UNIT 3 COUNSELLING ON SEXUALITY AND SENSITIVE ISSUES

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3.0 OBJECTIVES

The aim of this unit is to sensitize you to the complex issues involved in counselling a client on sexuality and other sensitive matters, and the appropriate attitudes that need to be developed by counsellors working in this area. At the end of the unit we hope you will:

- understand the concept of sexuality;
- get sensitized to issues of normality and abnormality in sexuality;
- get oriented to different kinds of sexual behaviours and their risks in terms of STIs and HIV/AIDS;
- develop a basic understanding of issues related to sexual orientation;
- understand some sexual myths and misconceptions;
- get a basic understanding of issues related to sexual coercion and violence;
- develop some level of comfort in discussing sensitive issues; and
- begin exploring your own views and values on sexuality with a view to developing appropriate attitudes.

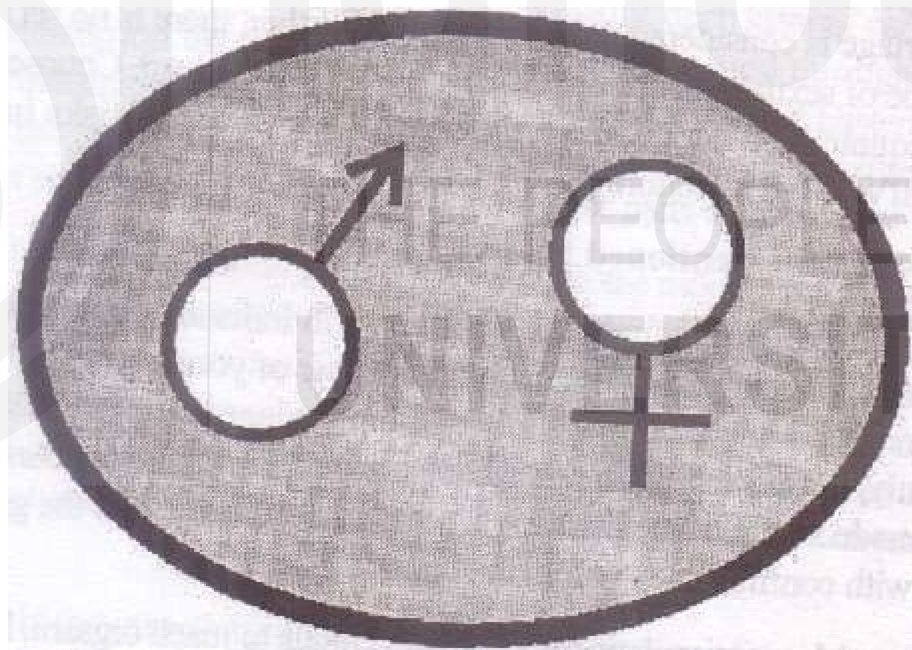
3.1 INTRODUCTION

It is essential to be able to discuss sex and sexuality openly and comfortably when working in the field of HIV/AIDS since almost nine out of ten persons in India are infected through sex. It is impossible to talk about AIDS without talking about sex. Some of the myths, misconceptions and incomplete information about sex and sexuality influence our ability to effectively prevent HIV transmission. Unfortunately, many counsellors find it difficult to get over being shy, embarrassed and put off dealing with the sexual issue; at other times, they are judgmental and label a sexual behaviour as not normal. Counsellors will need the essential 4 C's

– compassion, care, communication and counselling to be effective. To be able to counsel effectively, it is also important to have a basic knowledge of sexuality and the range of sexual behaviours that people practice.

3.2 WHAT IS SEXUALITY?

Sexuality refers to gender – male or female – but has been relegated to imply "doing" something, such as having an intercourse or orgasm; or to the vagina, the penis, and the genitals. Sexuality is a more complex phenomenon, which is difficult to define but perhaps easy to understand. Sexuality refers to the total sexual makeup of an individual. Self-esteem, body image, social roles and relationships are just few of the determinants of our sexuality. It includes sex, sexual behaviour and sexual intercourse. It is expressed in many physical ways. It is not confined to sexual intercourse; but includes touching, talking, embracing, fantasizing, kissing, caressing, even just holding hands. In addition to covering the physical aspects, sexuality also encompasses feelings, attitudes, values and preferences. It involves also a lot of caring and sharing. The World Health Organisation (WHO) defines sexual health as the integration of physical, emotional, intellectual and social aspects of sexuality in a way that positively enriches and promotes personality, communication and love. Understanding sexuality is important for healthy sexual behaviour.



What Exactly is Normal?

Today, it is recognized that there are many variations of sexual behaviour. No two people behave exactly the same way sexually. On the other hand, we all like to think that how we act and how we think about sex is "normal". In reality, culture, tradition, society and our own emotions and experiences have conditioned our thinking. For example, when we think of homosexuality, a range of emotions and judgements are expressed by different people about it:

- "They are unnatural;"
- "They should not be tolerated;"

- "It is abnormal;"
- "They should be ostracized;"
- "It is alternative sexual behaviour;" and
- "Homosexuals are as good as heterosexuals."

Whatever may be the beliefs or personal views; counsellors must be non-judgmental in viewing the client as a person requiring compassion, understanding and help to adopt healthy attitudes to sex and sexual mores.

Certain criteria to evaluate what is "healthy" in a sexual relationship could be:

- There should be consent between the husband and wife to engage in what gives them mutual satisfaction;
- The sexual activity should not cause physical or mental harm;
- It should be a private affair, not public; and
- The activity should not be exclusive (for example, one partner insisting that only masturbation should be done). It is important to remember that vaginal insertion is the usual and necessary condition for procreation.

Spectrum of Sexual Behaviours

The spectrum of sexual behaviours between two individuals is wide. Although our society has given sanction for sex only between husband and wife, it is a known fact that people do involve in pre-marital and extra-marital sex. Generally, any sex outside marriage is considered to be 'immoral.' Further, there is no set pattern as far as the type of sexual activities in which one can be involved. Counsellors need to have adequate knowledge about them and their probable risks in terms of STIs and HIV/AIDS infection.

Some activities are mentioned below:

Abstinence: Keeping away from sex. Culturally, in India and in most other parts of the world, people in general and a good number of young people believe that sexual intercourse should be done only within marriage. Virginity is still prized. Consequently, those wishing to practice abstinence should be encouraged. They should be made aware of the positive aspects of abstinence and the great values associated with confining sex within the bounds of marriage.

Masturbation: Means stimulating one's own genitals to reach orgasm. Most males masturbate with their hands, while some rub their penis against the surface of the bed, or use some object to bring about arousal. Females also masturbate in the same way. Masturbation is still a taboo topic. However, masturbation has been considered as one of the satisfactory and harmless ways to achieve sexual release. However, it may produce 'guilt feelings' in those who are riddled with many misconceptions regarding it. Many others, while rejecting the myths, the taboos and the 'do's' and 'don'ts' about masturbation, may still feel anxious, uncomfortable or guilty about it. It is important that, while attempting to change a client's behaviour, he/she must be made to understand the views of the two schools of thought on the subject:

1) The ‘School of Ethical Thought’ argues that masturbation is a selfish sexual activity through which one looks for personal satisfaction, pleasure, release of tension etc. It is argued that the primary purpose of sex is procreation and for expression of love between a husband and a wife. The husband has the right over the body of his wife; and the wife has the right over the body of her husband. If individuals look for sexual satisfaction through self masturbation, then the primary duty of providing sexual satisfaction to the spouse gets diminished. This will ultimately lead to avoiding sexual intercourse, or limiting it which will have far reaching consequences on the ‘husband-wife relationship’. In course of time, values such as concern for the spouse, his/her satisfaction, love for one another, self-giving, loving-kindness, thoughtfulness, attraction towards him/her etc. will get diminished. This is bound to result in defeating the very purpose of marriage, family life and sex in one’s life.

2) The ‘School of Safe-Sex Thought’ argues that masturbation is a harmless activity and may be practiced as a “safe sex” activity instead of indulging in high-risk behaviour like pre-marital and extra-marital sex. They argue that the only harm it does is development of “guilt feelings”. The proponents of safe-sex practices say that masturbation can help in avoiding pregnancy and infection with HIV/AIDS/STIs. This practice has been recommended as one of the ‘safe sex’ practices by several psychologists and institutions (including governments) who are involved in the prevention and control of HIV/AIDS all over the world.

It is for the individual to choose what in best for him/her for a satisfactory life.

Kissing: It is the pleasurable touching of one’s lips against another’s. Deep kissing is pressing the mouths together with the lips parted, which allows for one’s tongue to play in the others mouth. Although, theoretically, deep kissing carries a slight risk of transmission because HIV infection can be carried through saliva, the chances of transmitting the virus are virtually nonexistent even if blisters or cuts are present in the mouth of either partner. Partners also derive pleasure as well as satisfaction and intimacy through kissing on other parts of each other’s body.

Oral Sex: It is the stimulation of the genitals with the mouth. Transmission of the HIV virus is possible through oral sex because of the chance of coming in contact with the vaginal fluid or semen. Fellatio is when a man’s penis is stimulated through the mouth of another man or a woman. Cunnilingus is when a woman’s clitoris and vaginal area are stimulated through the mouth of another woman or man. Persons involved in both same sex and heterosexual activities often practice oral sex.

Anal Sex: It is the insertion of the penis into the rectum of a woman or a man. This is risky in terms of HIV transmission for the recipient, because the lining of the rectum is thin and can tear exposing white blood cells directly to the semen. Even without tearing, HIV virus can pass through the mucus membrane lining the rectum. Men who have sex with men or between heterosexual partners practice anal sex.

Vaginal Penetration: It is the insertion of the penis (or any other object) into the vagina of the woman. This can be a high-risk activity because, when the vagina is penetrated by the penis, HIV-infected semen can pass through the mucus

membrane lining the vagina and enter the white blood cells of the woman. Conversely, if a woman is infected, the HIV virus in her vaginal secretions can enter the man through the mucus membrane of the head of the penis. Withdrawal of the penis before ejaculation does not reduce the risk of HIV transmission. However, sexual intercourse between a mutually faithful couple is certainly a 'safe sex' practice which needs to be encouraged.

Sexual Orientation

A person's sexual orientation, that is, whether a person is emotionally and sexually attracted to a person of the same sex, opposite sex or both, is a fundamental part of the person's overall identity. It also plays a large part in determining a person's intimate relationships. In the context of HIV/AIDS, an understand of the client's sexual orientation is important for purposes of assessment of sexual behaviours and risk perception to self and partners.

Heterosexuality: People who are emotionally attracted to and chose to share their bodies sexually with persons of the opposite gender are called heterosexuals (i.e., man-woman relationships). Generally speaking, these male-female relationships are more common among people. In the context of HIV/AIDS in India, the spread of HIV infection is highest among the heterosexual group who are also involved in sex outside the marriage.

Homosexuality: Persons who choose to share their bodies sexually with persons of the same gender are called homosexuals. In a male-male relationship, the person may be termed gay. In a female-female relationship, the person is known as a lesbian. Why some prefers homosexual behaviour is still being debated. The term "alternative sexuality" is becoming a more acceptable term. It is to be noted that attitudes towards homosexuality are changing, although there is still a great deal of antagonism towards homosexuals, as well as contempt, anger and misunderstanding among the general public. Health professionals are now coming to accept homosexuality more as a sexual variation than as an illness. Sometimes, homosexual experiences may be situational like when it happens in prisons, boarding schools, colleges and hostels. The person may participate voluntarily or be even forced when he or she usually prefers to avoid indulging in any sexual activity. Homosexual behaviour is dangerous when penetrative anal sex and oral sex occurs. Fine injuries or ruptures around the anus and mouth help the meeting of HIV infected blood or semen with the blood of the uninfected partner. Oral sex, which is a popular sexual activity among the homosexuals, can be unsafe if a partner has oral, vaginal or penile lesions. Often, behaviours like "cruising", where a person goes out to find an unknown partner or stranger in a train, or exhibition etc., can be very unsafe behaviours. The dangers associated with such behaviours should always be explained to the client. Sex between lesbians can be unsafe in terms of HIV/AIDS risk if there is an exchange of body fluids or sharing of unsterilised sex objects (used for penetration) with more than one partner.

Bisexuality: Bisexuals are persons who frequently indulge in both homosexual and heterosexual activities. They are persons who are sexually attracted to or have intercourse or other sexual activities with both men and women. A number of homosexuals are unable to stand up to societal disapproval or family pressure to marry; and, may thus enter into a bisexual role. Studies also suggest that

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homosexuals in India sometimes maintain a bisexual existence, the heterosexual side being their public posture to gain social acceptance. There are also men who perceive themselves to be heterosexuals but occasionally have sex with other men, which they consider to be "masti." Often, such practices are not viewed as risky in terms of HIV infection. However, they can be dangerous not only for themselves but also for their sexual partners.

On Counsellors and Sexuality

A few words for counsellors on sexuality is essential which will help them during the process ofcounselling:

— They should be comfortable and familiar with the terminology of human anatomy, physiology and sexual behaviour;

— They should understand the basic underlying processes of reproductive and sexual physiology;

— They need to appreciate the range and variety of sexual expression in the human culture;

— They must recognize the social implications of human sexual behaviour and the relative nature of these implications in different societies; and

— They have to work at being able to deal candidly with their own sexuality in relation to themselves and others; and,

— They should be persons who reflect on the related moral and ethical dilemmas.

Check Your Progress I

Note: Use space given below for your answer.

1) Briefly highlight the argument of 'school of ethical thought' on masturbation.

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3.3 GUIDELINES FOR TALKINGABOUT SENSITIVE TOPICS

It is necessary for the counsellor to obtain an understanding and history of the behaviour, which may have exposed the client to HIV infection or AIDS. This means that he must be able to gather and interpret information about very private – and sometimes illegal or socially condemned – behaviour. There is no simple

formula for getting people to talk about topics such as their own sexual activities, drug injecting or responses to infection from blood transfusions. Effective discussion of sensitive topics will depend in large part upon the ability of the counsellor to:

- gear his/her communication to the emotional and intellectual level of the client;
- make the client feel safe, secure and accepted by establishing a supportive relationship; and
- demonstrate his/her own ease in talking about topics usually avoided in ordinary social life or in medical consultations.

Whatever approaches counsellor uses, this will require skill, tact and sensitivity towards the client. With some clients, counselling can be a process, which develops gradually and may need to be eased into slowly. Early on, a rapport will need to be established, together with an overall atmosphere that helps the client to develop a feeling of safety and trust, without which the counselling process will not be completely successful. The counsellor's style must, therefore, be reassuring, confident and direct, but considerate of the client's feelings and fears and acknowledging the client's difficulty.

Guidelines

The following specific guidelines on talking about sensitive topics will be useful to counsellors:

- Ask direct questions so as to be clear about what is worrying the client, and what he or she wants and expects from the counsellor.

  Example: "What do you want from me (this clinic, hospital, etc) right now? What made you decide to come here now?" (Anticipate a certain degree of embarrassment at discussing sex; point out that you realize that people do not usually discuss it in such depth.)

  Example: "We do not usually talk very openly about sex in our country. But, now, since you believe you may have been at risk of infection, you and I must determine the degree of risk. To do that, I have to ask some very specific questions. Most people feel a bit embarrassed by these questions, and you too may feel the same. For example, I need to know how many sexual partners you have had over the past six months."

- Explain clearly why you must inquire into sexual practices and drug injection habits, namely, that it is in order to determine precisely what the client needs to do to prevent becoming infected or passing the infection on to others.

  Example: "HIV is transmitted in a number of quite specific ways. You know that sharing needles is dangerous for you and for others. What can you do to keep yourself free of infection, or to protect other people?"

- In such interviews, the counsellor should use formal expressions first (e.g., vaginal intercourse). If it is not understood, the slang expression should be

used and the client should be asked which one he or she prefers. The client must not feel that the counsellor is making any moral judgment on any sexual behaviour or other risky behaviour. (The counsellor should check frequently to make sure that the client understands what is being said; for instance, by asking the client to repeat in his or her own words what the counsellor has been saying.)

- Cultural factors influencing sexual behaviour.

  It is important to note that, in some cultures, the absence of penetrative sex is the same as not having had sex at all – suggestions for safe sexual practices may, therefore, not be well received in such cultural and religious settings. In these cases, it must be reiterated that the only complete safe behaviour is a monogamous long-lasting relationship in which neither partner is infected with HIV. In our society, this monogamous relationship is only between the husband and the wife.

  The counsellor should anticipate that some of this information might be met with embarrassment, laughter, turning away, or even anger depending on the cultural context. On religious grounds, for example, a person might become angry with a counsellor who mentions masturbation and, perhaps, safe sex. As always, the counsellor should respect the client's beliefs, but point out that everyone is entitled to complete information, whether or not a decision is made to act on it.

3.4 SEXUAL MYTHS AND MISCONCEPTIONS

Some of the common myths and misconceptions that counsellors may encounter are mentioned below:

I) *Nocturnal emissions make boys weak*: Loss of semen through a "wet dream" or nocturnal emissions (involuntary ejaculation during sleep) is perfectly normal, and a harmless occurrence. It does not make one weak. A male client may suffer from guilt, shame or anxiety when such dreams occur. Counsellors must make their clients understand that nocturnal emissions are perfectly normal.

II) *The size of penis equivalent to masculinity or virility*: The size of the penis, either when it is flaccid or when it is erect, is no indication of a man's masculinity or ability. It is a myth that a long penis is necessary for adequate sexual pleasure. In the woman, primarily, it is the labia, the clitoris and the outer one-third of the vagina that are sensitive to sexual touch. As such, the size of the penis is not an important factor.

III) *A drop of semen is equal to 20 drops of blood*: Semen has no relationship to blood and its loss causes no weakness to the body. Semen is meant to be released from the body. Dissipation of semen does not devitalize a man, nor promote ageing, or lead to seminal bankruptcy.

IV) *Masturbation is harmful*: It is a common sexual activity practiced by both males and females. It does not affect sexual functioning. Masturbation does not lead to acne, insanity, impotence, homosexuality, mental retardation, reduction of the size of the penis or changes in the angle of the penis as may be commonly believed.

V) *Using a Copper "T" or having undergone a tubectomy or vasectomy for birth control also protects from HIV*: This is not true. Use of Copper "T" may actually increase the rate of transmissions, especially infection of the reproductive tract.

VI) *Condoms are the only form of birth control and safety measure to protect from HIV transmission*: This is not true. There are other methods of family planning. Similarly, condoms do not provide full safety either from HIV transmissions or pregnancy.

VII) *STIs can be cured if the infected man has sex with a virgin*: STIs require medical treatment. Sex with a virgin will only pass on the infection to that innocent girl, very often a girl child.

VIII) *A girl cannot get pregnant if a boy doesn't ejaculate or "come" inside her*: Even if a boy does not ejaculate inside a girl's vagina, it is still possible that the pre-seminal fluids, which contain sperm, can cause pregnancy. If the boy is infected with HIV, the girl also will be at risk because the fluids could contain the virus.

IX) *Coitus should be avoided during pregnancy*: Coitus during pregnancy is permissible unless the doctor advises otherwise for medical reasons. However, the sexual activity should not be uncomfortable for the pregnant woman. In case of pain, vaginal bleeding or a past history of abortion, coitus must to be avoided. It is necessary to consider the wishes of the pregnant woman particularly during certain periods of pregnancy when it could affect the safety of the child.

Check Your Progress II

Note: Use space given below for your answer.

1) Write briefly about any three guidelines on talking about sensitive topics, which will be useful to counsellors.

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3.5 SEXUAL COERCION AND VIOLENCE

Many sexual behaviours, particularly rape, incest, and abuse of children, are universally prohibited. Yet they occur with some frequency and often leave the survivor severely traumatized. Every form of violence is a manifestation of power and threatens the individual with physical or psychological violation and limits his or her ability to make their own life choices. They can have debilitating

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mental (depression, low self-esteem, anxiety, suicidal thoughts, etc.) and physical health consequences (physical injury, STIs, HIV, and in some cases, death). Many types of sexual behaviour are punishable by law since they infringe on another person's right to safety and security. The law, however, may not deal adequately with the degree to which sexual abuse violates the individual's (usually a women's or a child's) personhood, mental or physical integrity, or freedom of movement.

Rape: Rape refers to forced sexual relations often with actual or threatened violence. Often the rapist's motivation is not to enjoy sexual pleasure but to express anger, hostility, power, or aggression, either towards the victim personally or towards a class of people whom the victim represents.

There are many myths in society regarding rape that helps to romanticize it, especially in films. The truth is that rape is a forced sexual act. It can affect a person of any age, of any sex, and at any place. Most rape victims are women.

According to section 375 of the Indian Penal Code (IPC) a man is said to commit 'rape' when he has sexual intercourse with a woman under any of the following six circumstances:

- First – Against her will
- Secondly – Without her consent
- Thirdly – With her consent, when her consent has been obtained by putting her or any person in whom she is interested in fear of death or hurt.
- Fourthly—With her consent, when the man knows that he is not her husband, and that her consent is given because she believes that he is another man to whom she is or believes herself to be lawfully married.
- Fifthly – With her consent, when, at the time of giving such consent, by reason of unsoundness of mind or intoxication, caused or administered by him personally or through another person.
- Sixthly – With or without her consent when she is under sixteen years of age.

The IPC considers rape to occur only when a man assaults and has intercourse with a woman. It does not cover the rape of a man. While the very idea seems unbelievable, it is true that a male can be coerced into having sexual relations.

Unfortunately forced sexual intercourse between a husband and a wife is not considered to be rape, according to the IPC, unless the wife is under sixteen years of age. The final version of section 375 of the Indian Penal Code, which emerged after deliberations in the Select Committee, is a crystallized form of Clause 359 of the Macaulay's Draft Penal Code. Section 375, the provision of rape in the Indian Penal Code (IPC), has echoing very archaic sentiments, mentioned as its exception clause- "Sexual intercourse by man with his own wife, the wife not being under 15 years of age, is not rape."

As per the Indian Penal Code, the instances wherein the husband can be criminally prosecuted for an offence of marital rape are as under:

1) When the wife is between 12 – 15 years of age, offence punishable with imprisonment upto 2 years or fine, or both

2) When the wife is below 12 years of age, offence punishable with imprisonment of either description for a term which shall not be less than 7 years but which may extend to life or for a term extending up to 10 years and shall also be liable to fine.

3) Rape of a judicially separated wife, offence punishable with imprisonment upto 2 years and fine

4) Rape of wife of above 15 years in age is not punishable.

In 2005, the Protection of Women from Domestic Violence Act, 2005 was passed which although did not consider marital rape as a crime, did consider it as a form of domestic violence. Under this Act, if a woman has undergone marital rape, she can go to the court and obtain separation from her husband. This is only a piecemeal legislation and much more needs to be done by the Parliament in regard to marital rape.

Statutory rape is a special category of offence in which the law considers rape to have occurred when, even though the abused individual may have consented, the latter was younger than a legally defined 'age of consent.' Here the 'consent' is invalidated by the fact that the victim of the rape is not old enough to make sexual decisions maturely. Under the IPC, this age bar is set at 16 years of age. Such a law is meant to protect minors.

If a woman has been raped, the most important step is to get help immediately. The initial response would be to go home, take a bath (to wash off the acute sense of violation she feels) and just try to forget the whole sordid event. But in this case, one's instincts are not necessarily right.

The best place to go, even if there are no obvious injuries, is a hospital emergency room. For emotional support and comfort, she could call a trusted friend, someone who will not blame her for getting raped but, on the contrary, would be very supportive.

Despite a strong desire to wash herself, she should avoid doing so until after the medical procedures are completed. This is in case she decides to take legal action later against the perpetrator. The medical procedures consist of:

- A pelvic examination, or a rectal examination; and
- Examination and treatment of any external injuries.

Later a VDRL test will help diagnose the presence of an STI. Prophylactic treatment by antibiotics for the prevention of sexually transmitted diseases can then be taken.

A woman who has been raped must also accept that the rape will affect her both physically and psychologically. The immediate responses can range from numbness and disbelief to extreme anxiety, fear and disorganisation. The woman will probably feel physical pain, depression, anger, fear, and humiliation as well. She may feel guilty, repulsive and defiled since her body has been violated. She

may feel impure and ashamed through no fault of hers. She may feel that she is not worthy of her husband or that she has brought disagree to her family.

The victim's pain or emotional scars should not be treated lightly. S/he should be reassured that, with support and professional help, she can look forward to recovery and resuming her life. The victim's family, especially the husband (if married), will also require lot of support and professional help to deal with this crisis.

Incest: This is a sexual abuse where the perpetrator, who is most often a male, is a close family relative of the victim (in most cases a female, though in some cases the victim can be a male) or a member of the extended family. The abuse generally involves sexual intercourse. Incest is more common than people like to believe. It occurs with shocking frequency; and, yet, these cases are not reported. The affected family can be from any race, religion, social, economic, or educational background.

The incest victim, be it a male or a female, will suffer guilt, pain and intense fear of continued abuse. In Indian homes, little support is given to the victim. The closest relatives will find the news outrageous; and, therefore, will not believe the victim. If they do believe the victim, they are likely to maintain silence and let the victim suffer rather than make public the family scandal. Hence, the vulnerable victim has no way out but to suffer in silence.

Incest is a crime: While legal help is very important, physically removing the victim from the exploitative environment should be the first priority. The victim should be provided with access to professional counselling to deal with the feelings of guilt and fear, and to help him or her rebuild his or her life. There are self-help groups for incest survivors where they could also be referred.

Child Sexual Abuse: Child sexual abuse occurs much more frequently than is likely to be believed. The abuser may inappropriately kiss, fondle or touch bodily parts associated with sex. In some instances, the abuse could also include sexual intercourse. Most sexual contacts are with relatives or friends. Studies show that the abuser is often the father or a male relative in case of females. In the case of boys, the abuser is often an older adolescent, a male acquaintance, a relative (father, uncle, and sibling), or a neighbour. A small proportion of sexual offences against children are committed by people who are strangers (men and in rare cases, women) who habitually molest children.

A child is almost always severely scarred emotionally by the abuse, especially if it has been extensive

and/or violence was involved. The child may withdraw, have eating, sleeping and school problems, be depressed, be afraid of strangers and may have a number of physical and psychological symptoms. Many also suffer long-range effects. Their social, psychological, and sexual adjustment could be impaired well into adulthood. The child, who has been deeply hurt, will need the concerted help of his or her family and of a professional therapist to recover.

Child Rights Legislations

The Protection of Children from Sexual Offences Act (POCSO Act) 2012 was formulated in order to effectively address sexual abuse and sexual exploitation of children. The Protection of Children from Sexual Offences Act, 2012 received the President's assent on 19th June 2012 and was notified in the Gazette of India on 20th June, 2012.

The Act defines a child as any person below eighteen years of age. It defines different forms of sexual abuse, including penetrative and non-penetrative assault, as well as sexual harassment and pornography. It deems a sexual assault to be "aggravated" under certain circumstances, such as when the abused child is mentally ill or when the abuse is committed by a person in a position of trust or authority like a family member, police officer, teacher, or doctor. The Act also casts the police in the role of child protectors during the investigative process. Thus, the police personnel receiving a report of sexual abuse of a child are given the responsibility of making urgent arrangements for the care and protection of the child, such as obtaining emergency medical treatment for the child and placing the child in a shelter home, and bringing the matter in front of the CWC, should the need arise.

The Act further makes provisions for avoiding the re-victimisation of the child at the hands of the judicial system. It provides for special courts that conduct the trial in-camera and without revealing the identity of the child, in a manner that is as child-friendly as possible. Hence, the child may have a parent or other trusted person present at the time of testifying and can call for assistance from an interpreter, special educator, or other professional while giving evidence. Above all, the Act stipulates that a case of child sexual abuse must be disposed of within one year from the date the offence is reported.The Act also provides for mandatory reporting of sexual offences. This casts a legal duty upon a person who has knowledge that a child has been sexually abused to report the offence; if he fails to do so, he may be punished with six months' imprisonment and/ or a fine.

3.6 SEXUAL PROBLEMS

It is not uncommon for clients to raise anxieties and fears about sexual functioning during counselling. Counsellors, therefore, need to be aware of the common sexual problems that clients face and where to refer them for appropriate help.

Sexual problems may be the result of medical, biological, relational, personal and related concerns. They affect desire as well as satisfaction. Most adults with sexual problems do not seek help. Some may consult their gynaecologists, family physicians or psychiatrists while others approach quacks with disastrous consequences. There are very few health professional in India who are trained in sex therapy. Counsellors need to refer clients to professionals who are trained to

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handle these issues or who at least have the sensitivity and correct knowledge to discuss these matters with clients. In most cases, such help in India is inadequate.

Problem in sexual desire: Sexual desire is a problem when the level of interest is persistently low or absent. In this case, the person wants sexual relations so rarely that it causes the partner considerable strain and dissatisfaction. Problems in sexual desire could be a symptom of other difficulties. What appears as low sexual desire may be hormonal dysfunction, or may be due to depression, relationship conflicts, stress, or a combination of these. Still other underlying concerns might include sexual inhibition, the inability to recognize or deal with one's own sexual arousal, or subtle but disabling negative sexual signals from one's partner. Couples need to see a counsellor or a physician for help.

Problems in arousal: Arousal problems manifest themselves in men quite dramatically. Despite foreplay and sexual interest, the penis does not get erect or seem firm enough for intercourse. At other times, the penis becomes erect but does not stay hard long enough for intermission.

Difficulty in arousal is less obvious in women but is nevertheless critical. The vagina does not expand and lubricate. Unlike the man with an erectile problem, the women with an unlubricated vagina may still have intercourse if she wishes. She may use a lubricant to enable the penis to be admitted and intercourse to take place. Arousal problems are common in both sexes, although they may be temporary or only occur once in a while. Such momentary difficulties are not likely to necessitate treatment; but if arousal is persistently problematic, professional help should be considered.

Orgasm and Ejaculation Problems

a) Delayed ejaculation: Orgasm/ejaculation problems in both sexes often centre about time. A woman or a man may require a good bit of sexual stimulation, perhaps an hour or so, before reaching a climax. The woman may then be diagnosed as having delayed orgasm, and the man as exhibiting delayed (or retarded) ejaculation.

b) Rapid (Premature) ejaculation/orgasm: Orgasm or seminal emission may occur so rapidly that it frustrates one or both partners.

Genital pain: Most men and women occasionally feel some discomfort during intercourse. Often, a pause in sexual activity (a little rest, talk, and tenderness) is very helpful in such cases. But relaxing and starting foreplay again may not correct the problem. Pain in the genital area, dyspareunia, could be serious and persistent.

A related problem can occur in the vagina, which usually opens to facilitate intercourse. The vagina may also close quite tightly. In vaginismus, the muscles associated with the vagina go into spasm. They contract and close the organ so effectively that even inserting a small-lubricated finger may be difficult or uncomfortable. Typically, the vaginal spasm occurs as foreplay intensifies; but it could also happen at any time. The vaginal spasm may be a reflex like response to dyspareunia or emotional distress: the organ is guarding itself from intercourse and pain.

Treatment of sexual problems generally consists of counselling, teaching of certain sex techniques, behaviour therapy and in some cases medical treatment.

Check Your Progress III

Note: Use space given below for your answer.

1) According to section 375 of IPC, what are the six circumstances under which a man is said to have committed a rape?

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3.7 LET US SUM UP

Human sexuality is a very important aspect of people's lives and needs to be well understood by the counsellor involved in HIV prevention and supportive counselling. It refers not only to sexual intercourse but also to feelings, attitudes and values. What is considered as normal by one person in one society may be considered as abnormal by someone else in another social environment. It is important for counsellors to be non-judgmental about client's sexual preferences and orientations. Some of the sexual behaviours that need special attention in connection with STIs and HIV are: abstinence, masturbation, nocturnal emissions, oral sex and homosexuality.

To obtain an understanding of the circumstances that led the client to place himself or herself at risk of HIV infection, the counsellor must be able to obtain information on such sensitive topics as sexual practices and drug injecting habits. This can be done only through informed questioning. Questions must also be used to ensure that all clients have the basic information on HIV infection and its prevention. Clients must be given advice on healthy and safe sexual practices. They should be made to understand that the only completely safe behaviour is sexual abstinence or a monogamous long-lasting relationship. The latter is particularly important in cultures in which advice on non-penetrative or safe sexual practice is not well received. In discussing levels of risk, counsellors will again have to talk to clients about sensitive topics, and will themselves need to decide how ready they are to talk about them. The importance of not sharing needles and syringes and other injection equipment should be emphasized and the methods of sterilizing injecting equipment should be explained.

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3.8 SUGGESTED READINGS

TISS (1994), *HIV/AIDS Prevention and Counselling*: A Manual For Grassroots Level Workers, Cell for AIDS Research Action and Training, Department of Medical and Psychiatric Social Work, Tata Institute of Social Sciences.

WHO (1994), An Orientation to HIV/AIDS Counselling, *A Guide for Trainers, World Health Organisation*, Regional Office for South-East Asia, New Delhi.

NACO (1994), *HIV/AIDS/STI Counselling Training Manual*, National AIDS Control Organisation (Ministry of Health and Family Welfare) Government of India, New Delhi.

Thomas Gracious (1997), *Prevention of AIDS: In search of Answers*, Shipra Publication, New Delhi.

Indian Penal Code (45 of 1860), Section 376A. Intercourse by a man with his wife during separation.—Whoever has sexual intercourse with his own wife, who is living separately from him under a decree of separation or under any custom or usage without her consent shall be punished with imprisonment of either description for a term which may extend to two years and shall also be liable to fine

Indian Penal Code (45 of 1860), Section 376(1).

Ibid 14 Indian Penal Code (45 of 1860), Section 376A.

Indian Penal Code (45 of 1860), Exception to Section 375.

The Protection of Women from Domestic Violence Act, 2005, Section 3 Explanation 1 (ii)