2021- Human Sexuality Notes-2021

Human sexuality (Kenyatta University)



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HUMAN SEXUALITY

APS 214

INTRODUCTION

The study of human sexuality provides knowledge and an understanding of Human Sexuality from a psychological, sociological, biological and cultural perspective. It deals with an understanding of how sexuality affects Human life and Psychological wellbeing.

Most societies do not to talk about sexuality openly, especially with young people. Depending on the religious and cultural beliefs, sexuality is rarely discussed and people who discuss it freely are regarded as immoral. However, a positive approach to human sexuality and an understanding of the complex factors that shape human sexual behavior is important for sexual health and well being.

Sexuality is part and parcel of a person's total personality from birth to death, with or without sexual activity. Sex is part of every culture and can be found historically in every period through the paintings and drawings.

We express our sexuality in various ways; whether by getting involved in sexual activity or choosing to celibate. All these are valid ways of being sexual. Being sexual is the aspect of who we are in: All our friendships (we are either male/female), in our feelings, the way we walk, think, talk to others, touch others and the way we relate to the world, in our work relationships , our play, prayers, etc.

Definitions of sex and sexuality

Sex

The meaning of sex has different meanings to different people depending on one's socialization, when and for what reasons it is being used. Sex may refer to whether a person is male or female, whether a person has a penis or vagina. Sex is also commonly used as an abbreviation to refer to sexual intercourse. Sex refers to the biology, anatomy, physiology of reproductive functions within humans.

Sex plays two major roles in nature: It ensures that living things reproduce their kind and ensures that hereditary materials people carry (genes) are repeatedly brought out in different combinations in each new individual.

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Sexuality

Sexuality refers to the total expression of who one is, as a human being, the femaleness or maleness. Everyone is a sexual being, our experiences and our expressions of ourselves as sexual beings, which are affected by our culture.

Human sexuality also refers to the expression of sexual sensation and related intimacy between human being. It is the quality of being sexual. Sexuality is part of the total person: physical, emotional, social, intellectual and spiritual. Your sexuality is interplay between body image, gender, identity, gender roles, sexual orientation, relationships, etc. It includes attitudes, values, knowledge and behaviors. Families, culture, society, values and beliefs influence how people express their sexuality.

Sexual identity

It is a person's understanding of who s/he is sexually including the sense of being male or female. It can be thought of as three interlocking pieces that together affect how each person sees him/herself. These pieces are:

- ✓ *Gender identity* – knowing whether you are Male or female
- ✓ *Gender role* – knowing what it means to be male or female or what a man or woman can or cannot do because of their gender.
- ✓ *Sexual orientation*: whether a person's primary attraction is; to people of the same gender (homosexuality) the other gender (heterosexuality) or both genders (bisexuality).

Sexual health and reproduction

It is the capacity to reproduce and the behaviors and attitudes that make sexual relationships healthy; physically and emotionally.

Specific aspects of sexual behaviour include:

- ➢ Factual information about reproduction
- ➢ Feelings and attitudes
- ➢ Sexual intercourse
- ➢ Information on prevention and control of STDs
- ➢ Responsible sexual practices and contraceptive information.

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Sexuality and Values

Values influence sexual attitudes & behavior. Values are the qualities in life that are deemed important or unimportant, right or wrong, desirable or undesirable

Our society is pluralistic: It embraces a wide range of sexual attitudes and values such as:

- Some people are liberal in their sexual views and behavior. Others may be conservative.
- Some are pro- choice on abortion; others, pro- life.
- Some approve of pre-marital sex for couples who know each other casually.
- Others hold the line at emotional commitment.
- Still others believe in waiting until marriage.

People's sexual attitudes, experiences, and behaviors are shaped, to a large extent, by their cultural traditions and beliefs and values. Some of these value systems are as follows:

- *Legalism* – strict adherence to the law
- *Ethical Relativism* – philosophy that maintains there is truths and values but denies that they are absolute; they say that what may be true/ rational in one situation may not be so in another.
- *Hedonism* - belief that pleasure is the most important achievement/highest good in life.
- *Asceticism* – philosophy/practice of self denial of physical pleasures/comfort.
- *Utilitarianism* – set of values based on the belief that an action is morally right if it benefits the majority of the people.
- *Rationalism* – theory that an individual actions and beliefs should be based on reason rather than on intuition or the teachings of others.

Approaches of sexual behaviour

Sexual behaviour is as a result of interaction between biological, psychological and social forces.

a. Biological

Biologically, it is the means through which a child is conceived and the lineage is passed on to the next generation. Sexuality involves the body, mind, and spirit; it is the ways in which people experience and express themselves as sexual beings; the awareness of themselves as males or females; the capacity they have for erotic experiences and responses.

b. Psychological

Psychologically, sexuality is the means to express the fullness of love between a man and a woman. The most widespread sexual norm historically, and the norm promoted nearly universally by the

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world's religions, is that sex is appropriate only within marriage. Sexuality is much more than being male/female, it is much more than sexual feelings and intercourse. It involves:

- ✓ Feelings, Thoughts, Behaviours of being male/female
- ✓ Being attractive and being in love
- ✓ Being in a relationship that excludes sexual intimacy, and also that which is physical and includes sexual activity
- ✓ It is referring to one's reproductive system
- ✓ It is the anatomy/physiology

Sexuality is an important part of who a person is and what s/he will become it begins when a person is born and ends when s/he dies. It creates a sense of identity; it is a way of self expression and a means of inter personal communication.

c. Social

Sexuality is considered as a force that binds people together. For this reason, the society provides opportunities for contact with sexual partners. Sex symbolizes social status. The company of a beautiful woman is a testimony and a tribute to a man's social standing (reputation). A woman's social status is more often enhanced by her man's social importance than by his works. Sexual behaviour or its restraints is a means to social acceptability. Most societies will not accept promiscuity amongst their members.

Critical Thinking

Sexual knowledge and critical thinking skills are of value because they allow us to make informed sexual decisions. Critical thinking is the avoidance of biases and preconceptions as we evaluate information, claims, and arguments (Smith, 1995; Wade & Tavris, 1996).

Principles of critical thinking are:

- ✓ Being skeptical - doubtful
- ✓ Examine definitions
- ✓ Examine assumptions or premises of arguments
- ✓ Be cautious about drawing conclusions
- ✓ Consider alternative interpretations of research
- ✓ Consider the kinds of evidence upon which conclusions are based
- ✓ Do not oversimplify
- ✓ Do not over generalize

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Perspectives of Human Sexuality

The Historical Perspective

a. ***Prehistoric Sexuality-***it involved emphasis on: Female idolatry whereby women are Adorned, emphasis was placed on reproductive organs in the world of art, there was phallic worship and symbols and incest was a taboo
b. ***The Ancient Hebrews -***They emphasized procreative function of sex. Sex strengthened marriage and solidified family. Women considered property of men.
c. ***The Ancient Greeks -***They valued family life and admired male body of muscle and health. The gods were viewed as sexually adventurous and viewed men and women were viewed as bisexual in nature. Male-male sex was considered normal as long as it did not interfere with the family and prostitution was very popular.
d. ***The Ancient Romans -*** The elite practiced sexual excesses, such as orgies, bestiality, and sadism
e. ***The Early Christians -*** If celibacy was not possible, sex was restricted to marriage and was for procreation and not for pleasure. Anything except for vaginal intercourse was strictly forbidden and was viewed as sinful and divorce was outlawed.
f. ***Islam -***The Islamic tradition values marriage and sexual fulfillment in marriage only. Only men may have more than one spouse. Social interactions between men and women restricted
g. ***Hinduism-***Hinduism views sex as a religious duty. Sexual fulfillment can lead to reincarnation at a higher level
h. ***Far East /Toaism (Chins)*** – sex is a form of worship that leads to harmony with nature, as well as immortality
i. ***The Middle Ages -***Conflicting views of women as; *sinful*, as Eve; *saintly*, as Mary – this view elevated women's status
j. ***The Protestant Reformation -***Priests are allowed marrying and rearing children. Sex is viewed not just for procreation but a binding union.
k. ***The Victorian Era -***Women's place was in the home and fields. Sexuality was repressed but prostitution was quite common
l. ***The Sexual Revolution-*** During the mid-1960s to the mid-1970s sexual attitudes and behaviors became more liberal

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m. ***Recent trends-*** Research is still going on in the study of human sexuality. There is inclusion of sex education in current school curriculum due to the increased rate of sexual activities among teenagers and sexual abuse as well, affecting children and adults as well.

Sex therapy is becoming more widespread and acceptable as new information keeps on evolving. More teenagers are involved in sexual activities. Pornography has become very common with many young people engaging in it. Sex is currently discussed openly with the transgender communities coming out to declare their sexual orientation without fear as compared to the past.

Theoretical Perspectives

a. Psychoanalytic Perspective (Sigmund Freud)

Psychoanalysis focuses on biological, instinctual drives (sexual and aggressive) that society attempts to control. We tend to use defense mechanisms to repress our sexual desires which are not morally accepted. There are psychosexual stages in which specific erogenous zones are involved in deriving pleasure. Children progress through these stages of psychosexual development.

The divisions of the mind

According to psychoanalysis, there are three divisions that build up our personalities.

- **Id-** it is the reservoir of psychic energy and pleasure principle. It is the part which the unconscious material lies in our mind. It is also the biological part of personality
- **Ego**-it is the psychological part of personality and the reality principle. It is the conscious part of our mind.
- **Superego-**it is the social part of personality and the idealism/moral principle. It is partially the conscious state of our minds.

b. Learning Theories:

Behaviorists -They focus on the measurement of observable behaviors, the role of the environment, and the effects of rewards and punishment on behavior. Events (such as rewards) that increase the frequency or likelihood of particular behavior are termed reinforcements. When applied to sexual behavior, children left to explore their bodies without parental condemnation will learn what feels good and tend to repeat it. Punishment tends to suppress behavior in circumstances in which it is

Stages of Psycho Sexual Development

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1. *Oral stage (0 – 1years)* the focus of pleasure is, the mouth. Sucking (only fluids are taken) and biting (during weaning) are favorite activities.
2. *Anal stage (2years)* - At this stage the Ego is beginning to emerge, and the reality principle is replacing the Id. Toilet training starts. The focus of pleasure is the anus
3. *Phallic (3 - 5 or 6 years)*- The focus of pleasure is the genital area. In this stage boys become interested with their mothers (Oedipus complex) and the girls with their fathers (Electra complex).This feeling can cause anxiety therefore the boy will try to identify with the father to avoid punishment and the girl with the mother .
4. *Latency (7 - puberty)* - during this stage, Freud believed that the sexual impulse was suppressed in the service of learning. The child's attention is focused on education, hobbies, friendship and sports. Energy is directed towards social development and intelligent skills
5. *Genital (Adolescence - Adulthood*) - Sexual interest begins to re emerge. Hormonal levels are altered and body changes take place. Adolescence work towards their own adult roles and responsibilities. The sexual impulse of the Id starts to dominate and make demands. They form relationships with opposite sex with a view to lasting commitment and marriage

According to Freud, female sexuality is inherently passive & masochistic. He distinguished between vaginal (mature) orgasm and clitoral (immature) orgasm expected to occur. Thus, if young people are severely punished for sexual exploration, we may come to associate sexual stimulation in general with feelings of guilt or anxiety.

Social-learning theorists **-**Focus on the importance of reinforcement and punishment but also cognitive influences (appraisal and expectations) and observational learning (modeling) **.***Observational learning* – learning by modeling, or observing others' behaviors and the consequences.

. *Social-cognitive theory* – children acquire gender roles by being reinforced for certain behaviors which were learned through observation

c. Cognitive Views/ Cognitive Perspective

Our most erogenous sex organ lies between our ears and should not be dismissed. The cognitive activity of the brain can quickly either augment or inhibit a sexual response cycle. Walen & Roth (1987) pointed out that **perceptions** and **evaluations** are the two major types of cognitive activity.

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That is, how a stimulus or situation is interpreted determines how the individual will respond to the stimulus.

Perception includes at least three components: detection, labeling, and attribution.

- ✓ *Detection* is defined by an individual's ability to note the presence of a stimulus or to discriminate it from other stimuli.
- ✓ *Labeling* is the descriptors that an individual uses to categorize the stimulus event.
- ✓ *Attribution* is an explanation for the perception. Individuals may of course rely heavily on situational cues when making attributions.

The inability to detect sexual stimuli, incorrect labeling, or misattribution may significantly impede sexual performance (Walen & Roth, 1987).

Evaluation - is a process of rating events from good to bad i.e. when an individual evaluates a sexual stimulus as good or positive, sexual arousal may be enhanced. However when a stimulus is evaluated negatively, sexuality will be diminished

d. Feminist theory

Among other things, feminist theory challenges: traditional views of men as breadwinners and wome n as homemakers. Traditional views of men as political policymakers, especially because those policies affect women and children. Traditional views of men as sexual aggressors and women as sexual gate-keepers. Traditional gender roles that view men as objective and rational, and women as emotional and irrational and focus on power dynamics.

Research Methods Used in Human Sexuality

Sexology is the scientific study of human sexuality. One of the major goals of scientific research is to find information that can be generalized and assist to understand, predict, and control various phenomena. There are six common research designs used in sexology.

a. Surveys

This is one of the most common methods used. It involves getting information about people's sexual attitudes or behaviours. This information is gathered through face to face interviews, completion of questionnaires or daily diaries in which behaviors are recorded. Surveys are used in a large group that represents a particular target population. Ethnic and gender differences should be taken into consideration.

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b. Case studies

Case studies entails an in depth look at a particular individual's circumstance and how s/he might be helped to solve sexual or other problems. These studies do offer new ideas, information and perspectives to be considered.

c. Clinical research

This is when some treatment strategy is tested with larger numbers of people. The study may consider the cause, treatment and prevention of a disease or condition. For instance, clinical studies were conducted for several years on 800 individuals who complained of various forms of sexual dysfunction, categorizing and labeling the problems, looking for possible causes and trying out a variety of treatment methods (Masters and Johnson, 1970).

d. Observational research

This entails observing an aspect of human sexual behavior directly. This takes place in laboratories or in the field. Masters and Johnson conducted the clinical research through observation on the response of the participants. However, most people may feel uncomfortable with the research conditions.

e. Ethnography

This is information gathering that describes a particular culture. This information involves sexual practices and beliefs of a particular culture. Cultural values can affect information gathering since certain behaviors are not accepted, leading to reluctance and embarrassment when reporting these behaviours.

f. Experiments

This involves examination of one variable while all other variables are kept constant. The researcher examines what happens to a particular variable being studied and manipulated while an attempt is made to control all other variables. However, such experiments may be difficult in human beings since the artificiality of the controlled setting may influence the outcome of the research. This is why such researches in human sexuality are few.

Since sexuality is a sensitive and private aspect of life, it is important to consider the ethical issues involved in research. Everyone has a right to informed consent, that is, they must give prior information about the purpose of the study and the process of conducting it. The researcher has the

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obligation to protect the confidentiality of the participants. This is done by avoiding exposure of personal information and facts that are connected with a particular individual. Protection of the participants from physical and psychological harm is also very crucial

GENDER IDENTITY AND ROLES

Introduction

There is a relationship between sexuality and gender. It is therefore important to understand several aspects of gender that contributes towards sexual health and appropriate sexual behaviour. We are therefore going to discuss the factors and process involved in developing gender identity and roles.

Gender Identity

Gender is the wide set of characteristics that distinguish male from female. According to World Health Organization (WHO), gender is "the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for men and women". It can be thought of as three interlocking pieces between gender identity, gender role and sexual orientation that together affect how each person sees himself/herself.

Gender identity is knowing whether you are Male or female. It is that part of a person's self image that is determined by the person's gender. It is the parts of male or female role that a person accepts and lives by, that becomes that individual's gender identity. Our *gender identity* determines how an individual is perceived, expected to think and act as a woman or man because of the way the society is organized.

Prenatal sex differentiation

Prenatal sex differentiation occurs when a fetus gains characteristics of either male or female during development, depending on gonadal steroid hormones. These hormones perform 'organizing functions' to permanently differentiate sex organs during development. This process starts at the embryo stage before the fetal development stage.

By the sixth week of development, all embryos have both Wolffian ducts and Müllerian ducts. The internal organs are bipotential, meaning they have the potential to develop into both male and female sex organs. The way they develop is influenced by hormones, and each fetus will only have one of pair of these ducts by the end of differentiation.

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The differentiation process is started for males by a gene on the Y chromosome known as the SRY-gene (Sex determining Region Y). When expressed, this gene initiates the correct biochemistry inside of a male fetus for him to develop male sex organs. The Wolffian ducts develop into the vas deferens and the seminal vesicle, and the Müllerian ducts degenerate. The undifferentiated gonads develop into testes, and other structures such as the prostate gland and scrotum develop.

Females have two X chromosomes, so they do not have the initiation of sex differentiation signaled by the SRY-gene; instead, their sex organs develop in the absence of these cues. The Müllerian ducts, the undifferentiated gonads develop into ovaries, and other structures such as the labia and vagina develop.

The external genitalia of males and females are not as radically different as one might expect. The external genitalia are undifferentiated at four and six weeks, and then start to differentiate at ten weeks for males and twenty weeks for females. The final illustrations are the external genitalia at birth. It is interesting to realize that the same initial tissue makes up different structures in males and females, such as how the genital tubercle develops into the glans in males and the clitoris in females.

Formation of gender identity

Although the formation of gender identity is not completely understood, many factors have been suggested as influencing its development.

- *Biological factors* that may influence gender identity include pre- and post-natal hormone levels and gene regulation.
- *Social factors* which may influence gender identity include gender messages conveyed by family, mass media, and other institutions.

In some cases, a person's gender identity may be inconsistent with their biological sex characteristics, resulting in individuals dressing and/or behaving in a way which is perceived by others as being outside cultural gender norms; these gender expressions may be described as *gender variant* or *transgender*. People who identify as *Transsexual* may strongly desire that other people consider them to belong to a gender opposite to that of their type, but often are simply trying to modify their bodies and behaviors to match how they feel inside, which may not have anything to do with being either male, female, a man, or a woman. (*Sexual orientation* is whether a person’s primary attraction is; to

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people of the same gender (homosexuality) the other gender (heterosexuality) or both genders (bisexuality).

Before the 20th century a person's sex would be determined entirely by the appearance of the genitalia, but as chromosomes and genes came to be understood, these were then used to help determine sex. Those defined as female by sex, have genitalia that is considered female as well as two X chromosomes; those viewed as male by sex, are seen as having male genitalis, one X and one Y chromosome. However some individuals have combinations of chromosomes, hormones, and genitalia that do not follow the traditional definitions of "men" and "women" genitalia vary greatly or individuals may have more than one type of genitalia, and other bodily attributes related to a person's sex (body shape, facial hair, high or deep voice, etc.) may or may not coincide with the social category, as woman or man. This is termed as intersex.

Gender role and stereotypes

Gender role refers to a pattern or set of behaviours considered appropriate for males or females. They are the expectations regarding the proper behavior, attitudes and activities of males and females. It understands what it means to be male or female or what a man or woman can or cannot do because of their gender. A gender role also called *sex role* is a learned pattern of behavior based on gender. These roles are defined in terms of behaviours personality characteristics and attitudes that cultures find appropriate for each sex.

These are roles assigned by society to people of each gender. The male or female roles that people play. Clearly the society's expectations are powerful in the development of a person's gender role. Every society train trains its people from birth, to act as it expects male or female people to act. Gender roles vary from culture to culture; however generally, the society feels that boys or men should be more aggressive, boisterous, adventurous and less emotional; while girls/women should be more passive, more tender, emotional, and less boisterous (Holland, Magoon, Spokane 1981).

Women's Gender Roles

How does a girl come to develop feminine self image?

- In part, by identifying with females in their families and television e.g. On TV if a girl always watches female lawyers/judges she may believe she can become a lawyer.

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- A study in the US in 1940's and 1960's showed that children's books portrayed women as helpless, passive, incompetence and need a strong male care taker.
- In 1980's women were portrayed to be more active. However boys were still shown engaged in active play three times as often as girls.
- In most societies, women experience a mandate to both marry and be a mother. Marriage is viewed to be a true entry into adulthood. They are expected not only to become mothers but to want to be mothers.
- Generally women may achieve recognition in the labour force but it's not as important to their identity as it is for men.

Men's Gender Roles

According to *Doyle, J (1995)* Men's roles are also socially constructed. Aspects of male gender role include the following:

- *Antifeminine element* – 'show no sissy stuff' or any expression of openness/vulnerability.
- *Success element* – prove one's masculinity at work and in sports.
- *Aggressive elements* – use force in dealing with others.
- *Sexual element* – initiate or control all sexual relations.
- *Self-reliant element* – keep cool and unflappable(composed)

Lately, there has been tremendous reaction against the basic inequalities of these roles and the stereotypes they foster plus the injustices of traditionally male-dominated societies.

- *Sex typing* is the learning of behaviours suitable for each gender. It is a process by which children develop the behaviours and attitudes considered appropriate for their gender. For instance how a boy becomes masculine.
- A male who acts like a female and vice versa is said to be *cross sex typed.*
- A person who incorporates both masculine and feminine qualities is referred to as *androgynous.*
- ***Sexism*****:** is the ideology that one sex is superior to others. It is used to refer to male prejudice and discrimination against women.

Determinants of gender Roles

There are three important factors involved in determining sex roles:

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1. genetic/biological
2. family based
3. Cultural.

1. Genetic / biological contributions

The sex chromosomes (X and Y chromosomes) determine whether an embryo develops as male or female. The principal fetal hormones are: androgens in males and progesterone & estrogens in females. Production of androgens by the testes is necessary for the embryo to develop as male. Androgens also affect the organization of the fetal brain. Genetic contributions to sex typing are evident in the innate tendencies for sexes to act, think and feel differently. Though there is massive evidence that most gender components are environmentally determined, there is also some compelling evidence that certain aspects of male-female differences have biological basis.

2. Family Based Socialization

a. Socialization by parents

Parents are the most important figures and models in their childrens' lives. Homes where parents perform non-traditional jobs and chores, their children hold less stereotyped ideas about the proper roles of men and women. Parents may treat sons and daughters differently e.g. Fathers recruiting sons to help in repairs. There is evidence that parents treat manifestations of aggression differently in their male and female children. They encourage it in one and discourage it in the other (Russell & Ward 1982). Likewise teachers tend to expect more aggressiveness in boys; they tolerate and even encourage it.

b. Socialization by opposite-sex siblings

Research shows that having an older brother had a bigger effect on the younger siblings than having an older sister. Activities of the older brother are highly regarded, more acceptable for girls to behave like boys than boys to behave like girls. Girls are more likely to imitate male models than boys.

c. Socialization by self

Self represents the sum total of people's conscious perceptions of their own identity as distinct from others. It is not static; it develops and changes throughout our lives. Self is a product of our social interactions with other people.

Cooley (1902) proposed that the process of developing a self-identity/concept has three phases:

- ✓ we imagine how we present ourselves to others e.g. relatives, friends, strangers
- ✓ We imagine how others evaluate us (attractive, intelligent, shy or strange)

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- ✓ We develop some sort of feeling about ourselves e.g. respect, shame etc as a result of these impressions (Cooley 1902)

According to Cooley's *Looking-glass-self*; the self results from an individual's imagination of how others view him. Therefore, we may develop self identity based on incorrect perceptions of how others see us.

3. society/culture based

a. Socialization by society/culture

Children learn through modeling, by observing those around them and differential treatment. E.g. access to formal education in some cultures differs between males/females and also opportunities and experiences available to each of them – boys are granted autonomy than girls.

The expectations the society has for males and females also differ. Society expects girls to be more emotional, tolerate and encourage it while it is regarded inappropriate in boys. Likewise teachers tend to expect more aggressiveness in boys; they tolerate and even encourage it.

b. Socialization by Peers

They reinforce one another for engaging in gender-typed play and punish those who deviate from established norms. In some cases cross gender play has consequences; and these are more severe for boys than girls.

Girls who engage in boys' activities could be allowed to join boys groups and go back and forth with ease; however for boys it's different; those who play with girls are teased and taunted. Another way is through their selection of role models – children tend to focus on models of their own gender. They adapt their toy preferences to win approval from peers.

Gender roles are biologically determined to a limited extent only; they are for the most part socially constructed. Their respective roles are assigned to men or women in a given society and at a given time on the basis of various factors (social, cultural, ideological, religious, ethnic, economic, etc.) 'Female' and 'male' role allocations therefore differ from one society to another and within societies. In nearly all societies, these role allocations specify a subordinate social position for women.

Gender Stereotypes:

Gender stereotypes include strict roles, fixed pictures of how everyone in a group is thought to be; ideas that do not recognize anyone's individuality. Gender Stereotyping arises from the distinct

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division of tasks that woman and men are associated with in playing their role and responsibilities society has assigned to them.

Women are associated more with reproductive and maintenance roles e.g. cooking, fetching water, firewood, cleaning, child care; while men are to have productive role that society has placed more value e.g. provide security, decision makers, bread winners, heads of households etc.

Some dominant old Gender Stereotypes that are slowly changing include:

- Men are active and independent while women are passive and dependent
- Men hide their emotions; while women show their emotions
- Men discipline their children; women nurture them
- A man' success is viewed thro' his earnings/status; a woman's is seen thro' the man she marries.

Changes emerging: Women are now accepted in the armed forces; nursing profession welcome men. Today, women work in politics, become corporate executives, and build bridges; while men enjoy some roles formerly reserved for women such as: cooking, nurturing children and other house chores. Both men and women are now openly speaking out against sexual harassment.

Sexual health and reproduction

- Sexual health requires a positive approach to human sexuality and an understanding of the complex factors that shape human sexual behavior. These factors affect whether the expression of sexuality leads to sexual health and well-being or to sexual behaviors that put people at risk or make them vulnerable to sexual and reproductive ill-health.
- Specific aspects of sexual behaviour include:
  - Factual information about reproduction
  - Feelings and attitudes
  - Sexual intercourse
  - Information on prevention and control of STDs
  - Responsible sexual practices and contraceptive information.

HUMAN SEXUAL ANATOMY

Introduction

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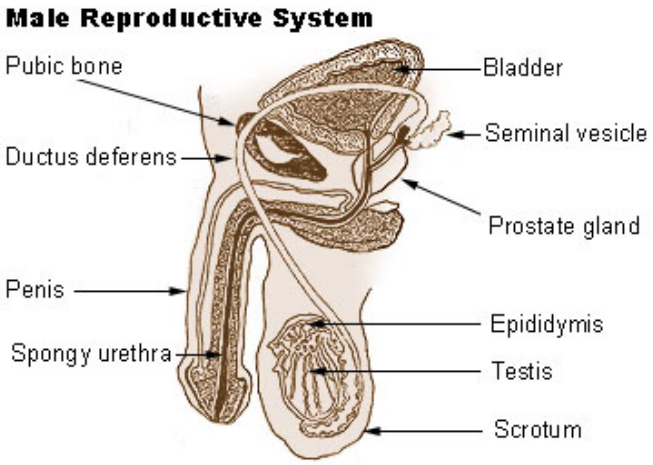
In order to understand sexual behaviours between individuals, it is important to be aware of both the anatomy and physiology of both male and female. This knowledge will help you to understand the attitudes and emotions that shape people's feelings about their own sexuality and that of others. It is in this light that we are going to analyze the physiology and anatomy of both male and female and their corresponding sexual and hormonal responses in both sexes.

ANATOMY AND PHYSIOLOGY OF HUMAN REPRODUCTIVE SYSTEM

The sexual organs always elicit different responses. Some respond with praise while others with shame. Both men and women have a combination of feelings of pride and pleasure with shame and confusion with respect to their sex organ. Sex organs are best understood in the context of reproductive system.

Male Sexual Anatomy And Physiology

The male reproductive system, like that of the female, consists of those organs whose function is to produce a new individual, i.e., to accomplish reproduction. This system consists of a pair of testes and a network of excretory ducts (epididymis, ductus deferens (vas deferens), and ejaculatory ducts), seminal vesicles, the prostate, the bulbourethral glands, and the penis.



a) Penis

The penis is the external sex organ of the male through which both urine and semen pass. It consists of three cylinder-shaped bodies of spongy tissue filled with tiny blood vessels, which run the length of the organ. Two of these bodies lie side by side in the upper portion of the penis. The third is a tube

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which lies centrally beneath the others and expands at the end to form the tip of the penis, which is called the "glans." The penis transfers sperm to the woman's body during sexual intercourse and is a duct for the disposal of fluid waste.

- The penis becomes erect during sexual excitement, because extra blood is pumped into spongy tissues, resulting in enlargement and hardening which allows penetration into the female organ.
- The "head" of the penis is called the "glans" and is normally covered with a protective, retractable skin or "hood."
- This skin is often cut off at birth, or "circumcised," and it is believed that its removal lessens risk of cancer and bacterial infections.
- At the center of the penis is a tube which carries urine from the bladder and semen from the prostate gland, called the "urethra."
- During sexual intercourse, reflexes prevent urine from entering this duct and alkaline solutions are produced and secreted to flush out any traces of urine from the urethra before semen is secreted.

b) Testicles

- The scrotum is a sac that hangs under the penis and holds the testes.
- It is divided internally into two halves by a membrane; each half containing a testis.
- It has an outer layer of thin, wrinkled skin over a layer of tissue which contains muscle.
- The testicle lies inside the scrotum and produces as many as 12 trillion sperm in a male's lifetime, about 400 million of which are ejaculated in one average intercourse.
- Each sperm takes about seventy-two days to mature and its maturity is overseen by a complex interaction of hormones.
- The scrotum has a built-in thermostat, which keeps the sperm at the correct temperature. It may be surprising that the testicles should lie in such a vulnerable place, outside the body, but it is too hot inside.
- The sperm production needs a temperature which is three to five degrees below body temperature. If it becomes too cool on the outside, the scrotum will contract to bring the testes closer the body for warmth.

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c) Ductus Deferens

The "ductus deferens" (also called the "vas deferens") is a muscular tube that begins at the lower end of the epididymis and passes upward along the side of the testis to become part of the spermatic cord. It passes through the inguinal canal, enters the abdominal cavity, and courses over the pelvic brim. From there, it extends back into the pelvic cavity, where it ends behind the urinary bladder. Near its termination, it becomes dilated into a portion called the "ampulla." Just outside the prostate gland, the tube becomes slender again and unites with the duct of a seminal vesicle. The fusion of these two ducts forms an ejaculatory duct, which passes through the substance of the prostate gland and empties into the urethra through a slit-like opening.

d) Prostate Gland

- The prostate gland is a solid, chestnut-shaped organ surrounding the first part of the urethra (tube which carries the urine and semen) in the male.
- It produces secretions which form a part of the semen.
- The prostate gland lies just under the bladder and in front of the rectum.
- It consists of two main zones: the inner zone, which produces secretions to keep the lining of the male urethra moist, and the outer zone, which produces seminal fluids to facilitate the passage of semen into the female.
- The "urethra" is a two-stemmed duct leading from the bladder and from the prostate gland into the penis.

The word, "aphrodisiac," is derived from Aphrodite, the Greek goddess of love and sexual pleasure. The ancient Greeks thought honey would produce an increase in sexual powers and they believed the same of the hair from a wolf's tail and ground snake bones. The French used an "aphrodisia" which they called the "love apple" - actually a tomato. Today, the hope lies in oysters. Sadly, the fallacy that a ground rhinoceros horn will help in this plight has put this animal on the endangered species list. Actually, aphrodisiacs are in the mind and operate only by the power of suggestion - if at all.

e) Cowper's (Bulbourethral) Glands

- The bulbourethral, or Cowper's, glands, are two small structures about the size of peas, which are located below the prostate gland.

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- They are composed of many tubs whose linings secrete a fluid that is released in response to sexual stimulation to provide some lubrication to the end of the penis in preparation for sexual intercourse. Most of the lubricating, however, is provided by the female reproductive organs.

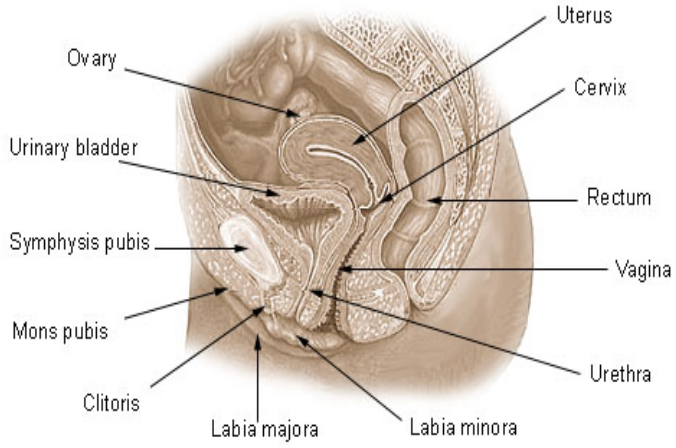
Male Sexual Response and Hormonal Control

- The male sexual response includes erection and orgasm accompanied by ejaculation of semen. Orgasm is followed by a variable time period during which it is not possible to achieve another erection.
- Three hormones are the principle regulators of the male reproductive system.
- Follicle-stimulating hormone (FSH) stimulates spermatogenesis; luteinizing hormone (LH) stimulates the production of testosterone; and testosterone stimulates the development of male secondary sex characteristics and spermatogenesis.

Female Sexual Anatomy And Physiology

The organs of the female reproductive system produce and sustain the female sex cells (egg cells or ova), transport these cells to a site where they may be fertilized by sperm, provide a favorable environment for the developing fetus, move the fetus to the outside at the end of the development period, and produce the female sex hormones. The female reproductive system includes the ovaries, Fallopian tubes, uterus, vagina, accessory glands, and external genital organs.

Organs of the Female Reproductive System



a) Ovaries

The primary female reproductive organs, or gonads, are the two ovaries. The ovaries are a pair of oval or almond-shaped glands which lie on either side of the uterus and just below the opening to the fallopian tubes. The ovaries are located in shallow depressions, called ovarian fossae, one on each

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side of the uterus, in the lateral walls of the pelvic cavity. They are held loosely in place by peritoneal ligaments.

Each ovary is a solid, ovoid (3dimensional egg shaped) structure about the size and shape of an almond, about 3.5 cm in length, 2 cm wide, and 1 cm thick.

- They produce eggs or "ova," and are homologous (have the same value) to the testes of the male.
- In addition they manufacture female sex hormones called *estrogen* and *progesterone* that prepare and maintain the uterus for implantation of the fertilized ovum.

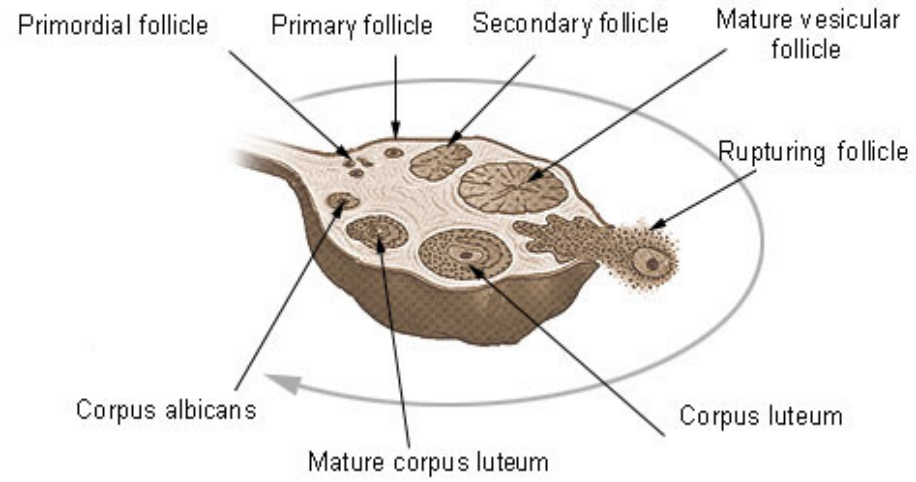
- In physically mature female, ovulation is generally assumed to occur alternately in each ovary, but one ovary may discharge several times in succession.
- A single egg is usually released during ovulation; however, two or more ova may be discharged. Generally all women ovulate once in a month, but additional egg may be discharged in the month especially during the peak of sexual excitement; this may lead to impregnation occurring during the so-called ‘safe’ period (the time in a menstrual month at which conception is considered less likely).

- The female, unlike the male, does not manufacture the sex cells.
- A girl is born with about 60,000 of these cells, which are contained in sac-like depressions in the ovaries.
- Each of these cells may have the potential to mature for fertilization, but in actuality, only about 400 ripen during the woman's lifetime.

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Structure of an Ovary



b) Fallopian Tubes

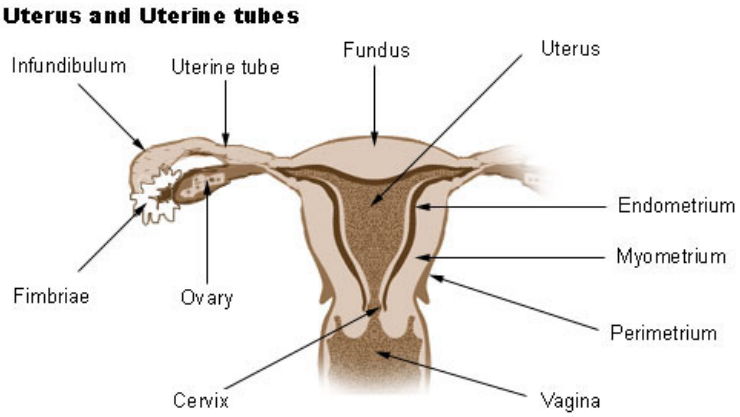
- There are two uterine tubes, also called Fallopian tubes or oviducts.
- There is one tube associated with each ovary.
- The fallopian tube extends from the uterus to the ovary.
- This tube carries eggs and sperm and is where fertilization of the egg, or "ovum" takes place.
- The fallopian tubes lie in the pelvic portion of the abdominal cavity and each tube reaches from an ovary to become the upper part of the uterus.
- The end of the tube near the ovary expands to form a funnel-shaped infundibulum, which is surrounded by fingerlike extensions called fimbriae.
- This funnel-shaped tube is about three inches in length.
- The larger end of the funnel is divided into feathery, finger-like projections which lie close to the ovary.
- These beating projections, along with muscle contractions, force the ovum down the funnel's small end, which opens into the uterus.
- Fertilization occurs in the ampulla portion of the fallopian tube which cups the ovary and picks up each ovum as it is discharged.
- The conceptus (fertilized ovum) is then swept by tiny, hair-like projections called cilia towards the uterus.
- After sexual intercourse, sperm swim up this funnel from the uterus.

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- The lining of the tube and its secretions sustain both the egg and the sperm, encouraging fertilization and nourishing the egg until it reaches the uterus.
- If an egg splits in two after fertilization, identical or "maternal" twins are produced. If separate eggs are fertilized by different sperm, the mother gives birth to un-identical or "fraternal" twins.

c) Uterus

The uterus is a hollow, thick-walled, pear-shaped muscular organ in the female reproductive system. The fallopian tubes enter the uterus at the upper, larger portion of the organ known as the *corpus* or *body*. During pregnancy the uterus expands to accommodate a developing embryo. It is located between the urinary bladder in front and the rectum behind, and sits above the vagina. The cavity of the uterus is a flattened space and its total length is 2.5inches. It usually tilts forward at a ninety degree angle to the vagina, although in about 20% of women, it tilts backwards. After childbirth, the uterus is usually larger and then regresses after menopause.



The uterus is lined with tissues which change during the menstrual cycle. These tissues build under the influence of hormones from the ovary. When the hormones withdraw after the menstrual cycle, the blood supply is cut off and the tissues and unfertilized egg are shed as waste.

- During pregnancy, the uterus stretches from three to four inches in length to a size which will accommodate a growing baby.
- During this time, muscular walls increase from two to three ounces to about two pounds and these powerful muscles release the baby through the birth canal with great force.
- The womb shrinks back to half its pregnant weight before a baby is a week old.

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- By the time the baby is a month old, the uterus may be as small as when the egg first entered.
- The flattened cavity narrows to a tiny opening near the center of the organ, this continues through the cervix (the lower end of the uterus) as an opening smaller than a soda straw. A girl's first menses is celebrated in some societies, because it is a sign that she can bear children.

d) Cervix

- The lower narrow, tubular one-third portion of the uterus is called the cervix and it protrudes downward into the opening of the vaginal canal.
- The cervix surrounds the opening called the "cervical orifice," through which the uterus communicates with the vagina.
- The cervix is smaller than the body of the uterus, the size ratio in mature women is about one to two. In newborn females this ratio is reversed, the cervix is twice as large as the corpus; while in young children the ratio is about one to one.

e) Vagina

- The vagina is a muscular passage which forms a part of the female sex organs and which extends from the neck of the uterus (cervix) connecting it with the external genitals.
- It is capable of considerable dilation.
- The vagina, which is approximately three inches long on the front wall and 3.5 inches on the back wall, has muscular walls which are supplied with numerous blood vessels.
- These walls become erect when a woman is aroused as extra blood is pumped into these vessels.
- It is located between the rectum and the urinary bladder. Because the vagina is tilted posteriorly as it ascends and the cervix is tilted interiorly, the cervix projects into the vagina at nearly a right angle. About 1/3 to ½ inch of the cervix extends into the vagina, providing a path for the sperms' passage into the fallopian tubes where they meet the ovum if fertilization takes place.
- **The vagina has three functions:**

✓ A receptacle for the erect penis during love-making;

✓ An outlet for blood during menstruation/ passageway for menstrual flow

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- ✓ A passageway for the baby to pass through at birth/ the birth canal during childbirth.

The vagina tube elongate somewhat during sexual excitation. The walls of a vagina are in contact with each other under ordinary conditions, they have a wrinkled appearance and contain an intricate network of erectile tissue which helps to dilate and close the vaginal channel.

- ➢ During pregnancy the cervix is closed by a mucous plug which separates the uterus from the vagina and keeps bacteria and undesirable matter from entering the uterus, thus reduces the possibility of infections in the uterus.

During sexual intercourse, as sexual excitement builds, small beads of 'sweat' appear on the vaginal surface. The vaginal muscles occasionally contract suddenly bringing the vagina walls together thus forcing secretions out in a spurting manner. These secretions plus the contractions that accompany orgasm are probably the cause of a mistaken notion that women ejaculate. The sweat merely serves as a lubricant for the penile penetration to make intercourse easier to perform.

f) Hymen

The hymen/maidenhead is the fold of connective tissue that partially closes the external opening of the vagina. It may prevent full penetration of the penis and if intact it is usually ruptured by the first act of sexual intercourse. It can be ruptured by masturbation or other sexual experimentation.

g) External Genitalia (Vulva)

The external genitalia are the accessory structures of the female reproductive system that are external to the vagina. They are also referred to as the *vulva* or *pudendum*. The external genitalia include the following:

- ➢ mons pubis,/ Mons veneris
- ➢ labia majora,
- ➢ labia minora,
- ➢ clitoris,
- ➢ the vestibule.
- ➢ the outer one-fifth of the vagina

- *The clitoris* The clitoris is a very small cylindrical erectile structure which terminates in the glans or head. It is a, sensitive organ with numerous nerve endings that, like the penis, contain tissues which fill with blood when sexually aroused. It is underneath the upper part of the labia minora where the two lips join to form the clitoris prepuce.

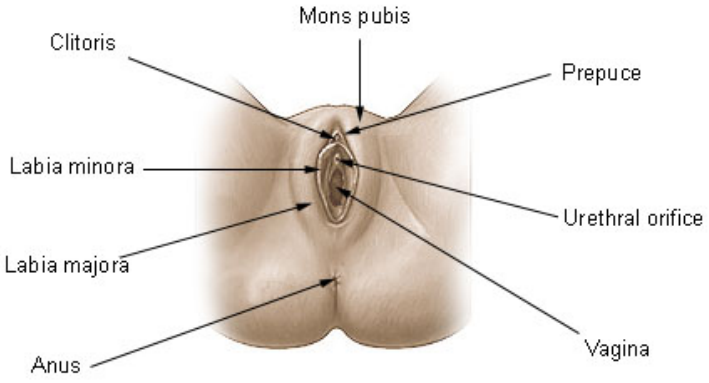
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Like the penis it is composed of spongy erectile bodies which become engorged with blood and erect when stimulated

- *Mons pubis,/ Mons veneris*: is a small, rounded pad made up of fat which protects the pubic bone it is covered with springly curly hair. Certain nerve endings concentrated in thie area can produce sexual excitement when stimulated by weight, pressure etc
- *Labia majora*: Reaching down almost to the anus are two longitudinal folds of fatty tissueor skin which arise from the mound of mons veneris, called the "larger lips," to protect the inner genitals. These folds bear pubic hair on their their outer sides sweat glands on their inner side.
- *Labia minora:* Just inside are two "smaller lips," which enclose the opening of the urethra (which comes down from the bladder) and the vagina. they are also two longitudinal folds located within the major lips. They are rich in blood vessels,nerve endings, and small sebaceous glands, they contain no hair or fat cells. They are highly erogeneous (sexually sensitive). Under influence of stimulation they flare out, exposing the vestibule, while normally the lips are together.

Female External Genitalia



h) The Mammary Glands

The mammary glands are accessory organs of the female reproductive system that are specialized to secrete milk following pregnancy. They are located in the subcutaneous tissue of the front thorax within the elevations which are called breasts. A "nipple" is located near the tip of each breast, and it is surrounded by a circular area of pigmented skin called the "areola." A mammary gland is composed of fifteen to twenty irregularly shaped lobes, each of which includes alveolar glands, and a duct (lactiferous duct) that leads to the nipple and opens to the outside. The lobes are separated by dense

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connective tissues that support the glands and attach them to the tissues on the underlying pectoral muscles. Other connective tissue, which forms dense strands called "suspensory ligaments," extends inward from the skin of the breast to the pectoral tissue to support the weight of the breast. The breasts are really modified sweat glands, which are made up of fibrous tissues and fat that provide support and contain nerves, blood vessels and lymphatic vessels.

Female Sexual Response and Hormonal Control

The female sexual response includes arousal and orgasm, but there is no ejaculation. A woman may become pregnant without having an orgasm. Follicle-stimulating hormone, luteinizing hormone, estrogen, and progesterone have major roles in regulating the functions of the female reproductive system.

At puberty, when the ovaries and uterus are mature enough to respond to hormonal stimulation, certain stimuli cause the hypothalamus to start secreting gonadotropin-releasing hormone. This hormone enters the blood and goes to the anterior pituitary gland where it stimulates the secretion of follicle-stimulating hormone and luteinizing hormone. These hormones, in turn, affect the ovaries and uterus and the monthly cycles begin. A woman's reproductive cycles last from menarche to menopause.

The monthly ovarian cycle begins with the follicle development during the follicular phase, continues with ovulation during the ovulatory phase, and concludes with the development and regression of the corpus luteum during the luteal phase. The uterine cycle takes place simultaneously with the ovarian cycle. The uterine cycle begins with menstruation during the menstrual phase, continues with repair of the endometrium during the proliferative phase, and ends with the growth of glands and blood vessels during the secretory phase.

Menopause occurs when a woman's reproductive cycles stop. This period is marked by decreased levels of ovarian hormones and increased levels of pituitary follicle-stimulating hormone and luteinizing hormone. The changing hormone levels are responsible for the symptoms associated with menopause.

SEXUAL AROUSAL AND RESPONSE

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Introduction

Sexual arousal, or sexual excitement, is the arousal of sexual desire, during or in anticipation of sexual activity. Things that precipitate human sexual arousal are called erotic stimuli, or colloquially known as turn-ons. There are many potential stimuli, both physical or mental, which can cause a person to become sexually aroused. Sexual arousal usually leads to physiological changes in the aroused person, some of which are pronounced while others are more subtle. We are therefore going to discuss the process and factors that leads to sexual arousal and the physiological and psychological response

Human Sexual Arousal

- Depending on a situation, a person can be sexually aroused by a variety of factors, both physical or mental. A person may be sexually aroused by another person or by particular aspects of that person, or by a non-human object.
- Sexual arousal may not lead to an actual sexual activity, beyond a mental arousal and the physiological changes that accompany it. Given sufficient stimulation, sexual arousal in humans will typically end in an orgasm; but arousal may be pursued for its own sake, even in the absence of an orgasm.
- A physical stimulation of an erogenous zone or acts of foreplay can result in arousal, especially if it is accompanied with the anticipation of imminent sexual activity. Sexual arousal may be assisted by a romantic setting, music or other soothing situation. The potential stimuli to sexual arousal vary from person to person, and from one time to another, as does the level of arousal.
- Stimuli are generally classified according to the sense involved: somatosensory (touch), visual, and olfactory (scent). Auditory stimuli are also possible, though they are generally considered secondary in role to the above-stated three.
- Erotic stimuli which can result in sexual arousal can include conversation, reading, films or images or a smell or setting, any of which can generate erotic thoughts and memories in a person.
- Given the right context, these may lead to the person desiring physical contact, including kissing, cuddling, and petting of the erogenous zones. This may in turn make the person desire direct sexual stimulation of those parts of their body which would normally be out of bounds, such as breasts, nipples, buttocks and/or genitals, and to sexual activity.

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- When sexual arousal is achieved by or dependent on the use of objects, it is referred to as sexual fetishism, or in some instances, a paraphilia. A person can take an active part in a sexual activity without sexual arousal.

Factors That Influence Sexual Arousal

The motivation to engage in sexual behavior has two roots: in external world and within ourselves

- ✓ External is through attraction of another person
- ✓ Internal – individual identity e.g. Sexual Orientation, biological and age

Sexual arousal may be caused by a sexually attractive person or by a particular aspect of the person.The following are the three major factors that influence sexual arousal:

a. Biological factors

- Sexual arousal and response are physiological reactions to sexual stimuli
- The body releases hormones when a person is sexually stimulated.Some of these hormones like testosterone decreases in age affecting the male sexual response.
- The ability to respond to sexual stimuli can be affected by illness, injuries or physical disabilities.
- The use of some drugs and alcohol can alter the sexual response.

b. Psychological factors

- Our feelings towards our partners influence the sexual response derived
- Our level of experience influences our response to sexual stimuli
- Learned attitudes and behaviours include discovering stimuli to which we respond to
- Body image influences our self concept. The better we feel about ourselves, the sexier an image we portray to others

c. Sociocultural factors

- Religious beliefs influence our feelings about sexuality in general. Culture and ethnic heritage influence what we find sensual or attractive.
- Media and adverts influence the types of sexual stimualtion to which they react.
- The society,including family, neighbours and friends provide information that influence our sexuality.
- Ethical decisions must be made regarding how far the two parties are willing to go to achieve sexual arousal.

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Physiological Changes

- Sexual arousal for a man is usually indicated by the swelling and erection of the penis when blood fills the corpus cavernosum.
- This is usually the most prominent and reliable sign of sexual arousal in males. In a woman, sexual arousal usually leads to vaginal lubrication in anticipation of sexual intercourse.

Female physiological changes:

- The beginnings of sexual arousal in a woman's body is usually marked by vaginal lubrication (wetness), swelling and engorgement of the external genitals, and enlargement of the vagina. When the female is sexually aroused, the vulva is wet and the labia are slightly engorged.
    - ✓ Erection of nipples
    - ✓ Vaginal lubrication
    - ✓ Vasocongestion of the vaginal walls
    - ✓ Tumescence and erection of the clitoris and labia
    - ✓ Elevation of the cervix and uterus, and expansion of the back of the vagina
    - ✓ Change in shape, color and size of the labia majora and labia minora
    - ✓ Pupil dilation
- Further stimulation can lead to further vaginal wetness and further engorgement and swelling of the clitoris and the labia, along with increased redness or darkening of the skin in these areas. Further changes to the internal organs also occur including to the internal shape of the vagina and to the position of the uterus within the pelvis.
- Other changes include an increase in heart rate as well as in blood pressure, feeling hot and flushed and perhaps experiencing tremors. A sex flush may extend over the chest and upper body.
- If sexual stimulation continues, then sexual arousal may peak into orgasm. After orgasm, some women do not want any further stimulation and the sexual arousal quickly dissipates. Some women have experienced such multiple orgasms quite spontaneously.
- While young women may become sexually aroused quite easily, and reach orgasm relatively quickly with the right stimulation in the right circumstances, there are physiological and psychological changes to women's sexual arousal and responses as they age.
- Older women produce less vaginal lubrication and studies have investigated changes to degrees of satisfaction, frequency of sexual activity, to desire, sexual thoughts and fantasies,

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sexual arousal, beliefs about and attitudes to sex, pain, and the ability to reach orgasm in women in their 40s and after menopause.

- Other factors have also been studied including socio-demographic variables, health, psychological variables, partner variables such as their partner's health or sexual problems, and lifestyle variables. It appears that these other factors often have a greater impact on women's sexual functioning than their menopausal status
- Reduced estrogen levels may be associated with increased vaginal dryness and less clitoral erection when aroused, but are not directly related to other aspects of sexual interest or arousal. The uterus typically contracts during orgasm, and with advancing age, those contractions may actually become painful.

Male physiological changes

Male sexual arousal.

- Penile tumescence and erection
- The veins in the penis may become more prominent
- Tightening and/or retraction of the foreskin (unless circumcised) often exposing the glans penis
- Emission of pre-ejaculatory fluid
- Swelling of the testes
- Ascension of the testes
- Tensing and thickening of the scrotum
- Pupillary response

- It is normal to correlate the erection of the penis with male sexual arousal. Physical or psychological stimulation, or both, leads to vasodilation and the increased blood flow engorges the three spongy areas that run along the length of the penis (the two corpora cavernosa and the corpus spongiosum).
- The penis grows enlarged and firm, the skin of the scrotum is pulled tighter, and the testes are pulled up against the body. However the relationship between erection and arousal is not one-to-one. After their mid-forties, some men report that they do not always have an erection when they are sexually aroused.
- Equally, a male erection can occur during sleep (nocturnal penile tumescence) or at any time simply due to a full bladder. A younger man can experience enough sexual arousal to create an

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erection from a passing thought or just the sight of a passer by. Once erect, his penis may gain enough stimulation from contact with the inside of his clothing to maintain and encourage it for some time

- As sexual arousal and stimulation continues, it is likely that the glans or head of the erect penis will swell wider and, as the genitals become further engorged with blood, their colour deepens and the testicles can grow up to 50% larger. As the testicles continue to rise, a feeling of warmth may develop around them and the perineum. With further sexual stimulation, the heart rate increases, blood pressure rises and breathing becomes quicker.
- The increase in blood flow in the genital and other regions may lead to a sex flush sometimes, in some men.
- As sexual stimulation continues, the muscles of the pelvic floor, the vas deferens (between the testicles and the prostate), the seminal vesicles and the prostate gland itself may begin to contract in a way that forces sperm and semen into the urethra inside the penis. This is the onset of orgasm and it is likely, once this has started, that the man will continue to ejaculate and orgasm fully, with or without further stimulation.
- Equally, if sexual stimulation stops before orgasm, the physical effects of the stimulation, including the vascongestion, will subside in a short time. Repeated or prolonged stimulation without orgasm and ejaculation can lead to a mild discomfort in the testes that is sometimes erroneously called ' blue balls'.
- After orgasm and ejaculation, men, like women, usually experience a refractory period characterised by loss of erection, a subsidence in any sex flush, less interest in sex, and a feeling of relaxation that can be attributed to the neurohormones oxytocin and prolactin.
- The intensity and duration of the refractory period can be very short in a highly aroused young man in what he sees as a highly arousing situation, perhaps without even a noticeable loss of erection. It can be as long as a few hours or days in mid-life and older men

Sexual response and the brain

The brain has a pleasure center that lets us know when something is enjoyable and reinforces the desire for us to perform the same pleasurable action again. This is the **reward circuit**, which includes all kinds of pleasure, including sex. Some of the brain areas responsible for pleasurable actions include:

- *amygdala* - regulates emotions
- *nucleus accumbens* - controls the release of dopamine

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- *ventral tegmental area (VTA)* - releases the dopamine
- *cerebellum* – controls muscle function
- *pituitary gland* - releases beta-endorphins, which decrease pain; oxytocin increases feelings of trust; and vasopressin, which increases bonding

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When we are first exposed to sexually arousing stimuli, certain neurochemical changes take place. Our brain releases dopamine, a neurotransmitter that has several functions including pleasure, arousal, desire, and attraction, motivation and drive, to name a few. Because of the strong association, dopamine has with both arousal/desire and motivation, it is also thought to play a role in addiction.

Dopamine and oxytocin plays a major role in enhancing pleasure. After our brain releases dopamine, we feel attracted to the object of our attention. We are then compelled to draw closer to it and to experience it more fully. If we are stimulated enough to a point of high arousal, like right before or during orgasm, oxytocin is triggered. Oxytocin is a neurotransmitter that is associated with attachment. When we closely interact with a person or object, and our brain releases oxytocin, we naturally form an attachment to it. Oxytocin has been found to play a big role in mother-baby bonding.

The dopamine-oxytocin release is the reason why after having sex people suddenly feel more bonded to each other emotionally. Fantasy and creation of sexual images in the mind, can trigger the brain to respond neurochemically, even in the absence of tactile stimuli.

Orgasms and Nerves

Just like any other area of the body, the genitalia contain different nerves that send information to the brain to tell it about the sensation that's being experienced. This helps to explain why the sensations are perceived differently depending on where someone is being touched. A clitoral orgasm, for example, differs from a vaginal orgasm because different sets of nerves are involved.

All of the genitalia contain a huge number of nerve endings (the clitoris alone has more than 8,000 of them), which are, in turn, connected to large nerves that run up through the body to the spinal cord. (The exception is the *vagus nerve,* which bypasses the spinal cord.) They perform many other functions in the body in addition to providing the nerve supply, and therefore feedback to the brain, during sexual stimulation.

The following are the nerves and their corresponding genital areas:

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- *Hypogastric nerve* – transmits impulses from the uterus and the cervix in women and from the prostate in men
- *Pelvic nerve* - transmits from the vagina and cervix in women and from the rectum in both sexes
- *Pudendal nerve* - transmits from the clitoris in women and from the scrotum and penis in men
- *Vagus nerve* - transmits from the cervix, uterus and vagina

We can conclude that during sexual stimulation and orgasm, different areas of the brain receive all of this information that lets it know exactly what is happening.

Sex hormones

Sex hormones are chemical substances produced by an endocrine gland that has a specific effect on the sexual activities of other organs in the body. The major female and male hormones can be classified as estrogens or androgens. Both classes of male and female hormones are present in both males and females alike, but in vastly different amounts. Male hormone testosterone (an androgen) is produce higher amount in men than women. Female hormones, estrogens, are also present in both sexes, but in larger amounts for women.

Estrogens

Estrogens are the sex hormones produced primarily by a female's ovaries that stimulate the growth of a girl's sex organs, as well as her breasts and pubic hair, known as secondary sex characteristics. Estrogens also regulate the functioning of the menstrual cycle. Estrogens are important in maintaining the condition of the vaginal lining and its elasticity, and in producing vaginal lubrication. They also help preserve the texture and function of a woman's breasts. In men, estrogens have no known function. An unusually high level, however, may reduce sexual appetite, cause erectile difficulties, produce some breast enlargement, and result in the loss of body hair in some men.

Androgens/ testosterone

Androgens are sex hormones produced primarily by a male's testes, but are also produced in small amounts by the female's ovaries and the adrenal gland, an organ found in both sexes. Androgens help trigger the development of the testes and penis in the male fetus. They jump start the process of puberty and influence the development of facial, body and pubic hair, deepening of the voice, and muscle development, the male secondary sex characteristics.

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After puberty, androgens, specifically testosterone, play a role in the regulation of the sex drive. Large deficiencies of testosterone may cause a drop in sexual desire, and excessive testosterone may heighten sexual interest in both sexes. However, testosterone levels are poorly correlated with sexual interest and drive when they are within the average range. Sex drive is much more likely to be affected by external stimuli (sights, sound, and touch) than by variations in sex hormones, except in extreme cases. Too little testosterone in men may cause difficulty obtaining or maintaining erections, but it is not clear whether testosterone deficiencies interfere with female sexual functioning apart from reducing desire.

However, there is no evidence whatsoever to suggest that because women have less testosterone than men do, they have lower sexual interest than their male counterparts. Instead, it seems that women detect and react to much smaller amounts of testosterone in their circulation than men do.

The sexual response cycle

During sexual arousal both blood pressure and heart rate rise. At the point of orgasm the heart rate has at least doubled. During orgasm muscular spasms affect various groups of muscles from the face downwards. Contraction of the rectum occurs as does, in some men more than others, sweating, flushing and erection of the nipples.They are two basic Physiological responses namely:

i. *Vasocongestions* – It occurs when a lot of blood flows into the blood vessels into the genitals as a results of dilatation of the blood vessels

ii. *Myotonia* – Occurs when Muscles contract in the body i.e inclusive of the Genitals

Masters and Johnson did a research to know how humans respond to sexual stimulation. They only accept people into their research who indicated that they reached orgasm. They came up with four stages for both male and female namely;

1. Excitement phase
2. Plateau phase
3. Orgasm phase
4. Resolution phase

Female sexual Response

1. **Excitement/ Desire Phase**

- There is vaginal lubrication within the first 10 to 20 seconds with effective stimulation
- Nipples become erect and breast Swells.
- The inner 2/3 of the vagina lengthens and distends in readiness to accept the penis.

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- The color of the vaginal wall changes from a purplish red to dark hue.
- There is involuntary muscle tension especially the rectal sphincter.
- The cervix and the Uterus pull up making an opening in the cervix that allow the sperms to move in to the Uterus more easily.
- A sex Flash resembles measles rush appear on the skin

2. Plateau Phase

- Vasocongestion reaches its peak
- The vaginal walls get so engrossed with Venus blood hence the vaginal opening increases with about a third.
- The labia minora undergoes a vivid color change from pink to bright ed. i.e. for those who have not given birth, for those who have given birth it changes from red to deep- wine color.
- The Clitoris retracts or draws up into the body.

3. Orgasm Phase (Climax)

- Breathing increases i.e. is three times more than normal
- Blood pressure goes up
- Heart rate increases to double. It is the peak of physical pleasure and most of the body muscles are tense. It lasts a few seconds to slightly less than a minute.
- The mind becomes focused inward on a gush of pleasure.
- The Uterus contracts rhythmically
- Some women may experience more than one orgasm.

4. Resolution Phase

- There is muscle relaxation.
- The swelling around the nipples disappear.
- The clitoris during the plateau and orgasmic phase retracts and at this phase it returns to normal size and shape.
- There is a feeling of relaxation and one goes to sleep.
- Some may feel like urinating.

The Male Sexual Response

1. Excitement Phase

- The person begins to have erotic thought of fantasies surrounding sex
- The penis gets erect and engrossed with blood.
- It can be maintained for very long time with careful control of stimulation.

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- Any destruction like a loud voice or change of environment will cause complete or partial lose of erection.
- Increased excitement leads to the scrotum being tense, congested and thick.

2. Plateau Phase

- The testes are pulled up and even closer to the body
- There is increased muscular tension
- The erection hardens.
- There is involuntary spasm of the face, neck and abdomen.
- A few drops of seminal fluid are emitted (a sudden abnormal involuntary muscular contraction).

3. Orgasmic Phase

- There is increase in breathing rate
- Heart rate goes up with blood pressure increasing as in the female phase.
- There is increased muscular tension all over the body.
- Involuntary contraction of the rectal sphincter.
- Ejaculation takes place and
- The longer the ejaculation the more the pleasure.

4. Resolution Phase

- The penis returns to its unstimulated size in two phases
- Half of the erection is lost very quickly, although scientists say that if the erection has been there for a long time, it is not going to return to normal.
- Lose of erection is now a slower process but it can still be retarded if the penis is retained in the vagina or if you hold the partner close to you.
- The Person enters re-fractory period, (not capable of being aroused again)
  "It depends"

NB: Problems may occur in any of the four phases of Sexual response Cycle .If problems related to arousals, desire or orgasms are recurrent and persistent they may be diagnosed as dysfunctions.

Controversies about orgasm

There has been alot of conflicting views about female orgasm.Compared to orgasm in male,female orgasm is complex and many research done has portrayed different findings. In early 1900s, Sigmund Freud theorized two different types of female orgasm;the clitorial and the vaginal orgasm. H e viewed

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clitorial orgasm as immature sexual response that women outgrow later in life. He considered the clitoris as a stunted penis. He believed the clitorial orgasm was an expression of masculine sexuality rather than feminine sexuality.

Master and Johnson (1966) identified one type of orgasm.Regardless of the point or method of stimulation,either clitorial or vaginal,there is the same physiological occurence during orgasm. However the sensation of orgasm depended on whether it was as a result of coital or non coital activities (coital activities involve penetration of the penis into the vagina while noncoital activities which include mutual masturbation, oral sex, and anal sex). This was validated by Hite (1976). They found that orgasm from coital is less intense than orgasm from non ciotal activities. The findings showed that clitorial stimuled orgasm is more intense than the orgasm from coitus. Hite also found that coital orgasm is more diffused throughout the body than the locally intense clitorial orgasm.

Other researchers like Singer & Singer, 1972 further reported three types of orgasm namely;

- *Vulva*- this is the same as described by Masters &Johnson
- *Uterine*-occurs only during vaginal penetration
- *And blended*-it is te combination of the above two,that is ,contraction of the outer third of the vagina and the penetration.

Despite the different views about female orgasm, what is important is that orgasm can be conceptualized as physiological reaction to sexual stimulation and a complex interraction between partners which involve other factors such as the setting of the room, mood etc.

SEXUAL TECHNIQUES, BEHAVIOR PATTERNS & SEXUAL ORIENTATION

Solitary Sexual Behavior

This involves lonesome pursuit of sexual thoughts and fantasies, use of erotic materials and toys. The most common solitary sexual behavior is masturbation, which involves self-stimulation of the genitals. Masturbation is common among adolescence and majority of people masturbate at some point in their lives. Some of the reasons for engaging in masturbation are: for relaxation, to relieve sexual tension, when partners are unavailable, to obtain physical pleasure and to help get to sleep. In the past, masturbation was prohibited by Jewish law and St. Augustine. It was viewed as physically and mentally harmful by the medical profession and some sexologists.

Masturbation in women

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Some women masturbate to get acquainted with their own sexual responsiveness and learn how to have an orgasm. According to Masters and Johnsons (1966), very few women use direct stimulation of glans clitoris. This is because the clitoris is too sensitive for any prolonged direct stimulation like the glans of penis. A more common way in which women masturbate is by manipulation of the entire mons area; this exerts less stimulation to the clitoris.

Although use of hands is the most common method of masturbation, some women use other means such as rubbing the mons against a pillow, bed, others insert finger, long shaped objects such as vibrators or flexible devices called dildos.

Some women are able to produce sexual arousal and orgasm by creating muscular tension in the pelvic region through tightening of the leg and abdominal muscles; others may cross their legs and apply rhythmic stimulation to the vulva by contracting and relaxing the thigh muscles. However, there are many individual differences in the ways women stimulate themselves for sexual pleasure.

Masturbation in men

According to Masters and Johnson, stimulation of the penis is a common method of masturbation among men. The penis is grasped by the hand and stroked until orgasm takes place. They stroke the shaft of the penis and others touch the top edge of the corona around the glans. Many males enjoy rubbing their penises on blankets, pillows, beds and other suitable objects.

A significant proportion of men try to put their penises into their mouth, a concept termed as *autofellatio*. Some other methods include inserting the penis in artificial vagina made of fleshy stimulating plastics.

Shared Sexual Behaviour

Currently, there are varied forms of shared sexual activities in addition to vaginal intercourse in heterosexual act.

a) Non genital oral stimulation

The lips, tongue and oral cavity are often associated with intimate, sexually arousing activity. Kissing is used to express affection in most parts of the world. It usually carries important messages concerning the depth of intimacy in a relationship. Kissing, licking or nibbling other parts of the body such as the abdomen, breasts, ears or genitals is also considered to be principally intimate by many. However, this varies from culture to culture and through individuals.

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b) Stimulation of erogenous zones

There are certain parts of the body that almost always generate sexual arousal when touched. The typical nongenital erogenous zones are the mouth, earlobes, breasts, buttocks, neck, lower abdomen, inner thighs and the anal perineal area. In a fulfilling sexual relationship, it is important for both partners to learn about the most pleasurable kinds of stimulation to exert on these zones.

The term *fellatio* refers to kissing and allowing the penis to move in and out of the mouth. *Cunnilingus* on the other hand involves kissing the clitoris, labia and the vaginal opening. Some chemicals and foods have been purported to act as sexual stimulants for those who consume them. These substances are known as *aphrodisiacs.* Examples of such substances are dried beetles, dried salamanders along with common food such as eggs, olives, peanuts, oysters, bananas among others. Some drugs such as cocaine, marijuana, and alcohol stimulates sexual arousal, however, this varies within individuals (Henderson, Boyd & Whitmarsh, 1995).

c) Intromission

Male-female sexual intercourse involves insertion of the penis into the vagina. Comfortable intromission requires suitable degree of penile erection, lubrication, relaxation of the vaginal opening and cooperation between the two partners.

Erection of the penis is a natural part of male sexual arousal and the vagina usually produces enough lubricant to permit easy movement of the penis in the vagina.

The vaginal opening is sometimes tense and gentle. If the outer vaginal muscle cannot relax to the point where intromission can take place comfortably, the woman may be experiencing vaginismus.

d) Intercourse

Intercourse usually involves movement of the penis in and out of the vagina,bresulting from pelvic movements of both partners. The rate and vigor of thrusting depend to a large degree on the mood of the couple and the duration which they wish to prolong coitus.

Rapid, forceful movements of the penis generally bring males to orgasm quite quickly and the amount of pre-coital stimulation is also important especially for women.

Positions of intercourse

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There are various body positions in which the penis may be comfortably inserted into the vagina. The positions couples find enjoyable depends on their individual characteristics such as body size and weight, degree of physical fitness, length and diameter of the erect penis , personal attitudes about particular positions and moods during the intercourse.

a) Man on top, woman supine

This is the most common position. This position gives the male maximum control over the coital thrusting since the female's pelvis is relatively immobile and allow deep penetration

b) Woman on top, man supine

The woman lies on the man with her legs fully extended, or may straddle him in a sitting, crouching or kneeling position. The position provides the woman more opportunity to control the coital movements and leaves the male's hands more free to caress her body. This position is more likely to result in orgasm for the female.

c) Side by side

Both partners lying on their sides. It causes less strain for both and are able to share in controlling their thrusting motions and both are free to use their hands for touching and caressing.

d) Both partners seated

Intercourse with the partners seated facing each other. The male sits on the chair /bed and woman sits on the man. The woman usually has greater control over the coital movements in this position.

e) Both partners standing

This is not very popular. Since the coital position may be difficult to manage and sustain. Deep penile penetration is also difficult while standing because the angles of the penis and vagina are not particularly complementary.

Sexual Orientation: Perspectives In Gay Male And Lesbian Sexual Orientation

Sexual orientation is a term used to describe a person's romantic, emotional or sexual attraction to another person. It also includes feelings as well as identity. A person attracted to another person of the same sex is said to have a *homosexual orientation* and may be called gay (both men and women) or lesbian. Individuals attracted to persons of the other sex are said to have a *heterosexual orientation and* individuals who are attracted to both men and women are said to be *bisexual.*

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Some people believe that sexual orientation is innate and fixed; however, sexual orientation develops across a person's lifetime. Individuals maybe become aware at different points in their lives that they are heterosexual, gay, lesbian, or bisexual.

Gay lifestyles

Fears and misunderstandings about homosexuality are wide spread. They present daunting challenges to the development and maintenance of a positive self-image in gay, lesbian and bisexual persons and often to their families as well. "Homophobia" is a term that refers to the irrational fear and prejudice against homosexual persons. Feelings toward gay men, lesbians and bisexuals have moved in a significantly positive direction. Nevertheless, homosexuals are still among the most stigmatized groups and their relationships are not legally recognized in most countries.

Coming Out

"Coming out" is the term used to describe the experience in which a person identifies himself or herself as gay, lesbian or bisexual. It is not a one-time event, but a lifelong process of identifying as gay, lesbian or bisexual to family friends and other significant members of one's social world. Each person's experience in coming out is unique and the process always stimulates anxiety as well as provides challenging possibilities for personal empowerment and emotional growth.

Patterns of sexual activity among gay males and lesbians

Some men fondle each other's genitals, shows loving gestures such as kissing, embracing and body stroking. Oral genital contact is common and most men practice fellatio and anal intercourse is practiced by few male couples. The practice of interfemoral intercourse (rubbing of one's penis on the other's abdomen) is also common.

Lesbians have a wide range of intimate activities. Compared to their male counterparts, they share sex less frequently but feels a greater sense of intimacy .Many of them use techniques such as kissing and generally body contact with one another .Manual manipulation of one another's genitals and finger penetration is one of the most frequently used forms of stimulation among the lesbian couples. They prefer oral- genital contact (cunnilingus) for reaching orgasm.

Women involved in a sexual encounter usually spend a longer period than male couples in gentle and affectionate foreplay. Single lesbians have sex less frequently than single gay men. Lesbians have relatively low levels of sexual activity when they are involved in a long term committed relationship. They often seem to prefer hugging and cuddling to more genitalized forms of sexual sharing

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CONCEPTION, PREGNANCY AND CHILDBIRTH

Introduction

Sexuality is linked with reproduction. One of the reasons for engaging in sexual activity is for childbearing. It is important to understand the biological, psychological and social impact in the child bearing process. It is in this view that we are going to discuss the child bearing process, from conception, pregnancy through to child birth.

CONCEPTION

Conception is the beginning of a new human life. It is the process whereby the sperm penetrates an ovum. These two microscopic cells carry the basic unit of heredity, the genes, which hold a complex and detailed design for building all the parts of the human body. More than one sperm cell may penetrate the ovum but only one can fertilize the ovum to create a new human being.

Sperm cells maintain their ability to fertilize an egg for a period of twenty four to forty eight hours and ova can be fertilized for a period of twenty four hours. Thus there is only forty eight hours during each menstrual cycle when conception can take place (pattern 1968). After fertilization the egg develops into a complex human being, differentiating into millions of cells specializing in hundreds of different functions. Each of these cells has the same hereditary information.

The genetics of conception

Every fertilized cell contains about 20,000genes. Genes play a major role in determining hereditary characteristics. There are millions of potential genotype or a combination of genetic makeup therefore it is hard to have a replica. Understanding how hereditary traits are transmitted help us to understand how birth defects and hereditary diseases occur.

The ova and the sperms are known as gametes. When the sperm cell penetrate and unites with an ovum, they form a single cell called a zygote. A normal zygote contains 46 chromosomes – 23 from the sperm and 23 from the ovum. The first 22 pairs of chromosomes are called autosomes. The 23 pairs of chromosomes are called sex chromosomes and they determine the child's sex.

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When a mature sperm fertilizes a mature ovum, each parent contributes 23 chromosomes of the genetic makeup of the new individual; 22 chromosomes and 1 sex chromosome. All normal mature ova contain one X chromosome. Normal mature sperm contain either an X (female producing) or a Y (male producing) chromosome and sperm containing X bearing and Y bearing chromosomes are produced in precisely equal numbers. Should the ovum be fertilized by an X bearing sperm, an XX (female) child is conceived. Should the ovum be fertilized by a Y bearing sperm, an XY (male) child is conceived. Thus it is the genetic characteristics of the newly conceived individual are equally given by his two parents, and the sex of the individual is determined by the kind of sperm which fertilizes the egg.

PREGNANCY

In the past, pregnancy and child birth were events into which women looked forward with an equal measure of joy and terror. Joy because producing and rearing children defined a whole purpose of a women existence, and terror not just because of the pain of child birth but because of grave risk that pregnancy would end in death of mother, baby or both.

How is pregnancy confirmed?

- When a woman becomes pregnant, the first signs she notices are a cessation of menstruation, nausea in the morning,
- Changes in the size and fullness of the breasts, dark colouration of the areole (the brown pigment area around the nipples, fatigue and frequency of urination.
- The uterus increases in size and the cervix softens.
- By the third month the abdomen is enlarged and there are slight intermittent contractions of the uterus.
- There are fetal heart beats, active fetal movements and x- ray detection of fetal skeleton.
- Despite the myths about the dangers of physical activity during pregnancy, moderate and sensible exercise is not dangerous for the healthy woman, and is often beneficial.
- Sexual intercourse is also encouraged during pregnancy until the final week.

Prenatal development

The fertilized ovum is called a conceptus from the moment of fertilization (conception) until its delivery. Three general stages of conceptus development are differentiated: it is first a zygote, then embryo and finally a fetus.

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(i) Germical stage (10days – 2 weeks)

- This stage begins at conception when the egg is fertilized and ends when the fertilized egg implants itself in the lining of the womb wall, which takes place about 2 weeks after conception.
- By this time the zygote is called a blastocyst. The zygote may die at this stage if implantation is not in a favourable location. If implantation occurs in the fallopian tubes it is called Ectopic pregnancy.
- The zygote may survive for 6-8weeks in the fallopian tubes before they rupture and the blastocyst dies. But if the environment is favourable, the blastocyst will continue to develop to be an embryo.

(ii) Embryonic stage (2 – 8 weeks)

- This stage starts from the second to eight week of gestation. Rapid cell duration and differentiation takes place during this stage. The inner cells differentiate into three distinct layers: the Ectoderm, Endoderm and Mesoderm.
- The *ectoderm* is the outermost layer which will later form the skin, teeth, hair and nervous system. The *endoderm* will develop into most of the body organs including the liver, pancreas and the lungs. The *mesoderm* (middle layer) will develop into muscles, the skeletal system and circulatory system.
- Before the body of the embryo has taken its shape, the amnion, a thin transparent tough membrane, forms. Within its hollow cavity is a clear watery fluid called the amniotic fluid. It equalizes the pressure around the embryo preventing jolts and injuries and the embryo from forming adhesions to the amnion.
- During the fifth week of pregnancy, the umbilical cord is formed by which embryo is suspended in the amniotic fluid. Fully developed cord is about 20 inches long.

  NB: because of rapid growth at this stage, the embryo is very vulnerable to environmental influences. Almost all development birth defects such as cleft palate, incomplete or missing limbs, deafness or blindness occur during this critical first trimester of pregnancy. The most defective embryos usually do not survive beyond this time and are aborted spontaneously. By the end of the 8^{th} week, the embryo has all of the organ systems and body parts in a rudimentary form except the sex organs.

(iii) Foetal stage (8 weeks until birth)

- The term foetus means “offspring”. Formation of the major organs and body parts continue during this stage. The basic structure of the body’s major organs, organs systems and body parts

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are usually complete by the end of the first trimester (12 weeks after conception). The central nervous system further develops and continues to do so until several months after birth. The sex of the foetus is now distinguishable.

- Foetal movement is distinct. The foetus kicks and can react to sound. The primitive skeleton is beginning to harden and the body and face appear more human.

Hazard to normal prenatal development.

- About 20% of the handicaps are due to hereditary while another 20% are caused by environmental factors such as drugs, vitamin deficiencies or vital infections. The rest 60% are due to the interaction of environment factors and genetic predisposition of the individual.
- Teratogenic agents are environmental factors that interfere with the development of an embryo and are responsible for producing physical defects in the embryo. These agents include viruses such as rubella, radiation (x-ray), chemicals and environmental pollution, and drugs (thalidomine, aspirin)
- Material influences including age of the mother, material nutrition, material emotions and stress, fever, diabetes and toxemia all affect normal pre-natal development.
- An immunological factor that is most commonly encountered is incompatibility between maternal and infant blood factors such as in case of Rh factor incompatibility. Genetic mutations in the ova due to exposure to radiation, drug or chemicals may be responsible for various inborn congenital anomalies especially after 45 years.

Stages of pregnancy

Pregnancy is convectional divided into three trimesters:

i) First trimester (from the first day to three months)

The foetus takes control of the mother's body in many respects. The oestrogen and progesterone enters the mother's circulation eventually rising to the levels that have never been experienced at any other time. The following are the symptoms and signs during the first trimester:

- Amenorrhoea-The absence of menstruation is the first symptom of pregnancy.
- Nausea excessive salivation, vomiting, swelling and tenderness of the breasts due to the developing placenta which produces hormones as soon as pregnancy is established

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- During the first twelve weeks the woman has frequent urge to urinate. This is due to the enlarging uterus which is still in the pelvis pressing the bladder.
- The woman feels depressed and generally weakly and tired. the cause is not established but it may be hormonal. These symptoms usually start about sis weeks after the date of the last menstrual period when the level of chorionic hormones rises appreciably.
- The cervix becomes bluish in colour because of the increase vascularity and congestion with blood, it also becomes softer.

ii) Second trimester (13-24 weeks)

Symptoms include:

- The woman feels generally better in health. Nausea and vomiting decrease and later disappear.
- Between the 18th and 20 weeks of pregnancy, the mother feels the fetal movements or quickening.

iii) Third trimester (25 weeks to birth)

- During the last trimester, the foetus is much bigger. The mother might get backache and low abdominal pain due to pressure of the head and the baby.
- Due to the pressure, she might also feel abit breathless and have hyperacidity as the enlarging uterus presses on the lungs and stomach.
- The foetal heart sounds can be heard. The rate varies between 120 to 160 beats per minute. Its is important to note that during this stage, the mother may experience false labour.
- During this trimester, the mother should undergo child birth classes which are normally referred to as Lamaze classes(Lamaze 1981).This are basically breathing exercises, techniques for relaxing perineal muscle and techniques for focussing attention away from potentially painful sensations during labour.
- During the third trimester (27 – 38 weeks) the foetus gains weight by developing fatty tissues under the skin which will insulate it from the outer environments where the temperature is much lower and unstable.
- Just before birth the brain and other central nervous system develop further with a general finishing of the various body systems. The placenta reaches its maximum size and working capacity. Full term has now been reached and the baby is ready to be born.

NB: The chance of survival is minimal if a foetus were to be born at 24 weeks. However by the end of second trimester (13 – 26 weeks) the foetus has a good chance of surviving. The expected birth

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date can be estimated by adding 280 days to the date on which the mother's last menstruation started. Although about 3out of 5 pregnancies last 300 days or more, placental withering may occur after an overlong gestation increasing the possibility of infant death.

The functions of a placenta

- *Formation of hormones*- Chorionic gonadotrophin maintains the pregnancy and encourages changes in the breast, vagina, and cervix to anticipate the birth of the baby
- *Respiratory exchange*(Gaseous exchange)-The placenta provides the foetus with the surface from which to receive well oxygenated blood in exchange for its carbon dioxide laden blood.
- *Transfer of nutrients*-It takes place a cross the placenta with various substances necessary for normal foetal growth being brought by maternal blood stream.
- *Excretion of waste* -Waste passes in the opposite direction to the foodstuffs in solution. Nitrogen containing waste products are also excreted into amniotic fluid in the form of foetal urine.
- *Formation of barrier against harmful substances* in the maternal blood stream. These are mostly drugs, bacteria or viruses

The Amniotic fluids

- The amniotic fluid fills the space occupied by the amnion (the innermost membrane enclosing the fetus) its constantly in circulation being secreted by the placenta and amnion itself.
- Later in pregnancy, the fetus swallows the fluid and passes it out as urine so that towards full term there are two circulation of the amniotic fluid, one through the fetus and one through the maternal blood stream via the placenta and membranes.
- It has another function as the fluid forms weightless environment in which the fetus can develop using as little energy as possible. In order to develop muscle, there has to be movement and if such movement takes place in fluid filled cavity, a minimal number of calories are used in the process

CHILD BIRTH

The process of child birth or parturition takes place in three stages;

1. Labour stage:

- When contraction of uterus commence-usually 15-20 minutes intervals.
- Initially, each contraction lasts 30seconds, then increase steadily in frequency until they finally occurs every 3-4minutes at which the fetus is on its way.
- The cervix dilates from its normal size of about one-eighth inch to approximately 4inches.

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- There is expulsion of the mucous plug from the base of the uterus and the rupture of the amniotic membrane with a resulting flow of clear water - like fluid from the vagina.

2. Expulsion/delivery stage;

- The second stage extends from time the cervix is completely dilated until the fetus is expelled.
- When the infant's head emerges from the vagina, it turns spontaneously to right or left, depending upon the way the shoulders are turned. After expulsion, delivery of the rest of the infant is a simple matter because the trunk and limbs are quite small in comparison to the head and shoulders.
- Over 99% of all infants are born in a longitudinal position. (Body trunk presented vertically) with their heads first.

3. Placental separation/expulsion stage:

- About15minutes after birth, the placenta is delivered.
- Muscular contractions shrink the uterus and the area of placental attachment detaching the placenta from the uterine wall and expelling it into the vagina.
- The cord is then clamped and cut about three centimeters/inches from the infant's abdomen. The clamp is left in place until the stub dries up and drops off.

Lactation

It is the process of milk secretion from the mother's breasts following child birth. The placenta not only provides for development of the fetus, but also produces hormones that prepare the mammary glands in the breasts for secretion of milk. The same hormones inhibit the pituitary gland from producing the milk forming chemical until such time as it is needed. Although breastfeeding prolongs the absence of menstruation following childbirth, it is possible for a woman to ovulate before her first postpartum (after birth) menstruation flow. About one woman out of twenty becomes pregnant again without having menstruated after childbirth.

CHILD BIRTH PROBLEMS

Sometimes complications occur during pregnancy and birth. About one out of four pregnancies experiences some potentially serious complication. Currently the infant mortality rate is high in Kenya and other countries in Africa. Childbearing takes its toll on mothers as well and many women die each year around the globe in pregnancy and child bearing. Most of these occur as a result of inadequate medical care.

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In 45 of longitudinal births, the buttocks are presented first *(breech birth*),resulting in temporary swelling and discoloration of the infant's buttocks and genital areas.50% of infants assume the breech presentation prior to the seventh month of fetal life, then make a 180^0 turn before the ninth month. One in every 200 births, the fetus lies crosswise with a shoulder, arm or hand entering the birth canal first. In this case, either the fetus must be turn during labour or a caesarean section (surgical incision in the abdominal and uterine walls) must be performed.

Pregnancy induced hypertension

This problem begins with a rise in blood pressure, swelling in the ankles and other parts of the body and protein components appearing in the urine. If not treated it can lead to life threatening conditions for the mother such as blindness, convulsions or coma. It also increases the risk of stroke during the first few weeks after birth.

Premature birth

This is any birth that takes place before the 37^{th} week of pregnancy. This occurs commonly in fetuses that are growing more slowly than they should be and it's most common in male foetus. The more a prematurely baby is born, the lower its chances of survival. More than 60 percent of infants born at 22 to 25 weeks of gestation die prior or during birth or within 6months of delivery. Respiratory problems, cranial abnormalities and other complications are common. Although the cause of a premature birth is not always known, it is common particularly among teenage mothers, women who smoke or have a genitourinary tract infection during their pregnancies, high stress, inadequate nutrition or lack of proper prenatal medical care. In some cases the foetal membrane rupture earlier leading to premature delivery.

Rh incompatibility-RHESUS-

The Rh factor is a blood protein; that may be either Rh positive if it contains this factor or Rh negative if it does not. A baby has its own blood type as the result of a genetic combination from the father and mother. If the mother has Rh negative blood and her baby is Rh positive, the mother's body will begin to produce antibodies that Pregnancy is convectional divided into three trimesters:

Postpartum period

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This is the period after birth. Many women experience feelings of sadness and periods of crying sometimes during the first 10 days after delivery. These postpartum blues are attributed partly to psychological factors and partly to the drastic hormonal changes which occurs at this time.

There are many physical and psychological adjustments to be made by both the mother and the child. At this stage the mother's body returns to its pre-pregnancy state, the reproductive organs must recover and internal hormonal balances are re-established. This can be a very emotional period and support from significant others is very important to the mother. Some women experience a brief period of post partum depression which is characterized by low energy levels, feelings of being overwhelmed by new responsibilities and sleep disturbances.

INFERTILITY

What are the causes of infertility?

A wide range of physical and emotional factors can cause infertility. Infertility may be due to problems in the woman, man, or both.

Female Infertility

Female infertility may occur when:

- A fertilized egg or embryo does not survive once it sticks to the lining of the womb (uterus)
- The fertilized egg does not attach to the lining of the uterus
- The eggs cannot move from the ovaries to the womb
- The ovaries have problems producing eggs

Female infertility may also be caused by the following health problems:

- Cancer or tumor
- Clotting disorders
- Diabetes
- Growths (such as fibroids or polyps) in the uterus and cervix
- Birth defects that affect the reproductive tract
- Excessive exercising
- Eating disorders or poor nutrition
- Use of certain medications, including chemotherapy drugs
- Drinking too much alcohol
- Obesity

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- Older age
- Ovarian cysts and polycystic ovary syndrome (PCOS)
- Pelvic infection or pelvic inflammatory disease (PID)
- Scarring from sexually transmitted infection, previous abdominal surgery, or endometriosis
- Smoking
- Surgery to prevent pregnancy (tubal ligation) or failure of tubal ligation reversal (reanastomisis)
- Thyroid disease
- Too little or too much of certain hormones

A woman's peak fertility occurs in her early 20s. After age 35 (and especially 40), the chance that a woman can get pregnant drops considerably. However, the age when fertility starts to decline is different from woman to woman.

Male Infertility

Male infertility may be due to the following:

- A decrease in sperm count
- Sperm being blocked from being released
- Sperm that do not work properly
- Being in high heat for prolonged periods
- Birth defects
- Cancer treatments, including chemotherapy and radiation
- Environmental pollutants
- Heavy use of alcohol, marijuana, or cocaine
- Impotence
- Infection
- Obesity
- Older age
- Scarring from sexually transmitted infections, injury, or surgery
- Smoking
- Too little or too much hormones
- Use of certain drugs, such as cimetidine, spironolactone, and nitrofurantoin
- Vasectomy, or failure of vasectomy reversal

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Infertility for both partners can create stress and anxiety. Male are more distressed when the problem is found to be theirs. Infertility may also create feelings of personal inadequacy and interfere with sexual spontaneity. Nevertheless, couples working together on infertility often bring a deepened sense of commitment and intimacy to the relationship.

CONTRACEPTION AND ABORTION

Introduction

In the current century, people are interested in mean of controlling birth. Birth control is essential in order to keep the world's population at a level which can be sustained by the earth's resources. There is often a need to postpone a first pregnancy and to control the spacing of subsequent pregnancies. Young couples need time to adjust to each other and to marriage first. Most couples also require some time before they become completely sexually compatible. The fear of pregnancy can interfere with both sexual and marital adjustment. Due to these concerns, we are going to look at different methods of birth control and effects of abortion.

Methods of contraception

There are different methods of contraception for both men and women. The choice depends on individual preference and health.

a) Abstinence

It is the self denial of sexual gratification –it's the most socially acceptable form of birth control for the unmarried. Within marriages, there are some reasons for abstinence e.g. during illness, during late pregnancy, or immediately after childbirth. In these cases, other sexual outlets may be enjoyed, such as mutual oral or manual stimulation. Any such practice should be a mutual decision of the partners involved and not the decision of one spouse who neglects to take into consideration the needs of the other person. While to abstain from sexual activity is possible, it is not possible to abstain from biological sexual urges. Whether abstinence is voluntary or an involuntary condition, normal sexual urges will find outlets in both men and women. Dreaming to orgasm is one example of an involuntary method of obtaining sexual relief.

b) Sterilization

It is a procedure usually surgical that renders a person incapable of reproduction. It may be sought by men and women who wish to end permanently any possibility of their having more children. *Eugenic*

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sterilization is performed as a means of protecting the physical or mental well being of the next generation. Such cases are usually involuntary, and may be performed on the habitual criminal, the moral pervert, or a person with an inheritable mental disease or deficiency. *Therapeutic sterilization* is sometimes performed when either the husband or the wife suffers from certain chronic diseases or disabilities, or when certain irreversible blood incompatibility exists.

Methods of sterilization in women

- *Tubal litigation* is a major surgical procedure in which the fallopian tubes are cut, a small section of the tube removed and the ends are tied to prevent them from meeting. The sperm and the ova are thus kept from coming into contact. The operation takes 15 minutes to perform but requires a 5 day hospitalization and takes 3-4 weeks for the woman to regain preoperative physical strength.
- *Laproscopic sterilization*-performed under general anesthesia, it involves two small incisions, which are made in a woman's abdomen. The fallopian tubes are severed and the ends cauterized (sealed) by an electrical instrument. The procedure is inexpensive and leaves no unsightly scars.
- *Oophorectomy*-this is the surgical removal of the ovaries. it brings the process of ovulation permanently to a halt.
- *Hysterectomy*-the surgical removal of the uterus, may or may not include the removal of he uterine tubes and the ovaries.
- *Salpingectomy*-the surgical removal of fallopian tubes.
- A form of *reversible sterilization* has been developed with minimal complications. Small clips are placed round the fallopian tubes, sealing them closed and blocking the union of sperm and egg. The clips can easily be removed if the woman later wishes to become pregnant.

Methods of sterilization in men

- *Vasectomy*-this consists of cutting and tying the vas deferens, thus preventing the passage of sperm to the ejaculatory ducts. The site of incision is the scrotum, well above the testicles and can be performed with a local anesthetic. The man is usually advised to remain relatively inactive for about 48 hours and to wear a suspensory (fabric supporter for the scrotum) for a week or two to prevent any pulling of the testicles.

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- For men who would like to retain the option of fathering a child without undergoing reversal surgery, the man's sperm may be frozen and stored for future insertion into the vagina or uterus of a woman in a process called *Artificial insemination.*
- *Castration* involves removal of both testicles. This operation does not necessarily means impotence if performed on an adult, although there is gradual loss of sexual desire because of the loss of male hormones produced by the testicles. The hormonal deficiency may also cause the man's voice to become higher, his beard may become sparse, and he may acquire excess fat. Hormone therapy can correct these undesirable changes in secondary sexual characteristics.

ABORTION

Abortion is categorized into two:

a) *Spontaneous abortion* is the term applied to an unintentional expulsion of the fetus from the uterus before the third month of pregnancy. It's not a purposeful birth control.
b) *Induced abortion* on the other hand is intentional termination of pregnancy.

Historically, attitudes towards abortion have varied, the Chinese, ancient Jews, Japanese, Greeks and the Romans had no proscription against abortion. Abortion's strongest and most vocal opponent today is the Catholic Church.

Abortion techniques

Research has indicated that the optimum time to perform an abortion is between the eight and tenth week of pregnancy. Abortion taking place after the thirteenth week of pregnancy are 3 to 4 times more risky than those performed earlier. The greatest risk of all is to women who wait until the fifteenth week or later to seek an abortion.

A wide range of techniques is utilized in attempts to induce an abortion. Primitive methods include:

- ✓ jumping on the abdomen;
- ✓ probing the uterus with sticks;
- ✓ using portions made from animal secretions, dung, herbs, or seawater;
- ✓ relying on magic and mystical incantations.
- ✓ Many women attempts abortion through medications and violent physical exercise.

Abortion may be attempted by persons other than the pregnant woman who are equally untrained such as a husband or an abortionist who is not a physician. These abortions are illegal and may

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involve such methods as spraying the uterus with chemicals or using various drugs. The most common involves inserting some sort of instrument into the uterus and scraping the embryo away with the attendant dangers of perforating the uterus or causing an infection.

Therapeutic abortions are recommended when certain conditions exist such as serious heart disease, kidney diseases or Measles during the first three months of pregnancy. They are performed in several ways; dilation and curettage. This method is frequently used before the 12^{th} week of pregnancy and should be performed only in a hospital with the patient under anesthesia. The cervix is gradually dilated and a curette, a spoon like instrument is used to scrape the embryo from the uterus.

Another new method is *vacuum curettage*. A tube is inserted into the uterus and a vacuum pump is used to suck out the embryo and other uterine content. The technique is safe, easier and faster to perform than he Dilation and Curettage.

Hysterectomy is a method used after pregnancy has reached 12 weeks. A minor caesarean section is resorted to because the fetus is too large for the usual vaginal methods of removal.

Attitudes towards abortion

- Generally speaking, the higher a woman's education level, the more receptive she is to the idea of abortion. More white women tend to favor abortion than black women at all levels of education.
- Better mental adjustment is reported in women who have sought and been granted therapeutic abortions than in women whose requests for therapeutic abortion were denied. Children who are born to those mothers who had requested and been denied therapeutic abortions have greater social and emotional handicaps than do their peers.
- Most physicians, psychiatrists and psychologists agree that abortion in itself is a safe, simple procedure which does not result in emotional problems. The obstacles erected by laws against it however caused it to become an emotionally traumatic experience.

TYPES OF CONTRACEPTIVES

Modern contraceptive methods are evaluated according to their effectiveness in preventing pregnancy. A formula is used to compare the number of pregnancies which occur when a given

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contraceptive method is used with the number of pregnancies which occur when no contraceptive is used.

When the pregnancy rating of a contraceptive method is below 10,its effectiveness is rated as high; if rating is between 10 and 20,the effectiveness is considered to be medium, and if the rating is above 20,the effectiveness is ranked as low. As in other forms of birth control, the higher the level of education, the higher the likelihood that an individual will use some forms of contraception.

Contraceptives available only with a doctor's prescription

1. A *diaphragm* is a thin rubber dome shaped cup stretched over a collapsible metal ring, designed to cover the mouth of the uterus.
    - ✓ It must be fitted by a physician because of individual physiological differences in women.
    - ✓ Having the correct size and shape in a diaphragm is important for both wearers' comfort and for its effectiveness as a contraceptive.
    - ✓ A virgin cannot be fitted with one until her hymen has been broken or incised by the physician.
    - ✓ The device in no way interferes with the conduct or pleasure of intercourse for either partner.
    - ✓ Used with contraceptive cream or jelly, the diaphragm seals off the cervix and prevents sperm from entering the uterus.
    - ✓ The jelly is toxic to sperm and provides lubrication as well.
    - ✓ It must not be removed until 4 to 6 hours after intercourse and may be left in place for as long as 24 hours.
2. *Oral contraceptive* in the form of a pill is a combination of synthetic progesterone and estrogen that prevents ovulation by mimicking the hormonal state of the body during pregnancy. Since no ovum is released, pregnancy cannot occur.
    - ✓ Most pills are taken for 20 days, beginning on the fifth day after the beginning of a menstrual period. They are taken at the same hour each day.
    - ✓ If one pill is missed, there is a chance of pregnancy. Authorities warn women to expect a reduction in sex drive after taking the pill for 18 to 36 months, and women are advised to substitute other methods of contraception after 18 months of continual use in order to restore the original hormone balance.

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3. *Intrauterine contraceptive devices (IUDs*)-are small plastic devices of various sizes and shapes that are designed to fit into the womb.
    - ✓ The device must be placed by a physician who can remove it at any time that the woman whishes to become pregnant.
    - ✓ After birth of a child it may be repositioned in the uterus until other pregnancy is desired.
    - ✓ The device does not affect the fertility of the woman or the health of children who are born after the removal of the IUD.

Contraceptives available without a doctor's prescription

1. The *condom* is cheap, easy to use and to obtain, and easily disposable. It's designed to fit the erect penis.
    - ✓ It's made of thin rubber or of sheep's intestine and measures about 71/2 inches in length. Unless the condom breaks during intercourse or slips off after ejaculation, it offers almost total effectiveness.
    - ✓ After intercourse he should carefully hold it while he withdraws his penis from his partner's vagina in order to prevent semen from spilling into the vaginal opening.
    - ✓ He can then fill the used condom with water in another test to make sure that no breakage has occurred.
2. *Chemical methods* include creams, jellies and vaginal foams which block the entrance to the uterus and which are toxic to the sperm. They must be inserted into the vagina at least 5 to 15 minutes before ejaculation.
3. *Vaginal suppository* is a small solid cone that melts at about 95^0f.it must be inserted at least 15 minutes before ejaculation.
4. *Vaginal tablets* need more moisture to dissolve than may be present in the vagina, and the tablets are very unstable in damp climates.
5. *Douching*, while it cleans the vagina and offers a feeling of security to many women, it has a very unsatisfactory pregnancy rate of 36.Sperm move so quickly that a douche fails to reach them in time.

Other methods of birth prevention

1. *Coitus or withdrawal* it requires that the male withdraw his penis from the vagina of the female before he ejaculates.

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2. *The rhythm method* requires that a couple abstain from sexual intercourse during period of a woman's menstrual cycle when she is capable of contraception-just before, during and just after ovulation.
3. *The temperature method*-a variation of the rhythm method and based on the belief that a woman's temperature changes according to the changes in her menstrual cycle.

Birth control in the future

- The *mini pill*-contains no estrogen and little progestin. Unlike the pill, it does not interfere with the woman's ovulatory process. It makes the cervical mucosa thick and sticky, thus preventing sperm from passing through the uterus. It must be taken every day of the month.
- The *vaginal ring*-made of progestin and plastic. It's inserted into the vagina, where it releases enough progestin to keep a woman infertile for one month, after which it must be replaced.
- *Insertion into the vagina tablets* containing prostaglandins, fatty acids derivatives produced by the body which act on the uterus to cause contractions. The tablets are inserted every 2.5hrs until menstrual bleeding begins.
- Other *futuristic contraceptive* methods include vaccines to immunize a woman against her husband's sperms, or to immunize a man with substances inhibitory to sperm production.

SEXUALITY ACROSS THE LIFESPAN

Introduction

Sexuality develops throughout our lives. There are different stages from childhood through to adulthood in which we develop physically, psychologically and portray different sexual behaviours. We are therefore going to explore the different sexual responses in different stages in development.

Childhood Sexuality

Child sexuality is the sexual feelings, behaviors, and development of children. Most people believe that children are innocent and sexless; that is they lack sexual feelings, engage in no sexual behavior and have little or no knowledge about sex. Children were often regarded as asexual, having no sexuality until later development. However, Sigmund Freud in his theory believed that young children have an active sex life. The infant's libido goes through transformational phases – oral, anal, and genital. At the phallic (oedipal phase) children fall in love with their opposite sex parents, which triggers castration anxiety in boys and penis envy in girls. They eventually resolve these conflicts.

Given the difficulties involved in studying sexuality in children, it is not easy to reach a definitive conclusion. Studies among animals (non-human primates) show that their infants start engaging in

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presenting and mounting behaviours soon as they begin to wander away from their mothers (Wallen, 2000). These appear to be play behaviours since they are not accompanied by actual coitus; thus, they serve a rehearsal function and are also used as a form of aggression or submission.

Different cultures vary in the way they encourage, tolerate or suppress sexual behaviour in children. In most cases adults restrain children's' sexual expression. The degree of restraint varies with the sexual attitudes in the society. Cross-cultural studies reveal that childhood sexuality among the Chewa people in Malawi is encouraged, whereby parents encourage their children to play husband and wife in little huts away from home. Women of the Siriono people of Bolivia used to have sex with their prepubescent brothers of their husbands. The Western cultures have gone through various radical changes. Before the 19th century, families slept together therefore children observed their parents sexual behaviours and also that of animals since farming was the commonest occupation. Children also walked naked and they could freely and openly explore their body anatomies.

By the end of the 19th century, sexual innocence among children was fully adopted; formal sex educational programs portrayed sex as something dangerous carrying three major risks: disease, pregnancy and sexual deviance. Television only tends to deal with the romantic aspects of sex making it uninformative in terms of sexual anatomy and behaviours.

Does witnessing parental sex harm children?

Children may acquire sexual knowledge by observing their parents naked or witnessing their sexual encounters. This may happen accidentally in some cases but for families living in crowded conditions, it is inevitable.

Some researchers have claimed that children who see their parents naked or witness their sexual encounters do not experience psychological problems in future (Okami et al., 1998). However therapists and clinicians hold that this experience may cause harm and that it may represent sexual abuse (Kritsberg, 1993).

Children Engage in Sexual Behaviours

Newborn babies exhibit penile erections or vaginal lubrication. (Masters et al., 1982). Some studies reveal the erections have been detected in male fetuses several weeks before birth by means of ultra-

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sound imaging. These physiological processes continue to occur through infancy and childhood. They are not however necessarily brought by external sexual stimuli (LeVay & Valante, 2002).

In a research conducted by Kinsey et al. (1948) Penile erections in boys is triggered by a wide variety of physical stimuli such as car motion, sitting on warm sand; or exciting or fearful events (games, when asked to go to the front of a class, punishment etc.). During the first minutes, hours, and days after birth, the neonate is in a state of readiness, ready to develop its first intimate relationship with a person. The neonate is able to respond to the faces of others, especially their eyes, through eye-to-eye and face interaction. A high degree of eye-to-eye contact between mother and infant has been observed to lead to an immediate cessation of crying, for instance, and to the development of a strong bond with the mother.

Children generally are curious about their bodies and those of others, and explore their bodies through explorative sex play. A common practice among children is masturbation. Infants fondle or touch their genitals in a fairly causal manner. Between 6 – 12 months children engage in more purposeful self- stimulation like rubbing or thrusting their genitals rhythmically against bedding or a doll and later manual masturbation is seen; some children reach a climax of excitement followed by relaxation, which is similar to orgasm, however boys do not ejaculate (Kinsey et al., 1953).

Young children like showing their genitals to adults and other children; and they attempt to view or even touch the genitals of each other. They may also hug or kiss. According to these studies, children rarely engage in adult like behaviours like penetrative sex, oral sex etc. However, some children have had sexual contacts with adults and older children. Some such contacts are quite harmful to the child and are referred to as child abuse. This has led to both short term consequences such as fearfulness, depression, inhibition of emotions, hostility and antisocial behaviours; and long term effects like; mood disorders, phobias, panic disorders antisocial and suicidal behaviours, substance abuse sexual promiscuity, poor academic performance among others.

In schools there are programs that teach young children how to avoid sexual encounters with adults by learning between good (patting, hugging) and (genital fondling) bad touch. Therapy may also be focused on helping the abused child to experience the missing motions and to realize that the adult perpetrator was the sole guilty party.

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Characteristics of sexual development at different ages

Three to four years

- Three- and four-year-olds are curious about where babies come from.
- They explore other children's and adults' bodies because of their curiosity. "Playing doctor" and pretending to be mommy or daddy become more common activities.
- They have increased interest in the differences between adults' and children's bodies.
- By age four, girls may become intensely attached to their fathers and boys to their mothers.
- Children begin to have a sense of modesty and can begin to understand the difference between private and public behavior.
- For many children, genital touching increases, especially when they are tired or upset.
- Three- and four-year-olds still have a concern about elimination and frequently use words that refer to bowel movements and urination

Five to seven years

- Children in this age group begin to have more contacts outside the family. Other children may bring up new ideas about sex.
- They have increased need for privacy while bathing and dressing.
- Five- to seven-year-olds often increase their use of sexual or obscene language (frequently to test parental reaction).
- They are more interested in what it means to be male or female.
- They give up wanting to "marry" mom or dad. Girls become closer to their mothers and boys to their fathers.
- Children in this age group become more reticent (reserved) about asking questions.
- Masturbation continues to be common.

NB: It is important to let your children know they can come to you with questions. Starting early with sexuality education can help you communicate with your child now and during the teen years. Some guidelines to help you become an "askable" parent are:

- Let your child know he or she can come to you for information.
- Be willing to repeat information until your child understands.
- Check out what your child already knows by asking what he or she thinks.
- Keep your answers simple. Think about what your child can and can't understand.

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- Realize it's OK to say, "I don't know." There are many good books for you and your child to read together.
- You want to help your child understand that sexuality is a valuable part of human experience. Review the facts of reproduction if you need to.
- Have a sense of humor and make this learning experience fun for you and your child.

Research in child sexuality

- Sigmund Freud in his 1905 work, *Three Essays on the Theory of Sexuality* outlined a theory of psycho-sexual development with five distinct phases: the oral stage (0 - 2 years), the anal stage (2 – 3 years), the phallic stage (4 – 6 years) which culminates in the resolution of the Oedipus complex, the latency phase (6–12 years of age), and the genital, or adult stage.
- Alfred Kinsey in the Kinsey Reports, (1948 and 1953) included research on the physical sexual response of children, including pre-pubescent children (though the main focus of the reports was adults). It has been stated that some of the data in his reports could not have been obtained without observation or participation in child sexual abuse, or through collaborations with child molesters.
- Currently, empirical knowledge about child sexual behavior is not usually gathered by direct interviews of children, partly due to ethical considerations. Information about child sexual behavior is gathered by the following methods:
  - Observing children being treated for problematic behavior, such as use of force in sex play, often using dolls that have genitals.
  - Recollections by adults.
  - Observation by caregivers.

ADOLESCENCE SEXUALITY

Pre-Adolescence (8 – 13years)

Sexual development begins in the pre-teen years and continues into adulthood. The body produces hormones that cause outward changes, including breast development in girls, the appearance of facial hair in boys, and growth of hair under the arms and in the genital area of both boys and girls.

Puberty is more than physical changes. As the body grows into adulthood, the individual's way of thinking, emotions, wants and needs will change as well. Due to biological processes; this stage is marked by some degree of increased sexual feelings although this varies from person to person.

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The early pre-adolescent years are the time when most children learn about coitus and 'facts of life' through peer networks rather than parents. Thus there are misunderstandings such as: the difference between the anus and the vagina; they think babies grow in the mother's stomach and emerge through the belly button.

These children spend their time in all-female or all-male groups which is referred to as *homosociality.* This minimizes their opportunities for heterosexual interactions. They therefore, may end up engaging in homosexual behaviours. One study showed that some of these pre-adolescents had engaged in sexual intercourse (Kinsman et al., 1998).

Adolescent sexuality (13-18yrs)

The beginning of adolescence may correspond to the biological events of puberty such as menarche and first ejaculation. There is a marked increase in a boy or girl's sexual feelings and behavior. The bodily changes and the rising blood levels of gonadol steroids especially testosterone directly activate the brain circuit underlying sexual responsiveness.

Various cultures perform different puberty rites. Because this period is an important event in a young person's life and it is characterized by increase in sexual feelings and expression, there are special ceremonies that are conducted to mark it. Common features of *girls*' rites include: seclusion, cleansing, instruction and body modification. In some cultures girls are taken in an 'initiation school' after breaking of the hymen using special tools; others mark puberty by tattooing, ear piercing, tooth filing, female circumcision or stretching of the labia minora.

For boys circumcision ceremonies are carried out after which, they are taken for special training in various roles of men. In some cultures e.g. in New Guinea, boys are confined for a year after a parade and a feast, then the older males have anal sex with them; thereafter they qualify as adults. Body modification is also a common feature. Some contemporary rituals are religious in nature. Nowadays in the modern society, some of these rituals are not performed.

Social Influences on Teen Sexual Behavior

Sexual behavior may start early among the low socioeconomic levels e.g. communities which have low average income, few college graduates, a high crime rate or high unemployment. This may be

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attributed to the fact that it is likely for such communities to offer adolescents few constructive goals and this gives them little motivation to avoid risky sexual behavior.

Having an older boyfriend or girlfriend is another factor that could lead to early sexual encounters because the older partners are more sexually experienced (VanOss Marin et al., 2000). In children who are religiously observant and of higher intelligence, sexual behaviours begin late (Halpern et al., 2000). This is because the intelligent ones are occupied with educational and other career related activities and they therefore have less time for relationships. Generally although the common sexual behavior among adolescents is masturbation, male adolescents masturbate more than girls. They begin masturbating to ejaculation as soon as they are physiologically capable of it (Kinsey et al., 1948).

The general trend in adolescent sexual behavior has changed greatly. In the earlier times, adolescents focused on completion of school, joining labor force, marrying and starting a family. Dating then, was to help develop gender-appropriate roles and involved sexual behaviours short of coitus. Engaging in sexual intercourse endangered the status of the unmarried females. Males found it difficult to persuade females to have intercourse with them, thus for some they found an outlet with the prostitutes.

In the 1940's there was a major social change in the US which led to more widespread engagement of female and male adolescents in sexual behaviours including coitus (Center for Disease Control, 2000, Kinsey et al., 1948, Kinsey et al., 1953). This was especially due to the following factors:

- ✓ introduction of contraceptives (1960)
- ✓ legalization of abortion in US (1973)
- ✓ introduction of effective treatment of STI's
- ✓ feminism which led to more women in the labor market
- ✓ increased college attendance by women
- ✓ Postponement of marriage.

All these reduced inhibitions on adolescent sexuality. Some children of single sexually active mothers are likely to view non marital sex as acceptable since they observe their parents who are their important role models.

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In the US, oral sex among adolescents has become common because they achieve orgasm without the risk of pregnancy or loss of virginity (Ramez, 2000). They also believe that it lowers risk of transmitting STDs. There are various factors that tend to limit the trend towards more wide spread sexual behavior/intercourse among adolescents in the US, such as fear of AIDS and social movements led by conservative Christian groups which encourage youth to postpone sexual intercourse (abstinence).

Adolescence involves development of an identity and a social role independent of one's parents (Erickson 1968; Steinberg, 2001). Adolescent sexuality plays a very important role in the process of growing up. Adolescent sexual relationships often have a playful quality and it is less focused than that of adults.'Crushes' on older persons e.g. teachers, film and pop stars etc are all common. They do not maintain a sharp boundary between sexual and non sexual attachment like many adults do. Social and sexual anxiety has probably increased greatly for the male teens and has therefore had some negative consequences e.g. psychological distress and even suicide among teenagers.

Since traditional gender norms are loosening, there has been an increased interest among adolescence in the issue of gender and sexual orientation; thus more teens are personally acquainted with one or more gay or transgendered people because they see a wide range of options open to themselves.

Generally, studies show that most young men and women have only a few sex partners. However, there are a minority that marry without prior cohabitation and these are the traditionally minded who have had fewer dating partners before marriage. Those that enter into cohabitation before or instead of marriage, are more liberally minded and therefore have had more dating partners prior to cohabitation. Personality differences such as intelligence and impulsivity influence how sexual decisions are made.

ADULTHOOD SEXUALITY

The institution of marriage has changed greatly over the years. In ancient Greek, marriage was not companionate i.e. a wife was not expected to be a social partner to her husband but was mainly to have children. Companionate marriage originated in the roman culture and was boosted by the

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banning of polygamy by the early Christian church. Later in the 20th century with improvement in women education, they became more desirable companions for men.

In the US marriage may soon become a minority status. The number of men and women who are never married, separated or divorced is steadily rising while the percentage of those who are currently married is falling. Most people tend to prefer the informality of cohabitation. Despite these social changes, many people even in the US still want to be in long term, two-person, live-in sexual relations.

Marriage has many functions one being marital sex. Married women are less likely to have sex more than twice a week, they are less adventurous sexually and are less likely to experience orgasm than women in short term dating relationships. On the other hand, men have a higher likelihood of experiencing orgasm regardless of the kind of relationship they are in.

Generally, marriage makes sex more satisfying emotionally for women. This is due to the virtue of that relationship of being in a marriage. However, sexual interaction between marriage partners tends to decline over time due to the following factors:

- ✓ Lose of sexual interest associated with increased familiarity between partners (habituation)
- ✓ The dimming of passionate love
- ✓ The birth of children (Fischman et al 1986)
- ✓ The process of aging which leads to:
    - lessening of physiological processes associated with arousal,
    - decline in sex drive,
    - general decrease in health and fitness,
    - increased likelihood of obesity and
    - External factors e.g. decrease in physical attractiveness between aging partners.

Though some couples remain highly satisfied with their marriage, marital satisfaction generally declines with time. This may be due to the birth of the first child that increases family responsibility for both partners, entry of the older child into adolescence (Gottman and Levenson 2000) and retirement. All in all, wives are less satisfied with their marriage unlike their husbands. Lately, a large

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fraction of marriages end in separation or divorce. Marital disruption is attributed to three major factors:

- ✓ passage of time,
- ✓ age of marriage and
- ✓ Ethnicity (CDC 2001).

Marriage during the teen years increase the risk of disruption, this may be due to immaturity of the partners, economic stresses of early marriage and the fact that some teen marriages are as a result of pregnancy. According to research, premarital sexual relationship has an effect on the length of marriages i.e. virgins have been found to have longer marriages this may be due to the fact that partners who are virgins at marriage have religious or moral convictions that make them value virginity and avoid marital breakup.

Marital disruption may have negative consequences such as anger, guilt, sadness, and fear for the future. Divorced people suffer higher rates of psychological and physical ill health than do married people. The children of divorced parents experience a high risk of depression, behavior problems, low academic performance, substance abuse; criminality and early sexual activities (Amato, 2000).There are however, people who are generally happy after divorce. Some of the positive consequences of marital disruption include: escape from unhappy/abusive relationship and a potential for forming a better relationship; it leads to discovery of untapped sources of talent and energy for women. Remarriages may occur after divorce but they are somewhat less durable than first marriages.

Transition period

In their early and mid forties, *women* may experience the onset of a gradual transition to infertility (climacteric). The final cessation of menstrual cycle (menopause) occurs at an average age of 51 or 52 in the US women. It's not known what triggers menopause it is believed that women who start menstruating early, have fewer pregnancies, short cycle lengths, have had one ovary removed or do not use oral contraceptives are likely to experience early menopause than others (Cramer and Xu, 1996). Women who smoke accelerate the effects. Menopause may occur due to depletion of oocytes and diminishing ability of the remaining oocytes (germ cell) to respond to pituitary hormones.

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Menopause influences women sexuality in many ways including:

- ✓ The reduction in circulating ovarian hormones especially oestrogen affects the body in many ways-leads to reduction in virginal lubrication and a rise in the Ph of virginal fluids which can lead to painful coitus (dispareunia) and virginal inflammation (virginitis)
- ✓ Reduction of estrogen leads to instability in the control of blood vessels leading to hot flashes (dilation of blood vessels in the skin), night sweats, headaches and heart palpitations.
- ✓ Lowered estrogen can lead to loss of bone density which may lead to fractures; changes in blood lipid chemistry which increase the risk of athrosclerosis.

Generally, menopause leads to a decrease in sexual desires and arousal. Other factors include general health, marital status and smoking. Psychological effects of menopause on sexuality are diverse. For some, loss of fertility at menopause may lead to loss of interest in sex, while for others it removes the fear of unwanted pregnancy and may increase sexual pleasure. Hormone replacement therapy (HRT) can reduce menopausal symptoms.

Men's fertility declines gradually with age, they do not experience sudden or cessation fertility like in menopause, and instead they experience a gradual reduction in fertility and sexual aging evidenced by:

- ✓ declining sperm counts and ejaculate volumes,
- ✓ erectile dysfunction, and
- ✓ decreased sexual desire and frequency of sex
- ✓ loss of muscle bulk and low density,
- ✓ change of skin and hair,
- ✓ Cognitive changes e.g. memory impairment.

Sometimes these changes are referred to male menopause or andropause (Hiton and Morales 2001). Testosterone replacement therapy has been used to treat aging men.

SEXUALITY IN THE ELDERLY

Traditionally it has been assumed that old people are asexual, the fact is that nearly everyone continues to have sexual feelings in old age. Because old age brings physical changes and illnesses

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that may affect sexual expression, it may necessitate some changes in sexual behavior. Some of the physical changes associated with aging include:

- ✓ Penis becomes erect more slowly in response to stimulation and it is less hard.
- ✓ Some experience erectile dysfunction
- ✓ Ejaculatory volume is smaller and less forceful
- ✓ Erection is lost more rapidly and the refractory period is longer

Women may experience the following changes:

- ✓ The walls of vagina becomes thinner and the vagina becomes shorter and narrower
- ✓ There is decreased vaginal lubrication
- ✓ There are fewer contractions during orgasm
- ✓ There is a more rapid decrease in arousal after orgasm
- ✓ Medical conditions, drugs and social factor can impair the sexuality of old people

Conditions such as arthritis, heart disease, osteoporosis, incontinence, diabetes, and obesity may impair sexual performance. Surgeries such as prostatectomy, colostomy, mastectomy, hysterectomy (removal of the uterus) or heart surgery can also affect sexual performance. Prescription drugs such as anti-hypertension drugs diuretics, tranquilizers, antidepressants, cancer chemotherapy, and ulcer medicine among others impair sexual desires and performance.

Psychological and social factors such as depression, poor self image, performance anxiety, bereavement, lack of a partner and internalization of negative expectation of others e.g. their old children; can also impair sexual expression.

Coping strategies

- Widowed or divorced people can remarry
- For those with difficulty with coitus due to physiological changes can practice oral sex instead.
- Some old people remain sexually active
- According to research, the most common sexual activity among old people is touching and fondling without coitus, followed by masturbation then coitus.
- Even those in declining health such as, in nursing homes may desire sexual and affectional contacts which can be facilitated in privacy.

SEXUAL DYSFUNCTIONS AND SEXUALLY TRANSMITTED DISEASES

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9.0 Introduction

There are several sexual problems and ailments that some people may experience, affecting their sexuality. Due to cultural beliefs, most people would not come out to ask for assistance openly, but they may confide with an expert. It is therefore important to understand various sexual problems and dysfunctions that may be experienced during sexual contact and the treatment for these dysfunctions and prevention measures. We are therefore going to learn about different categories of sexual dysfunctions and diseases and the treatment of these problems.

SEXUAL DYSFUNCTIONS DISORDERS

Sexual dysfunction or sexual malfunction refers to a difficulty experienced by an individual or a couple during any stage of a normal sexual activity, including desire, arousal or orgasm.

The sexual dysfunctions are essentially forms of pathology in which there is some inhibition and/or impairment in the individual's capacity to engage in heterosexual intercourse. A psychogenic component is considered to be important in bringing about such disorders, but physiological factors may also be operative, especially in the presence of physical disease.

These include impairments in sexual desire, aversion to sexuality, impairment in the ability of a man to attain or maintain an erection, a man or a woman's inability to achieve orgasm, premature ejaculation, dyspareunia (pain on sexual intercourse), and vaginismus (vaginal spasm on penile entry). Clearly, all of these difficulties interfere with the likelihood of procreation and thereby warrant being included as disorders or "diseases."

Sexual disorders include problems of sexual identity, sexual performance, and sexual aim. There are three major categories of sexual disorders:

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1. Sexual dysfunctions
2. Paraphillias
3. Gender identity disorders

Sexual dysfunctions prevent or reduce an individual's enjoyment of normal sex and prevent or reduce the normal physiological changes brought on normally by sexual arousal. These dysfunctions can be classified by the phase of the sexual cycle in which they occur. It is important to keep in mind that the diagnosis of sexual dysfunction is made only when the disability persists. Any of them could occur occasionally or be caused by a temporary factor such as fatigue, sickness, alcohol, or drugs.

Sexual Desire Disorders (The Desire Phase)

Sexual desire disorders or decreased libido are characterized by a lack or absence for some period of time of sexual desire or for sexual activity or of sexual fantasies. The condition ranges from a general lack of sexual desire to a lack of sexual desire for the current partner.

The causes vary considerably, but include a possible decrease in the production of normal estrogen in women or testosterone in both men and women. Other causes may be aging, fatigue, pregnancy, medications (such as the selective serotonin reuptake inhibitor (SSRI) or psychiatric conditions, such as depression and anxiety.

There are two types of dysfunctions that can occur during the desire phase:

i. *Hypoactive desire*: which is basically a disinterest in sexual activity. It results in a complete or almost complete lack of desire to have any type of sexual relation. This can often result in the participation in intercourse as a simple marital duty.

ii. *Aversion to sex*: This is different from simple hypoactive sexual desire in that sexual activity actually repulses the person or makes them unusually apprehensive. This is most often the result of a traumatic sexual experience, such as molestation as a child or rape.

Sexual Arousal Disorders (The Arousal Phase)

Erectile dysfunction is the inability of males to attain or sustain erection long enough for coitus. The inability of females to become sexually aroused is sexual arousal disorder.

The Orgasm Phase

When males are unable to control ejaculation so that it occurs before satisfying sexual relations can take place with the partner, it is known as premature ejaculation. Ejaculatory incompetence is the lack

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or delay of reaching orgasm in males. The female version of this is inhibited female orgasm, the lack or delay of reaching orgasm in females.

Sexual Pain Disorders

There are two sexual pain disorders. Dyspareunia is when pain occurs during intercourse. This is predominantly a female complaint, but it does occur in males occasionally. Vaginismus is a female disorder in which involuntary spasmodic muscle contractions occur at the entrance to the vagina when an attempt is made to insert the penis. If intercourse is attempted despite these contractions, a painful sexual experience results.

Paraphilia

Paraphilias are sexual behaviors in which unusual objects or scenarios are necessary to achieve sexual excitement. Eight paraphilias are recognized which are grouped into 3 broad catergories.

A paraphilia is defined as a form of sexual expression that is atypical or "off the beaten track." It is a sexual activity that is found on a parallel track (thus the prefix "para" [Greek: besides]), but is still a form of lovemaking (thus the word "philia" [Greek: love]).

Preferences for nonhuman objects

There are two types of preferences for nonhuman objects: fetishism and transvestism.

a) Fetishism

A fetish exists when a person is sexually aroused by a nonliving object. It can manifest in two ways, one more extreme than the other. One form associates coitus with some object (most frequently women's panties or other undergarments[1]). It is relatively harmless if the action is taken playfully and is acceptable to the person's partner. Focus on certain parts of the body (feet, hair, ears, etc) aside from those part of the pleasurable foreplay, can become fetishistic in its hold on the individual. Over a period of at least six months, recurrent intense sexual urges and sexually arousing fantasies involving the use of nonliving objects by themselves (e.g., female undergarments).

The fetishes are not only articles of female clothing used in cross-dressing (Transvestic Fetishism) or devices designed for the purpose of tactile gental stimulation (vibrator). The more extreme form of fetishism is when a nonliving object completely substitutes for a human partner, such as underwear, boots, and shoes or such textured objects as velvet or silk. Here, orgasm is achieved when the person is alone, fondling the object.

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b) Transvestism

This paraphilia exists when the person achieves sexual excitement by cross-dressing. This is very rarely found in females so the male side of this paraphilia will be used as the example.

Two different purposes seem to be associated with this act in different individuals. In one aspect the person seeks to intensify sexual excitement in intercourse with a partner by only partially dressing as a woman. In the other form, the male moves about in full female regailia, which suggests some type of gender identity problem but not necessarily homosexuality.

Preferences for Situations Causing Suffering

Sadism and Masochism

The term sadist is derived from the reported violent sexual exploits of the Marquis de Sade. "Sadist" is applied to those who derive sexual excitement from the pain of others. The term masochist was derived from the writing of Leopold von Sacher-Masoch whose characters sought out women who would beat them. "Masochist" is applied to those who derive sexual excitement through their own pain. Hence, sadists and masochists go hand in hand, one depending on the need of the other. The danger of these needs is that each may need succesively more brutal treatment to satisfy their sexual needs.

Preference for none consenting Partners

The three types of this category of paraphilia are exhibitionism, voyeurism, and pedophilia. All three are considered crimes in this country and are almost entirely male crimes.

a) Exhibitionism

Exhibitionism is the exposure of one's genitals in a public place. It is the most prominent sexual offense leading to arrest and makes up one third of all sexual crimes.[1] From the psychological point of view, there are three characteristic features of the exhibition. First, it is always performed for unknown women; second, it always takes place where sexual intercourse is impossible, for example in a crowded shopping mall; and third, it must be shocking for the unknown woman or it seems to lose its power to produce sexual arousal in the individual. Exhibitionists are not assaultive and are considered more of a nuisance than an actual danger.

b) Voyeurism

Looking at sexually arousing pictures or situations is a relatively common, apparently normal activity. The difference between this and voyeurism is that in normal watching, the viewing is a

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prelude to normal sexual activity. In the voyeur or "Peeping Tom" the experience *replaces* normal sexual activity. Nevertheless, voyeurism may exist in a person who also engages in normal heterosexual activity.

c) Frotteurism

Over a period of at least six months, recurrent intense sexual urges and sexually arousing fantasies involving touching and rubbing against a non consenting person. It is the touching, not the coercive nature of the act, that is sexually exciting.

These are the people who rub up against others in subways, buses, elevators, and other crowded places.

d) Pedophilia

Pedophilia is the act of deriving sexual excitement through the physical contact of children. This paraphilia is radically different from exhibitionism and voyeurism in its severely damaging impact on the nonconsenting partner, a child. Ordinarily, the pedophiliac is someone who has ready access to the child. The child or parent would have no reason to suspect that the individual has a pedophilic orientation.

e) Necrophilia (Corpses)

One could argue that necrophilia cannot possibly serve procreative purposes. I am in agreement that a dead woman is not going to conceive a child, but this is only half the story. A man who must resort to having sexual intercourse with dead bodies has serious difficulties in his ability to relate well to live human beings.

f) Zoophilia (Animals)

Zoophilia, which is reputed to be a traditional activity among farm boys, also provides for sexual release when other outlets are not available. It may also be attractive to those who may have fears and inhibitions regarding overtures to females who are more unpredictable than animals regarding their sexual receptivity.

g) Coprophilia (Feces)

The activities most often involve defecating on one's "loved one." The term also refers to the partner who becomes sexually excited by being defecated upon. Coprophilia is also related to

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sadomasochism in that the person who enjoys this activity is often involved in a sadomasochistic act with domination/submission and hostile release ("shitting on someone").

h) Klismaphilia (Enemas)

Anal stimulation in itself can provide sexual pleasure. An enema can be to the anus what the vibrator is to the vagina. Association of the enema with mothers who provided them in childhood may play a role in producing this type of sexual behavior.

Gender Identity Disorder

A gender identity disorder exists when a person, male or female, experiences confusion, vagueness or conflict in their feelings about their own sexual identity. There is a struggle between the individual's anatomical sex gender and subjective feelings about choosing a masculine or feminine style of life.

Children can distinguish the difference between males and females by the age of two and by their fourth birthday can recognize the different roles that each sex plays in society. By the age of fifteen or so a person can relate to what arouses sexual feelings in themselves. Those with a gender identity disorder may have a problem with one or all of these aspects of identity.

Treatment of Sexual Dysfunctions

a) Behaviour and cognitive behaviour therapy

Behaviour and cognitive behaviour therapy are quite effective. According to behavior therapy, if sexual dysfunction results from learned anxiety, then the problem can be cured through a new learning.

- ***Direct symptomatic treatment***-the couple is retrained to experience sexual excitement without performance pressure. Training takes the form of *sensate focus exercises*. During this exercise, the couple initially only focus on gentle stroking and caressing in the nude, then gradually the sexual play is increased, but without performance demands. The idea is to allow the partners rediscover their natural sexual response without anxiety and to improve on their communication. Since each provides the other with feedback during the exercise.
  - *The start-stop technique*- this is used for premature ejaculation. The woman stimulates the man's penis until he feels ready to ejaculate, at which point he signals her to stop. Once the need to ejaculate subsides, she stimulates him again until he once again signals her to stop.

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Repeated many times, this technique gradually increases the amount of stimulation required to trigger the ejaculation response, so that eventually the man can maintain an erection for a longer time.

- Another technique is the '*squeeze' technique* in which the woman squeezes the shaft of the man's penis when he feels close to ejaculation.

b) Cognitive and direct treatment

According to Masters and Johnson, attitudes and thoughts about sex can block arousal. During therapy, the counselor explores the beliefs and experiences that may have led to the present dysfunction. Shame-ridden memories are discussed with comforting matter of factness; repressive attitudes are challenged, the partner is encouraged to appreciate his sexuality. Resentments and fears that may have blocked communication are aired.

c) Multi faceted approach

Some researchers are dissatisfied with the theory that sexual dysfunctions are caused by faulty learning. It may be as a result of other factors and experiences. Some people were taught that sex is dirty, for many, the first intercourse experience was painful and embarrassing. A combination of direct treatment, exploration of intrapsychic or relationship factors that may cause the dysfunction. As a result, psychosexual therapy was established. There is need for brief insight therapy before applying direct treatment. Psychodynamic exploration of the patient's conflict is necessary before direct therapy is resumed.

d) Family systems theory

The main principle for Master and Johnson's treatment is that the patient is the couple; to solve sexual problem, the therapist has to address the psychological conflicts between the partners. The therapist generally addresses the function of dysfunction from the beginning of treatment, asking patients to describe the benefits they derive from the problem, warning them that they may feel considerable fear, once it appears, as the product of a shaken system; and helping them to devise a better system.

Treatment of Paraphilias

a) *Cognitive-behavioral therapy*: This type of therapy involves applying behavioral therapy techniques to modify the patient's sexual deviations by altering *distorted thinking patterns* and making patient's schemas of the irrational justifications that lead to their sexual variations.

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This therapy also incorporates relapse prevention techniques, helping the patient to control the undesirable behaviors by avoiding situations that may generate initial desires. Many times, therapists apply the technique of "covert sensitization," in which patients' harmful sexual variation is paired with an unpleasant stimulus, such as that of a person with alcoholism who is administered Antabuse, in order to deter them from repeating the act. This approach has been proven effective in cases of pedophilia and sadism.

b) *Orgasmic reconditioning.* In this approach, a patient is reconditioned to a more appropriate stimulus by masturbating to his or her typical, less socially acceptable stimulus. Then, just before orgasm, the patient is told to concentrate on a more acceptable fantasy. This is repeated at earlier times before orgasm until, soon, the patient begins his masturbation fantasies with an appropriate stimulus.

c) *Social skills training:* Because many believe that paraphilias develop in patients who lack the ability to develop relationships, many therapists and physicians use social skills training to treat patients with these types of disorders. They may work on such issues as developing intimacy, carrying on conversations with others, and assertive skills training. Many social skills training groups also teach basic sexual education, which is very helpful to this patient population.

d) *Twelve-step programs:* Many physicians and therapists refer patients with paraphilias to 12-step programs designed for sexual addicts. Similar to alcoholics anonymous, these programs are designed *to give control to group members*, who lead most of the sessions. The program incorporates *cognitive restructuring* with social support to increase awareness of the problem. The group also focuses on the sense of a "higher power" and each individual's reliance upon his or her spirituality.

e) *Group therapy*: This mode of therapy involves breaking through the denial so commonly found in people with paraphilias by surrounding them with other patients who share their illness. Once they begin to admit that they have a sexual divergence, the therapist begins to address individual issues such as past sexual abuse or other problems that may have led to the sexual disorder. When these issues have been identified, beginning Gestalt-type therapy (with the victim, if any) may be desirable to help patients get past the guilt and shame associated with their particular paraphilia. The goal of this type of therapy is to lead the patient to a

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"*healthy remorse."* These patients require lifetime therapy in order to reduce the likelihood of relapse.

f) *Individual expressive-supportive psychotherapy*: This type of therapy requires a psychologically minded patient willing to focus on the paraphilia. The therapist should not set high goals but needs to *break through the denial*. Countertransfence and avoidance of the patient can be a problem with this form of therapy. If the patients can break through the denial, then the patient can work on the unconscious meaning behind the particular paraphilia.

g) *Medications:* Antidepressants, Long-acting gonadotropin-releasing hormones (GnRH, ie, medical castration), Antiandrogens, Mood stabilizers

SEXUALLY TRANSMITTED DISEASES

History of sexually transmitted diseases

Many sexually transmitted diseases are continuing to spread rapidly among several populations all over the world.

At various times in history, some STDs such as syphilis have afflicted many societies. These diseases were feared and often assumed to serve as punishment from the gods. During war, the French army suffered syphilis sores on the genitals. The Italians called syphilis the “French sickness” although the French blamed it on the Italians. The Turkish called it the Christian disease. Almost every ethnic group or nationality and religion was eventually blamed for the scourge of syphilis.

Gonorrhea and syphilis were a major problem among the US troops during the World War II. The spread of the diseases were at an alarming rate despite of the effective and rapid medical treatment. Penicillin and other antibiotics were discovered for treatment in the late 1940s.The number of cases of both gonorrhea and syphilis dropped tremendously. However, public concern begun to fade and STIs infections began to increase again. More antibiotics resistant strains of these diseases developed and new disease causing microbes such as Chlamydia and other new viral diseases have increased. Several new STIs have been identified in recent years and the problem is an ever evolving one.

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Many STDs lack clear symptoms and may go undetected for a long time. It is for this reason that they may also have serious long term health consequences including infertility, cancer, and other chronic illnesses, even death.

Because of the stigma of STI, public discussion and education about these diseases are often avoided, which may inhibit health professionals from educating their patients about the potential consequences.

Many people are mistakenly convinced that they could not contract an STD because of their care in choosing sexual partners or because they maintain high standards of personal hygiene. In addition, some people are embarrassed to seek treatment once they realize their symptoms are suggestive of STD.

Non viral sexually transmitted infections

These are sexually transmitted infections that are caused by bacteria or bacterialike organisms. When diagnosed and treated in early stages, they are most likely to be cured.

a) Gonorrhea

It is a bacterial infection of the cervix, urethra, rectum or throat. It is contracted through sexual contact, intercourse, oral sex or anal sex with an infected partner.

There are 50% chances of women contracting the disease on a single exposure during intercourse and 25% in men. Babies may pick up the bacteria during the birth process if the mother is infected, their eyes are more vulnerable to the infection and can result to blindness.

Symptoms

- Burning and itching sensation in the urethra especially during urination in men.
- Green or yellow discharge from the cervical area
- Vaginal irritation or irregularities in menstruation
- Soreness and mucus in the throat
- Soreness, itching, rectal discharge and bowel abnormalities
- If not treated in its early stages, the initial symptoms usually disappear and the infection often moves to other organs, causing more serious infections and complications. For instance, in men it may affect the bladder, prostate, kidneys, or the epididymis of the testes. Left untreated the disease can cause sterility.

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- In women, the infection can move to the reproductive organs such as the uterus, fallopian tubes and the ovaries and can result into the pelvic inflammatory disease.
- In both male and female, the bacteria can create systemic infections throughout the body, with generalized symptoms and complications in major organs such as the heart and the brain.

Treatment

- The disease is treated with oral dosages of antibiotics such as cetriaxone, ciprofloxacin or ofloxacin.
- Treatment should be made for both partners.

b) Syphilis

- It is a bacterial infection usually acquired through vaginal, anal, or oral sex with someone who has an active infection. It was the first disease to be identified as an STD and is passed through contact with the sores of an infected person.
- It is more common in men than in women but, like many STDs, it can be very serious if not treated. It can also be passed to a fetus during the last 5 months of pregnancy.
- People with syphilis are much more likely to get HIV if they have sex with an infected person. People with HIV will get sicker faster if they get syphilis.

Signs and symptoms

There are four major stages in which this disease progresses. Each stage has different signs and symptoms as follows:

1. **Primary stage**

Appearance of painless sore called a chancre. The sore begins as a reddish bump that develops into a pimple. These sores can appear anywhere in the body, but commonly around the genitals, mouth, anal area, and on fingers, breasts and along the vaginal wall or cervix. The sore is highly infectious, and can be easily transmitted to other people. The chancre can heal within 4-6 weeks without treatment and there may be no further symptoms until 6months.

2. **Secondary stage**

At 6 or 7 weeks, infected people develop a rash, usually on the body and the palms of the hands and soles of the feet. The rash is usually accompanied with symptoms such as fever, swollen lymph nodes

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on the neck, nausea, headache, sore throat, loss of appetite and scalp hair. These symptoms appear for 2 weeks upon which if not treated the disease moves to the next level.

3. **Third or latent stage**

Most untreated people remain in this stage for the rest of their lives. At this stage there are no symptoms showing but the hidden damage worsens without treatment.

4. **Tertiary stage**

Serious complications results from the disease infecting the inner tissues and organs. It may infect the heart, brain and the spinal cord, eyes and other organs. This can lead to life threatening conditions such as blindness, paralysis or psychosis. At this stage the disease cannot be transmitted to others.

Diagnosis and treatment

- Syphilis can be identified through blood tests and microscopic examination of fluid from the chancre in the initial stage of the disease.
- After diagnosis, syphilis is usually treated in the primary and secondary stages.
- Injection of penicillin or tetracycline or other antibiotics are given used for treatment.
- Latent and tertiary stages requires larger doses of he antibiotics for treatment.
- Most patients with syphilis also suffer from HIV and therefore HIV should be tested as well.

c) Chlamydia

Chlamydia was recognized as a widespread STD in the 1980s. The Chlamydia organism invades the cells it attacks and multiplies itself within those cells. This makes it resistant to some antibiotics.

If left untreated it can cause sterility in both men and women. Babies born to mothers with chlamydia can get conjunctivitis (eye inflammation) and even blindness. They may also develop Chlamydia pneumonia during the first few months of life.

Although the disease is spread primarily through sexual contact, once established it can be spread to other areas of the body or other people through hand contact, insects or through contact with human excretion.

Symptoms

The symptoms are nonexistent and masquerade as symptoms of other diseases. However, men who show symptoms might have a burning sensation during urination or a slight discharge of pus from the penis and swelling of the testicles. Women may experience a little more discharge than normal, they

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may also have a burning sensation, itching in the vulva, abdominal pain it can also damage the fallopian tubes causing infertility and ectopic pregnancy.

Diagnosis and treatment

Antibiotics are used for treatment. Ointment containing tetracycline or erythromycin may also be applied to the eyes of the newborns to prevent developing chlamydial conjunctivitis.

Viral Sexually Transmitted Infections

These are STDs caused by viruses. Most viruses can be managed with anti-viral drugs, but they cannot be cured with antibiotics. Most viral STDs are controllable but not curable.

a) Genital Herpes

It is caused by the Herpes simplex virus and is characterized by painful sores on the sex organs. The appearance of the painful blisters are associated with periods when disease resistance might be weakened by other illnesses, stress, exhaustion or inadequate nutrition.

Symptoms

- Painful itchy blisters on the sex organs. The sores usually last from 1–3 weeks the first time that they appear.
- Women usually have the blisters on the cervix and externally on the vulva.
- After a few days the blisters open up leaving wet and open sores that are ulcerated and highly contagious.
- Scabs form and the sores heal but the virus stays hidden in the body.
- More sores may appear later, for some people but not always.

Diagnosis and treatment

The disease is usually diagnosed by direct observation of the blisters and other tests conducted.

Although there is no cure, antiviral drugs are used to suppress recurrence of the disease.

b) Genital warts

Genital warts are caused by the Human Papilloma Virus (HPV). It is a virus that lives on the skin and causes warts. The condition is also known as condylomata acuminate or venereal warts. The disease is common among people with multiple partners and casual sexual relationships.

Symptoms

- Symptoms do not appear for about 3months after exposure to an infected person.

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- Genital warts can grow on or inside the penis, on the cervix, inside the vagina or anywhere in the genital area.
- They can also grow on the thighs, anal area or, in the mouth.
- The color and texture of the skin can vary from soft, pinkish lesions in moist areas, grayish white in dry areas and have irregular surfaces.
- It can cause abnormal cell division in the cervical tissues causing cervical cancer.

Treatment

The warts can be removed with laser surgery, electro surgery or excision. For external warts, chemicals such as podophyllin may be applied (Cates,1998)

c) Hepatitis B

Hepatitis means inflammation of the liver. It can be caused by many things, including drugs, toxins, alcohol and viruses. Hepatitis B Virus (HBV) is a sexually transmitted virus that attacks the liver. Some people can be carriers and may have no symptoms, but they can spread the infection to others. HBV can be easily contracted through sexual contact, touching an infected person's sore or cut and sharing needles or razors with an infected person. Women can also pass this virus on to their babies during childbirth.

Symptoms

Early symptoms include loss of appetite, lethargy, headache, joint pains, nausea, diarrhea, jaundice, darkening of the urine and enlargement of the liver. Later risks of developing liver cancer.

Diagnosis and treatment

Diagnosis is done by a blood test to check for the disease. There is a vaccine that prevents Hepatitis B, but it cannot be cured. There are drugs given to help decrease the chance of liver damage.

d) HIV/AIDS (Acquired Immune Deficiency Syndrome)

AIDS is caused by a virus called Human Immunodeficiency Virus (HIV), found in the blood, semen or vaginal fluids of an infected person. It can be spread during through sexual contacts, sharing needles, razors by infected person and contact of sores, wet skin in the genital area and tiny breaks in the skin.

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People with other STDs that cause sores or rashes are at greater risk for getting HIV. The virus slowly attacks white blood cells which are part of the body's fighting system. When this system is weak, harmful germs can take over. These infections can lead to AIDS, which is a very late stage of HIV.

Symptoms

- The symptoms may not show for years. However, when they first get HIV, they may feel flu-like symptoms which quickly disappear. Later, they may have fever, fatigue, loss of appetite, severe weight loss, night sweats, diarrhea, swollen glands, cough, sores and yeast infections.
- These symptoms can last for more than 2 weeks (these are the primary symptoms). At this stage the antibody testing may still be negative, the so-called window period. Identifying and diagnosing individuals with primary infection is important to assure early access into care and to counsel them regarding the risk of transmitting to others.
- Shortly after primary infection, most individuals enter a period of many years where they have no symptoms at all. During this time, CD4 cells may gradually decline, and with this decline in the immune system
- With a further decline in function of the immune system, patients are at increasing risk of developing more severe complications of HIV, including many more serious infections (opportunistic infections such as tuberculosis, Esophagitis, Dementia), malignancies, severe weight loss, and decline in mental function.

Stages of opportunistic infections

In 1990, the World Health Organization (WHO) grouped these infections and conditions together by introducing a staging system for patients infected with HIV. Most of these conditions are opportunistic infections that are easily treatable in healthy people. These stages are as follows:

- ✓ ***Stage I***: HIV infection is asymptomatic and not categorized as AIDS
- ✓ ***Stage II***: includes minor mucocutaneous manifestations and recurrent upper respiratory tract infections
- ✓ ***Stage III***: includes unexplained chronic diarrhoea for longer than a month, severe bacterial infections and pulmonary tuberculosis
- ✓ ***Stage IV:*** includes candidiasis of the esophagus, trachea, bronchi or lungs. These diseases are indicators of AIDS.

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Treatment

- There is no cure for HIV/AIDS. But the current treatment for HIV infection consists of highly active antiretroviral therapy, or HAART. This has been highly beneficial to many HIV-infected individuals since its introduction in 1996.
- Current optimal HAART options consist of combinations consisting of at least three drugs belonging to at least two types, or "classes," of antiretroviral agents.
- The therapy constitutes improvement in the patient's quality of life, reduction in complications, but it does not cure the patient of HIV.

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