense won’t work in court.

Women

❖ Think about and acknowledge your sexual limits. Believe in your right to set those limits and if you’re not sure, stop and talk about it.

❖ Communicate your limits clearly. If someone does something with which you’re uncomfortable, tell the person firmly and quickly. Polite responses may be misunderstood or ignored. Say “No” when you mean “No.”

❖ Be assertive. Often men interpret passivity as permission. Be direct and firm with someone who might be pressuring you sexually.

❖ Be aware that your nonverbal actions send a message. If you dress in a very sexy manner and flirt a great deal, some men may assume you want to have sex. This does not make
your dress or behavior wrong, but being aware of how you may be perceived is important information.

- Pay attention to what is happening around you. Watch for nonverbal cues that possibly might make you feel uncomfortable.

- Trust your intuitions. If you feel you are being pressured into having sex, you probably are. If something doesn’t feel quite right, it probably isn’t. Trust your instincts.

- Avoid excessive amounts of alcohol and/or other drugs. These will impair your thinking and ability to communicate.
This film was made possible thanks to the generous support of Delta Tau Delta Fraternity, Alpha Chi Omega, the Fraternity Executives Association, and Margaret Bridwell, M.D.

This film features

“Gimme Shelter” by The Rolling Stones

Courtesy of ABKCO Music & Records, Inc.

www.abkco.com

Get The Tone: Text STONES2E to 30303

Get The CD: Let It Bleed
The Cycle of Intimate Partner Violence

**Acute Incident**
Physical violence – Hitting, Kicking, Slapping, Pushing, Rape
Other – Abuse to children or pets, Destruction of property, Threats of harm with weapon or death, Stalking

**Honeymoon Phase**
In beginning, before violence: Charming, Loving, Complementary, After acute incident: Apologies, Excuses, Gift-Giving, “It will never happen again”

**Tension-Building Phase**
Suspicious, Jealous, Arguing, Controlling (of activity and/or finances), Critical, Angry, Threatening
References


Appendix 1

Sexuality Curricula, Curricula Descriptions, and Curricula Compendia Reviewed

A plethora of curricula on various topics in sexuality exist. These curricula apply to audiences across the lifespan as well as across professional disciplines. In the interest of producing the best curriculum possible, we conducted a broad search to survey the landscape of sexuality education curricula globally.

The CESH team of experts reviewed medical school curricula, curricula for health professionals, sexuality degree program curricula, curricula for parents, K-12 curricula, faith-based curricula, and HIV prevention curricula. We gathered our information in a number of ways including: through literature searches, Internet searches, social and conference networking, organizational partnerships, interviews, listservs, and professional experience.

The following is a list of curricula, curricula descriptions, and curricula compendia reviewed that were most relevant in the development of this curriculum. Listing of these curricula, curricula descriptions, and curricula compendia does not imply endorsement by CESH.

Curricula, curricula descriptions, or curricula compendia reviewed (in alphabetical order):


5. Case Western Reserve School of Medicine Sexual Health Curriculum in the following publication:


23. Morehouse School of Medicine Medical Curriculum. (M. Elks, personal communication, 2007).


25. Our Whole Lives, Sexuality Education Curricula:


Also in the following publication:

Also in the following publications:


Appendix 2
Compilation of Evaluation Questions

Questions are sequentially broken down by lesson. Instructors, please email cesh@msm.edu to request answers.

Sexuality Language & Communication
1. The language used for communicating about sexuality changes based on the audience.
   A. True
   B. False
2. Which audiences do we need to be prepared to communicate with when it comes to sexuality issues?
   A. Adults
   B. Children
   C. Colleagues
   D. Partners
   E. Friends
   F. All of the above
3. Which of the following are barriers to communicating about sexuality?
   A. Personal discomfort with sexuality language
   B. A history of positive sexuality education
   C. Feeling ashamed or embarrassed about sexuality
   D. A & C
   E. All of the above
   F. None of the above

Models of Sexuality
1. Which of the following is not one of the Circles of Sexuality?
   A. Intimacy
   B. Masturbation
   C. Sexual Identity
   D. Sexualization
2. Which of the sexuality models depicts the environmental impact on sexuality?
   A. Sexual Health Model
   B. Healthy Sexuality Flower Map
   C. Circles of Sexuality
   D. Parental Education Circles Model
3. Which of the sexuality models was developed for HIV Prevention?
   A. Sexual Health Model
   B. Healthy Sexuality Flower Map
   C. Circles of Sexuality
   D. Parental Education Circles Model
Values, Attitudes & Beliefs
1. Which of the following influence one’s sexuality values, attitudes, and beliefs?
   A. Culture  
   B. Religion  
   C. Education  
   D. A & C only  
   E. A, B, & C  
2. Sexuality values, attitudes, and beliefs may change over time?
   A. True  
   B. False  
3. When encountering someone whose sexuality values differ from yours, you should do which of the following:
   A. Ignore the person’s values and exert that your values are the only correct values.  
   B. Respect the person’s values and engage in a discussion to understand them further.  
   C. Judge the person based on stereotypes.  
   D. A & C only  

Sexuality Across the Lifespan
1. It is perfectly normal for a child of three or four years of age to engage in sex play with members of their own sex.
   A. True  
   B. False  
2. All of the following are typically considered as rites of passage in adolescents except:
   A. First masturbation  
   B. Getting your driver’s license  
   C. Confirmation  
   D. Going to the prom  
   E. Starting your period  
3. Which of the following would you expect to see in both young and older adults?
   A. Use of online dating sites  
   B. Experimenting sexually with members of the same sex  
   C. Getting married  
   D. Unprotected sexual intercourse  
   E. All of the above  
   F. A and C  

Sexual Anatomy, Physiology & Response Cycles
1. What is the largest sexual organ in/on the body?
   A. Brain  
   B. Skeleton  
   C. Skin  
   D. Heart
2. Which organ systems are involved in one’s sexual response?
   A. Circulatory System
   B. Nervous System
   C. Respiratory System
   D. Reproductive System
   E. All of the above

3. Women and men have the same sexual response cycles.
   A. True
   B. False

Gender & Gender Variation
1. What influences prenatal sex differentiation?
   A. Chromosomes
   B. Testosterone
   C. Maternal nutrition
   D. Both A and B
   E. All of the above

2. Approximately how many live births are believed to be intersex?
   A. 1 in 150
   B. 1 in 2,000
   C. 1 in 10,500
   D. 1 in 150,000

3. What condition is present when one’s sex assignment does not match one’s gender identity?
   A. Androgyny
   B. Intersex
   C. Asexuality
   D. Transgender

Sexual Orientation, Identity & Behavior
1. Which model conceptualizes movement through subsequent levels of sexual identity formation?
   A. Kinsey
   B. Whipple
   C. Cass
   D. Klein

2. What term describes how one experiences attraction?
   A. Sexual behavior
   B. Sexual identity
   C. Sexual fetish
   D. Sexual orientation
3. An individual who has equal heterosexual and homosexual experiences would place where on the Kinsey Scale?
A. 0
B. 2
C. 3
D. 6

Relationships & Love
1. Which of the following is not one of Chapman’s Love Languages?
   A. Attachment
   B. Quality Time
   C. Physical Touch
   D. Acts of Service
2. Sex drive or libido refers to which of Fisher’s core systems?
   A. Romantic Attraction
   B. Lust
   C. Attachment
   D. None of the above
3. What characteristics are generally present in unhealthy relationships?
   A. Abuse
   B. Coercion
   C. Communication
   D. A & B only

Sexual Function, Problems & Concerns
1. Orgasm is possible even in someone with a complete transection of their spinal cord
   A. True
   B. False
2. Your 25-year-old patient or patient reveals that she is not sexually satisfied because her husband has problems with erections. What sexual dysfunction might the husband be dealing with?
   A. Erectile dysfunction
   B. Premature ejaculation
   C. Hypoactive Sexual Desire Disorder
   D. Any of the above
3. One of the most common approaches to addressing sexual problems used by health professionals is:
   A. Sensate focus
   B. Cognitive-behavioral therapy
   C. PLISSIT Model
   D. Psychosexual therapy
Disabilities & Chronic Conditions
1. Rebecca is a 28-year-old female with a SCI at T9. She is 1 year post injury and pregnant for the first time. Chances are more likely Rebecca will have what type of delivery?
   A. Premature
   B. Vaginal
   C. Cesarean
   D. High-risk
   E. Dangerous
2. Bill has a SCI and reports a bit of swelling in his penis when having sex with his partner followed by emission of a few drops of semen. Bill’s report suggests which of the following nerve pathways is still intact?
   A. Vagas
   B. Hypogastric
   C. Pelvic
   D. Pudendal
   E. Sciatic
3. Men and women who report an impairment in an activity of daily living or the need for an assistive device to walk more than three blocks (men and women with disabilities) are more likely than men and women without disabilities to think of themselves as homosexual or bisexual.
   A. True
   B. False

Fertility, Pregnancy & Contraception
1. How long does the ova/egg survive in the woman’s body after ovulation?
   A. 24 hours
   B. 48 hours
   C. 72 hours
   D. 96 hours
2. At what point is it generally safe to engage in sexual intercourse in the postpartum period?
   A. Immediately after delivery
   B. 3 weeks after delivery
   C. 6 weeks after delivery
   D. None of the above
3. Which of the following contraceptive methods does not involve hormonal manipulation?
   A. Abstinence
   B. Birth control pills
   C. Condoms
   D. A & C only
   E. A, B, & C

Infertility
1. Women experience a higher rate of infertility than men.
   A. True
   B. False
2. Which of the following are used to treat infertility?
   A. Surgery
   B. Gamete Intra Fallopian Transfer (GIFT)
   C. Intrauterine Insemination (IUI)
   D. Ovulation Induction Agents
   E. All of the above

3. What is the average cost of one cycle of In vitro Fertilization (IVF)?
   A. $100-$500
   B. $5,000-$9,000
   C. $10,000-$15,000
   D. $25,000-$30,000

Body Image, Self Esteem & Sexual Self Esteem
1. What psychiatric disorder is characterized by cycles of excessive calorie intake followed
   by compensatory behaviors to rid one’s body of the calories?
   A. Binge eating disorder
   B. Anorexia nervosa
   C. Compulsive eating
   D. Bulimia nervosa

2. What percentage of patients with eating disorders are women?
   A. 50%
   B. 70%
   C. 85%
   D. 90%

3. One’s level of regard for and confidence in capacity to experience sexuality in a
   satisfying and enjoyable way is:
   A. Sexual self-esteem
   B. Sexual self-schema
   C. Bodiosexuality
   D. Sexual disposition

Media & the Internet
1. The Center for Media Literacy’s five core concepts include:
   A. All media messages are constructed
   B. Media messages are constructed using a creative language with its own rules
   C. Different people experience the same media message differently
   D. Media have embedded values and points of view
   E. Media is neither positive or negative
   F. Most media messages are organized to gain profit and/or power
   G. A through E
   H. B through F
   I. A through F excluding E
2. The acronym, “AAA,” and the term AAA engine stands for:
   A. Anonymous, Affordable, Accurate
   B. Accessible, Attractive, Affordabile
   C. Access, Anonymity, Affordability
   D. Access, Anonymity, Asexual

3. .org sites are inherently more accurate and less biased than.com sites.
   A. True
   B. False

Culture & Religion
1. Culture is to sexual orientation as:
   A. Judaism is to Christianity
   B. African-American is to Native American
   C. Morality is to religion

2. Humility can compensate for a lack of knowledge about a specific culture and/or stereotyping based on culture when taking a sexual history.
   A. True
   B. False

3. What plays a bigger role in shaping our sexual value system?
   A. Race and ethnicity
   B. Cultural background
   C. The media
   D. Secular and religious constructs of morality
   E. It depends

Behaviors, Practices & Expressions
1. The majority of paraphilias are believed to occur equally among males and females.
   A. True
   B. False

2. What three tenets must be present in order for BDSM to be sexually healthy?
   A. Spontaneous, reciprocal, monogamous
   B. Safe, sane, consensual
   C. Heterosexual, androcentric, hygienic
   D. Predetermined, frequent, submissive

3. Recreational sex outside of a committed relationship with one partner, with the partner’s full knowledge and permission is referred to as:
   A. Polyamory
   B. Gerontophilia
   C. Bisexuality
   D. Swinging
Sexually Transmitted Diseases, HIV & AIDS
1. As of 2009, what is the estimated disease burden of HIV worldwide?
   A. 26 million  
   B. 33 million  
   C. 57 million  
   D. 81 million  
2. Use of spermicides can decrease risk for STD and HIV infection.
   A. True  
   B. False  
3. According to CDC, the surest way to prevent the spread of STIs and HIV is to:
   A. Abstain from sexual intercourse  
   B. Use male condoms  
   C. Use microbicides  
   D. Get tested every 6 months  

Sexual Abuse, Violence & Harassment
1. Approximately what percentage of rapes are perpetrated by strangers?
   A. 11%  
   B. 27%  
   C. 65%  
   D. 80%  
2. Which is not a phase in the cycle of intimate partner violence?
   A. Tension-building  
   B. Honeymoon  
   C. Acute incident  
   D. Resolution  
3. Women do not perpetrate rape, sexual harassment or intimate partner violence
   A. True  
   B. False