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THE SOCIO-EMOTIONAL INFLUENCE OF SEXUAL PROBLEMS ON YOUNG WOMEN: A SOCIAL WORK INVESTIGATION

by

TANYA MARIE ROBINSON

for the degree

MAGISTER SOCIALIS DILIGENTIAE
PLAY THERAPY

in the Department of Social Work

Faculty of Humanities

University of Pretoria

SUPERVISOR: DR. C E PRINSLOO

JULY 2003

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TANYA MARIE ROBINSON

The Maiden ***by Gustav Klimt***

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Once again, I am grateful towards God and the following people in my life...

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feel your warm, peaceful breathing, and hope

that through you I may become what

I wishes to be.

Thank you for the reading of my work, thank you for the support, the patience and the last minute editing .... (I can go on for pages)

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SUMMARY

THE SOCIO-EMOTIONAL INFLUENCE OF SEXUAL PROBLEMS ON YOUNG WOMEN: A SOCIAL WORK INVESTIGATION

by

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Degree: MSD (Play Therapy)

At DISA-clinic the researcher found that young women between the ages of 16 and 25 are faced with various sexual problems. As a result the aim of this study was to explore the socio-emotional influence of sexual problems on young women. For the purpose of this study an exploratory research design was used because little information was found on the socio-emotional influence of sexual problems on young women in available literature.

A contribution can be made through exploring the socio-emotional influence that sexual problems have on young women. Sexual problems for the purpose of this study were organised in three main groups: Sexual dysfunctions; these include Dyspareunia, Vaginismus, Anorgasmia. Unintended pregnancy; these include abortion, adoption, early parenting. Sexually transmitted diseases and sexually related diseases; these include HIV infection and AIDS, Gonorrhea, Syphilis, Herpes.

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It was essential in this study to use a qualitative research approach because the researcher wanted to explore the socio-emotional influence of sexual problems on young women and formulate a holistic understanding of this phenomenon. This qualitative study consequently presented the reader with an understanding of the socio-emotional influence that sexual problems have on young women.

The data collection method which was used is document study. In this study personal letters of young women received between June 2002 and February 2003 were included. The researcher gathered one hundred and fifteen personal letters of young women that fitted the sample criteria. Seven main themes and related themes were identified in the personal letters and the researcher analyzed the information according to Creswell's spiral model.

After these **themes** were identified it can be emphasised that there is definitely a sense of similarity between the influence of the three main groups of sexual problems on the socio-emotional functioning of young women. Consequently the researcher states that from the above seven themes that were identified, it became clear that various sexual problems influence young women's socio-emotional functioning in a similar manner.

Further research on preventing the rising statistics of sexual problems under young women is recommended.

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OPSOMMING

DIE SOSIO-EMOSIONELE INVLOED VAN SEKSULE PROBLEME OP JONG VROUENS: 'N MAATSKAPLIKEWERKONDERSOEK

deur

TANYA MARIE ROBINSON

Supervisor: Dr. C.E. Prinsloo
Departement Matskaplike Werk
Universiteit van Pretoria

Graad: MSD (Spelterapie)

Die navorser het by DISA-kliniek gevind dat jong vrouens tussen die ouderdom van 16 en 25 gekonfronteer word met verskeie seksuele probleme. Gevolglik is die doel van die studie om die sosio-emosionele invloed van seksuele probleme op jong vrouens te eksploreer. Vir die doel van hierdie betrokke studie is 'n eksplorerende navorsingsontwerp gebruik omrede min informasie gevind is ten opsigte van die sosio-emosionele invloed van seksuele probleme op jong vrouens in beskikbare literatuur.

'n Bydrae kan gemaak word deur die sosio-emosionele invloed wat seksuele probleme op jong vrouens het, te eksploreer. Seksuele probleme is vir die doeleindes van die studie in drie hoofgroepe georganiseer: Seksuele disfunksies; wat insluit Dyspareunia, Vaginismus en Anorgasmia. Onbeplande swangerskappe; wat insluit aborsie, aanneming en vroeë ouerskap. Seksueel

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oordraagbare siektes en seksueel verwante siektes; wat insluit MIV infeksie en VIGS, Gonorrhea, Sifilis en Herpes.

Dit was essensieël in die studie om 'n kwalitatiewe navorsingsbenadering te volg omrede die navorser die sosio-emosionele invloed van seksuele probleme op jong vrouens wou eksploreer en 'n holistiese begrip van die betrokke fenomene wou kry. Die kwalitatiewe studie verskaf die leser gevolglik met 'n begrip van die sosio-emosionele invloed wat seksuele probleme op jong vrouens het.

Die data-insamelingsmetode wat gebruik is, is dokumentanalise. In die studie is anonieme, persoonlike briewe van jong vrouens ingesluit wat tussen Junie 2002 en Februarie 2003 ontvang is. Die navorser het een honderd en vyftien briewe van jong vrouens volgens die vasgestelde steekproefkriteria geselekteer. Sewe hooftemas en verwante temas is geidentifiseer vanuit die anonieme persoonlike briewe en die navorser het die data volgens Creswell se spiraal model geanaliseer.

Na identifisering van die temas kan klem daarop geplaas word dat daar definitief 'n ooreenkoms bestaan tussen die invloed wat die drie hoofgroepe seksuele probleme op die sosio-emosionele funksionering van jong vrouens het. Gevolglik maak die navorser die aanname dat vanuit die geidentifiseerde sewe temas, dit duidelik is dat verskeie seksuele probleme 'n soortgelyke invloed op die sosio-emosionele funksionering van jong vrouens het.

Verdere navorsing op die voorkoming van die stygende statistieke van seksuele probleme onder jong vrouens, word aanbeveel.

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KEY CONCEPTS

Young women

Sexual problem

Sexual practices

Social work investigation

Socio-emotional functioning

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KERNBEGRIPPE

Jong vrouens

Seksuele probleme

Seksuele praktyke

Maatkaplikewerkondersoek

Sosio-emosionele funksionering

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CHAPTER 1

GENERAL INTRODUCTION

1. 1 Introduction

In South Africa women constitute almost 52 percent of the population (South African Institute of Race Relations, 2001/2002:14). Gouws, Kruger and Burger (2000:169) emphasise that along with the increase in the percentage of young people who are sexually active, there is an increase in the number of youth pregnancies. Sexual dysfunction is also seen more often under young women in today's society. This is often caused by stress related issues (Gouws, *et al.*, 2000:169).

Furthermore, young people's tendency not to use contraceptives contributes to the epidemic proportions this social problem is assuming. The World Health Organisation (WHO) found that in African countries, young people between the ages of 15 and 24 years make up 60 percent of all new HIV infections, while HIV infection in young women outnumber the infection in young men by two to one (South African Institute of Race Relations, 2001/2002:14).

Elliot (1996:148) states that sexual practices can lead to sexual problems, as seen clearly in above statistics. For the purpose of this study sexual problems were organised in three main groups:

1. Sexual dysfunctions; these include Dyspareunia, Vaginismus, Anorgasmia.
2. Unintended pregnancy; these include abortion, adoption, early parenting.
3. Sexually transmitted diseases and sexually related diseases; these include HIV infection and AIDS, Gonorrhea, Syphilis, Herpes.

It is important to remember that every individual experiences their sexual problem differently but it is postulated by the researcher that there is a sense of similarity between the influence of the three main groups of sexual problems on

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the socio-emotional functioning of young women. As a result the focus of this study was to explore the socio-emotional influence of sexual problems on young women.

The following aspects will be discussed in this chapter: motivation for the choice of the topic, problem formulation, goal and objectives, pilot study, overview of the feasibility of study, research methodology, description of universe, research population, delimitation of sample and sampling method and definition of key concepts.

1.2 Motivation

It appears that people are much more open than in the past to discuss sex, but the problems of sexual practices and how it effects peoples lives are still kept in the dark (South African Institute of Race Relations, 2001/2002:360). The researcher works at DISA-clinic[1] (a Sexual and Reproductive Health Clinic) and personal letters are received from young women, where they explain how they live their lives with a sexual problem. Therefore the researcher is of opinion that it is a profound statement to make that sexual problems that young women experience influence their socio-emotional functioning.

Ample research has been done on the various sexual problems that young women experience. However, when recent research was explored, it indicated a lack of research done on the socio-emotional influence of sexual problems on young women. For the purpose of this study it is necessary to focus on various sexual problems which include sexual dysfunction, unintended pregnancy, sexually transmitted diseases and sexually related diseases.

[1] DISA-Die Intensiewe Sorg Agentskap

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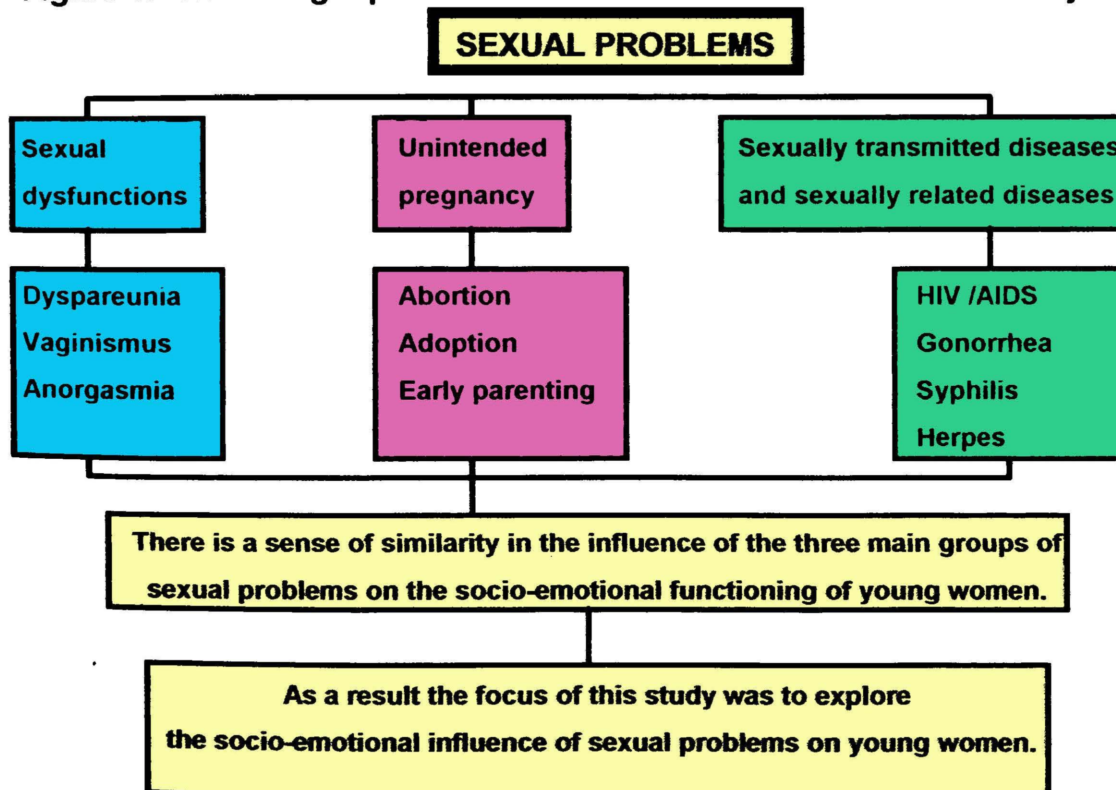
The researcher is aware of the diversity of the various sexual problems but it is postulated by the researcher that there is a sense of similarity in the influence of the three main groups of sexual problems on the socio-emotional functioning of young women. As a result the focus of this study was to explore the socio-emotional influence of sexual problems on young women.

The researcher wishes to specify that there is a shortcoming of cultural aspects in the research process. It is important to emphasise that the acceptance of sexual practices varies from culture to culture but for the purpose of this study culture did not play a significant role. For the purpose of this study women from various cultures were included and the researcher did not see sexual problems in a culture specific manner. Therefore, the researcher included all personal letters from young women that fit the criteria for selecting the sample and culture did not form part of the criteria in selecting the personal letters.

Figure 1: The thought process that led to the motivation of this study



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1.3 Problem-formulation

Given the motivation for the study the following problem statement was formulated:

Sexual problems influence young women in that these sexual problems have a profound impact on their socio-emotional functioning. A contribution can be made through exploring the socio-emotional influence that sexual problems have on young women.

For the purpose of this study sexual problems were organised in three main groups:

1. Sexual dysfunctions; these include Dyspareunia, Vaginismus, Anorgasmia.
2. Unintended pregnancy; these include abortion, adoption, early parenting.
3. Sexually transmitted diseases and sexually related diseases; these include HIV infection and AIDS, Gonorrhea, Syphilis, Herpes.

Gouws, *et al.* (2000:110) state that changed sexual attitudes and behaviour are evident at present in greater candor and permissiveness about premarital and extramarital sex and about homosexuality. This changed behaviour is visible in the rising statistics of sexual problems that are found under young women.

Statistics show that sexual dysfunction is often found after a woman has been raped (King, 1999:45). Research on violence against women estimates that between one out of four and one out of six women are in abusive relationships. Furthermore, between 1994 and 2000 rape increased by 24,6%, there is a rape every 35 seconds. One in three girls under the age of 18 could expect to be raped (South African Institute of Race Relations, 2001/2002:360). With these statistics it is a reality that young women are most likely the victims of violent sexual acts in South Africa and as a result encounter sexual problems.

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Work has been done with young people in the Eastern Cape and Kwazulu-Natal which demonstrates how closely the culture of violence is linked to young women's experience of sex and their own sexuality. The sign of manhood is the number of girlfriends you have (Women, Sexuality and the era of HIV, 2000:1). A young man experiences his sexuality through the young women he has under his control, consequently "you are a man if you can control your women".

It is indicated that both young men and young women see physical violence as a sign of love. It is also a sign of love and trust when you do not use a condom (Women, Sexuality and the era of HIV, 2000:1). A women's right to experience her sexuality is obviously threatened under these circumstances and can enhance the chances of unintended pregnancy, sexually transmitted diseases and sexually related diseases.

1.4 Aim and Objectives

1.4.1 Aim

The aim of this study is to explore the socio-emotional influence of sexual problems on young women.

1.4.2 Objectives

- To do a literature study on various sexual practices and sexual problems in order to build a knowledge base for further exploration.
- Through an empirical study the socio-emotional influence that sexual problems have on young women will be explored.
- To draw conclusions and make recommendations to improve young women's socio-emotional functioning.

1.5 Research question

Royse (1998:28) says that exploratory research designs are used with topics about which very little information is available. Their values derive from the new insights they provide or the unanswered questions they generate for future

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research. For the purpose of this study an exploratory research design was followed and as a result a research question needed to be formulated. Creswell (1998:16) states that the nature of the research question relates to "how" or "what". Fouche (2002a:106) emphasises that if a qualitative study was opted for, the researcher would formulate the research question carefully. Qualitative research was suitable for this particular study and therefore a research question was formulated as follows:

How do sexual problems influence the socio-emotional functioning of young women?

1.6 Research approach

The purpose of conducting a qualitative study is to produce findings (De Vos, 2002:339). Qualitative research depends on the presentation of solid descriptive data, so that the researcher leads the reader to an understanding of the meaning of the experience or phenomenon being studied. Delport & Fouche (2002:356) emphasise that when working from a qualitative perspective the researcher attempts to gain a first-hand, holistic understanding of phenomena and data collection gets shaped as the investigation proceeds. Van Manen (1990:67) adds that qualitative methodology is based on the assumption that valid understanding can be gained through accumulated knowledge acquired at first hand by a single researcher.

Therefore, it was essential in this study to use a qualitative research approach because the researcher wanted to explore the socio-emotional influence of sexual problems on young women and formulate a holistic understanding of this phenomenon. This qualitative study consequently presents the reader with an understanding of the socio-emotional influence that sexual problems have on young women. Document study was used as data collection method. Royse

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(1998:217) states that a document study is an unobtrusive research process that objectively examines the content of documents.

Primary sources are seen as the original written material of the author's own experiences and observations, while secondary sources consist of material that is derived from someone else as the original source (Strydom & Delport, 2002a: 322). According to Strydom & Delport (2002a:322) this implies that a primary source should therefore be more reliable than a secondary one. Since secondary sources are always someone else's interpretation of primary sources, secondary sources should be thoroughly scrutinised for accuracy. Based on this, the researcher used primary sources that consist of reliable information.

According to Mark (1996:264) personal documents, such as wills, diaries, notes, correspondence and suicide notes, are a particularly interesting source of data. Strydom & Delport (2002a:323) emphasise that personal documents are thus a personal account of the author's environment and his subjective perception and interpretation of his own life and the events in the world around him. The researcher used personal letters that were sent anonymously to DISA-clinic by young women who visited the clinic for help because of their sexual problems.

1.7 Research methodology

1.7.1 Type of research

The type of research implemented was applied research. An empirical study was performed on this problem. This proved to be an appropriate way of addressing the research problem.

According to Fouche (2002a:108) applied research is aimed at solving specific policy problems or at helping practitioners accomplish tasks. It is focused on solving problems in practice. Most applied research findings have implications for knowledge development. The question here is how to make things work for

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human improvement. The overall emphasis is on knowledge for information, with implication that values are much more involved in the entire process from the beginning to the end.

Applied research was implemented as the main aim of this study was to explore the socio-emotional influence of sexual problems on young women. Consequently knowledge was obtained on the socio-emotional influence of sexual problems on young women and recommendations were made to improve their socio-emotional functioning.

1.7.2 Research strategy

According to Creswell (in Fouche, 2002b:275) a case study can be regarded as an exploration or in-depth analysis of a "bounded system" (bounded by time and/or place) or a single or multiple cases, over a period of time. Fouche (2002b:274) states that the exploration and description of the case take place through detailed, in-depth data collection methods, involving multiple sources of information that are rich in context. These can include interviews, **documents**, observations or archival records. As such, the researcher needs access to and the confidence of participants. The product of this research is an in-depth description of a case or cases.

Mark (1996:219) adds that the collective case study furthers the understanding of the researcher about a social issue or population being studied. The interest in the individual case is secondary to the researcher's interest in a group of cases. Cases are chosen so that comparisons can be made between cases and concepts and so that theories can be extended and validated.

The data collection method which was used is document study. Personal accounts of how young women's lives have been influenced by a sexual problem were given. These accounts took the form of personal letters which were sent

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anonymously to DISA-clinic by young women. Therefore the collective case study helped to give an understanding regarding the socio-emotional influence of sexual problems on young women. Royse (1998:217) states that data analysis involve searching for and counting key words, phrases, or concepts in the document. Accordingly, the researcher made comparisons between cases to see how sexual problems influence the socio-emotional functioning of young women.

1.7.3 Research design

Little information was available on the socio-emotional influence of sexual problems on young women. No specific research or sources could be found on this specific topic and as a result an exploratory study was done. Babbie (1998:90) states that much of social research is conducted to explore a topic, or to provide a beginning familiarity with that topic. This approach is typical when a researcher examines a new interest or when the subject of study itself is relatively new. Exploratory studies are also appropriate for more persistent phenomena.

Babbie (1998:91) explains that exploratory studies are more typically done for three purposes: (1) to satisfy the researcher's curiosity and desire for better understanding, (2) to test the feasibility of undertaking a more extensive study, and (3) to develop the methods to be employed in any subsequent study. Preliminary exploratory study is a very valuable manner in which practical knowledge of and insight into a certain research area can be gained.

1.7.4 Research procedures and strategy

Different writers have different opinions as to how the research procedure should be followed. The author who has the most comprehensive and easy to follow procedure is De Vos (in Fouche & Delport, 2002:85-86) and therefore this author's procedure was followed in this study. The procedure is as follows:

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1. Selection of a researchable topic

The researcher looked for a researchable topic that is relevant in today's society. Because of the devastating rising statistics of abortion, sexually transmitted diseases, HIV/AIDS and sexual violence against women it was thought necessary to explore the socio-emotional influence of sexual problems on young women.

The researcher was aware of the diversity of the various sexual problems but it was postulated by the researcher that there appeared to be a sense of similarity between the influences of the three main groups of sexual problems on the socio-emotional functioning of young women. As a result the researcher focused this study on the exploration of the socio-emotional influence of sexual problems on young women.

2. Formal formulations

A qualitative research approach was utilised in order that the researcher could lead the reader to an understanding of the meaning of the experience or phenomenon being studied. The research question is: **How do sexual problems influence the socio-emotional functioning of young women?**

3. Planning

- The research study was done at DISA-clinic.
- The researcher decided on the size of the sample, the sampling method and the research population.
- An in-depth literature review was done on women's sexuality, sexual practices and sexual problems.
- A document study was done on personal documents (personal letters which the clinic received from young women who experience sexual problems), which formed the collective case study.

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4. Implementation

The researcher implemented the steps as planned (phase 3).

5. Interpretation and presentation

The researcher analysed the information which was gathered by the document study. Royse (1998:217) states that content analysis is another unobtrusive research process that objectively examines the content of communications. Content analysis involves searching for and counting key words, phrases, or concepts in communication.

The researcher read the personal letters of the young women which fitted the **following criteria**:

- Female,
- between the ages of 16 and 25,
- who experience or have experienced a sexual problem,
- who have written to DISA-clinic about their personal experience in English and
- all personal letters received between June 2002 and February 2003.

During the reading process of the personal letters, the researcher made notes and organised key words and phrases. Accordingly, key words and phrases which repeat themselves in the various letters and themes were identified and written down. The researcher looked for categories, themes or dimensions of information. As stated by Creswell (1998:144) five or six general themes were identified. The researcher identified the relationship among themes and represented this information. Accordingly, the researcher wrote the study as a research report and wrote an article to communicate the findings to colleagues.

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1.7.5 Pilot study

1.7.5.1 Literature study

Little information was found on the socio-emotional influence of sexual problems on young women in available literature. A search was done by Me. Stieger (librarian at the Academic Information Service, University of Pretoria) and little information was found. Literature from other disciplines was used, such as sexual health education, psychology and sociology.

In this study the researcher used national and international literature to explore relevant topics, facts and techniques. These resources were gathered from a variety of universities and access to Internet sites was utilised. DISA-clinic has their own library and was used to gather literature and to study videos on various sexual problems that exist.

1.7.5.2 Consultation with experts

Meeting with the experts was of great importance to the researcher and gave the researcher a sense of guidance to set forth with the research process.

- **Dr. Elna McIntosh, the MD of DISA-clinic**, is a **clinical sexologist** in private practice and provides sexual and reproductive health services at DISA-clinic in Sandton, Johannesburg.
- The researcher consulted Dr. McIntosh and was provided with information about women's sexuality.
- Guidance was given to the researcher on the research topic and Dr. McIntosh was more than willing to let the researcher do her research at the clinic.

It was established that there is a great need within the clinic to establish the socio-emotional influence that sexual problems have on young women. It was pointed out that the staff at DISA-clinic needed information on how the influence

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of sexual problems affects the socio-emotional functioning of young women and this was provided through this study.

Experts that were consulted:

Mrs. Glenda Baitman: Nurse and counsellor at DISA-clinic. Mrs. Baitman does pre-and-post abortion counselling at DISA-clinic and informed the researcher on the emotional change that she normally observes with an abortion. She is also involved with STD screenings and HIV/AIDS counselling and the researcher gathered information from Mrs. Baitman for the literature study.

Mr. Gareth Hunt: Clinical Psychologist that specialises in sexual dysfunction (in private practice). The researcher discussed sexual dysfunctions with Mr. Hunt to gather information on this specific sexual problem and to get some insight on the various sexual dysfunctions that women experience.

Dr. Karine Watson: Specialist Gynaecologist and Obstetrician (MD, MRCOG {UK}). Dr. Watson specialises in sexual problems and the researcher consulted her with regards to what she observed in the United Kingdom and how it compares with South African sexual problems. This gave the researcher some insight on sexual problems in the United Kingdom and made the research process more universal.

1.7.5.3 Feasibility of study

As a result of the researcher's experience in sexual and reproductive health, the feasibility of this study was found to be positive because of the healthy working relationship that prevails amongst the team members at DISA-clinic. The

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researcher is involved at the clinic and had time to do the research at the clinic while waiting for patients visiting the clinic.

Royse (1998:222) states that a document study has the advantages of being (1) unobtrusive, (2) generally inexpensive to conduct and (3) able to deal with large volumes of data. No special training or expertise is required - all that is needed is a research question or hypothesis and a set of communications or body of materials from which to begin developing categories. As a result the use of a document study was found suitable for this study and added to the feasibility of this particular research process.

Permission for this study was obtained from the MD of the clinic, Dr. McIntosh. Personal letters (primary sources) which were used in the document study were available and accessible at the clinic. Although the cost of document study is influenced by factors such as the dispersion and availability of documents, the type of document that is being studied and the distance that needs to be covered in order to obtain the documents, document study is relatively more affordable than, for instance, a comprehensive survey (Monette, Sullivan & De Jong, 1994:204). The cost for this study merely included copying, stationery and travelling to the clinic.

1.7.5.4 Study of strategic entities/Pretest of document study

Strydom & Delport (2002a:324) state that when documents are studied, it is of cardinal importance that the researcher evaluates the authenticity, or validity and reliability of the documents. There are different ways in which the validity and reliability of documents can be tested. Relevant documents were compared with other written documents. Data was verified by discussing it with the experts (at DISA-clinic) that are knowledgeable on the subject.

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1.8 A description of universe, research population, delimination of sample and sampling method

Strydom & Venter (2002:197) define a universe as all potential subjects who possess the attributes in which the researcher is interested.

Universe: All young women with sexual problems.

Babbie (1998:201) defines a population as the theoretically specified aggregation of study elements. Bless & Higson-Smith (2000:85) see a population as the set of elements that the research focuses on and to which the obtained results should be generalised. Strydom & Venter (2002:199) emphasise that we study the sample in an effort to understand the population from which it was drawn.

Population: All young women who are currently or have been influenced by a sexual problem, who have written to DISA-clinic about their personal experience.

Sample: The **following criteria** were used in selecting the personal letters of the respondents:

- Female,
- between the ages of 16 and 25,
- who experience or have experienced a sexual problem,
- who have written to DISA-clinic about their personal experience in English and
- all personal letters received between June 2002 and February 2003.

* Normally the young women do not mention their culture in the personal letters. But, if they mention their culture and it has an additional influence on their socio-emotional functioning it was considered when themes were identified. *

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Boundary of sample: According to McKendrick (1990:268) sampling methods are used in research when one is unable to investigate the total population that is involved in the information that the researcher needs to obtain. A non-probability sampling method was used in this study. The type of non-probability sampling that the researcher used is purposive sampling.

Strydom & Delport (2002b:336) state that in purposive sampling the researcher must think critically about the criteria of the population and then choose the sample case accordingly. Clear identification and formulation of criteria for the selection of respondents are therefore, of cardinal importance. The size of the sample depended on the number of letters received by the clinic between June 2002 and February 2003.

1.9 Ethical issues

Williams, Tutty and Grinnell (in Strydom, 2002:62) emphasise that the fact that human beings are the objects of study in the social sciences, brings unique ethical problems to the fore that would never be relevant in the pure, clinical laboratory settings of the natural sciences. For researchers in the social sciences, the ethical issues are pervasive and complex, since data should never be obtained at the expense of human beings.

The ethical issues which the researcher concentrated on are as follows:

1. Harm to experimental subjects and/or respondents

Strydom & Delport (2002a:325) state that unlike surveys or experiments where respondents are aware of the fact that they are being studied, producers of documents do not necessarily anticipate the analysis of their documents at a later stage. The contents of the documents are thus not affected by the activities of the researcher. One of the basic advantages of document study is the fact that it is the only method where the researcher does not need to make personal contact with the respondent(s).

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Therefore, no harm was inflicted on the respondents as document studies were focused on personal letters from young women that knew that their letters are used by DISA-clinic to obtain insight into their personal experience.

2. Informed consent

"Informed consent implies that all possible or adequate information on the goal of the investigation, the procedures that will be followed during the investigation, the possible advantages, disadvantages and dangers to which respondents may be exposed, as well as the credibility of the researcher, be rendered to potential subjects or their legal representatives" (William, *et al.*, 1995:30). The researcher obtained consent[2] from the MD of DISA-clinic, Dr. McIntosh.

3. Deception of subjects and/or respondents

Strydom (2002:66) describes the deception of subjects as "deliberately misrepresenting facts in order to make another person believe what is not true, violat[ing] the respect to which every person is entitled". Lying about research purposes is common, especially in the case of small qualitative projects. The main aim of the study and the manner in which documents were to be used, was explained to Dr. McIntosh. The researcher kept Dr. McIntosh informed at all times in the research process.

4. Violation of privacy/anonymity/confidentiality

DISA-clinic places high value on the privacy of their patients and all patients are seen anonymously. Names are not taken at the clinic and therefore it was impossible to do interviews with a tape recorder to gather data and still be ethical. Strydom & Delport (2002a:325) emphasise that one of the basic advantages of document study is the fact that it is the only method where the researcher does not need to make personal contact with the respondent(s). Through using the documents the respondents were protected as the personal

[2] See Appendix A for letter of consent

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letters were written anonymously and therefore the researcher could not exploit their privacy.

5. Actions and competence of researcher

Strydom (2002:69) emphasises that researchers are ethically obliged to ensure that they are competent and adequately skilled to undertake the proposed investigation. The researcher had experience in this particular field and used these skills to gather and analyse the documents in a professional manner. The researcher also successfully completed theoretical and practical modules of MSD (Play Therapy) and is registered at the SA Council for Social Service Professions.

6. Release or publication of the findings

The findings of the study must be introduced to the reading public in written form, otherwise even a highly scientific investigation will mean very little and will not be viewed as research (Strydom, 1994:18-19). The researcher compiled the research report according to the requirements for a mini-dissertation of the Department of Social Work: University of Pretoria. This research report was completed accurately, objectively, clearly and unambiguously to inform the readers of the socio-emotional influence of sexual problems on young women.

1.10 Definition of key concepts

The definitions provided for each concept were applicable throughout the research report unless stipulated otherwise in the report.

1.10.1 Young women

“A ‘girl child’ or the ‘young women’ as defined by the Beijing Platform for Action, resides roughly between the ages of 15 and 25 years” (A Call for inclusion: Young Women in leadership and decision making, 1999:1).

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Ing & Gilford (1996:1) define a young woman as aged between 16 and 25 years.

For the purpose of this study the researcher used the term **young women** to include women between the ages of 16 and 25 years.

1.10.2 Sexual problem

The Oxford Paperback Dictionary (1988:642) defines a sexual problem as something difficult to deal with or understand or something difficult that has to be accomplished, answered, or dealt with because of sexual intercourse or sexual acts.

Heidensohn (1996:24) states that a sexual problem is a result, outcome, effect or repercussion because of specific sexual deeds or behaviour.

For the purpose of this study **sexual problems** were organised in three main groups:

1. Sexual dysfunctions; these include Dyspareunia, Vaginismus, Anorgasmia.
2. Unintended pregnancy; these include abortion, adoption, early parenting.
3. Sexually transmitted diseases and sexually related diseases; these include HIV infection and AIDS, Gonorrhea, Syphilis, Herpes.

1.10.3 Sexual practices

Humphrey (1983:71) states that sexual practices are natural and are when people meet to partake in sexual actions. In healthy relationships, male and female sexual response cycles occur as a result of normal erotic stimulation. Every human being has his or her own unique sexual value system. If a person does not act in accord with his or her sexual value system, conflict, guilt and other such emotions will occur. These emotions usually result in sexual problems because of the sexual practice.

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Elliot (1996:148) states that sexual practices are when people have sexual experiences. Safe or very low risk sexual practices are sexual fantasies of any kind, sex talk and masturbation. Sexual practices also include oral sex and penetrative sex within a relationship or out of a relationship context, for example when being raped or gang raped, sexually molested, partaking in prostitution and casual sex.

For the purpose of this study the researcher construed the definition of **sexual practice** to be any sexual act from cybersex to penetrative sex.

1.10.4 Social work investigation

New Dictionary of Social Work (1995:60) defines social work as professional services by a social worker aimed at the promotion of the social functioning of people.

The Oxford paperback dictionary (1988:426) defines investigation as to make a careful study of (a thing) in order to discover the facts about it, or to make a search or systematic inquiry; to examine.

The researcher used the term **social work investigation** as a careful study of exploration to discover facts and to promote the socio-emotional functioning of people.

1.10.5 Socio-emotional functioning

New Dictionary of Social Work (1995:21) defines social functioning as the individual's role performance in its entirety at all levels of existence in interaction with other individuals, families, groups, communities and situations.

New Dictionary of Social Work (1995:21) defines emotional security as a feeling of a person that his deeper emotional needs, particularly the need for love, acceptance and security are met.

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Socio-emotional functioning for the purpose of this study was a combination of social functioning and emotional security. Therefore, **socio-emotional functioning** was defined as the individual's role performance in its entirety at all levels of existence in interaction with other individuals, families, groups, communities and situations because the person's emotional needs, particularly the need for love, acceptance and security are met.

1.11 Problems and limitations of the study

The problems and limitations which were identified in this study are as follows:

- Little information was found on sexual practices and sexual problems in social work literature and most literature was used from the Institute of Human Sexuality.
- It was difficult to find literature that was applicable to South African context of sexual problems. Numerous amounts of international literature was found but South African literature on sexuality and sexual problems is limited.
- One hundred and fifteen personal letters were used in the document study and because of the length of some of the letters it was altogether time consuming to read the personal letters.
- It was difficult to analyse the personal letters because no examples were available on a previous document study in the Social Work Department.
- The interpretation of the empirical findings became difficult and took a longer period because of the researcher's uncertainty as to how to analyse the information.
- The researcher wants to specify that there was a shortcoming of cultural aspects in the research process. It is important to emphasise that the acceptance of sexual practices varies from culture to culture. For the purpose of this study culture did not play a significant role because of the limited length of the research report according to the requirements for a mini-dissertation of the Department of Social Work: University of Pretoria, it could not be included.

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1.12 Contents of research report

The research report consists of five chapters.

Chapter 1 consists of the general introduction with regards to the investigation. The following important aspects receive attention; a general introduction, motivation for the choice of study, problem formulation, sampling and aim of the study. Question formulation, research methodology, pilot study and definitions of main concepts with regard to the study are also discussed.

Chapter 2 consists of a literature study investigating the socio-cultural context, norms and values of sex; sexuality and women's rights; basic sexual rights; the politics of sex; sexual development and young people's involvement in sexual practices and lastly focuses on sexual practices.

Chapter 3 focuses on special concerns for young women. It also seeks to investigate the three groups of sexual problems namely: Sexual dysfunctions; Unintended pregnancy; Sexually transmitted diseases and sexually related diseases.

Chapter 4 discusses the empirical details and findings of the study.

Chapter 5 focuses on the conclusions and recommendations concerning the study.

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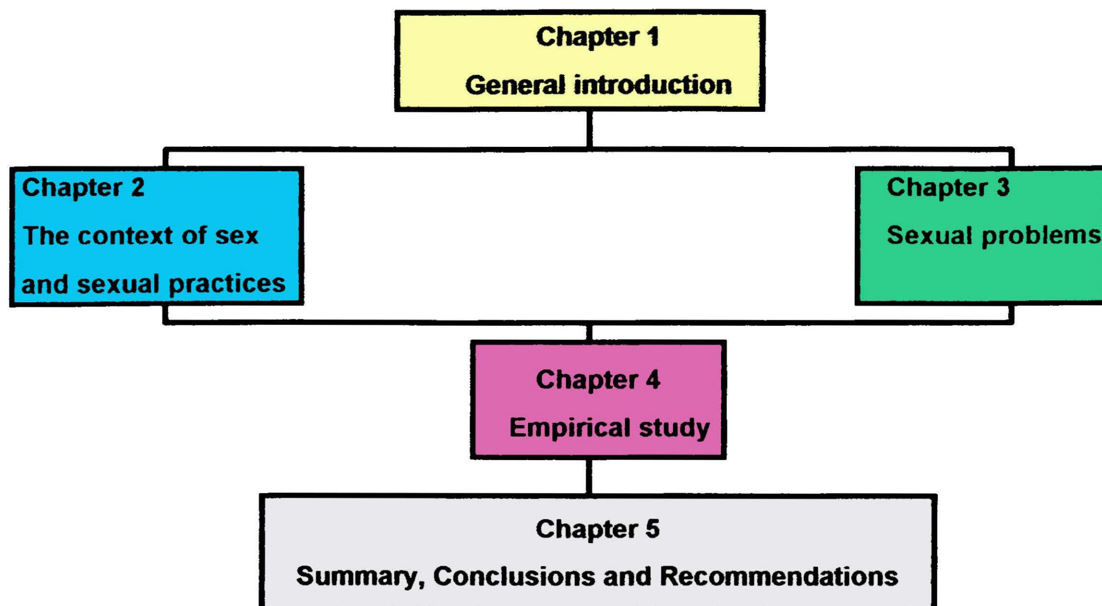
Figure 2: Schematic presentation of the contents of the research process



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CHAPTER 2

THE CONTEXT OF SEX AND SEXUAL PRACTICES

2.1 Introduction

Sexual practices form part of all societies and the researcher is of opinion that it is necessary that sexuality be placed into context, before discussing sexual practices that young women are involved in. Therefore, this chapter will commence with information on sexuality and will introduce a discussion of various sexual practices.

2.2 Sexuality in context

It's hard to remember that there was a time of great media prudery until the so-called and much-vaunted sexual revolution that took over the magazines, movies and eventually television. Values, experiences, families, peers, media, school, religion, law and government all influence sexuality, gender roles and sexual behaviours (Compare Huang & Uba, 1992:227; Baron & Byrne, 1997:290 and Sexuality and Sexual Health Online Course, 2001:30.) Society determines which sexual information and behaviours are legally permitted or considered appropriate on the basis of: tradition, customs, religion, values and beliefs; the history and experience of the culture; economic and political conditions.

Baron & Byrne (1997:297) and Girard (2002:1) are of the opinion that in many places, young people continue to experience countless violations of their human rights, especially with regard to having access to sexual health education and services. Sexual and reproductive health services for young people are often absent because of reluctance to address or even acknowledge young people's sexuality. Even where services do exist, health providers often discriminate on the basis of age, marital status, sex, parental or spousal consent. Young people often do not have access to sex education - because it is not provided at all, because it is only offered in schools, or because its content is severely limited by

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cultural barriers or ideological considerations. Parents are all too often unable or unwilling to discuss matters of sexuality and sexual health with their children.

According to Louw & Edwards (1998:435) and Girard (2002:1) failure to respect, protect and fulfill young people's sexual and reproductive rights results in ignorance of basic facts about sexuality, lack of access to contraception and other necessary services and vulnerability to sexual violence and abuse. It puts young people at high risk of unwanted pregnancy, unsafe abortion and HIV/AIDS. For example:

- Young women aged 15-19 are twice as likely as those in their twenties to die at childbirth; girls under 15 are five times as likely to die.
- Every day, 7000 young people around the world become infected with HIV.
- At least one-quarter of all unsafe abortions (estimated at 20 million per year) are to girls aged 15-22.

The researcher is of opinion that society is not in control of pregnancies and is not in control of sexually transmitted diseases and HIV/AIDS. Due to the fact that society denies or underestimates the risks involved in being sexually active, the statistics of sexual problems are rising in communities.

2.2.1 Norms and values

It is important to realise that sexual information and behaviours are seen as part of a socio-cultural context. Some sexual behaviours are inappropriate in certain cultures and sexual acceptance differs from culture to culture. As a result, sexual information and behaviours are guided by formal and informal values of a community. (Compare Pan, 1993:62; Elliot, 1996:270 and Baron & Byrne, 1997:298.) Every culture has norms related to sex and sexuality. These norms are reflected in gender roles, relationships, marriages, partnerships, friendships and family. Societal norms often determine sexual practices, marriage customs,

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punishment for disapproved sexual behaviours and attitudes toward prostitution, homosexuality, contraception, sexual taboos and sex education.
All societies have values that guide private and public behaviour. These values are formal - that is, defined by religions, governments and other official entities shaping a society's laws. However, informal values - those reflecting a person's day-to-day behaviour - may not be consistent with the culture's formal values (Sexuality and Sexual Health Online Course, 2001:30).

The researcher is of opinion that norms and values have changed dramatically in the last decade and it is now more acceptable to be sexually active before marriage. Even though people know the risk of sexual practices they still partake freely in these practices. Love Life: Portrait of Young South Africa (2002:8) states that many young people are sexually active and begin having sexual experiences at a very young age. Overall 31% of South African youth are sexually experienced (defined as having sexual intercourse).

Sexually experienced youth report having had their first sexual experience involving more than kissing or touching at a young age. Almost one in three (32%) of this group had their first sexual experience at the age of thirteen or younger (Love Life: Portrait of Young South Africa, 2002:8). The researcher is of opinion that with these statistics the emotions regarding sexual practices have to have an enormous impact on the individuals' socio-emotional functioning because of their age and the developmental stage that they are in.

2.2.2 Taboo behaviours

Sex is an important part of life. Tucker-Ladd (2002:2) states that sex gives humans physical pleasure and babies. It sometimes expresses love beautifully. Sex leading to children is the only way for the species to survive and for most people to achieve a form of immortality of living beyond death. Although simple, fun and necessary, sex is restricted by a complex set of morals, social customs

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and taboos. Any drive that is so strong and valued, yet so controlled and prohibited, is going to generate stressful, ambivalent, confusing feelings.

While a particular society may have strict taboos on homosexual behaviour and may deny the presence of homosexuality, there is evidence that homosexual identity or orientation exists in nearly all societies and cultures (Compare Huang & Uba, 1992:236; Pan, 1993:60 and Sexuality and Sexual Health Online Course, 2001:30.) Under these circumstances, homosexual practices in that society may be suppressed or kept within a private subculture. Equally, while a society may publicly prohibit sexual activity outside of marriage, many people may practice sex with a person who is not their spouse.

According to Pan (1993:56) and Tucker-Ladd (2002:4), in some cultures it may be understood informally that this is common - even acceptable - while in other cultures, norms and even laws based on these norms may make these behaviours acceptable for one sex and not the other. For example, in some cultures it is acceptable for men to have multiple sexual partners or sex with a person who is not their spouse, where as a woman in the same culture who has sexual relationships outside of marriage may be stigmatised, punished, or socially ostracised - even if the woman has been raped.

2.3 Sexuality and Women's Rights

Sexuality is reflected in the total expression of who people are as human beings. It is shaped by their values, attitudes, behaviours, physical appearance, beliefs, emotions, personality, likes and dislikes and spiritual selves, as well as all the ways in which they have been socialised (Compare Elliot, 1996:275 and Sexuality and Sexual Health Online Course, 2001:22.) Sexuality begins before birth and lasts a lifetime, and it is influenced by ethical, spiritual, cultural and moral factors. It involves giving and receiving sexual pleasure, as well as enabling reproduction.

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Sexuality is a total sensory experience, involving the whole mind and body - not just the genitals and consequently it is important that each person has the right to sexual health. Reproductive Rights Alliance (1998:1) and Sexuality and Sexual Health Online Course (2001:22) state that sexual health is the ability to express one's sexuality free from the risk of sexually transmitted infections, unwanted pregnancy, coercion, violence and discrimination.

The researcher adds that this means being able to have an informed, enjoyable, and safe sex life, based on a positive approach to sexual expression and mutual respect in sexual relations. It is positively enriching, includes pleasure and enhances self-determination, communication and relationships. The researcher is of opinion that few women experience sexual health and this hinders them from expressing their sexuality.

According to Sexuality and Sexual Health Online Course (2001:32) during the 1990s, several international conferences were organised by the United Nations to develop an agenda for social equality, justice, development and peace. The cornerstone of the resulting international agreements is the protection of human rights. Ensuring women's rights as human rights enables full and equal participation in decision making and access to opportunities in all social and economic activities.

Certain sexual acts to which women are particularly vulnerable are considered violations of human rights (Compare Elliot, 1996:233 and Baron & Byrne, 1997:305.) For example, when sexual and reproductive rights are abused or ignored, women and girls may be placed at risk of violence, sexual abuse, rape, sexually transmitted infection such as HIV/AIDS, unintended pregnancy, abortion complications, abandonment, harmful practices (such as female genital cutting) and poverty.

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Any meaningful discussion of sexual and reproductive health services must address the politics of control of women's sexuality and must appreciate the constraints on service delivery posed by the issue. According to Girard (2002:3) social factors affecting women's ability to control their sexuality include culturally determined gender inequalities, economic dependency, inadequate access to health services, culturally sanctioned sexual abuse and violence.

Reproductive Rights Alliance (1998:1) adds that reproductive rights are the rights which protect the health and well being of both men and women. Reproductive rights are however of fundamental importance to women because only when armed with such rights can women effectively exercise the rest of their rights and become full and equal members of this society.

Elliot (1996:278) and Girard (2002:2) are both of opinion that in their narrowest sense reproductive rights demand respect for women's bodily integrity and decision making in an environment that is free from fear of abuse, violence and intimidation.

The researcher is of opinion that more emphasis must be placed on reproductive rights. This would empower women to stand up for their rights and consequently help them to express their sexuality freely. As a result women's socio-emotional functioning will be enhanced because of their empowered position.

2.3.1 Basic sexual rights

Sexual rights are universal human rights based on the inherent freedom, dignity and equality of all human beings. Health is a fundamental human right and as a result sexual health becomes a basic human right (Declaration of Sexual Rights, 1999:1). In order to assure that human beings and societies develop healthy sexuality, sexual rights must be recognised, promoted, respected and defended

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by all societies by all means. Sexual health is the result of an environment that recognises, respects and exercises sexual rights.

The following are classified as sexual rights:

1. The freedom of any sexual thought, fantasy or desire.
2. The right to sexual entertainment, freely available in the marketplace, including sexually explicit materials dealing with the full range of sexual behaviour.
3. The right not to be exposed to sexual material or behaviour.
4. The right to sexual self-determination.
5. The right to seek out and engage in consensual sexual activity.
6. The right to engage in sexual acts or activities of any kind whatsoever, providing they do not involve nonconsensual acts, violence, constraint, coercion or fraud.
7. The right to be free of persecution, condemnation, discrimination, or societal intervention in private sexual behaviour.
8. The recognition by society that every person, partnered or unpartnered, has the right to the pursuit of a satisfying consensual socio-sexual life free from political, legal or religious interference and that there need to be mechanisms in society where the opportunities of socio-sexual activities are available to the following: disabled persons; chronically ill persons; those incarcerated in prisons, hospitals or institutions; those disadvantaged because of age, lack of physical attractiveness, or lack of social skills; poor or lonely.
9. The basic right of all persons who are sexually dysfunctional to have available nonjudgemental sexual health care.
10. The right to control conception (Institute for Advanced Study of Human Sexuality, 1994:12).

The researcher is of opinion that because sexual rights are human rights, all people must have access to sexual rights and must consequently be provided

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with sex education. Therefore, sexual health must be prioritised in the country and an environment must be built that recognises various sexual preferences and these preferences must be respected because of each person's freedom of choice.

2.4 The politics of sex

Gender inequality influences decisions and gender-based power imbalances may greatly affect a woman's control and ability to make these decisions. For example, a woman may decide that she wants to protect herself from HIV and STD's because of her partner's behaviour, yet she may not have the power to confront her partner, negotiate condom use, or even discuss the matter without fear of reprisal (Compare Elliot, 1996:276; Sexuality and Sexual Health Online Course, 2001:32 and Girard, 2002:4.) A woman may want to avoid having additional children, yet must choose a method that can be used secretly without her partner's knowledge, even if it is not the ideal method for her in other respects.

Avery, Rodriguesz-Trias & Steinem (1992:225) and Elliot (1996:278) are of the opinion that it can be difficult, even painful, to be sexual in a sexist, violent society. Women have blamed themselves and been blamed if sex didn't go well. Men as a group have more power in society than women do. Even if a wife feels equal to her husband, male lover, friends, colleagues or co-workers, culture still values a patriarchal society.

It is a cruel fact of life that many men abuse women, often using sex as a weapon. Rape and early experience of incest, sexual harassment by a boss or co-worker or teacher: Any of these can devastate what sex could be for a woman. If women do not experience violence directly, the possibility leers at them from pornography, news stories, movies or crude jokes.

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One man's violence against one woman may seem to result from his individual psychological problems, sexual frustration, unbearable life pressures or some innate urge toward aggression. Though each of these "reasons" has been used to explain and even justify male violence, they hide the truth (Compare Avery, *et al.*, 1992:225; Elliot, 1996:277 and Baron & Byrne, 1997:407.) Men use violence against women to exert and maintain their power and control.

Avery, *et al.* (1992:225) and Elliot (1996:278) are of the opinion that when a battering husband uses beatings to confine his wife to the home and prevent her from seeing friends and family or pursuing outside work, he exerts dominance, hostility and control. When a boss sexually harasses his employee, he exerts his power to restrict her freedom to work and improve her position. When men rape women, they act out of a wish to punish or dominate, a desire that is often eroticized.

According to Avery, *et al.* (1992:225) whether or not an individual man who commits an act of violence views it as an expression of power is not the point. The fact that so many individual men feel entitled to express their frustration or anger by being violent to so many individual women, illustrates the power men as a group hold over women as a group. In this distorted way even the most powerless men benefit from sexism.

Thousands of daily acts of violence throughout the world create a climate of fear and powerlessness that limits women's freedom of action and controls many of the movements of women's lives (Compare Avery, *et al.*, 1992:226 and Girard, 2002:3.) The researcher emphasises that the threat of male violence continues to keep women from stepping out of traditional roles and boundaries. It literally "keeps women in their place".

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2.5 Life-span sexual development

The sexual development of human beings is an integral part of the developmental process of every individual. A person's full development depends upon the satisfaction of basic human needs such as the desire for contact, intimacy, emotional expression, pleasure, tenderness and love. Sexuality is constructed through the interaction between the individual and social structures (Compare Declaration of Sexual Rights, 1999:1 and Tucker-Ladd, 2002:24.) The researcher is of opinion that full development of sexuality is essential for individual, interpersonal and societal well being.

To understand the impact of sexual practices on young women, it is necessary to understand the sexual developmental process that human beings go through and why women partake in sexual practices at such a young age. According to King (1999:246) to deny sexuality is to deny humanity. It should come as no surprise, therefore, that sexuality begins from the moment of birth (and perhaps before) and lasts until death.

King (1999:344) and Tucker-Ladd (2002:37) are both of the opinion that girls are sexually ripe at the age of fourteen and consequently interested in partaking in sexual practices. However, the problem arises that they are not emotionally strong enough to deal with the consequences of sexual practices because of the developmental phase that they are in.

Mentally, girls are not ready for the emotional aspects that come with sex. The researcher is therefore of opinion that it is important to understand the developmental phases that people go through so that the information can be used to understand young women's behaviours, needs, fears and attitudes related to sex.

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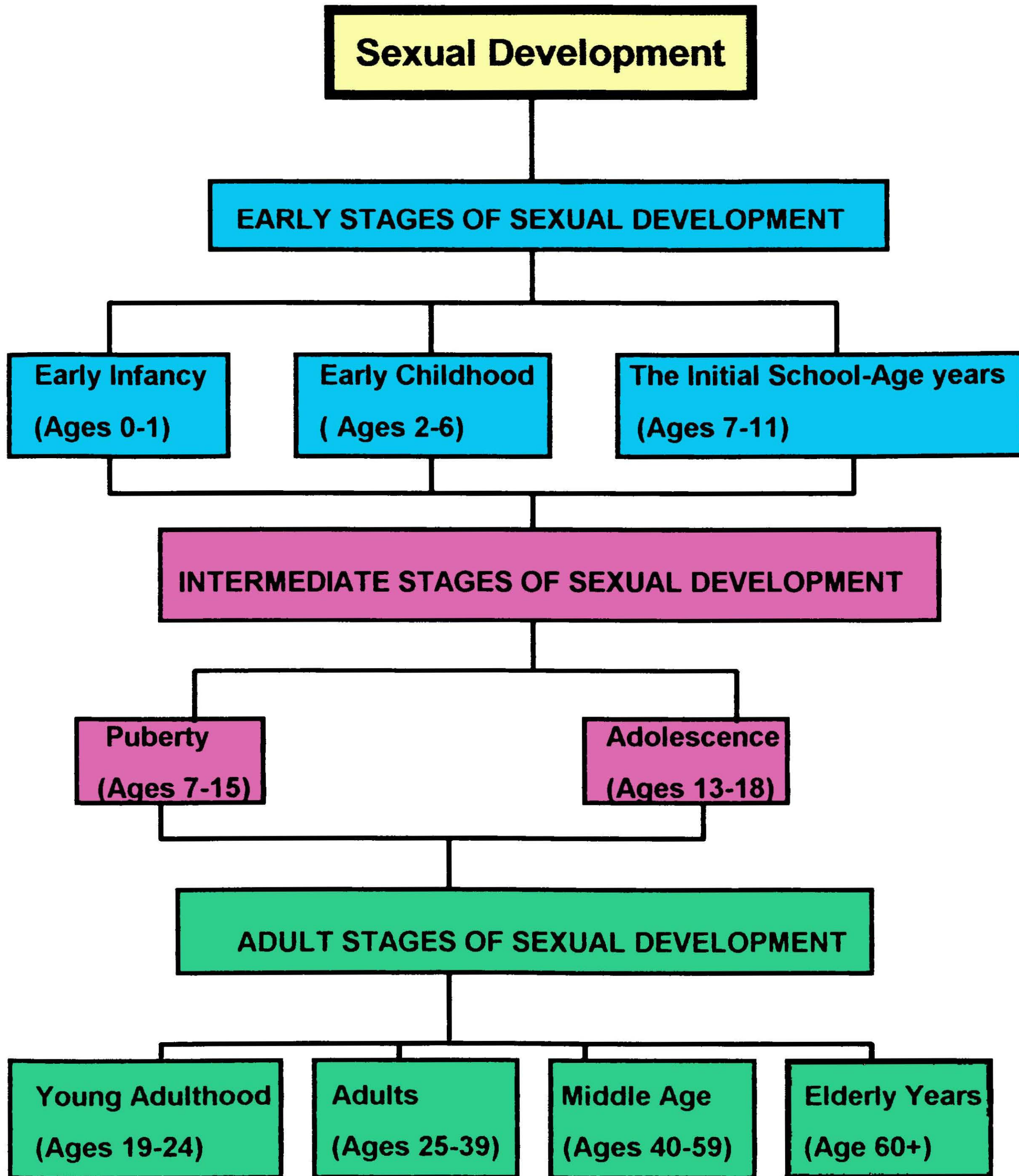
Figure 3: Stages of Sexual Development



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2.5.1 Early stages of sexual development

2.5.1.1 Early Infancy (Ages 0-1)

According to King (1999:246) sexuality starts in the womb. Ultrasound recordings have discovered that male fetuses have erections months before they are born. After birth, male babies often have erections before the umbilical cord is cut. Similarly, female babies can have vaginal lubrication in the first 24 hours after birth (Compare King, 1999:246 and Tucker-Ladd, 2002:24.) An important part of sexual development involves the amount of hugging and cuddling that an infant has with its caregivers.

2.5.1.2 Early Childhood (Ages 2-6)

At this age children begin exploring their world. King (1999:247) and Tucker-Ladd (2002:27) are both of the opinion that sex is a part of the world that the children explore. The children learn that touching feels good and begin to explore their own bodies. Children receive non-verbal messages about sex in particular and begin to understand the difference between the sexes and learn sex roles. Most children will ask questions about their bodies, about birth and babies.

By the age of two, King (1999:247) explains that children are very interested in their own bodies. Because of this, they will try to watch their siblings and parents bathing and urinating. They will also take their clothes off together and will play games that allow for sexual exploration, such as "playing doctor" and "playing house". The researcher is of opinion that it is important to remember that sexual exploration games will not harm a child's development and that it is part of normal sexual development.

2.5.1.3 The Initial School-Age years (Ages 7-11)

Children at this stage may think in terms of "good" and bad" parts of their bodies. They are aware of bodily functions and their link to sex. According to King

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(1999:247) the amount of sex play does not slow down at this stage but is simply hidden more from parents. Although the amount of overly sexual play may decrease during the initial school-age years, curiosity about sex does not disappear.

In this stage children are very same sex oriented and may have some discomfort about discussions on sex. The children can be very sensitive to sex as well as other "feelings" topics. Baron & Byrne (1997:417) and King (1999:247) are of the opinion that masturbation and exploration are common at this age. The outward attitude in this stage is that, sex is disgusting. Children may appear to be unconcerned with sex, but actually they are quite interested in the subject.

2.5.2 Intermediate stages of sexual development

2.5.2.1 Puberty (Ages 7-15)

This stage marks the beginning of puberty. Children are often confused and frightened about body changes and may be unaware of or uncomfortable with social and sexual roles. Tucker-Ladd (2002:54) states that the children are easily influenced by peers and the media and may often hesitate to seek assistance.

According to King (1999:250) puberty is the time of life when children first show sexual attraction and become capable of reproduction. Changes in girls are development of breasts, the growth of pubic hair, increase in estrogen levels that also cause an increase in fatty deposits in the hips and buttocks, menarche followed by a menstrual cycle. Changes in boys are growth in testes and scrotum, increased levels of testosterone. Testosterone then stimulates growth of the penis, prostate gland, and seminal vesicles. Children have difficulty adapting to all these changes and have difficulty asking for information they need to adjust to their awakening sexuality and changing body image because they feel embarrassed.

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The researcher wants to emphasise the fact that because of these changes, children may be confused, embarrassed and self-conscious. King (1999:250) and Tucker-Ladd (2002:57) are both of the opinion that children's ideas about themselves and their future are incomplete in this stage, as their development allows them to focus only on the present. Because it is hard for them to see the causes and effects on their behaviour, there are rising rates of sexual activity, pregnancy, AIDS and other sexually transmitted diseases at this stage.

2.5.2.2 Adolescence (Ages 13-18)

According to King (1999:254) adolescence is the time of life between puberty and adulthood. There is an intensification of body awareness and adolescents experience with masturbation, sexual fantasies, petting and sexual intercourse. Teenage pregnancies are becoming a trend during this stage, have enormous emotional effects on the young women and can cause self-destructive behaviour such as suicide and mutilation of the body. King (1999:254) and Tucker-Ladd (2002:50) are both of the opinion that at this time individuals are forming their identities and self-concepts. During this stage approximately 50% of adolescents are sexually experienced or active.

Children are emotionally and socially becoming adults. However, they may be easily influenced by media and peer messages and pressures. Adolescents decision making and value judgement skills need practice. Their abilities to think clearly and keep themselves in control may also be underdeveloped. (Compare Louw & Edwards, 1998:476; Gouw, *et al.*, 2000:12; Tucker-Ladd, 2002:56.) The researcher is of opinion that in this stage children will be uncertain and confused by sex. In this stage children become defensive when they feel confronted or threatened and as a result must be handled with care and must be respected.

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2.5.3 Adult stages of sexual development

2.5.3.1 Young Adulthood (Ages 19-24)

Young adulthood has its own problems, but it is definitely an easier and less emotionally strenuous stage than adolescence. This is the stage where a person is not a child anymore and is now facing the responsibilities that come with being an adult. According to King (1999:258) this is an extended period of being a single adult that occurs between adolescence and parenthood. Young adults have more freedom from parental restraints and more opportunity for privacy than in the past.

Accordingly, the sexual activity of young adults is generally different from that of younger and older age groups. By the age of 20, approximately 90 percent of young adults are sexually experienced and have sex regularly and most young adults have had multiple sexual partners during their young lifetimes (Compare Pan, 1993:57; King, 1999:258 and Tucker-Ladd, 2002:75.) The researcher is of opinion that in this stage young women are most often faced with sexual problems.

2.5.3.2 Adults (Ages 25-39)

Approximately 90% of all adults are sexually active. By the time people have reached this stage of development, sex and sexuality have become a part of their lives. Adults hold views about their sexuality which have been influenced by society and its standards of normal behaviour (Compare Baron & Byrne, 1997:303 and Tucker-Ladd, 2002:58.)

Baron & Byrne (1997:303) and King (1999:260) are of the opinion that the next step of sexual development in the adult phase is; marriage, living together (cohabitation), parenthood. Adults generally have more comfortable, open and tolerant attitudes regarding sex and they take responsibility for their own sexual choices.

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2.5.3.3 Middle Age (Ages 40-59)

The frequency of sexual intercourse may change in this phase. According to King (1999:267) male and female sexual needs change and physical changes occur because of the ageing process. Uken (1983:24) and Kinsey (2001:4) are both of the opinion that in this stage of a couples life sexual problems may arise. Anorgasmia and penile dysfunction is often found in the middle ages of a person's life.

2.5.3.4 The Elderly Years (Age 60+)

According to King (1999:274) the conclusion is that sexuality does not have to end at any given age. This age is definitely not sexless.

This particular study focuses on the adolescent and young adulthood phase. In these phases of development the adolescent and young adult endure a lot of freedom and this generally leads to participating freely in sexual activities. Young women are exposed to various sexual practices and are not emotionally ready for the consequences of their sexual actions. Therefore, the researcher finds it important to discuss young people's involvement in sexual practices.

2.6 Young people's involvement in sexual practices

Not all young people are sexually active by choice as a number of young people deal with sexual coercion and a concerning number have experienced sex by force. Love Life: Portrait of Young South Africa (2002:10) states that almost four in ten sexually experienced young women (39%) say that they have been forced to have sex when they did not want to; 7% of sexually experienced young men also report being forced to have sex.

In addition to force, coercion and fear are also a part of many young people's sexual relationships. Thirty three percent of sexually experienced young women say they are afraid of saying no to sex. Over half of sexually experienced girls

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(55%) agree with this statement: "There are times when I don't want to have sex, but I do because my boyfriend insists on having sex" (Love Life: Portrait of Young South Africa, 2002:10). Young people are both the perpetrators and victims of sexual coercion.

In comparison with South African statistics Craig (1996:481) states that researchers from the University of Chicago conducted a random survey of nearly 3500 Americans. Trends in sexual behaviour have shifted over the decades. In 1937 and again in 1959, only 22% of the U.S. population condoned premarital sex for both men and women. In 1974, 75% of the men approved of premarital sex for men, and over 50% of them found it acceptable for women. Some behaviours have not increased much, including mate swapping, group sex, and extramarital sex. The double standard persisted, with 50% of college men approving of premarital sex for women but still preferring a virgin wife.

This was comparable to the 35% reporting sexual activity at least monthly in the early 1970s. According to Craig (1996:481) this swing back towards more conservative sexual behaviour among college women may be attributed to an increased fear of disease (including AIDS and herpes). It may also reflect the growing self assurance of young women who feel less compelled to please their boyfriends. Or it may be that as social pressure to have sex has declined, women are more likely to follow their own belief systems.

The researcher does not agree with the above statements and emphasises the high rate of premarital sexual activity, the HIV/AIDS and STD statistics as well as the number of women that have abortions on a daily basis. The researcher is of opinion that sexual practices have changed but for the worse and young women especially, suffer serious socio-emotional problems caused by the trauma of sexual practices, for example unwanted pregnancy, STD's, Vaginismus and Dyspareunia.

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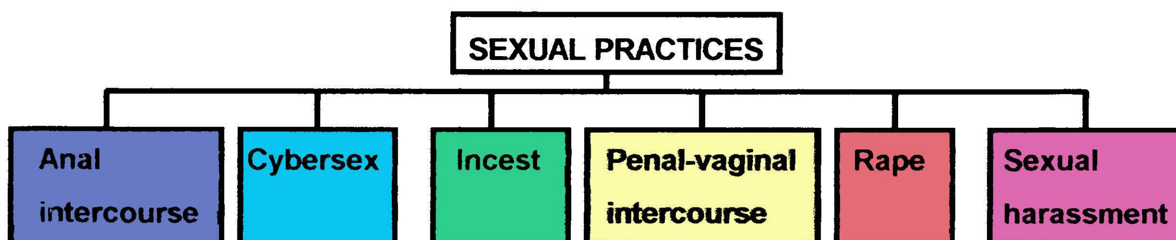
2.7 Sexual Practices

There are numerous sexual practices, variations on sexual practices and terminology for sexual practices. Sexual practices for the purpose of this study will include all sexual practices in the society but it is impossible to name all the sexual practices. As a result, the researcher thought it appropriate to discuss the following sexual practices, namely anal intercourse, cybersex, incest, penal-vaginal intercourse, rape and sexual harassment.

Figure 4: Selected sexual practices for research purposes



2.7.1 Anal intercourse

According to Sexuality and Sexual Health Online Course (2001:115) anal intercourse is the insertion of the penis into the rectum. This practice is widespread among both homosexual men and heterosexual couples. Anal sex encompasses a variety of commonly practised sexual activities. Although there is nothing remarkable about them in practical terms, there are taboos surrounding them that may arouse strong feelings of moral indignation and anxiety. It is important to remember that while some people find these activities repugnant, other may find them stimulating, exciting and a normal part of their sexual intimacy (McIntosh, 2003).

Taormino (1998:19) states that because anal and rectal tissue is delicate and easily torn, viruses can be easily transmitted through the tissue into the bloodstream; so, unprotected anal intercourse with an infected person is a high-risk activity for both partners - statistically higher than vaginal intercourse with

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an infected person - for all STD's, including HIV. In the 1990's, anal sex has been given the bad rap because HIV, the virus that causes AIDS, is most easily transmitted by anal intercourse (Anal Intercourse and Analigus, 2001:1).

Most sexual activities carry a risk of transmission of sexually transmitted diseases (STD's) from Gonorrhoea and Herpes, to Hepatitis B and HIV. There is evidence that anal intercourse carries a higher transmission risk than almost any other sexual activity (Compare Taormino, 1998:19 and Sexuality and Sexual Health Online Course, 2001:115.) Therefore, the conclusion can be made that anal sex has a high risk of transmission of diseases and unprotected oral-anal contact and digital penetration puts both partners at risk.

2.7.2 Cybersex

The researcher is of opinion that this sexual practice must be included in the research study because it is becoming a trend in the 21st century to partake in cybersex. Sexuality and Sexual Health Online Course (2001:112) defines cybersex as sex-related products, services and activities involving the Internet. This includes sexual fantasy between individuals or groups through games, chat rooms, bulletin boards, instant messaging services and other sources.

It has happened numerous times that young women log onto these Internet sites and the men then want to meet them. When meetings are arranged women sometimes become victims of sexual offences, for example rapes, molestation or even sexual harassment. Schneider & Weiss (2002:1) state that cybersex is a powerfully addictive mix of Internet use, sexuality and romantic fantasy. Professional expertise is needed in treating sexual addiction to their careful consideration of the emerging and complicated problem of on-line sexual addiction. Internet anonymity and accessibility can lead to addictive sexual behaviour resulting in broken relationships, isolation and money troubles.

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Cyberstalkers exist to find more than the casual one-nighter. They, by their own explanations of the effect, fall in love (Critical information - cyber romance, 2002:1). The quality of their "love" is twisted and they will, quite literally, stop at nothing to initiate real life contact with the object of their affection. They seem perfectly nice, quite normal, until they're scorned. Then life becomes a living hell (Compare Critical information - cyber romance, 2002:1 and Schneider & Weiss, 2002:1.) Cyberstalkers usually obtain personal information on the person that is being stalked and uses the personal information to blackmail the victim.

Cybersex can be very dangerous because young women can become victims of sexual harassment. Consequently, young women can become highly strung and as a result develop severe psychological and anxiety problems.

2.7.3 Incest

According to Sexuality and Sexual Health Online Course (2001:115) incest is sexual contact between closely related individuals that violates socio-cultural or religious norms or laws. Definitions of the type of kinship within which sex is forbidden vary widely between cultures. King (1999:385) adds that the term incest comes from the Latin word meaning "impure". Incest refers to sexual activity between relatives who are too closely related to marry and is illegal in all 50 states of America.

> "We define incest very broadly as a sexual encounter by a family member, or by an extended family member that damaged the child. By 'extended family' member we mean a person that you/or your family has known over a period of time. This may be any family member, a family friend, clergy, another child, or anyone that betrayed the person's innocence and trust" (S.I.A. World Service Office, 2002:1).

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One reason incest is illegal is that this type of mating has the highest probability of producing defective offspring. Until recently, many people thought that incest was rare, but it happens more often that people might believe. Children who are victims of incest often have a variety of long-term problems besides self-blame. However, King (1999:389) states that as with other types of molestation, there is no definite or typical "incest syndrome". As young adults, victims may have feelings of anxiety, helplessness and powerlessness. Many victims suffer from problems with self-esteem and poor self-image.

It is found that some victims later develop eating disorders, while others suffer from major depressive episodes and alcohol or drug abuse. Victims of incest may also suffer from a variety of sexual problems. Some of the social mal-adjustment's arising from incest are alcoholism, drug addiction, prostitution and promiscuity.

Eating or sleeping disorders, migraines, back or stomach pains are just a few of the physical consequences that a victim suffers. Food, sex, alcohol, and/or drugs deaden painful memories of the abuse and expel reality temporarily (Compare King, 1999:389 and S.I.A. World Service Office, 2002:1.) If a victim perceives obesity to be unattractive and if she believes she was abused because she was pretty, a victim may overeat in a misguided attempt to defend herself from further sexual assault.

The researcher is of opinion that there are many emotional problems emerging from the abuse, including inability to trust, perfectionism, phobias, avoidance of both intimacy and emotional bonding.

2.7.4 <u>Penal-Vaginal Intercourse</u>

Bell (1998:120) and Sexuality and Sexual Health Online Course (2001:115) both define intercourse as the insertion of the erect penis into the vagina or anus.

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Bell (1998:120) states that a women's virginity has traditionally been seen as a sign that she is pure, "untouched", virtuous. In many cultures and ethnic groups, it is considered a disaster for the family if a young women loses her virginity before she marries. In one sense, the only difference between intercourse and other sexual practices that people partake in, is that in intercourse a man's penis penetrates a women's vagina.

But, that simple difference of penetration is a major one for most young women. The decision about intercourse is bigger, tougher and often more confusing than any of the others. The time after first intercourse can often be as complicated, if not more so, than what led up to the act. Emotions common after first intercourse can be as simple as exhilaration and happiness at a successful first time to disappointment and sorrow at a negative experience (Compare Bell, 1998:120 and First Sexual Intercourse, 2000:1.) Most of the time though, it is a mixture of emotions - probably more so for the female than the male.

According to Bell (1998:120) having sexual intercourse means risking pregnancy. Intercourse also means an increased risk of sexually transmitted disease. HIV is spreading fast among young people, and one of the reasons is that young people are less likely than older couples to use protection every time they have intercourse. King (1999:255) emphasises that the number of unmarried young people engaging in sexual intercourse has risen in recent years, and the average age at which they first have intercourse has been steadily declining.

Emotionally, having sexual intercourse often means making yourself vulnerable, more open to intense feelings of both joy and hurt, closeness and distance. Bell (1998:119) and King (1999:256) are both of the opinion that young women experience a range of emotions during and after sexual intercourse. About one-third have strongly negative emotional reactions (e.g., guilt, anxiety, shame, fear,

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regret), while another third have highly positive emotional experiences. For the final third, their experience is neither positive or negative.

2.7.5 Rape

> "Sexual assault happens when a person does something sexual to someone else by force or without the other's permission. Unwanted sexual intercourse is also called rape. Sexual assault of any kind is a criminal offence, even in marriage and common-law or dating relationships. Statistics show that 1 in 4 females and 1 in 8 males have been sexually assaulted" (Basic Information on Sexual Development, 2002:1).

Rape can be defined as sexual intercourse (vaginal, anal, oral) or other sexual contact forced by one person upon another using physical force, threat, or coercion (Sexuality and Sexual Health Online Course, 2001:115). Bell (1998:233) and King (1999:360) are both of the opinion that rape is any sexual activity forced on another person. Legally, it is commonly defined as forced sexual activity, committed against a person's will, that involves some kind of sexual penetration. Anyone can get raped. It doesn't seem to matter whether an individual is young or old, rich or poor, short or tall, flashy or conservative. Grandmothers have been raped and so have babies. Boys have been raped, and many young women have been raped.

In 1996, only 31% of rapes and sexual assaults were reported to law enforcement officials - less than one in every three. Approximately 68% of rape victims knew their assailant and approximately 28% of victims are raped by husbands or boyfriends, 35% by acquaintances, and 5% by other relatives (Rape, abuse and incest national network, 2000:1). One of the most startling aspects of sex crimes is how many go unreported. The most common reasons given by young women for not reporting these crimes is the belief that it is a private or personal matter and that they fear reprisal from the assailant.

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One way to classify rapes is by the relationship that exists between the rapist and the victim. King (1999:360) uses the term stranger rape to refer to a rape committed by someone the victim does not know. But, remember that most rapes are committed by someone the victim knows, and thus are often called acquaintance rape. Acquaintance rape is called date rape if the rape occurs during a social encounter agreed to by the victim.

The expression “date rape”, though purely descriptive in intent, has turned out to be unfortunate because many people believe that it is somehow different from rape by a stranger. Many people attribute more blame and are less sympathetic to victims of date rape than they are to victims of rape by a stranger (Compare Bell, 1998:233; King, 1999:360 and Rape, abuse and national incest network, 2000:1.) King (1999:360) explains that gang rape refers to cases in which a victim is assaulted by more than one attacker. There are several forms of gang rape. With female victims, some cases of gang rape can begin as date rape. In other instances, the victim may be chosen at random.

A rape victim experiences a tremendous amount of hurt and pain and the researcher found this poem to give meaning to how a young women that has been raped experiences intense emotional pain.

> “I have killed you a thousand times inside. I have gotten my revenge safely. I have seen the good in people, and the bad, but I can see no good in you. There are animals that are more human than you. Have you once thought back and regretted a thing? Probably not. I have killed you a thousand times inside. But you haven’t died in my mind. It is a fine scar you have left on me; inside and out. I have killed you a thousand times inside. Please die” (Bell, 1998:235).

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According to King (1999:372) female victims of rape go through what is called rape trauma syndrome. For most victims, it can be considered a form of posttraumatic stress disorder. Victims who seek help shortly after being raped generally suffer fewer long-term emotional problems. In addition to the immediate physical trauma that may occur during rape, the victim of sexual abuse is also burdened with the fear of possible pregnancy and/or sexually transmitted disease.

2.7.6 Sexual Harassment

Sexual harassment is unwelcome sexual advances, requests for sexual favours, and other verbal or physical conduct of sexual nature constitute unlawful sexual harassment when (a) submission to such conduct is made either explicitly or implicitly as term or condition of an individual's employment, (b) submission to or rejection of such conduct by an individual is used as the basis of employment decisions affecting such individuals, or (c) such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment (Compare Bell, 1998:213 and King, 1999:376.)

Sexual harassment can occur in a variety of circumstances, including but not limited to the following:

- The victim as well as the harasser may be a woman or a man. The victim does not have to be of the opposite sex.
- The harasser can be the victim's supervisor, an agent of the employer, a supervisor in another area, a co-worker, or a non-employee.
- The victim does not have to be the person harassed but could be anyone affected by the offensive conduct.
- Unlawful sexual harassment may occur without economic injury to or discharge of the victim.

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- The harasser's conduct must be unwelcome (Facts About Sexual Harassment, 2002:1).

Bell (1998:213) and King (1999:376) are both of the opinion that no one has the right to intimidate or terrorise another person, to disrupt that person's life so that he or she is afraid. Sexual harassment is a problem for young women especially in the workplace. Sexual harassment usually occurs in a relationship where there is unequal power, such as employer-employee or teacher-student relationships (Compare Bell, 1998:213; King, 1999:376 and Facts About Sexual Harassment, 2002:1.) This makes the victims of harassment very vulnerable, especially if they are economically dependent on their jobs.

Victims may feel that there is no recourse. King (1999:378) emphasises that the end result is that victims of sexual harassment often are left with feelings similar to those of other victims of sexual abuse - feelings of helplessness. In addition, victims often feel humiliation, shame and anger. The researcher is of opinion that prevention is the best tool to eliminate sexual harassment in the workplace. Employers must be encouraged to take steps necessary to prevent sexual harassment from occurring through clearly communicating to employees that sexual harassment will not be tolerated.

2.8 <u>Summary</u>

- Sexual rights were discussed and it was found that sexual rights are human rights based on the inherent freedom, dignity and equality of all human beings. However, it appears that young people experience countless violations of their human rights.

- It was found that sexual and reproductive health services for young people are often absent because of reluctance to address or even acknowledge young people's sexuality.

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- The sexual development of human beings is an integral part of the developmental process of every individual. It was discovered that a person's full development depends upon the satisfaction of basic human needs such as the desire for contact, intimacy, emotional expression, pleasure, tenderness and love. With regards to sexual developmental stages it was detected that sexual problems arise in various developmental stages.

- High rates of promiscuous sexual activity, rising statistics of HIV/AIDS and STD's and abortions are found under young women. The researcher is of opinion that partaking in sexual practices at a very early age is fashionable and consequently young women especially, suffer of serious socio-emotional problems caused by the trauma of sexual practices.

- Numerous sexual practices and variations on sexual practices were found. It was impossible to name all of these sexual practices. As a result, the researcher thought it appropriate to discuss the following sexual practices, namely anal intercourse, cybersex, incest, penal-vaginal intercourse, rape and sexual harassment.

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CHAPTER 3

SEXUAL PROBLEMS

3.1 Introduction

Socio-cultural and health problems arise because young people are uninformed and the problems are normally more severe for young women than for young men (Sexuality and Sexual Health Online Course, 2001:150). This leads to sexual problems and are mainly associated with unintended pregnancy, early parenting, STD's (including HIV infection), unsafe abortion, forced termination of pregnancy, less opportunity for economic achievement and social ostracism by the community.

For the purpose of this study, sexual problems will be organised in three main groups: Sexual dysfunctions; these include Dyspareunia, Vaginismus, Anorgasmia. Unintended pregnancy; these include abortion, adoption, early parenting. Sexually transmitted diseases and sexually related diseases; these include HIV infection and AIDS, Gonorrhea, Syphilis, Herpes.

3.2 Special concern for young women

Young women are faced by many health issues today (Teagno, 2002:1). Birth control, eating disorders, PMS, pregnancy, depression, body image, STD's and smoking are just a few of the issues that today's young women face. They are however fortunate in having a more open society today in which to discuss and acknowledge some of the more common health issues. Sex, pregnancy, STD's and birth control have become topics that society over the past few years have become used to discussing in public (Baitman, 2003).

Unfortunately, researchers know relatively little about young women's sexuality, despite the relevance of sexual behaviour to young people's health. In comparison with the health status of children and adults, the in-between age has

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largely been ignored (Sexuality and Sexual Health Online Course, 2001:150). This in-between age referred to, includes the adolescent and young adult sexual developmental stages (13 - 24 years).

One of the most common concerns that young women have is whether or not they are "normal". They have concerns about their bodily function, about being sexually attracted to others, about sexual identity and orientation, about having sexual feelings and about how to handle those feelings (Compare Girard, 2002:1 and Teagno, 2002:2.) In environments where young women's sexuality is considered inappropriate, young people are faced with tremendous barriers to accessing accurate information, trustworthy health care, counselling and confidential health services.

The conflict between young women's environment and their needs often leave them feeling isolated, lonely, emotionally vulnerable and at risk of sexually transmitted diseases and unintended pregnancy. In these environments, young women may seek information from their peers, who might be equally uninformed or incorrectly informed (Sexuality and Sexual Health Online Course, 2001:150). Poor communication skills and authority dynamics within families often act as a barrier between parents and young women on discussing sexuality issues and concerns.

Girard (2002:1) and Teagno (2002:2) are both of opinion that more and more young women can be found discussing sexual issues among their friends and are more empowered when it comes to their sexual health. This could be due to the constant bombardment of sexuality in the mass media, making young women more and more comfortable discussing their own sexual health. Many credit the mass media with opening of the society to discussing sexual health, while others simply call the mass media distasteful and argue that the mass media has

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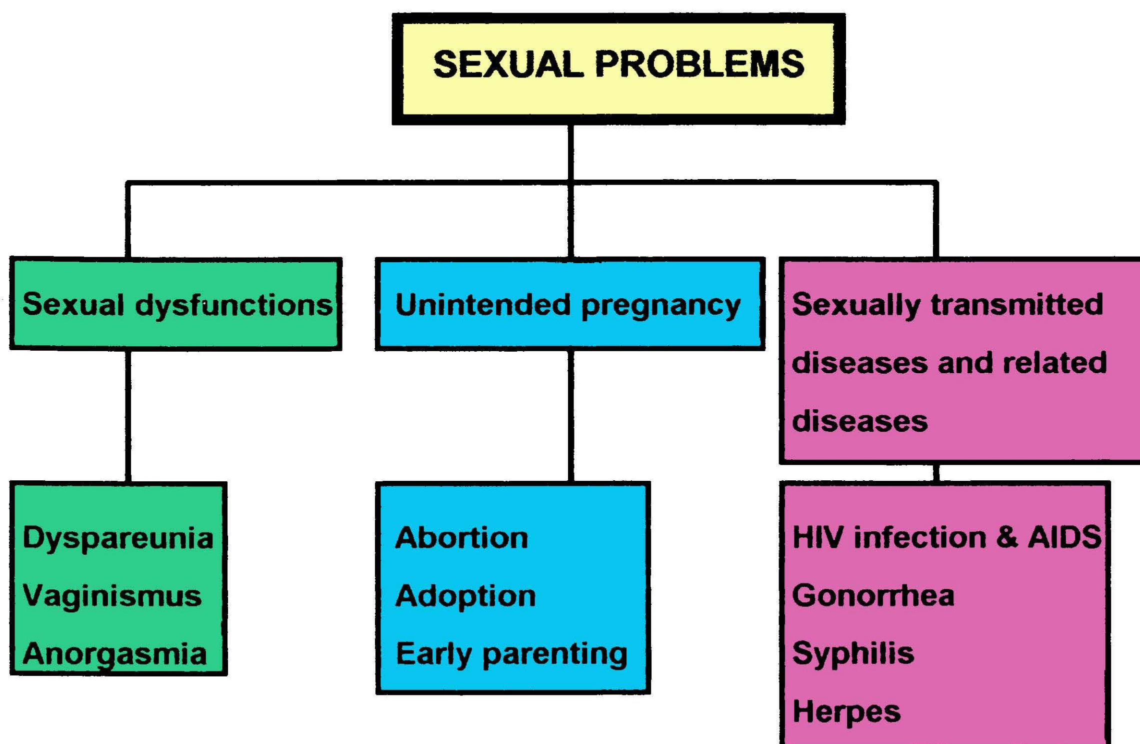
contributed to young women's pregnancy statistics. Clearly, the mass media's contribution to young women's sexual health is debatable.

3.3 Sexual problems

Various sexual practices do exist in society and young women partake in these sexual practices and are often faced with the consequences of their sexual actions. Sexual problems arise and young women struggle to cope with these problems (McIntosh, 2003). The researcher is of opinion that this brings forth a great concern for women's health as these sexual problems influence the socio-emotional functioning of young women.

Figure 5: Three main groups of sexual problems



3.3.1 Sexual dysfunctions

Uken (1983:7) and Maurice (1999:54) are both of opinion that acquired sexual dysfunctions always require a diligent search for an explanation of the change

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that has occurred. The female's developmental years are marked by suppression and inhibition with regard to her sexuality resulting in a negative value being attached to sex and in negative attitudes towards her sexuality. Consequently female sexuality, still today, carries with it a stigma of shame and sin. This appears to be the major cause of women's sexual dysfunctions that include Dyspareunia, Vaginismus and Anorgasmia.

3.3.1.1 Dyspareunia

"Dyspareunia is the medical term for pain during intercourse" (Causes of Dyspareunia - Pain During Intercourse, 1999:1). According to Sexuality and Sexual Health Online Course (2001:200), Dyspareunia is a condition in women characterised by recurrent genital pain with sexual activity (usually with vaginal penetration but can occur during nonpenetrative genital stimulation).

The causes of pain during intercourse include; tipped or retroverted uterus, Endometriosis, infection, Vulvodynia, physical problems, pelvic floor Myalgia, emotional issues (Causes of Dyspareunia - Pain During Intercourse, 1999:1). Emotional issues caused by for example a history of sexual abuse or communication problems within a relationship, can translate into sexual difficulties.

Symptoms of Dyspareunia include burning, itching, stinging and feeling inflamed in any area of the perineum. King (1999:325) and Maurice (1999:283) are both of opinion that the main causes of Dyspareunia are vulvovaginitis, genital Herpes, atrophic vulvitis, urethral problems, episiotomy, radiation vaginitis and sexual trauma. Other features of the syndrome may include the following:

- Variability in appearance of the pain, age of patient (youth), sexual inexperience
- The presence of psychological explanatory factors

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- The lack of pathological findings with pelvic examinations (Maurice, 1999:283).

Dyspareunia can have psychological causes. Treatment involves treating the physical or psychological causes of the pain. King (1999:325) adds that painful intercourse is much more common in women than in men. It has been estimated that 1 to 2 percent of women suffer from chronic Dyspareunia, with as many as 15 percent experiencing problems lasting several months or longer.

Maurice (1999:282) gives a very good example of Dyspareunia:

> "A 19-year old single woman was concerned that since about six months ago, intercourse was associated with pain - a facet of her sexual experiences that had never occurred before in previous relationships. Although Dyspareunia was frequent now, it was also quite irregular. Her relationship with her boyfriend of ten months was frequently stormy and on two occasions they decided to stop dating. She was still unsure about continuing the relationship and has not told him of her sexual discomfort. The pain that she experienced was not localised, would arise only with vaginal entry, and disappeared when the penis left her vagina. When seen three months later, she had begun a relationship with another man with whom she was in love and found that her Dyspareunia had disappeared".

Young women that suffer from Dyspareunia more than often suffer extreme pain and struggle to be in a sexual relationship (Maurice, 1999:282). As a result Dyspareunia can be the cause of a diminished self esteem, hostility and anger problems. Most young women with Dyspareunia have a negative attitude toward sexuality.

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3.3.1.2 Vaginismus

Vaginismus is when penetration is difficult, uncomfortable, or impossible due to involuntary contraction of vaginal muscles (Sexuality and Sexual Health Online Course, 2001:200). According to Laing (1995:135) Vaginismus is a condition where the muscles around the vagina tighten involuntarily, making intercourse painful or impossible. It may occur in women from very sexually repressive backgrounds or women who have suffered a painful or traumatic sexual experience. The cause of the condition is often physical or sexual abuse that causes a phobic reaction at the prospect of vaginal penetration. Other causes include painful first intercourse, relationship problems, fear of pregnancy, rape, religious orthodoxy and belief that the vagina is too small.

Vaginismus is caused by fears a woman might have about her body and its functions, about the 'unknown of penetration' or about feeling pain. These fears can be a result of parental over protectiveness or parental secrecy about intimacy/sex, lack of knowledge about how the body works, or frightening stories about painful sexual experiences (Compare Laing, 1995:135 and Women's therapy center -Vaginismus, 2002:1.) Vaginismus can also be a result of trauma such as childhood illnesses where the body was repeatedly exposed to treatments, complication during childbirth, physical abuse, rape, verbal abuse or sexual abuse (Hunt, 2003).

Laing (1995:136) and King (1999:332) are both of the opinion that about two percent of all women have Vaginismus. The cause is usually psychological. It is normal for inexperienced women to have anxieties before intercourse that may result in some degree of involuntary muscle contraction, but the vast majority of women soon learn to relax. Persistent and recurrent involuntary muscle spasms are often associated with past trauma (e.g., rape, abortion) or negative first sexual experiences.

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Patients give various explanations for Vaginismus including:

1. Thinking sexual activity to be sinful or offensive
2. Fear of pregnancy or childbirth
3. Lack of anatomical awareness
4. Homoerotic feelings
5. Dislike of semen
6. Aversion to a man's penis or men in general (Compare King, 1999:332 and Maurice, 1999:286.)

Since there is no "quick fix" to Vaginismus, it is imperative to recognise that effective treatments must address the physical and the emotional aspects of this condition (Women's therapy center - Vaginismus, 2002:1). Sadly, it has been observed that medical and mental health professionals shy away from addressing Vaginismus because of limited understanding of this complicated phenomenon (McIntosh, 2003).

3.3.1.3 Anorgasmia

Anorgasmia is a female sexual dysfunction that did not receive much attention until relatively few years ago (Kinsey, 2001:1). Anorgasmia, or the failure/inability of women to achieve orgasm, was never seen as a problem in the male-focused culture of the past. Fortunately, forces of social change such as World War II and the sexual revolution allowed attention to be redirected from the woman being seen as the sexually passive woman who does her "duty" as the acceptor of the gift of life; to seeing the woman as a fully sexual being who can share in the experience of pleasure which accompanies a mature sexual relationship.

Anorgasmia is a condition in men and women characterised by a persistent or recurrent delay in or absence of orgasm following a normal sexual excitement or plateau phase (Compare Kinsey, 2001:1 and Sexuality and Sexual Health

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Online Course, 2001:200.) King (1999:332) and Kinsey (2001:1) are both op the opinion that causes of Anorgasmia in women include anger and hostility toward the partner, ineffective sexual technique, anxiety, familial or religious teachings that cause women to avoid or actively discourage effective sexual stimulation and a strong fear of loss of control over feelings and behaviour.

According to Kinsey (2001:1) Anorgasmia is usually categorised or specified in one of three ways; as primary, secondary, or situational. Primary Anorgasmia means that the diagnosed woman has never been able to achieve orgasm at any point in her life. King (1999:332) adds that many cases of primary orgasmic disorder, for example, are associated with negative attitudes about sex or feelings of guilt about sex (often due to a very strict religious upbringing, where sexual feelings are associated with sin rather than something positive).

Kinsey (2001:1) further explains that a diagnosis of secondary Anorgasmia means that the woman was consistently able to have orgasms at one time, but is no longer able to achieve them. Situational Anorgasmia refers to women who can achieve orgasm in certain sexual situations, but never orgasm in other specific situations. Many possible causes for Anorgasmia have been proposed, but all are inconclusive or inadequate at explaining the problem as a whole. Therefore, Anorgasmia is most often treated as a complex combination of many variables.

3.3.2 Unintended pregnancy

Pregnancy is the natural consequence of having sex without using birth control. When a young women knows for certain that she is pregnant, she may continue the pregnancy and have a baby, consider adoption or she may choose to end the pregnancy by having an abortion (Compare Bell, 1998:319 and King, 1999:157.) It will probably help a young women to make her choice if she answers the following question for herself honestly:

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- Can I raise a child?
- Can I have a baby and allow the baby to be adopted?
- Can I have an abortion?

According to Bell (1998:319) some young women know what they want to do about pregnancy. For others, the decision is confusing, painful and difficult. The young women's feelings about parenthood, marriage, babies, adoption and abortion will influence her decision. All three of the choices may have life-long implications. Not one is easy. But, it is the pregnant woman's choice (Basic Information on Sexual Development, 2002:1). It must be based on the young woman's needs and hopes, on what she decides is right for her now.

Bell (1998:319) and King (1999:157) are both of opinion that there is no reversible method of contraception that is 100 percent effective (although Norplant, Depo-Provera and the pill come close); thus, unwanted pregnancies sometimes occur even for couples who are using the most reliable forms of contraception. If an unwanted pregnancy should occur, a young woman really has only three options: to continue with the pregnancy and keep the baby; to continue with the pregnancy and put the baby up for adoption; or to terminate the pregnancy (abortion). In many cases, none of these is an easy choice.

The responsibility involved with keeping and raising a baby forces many young women to drop out of school and remain uneducated and unskilled, locking them into a lifetime of poverty and reliance on state funds and services to raise the child. The rate of child abuse resulting from the emotional frustration in these situations is much higher than normal. Some young women choose to put an unplanned baby up for adoption by others who are better able to care for it (Basic Information on Sexual Development, 2002:1). In many cases, this may be best for the child, but nevertheless, it often results in long-lasting adjustment problems for those who have surrendered their child.

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For many young women, abortion is a favourable option. Reproductive Rights Alliance (1998:2) states that the large majority of women who have first-trimester abortions do not experience emotional or psychological problems afterwards, but it can have an impact on how they view future sexual relationships. Many feel a sense of relief because of compelling health or economic considerations.

3.3.2.1 Abortion

> "Too many people use abortion as a form of birth control. And that's very wrong. I could never, ever have an abortion...**Brooke Shields**" (Katz, 1999:1).

> "The greatest destroyer of peace is abortion because if a mother can kill her own child, what is left for me to kill you and you to kill me? There is nothing between. If we have no peace, it is because we have forgotten that we belong to each other...**Mother Teresa**" (Katz, 1999:1).

This is some basic, but important information about abortion. Some people say 'therapeutic' or 'surgical' abortion, but most people just use the word abortion. Abortion means ending a pregnancy. It is a choice that many young women consider for an unplanned or unwanted pregnancy (Basic Information on Sexual Development, 2002:1).

Reproductive Rights Alliance (1998:1) states that more than 500 women around the world will die today from complications from unsafe abortion. Most of these women will be poor and living in countries where abortion is illegal or severely restricted by law or living in countries where abortion is legal but abortion services are not provided. These women will resort to dangerous practices or unskilled practitioners to end unwanted pregnancies. Many of them will pay with

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their lives or their health for their desperate attempts to control their fertility. The researcher is of opinion that the society is characterised by division on the morality surrounding abortion. There are not only two positions, but many countless positions on abortion. Opinions on abortion will always differ from person to person and it is the duty of each person to respect each others views.

introduction

Reproductive Rights Alliance (1998:1) defines abortion as the separation and expulsion of the contents of the pregnant uterus up to twenty four weeks gestational age. Choice on Termination of Pregnancy Act, 1996 (Act No. 92 of 1996) states the circumstances in which and conditions under which pregnancy may be terminated:

(1) A pregnancy may be terminated -

(a) upon request of a woman during the first 12 weeks of the gestation period of her pregnancy;

(b) from the 13th up to and including the 20th week of the gestation period if a medical practitioner, after consultation with the pregnant woman, is of the opinion that -

(I) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or

(ii) there exist a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or

(iii) the pregnancy resulted from rape or incest; or

(iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman; or

(c) after the 20th week of the gestation period if a medical practitioner, after consultation with another medical practitioner or a registered midwife, is of the opinion that the continued pregnancy -

(I) would endanger the woman's life;

(ii) would result in a severe malformation of the fetus; or

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(iii) would pose a risk of injury to the fetus.

(2) The termination of a pregnancy may only be carried out by a medical practitioner, except for a pregnancy referred to in subsection (1)(a), which may also be carried out by a registered midwife who has completed the prescribed training course.

The researcher emphasises that many young women feel tired or depressed after having an abortion. These reactions are usually due to abrupt changes in hormone levels. Bell (1998:338) states that young women may have a lot of strong emotions for a while after the abortion. Many people experience a deep sense of relief, but lots of young women also feel sad. Experiencing both these feelings are quite natural. Other emotions are common too. For some young women it is confusing to feel so ambivalent - positive and negative at the same time - about something they have done. Some other feelings young women have experienced after an abortion are anger, guilt, depression and fear (Baitman, 2003).

Most women who undergo surgical abortions done in appropriate medical facilities recover without any physical complications. Any significant emotional and psychological issues should be considered and addressed before and after an abortion (Abortion: Disease, Condition or General Health Topic, 2001:1). It is very important that the young woman returns for her follow-up appointment to ensure that the procedure was successful and that she has recovered from the abortion.

The pregnancy hormone, which creates a positive pregnancy test, gradually leaves the body after the pregnancy is over. Small amounts of this hormone are still present for 2 to 3 weeks after pregnancy and many sensitive pregnancy tests remain positive during this time (Compare Bell, 1998:338 and Abortion:

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Disease, Condition or General Health Topic, 2001:1.) After everything is over, there is no better way of taking care than learning the facts about birth control, selecting a method and using it correctly.

3.3.2.2 Adoption

Another option is to choose to allow the baby to be permanently adopted. In adoption, the young woman gives over her rights as a parent to another person or family (Bell, 1998:357). Legally, the young woman will no longer be considered the child's parent. Bell (1998:357) and King (1999:195) are both of opinion that today, the majority of single mothers keep their babies. It is estimated that only 2 to 4 percent of young mothers choose adoption.

Given all the options, if a young woman finds herself with an unwanted pregnancy, adoption is definitely a wise and caring option to consider:

- A young mother who places her baby with adoptive parents has a better chance of completing her education and is less likely to live in poverty.
- The baby is more likely to live in a home with two parents and have social, economic and educational advantages.
- The adoptive parents are likely to be older and more established in their careers and have more education. They are ready to take on the full-time responsibilities of raising a child and have gone to great lengths emotionally, financially and legally to become adoptive parents (Bell, 1998:357).

Most young mothers choose adoption because they love their baby and believe that their child should grow up in a family that very much wants to raise a child and is prepared to do so. The choice to place a child for adoption is not easy. But neither is raising a child, or having an abortion (Basic Information on Sexual Development, 2002:1). King (1999:195) adds that many couples become parents by adopting a child. One difficulty with the option of adoption is that the demand for children to be adopted is very high. Long waits - sometimes months

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or even years - may be required before a couple is able to find and adopt a healthy child.

There are two main categories of adoption: closed and open (Bell, 1998:359). According to Bell (1998:359) closed adoption is when the names of the birth mother and the adoptive parents are kept secret in a closed adoption. An open adoption is when the birth mother (or parents) and adoptive parents are known to each other. In this type of adoption, the birth mother (or parents) may choose who adopts her child. A wide variety of adoption situations may be considered "open", ranging from having birth parent(s) and adoptive parents send letters and photos to each other (through the agency) as the child grows up, to the birth parent(s) and the adoptive parents carrying on an ongoing relationship with each other. In either case, the adoptive parents have all parental rights to the child.

The researcher is of opinion that adoption is a wise and responsible choice for a young women who did not plan the pregnancy. Adoption is especially a good option for young women who do not consider abortion because of their religious views. But, adoption also comes with it's problems and many young women manifest serious signs of depression after the baby has been adopted.

3.3.2.3 Early parenting

Pregnancy demonstrates independence but, also causes continuing dependency on parents. A baby is a huge responsibility and has tremendous financial implications.

> "I am an admitted 'serial monogamist'. One of these types of relationships led to pregnancy right after high school.... My ex and I no longer speak to each other and he has never been a part of his own child's life (by choice)...from the author's file" (King, 1999:133).

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Approximately one of every eight young women between 15 and 19 years of age become pregnant - a rate that has not changed for the last 15 years (Lachman, 1995:456). According to Bell (1998:341) having a baby is a lifetime commitment. A baby will only be a baby for a very short time. He or she will become a toddler, a pre-schooler, a school-age child and after only twelve years a teenager. He or she will have a personality and will of his or her own. Parents sacrifice a lot of their time, energy and attention to a child, because healthy, normal children need their parent's love and help.

Lachman (1995:456) and King (1999:133) are both of the opinion that being a parent is a full time job. If the child should be sick or have chronic problems, the parent will require even more help and attention from her support systems. Being a parent is very demanding, it's hard to do unless a person has lots of emotional and financial support. A young parent will need someone to share in the everyday care of the child. All parents need this regardless of whether they are fourteen or thirty years old.

The researcher emphasises that perhaps the most unfortunate part of all this is that the high rate of births to teens continues to occur in a day and age when highly effective means of birth control are available. Today, male and female condoms and spermicides are sold openly in most drug stores, yet the number of youth pregnancies continues to be high (McIntosh, 2003).

3.3.3 Sexually transmitted and sexually related diseases

"When a person has sex, they're not having it just with that partner. They're having it with everybody that partner has had it with for the past ten years" (King, 1999:106).

According to Farber & Ballard (1999:13) there are more than 25 diseases which are or can be spread by sexual intercourse. It is important to recognise that

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women are more vulnerable to diseases of the genital tract than men. The lining of the vagina is a mucous membrane and more permeable than the outside of the penis and women have more surface area through which infection can occur (Sexuality and Sexual Health Online Course, 2001:54). Lack of lubrication during intercourse, changes in the cervix during the menstrual cycle and asymptomatic infections facilitate more efficient transmission of infection to women (Watson, 2003).

Young women are particularly vulnerable because their cervical tissue may be less mature and more readily penetrated by organisms (e.g., *chlamydia* and *gonococcus*). Older women are more likely than younger women to get small abrasions in the vagina during sexual activity as a result of thinning of the tissue and dryness. Women who already have an infection (particularly one that causes genital lesions) are more likely to get or transmit another STD, including HIV (Compare Farber & Ballard, 1999:13 and Sexuality and Sexual Health Online Course, 2001:54.)

Baron & Byrne (1997:301) and Farber & Ballard (1999:11) are of the opinion that STD's are affecting young adults more and more because people are starting their sex lives earlier and are having more partners. Some people think that having a STD is a bit of a joke. This attitude is not only very childish, it is very dangerous. STD's can affect a person in different ways:

- There are some that cause mild diseases and can be cured.
- Others are more severe and can seriously affect a person's health.
- Some STD's can damage a person and make it impossible to have children.
- Two of the STD's can cause changes in certain parts of the body that may lead to cancer.
- AIDS is the most devastating of the STD's and it can make the sufferer very prone to some serious infections and also to certain cancers.

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- Many people, including young ones, die from AIDS all over the world every day (Farber & Ballard, 1999:11).

Most of the STD's can be successfully cured with the right treatment. There are a number, however, that are incurable namely the viral STD's such as Herpes and AIDS (Compare Baron & Byrne, 1997:301 and Farber & Ballard, 1999:13.) From these examples it is clear that STD's are certainly not a joke. Sexually transmitted and sexually related diseases that are going to be emphasised for the purpose of this study are HIV Infection and AIDS, Gonorrhea, Syphilis and Herpes.

3.3.3.1 HIV Infection and AIDS

AIDS stands for Acquired Immune Deficiency Syndrome and HIV stands for Human Immunodeficiency Virus (Basic Information on Sexual Development, 2002:6). According to Bell (1998:257) Human Immunodeficiency Virus (HIV) is a tiny virus that gets into the body and destroys the immune system, the system that protects humans from dangerous illnesses. HIV grows in the body for years, breaking down and overpowering the immune mechanisms, until the body can no longer fight off sickness. At that point, in the most advanced stages of HIV infection, immune deficiency syndrome (AIDS) has been acquired.

> "Dispite the laws of the land, discrimination continues to play a brutal and important role in the lives of those infected with HIV. The extent and cruelty of such discrimination have been brought forth in heartrending testimony to the National Commission at each of its many hearings. As a colleague and I wrote recently, 'The pain, suffering and despair of the disease alone are dreadful enough. The added stigma makes it virtually unbearable. You lose not only your life, but also your pride, your job, your insurance,

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your friends and your family. Posterity remembers you for dying of AIDS, not for having lived" (King, 1999:118).

Lees (2001:19) emphasises that it is no secret that a HIV crisis of staggering proportions faces many nations of the world today. AIDS has become the single biggest cause of death in South Africa, responsible for about 40 percent of deaths of South Africans aged 15-49 in 2000 (AIDS devastating South Africa, 2001/2002:11). According to Whiteside & Sunter (2000:66) as result of the growth in HIV prevalence and the failure to control the spread of HIV, South Africa faces a major AIDS epidemic. Instead of being able to focus purely, or even largely, on prevention activities, the country is about to have to deal with the consequences of large-scale conversion from HIV to AIDS. These will be far-reaching.

Lachman (1995:456) and Lees (2001:19) are both of the opinion that the youth group in the current AIDS climate is heterogeneous; from those already infected; to those at risk because of their behaviour; to those at no risk who may be affected by the epidemic in their attitudes towards sexuality and intimacy. The majority (70%) of South African youth named HIV/AIDS as one of the five greatest concerns for young people today (Love Life: Portrait of Young South Africa, 2002:20). Their responses indicate that they are very worried for themselves, their families and for the country.

According to Love Life: Portrait of Young South Africa (2002:20) over half (54%) of young people say they are afraid they may get AIDS and of those who have heard of HIV/AIDS (91% of all youth), 66% agree with the statement, "I could die of AIDS". Some sexually experienced youth recognise that they are at risk of HIV infection, but many others fail to acknowledge any personal risk. Thirty two percent of those who are sexually experienced disagree with the statement that they feel very sure they will not get HIV/AIDS from their sexual partner and 37%

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of those who are sexually experienced agree that every time they have sex with their partner they are afraid they are going to get HIV/AIDS.

The large majority (94%) of sexually experienced young people indicate that they take responsibility for protecting themselves against HIV (Love Life: Portrait of Young South Africa, 2002:20). Despite this assertion, however, many youth are engaging in risky sexual behaviours and in reality, not taking the necessary precautions to prevent pregnancy or infection.

3.3.3.2 <u>Gonorrhea</u>

According to King (1999:93) Gonorrhea is caused by a bacterium (*Neisseria gonorrhoeae*, often referred to as *gonococcus*) named after Albert Neisser, who discovered it in 1879. Farber & Ballard (1999:13) add that Gonorrhea is an infection that is spread mainly by sexual contact. It is often referred to as 'The drop', or 'The drip', or ironically, as 'The Clap'. King (1999:93) emphasises that it lives on warm, moist mucous membranes in the urethra, vagina, rectum, mouth, throat and eyes. A person gets Gonorrhea by having his or her mucous membranes come into contact with another persons infected membranes (Compare Morin, 1998:214 and King, 1999:93.) Because of the location of these membranes in the body, this normally occurs only during intimate contact.

However, the chances of catching Gonorrhea from having vaginal intercourse once with an infected person are not 100 percent. Morin (1998:214) states that a man's risk of infection during intercourse with an infected woman is about 30 to 50 percent, while a woman has about a 50 to 60 percent chance of catching it the first time she has intercourse with an infected man.

Health officials estimate that nearly one and a half million new cases of Gonorrhea occur every year (Bell, 1998:263). An increase in Gonorrhea infections in recent years, particularly among the group of 15-29 years old, is a

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disturbing sign that the prevalence of unsafe sex is increasing (Watson, 2003). The following are some of the possible symptoms females may experience. Bell (1998:263) and Farber & Ballard (1999:13) emphasise that most females (about 80 percent) show no symptoms at all at first. The following are symptoms of Gonorrhea:

- Vaginal discharge with an unusual odour and a whitish, greenish, or yellowish colour.
- Pain and/or a strong burning sensation during urination; inflamed vulva.
- Sore throat and/or swollen glands.
- Groin or stomach pain.
- Bleeding between menstrual periods.
- Discharge from anus.
- Chills, fever, flu-like symptoms with joint pain.
- Painful bowel movements (Bell, 1998:263).

Bell (1998:265) and Morin (1998:214) are both of the opinion that if untreated or incompletely treated, Gonorrhea bacteria will continue to infect. Gonorrhea will not go away by itself, even if the warning symptoms go away. If it is not treated, Gonorrhea causes serious health problems. In women it can cause an infection in the uterus, or womb and tubes (Basic Information on Sexual Development, 2002:1). This infection may cause infertility. A woman who has Gonorrhea when she gives birth may infect the baby - this infection can cause blindness in the child.

According to Bell (1998:265) the germs will spread and cause infection and scarring of the reproductive organs. This can lead to permanent infertility, meaning a person will no longer be able to get pregnant or get someone pregnant. Untreated Gonorrhea can also cause crippling arthritis in some people. If the germs infect the eyes, blindness may result and if a baby is born, the baby can be born blind.

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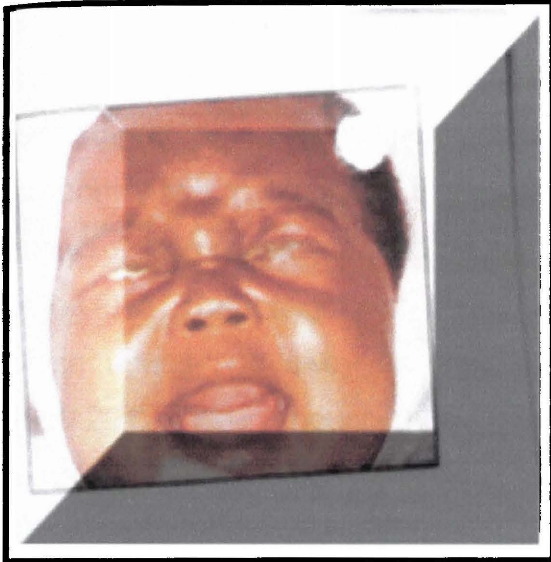

Illustration 1: Neonatal gonococcal eye infection

The most common complication of Gonorrhea in young women is Pelvic Inflammatory Disease (PID). This may cause severe pain in the stomach and groin areas and swelling in and damage of the female internal organs. PID is the leading cause of infertility among young women.

3.3.3.3 Syphilis

Syphilis is a Sexually Transmitted Disease caused by bacteria. These bacteria are passed from person to person, usually during vaginal or anal intercourse, or oral sex (Basic Information on Sexual Development, 2002:1). Farber & Ballard (1999:19) explain that Syphilis is the best known of the STD's. In former times this disease was the scourge of Europe and caused as much misery and terror as AIDS is doing now. Syphilis invades most of the organs of the body and can cause a wide variety of different conditions. Because of these widespread effects, it mimics many other diseases and was often referred to as "The Great Pretender".

Morin (1998:221) states that Syphilis is caused by a microscopic organism shaped something like a corkscrew, a spirochete called *T. pallidum* that can

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survive only in warm, moist areas of the body. Bell (1998:272) agrees that Syphilis is a STD caused by tiny spiral-shaped bacteria. The disease comes in four stages: primary, secondary, latent and late. At first, there may be some temporary external signs of the disease, like a painless sore or blister, called a chancre, then possibly a rash on the body or on the palms of the hands or soles of the feet. There might also be flu-like aches, a mild fever, or a headache, all of which usually go away on their own (Compare Bell, 1998:272 and Morin, 1998:221.) Even though these initial symptoms may disappear, the disease remains alive in the body.

Bell (1998:272) and Farber & Ballard (1999:19) are of the opinion that Syphilis is conveniently divided in early and late manifestations and describes three stages.

1. Primary Syphilis

Syphilis has an incubation period of between 9 and 90 days. The typical lesion that is seen in primary Syphilis is the *primary chancre* (Farber & Ballard, 1999:19). According to Farber & Ballard (1999:19) this starts as a hard nodule which breaks down and forms an ulcer. This ulcer is painless and does not bleed easily. It is seen on the penis, the vulva, the vaginal walls and the neck of the womb. Even without treatment the ulcer will heal in 3 to 8 weeks without leaving a scar.

2. Secondary Syphilis

The second stage of Syphilis follows about 6 to 8 weeks after the primary chancre appears. The onset is heralded by fever, headache and malaise. Most patients have a rash and/or swollen lymph glands. In warm moist areas warty growths appear. These enlarge and are called *condyloma lata*. If the Syphilis is left untreated all of the manifestations described above will resolve and the patient will appear to be in good health (Compare Farber & Ballard, 1999:19 and

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King, 1999:98.) During the latent phase the only way to diagnose that the patient has Syphilis will be by blood tests.

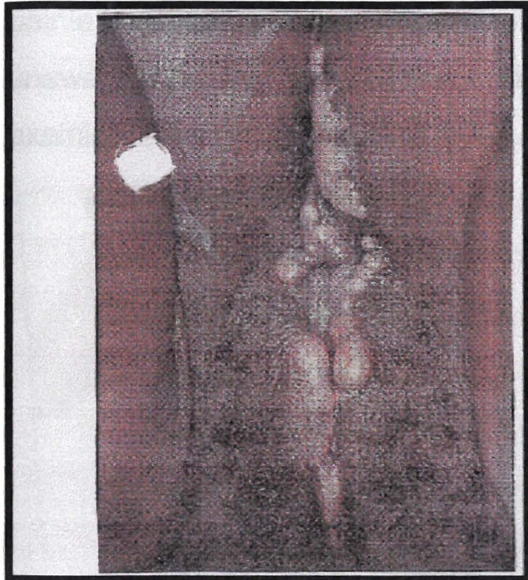

Illustration 2: Condylomata lata of secondary Syphilis

3. Tertiary Syphilis

According to Farber & Ballard (1999:19) this is the destructive phase of the disease. Even though Syphilis is common in South Africa not many people encounter these late effects. This is possible because people take antibiotics for other reasons and these antibiotics are *troponemacidal*. Tertiary Syphilis is mainly characterised by the gumma and involvement of the vascular and nervous systems.

Without treatment, Syphilis can eventually cause major damage to the vital organs and even death (Watson, 2003). Syphilis is not as common as Gonorrhea, but it is very dangerous. King (1999:98) adds that the majority of cases of Syphilis are transmitted by sexual contact. However, unlike the bacteria that cause Gonorrhea which require contact of mucous membranes for transmission, the spirochete that causes Syphilis can also pass directly through

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any little cut or scrape of the skin into the bloodstream. This means that a person could potentially get Syphilis by merely touching the sores of another person as has happened to some dentists and physicians. Because the painless chancre generally appear on the cervix in women, they usually are unaware that they are infected during the initial stage unless they get a pelvic examination.

Illustration 3: Congenital Syphilis

3.3.3.4 Herpes

Before all the attention given to AIDS, Herpes was the media's favourite STD, appearing on the cover of *Time* and *Newsweek* and even the subject of a feature article in *Rolling Stone* magazine. The threat of Herpes infections burst into public consciousness during the sexually adventurous 1970's. Now, more than 30 million Americans are currently living with Herpes (Compare Morin, 1998:214 and King, 1999:100.)

According to Farber & Ballard (1999:22) genital Herpes is an infection which causes much unhappiness. It is caused by the Herpes simplex virus of which types have been described (HSV-1 and HSV-2). These viruses also cause fever

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blisters or cold sores on the lips and face. In common with other Herpes virus infections, infections caused by HSV have a tendency to recur. Genital Herpes is transmitted by direct contact, either oro-genital or purely genital. The incubation period varies from two to twenty days, but is usually around one week. The main effects are vesicles and ulcers. Initially there is itching and burning at the site of the infection associated with a patch or redness.

Later small vesicles appear. When these rupture, painful shallow ulcers form. There are usually two or more lesions. They are found on the penis in men and on the vulva and the cervix in women. These ulcers can be very painful and if they are situated near the external *urethral meatus*, they may cause difficulty in passing water. They usually resolve in about 14 days. A notable feature of Herpes is that it recurs (Compare Farber & Ballard, 1999:23 and King, 1999:102.) The recurrences are believed to be precipitated by certain factors such as emotional or physical stress and sexual intercourse. They also recur at certain times of the menstrual cycle.

Illustration 4: Genital Herpes

Morin (1998:215) and Farber & Ballard (1999:23) are of the opinion that the episodes of recurrent disease may be prolonged if the sores are secondarily infected with bacteria; or the patient's immunity is reduced e.g., with HIV

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infection. Complications are rare in men, although meningitis has been reported. In women there may be retention of urine. A potentially serious problem relates to infection during pregnancy. The child may be infected during passage through an infected birth canal.

According to King (1999:103) most people with oral Herpes continue to lead normal lives. A person with oral Herpes can engage in sexual intercourse without worrying about infecting his or her partner, but kissing and oral-genital relations during an active attack should be avoided, of course. Genital Herpes is almost always contracted by intimate sexual contact. Recall too, that people with genital Herpes usually have frequent recurrent attacks. Besides the physical symptoms, individuals suffering with genital Herpes almost always have some psychological difficulties adjusting to their infection.

They often pass through several stages; namely shock, emotional numbing, isolation and loneliness and sometimes severe depression and impotence. Initially there is often a frantic search for a second or even third doctor's opinion (denial); a lot of "Why me?" responses; and guilt and anger. The anger is sometimes directed at the medical profession for its inability to cure Herpes, but almost always at the partner responsible for the infection and/or the opposite sex in general (Compare Morin, 1998:214; Farber & Ballard, 1999:24 and King, 1999:103.) Others invest a great deal of time and effort in experimental drugs, fad diets and even faith healers.

After the initial shock, many genital Herpes sufferers have feelings of ugliness, self-loathing and guilt (King, 1999:103). The reactions of others may make them feel like "social lepers". As a result, some may have sexual problems and others may just swear off sex.

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3.4 Summary

- It is found that young women have various concerns about their bodily function, about being sexually attracted to others, about sexual identity and orientation, about having sexual feelings and about how to handle those sexual feelings.

- In environments where young women's sexuality is considered inappropriate, young people are faced with tremendous barriers to accessing accurate information, trustworthy health care, counselling and confidential services.

- Many young women struggle with sexual problems that have been caused by partaking or being forced in one or other sexual practice.

- It is detected that female sexuality, still today, carries with it a stigma of shame and sin. This appears to be the major cause of women's sexual dysfunctions which include Dyspareunia, Vaginismus and Anorgasmia.

- When a young woman knows for certain that she is pregnant, she may continue the pregnancy and have a baby, consider adoption or she may choose to end the pregnancy by having an abortion.

- It is found that there are more than twenty five diseases which can be spread by sexual intercourse. It is important to recognise that women are more vulnerable to diseases than men.

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CHAPTER 4
EMPIRICAL STUDY

4.1 Introduction

In Chapters two and three a literature study was done to explain the relevant topic of the research study. Emphasis was placed on sexual practices and the sexual problems that young women are faced with in their lives. For the purpose of this study sexual problems were organised in three main groups:

1. Sexual dysfunction; these include Dyspareunia, Vaginismus, Anorgasmia.
2. Unintended pregnancy; these include abortion, adoption, early parenting.
3. Sexually transmitted diseases and sexually related diseases; these include HIV infection and AIDS, Gonorrhea, Syphilis, Herpes.

In this study it proved essential to utilise a qualitative research approach as the researcher set out to explore the socio-emotional influence of sexual problems on young women. The research question needs to be answered and has been formulated as follows: How do sexual problems influence the socio-emotional functioning of young women? The qualitative study has bestowed the researcher with an understanding of the socio-emotional influence that sexual problems have on young women and will be presented in the empirical study. As a result, the researcher will be able to answer the research question that was formulated for this study.

4.2 Process of qualitative data analysis

Creswell (1998:142-165) in De Vos (2002:340) believes that the process of data analysis and interpretation can best be presented as a spiral image - a data analysis spiral. The researcher moves in analytic circles rather than using a fixed linear approach. For the purpose of this study Creswell's spiral image will be applied and the researcher will pursue the steps as follows:

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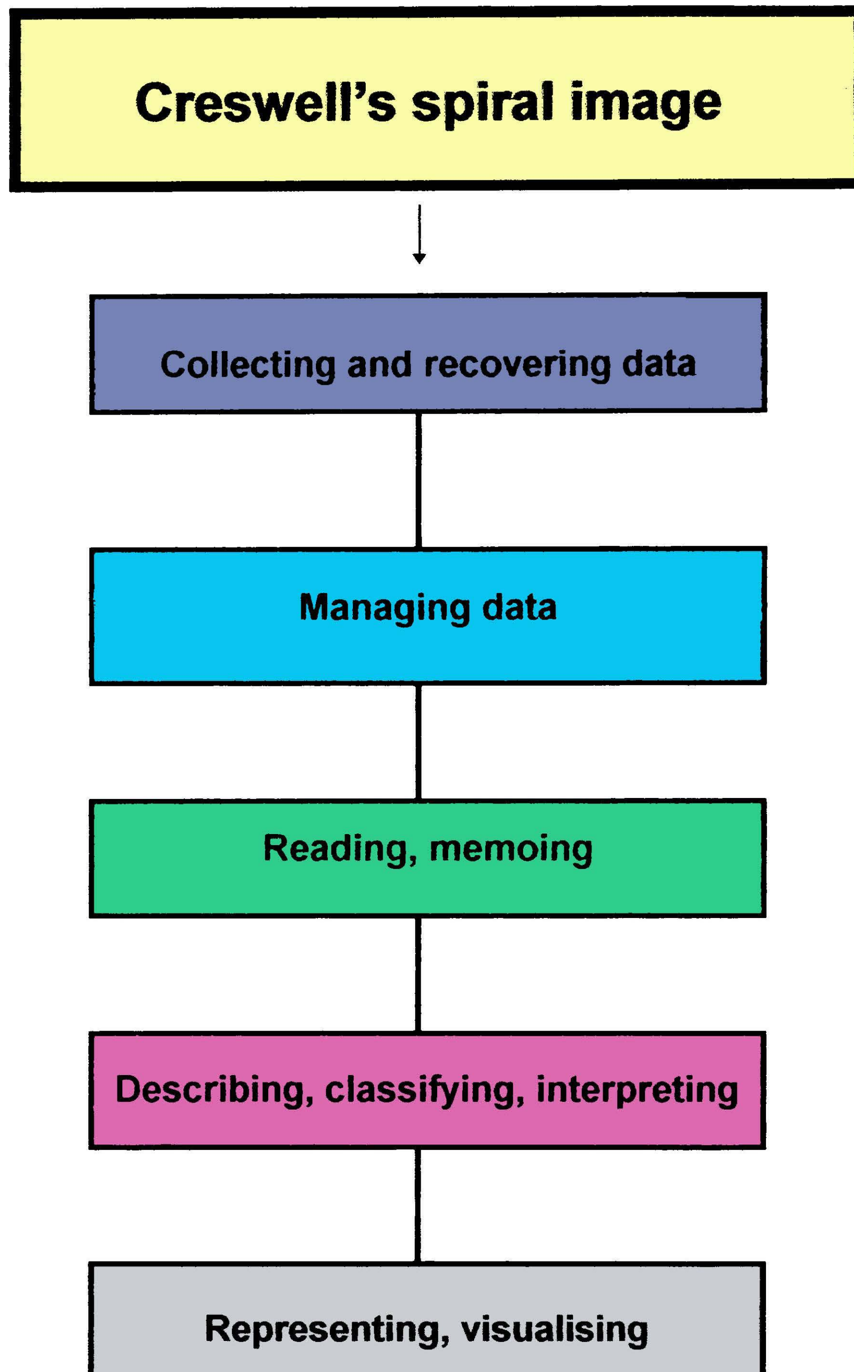
Figure 6: Creswell's spiral model



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4.2.1 Data collection and recording: the twofold approach

De Vos (2002:340) states that the researcher should plan for recording data in a systematic manner that is appropriate and will facilitate analysis, before data collection commences. Data analyses in a qualitative inquiry involves a twofold approach. The first aspect involves data analysis at the research site during data collection. The second aspect involves data analysis away from the site following a period of data collection.

For the purpose of this study the researcher firstly gathered the anonymous personal letters[3] at DISA-clinic between June 2002 and February 2003. Secondly, the researcher had to organise and select the appropriate selection of personal letters according to the sample criteria. The **following criteria** were used in selecting the personal letters of the respondents:

- Female,
- between the ages of 16 and 25,
- who experience or have experienced a sexual problem,
- who have written to DISA-clinic about their personal experience in English and
- all personal letters received between June 2002 and February 2003.

4.2.2 Managing data

According to De Vos (2002:343) this is the first step in data analysis away from the site. As the first loop in the spiral, it begins the process proper. At an early stage in the analysis process, researchers organise their data into file folders, index cards or computer files. The researcher organised the personal letters into three different files. The personal letters were organised according to the sexual problem of the young woman. As a result the files were labelled as follows:

[3] See Appendix B for an example of a personal letter

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1. **Sexual dysfunction**; devided in sub-categories of Dyspareunia, Vaginismus, Anorgasmia.
2. **Unintended pregnancy**; devided in sub-categories of Abortion, Adoption, Early Parenting.
3. **Sexually transmitted diseases and sexually related diseases**; devided in sub-categories of HIV infection and AIDS, Gonorrhea, Syphilis, Herpes.

4.2.3 Reading and writing memos

De Vos (2002:343) explains that after the organisation and conversion of the data, researchers continue analysis by getting a feeling for the whole database. Creswell (1998) quotes Agar (1980) in De Vos (2002:343) as follows: "Read the transcripts in their entirety several times. Immerse yourself in the details, trying to get a sense of the interview as a whole before breaking it into parts." De Vos (2002:343) states that during the reading process, the researcher can list on note cards the data available, perform the minor editing necessary to make field notes retrievable and generally "clean up" what seems overwhelming and unmanageable.

The researcher read the letters numerous times to form a holistic picture of the documents. Royse (1998:217) states that a document study is an unobtrusive research process that objectively examines the content of documents. The researcher examined the content of the personal letters thoroughly and focused and underlined the following:

The influence of the sexual problems on:

- **their social functioning (focused on key words and phrases that indicate the influence on relationships, religion, or any other social system)**
- **their emotional functioning (focused on key phrases that indicate emotions and feelings)**

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4.2.4 Describing, classifying and interpreting

De Vos (2002:344) states that in this loop of the spiral, category information represents the heart of qualitative data analysis. Creswell (1998:144) in de Vos (2002:344) states that classifying means taking the text or qualitative information apart and looking for categories, themes or dimensions of information. Interpretation involves making sense of the data, the "lesson learned". The researcher used the examined content of the personal letters to identify main themes and related themes to make sense of the data.

4.2.5 Representing and visualising

De Vos (2002:344) states that in the final phase of the spiral researchers present the data, a packaging of what was found in text, tabular or figure form. A hierarchical tree diagram represents another form of presentation. This shows different levels of abstraction, with the boxes in the top of the tree representing the most abstract information and those at the bottom representing the least abstract themes. Finally, authors present metaphors to analyse the data - literary device in which something borrowed from one domain applies to another. Qualitative writers may compose entire studies shaped by analyses of metaphors.

Direct quotations from the personal letters will be given and the researcher will represent the main themes and related themes that were extracted from the quotations in boxes. A table will be drawn up to show the various main themes and related themes that were identified. Further more, a diagram will present how the various sexual problems link up and how sexual problems influence the socio-emotional functioning of young women.

4.3 Quotations and identified themes

The data collection method that was used in this study, is a document study. A personal account of how young women's lives have been influenced by a sexual

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- "I sat back in my seat and curled myself into a ball. As I waited tears started to fall down my face. One by one. I looked at all the other people in the room and thought how can everyone be so calm and in control of their emotions. They acted if nothing was wrong. I felt if I was the only one that is losing control over my own life". **(Abortion)**
- "I am a very organised person and my life was perfect until I had to face the problems in my sex life. While having sex I always try not to lose control and after a while sex started to be a power struggle in my life. I couldn't bare to think of loosing control (having an orgasm) and let my boyfriend see how vulnerable I have become". **(Vaginismus)**
- "I am holding back what I am really thinking because I am to scared for how I would react if I for once relaxed and lost control". **(Anorgasmia)**

Main theme: **Young women experience control related problems.**

Related themes: *** The lack of control that women feel over their lives.**
***The fear of losing control over feelings and behaviour.**
***Obsessed with being in control.**

Control related problems: Young women who experience control related problems present one way in which sexual problems influence the socio-emotional functioning of young women. The researcher found that various sexual problems can be interrelated with a control factor. Some women feel that they struggle to be in control of their lives while other women fear losing control over their feelings and behaviour.

There is consequently a fear factor involved in these control related problems. The researcher found that women are both afraid of being obsessed with being in control and also of not being in control. This fear of losing control and control

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obsessions have an effect on how women deal with the specific problem that they are faced with.

According to Girard (2002:3) social factors affecting women's ability to control their sexuality include culturally determined gender inequalities, economic dependency, inadequate access to health services, culturally sanctioned sexual abuse and violence. (According to Chapter 2 - 2.3) In addition to force, coercion and fear are also a part of many young people's sexual relationships. Thirty three percent of sexually experienced young women say they are afraid of saying no to sex. Over half of sexually experienced girls (55%) agree with this statement: "There are times when I don't want to have sex, but I do because my boyfriend insists on having sex" (Love Life: Portrait of Young South Africa, 2002:10). (According to Chapter 2 - 2.6)

4.3.2 <u>Theme 2</u>

<u>The following quotations were extracted from the personal letters:</u>

- "I have significant body image concerns. I have not allowed my husband to see or touch me naked since the mastectomy". **(Anorgasmia)**
- "I feel fat and ugly." **(Early Parenting)**
- "A negative feeling towards my body and a feeling of disgust towards my genitals." **(Anorgasmia)**
- "I have never discussed this with anyone before feeling that his erection problems are my fault, I always blamed myself". **(Dyspareunia)**
- My whole body felt dirty and I could not stop blaming myself for my irresponsible behaviour". **(Gonorrhea)**
- "My sense of worth is threatened by the anxiety of rejection and isolation. The termination of the unwanted pregnancy during my adolescence has impaired my fragile sense of self". **(Abortion)**

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- "I had come in about a spider bite and heard it was Herpes. Incurable with unmistakable sexual connectations. In a word, dirty. That was all I'd known and thought about a disease I now had. It's unsurprising my sexual self estimation went from haughty to whore. I plummeted I was unclean". **(Herpes)**
- "Every inch of my body felt itchy and I couldn't help scratching myself. It would get so bad that I had to stop the bleeding with a cloth". **(Syphilis)**
- "I hated myself, I considered suicide..." **(Adoption)**
- "I always worry that I will be viewed as a slut if I enjoy sex too much, this makes me feel very uncomfortable". **(Anorgasmia)**
- "I felt dirty and wanted to cleanse myself the whole day". **(Syphilis)**
- "I hated myself for letting someone else rape me. After ten years I still feel dirty". **(Vaginismus)**
- "The way I look is disgusting, I am so ashamed". **(Early Parenting)**
- "I would cut myself and then the pain would go away". **(Dyspareunia)**
- "My whole body is polluted inside-out". **(Syphilis)**
- "Everyone sees me as dirty and my disease is something to be ashamed of. I hate myself, how am I going to live a normal life with HIV". **(HIV positive)**

Main theme: Negative feelings towards one's own body.

Related themes: * Feelings of disgust and a low self-esteem.
***Perception of body as dirty and unclean.**
***Self-destructive behaviour and self-blame.**

Negative feelings towards one's own body: Sexual problems have an impact on how young women see themselves and on their self-critical thoughts. The researcher has found that the young women that have experienced sexual problems do experience a problem with their own body and normally have a low-

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self-esteem and focus on images of bodily injury. They have an unrealistic perception of their body and this can lead to obsessive compulsive behaviour or even self-destructive behaviour. The researcher found that the young women mostly develop an obsession with their weight, hygiene and feel ashamed of their body image.

Young women are faced by many health issues today (Teagno, 2002:1). Birth control, eating disorders, PMS, pregnancy, depression, body image, STD's and smoking are just a few of the issues that face today's young women. One of the most common concerns that young women have is whether or not they are "normal". They have concerns about their bodily function, about being sexually attracted to others, about sexual identity and orientation, about having sexual feelings and about how to handle those feelings (Compare Girard, 2002:1 and Teagno, 2002:2.) (According to Chapter 3 - 3.2)

4.3.3 <u>Theme 3</u>

<u>The following quotations were extracted from the personal letters:</u>

- "I was hurt more and anger rose in me". **(Abortion)**
- "Sometimes when I think about boyfriends, I want the virus to go away. Because when you're older, some boys might not want to get involved with you because you can't ever have sex without using a condom". **(HIV positive)**
- "Just prior to entering the group, I had become pregnant and required an abortion. This section had distressed me greatly, and I felt that I could no longer trust men". **(Abortion & Anorgasmia)**
- "My husband continues to act like the androgen insufficiency and the sexual problems are my fault, if it was my deliberate action. My husband feels as if it was my deliberate action. My husband feels as if he has been ripped off all

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the years. He is not very nice to me - I am not a bad person. I am fearful to discuss my needs with my husband because of the vulnerability I feel in the sexual arena". **(Anorgasmia)**

- "I will never be able to be in a relationship because sex is just too painful. When I become too involved with a man I tend to run away!". **(Dyspareunia)**
- "I have lost many relationships over the painful sexual dysfunction, having never had a 'Steady boyfriend'. At present I do not date". **(Dyspareunia)**
- "Though I am convinced sexual exclusivity is an unspoken code in LTRs no matter how modern it is to have discreet dalliances). LTR: Live Together Relationships". **(Herpes)**
- "Anger took hold and armed with it I returned to work.... His non-committal response of 'so that's what it is' defused my anger.... I looked at the man I had adored and what I now saw was what I was stuck with". **(Herpes)**
- "I didn't know what was going on then, but now I do. I find I can't forgive him. I had become pregnant. I wanted to be loved, I thought sex was a way of showing love". **(Early Parenting)**
- "Days went by without me hearing anything of him. Devastated by the knowledge that I have lost my child and my lover". **(Adoption)**
- "Closer to home, teen moms have to deal with relationship problems that may not be such a problem for a mom to be who has been in a relationship for a longer period of time. Boyfriends tend to drop out of the picture or promise to be around, only to leave later. Often the mom will realise he isn't the best person in the world to be a dad, so she doesn't push the issue". **(Early Parenting)**
- "I do not see my inability to have an orgasm as a big problem, while my situation is making my boyfriend feel like an inadequate lover. It seems that my negative ideas about sex are keeping us from being close". **(Anorgasmia)**

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- "I would never trust a man again. He was the one sleeping around". **(Gonorrhea)**
- "Lately it has become an even harder secret to hide because sex has begun to hurt. I think my husband is now starting to think that I am having an affair because I am pulling away when he wants sex". **(Dyspareunia)**
- "Our relationship will never be the same... how could it. If I passed this on to someone else, I will never forgive myself. I have to tell... but if I do I may lose the one I love so much". **(HIV positive)**
- "I hate all men! They are all deceitful". **(Syphilis)**
- "Can't men stay faithful. How would I ever trust a man in my life". **(Gonorrhea)**
- "How many times must I tell him that he is hurting me!" **(Vaginismus)**
- "I am now afraid of being in a relationship because that means I need to have an orgasm". **(Anorgasmia)**

Main theme: A fear for engaging in future relationships.

Related themes: * Anger to male sexual partners.
***Ambivalent feelings about relationships.**
***Anticipation of relationship problems.**

A fear for engaging in future relationships: Once again the fear factor is found as well as the thought of being hurt. The researcher has found that no matter what sexual problems the women experience, they all have some form of fear for current or future relationships. They experience problems in their relationships or they have ambivalent feelings whether the relationship is worth while.

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Another element that was found in the letters was the anger towards male sexual partners. The young women who have gone through a bad experience and who had to deal with the consequences of a sexual practice feel betrayed or feel angry because of the lack of support that was given. As a result most of the young women indicated in their letters that they anticipate relationship problems.

Young women that suffer from Dyspareunia more than often suffer extreme pain and struggle to be in a sexual relationship (Maurice, 1999:282). As a result Dyspareunia can be the cause of a diminished self esteem, hostility and anger problems. Most young women with Dyspareunia have a negative attitude toward sexuality. (According to Chapter 3 - 3.3.1.1)

4.3.4 Theme 4

The following quotations were extracted from the personal letters:

- "I shared my situation with my pastor and the other members of the congregation. They prayed for me and warned me strongly that abortion is murder, and the breaking of the fifth commandment. 'You should not murder'. I consented to be a murderer. I broke the commandment of God". **(Abortion)**
- "I confessed in my prayers to God that I was a murderer and responsible for the murder of my child in the face of the threats of my husband". **(Abortion)**
- "I feel so ashamed. My body is rotten. God will never forgive me". **(Syphilis)**
- "... Catholics were pro-life and didn't believe in abortion". **(Abortion)**
- "I sometimes face the dilemma of feeling guilty when I masturbate because I have been taught that God will punish me or perhaps even kill me for this 'perversion'" **(Anorgasmia)**

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- Conversely, guilt can have negative effects and I experience emotional and physical pain because of this feeling of sin". **(Dyspareunia)**
- "My spiritual conclusion was that as punishment for my sins, I'd no choice but to stay with the man I could not longer trust or particularly like. It was the price to pay". **(Herpes)**
- "God will never forgive me for what I have done!". **(Gonorrhea)**
- "He said to me, I had a long talk with God and He promised to take care of us". **(Adoption)**
- "I feel dirty! Will God forgive me for my impure body". **(Syphilis)**
- "Am I going to be punished...." **(HIV positive)**
- "How can God do this to me! I am not normal like other women". **(Vaginismus)**
- "I feel betrayed by everyone, even God". **(HIV positive)**
- "Does even God think that I am dirty!" **(Gonorrhea)**
- "I feel so ashamed of what I have done, how would God ever forgive me". **(Early Parenting)**

<u>Main theme:</u> A feeling of sin.

<u>Related themes:</u> * Religious problems.
***Experience a moral dilemma, feelings of rejection.**
***Feelings of guilt and shame.**

A feeling of sin: According to Gouws, *et al.* (2000:116) critical analysis of religious convictions often result in young people becoming sceptical about religious practices (such as prayer and church). Consequently some young people tend to lose interest and drift away from the religious institutions while some turn to alternative religions.

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Most of the women indicated in their letters that they feel guilty. They have feelings of shame and rejection. The researcher found that the young women have trouble in accepting that God is going to forgive them. As a result they experience a moral dilemma and develop religious problems and some seek alternative religions. Another interesting element that was found in the letters was that the young women were rejected by family members and friends because of their religious values. The researcher found that various sexual problems had a similar influence on the young women's religious life.

4.3.5 Theme 5

The following quotations were extracted from the personal letters:

- "...my emotional state was in turmoil". **(Abortion)**
- "...so for a week I became really silent and withdrawn...." **(Abortion)**
- "I had lost all that mattered to me in the world". **(Abortion)**
- "It feels if I am the only person on earth that has Herpes". **(Herpes)**
- "For the next two years I fell into a depression and tried to have all the fun I could to ease the pain". **(Abortion)**
- "I feel alone, how am I ever going to have a normal life again". **(Syphilis)**
- "The test result and my fiancé's desertion pushed me into a depression so deep that I spent four months cocooing in bed". **(HIV positive)**
- "I have long periods of depression. I am having a difficult time with my marriage, my ageing, and my children". **(Anorgasmia)**
- "I have severe anxiety attacks with depression and am socially isolated". **(Dyspareunia)**
- "Days turned to weeks, and my grief knew no end". **(Adoption)**
- "I simply sank so deeply into a depression that even escape was unthinkable". **(Adoption)**

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- "I thought that my life would be over if I had a baby...it ended that very day. I'm left picking up the pieces". **(Abortion)**
- "My life feels empty and I feel as if no one can help me". **(Gonorrhea)**
- "... I am going through what they call temporary depression". **(Abortion)**
- "The sky, so blue and bright just a short time ago, now looks dull and gray. I am HIV positive, and realise my life will never be the same". **(HIV positive)**
- "I have never felt so alone.... Nobody understands. I am so tired". **(HIV positive)**
- "After a while I could not get out of bed in the mornings. I had so many problems when I was a child and now everything is coming back. I struggle everyday with sex and I have given up hope for a normal sex life. I would not be surprised if my boyfriend has an affair...." **(Vaginismus)**

Main theme: Manifestation of depression.

Related themes: * A dominant sense of loneliness and helplessness in their lives.
***Altogether eminently over-emotional or apathetic and indifferent.**

Manifestation of depression: Gouws, *et al.* (2000:152) state that in the past several decades there have been enormous changes in the recognition of depression as a problem of young people. Perspectives have changed from an initial view that depression could not occur in young people to an acknowledgement of depression as a major health concern among young people.

The researcher found that various sexual problems had a corresponding influence on the young women's state of mind. The young women mentioned in their letters that they felt alone, helpless and depressed. Two poles were

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identified by the researcher. Firstly, it was found that the young women felt very emotional and cried a lot because of the feeling of helplessness. Secondly, it was found that some women just became totally apathetic and became so depressed that they lost interest in almost everything. They became indifferent and felt that there was no way out of this predicament.

4.3.6 Theme 6

The following quotations were extracted from the personal letters:

- "For 24 hours I had some inexpressible distress and remorse. I think the torment of hell could be something similar to this, but worse, of course. I was distressed for about 40 more days as I was weeping and crying". **(Abortion)**
- "He said that if I chose to have the abortion, that it could result in 'Psychological consequences' later. Now I had no idea what he meant, and I didn't understand how a physical surgery and removing something from the body would affect my mind.... Now I understand all to well what he meant". **(Abortion)**
- "The stress of the situation, the hopelessness I felt..." **(HIV positive)**
- "I do think I lost it mentally, I remember slamming the phone down.... I retreated into a corner on the floor and sobbed, while I rocked back and forth". **(Adoption)**
- "There were nights that I would sit on my bed, holding my baby doll in my arms and wailing for the lost child, my arms ached for. There were the dreams, or if you would rather call them nightmares, of bloody parts or babies ripped in half pulling themselves across the kitchen counter crying and calling my name". **(Abortion)**
- "The inability to have an orgasm causes me personal distress". **(Anorgasmia)**

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- "I have seen 14 counsellors for a dissociative disorder. I have nightmares of men chasing me and raping me. Concerning the psychological issue I am undergoing therapy". **(Dyspareunia)**
- "I am so angry, I can't believe this has happened to me! When I speak to other people about my situation, it feels as if I am going to have a panic attack". **(Gonorrhea)**
- "...he seemed to understand that my coping mechanism for shock is to focus on cognitive reason and such keep the intellect occupied. The concomitant emotions can have an appropriate outlet later". **(Herpes)**
- "It was so gross, so perverted that I ended up in psychological counselling. With the help of my therapist I tried to return to a normal life, but the nightmares kept haunting me". **(Vaginismus)**
- "Panic begins to swell inside, my heart races and my chest pounds in fear.... What I dread the most, is the fact that this feeling of fear and isolation may never go away. I feel that I will never be able to escape the realisation that I am sick and too frightened to tell anyone". **(HIV positive)**
- "I feel so anxious and stressed when I think about the disease". **(Syphilis)**
- "When my boyfriend touches me, I freeze. I am anxious that this would lead to sex". **(Dyspareunia)**
- "I am troubled with how things are but the doctor says that I must relax because it is all in my head. I feel like I have a psychological problem but for years the doctor said that there is nothing to worry about". **(Vaginismus)**
- "When I see a child walking on street, I immediately start tensing up and I feel anxious". **(Adoption)**
- "I thought things are going to be different after the medication but I am now more stressed than ever". **(Gonorrhea)**
- "After I was told that I am HIV positive, I am constantly in a panic of when am I going to die. I project my anger towards everyone and blame everyone around me". **(HIV positive)**

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- "I feel stressed...." **(Anorgasmia)**

Main theme: Emergence of psychological problems and personal distress.
Related themes: * Anxious and distressed. *Troubled and highly strung. *Project extreme anger towards everyone.

Emergence of psychological problems and personal distress: Gouws, *et al.* (2000:152) emphasise that depression during young adulthood has a tendency to occur with other disorders such as internalising problems (e.g. anxiety) and externalising problems (e.g. aggression). Anxiety is defined as a complex pattern of three types of reactions to a perceived threat: motor responses, physiological responses and subjective responses.

The researcher found that the young women that wrote the letters mentioned that they are anxious and that they feel distressed. The young women indicated that their situation made them highly strung and they experienced nightmares, sleeplessness and extensive crying episodes. The researcher found that the young women developed psychological problems and personal distress because of their specific sexual problems. Interestingly enough, the various sexual problems had the same psychological effect on the young women.

4.3.7 Theme 7

The following quotations were extracted from the personal letters:

- "He said that if I chose to have the abortion, that it could result in 'Psychological consequences' later. Now I had no idea what he meant, and I

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didn't understand how a physical surgery and removing something from the body would affect my mind. It didn't make sense to me. I wish he had elaborated more on that, and I was scared really to ask. Now I understand all to well what he meant". **(Abortion)**

- "The positive sign in the tiny window of the home pregnancy test was a green-eyed monster... threatening to take away all my hopes and dreams. But I made a mistake and did something that I knew I shouldn't have done". **(Early Parenting)**
- "I love my son more than anything in the world and although I do not see my son as a mistake I would be much more careful if I could go back in time". **(Early Parenting)**
- "I know a lot about Herpes now and just regret that I had to get it before becoming informed". **(Herpes)**
- "What grieves me, and deeply so, is that it is preventable". **(Herpes)**
- "My tragic story of adultery lay strewn before me, my life shattered like a broken window, broken into tiny pieces. I have to live with betrayal, shame and guilt, anger and a sense of failure. I wish things can be different". **(HIV positive)**
- "Contrary to what I had learned in my family, I turned to prostitution to make a fast buck and an easy living. Now I am infected with Gonorrhea and wish that I had thought twice about that so called 'easy living'". **(Gonorrhea)**
- "Birthmothers never forget, as we are told we will.... A mother cannot forget the child that she carried for nine months, no matter how hard she tries.... I have never forgotten her and will always love her". **(Adoption)**
- "One couple's dream come true was fixing to be the beginning of our worst nightmare". **(Adoption)**
- "If only things could be different". **(Herpes)**

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- "As a former teen mom, I wouldn't wish a teen pregnancy on any teen. Trying to work, go to school, raise a baby and still having some growing up to do is nowhere near easy". **(Early Parenting)**
- "If you are pregnant and are considering an abortion, please change your mind! I'm not saying that it will be easy, but take that blessing and run with it! I wish I had. I wish that someone had told me how I would feel after my precious baby was gone". **(Abortion)**
- "I wish my husband can understand that he is hurting me". **(Dyspareunia)**
- "Obviously he thinks that I am enjoying it, but I am not. I wish that he can understand how I feel". **(Anorgasmia)**
- "My mother had always warned me but I never listened. I wish I could go back in time". **(Adoption)**
- "If only he can realise that it is not him that is causing my pain". **(Dyspareunia)**
- "I have never realised how hard this is going to be. Everyday is a struggle and I wish that my sex life would improve". **(Vaginismus)**
- "I wish I never found the rash". **(Syphilis)**
- "I would think twice before jumping into bed with someone. I wish I would have thought that before contracting the disease". **(Gonorrhea)**

Main theme: Feelings of serious regret and sadness.

Related themes: * "I wish..." statements.
*** "If only..." statements.**

Feelings of serious regret and sadness. The researcher found that the young women had problems accepting their current situation and that they are very much living in the past. The young women identified in their letters that they regret what they had done or are sad as to how things turned. They blame themselves for what had happened and in some cases they also shift the blame

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onto someone else. The researcher found that "I wish..." and "If only..." statements are frequently used by the young women to express their regret.

4.4 The use of personal documents to gain insight on the main themes identified.

4.4.1 The value of personal documents to this study

The personal letters that were used in this document study gave the researcher some insight into the young woman's personal experience. This was very useful because of the sensitivity of the particular subject matter. Plummer (1983:64-83) and Babbie and Mouton (2001) in Strydom & Delport (2002a:323) present a meaningful version of the usefulness and value of personal documents, which can be briefly summarised as follows:

Personal documents serve as a touchstone for the evaluation of theories, hypotheses and assumptions (Babbie & Mouton, 2001:303). They enable the researcher to probe into the phenomenological heart of a human phenomenon. They complement objectivity with subjectivity in the research process. Personal documents provide the researcher with a holistic and total perspective of a person in the context of his total life. Personal documents add to the sensitising of concepts, theory development and verification. The researcher found this summary useful as a guideline to extract meaning from the young women's personal letters.

The personal letters gave the researcher insight into the human phenomenon and complemented the objectivity of the study. As a result personalizations from the subject's point of view was derived from the personal letters and consequently main themes were identified. The main themes indicate that sexual problems influence young women in that these sexual problems have a profound impact on their socio-emotional functioning.

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4.4.2 Themes identified in the personal letters.

Table 1: Identified main themes and related themes

	MAIN THEMES	RELATED THEMES
1	**Young women experience control related problems.**	*The lack of control that women feel over their lives. *The fear of losing control over feelings and behaviour. *Obsessed with being in control.
2	**Negative feelings towards one's own body.**	*Feelings of disgust and a low-self esteem *Perception of body as dirty and unclean. *Self-destructive behaviour and self-blame.
3	**A fear for engaging in future relationships.**	*Anger to male sexual partner. *Ambivalent feelings about relationships. *Anticipation of relationship problems.
4	**A feeling of sin.**	*Religious problems. *Experience a moral dilemma, feelings of rejection. *Feelings of guilt and shame.
5	**Manifestation of depression.**	*A dominant sense of loneliness and helplessness in their lives. *Altogether eminently over-emotional or apathetic and indifferent.
6	**Emergence of psychological problems and personal distress.**	*Anxious and distressed. *Troubled and highly strung. *Project extreme anger towards everyone.
7	**Feelings of serious regret and sadness.**	*"I wish..." statements. *"If only..." statements.

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4.5 The relationship between various sexual problems and similar themes identified in the personal letters.

The researcher is aware of the diversity of the various sexual problems but it is postulated that there is a sense of similarity between the influence of the three main groups of sexual problems on the socio-emotional functioning of young women. As a result, the focus of this study will be to explore the socio-emotional influence of sexual problems on young women.
(According to Chapter 1 - 1.2)

After **themes** were identified in the personal letters of the young women who have experienced various sexual problems, it can be emphasised that there is definitely a sense of similarity between the influence of the three main groups of sexual problems on the socio-emotional functioning of young women. Consequently the researcher states that from the above seven themes that were identified it became clear that sexual problems influence young women's socio-emotional functioning in a similar manner.

The researcher found that there is definitely a significant correlation between various sexual problems and the influence these have on the socio-emotional functioning of young women. The researcher will use this section to indicate the process of how sexual problems stem out of sexual practices and the way in which these various sexual problems influence the socio-emotional functioning of young women.

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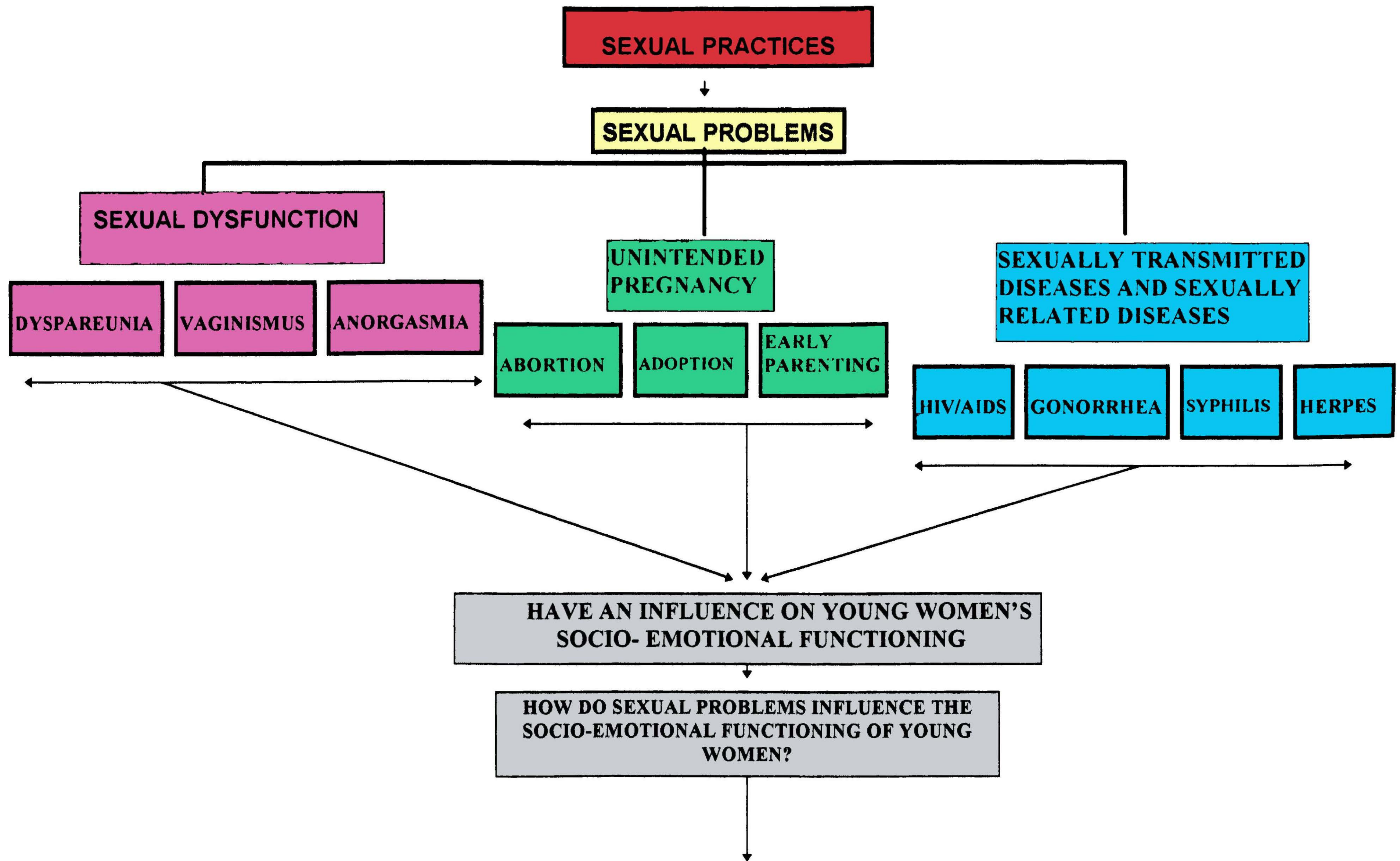
Figure 7: The influence that sexual problems have on young women's socio-emotional functioning



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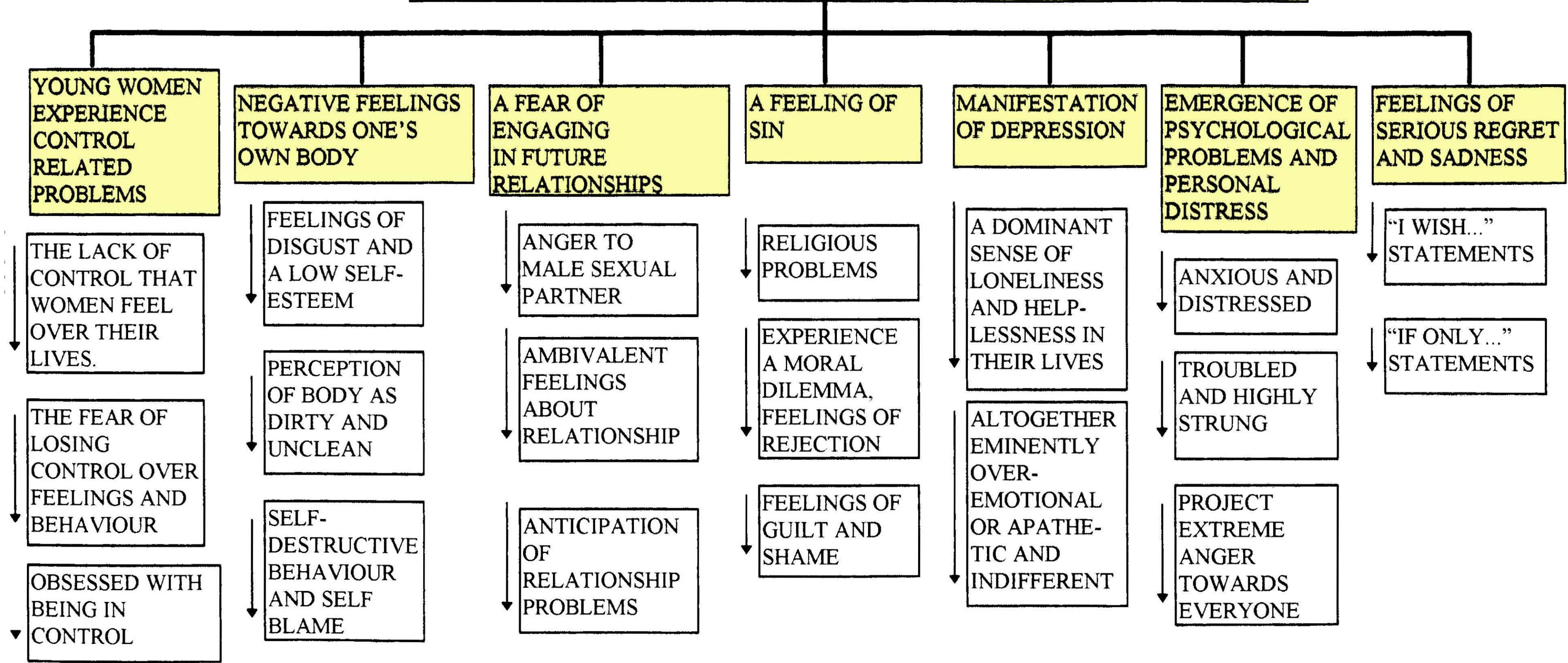

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4.6 Summary

In this study personal letters of young women received between June 2002 and February 2003 were included. The findings of the empirical study revealed the following information:

- Young women between the ages of 16 and 25 are faced with various sexual problems.

- Various sexual problems cause young women to experience control related problems in their lives.

- Young women that experience sexual problems develop negative feelings toward their own bodies as a result of the sexual problems.

- It is evident from the results that young women develop a fear for engaging in future relationships because of their personal experience.

- Most young women are faced with feelings of guilt and shame. As a result they experience religious problems and view themselves as sinners.

- A number of young women had some form of manifestation of depression and felt lonely and helpless.

- The emergence of psychological problems and personal distress was dominant under the young women.

- Feelings of serious regret and sadness under the young women were evident from the results of the study.

- The results of this study revealed that there is a sense of similarity between the influence of the three main groups of sexual problems on the socio-emotional functioning of young women.

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CHAPTER 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The content of the research report is composed as follows: In Chapter 1 the general introduction with regards to the investigation was the focus point. The research process was described thoroughly in this chapter. The motivation for the choice of study, problem formulation, sampling methods and the research question was supplied.

In Chapter 2 an investigation of the socio-cultural context, norms and values of sex were done. Furthermore, women's rights and basic sexual rights were discussed to obtain insight into the politics of sex. The chapter emphasised sexual development and focused on young people's involvement in sexual practices.

In Chapter 3 the focus was on special concerns for young women. This Chapter seeked to investigate the three groups of sexual problems namely: Sexual dysfunctions; Unintended pregnancy; Sexually transmitted diseases and sexually related diseases.

In Chapter 4 empirical details and findings of the study with regard to how sexual problems influence the socio-emotional functioning of young women, were discussed. Main themes and related themes were identified in the personal letters and the researcher analysed the information.

In Chapter 5 a summary, conclusions and recommendations will be given concerning the preceding chapters of this study. The aim, objectives and research question will be tested in this chapter.

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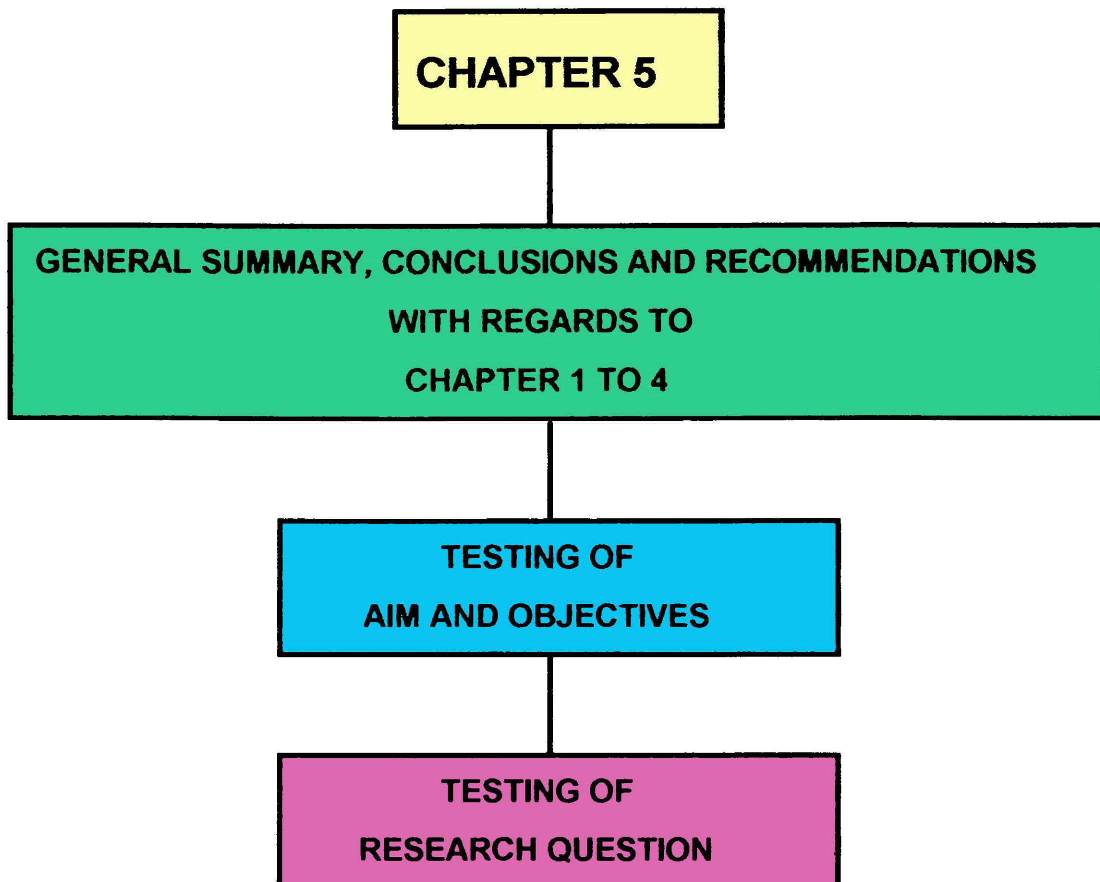
Figure 8: Schematic presentation of Chapter 5



5.2 Chapter 1: General introduction

5.2.1 Summary

Sexual problems influence young women in that these sexual problems have a profound impact on their socio-emotional functioning. The researcher operationalised a definition of sexual problems and consequently three groups of sexual problems formed the foundation of the study. For the purpose of this study it was necessary to focus on various sexual problems which included sexual dysfunction, unintended pregnancy, sexually transmitted diseases and sexually related diseases.

The researcher was aware of the diversity of the various sexual problems but it was postulated by the researcher that there was a sense of similarity in the

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influence of the three main groups of sexual problems on the socio-emotional functioning of young women.

The aim of this study was set to explore the socio-emotional influence of sexual problems on young women. Qualitative research was suitable for this particular study and therefore a research question was formulated as follows: How do sexual problems influence the socio-emotional functioning of young women?

The data collection method that was used is the document study. A personal account of how young women's lives have been influenced by a sexual problem has been given in the form of personal letters that have been sent anonymously to DISA-clinic by young women. Therefore the collective case study has helped to give an understanding regarding the socio-emotional influence of sexual problems on young women. A non-probability sampling method was used in this study. The type of non-probability sampling that the researcher used was purposive sampling.

5.2.2 Conclusions

The following conclusions were drawn from the introduction of the study:

- Sexual practices can lead to sexual problems, as seen clearly in statistics. It is found that there is an increase in the percentage of young people who are sexually active and as a result this causes an increase in sexual problems under young people.
- A qualitative method was suitable for this study, as the qualitative study will consequently present the reader with an understanding of the socio-emotional influence that sexual problems have on young women.
- Document study was used as data collection method. This proved the ideal data collection method as a document study is an unobtrusive research method that objectively examines the content of documents and ensures that the respondents are kept anonymous.

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- The sampling method was guided by certain criteria and gave the researcher a guideline as to how to select the personal letters.

5.2.3 Recommendations

The following recommendations are made in light of the above mentioned conclusions:

- The criteria on selecting the sample was set to include only English letters. The recommendation can be made to include letters of all languages to make the sample more representative of all cultures.
- This study was done mainly to explore the socio-emotional functioning of young women that have experienced a sexual problem and it could serve as the basis for further in-depth study on the subject of sexual practices that young women partake in.

5.3 Chapter 2: The context of sex and sexual practices

5.3.1 Summary

Sexual practices make part of all societies and it was important to place sexuality in context and to discuss sexual practices that young women are involved in before understanding the concept of sexual problems. Society determines which sexual information and behaviours are legally permitted or considered appropriate on the basis of: tradition, customs, religion, values, and beliefs; the history and experience of the culture; economic and political conditions.

There are numerous sexual practices, variations on sexual practices and terminology for sexual practices. Sexual practices for the purpose of this study included all sexual practices in the society but it was impossible to name all the sexual practices. As a result, the researcher thought it appropriate to discuss some of these sexual practices to give the reader a better idea of what is meant by sexual practices and how sexual practices can be the cause of sexual problems.

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5.3.2 Conclusions

The following conclusions were drawn from Chapter 2 that focused on the context of sex and sexual practices:

- Sexual rights are universal human rights that are based on the inherent freedom, dignity and equality of all human beings. Sexual health is the result of an environment that recognises, respects and exercises sexual rights.
- Sexuality is an integral part of the personality of every human being. A person's full development depends upon the satisfaction of basic human needs such as the desire for contact, intimacy, emotional expression, pleasure, tenderness and love.
- Sexual practices have changed over time, but for the worse and young women especially, suffer serious socio-emotional problems caused by the trauma of sexual practices, for example unwanted pregnancy, STD's, Vaginismus and Dyspareunia.

5.3.3 Recommendations

The following recommendations are made in light of the above mentioned conclusions:

- Sexual rights must be prioritised in the society to prevent the increasing statistics of arising sexual problems.
- In order to prevent the rising statistics of sexual problems that arise from young people that partake in various sexual practices, education must be provided to young people on sexual practices and related problems.

5.4 Chapter 3: Sexual problems

5.4.1 Summary

It is found that sexual problems arise because young people are uninformed and the problems are normally more severe for young women than for young men. Sexual problems and related problems that are mainly found under young women are unintended pregnancy, early parenting, STD's (including HIV infection), unsafe abortion, forced termination of pregnancy, less

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opportunity for economic achievement and social ostracism by the community.

Sexual problems for the purpose of this study were organised and outlined in three main groups. Firstly, sexual dysfunctions which included Dyspareunia, Vaginismus and Anorgasmia. Secondly, unintended pregnancy that included Abortion, Adoption and Early Parenting. Lastly, Sexually transmitted diseases and sexually related diseases that included HIV infection and AIDS, Gonorrhea, Syphilis and Herpes.

5.4.2 Conclusions

The following conclusions were drawn from Chapter 3 which focused on sexual problems of young women:

- There is a marked number of young women that experience sexual problems.
- It is detected that sexual problems arise because young people are uninformed concerning the consequences of sexual practices.
- Young women are faced with various sexual problems and these sexual problems have an influence on their socio-emotional functioning.
- There is a need for guidelines for women that have to deal with sexual problems.

5.4.3 Recommendations

The following recommendations are made in the light of the above mentioned conclusions:

- Young women must be informed and educated about the consequences that sexual practices may hold for them in order to prevent the rising statistics of sexual problems under young women.
- Guidelines should be drawn up for women that have to deal with sexual problems. These guidelines should provide the means to cope with the influence that sexual problems have on their socio-emotional functioning.

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5.5 Chapter 4: Empirical study

5.5.1 Summary

For the purpose of this study Creswell's spiral image was applied and the researcher pursued the steps as follows: collecting and recovering data; managing the data; reading and memoing the personal letters; describing, classifying and interpreting the content of the personal letters; representing and visualising the quotations of the young women's personal experiences in an organised manner.

Direct quotations from the personal letters were given and the researcher represented the main themes and related themes in boxes as extracted from the quotations. A table was drawn up to show the various main themes and related themes that were identified. Further more, a diagram presents how the various sexual problems link up and how sexual problems influence the socio-emotional functioning of young women.

5.5.2 Conclusions

The following conclusions were drawn from Chapter 4 which focused on the empirical findings of the study:

- Young women between the ages of 16 and 25 are faced with various sexual problems which influence their socio-emotional functioning.
- The results of this study revealed that there is a sense of similarity between the influence of the three main groups of sexual problems on the socio-emotional functioning of young women and can be organised in seven main themes.

5.5.3 Recommendations

- Groupwork regarding how to cope with the influence that sexual problems have on the socio-emotional functioning of young women must be prioritised in the future.
- The fact that there is a sense of similarity on how various sexual problems influence the socio-emotional functioning of young women must be

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included in the developing of programs on coping mechanisms for young women that have been affected by a sexual problem.

- It has become important that children be taught about sexuality as early as possible on the strength of the fact that numerous young women are faced with sexual problems because they are uninformed about the consequences of sexual practices.
- There is a need to develop programs on how to help women who experience various sexual problems and how to deal with these problems.
- The recommendation can be made to use play therapy techniques to help women to project their anger caused by their sexual problem and to bring them in contact with the here and now which is a basic principle of Gestalt therapy.
- The combination of play therapy and groupwork is recommended for young women where they can feel safe in a group therapy environment and discuss the different aspects of their sexual problem before serious socio-emotional functioning is affected.
- Further research on preventing the rising statistics of sexual problems under young women is recommended.

5.6 Testing of aim and objectives

5.6.1 Aim

The aim of this study was to explore the socio-emotional influence of sexual problems on young women.

The aim of this study was met by means of a thorough exploration of young women's personal experiences of various sexual problems. Through the document study and the analysis of the personal letters of young women seven main themes were extracted. As a result of this analysis insight was gained on the various sexual problems. It was found that there is a sense of similarity in the influence of the three main groups of sexual problems on the socio-emotional functioning of young women.

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5.6.2 Objectives

5.6.2.1 Objective 1

To do a literature study on various sexual practices and sexual problems in order to build a knowledge base for further exploration.

This objective was met by means of a thorough literature study on the subject. Information was gathered through various literature sources to build a knowledge base on various sexual practices including anal intercourse, cybersex, incest, penal-vaginal intercourse, rape and sexual harassment. Literature was furthermore gathered on sexual dysfunctions that included Dyspareunia, Vaginismus and Anorgasmia. Unintended pregnancy that included Abortion, Adoption and Early Parenting. Sexually transmitted diseases and sexually related diseases that included HIV infection and AIDS, Gonorrhea, Syphilis and Herpes.

5.6.2.2 Objective 2

Through an empirical study the socio-emotional influence that sexual problems have on young women will be explored.

This objective was met by means of a thorough empirical study. Personal letters were gathered according to the criteria that were set for selecting the sample. One hundred and fifteen letters were analysed and seven main themes were extracted and identified through the process of analysis.

5.6.2.3 Objective 3

To draw conclusions and make recommendations to improve young women's socio-emotional functioning.

This objective was met by means of making conclusions and recommendations of the literature and the empirical study (Chapters 2-4). These recommendations are suitable with regards to applied research that endeavour to improve the current situation that the research was done on.

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5.7 Testing of research question

5.7.1 Research question

The following research question was formulated:

How do sexual problems influence the socio-emotional functioning of young women?

The research question has been answered through this study. Seven themes and related themes were extracted from the personal letters of the young women that indicated that there is a sense of similarity between the various sexual problems. Furthermore it indicates the way in which the sexual problems influence the socio-emotional functioning of young women.

5.8 Concluding statement

From this study it is evident that there is a huge diversity between the various sexual problems but that there is a sense of similarity in the influence of the three main groups of sexual problems (sexual dysfunctions, unintended pregnancy, sexually transmitted diseases and sexually related diseases) on the socio-emotional functioning of young women.

In closure the researcher would like to emphasise that the key to addressing sex as a problem is to get comfortable with sex as a topic by talking about it generally. Start being open about personal feelings and respect the feelings of others. It is important that young women find a safe environment where they can discuss the different aspects of sex before serious socio-emotional functioning is affected.

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APPENDIX A

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APPENDIX A

SA Council for Social Service Professions (SA CSSP)

T.M. Robinson
Reg No: 10 - 22144

In able to complete the MSD Play Therapy degree the student need to write a research report. The researcher will compile the research report according to the requirements for a mini-dissertation of the Department of Social Work: University of Pretoria. After careful consideration the following topic was selected.

THE SOCIO-EMOTIONAL INFLUENCE OF SEXUAL PROBLEMS ON YOUNG WOMEN: A SOCIAL WORK INVESTIGATION.

The aim of this study is to explore the socio-emotional influence of sexual problems on young women. The following objectives are set:

- To do a literature study on various sexual practices and sexual problems in order to build a knowledge base for further exploration.
- Through an empirical study the socio-emotional influence that sexual problems have on young women will be explored.
- To draw conclusions and make recommendations to improve young women's socio-emotional functioning.

To achieve the predetermined aim, the researcher requests permission from the MD of the clinic, Dr. McIntosh.

This permission will accommodate the researcher to:

- do research at DISA-clinic;
- to have access to all **anonymous** personal letters that young women have sent to DISA-clinic between June 2002 and February 2003.

Thank you for DISA-clinic's support and help so far in the research process.

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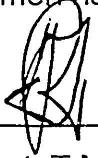
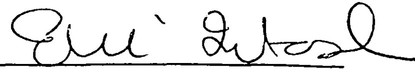
- I, E. N. M^c INTOSH here by give T. M. ROBINSON permission on 13 - 03 - 03, to do her research report at DISA-clinic and to have access to all **anonymous** personal letters that young women have sent to DISA-clinic between June 2002 and February 2003.



Student: T.M. Robinson

Student no: 22204386



Dr. McIntosh

MD of DISA-clinic

Date: 13 - 03 - 03

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APPENDIX B

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APPENDIX B

Thank you again for your help when I collapsed at the clinic. To give thanks in an appropriate manner is seemingly through advancing your studies. You are a credit to your profession and your progression in it merits much due recognition.

The following hopefully assists as a "Case Study" for the paper you mentioned.

Doctors say world changing things all the time. People sit the same but inside's a jumble as doctors patiently use words to the effect that terminal, debilitating, life altering outcomes have changed life as the patient knew it till moments before. We're surprised when we stand up that the floor's been there all this time, that the room's no different, that nothing's changed when *every*thing's changed. Which may seem a very female thing to say, but I'm not convinced men experience this the same. It stands to reason we don't, as for one thing it's more life altering to hear a positive pregnant result if one's to be the mother. Some men even shrug off news like that, women can't.

Having a healthy respect for healers and especially those who stay current made it easy to adore my doctor. His manner throughout a life altering consultation does the profession proud. Looking back, the single most important factor when a diagnosis impacts on life, is the patient-doctor bond. I'm fortunate and grateful Kim was my doctor. He did all the things then and there to best make it better.

He delivered his diagnosis when we were seated, which would have been ignonomous with my pants pulled down. I'd come in with a dashed burny spider bite that was in too awkward a spot for even minor self-examination. The sting had a persistency about it which prompted a doctor's visit. My startled boyfriend (for want of a better term for the 39 year old I shared a house in Bryanston with) had offered to have a look at it that morning, having seen bedding fruitlessly flung and intently examined to find the spider that had inflicted such a heinous sting. I mention Bryanston only as it may pertain to the demographics research is so fond of.

Something in the order of misplaced modesty made me decline my partner's offer to examine a silly bite, paltry in terms of medical attention required in areas *sans* 4X4, though bear in mind it was also early days as we'd only been living together for about 3 months.

The doctor's matter of fact delivery seemed out of keeping with the atrocity of the news. I'd come in about a spider bite and heard it was Herpes. Incurable with unmistakable sexual connotations. In a word, dirty. That was all I'd known and thought about a disease I now had. It's unsurprising my sexual self estimation went from haughty to whore. I plummeted. I was unclean. Preconceived notions rushed around – taunting me with my own judgements. I'd subconsciously looked on preventable diseases as a form of natural deselection – if one's going to be so utterly stupid as to get a preventable disease, so lacking in basic common sense as to pick up an avoidable virus for which there's no cure, then it's probably nature's way of eradicating the weaker of the species. Survival of the fittest includes mental agility.

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He waited those finitesmal moments it took to absorb the fact that I had a disease I deplored. To assimilate this with the private thoughts of fidelity and such that plague the female mind. Doctor Hay seemed to be following my thoughts as I'd been in a couple of months before to arrange contraceptives and about 6 months prior to that to have a full set of tests, as modern single sensible minds do before entering a sexual relationship. Sexually communicable diseases tested were negative, though it felt like that had been in another life (the tricks time plays when a shock's around.) My boyfriend's own doctor had done his set of tests.

Doc H had remarkable empathy – he seemed to understand that my coping mechanism for shock is to focus on cognitive reason and as such keep the intellect occupied - The concomitant emotions can have an appropriate outlet later.
It was Herpes. No tests or second opinion was needed to confirm this.
I'd been exposed to it in the last week, (sexual exclusivity as an unspoken code in a live together relationship meant not only thoughts of infidelity registered.)
It was incurable but there was a new treatment which showed promising results. Expensive, but episodes were less frequent and less severe and my chances were good as I was catching treatment on the first outbreak.
Episodes are known to recur with stress and increased hormonal activity, eg sex.

I know a lot about Herpes now and just regret that I had to get it before becoming informed. Though I didn't just broaden my knowledge base, as frankly my "before" mind sets benefited from the broadening this brought on. (Though I'm convinced sexual exclusivity is an unspoken code in LTRs no matter how modern it is to have discreet dalliances). LTR Live Together Relationship.

Doc H was calm and reassuring and seemed to think I'd find comfort hearing that about 7 out of 10 of his patients have this. Which actually had the reverse effect – what were all these advantaged people doing with the privilege of education. Surely there weren't this many people contracting, for heaven's sake, a PREVENTABLE disease. How were these things ever going to be eradicated if the greater majority of adults were quietly going about getting it and giving it.

Anger took hold and armed with it I returned to work. My boyfriend and I worked for the same blue chip company, which later served to complicate matters as he did not want the disease to reflect on his medical aid, so treatment for both was done via mine. His non-committal response of "so that's what it is" defused my anger. Reluctantly he said he'd started getting blisters about 5 years before after his since ex wife had been on a separate holiday to Cape Town. I looked at the man I had adored and what I now saw was what I was stuck with. I wasn't going out into the dating world with "Hi, pleased to meet you and best you know I have Herpes…"

From hero to zero in no time at all. A man who'd not the decency to mention this before, say sorry now, or ever attempt to make amends. My insistence on tests before the intimacy of sex made it appropriate to mention the "blisters", even if it "went away" before he'd get overly concerned. I was living with a man who'd taken away my choice about my own state of health. His was the bed that I was made to lie in. What added to the irony was having no choice about something that was *preventable*.

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My good estimation of mankind and how we behave toward one another altered with him and Herpes. Many have said, what's the big deal, don't tell anyone. Expose someone I liked enough to sleep with to a risk that I don't even mention ?! Condoms protect one's partner, but in the dalliances prior to condomising fluids can be in contact with sensitive bits, so some discussion is relevant, condom or not. These repercussions later had my self-regard craving some form of restitution for the gross injustice he'd served me. I'd been robbed of choice. I'd been deceived, felt betrayed and my good opinion of mankind suffered. As restitution I wanted to show value for a lost part of me that had been important in my own estimation.

Working together made it extremely difficult to consider legal recourse. My spiritual (then) conclusion was that as punishment for my sins, I'd no choice but to stay with the man I could no longer trust or particularly like. It was the price to pay. I'd hurt an honourable man very badly when I left him for this one, so we deserved each other and our matching states of health made us suited. The perils of the female mind.

As Doc H said, I was lucky. The ulcer forms on the same out-of-the-way spot where the nerve endings are damaged. It's only the one place, and episodes aren't all that frequent. It took months to come to terms with what had happened, to not feel disgusted with myself. My self estimation was so low I stayed with the man I'd not long before have stayed away from. To him this was something to shrug off.

I do not think men and women view STDs in the same way. For one thing a School teacher friend mentioned the difference in impact an American's same sex talk had at a brother and sister school. The Girls' School had a "noticeable cooling of ardour", while it was business as usual with the boys. Also when I questioned how a man can have intermittent outbreaks of burning blisters over a five year period without seeking medical attention, I was told this phenomenon can be ascribed to a philosophy of ignorance is bliss. Good old denial. What's undiagnosed doesn't exist. His dick would have to turn green and ooze goo before some men will take their willies to the doctor.

What grieves me, and deeply so, is that it is PREVENTABLE. That were we simply to care enough for the wellbeing of our fellow man, we'd spare others infection. That were we to be informed and accountable, we could do something instead of accepting the fatalistic statistics this disease reflects. Why are wealthy, educated people prone to this. Surely only the poor are excused, (treatment's more than R300 a throw.) Their lack of education excuses them contracting what intelligent and informed minds surely revolt at. It's in human to thoughtlessly go about spreading what's *unnecessary*.

The boyfriend with herpes ruined my good estimation of mankind and the manners with which we treat one another. A well bred person's instincts surely say it's just not done. It makes sense that if it's incurable, it compromises the immune system. Other far reaching effects are with delivery in pregnancy. Again something men can shrug off. So what if some feminine yearning for natural birth must be set aside for the possible practicality of ceasarian if an episode's present, which is likely.

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I love the medical use of "episode" to describe a raging outbreak which is extremely "discomfiting". It reminds one that the saga continues, and the next episode awaits. I can't shrug it off though I've learnt to have compassion for a disease I'd previously judged most dreadfully. I grew. I'm not ashamed of having Herpes. I'd taken reasonable precautions and I'd not expected a man to be so without honour, let alone the one I was living with. He knew - my insistence on the tests was the crux.

My sex life since has been interesting. My confidence was so low it resumed only with a man who'd enough for two. He thanked me for telling me and said it was okay as he also had it. Which wasn't okay as he'd not been about to disclose his condition. A much younger man's ardour later fuelled the embers of carnal desires I'd obviated, but concern about fluids spoilt spontaneity. Another time being tipsy helped pluck up the nerve needed to say those three words "I have Herpes." His subsequent scorn reminded me how stern my judgements had been, though I'd hope to have shown more sensitivity and kindness. Now I don't bother much about base urges at all. I tell men straight that I have Herpes, that though I appreciate that it doesn't bother them, it bothers me. I do not want to do to another what has me loathing the person who did it to me.

That I can prevent. That I won't shrug off.

I care, I'm accountable, I'm single and I'm happy. It's a comfort to my esteem that this infection's not being spread to trusting souls by my doing. Even if I'm alone, I'm not the only one. Many get off on a sense of doing the right thing and it's only that we hear most of those who don't.. A man infected me and for a while I allowed that to infect my opinion of all men. I still have reservations about what's acceptable to men and that standard not necessarily being the same for women. Regaining my good estimation of mankind made life better. I believe better ways we behave toward one another await us, as mankind's constantly in the process of looking back on old ways and introducing new manners of behaviour, and never more so than in our age.

Thank you for being a reminder of how good people can be towards our fellows, even strangers. You exemplify the best of a noble profession.

I hope the above will be useful for your paper. Dr Kim Haybittle was the medical practitioner involved, and I've no objection to his disclosing my files if needed for your research.

With appreciation,
Carmen

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