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Introducing Sexuality Into Contraceptive Counseling: A Training Manual

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INTRODUCING SEXUALITY INTO CONTRACEPTIVE COUNSELING: A TRAINING MANUAL

Allison McGhee Hile, B.A.

A Digest Presented to the Faculty of the Graduate School
of the Lindenwood Colleges in Partial Fulfillment of
the Requirements for the Degree of
Master of Art

1985

DIGEST

The present work is a training manual to be used with family planning counselors to increase their skills in dealing with sexual topics. Along with providing basic information about sexual anatomy and physiology, it attends to the issue of allowing sexual concerns to come up in a brief contraceptive counseling situation. This includes how to recognize when a client needs help with a sexual concern, how to listen and discuss comfortably, and how to refer for more in depth counseling. It is based on the premise that a great number of people in our society do not have access to complete and accurate information about sexuality and that the nationwide family planning network is an ideal place for the concise dessimination of this information.

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COMMITTEE IN CHARGE OF CANDIDACY

Susan Myers, M.S., Chair

Rebecca Glenn, Ph.D.

Edwin Harris, Ph.D.

This thesis is dedicated to Matthew,
who understood my need to grow.

Table of Contents

How to Use This Manual

Though the manual is set up as a training guide for conducting an all day workshop for family planning professionals, it can certainly be used in a variety of other ways. If an agency chooses to present a half-day workshop, Modules 2 through 5 can be read by the participants before the workshop, and Modules 1, 6, 7, and 8 can be used alone. Reading Modules 2 through 5 allows all participants to begin at the same level of knowledge.

In addition to being a workshop guide, the manual can provide useable information to the individual reader. Some readers might choose to read the manual from beginning to end. Others might choose to use it for a reference, when needed, in a "cookbook" fashion.

Course Objectives

The following course is designed to teach family planning counselors to assist clients with sexual concerns in a brief manner. As a result of taking the course the counselors will be able to:

1. Understand the value of sexuality counseling in a family planning setting.

2. Explain human reproductive anatomy, the human sexual response system and a number of sexual terms.

3. Ask specific questions of their clients to enable the topic of sexuality to arise.

4. Determine when a referral to a qualified professional for sex therapy is appropriate and know how to make that referral.

OUTLINE

8:45 - 9:10 * Module 1
Registration (25 minutes)

9:10 - 9:30 * Module 2
Presentation on the need for sexuality counseling within the family planning setting (20 minutes)

9:30 - 10:00 * Module 3
Exercise on Terminology (30 minutes)

10:00 - 10:10 * Discussion of exercise by presenter (10 minutes)

10:10 - 10:30 * Module 4
Anatomy exercise (20 minutes)

10:30 - 10:45 * Discussion of exercise by presenter (15 minutes)

10:45 - 11:00 * Break.

11:00 - 11:45 * Module 5
Presentation of human sexual response system (45 minutes)

11:45 - 12:00 * Discussion & questions (15 minutes)

12:00 - 1:00 * Lunch (1 hour)

1:00 - 1:25 * Module 6

Small group exercise on introducing sexuality into counseling setting (25 minutes)

1:25 - 2:00 * Discussion of exercise (35 minutes)

2:00 - 2:15 * Break (15 minutes)

2:15 - 2:35 * Module 7

Presentation on referring clients for long term therapy (20 minutes)

2:35 - 3:00 * Structured referral practice in pairs (25 minutes)

3:00 - 3:10 * Questions answered (10 minutes)

3:10 - 3:30 * Module 8

Evaluation (20 minutes)

3:30 - 4:00 * Presenter available for individual questions (30 minutes or as desired)

MODULE 1: REGISTRATION

Module 1: Guide for Conducting Registration

1. Have coffee, tea, and perhaps pasteries available.
2. Participants sign in.
3. Handout nametags.
4. Handout workshop packets.
5. Direct participants regarding the facility (restrooms, etc.) and where to be seated.
6. Ask participants not to smoke during the workshop itself unless it is a rare group of all smokers who do not mind.

MODULE 2: INTRODUCTION

Module 2: Guide for Introducing Workshop

1. Introduction of presenter.
2. Explanation of need for sexuality counseling within family planning setting (See Module 2: Presentation Guide).
3. Review of outline.

Module 2: Presentation Guide

The Need for Sexuality Counseling Within the Family Planning Setting

Though fraught with myths and fallacies; television, novels, `check-out stand' magazines, and motion pictures may be the main source of sexual information for a large percentage of our population.[1] Freely available to adults and adolescents, the media often exploits sexuality to catch and hold attention. For example, in a recent advertisement one blue jean manufacturer used a well known teenage, female model who was topless. In the media commonplace sensuality does not seem to be enough. Characters are portrayed as super-human individuals with voracious sexual appetites, perfect bodies, and extraordinary sexual performances. This portrayal is one of fantasy, not reality.[2]

Bernie Zilbergeld, author of the book, "Male Sexuality", contends that sexual learning takes place even when awareness of the messages being

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[1] Abramson & Mechanic (1973)

[2] Zilbergeld (1978)

sent and received does not exist.[3] When this "fantasy" model is all that is portrayed, its influence can be pervasive. Other authors[4] have concluded that this is the only concrete model of heterosexual behavior that many men and women have.

The lack of a realistic model for sexuality preys upon insecurities, compounds communication difficulties, and creates dissatisfaction within the sexual realm. Few remain immune to the barrage of myths. One study[5] demonstrated the need for professionals to disseminate more general information on human sexual response. It found that 85% of the participants in their classes on female sexuality learned something they did not know before they took the class. This same study cited other authors[6] who demonstrated that many women still hold the belief that they SHOULD be

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[3] Zilbergeld (1978)

[4] Goldstein & Kant (1973)

[5] Wilcox & Hager (1980)

[6] Wilcox & Hager (1980), Barbach (1975), Fisher (1973), and Hite (1976)

able to attain orgasm through intercourse without direct clitoral stimulation.

Research in the area[7] supports the contention that sexual problems are common, even in the "normal" population. Masters & Johnson[8] estimate that half of all marriages are troubled by sexual problems. Helen Singer Kaplan[9] contends that sexual dysfunction is "the most prevalent medical complaint in the world -- more common than the common cold". Another study[10] suggests that there are a significant number of sexual problems among the "normal" college, female population. Of 1000 young women receiving gynecologic or contraceptive services at a women's health service, 74% expressed orgasmic difficulties, 58% dyspareunia (painful intercourse), and 46% body inhibitions. The same respondents reported that they perceived that their partners had problems with premature ejaculation (46%), too much interest in sex (33%),

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[7] Frank (1978), Levine (1976), Golden (1977), Tyson (1979)

[8] Masters & Johnson (1970)

[9] Helen Singer Kaplan (1977)

[10] Weismeir & Forsythe (1982)

Forty-five percent of these women expressed a desire for sexual counseling and twenty percent thought their partners would desire sexual counseling.

Another study[11] looked specifically at family planning clinic staff and clients. They found that four out of ten family planning clients have sexual concerns with which they would like help. More importantly, they found that clinic staff underestimated by half the degree of sexual dysfunction among their clients.

An unpublished 1984 study at an abortion clinic in Illinois looked at the desire for sexuality counseling among its patients. For a year, each woman seen for an abortion was asked to complete a questionnaire and return it to the clinic approximately two weeks post-abortion. 16.48% of the respondents stated they felt that they and their partner could have benefited from sexuality counseling. This figure may be low as sexuality can seem the least of problems when going through an abortion experience.

[11] Golden, Golden, Price, and Heinrich (1977)

Where do these men and women turn for sexual information and counseling? Some (certainly a minority) will turn to trained, competent sex therapists. Unfortunately, many others will be faced with more difficulty. Helen Singer Kaplan[12] quotes William Masters as giving an informal estimate of 3,500 "quack" sex clinics in the U.S. The literature decries the lack of sexuality training in the field of mental health[13], special education[14], and medicine[15]. Sadly there is also a paucity of training available to family planning counselors. Yet, these professionals are the ones who are most likely to come into contact with sexually active couples, many of whom are experiencing sexual difficulties.

Sexuality counseling can be divided into several helpful steps that include permission giving, limited information, specific suggestions, and intensive therapy[16]. This format allows

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[12] Kaplan (1977)

[13] Fyfe (1980)

[14] May (1980)

[15] Tanner, et al. (1976)

[16] Annon (1974)

professionals, such as those in the family planning field, to provide useful assistance to couples without doing intensive therapy. As it is unusual for someone in the family planning field to be qualified to do intensive therapy, it seems imperative that they be trained to give adequate referral information.

There is a desperate need for more training to be available to family planning professionals in the areas of sexual permission giving, sexual information giving, and specific sexual suggestions. Though a counseling manual on handling sexual concerns has been written for family planning professionals[17], it was based on the assumptions that counselors understand their own sexual attitudes and are presenting themselves in an assured, comfortable manner that allows clients to bring up sexual topics. While this would be ideal, work in the field suggests that this is not typically the case.

The current manual assumes a basic knowledge of counseling skills as did Beresford and Garrity (1982). It does not assume, however, that (1)

[17] Beresford & Garrity (1982)

family planning counselors have mastered the field of sexuality, (2) that their intrinsic style gives clients permission to discuss sexual concerns, nor (3) that they typically ask questions to bring up the topic.

From a review of the literature and work in the field, the current manual is based on the following premises:

(1) There are many sexually active men and women with sexual concerns.

(2) Vast numbers of sexually active people are seen at family planning clinics, making these clinics an ideal place to bring sexual concerns.

(3) Family planning professionals are not typically well trained to respond to these concerns.

(4) Training can be provided in a relatively simple fashion with workshops designed similarly to the present manual.

(5) Sexuality counseling can (and should) be provided in the family planning setting without major changes in the amount or type of counseling currently being provided.

The present manual provides information about sexual anatomy and physiology in a manner that can be used by counselors in the family planning field. It attends to the issue of allowing sexual concerns to arise within the contraceptive counseling setting. This is accomplished by helping professionals recognize when a client has sexual concerns and giving the professionals practice at listening and discussing a number of these problems. Finally, it provides structured suggestions surrounding referral for long term therapy.

MODULE 3: TERMINOLOGY

Module 3: Exercise on Terminology

1. Explain exercise. EX. "You will each be given a list of five terms related to sexuality. I would like you to get up and move about the room to find another participant who can define the first term on your list. Have that participant explain the term to you and write their first name on the line beside the term. Repeat this until you have defined all the terms on your list. You will have a total of 20 minutes to complete this exercise."
2. Give each participant a list of terms (see Handouts 1-5 or design you own).
3. Reiterate 20 minute time limit and answer any questions participants have about your instructions.
4. Wait for participants to complete exercise.
5. Explain to participants that they should not be concerned if they have a term which no one could define. Discuss exercise (see Module 3: Discussion of Exercise). Place newsprint sheets with definition of all terms on wall

(or give participants a copy of the glossary in this manual).

HANDOUT 1

Term	Name of Participant who defined term
AMMENORRHEA	_____
CLITORIS	_____
DYSPAREUNIA	_____
FROTTAGE	_____
REFRACTORY PERIOD	_____

HANDOUT 2

Term	Name of participant who defined term
BOOTY	_____
DYSMENORRHEA	_____
FELLATIO	_____
LABIA MAJORA	_____
ORGASMIC PLATFORM	_____

HANDOUT 3

Term	Name or participant who defined term
COME DOWN	_____
EPISIOTOMY	_____
FRENULUM	_____
LABIA MINORA	_____
MUTUAL MASTERBATION	_____

HANDOUT 4

Term	Name of participant who defined term
ENDOMETRIUM	_____
GO DOWN	_____
HYMEN	_____
PERINEUM	_____
SEX FLUSH	_____

HANDOUT 5

Term	Name of participant who defined term
AREOLA	_____
CHERRY	_____
CUNNILINGUS	_____
FORESKIN	_____
HIGH NATURED	_____

Module 3: Discussion of Exercise

The Need for a Solid Understanding of the Terminology

As in other areas, the family planning and the sexuality fields have numerous important terms. The field of sexuality, however, bears a double burden. Professionals need to know not only clinical terms, but also slang terms which are often a client's only way of expression.

Imagine a post-abortion client telling you she really doesn't need a method of birth control as they "usually do it in the booty." Not knowing the term "booty", a counselor might think the couple only had sex in the car, during menstrual periods, or under water! The term "booty" actually refers to the buttocks and the client meant she and her partner usually have anal intercourse.

Though having a mastery of both the clinical and slang terminologies is extremely important in doing sexuality counseling, one cannot expect to know every possible term a client might use. This being the case, it is helpful to have a plan for

handling the unknown term. This "plan" might include the following:

- Expect clients to use terms you do not know.
- Be assured that there is no need to become embarrassed or flustered when you don't understand a term.
- Use the opportunity to model for the client how you clarify information that is confusing.
- Be honest and tell the client you do not know what was meant by the term used.
- Ask for the client's help in explaining what the term means to her/him. (Remember, what it means to her/him may be different than what it might mean to others.)
- If it is a term you are personally uncomfortable using, feel free to explain to the client that you would be more comfortable using another term or expression in its place. EX. "Everyone is comfortable with different words. I want to let you know that it is OK for you to

say, "down there" but I, myself, am more comfortable using the word vagina."

The glossary in this manual provides a broad coverage of terminology clients might use when discussing sexual issues. It can be useful to read through the glossary not only to learn new terms but also to gain an awareness of the terms that produce personal discomfort.

MODULE 4: ANATOMY

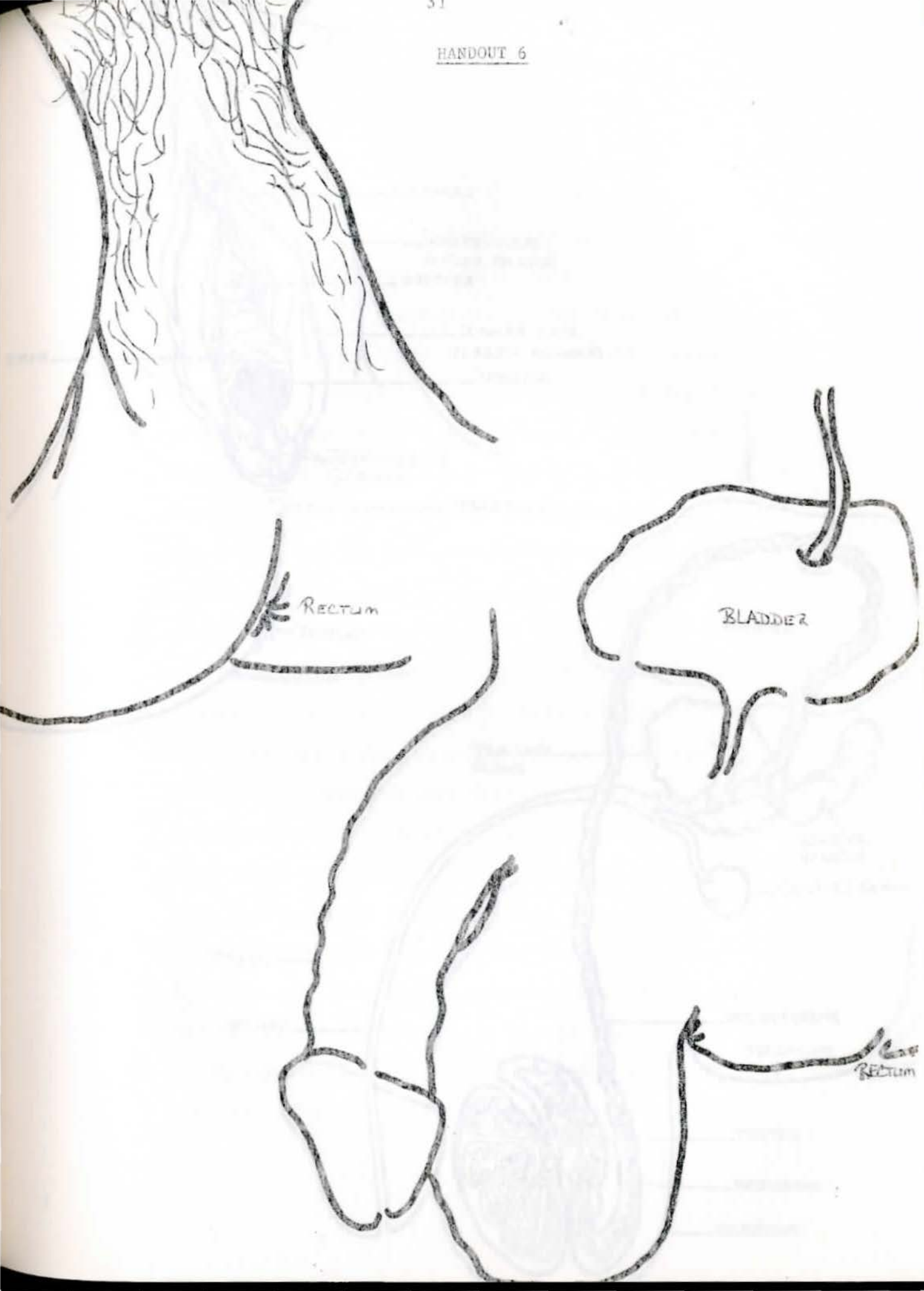
Module 4: Anatomy Exercise

1. Explain exercise. EX. "You will each be given a sheet of paper on which is printed a rough outline of the male reproductive system and the external female genitalia. What I would like you to do is fill in as many of the details in the drawings as you can, labeling each part. Please feel free to turn to the person sitting next to you and work in teams of two. You may also work individually, if you prefer. Please do not worry about the quality of your art work. Also, please work quickly as you will only have 15 minutes to complete both diagrams."
2. Hand each participant a rough diagram (see Handout 6).
3. Reiterate the 15 minute time limit and answer any questions participants have regarding your instructions.
4. Wait 15 minutes for participants to complete drawings.
5. Explain that the time is up and that participants who are not finished should not

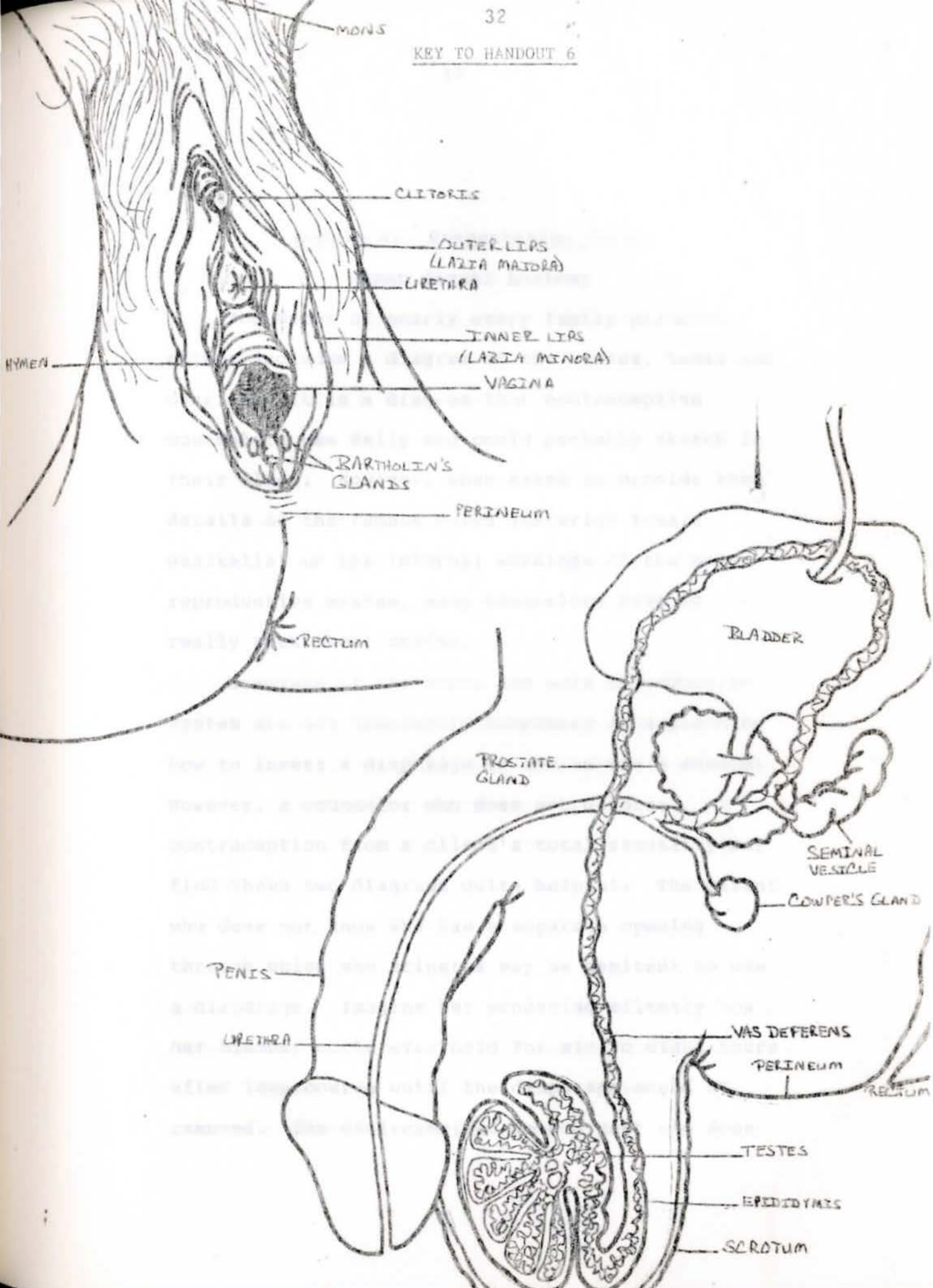
be concerned. Give each participant copies of the Key to Handout 6. It may also be helpful to place completed copies of both drawings on newsprint on the wall, or make a transparency of each of the drawings.

6. Discuss the drawings and the exercise (see Module 4: Presentation Guide).

HANDOUT 6



KEY TO HANDOUT 6



Module 4: Presentation Guide

Human Sexual Anatomy

The decor of nearly every family planning clinic includes a diagram of the uterus, tubes and ovaries. It is a diagram that contraceptive counselors use daily and could probably sketch in their sleep. However, when asked to provide the details of the female vulva (exterior female genitalia) or the internal workings of the male reproductive system, many counselors have to really pick their brains.

Diagrams of the vulva and male reproductive system are not absolutely necessary in explaining how to insert a diaphragm or how to use a condom. However, a counselor who does not divorce contraception from a client's total sexuality may find these two diagrams quite helpful. The client who does not know she has a separate opening through which she urinates may be hesitant to use a diaphragm. Imagine her wondering silently how her bladder could ever hold for six to eight hours after intercourse until the diaphragm could be removed. The uncircumcised condom user who does

not know whether or not the foreskin should be pulled back before applying a condom may be quietly wondering how on earth he is going to stuff the foreskin in the tip of the condom, ahead of his penis.

Since there is no way to know all possible myths and worries clients may have about sexuality, it is helpful for family planning counselors to have accurate knowledge about anatomy. By imparting this knowledge openly and accurately to clients, myths can be dispelled and troublesome concerns can be set to rest in a few moments.

With or without a diagram, the external female genitalia may be described as follows: The part of the female anatomy that can be seen is often called the vulva. It includes the mons, which is the area of fatty tissue over the pubic bone that is covered with pubic hair. The vulva also includes the inner and outer labia. The outer labia (or outer lips) consist of fatty tissue and are also generally covered with pubic hair. These outer lips have sweat glands and are often responsible for producing an odor which many

women mistake as coming from their vaginas. The inner labia are the hairless folds of skin surrounding the vaginal opening that meet at the top to form the clitoris. They are rich in blood cells but have no fat cells. The clitoris is the small mound of tissue that can be seen and felt in front of the vagina. (It also branches into two parts and extends inside the body attaching to the bony pelvis.) The exterior portion of the clitoris consists of a head and shaft covered by a hood. The clitoris is similar in structure to the penis and developed, embryologically, from the same tissue. This tiny mound of tissue contains about as many nerve endings as the penis and is the only organ in either gender which has erotic pleasure as its sole function. Between the clitoris and the vaginal opening is a separate, tiny opening called the urethra through which urine passes from the body. The vagina is a collapsed space within the body which can expand to accommodate a tampon, a finger, a penis, or a baby. Only the outer opening of the vagina can be seen. Surrounding that opening is a little ruffle of tissue called the hymen.

Hymens are like snowflakes, in that no two are exactly alike. Historically, intact hymens have become equated with virginity. Some women have hymens that can stretch without tearing to allow penile penetration while other women have hymens that tore years ago during physical activities unassociated with intercourse. A few women have hymens that totally cover the vaginal opening such that they need to be surgically removed at the time menstruation begins.

On either side of the posterior section of the vaginal opening are two tiny openings called the Bartholin's glands. Though these were once thought to be responsible for vaginal lubrication, and they do produce some fluid, their actual purpose is not known. Between the vagina and the rectum is an area called the perineum. It is in this area that an incision called an episiotomy is often made during childbirth to prevent it from tearing. The rectum, or anus, is the opening through which a bowel movement passes from the body. The perineum and the rectum are both areas that many people enjoy having stimulated during sex play.

The male sexual anatomy consists externally of the penis and the scrotum. The scrotum is a wrinkled, haircovered sack of skin which hangs just beneath the penis. Inside the scrotum are two testes or testicles which produce sperm. Sperm production requires a temperature slightly less than normal body temperature. The scrotum is capable of moving up or down to adjust the temperature of the testicles to help accommodate a hot bath or cold day. To mature, the sperm move into a twisted maze of tubes next to the testicle called the epididymis. From the epididymis the sperm travel through a spaghetti size tube called the vas deferens up around the bladder to the seminal vesicles. In the seminal vesicles 70% of the seminal fluid (ejaculate) is produced. The sperm and the fluid continue to the prostate gland where the rest of the seminal fluid is produced. Sperm is stored in both the seminal vesicles, the prostate gland, and the Cowper's gland. The Cowper's gland also produces a neutralizing fluid released at the beginning of sexual excitement to clean out the urethra. This is necessary because

the urethra is the passageway for urine as well as semen.

Inside the prostate gland is a valve like mechanism that closes off the passage from the bladder during sexual arousal preventing urine from being released during ejaculation. Since there is not another valve at the tip of the penis, men will have droplets of urine come from the penis after they have finished urinating.

The penis consists of three interior cylindrical structures, two corpus cavernosa and one corpus spongiosum. These spongy areas fill with blood during excitement causing an erection. The urethra is within the corpus spongiosum. At the tip of the penis is the head or glans. The edge of the glans (next to the shaft of the penis) is called the coronal ridge. On the underside (of a flaccid penis) the coronal ridge forms a triangular area called the frenulum, which is particularly sensitive. Flaccid penises may vary in size from about 3 to 4 inches in length. Erect penises are generally not more than 6 1/2 inches in length.

Some men are circumcised, which is the removal of the foreskin, and some aren't. To conceptualize this, grasp one of your arms just above the wrist. Slide the loose skin down your arm toward your wrist. This little bit of extra skin is similar to the foreskin of a penis. On a an uncircumcised penis, however, there is enough "extra" skin to hang down and cover the glans or head.

Though this anatomical description has been simplified, it can be further condensed while still providing a client with more information than they may have ever received. Since the source of sexual information for most people is not from medical texts or informed professionals, you may be dismayed over how little accurate information has been made available to many of your clients.

MODULE 5: HUMAN SEXUAL RESPONSE

Module 5: Information for Presenter

After a 15 minute break the course leader will present a 45 minute segment on the human sexual response system. It is helpful to keep the diagrams of human sexual anatomy posted on the wall during this presentation. It is also helpful to allow enough time in the presentation for the participants to ask questions, encouraging them to do so.

To help the participants organize and retain the information you are providing you might wish to place newsprint on the wall that outlines what occurs in each phase of sexual arousal for both males and females (See Module 5: Presentation Guide).

Module 5: Presentation Guide

Human Sexual Response

Masters and Johnson have provided one of the best descriptions of the human sexual response cycle. They have divided it into four phases (excitement, plateau, orgasm, and resolution) and documented changes that occur in both the male and female in each phase. The following is a summary of their description. More detailed information can be found in their book entitled Human Sexual Response (1966).

MALE PHYSIOLOGY

During the excitement phase of sexual response a man's penis becomes erect. This is a result of the blood flowing into but not back out of the spongy tissue inside the penis. In addition to the erection, the scrotum will smooth out and the testes will enlarge and rise toward the body. At the same time his nipples will become erect.

During the plateau phase the diameter of the head of the penis will enlarge and the penis will darken in color. The testes will become 50-100%

larger, continue to rise and will also rotate forward. It is at this point that the Cowper's gland releases its small amount of neutralizing fluid. Though this fluid may contain sperm its release is not an ejaculation.

The orgasm phase of sexual response is divided into two parts for men. In the first phase the vas deferens, prostate, and seminal vesicles contract to force semen into the bulb of the urethra. It is at this point that ejaculation is inevitable. In other words, once the semen reaches this point it does not matter what someone says or who walks in the room, the orgasm cannot be stopped. In the second phase of male orgasm the urethra, penis, and prostate gland contract to force the semen out of the penis.

It is noteworthy that orgasm is possible without ejaculation. The two are actually separate processes. It is also possible that the semen will be released back into the bladder instead of coming out of the penis. This is termed retrograde ejaculation. It is common among paraplegics and causes no health problems aside from infertility.

During the resolution phase, men's bodies return to their pre-aroused state. The blood flows back out of the spongy tissue in the penis and the penis becomes flaccid. Skin color returns to normal and the nipples relax. The testes return to their normal size and position. During this phase men experience what is called a refractory period. This is a span of time during which arousal is not possible. The length of this time span varies from man to man and typically increases with age.

FEMALE PHYSIOLOGY

In the excitement phase women's vaginas "sweat" producing lubrication. This is caused by vasocongestion or the rushing of blood to the pelvic area. There are no actual sweat glands in the vagina. The term "sweat" is merely descriptive. Lubrication will begin to happen within 10 to 30 seconds of arousal. It is important to note, however, that once lubrication begins it does not necessarily continue. Rather, it can start and stop depending on the woman's level of arousal. Also during the excitement phase, the inner two-thirds of the vagina expand,

the cervix and uterus move upward, and the outer lips flatten and move apart. The clitoris and breasts enlarge and the nipples become erect.

During the plateau phase the outer third of the vagina swells, narrowing the opening and forming what Masters and Johnson call the orgasmic platform. The inner two-thirds of the vagina expand more, creating a tenting effect. The clitoris retracts under its hood against the pubic bone. In this position the clitoris is stimulated by the hood moving back and forth over the head. When the penis moves in and out of the vagina it moves the inner lips which, in turn, move the hood. This type of clitoral contact is not as direct as manual stimulation. Still in the plateau phase, the inner lips enlarge (becoming double to triple their normal size) and their color darkens. The color changes from pink to bright red in women who have never had babies and from bright red to deep wine in women who have given birth. It is also during this phase that the areola or dark area around the nipple swells.

During orgasm, which occurs in only one stage for women, there are rhythmic contractions of the

uterus, anal sphincter and outer third of the vagina. At this point the sex flush (or darkening of the skin on the body) is greatest. Though the uterus contracts during orgasm, it is not necessary, and women who have had hysterectomies are still quite able to have orgasms.

During the resolution phase the vasocongestion diminishes and the body returns to its typical size and color. Women do not physiologically need a refractory period before continued arousal. For this reason they are physically capable of multiple orgasms, never dropping below the plateau level. Sadly, this piece of information has created unnecessary sexual pressures for some women.

In reviewing these phases of sexual arousal it is important to bear in mind that sexual excitement normally waxes and wanes. If people expect their arousal level to begin at point A and unwaveringly climb to a point of simultaneous, multiple orgasms, they may well be in for a disappointment or worse yet, a sexual dysfunction.

The following analogy[1] illuminates the natural patterns of rising and falling arousal: Sex is like climbing a mountain. First, you pick a partner to go with you and then you set aside a time that is convenient for both of you. You probably want to take along protective devices, such as rubber-soled shoes, so you don't slip. As you approach the path and see the mountain you become excited about the trip upward. The path, however, does not go in a straight line from the base of the mountain to the peak. Rather, it winds and curves, sometimes going up, sometimes staying level, and sometimes dipping back down a bit. When the path dips down you don't panic that you are no longer on your way to the top but you enjoy the rest and less strenuous steps. As you follow the path and its curves you stop and smell the flowers and enjoy the view. Sometimes you can see the top of the mountain and sometimes you can't. Sometimes you can look down and see where you've come from and sometimes you can't. The whole trip is enjoyable, not just carving your name on the rock at the top. It can be pleasant

[1] Personal Communication, Clifford (1983)

to stop and rest and talk or picnic along the way. It can be special just to stop and silently enjoy a particularly spectacular view; surely more pleasant than to climb furiously to the top with no rest, no conversation, and no appreciation of the view along the way. Some days you may just want to climb to a favorite spot half way or a third of the way up with no intention of going all the way.

MODULE 6: INTRODUCING SEXUALITY INTO CONTRACEPTIVE COUNSELING

Module 6: Exercise on Asking Sexual Questions

1. Introduce this section of the course. Ex. "Now that you have gained information on the topic of sexuality you're going to have a chance to see how it can fit into the birth control counseling situation. You will participate in a brief,simple, structured exercise that will give you a chance to see how the information can be incorporated into your counseling sessions without seeming intrusive or taking alot of time."
2. Explain exercise. EX. "You will each be given a list of questions that a counselor might ask a client during a birth control session. You are to pick a partner and ask them the first 6 questions on the list. You may paraphrase the questions. Your partner is to respond to each question very briefly. The two of you are to act as though you are client and counselor in a birth control clinic. Finally, your partner will ask you the last 6 questions on the list, to which you will respond briefly. Please do not get involved

in long role play situations, merely take note of how you feel both as you ask and as you are asked the questions. You will only have 15 minutes to complete the exercixe. Please choose someone to work with that you have not worked with today, and preferably someone you do not know well."

3. Hand out lists of questions (see Handouts 7 & 8 or design questions of your own). Try not to give identical lists to dyads sitting close to each other.
4. Reiterate the 15 minute time limit.
5. Give participants 15 minutes to ask each other the lists of questions.
6. Discuss the exercise asking the participants to share with the group (or in small groups if they are not comfortable talking in a large group) how they felt both as they asked and were asked the questions. Did they feel intrusive? Did they feel intruded upon? Did they feel as though they were offering something helpful? Did they feel as though they were being offered help? (see Presentation Guide: Introducing Sexuality

into Contraceptive Counseling).

HANDOUT 7

First 6 Questions

1. What effects has your current method of birth control had on your sexual relationship?
2. Do you ever have pain or discomfort with intercourse?
3. What questions about sexuality have you never gotten a chance to ask before?
4. How has this pregnancy (or a past one) affected your sex life?
5. How has your parnter's sex drive been affected by this method of birth control?
6. How might bringing your partner with you to the clinic effect the way the two of you discuss sex?

HANDOUT 7 (Continued)

Second 6 Questions

1. How has going on the pill effected the amount of lubrication you have during intercourse?
2. How might I help you regarding questions about sexual relationships?
3. How do you think this method of birth control effects your partner's sexuality?
4. What problems might you have in discussing this method of birth control with your partner?
5. How has this method of birth control effected your sexual relationship?
6. How do you think not having to worry about pregnancy would effect your sexual relationship?

HANDOUT 8

First 6 Questions.

1. How does fear of pregnancy affect your sex life?
2. How do you think changing methods of birth control would affect your sexual relationship wtih your partner?
3. How do you think asking your partner to participate in birth control would affect him sexually?
4. What effects has using a condom had on your lubrication?
5. How has using foam and condoms affected talking to your partner about what you enjoy sexually?
6. What questions about your body and sex can I answer for you?

HANDOUT 8 (Continued)

Second 6 Questions

1. What effects has using an IUD had on discussions about sex between you and your partner?
2. What differences do you expect in your sexual relationship with your partner now that you'll be using this method of birth control?
3. How has this method of birth control effected you in terms of having orgasms?
4. What would you like to ask the doctor about your sexuality?
5. What effects has the abortion had on your sexual relationship?
6. What effects has using a diaphragm during love making had on your partner?

Module 6: Presentation Guide

Introducing Sexuality into Contraceptive Counseling

There are a number of different types of questions that can be used in bringing up the topic of sexuality. These might include:

a) Questions that let clients know, in general, it is alright to discuss the topic with professionals
b) Questions regarding communication between partners
c) Questions regarding the client's sexuality
d) Questions regarding the client's partner's sexuality
e) Questions regarding effects of pregnancy and birth control methods on sexuality
f) Questions regarding the sexual relationship between the client and his or her sexual partner

Counselors in the family planning field need not memorize a specific list of questions to ask clients (though this may be helpful at first) but

rather should be aware of general areas in which there may be sexual concerns.

Clients may not be used to discussing sexuality within the family planning setting, they may be hesitant, responding only briefly. Asking open ended questions rather than yes/no questions can help encourage the client to discuss concerns. Open ended questions avoid the bind of a client responding by saying, "no" (but thinking they really wish they felt comfortable discussing it) and the counselor moving on to another topic because the client indicated no desire for help. If the question is phrased to indicate that clients are expected to provide a bit of information they will be less likely to retreat from the topic. They remain, however, free to respond that they have no concerns about sexuality.

The following example highlights differences in questioning style and responses elicited.

COUNSELOR A: Has the pill caused any problems with lubrication?

CLIENT: No. (Thinking: Well, I've always had problems with it so I guess it isn't the

pill.)

COUNSELOR B: How has going on the pill affected the amount of lubrication you have during lovemaking?

CLIENT: (Thinking: Oh, I didn't know they talked about this sort of thing here.) Well, not really.

COUNSELOR B: Not really?

CLIENT: I've always sort of had problems with that.

COUNSELOR B: That's not unusual, many women do. Tell me a little more about what the problem has been for you.

CLIENT: Well, I start out OK but then it just goes away.

COUNSELOR B: You mean you're lubricated at first but then your vagina becomes dry?

CLIENT: Yes.

COUNSELOR B: Many people don't know that once lubrication begins it can start and stop and then start again. Sometimes, if a couple begins to have intercourse just as a woman

begins to lubricate, her lubrication will dry up. If she focuses on her discomfort rather than pausing from intercourse to engage in other arousing activities she can loose interest and never begin to lubricate again.

CLIENT: I see, I guess I just don't always give myself a chance.

COUNSELOR B: Do you have any other questions?

CLIENT: No, just that, thank you.

It is helpful to remember that even when a question is worded in an open manner and the client really does have a concern, it still may not come out. Yet, by asking questions regarding sexuality, it allows clients to learn that it is appropriate to come to you or your agency with questions in the future. Some clients may need to hear you ask sexual questions on several different visits before they are able to take advantage of the opportunity to discuss their concern. Clients need permission to discuss sexuality. Routinely asking questions in the area lets them know that you are open to the topic.

A manual that is very helpful for counselors who are comfortable initiating the topic of sexuality is Beresford and Garrity's Short Term Counseling of Sexual Concerns put out by Planned Parenthood of Maryland.

No matter how much you know about sexuality, however, if you do not bring the topic up first, many clients will not feel comfortable asking even simple questions.

MODULE 7: REFERRAL

Module 7: Presentation Guide

When and How to Refer

Most family planning professionals sincerely wish to be of help to people or they probably would not have entered the field. How they can be of the most help to clients can vary. Counselors who are open to the topic of sexuality will undoubtedly encounter situations which require referral to a qualified therapist. The balance in this decision lies between sending every client who asks a sexual questions to someone else and attempting psychotherapy for personality disorders. For the counselor it is a balance between feeling incompetent each time the topic arises and stepping beyond the scope of their abilities.

One authority[19] gives two broad guidelines and several specific suggestions to provide structure for counselors in making referrals for sexual concerns. His first guideline suggests that a referral should be made if the relationship with the client would change as a result of

[19] Kennedy (1977)

continuing to discuss the concern. If the roles can be maintained, then it is probably alright to proceed. The second guideline is to refer when the needs of the client go beyond the services usually offered. He maintains that good intentions and well meant advice are no substitute for a sound referral.

Proceeding from these two general criteria, several suggestions are made. Evaluating the anxiety presented by the client can be a key. While anxiety is usually a part of the presentation of sexual difficulties, is the anxiety a normal reaction to the unexpected development of a sexual concern, a characteristic of the client's general personality, or a symptom of a more basic conflict? In the latter instance, the sexual problem may have resulted from ongoing depression or some other emotional conflict.

It is also suggested that the counselor look for "anchor points" in the client's perceptions of the problem. If the client tells of the concern in a disordered or incomplete manner, if there is a confusion about the presentation, or if he or she insists that only his or her (and no one

else's) interpretation of the situation could possibly be correct, then the counselor has evidence on which to base the decision to refer.

In addition to anxiety and the client's own perceptions, pay attention to the history of the problem. Note: if it is a long term difficulty, what the present motivation for treatment is; if the client blames someone else entirely; if she or he has a low sense of self esteem; the use of drugs and alcohol in dealing with the problem; and any past psychological difficulties. These can all provide information helpful in deciding on referral.

The previously mentioned manual[20] provides four clear guidelines for counselors to follow in referral: 1) when there is a major dysfunction that is longstanding, 2) when the client has many conflicts along with their sexual concerns, 3) when a couple is not committed to their relationship (or have had problems for a long time), and 4) when the problem is not in an area in which the counselor feels prepared to help.

[20] Beresford & Garrity (1982)

Counselors will deal with situations in which a referral is given and refused. Refusal may come in many forms; lack of money, denial that the problem warrants it, blame placed on partner, etc. Sometimes the reasons are legitimate and sometimes they are not. In either case, refusal of a referral is no justification for a counselor to continue to see a client who she or he is not qualified to help. If a client needed neurosurgery, a counselor would not agree to perform it.

Denying a client help can be particularly difficult, especially when the client claims that he or she could not get any (better) help elsewhere. Yet it may be a firm denial that provides the client with the structure and motivation to seek the help they need, if not now, in the future.

Where to refer will vary from location to location. Ideally, each family planning clinic would have a list of qualified therapists in their area. In formulating such a list it is helpful to begin with the local mental health clinic. They are affordable and available. It would be wise,

however, to contact them first and ask if they have someone on their staff qualified to deal with sexual issues.

Other sources from which to draw are the American Association of Sex Educators, Counselors, and Therapists (5010 Wisconsin Avenue NW, Suite 304, Washington, DC 20016), and the American Association of Marriage and Family Therapists (1717 K Street NW #407, Washington, DC 20006).

Module 7: Referral Exercise

1. Explain exercise. EX. "It is usually easier to do something that you have done before. To make it easier for you to refer clients when the need arises, you are going to have a chance now to practice it. You will divide again into pairs, preferably with someone with whom you have not yet worked individually. Each pair will be given a handout that describes two situations in which a sexuality concern has arisen. After reading the first situation, one person will play the role of the client while the other plays the the role of the counselor. The situations will be described in some detail so that you will have a chance to really show your acting abilities! You will have 20 minutes to complete both role plays, so please do not spend more than 10 minutes on either one. What you will be trying to do is give a referral, even if the client is hesitant or resistant about accepting it."

2. Distribute HANDOUTS 9 & 10 so that dyads sitting close to each other do not have identical handouts.
3. Reiterate 20 minute time limit.
4. Give participants 10 minutes to complete first role play and then alert them to the time such that they can begin the second role play.
5. Wait 10 minutes for participants to complete the second role play.
6. Discuss any questions that came up during the role plays.

HANDOUT 9

First Situation

CLIENT: You have finally found someone with whom you feel you can discuss the fact that you have never had an orgasm. It has taken alot of courage to bring it up and now that you've done so you are determined to get help. You feel comfortable with the counselor and do not want to have to talk to anyone else. You have been married for 3 years and have a very understanding husband. He does not know, however, that you have been faking orgasms.

COUNSELOR: You are fairly comfortable answering sexual questions and feel people have a right to information in this area. A female client has confided in you that she has been faking orgasms and she wants help. You have also faked orgasms and are in the process of deciding whether or not to tell your partner. Under the circumstances, you do not feel you are qualified to help her and suggest that she see a counselor at the local mental health clinic.

HANDOUT 9 (Continued)

Second Situation

CLIENT: You and your partner have not been getting along for the past several years and you feel it is time to get some help. In the past year even your sex life has fallen apart. Neither of you seem interested in each other sexually or otherwise. You have thought about ending the relationship but have invested alot in it and feel if only your sex life would improve the relationship would be OK.

COUNSELOR: You have just been to a workshop on sexuality and are anxious to practice the skills you have learned. The first client you see after the workshop states that they really want help with their sex life. You really want to help them and even ask several questions about the problems they've been having. You are torn between going farther or referring them to Dr. Peterson who is an excellent local marriage and family therapist.

HANDOUT 10

First Situation

CLIENT: You have come in the family planning clinic to get an IUD. You have used a diaphragm in the past but often your partner was not willing to wait until you put it in. You are on the pill now but he doesn't like you to take it and you are fearful you will get pregnant again. Your partner is abusive and you don't like to have sex with him. You fear that if you leave him no other man will ever have anything to do with you. You don't really want anyone to know he is abusive but would like to have some help with enjoying sex more. You do not have any extra money to use for therapy and have found someone you like at the family planning clinic who you think would see you for free.

COUNSELOR: You ask the client about her history of birth control use. Her answer leads you to suspect that she is involved in an abusive relationship. You feel you can help her with birth control but do not feel you are qualified to help her with her relationship problem. You want

to refer her to the local community mental health center because you know their fees are based on the ability to pay.

HANDOUT 10 (Continued)

CLIENT: You experience discomfort when you have intercourse and someone has finally asked you about it. You have seen therapists in the past but none of them has seemed concerned with the many physical complaints you have. You think even your gynecologist is insensitive to your medical problems. You are embarrassed to have to discuss sexual issues at all, but would like to enjoy it more so that it did not seem such a burden. You also find some relief in telling this understanding person about your many medical problems (backaches, headaches, horrible menstrual cramps, asthma, ulcers, etc.)

COUNSELOR: You ask if the client has ever had pain with intercourse and find that she has. In discussing it farther you find that she has discussed it with her gynecologist and has been told there is nothing physically wrong with her. As she talks you notice that not only does she seem embarrassed, but she has an inordinate number of medical problems. She claims to have been seen by many physicians and therapists but no one can seem to see her point of view. You feel that she

needs the services of a qualified therapist.

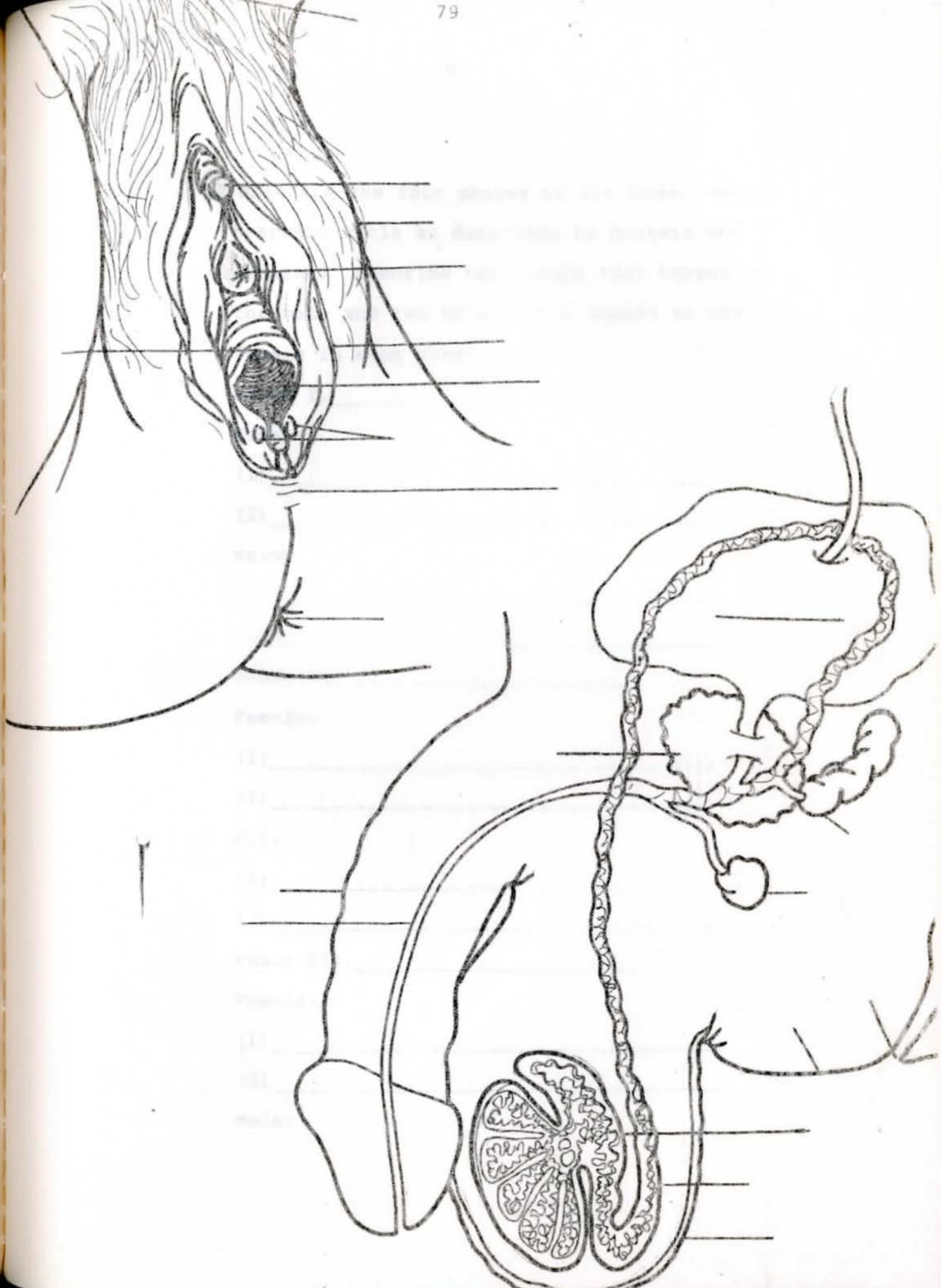
MODULE 8: EVALUATION

Evaluation

The evaluation section may be used in a number of ways. It can be used before a workshop to assess the areas that need to be covered, or at the end of a workshop to assess the amount of knowledge gained by participating. The evaluation may also be given to the participants to take home and use as a review, or to help them integrate the material into their own style of counseling.

Evaluation Section on Anatomy and Physiology

1. Label the following diagrams of male and female reproductive anatomy.



2. What are the four phases of the human sexual response cycle as described by Masters and Johnson? Describe two things that happen to the male and two things that happen to the female in each phase.

Phase I._____

Female:

(1)_____

(2)_____

Male:

(1)_____

(2)_____

Phase II._____

Female:

(1)_____

(2)_____

Male:

(1)_____

(2)_____

Phase III._____

Female:

(1)_____

(2)_____

Male:

(1)_____

(2)_____

Phase IV._____

Female:

(1)_____

(2)_____

Male:

(1)_____

(2)_____

Evaluation Section on Terminology

3.Give a brief definition of each of the following clinical and slang terms:

booty-

cherry-

clitoris-

come-

come down-

cunnilingus-

cunt-

douche-

down there-

erection-

fellatio-

foreskin-

go down-

high-natured-

hymen-

labia-

Monilia-

mutual masterbation-

retrograde ejaculation-

smegma-

testicle-

varicocele-

Evaluation Section on Discussing Sexuality

4. What are three questions you might ask a client during a contraceptive counseling session to asses the need for sexuality counseling?

(1)_____

_____

(2)_____

_____

(3)_____

_____

5. How often do you think you might ask one of these questions?

____Frequently

____Sometimes

____Seldom

____Never

Evaluation Section on Referral

6. The following concerns represent issues that could come up in counseling. Circle the letter preceeding those items which you feel would be most appropriate for referral to a specialized sex therapist.

a. A woman who has never had an orgasm

b. A man who has had ejaculatory difficulties for the past 5 years.

c. A woman who expresses that she has pain with intercourse.

d. A woman who is fearful that oral sex might cause disease or injury.

e. A man who is concerned that there is something physically wrong with him because he "drips" after urinating.

f. A woman who has not had an orgasm since her last child was born 3 years ago.

g. A man or woman who expresses that they can become sexually aroused only under certain circumstances such as in the presence of many others, bondage, etc.

h. A man who has had erectile problems since last month when he was intoxicated and lost an erection.

7. What might you be comfortable saying to one of those that you refer?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Evaluation Section on the Value of Sexuality Counseling

8. How valuable do you feel it is to include sexuality as a part of contraceptive counseling?

1	2	3	4	5
Of No Value	Of Little Value	Not Sure	Valuable	Very Valuable

(Place an X on the line to indicate how you feel.)

GLOSSARY

ABORTION
The termination of a pregnancy either through miscarriage (spontaneous abortion) or a surgical procedure (induced abortion).

ABSTINENCE
Refraining from some activity such as sexual intercourse.

AMENORRHEA
The lack of menstrual periods.

ANAL
Pertaining to the anus or rectum.

ANTERIOR
Toward the front.

AREOLA
The darkened circle of skin surrounding the nipple of the breast.

AUTOEROTIC
Having to do with self-stimulation or masterbation.

BARTHOLIN'S GLAND
Two very small glands located at either side of the vaginal entrance once thought to produce vaginal lubrication.

BEASTIALITY
Sexual relations with an animal.

BISEXUAL
Having a sexual interest in persons of both genders.

BOOTY
Slang for buttocks. "Doing it in the booty" is anal sex.

CELIBACY
The state of abstaining from sexual activity.

CHERRY
Slang for hymen.

CIRCUMCISION
Removal of the foreskin of the penis.

CLIMACTERIC
The stage in life in which there is a decline in the production of sex hormones, notably menopause in women.

CLIMAX
See orgasm.

CLITORIS
A small mound of tissue located at the anterior junction of the labia minora in women. The clitoris is highly sensitive, containing as many nerve endings as a penis. Its sole function is pleasure.

COITUS
Penis-vagina intercourse.

COITUS INTERRUPTUS
The cessation of intercourse just before male ejaculation for the purpose of contraception. Also called withdrawal.

COME
Slang for ejaculation.

COME DOWN
Slang for menstruation.Also referred to as "come on".

COPULATION
Intercourse.

CUNNILINGUS
Sexual stimulation of the external female genitalia by oral contact.

CUNT
Slang for vagina.

DOUCHE
To rinse the vagina with water or other fluid.

DOWN THERE
Slang for genitals. Clients who are uncomfortable using clinical terms may use this phrase.

DYSMENORRHEA
Painful menstruation. Spasmodic dysmenorrhea includes cramps, backaches, thigh pains, and nausea. Congestive dysmenorrhea is premenstrual syndrome.

DYSPAREUNIA
Painful intercourse.

EJACULATION
The release of seminal fluid from the penis, typically at the time of orgasm. Also, possibly, the release of fluid from some part of the female reproductive anatomy as a result of stimulation of the G-Spot. Slang: come shoot the wad, cream, etc.

ENDOMETRIOSIS
The abnormal presence of endometrial tissue (uterine lining) in other areas of the female pelvic cavity. This can cause strong cramping and a decline in fertility.

ENDOMETRIUM
The mucous membrane that forms the lining of the uterus.

EPIDIDYMIS
The network of tiny tubes in the male that connects the testicle with the vas deferens. It is in the epididymis that sperm mature.

EPISIOTOMY
The incision made in the female perineum at the time of childbirth to prevent the tissue from tearing irregularly.

ERECTION
The enlargement and stiffening of the penis due to vasocongestion usually during sexual excitement. Slang: hard on, boner, stiff, etc.

EROGENOUS ZONE
An area of the body particularly sensitive to sexual touch, such as the lips, nipples, anus, neck, etc.

EROTIC
Sexually stimulating or having to do with sexual stimulation.

EXHIBITIONISM
A syndrome in which an individual -- usually male -- feels a compulsion to inappropriately expose his genitals to others.

FELLATIO
Stimulation of male genitals by oral contact.

FETISHISM
A syndrome in which a particular object or type of object provides an individual with sexaul stimulation.

FOREPLAY
A term sometimes used to describe sex-play that precedes intercourse. The use of this term, however is goal oriented in that it does not allow such sex-play to be thought of positively as an end in itself.

FORESKIN
The loose skin covering the tip of an uncircumsized penis. Also the skin that covers the tip of the clitoris.

FORNICATION
A term used to describe intercourse between two unmarried persons. Adultery is a term used to describe intercourse between someone who is married and a person other than their spouse.

FOURCHETTE
The fold of tissue at the posterior junction of the labia majora.

FRENULUM
A particularly sensitive, triangular area just beneath the underside of the head of the penis. It connects the foreskin with the glans on an uncircumsized penis.

FRIGIDITY
A negativistic term used to describe a woman with inhibited sexual desire or orgastic dysfunction.

FROTTAGE
The induction of orgasm by rubbing against someone of the opposite sex, usually a stranger.

G-SPOT
An area about the size of a quarter on the anterior wall of the vagina reputed to produce female ejaculation and orgasm when stimulated.

GAY
Someone who is involved in a homosexual relationship, usually used to represent a male.

GO DOWN
Slang for fellatio or cunnilingus.

GLANS
The head of the penis or clitoris.

GYNECOMASTIA
Enlargement of the male breast.

HERMAPHROITE
An individual possessing both ovaries and testicles or
the external genetalia of both genders.

HETEROSEXUALITY
Sexual attraction to and preference for interaction with members of the other gender.

HIGH NATURED
Slang for strong sex drive.

HIRSUTISM
Abnormal hairgrowth such as that caused by some oral contraceptives for some women.

HOMOLOGOUS
Correspondence in origin, position and structure to another anatomical entity. The penis and the clitoris are homologous.

HOMOSEXUALITY
Sexual attraction to and preference for interaction with members of the same gender.

HYDROCELE
An accumulation of fluid in the scrotum.

HYMEN
The ruffled ring of tissue that surrounds the opening of the vagina. It was once thought that if this ring were torn or missing that the woman was no longer a virgin. It is now known that each women's hymen differs such that some allow penetration without damage and others tear from nonsexual activities.

HYSTERECTOMY
Surgical removal of the uterus. Removal of the ovaries is termed oophorectomy and removal of the Fallopian tubes is termed salpingectomy.

HYSTEROTOMY
An incision into the uterus. This term is also used to describe a seldom used type of abortion in which the fetus is removed by making an incision into the uterus.

IMPOTENCE
A negativistic term used to describe erectile difficulties.

INCEST
Sexual relations between close relatives as a father and daughter or a brother and sister.

INTROMISSION
The insertion of the penis into the vagina.

INVOLUTION
A shrinking or returning to original size as the involution of the uterus after childbirth.

LABIA MAJORA
The larger, hair covered outer lips of the female vulva or external genitalia. The posterior junction of these is a fold of mucous membrane called the fourchette.

LABIA MINORA
The smaller, inner lips of the female vulva or external genitalia which join at the top to form the clitoris.

LESBIAN
A female homosexual.

LIBIDO
Sex drive.

MAIDENHEAD
An outdated term used to describe the hymen.

MASTURBATION
Stimulation of one's own genitals or other sexually sensitive areas of the body.

MEATUS
An opening such as that at the end of the penis.

MONILIA
A vaginal infection, sometimes called a yeast infection, that causes itching, a discharge, and discomfort. It can be treated with various prescription creams and vaginal suppositories. Some women claim to have success in treating yeast infections by using plain yogurt or garlic vaginally.

MONS VENERIS
A triangular shaped mound of fatty tissue covered with pubic hair just above the vulva on a woman. Also called Mons Pubis.

MUTUAL MASTURBATION
Simultaneous manual stimulation of the other's genitals by sex partners.

NYMPHOMANIA
A dated term used to describe unsatiable sexual desire in a woman.

ORGASM
The release of a high degree of sexual tension.

ORGASMIC PLATFORM
A term used by Masters and Johnson to describe the shape of the vagina during sexual excitement. The inner two-thirds of the vagina expand and the outer one-third of the vagina contracts to form the orgasmic platform.

OS
An opening or mouth. The opening of the cervix in the vagina is called the cervical os.

PENIS
The male sex organ. Slang: rod, shaft, dick, prick, pecker, etc.

PERINEUM
That area of skin between the rectum and either the scrotum in the male or the vulva in the female

PETTING
A term used to describe sex play that does not include intercourse, such as kissing, holding, stroking a parnters genitals, etc.

POSTERIOR
Toward the back.

PREMATURE EJACULATION
A somewhat confusing term used to describe problems with ejaculatory control. The term premature is relative and not particularly useful in describing all situations of ejaculatory control difficulties.

PREPUCE
Foreskin.

PRICK
Slang for penis.

PROSTATE
A gland in the male body surrounding the urethra that produces about 30% of the ejaculate.

PUDENDUM
A term for external genialia, usually of the female.

REFRACTORY PERIOD
The span of time after ejaculation during which further orgasm is physiologically impossible. This span increases with age and is not physiologically required in a female.

RETROGRADE EJACULATION
Release of the semen back up into the bladder rather than out of tip of the penis. This condition is not unusual in paraplegic men and is not harmful.

ROD
Slang for penis.

SATYRIASIS
A term used to describe compulsive sexual activity in a man.

SCROTUM
The sac of skin covered with pubic hair that contains the testicles.

SEMEN
The fluid released from the penis at the point of ejaculation. It is produced by the seminal vesicles (about 70%) and the prostate gland (about 30%). Sperm from the testicles make up only about 3% of the fluid.

SEMINIAL VESICLES
Located on either side of the male prostate, these two small organs produce about 70% of the seminal fluid.

SEX FLUSH
A term used by Masters and Johnson used to describe the reddening of the skin caused by vasocongestion with sexual excitement.

SMEGMA
A thick, odorous, cheesy secretion that collects under the foreskin of the penis or clitoris.

SPHINCTER
A circular muscle that closes an opening such as the anal sphincter.

TESTICLES
Located in the scrotum, these two glands produce sperm.

TESTIS
See testicle.

TUMESCENCE
The process of swelling. A tumescent penis is one engorged with blood or erect.

URETHRA
Tube through which urine passes from the bladder outside the body. In the male, semen also passes through this same tube.

UTERUS
The pear-shaped muscular organ in the female body in which the embryo or fetus develops. The womb.

VAGINA
A flexible canal in the female genitalia which leads from the labia minora to the cervix. It is the canal through which a baby passes during birth, through which menstrual blood passes during menstruation, and in which a penis is inserted during intercourse. It is about 4 to 5 inches long in its relaxed state and does not remain an open space, but, rather, collapses unless something is inserted inside it. Slang: pussy, cunt, hole, slit, etc.

VAGINISMUS
Strong, involuntary contractions of the vaginal walls that prevent penile insertion.

VAGINITIS
An inflammation of the vagina, usually as a result of an infection or chemical irritation.

VARICOCELE
An enlargement of the veins in the vas deferens. Fertility may be affected as a result of this condition.

VASOCONGESTION
A congestion of the blood vessels, especially in the veins of the genital area. This surge of blood causes erection fo the male penis, enlargement of the female clitoris, and the sex flush, among other responses.

VESTIBULE
The area surrounding and including the vaginal opening.

VIRGIN
A term used to describe someone who has never had intercourse.

VULVA
The external genetalia of a female. It includes the labia majora, the labia minora, the cliorits, and the vestibule.

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* Denotes references cited within the text of the proposed manual.

Expert Review of Manual

The manual was sent to twelve readers in the family planning field across the country. The geographic regions represented include the northeast, the south, the midwest, the southwest, and the west coast. Of the readers, seven are family planning counselors, two are Executive Directors of Planned Parenthood affiliates, one is a Planned Parenthood Director of Education, one is a nurse practitioner, an one (who used to be a counselor) is on the executive staff of a regional Planned Parenthood office. All are women, as is typical of the field.

Each reader was asked to read the manual thoroughly, making comments and suggestions in the margins. In addition, each reader wrote a summary of her reactions on a separate sheet of paper. A compilation of their responses follows.

92% said they thought sexuality counseling was valuable, with 25% stating they thought it was very valuable.

Over half of the readers stated they felt the manual was an asset to the field, describing it as, "valuable," "excellent," "very necessary and important, and "informative."

25% were particularly impressed with how "well researched" the manual is. Several asked for copies of the bibliography and one called the manual a "good, concise review of the literature."

25% stated the the manual was informative and helpful, calling it "impressive" and stating it would be "helpful as required reading for reproductive health care counselors."

42% commented positively on the organization of the manual, calling it, "concise and well organized," "logical and easy to follow," "very clear," and "easy to understand."

42% expressed an obvious need for this type of manual or workshop.

17% liked the "cookbook" concept of the manual, though another 8% stated they felt using the term "cookbook" detracted from the professionalism of the manual.

8% complimented the professional tone and open attitude with which the manual was written.

25% stated they found the glossary "impressive" and indicated that they had learned new terms from reading it. 8% suggested the exercise in the terminology section of the manual be made easier as many of the terms were unknown to them.

While 42% of the readers did not complete the evaluation at the end of the manual as requested, 17% of those who did said they found it helpful as a review. One reader said, "The questionnaire at the end was a very helpful learning tool for me (I cheated a couple of times). It made me stop, reflect, rack my brains, guess, check the answer, reevaluate my sentence, put it in my own words...It made it stick in my brain because the questionnaire helped me integrate the workshop into my counseling style and my previous knowledge base."

8% of the readers made suggestions indicating they would have liked more details, more case histories, and more information on the area between permission giving and sex therapy.

8% suggested that they were uncomfortable with role plays and would have preferred a different mode of learning.

8% stated they felt it would be more valuable as a workshop than standing alone as a manual. Another 8% said it would be beneficial to use with small groups and would be useful as separate modules.

17% stated the manual helped increase their comfort level with the topic and an additional 17% indicated they liked the manual well enough to want to see it expanded to cover additional topic areas.