The Sexual Response System

Grade 11 and 12, Lesson #17

Time Needed

One class period

Student Learning Objectives

To be able to...

1. Define the sexual response system and distinguish it from the reproductive system.
2. Describe the three phases of human sexual response.
3. Describe at least three of the five most common sexual concerns/dysfunctions.
4. List the four categories of causes of sexual concerns/ dysfunctions: misconceptions and myths, feelings and values, alcohol and other drugs, and medical factors. Give an example from each category.
5. Recognize that s/he is already capable of resolving some common sexual response concerns (e.g., by acting consistently with his/her own values, abstaining from alcohol and certain other drugs) and describe a situation where professional help may be needed.

Agenda

1. Discuss the lesson's purpose and relevance.
2. Define the sexual response system and distinguish it from the reproductive system, using Transparencies 1-2.
3. Use the Worksheet and Transparencies 3-5 to:
   - explain the system's healthy functioning (the three phases of human sexual response),
   - introduce the five most common sexual response concerns/ dysfunctions, and
   - introduce the four categories of causes for these concerns /dysfunctions.
4. Use the Scenario Cards and Reference Sheets in small groups so that students can practice applying these new concepts. Debrief with the whole class.
5. Discuss simple, "low-tech" ways that many sexual response concerns can be resolved by the individual or couple themselves and suggest how one might know when professional help is needed.
6. Hand out the Sexual Response Resource List and, if requested, the Reference Sheets.

Materials Needed

Student Materials (one per student):

Sexual Response System Worksheet
Sexuality and Sexual Response Resource List

Classroom Materials:

*Sexual Response System Transparencies 1-5 **

Class Set:

2 sets of *Scenario Cards 1-5* **
10 copies of *Response and Dysfunction Reference Sheets 1-4* ***

* Alternately, beginning in late 2006, all FLASH transparencies will be available as PowerPoint files on the FLASH web site: www.metrokc.gov/health/famplan/flash

** We suggest taping these "cards" to 5X8" index cards to make them more durable or copying them onto card stock.

*** These are primarily for small group use, but there may be a handful of students in each class who would like to keep a copy.

Rationale

One of the goals of the entire ***FLASH*** curriculum is to discourage premature sexual involvement.

> There are any number of good reasons for teens to wait: to reduce their risk of giving or getting STDs, including HIV; to reduce the risk of an unplanned pregnancy; to reduce the pressures that lead to sexual exploitation. There is one very valid reason to wait, that most curricula never address: some early sexual experiences are disappointing, hurtful or lonely and lead to later sexual dysfunction ... especially when they are clouded by ignorance, alcohol and other drugs, and lack of communication. This lesson is intended to help students recognize this potential consequence of their choices. It's hoped that it will encourage some to abstain from early sexual intercourse. It may help others avoid the kinds of early sexual experiences that could be most damaging to their long-term sexual health.

A second goal of the ***FLASH*** curriculum is to prepare students for life-long sexual health... and to increase the likelihood of their communicating well and experiencing satisfaction in marriage or other long-term adult relationships.

> Regardless of the age at which they decide to become sexually intimate, or their marital status at that time, many will at some point have sexual concerns. If education can, as some experts contend, resolve a full fifty percent of all sexual response concerns (before they become dysfunctions), we have an obligation as educators to provide that education. The lesson attempts to:

- convey the attitude that our sexuality (including the sexual response system) is a gift,
- provide a positive, uncomplicated knowledge base regarding the sexual response system,
- replace common myths and misconceptions with accurate information about male and female sexual response,
- reassure students of the wide range of "normal" sexual response,
- help students recognize, name and be able to discuss some of the most common sexual response concerns,
- make clear that sexual response problems may be caused by one or more factors, including:
  1. myths, misconceptions and miscommunication,
  2. feelings and values (sometimes in reaction to negative early sexual experiences),
  3. alcohol and other drug use, and
  4. medical factors,
- give learners the tools for simple self-help, and
- suggest how to know when professional help may be called for and where to go to access it.

Juniors and seniors in high school are, for the most part, developmentally ready for the challenge. They know that romantic relationships take effort and they want and need to begin to grapple with some of the difficult issues that couples face. Of course, each educator knows his or her students best. Their social and emotional maturity must be factored into the decision about whether to use a lesson on the sexual response system.

Activities

1. Provide a glimpse of the importance of the lesson:

   Today we are going to talk about sexual response. Sexual feelings. Sexual problems.

   Acknowledge that sexual response is a somewhat controversial issue:

   *Most people believe that, under the right circumstances, sex is supposed to be pleasurable ... physically, emotionally, and, some believe, spiritually. People disagree, as you know, about what those right circumstances are (marriage? emotional maturity? love? etc.) Some people, however, believe sex is **not** meant for enjoyment, at least not physical enjoyment, **regardless** of the circumstances. They believe it should be only for reproduction, or perhaps for emotional and spiritual intimacy, but not for physical pleasure. This lesson is not intended to debate the issue. Both groups of people are absolutely entitled to their opinions. What this lesson **does** intend is to provide you with accurate facts about:*

   - *what the sexual response system is and how it functions,*
   - *some common sexual problems and their causes,*
   - *possible simple solutions for some of those problems,*
   - *and when and where people might want to seek expert help.*

   Why are we studying this?

   - *because there are all sorts of myths and misconceptions about the sexual response system, and*
   - *because most of us in this room some day will have questions or concerns about our sexual response, and possibly dysfunctions, and*
   - *because, in about half of all situations, education alone solves the sexual response concern, and*
   - *because ignorance can lead to embarrassment, so that some people can't even talk about these concerns with a doctor or other health care provider, and*
   - *so that you can act as sources of accurate information for your family and friends.*

2. Define the sexual response system and distinguish it from the reproductive system, using Transparencies 1 and 2.

   ***The sexual response system** is the set of body organs and structures (internal and external), which have to do with sexual feelings (desire, sensation, arousal, physical pleasure, orgasm). It includes parts of.*

   - *the reproductive system (e.g., genitals, lubricating glands),*
   - *the nervous system (e.g., the brain, nerves, skin)*
   - *the circulatory system (e.g., heart, blood vessels, etc.)*
   - *the musculo-skeletal system (all the muscles of the body especially, but not only, those of the pelvic area)*

*This differs from the reproductive system, although there is overlap. **The reproductive system** is the set of body organs and structures which have to do with creating babies. It doesn't technically include parts such as the clitoris (whose only function is sexual response), the breasts or other non-genital erogenous zones. It does include parts that are only peripheral to (rather than essential components of) sexual response, such as the seminal vesicles and the fallopian tubes.*

3. Hand out the Sexual Response System Worksheet. Use Transparencies 3-5 and the lecture notes below, to help students fill in the Worksheet, as a large group exercise. Point out that there is space on the Worksheet for them to jot notes as you lecture, rather than just filling in the blanks.

TRANSPARENCY 3: Human Sexual Response
Teacher's notes:

Phase I: Desire

*The first phase in sexual response is **desire** (sometimes called **libido**.) Desire is more a matter of "**interest**" — like one's interest in music or sports — than of "**drive**" — like one's need for food or water.*

It is more an interest (a want) than a drive (a need) in a number of ways. First, we all experience it differently. Just as some people are more interested in music than others ... some are more interested in sexual fantasy and behavior than others. And just as a person's interest in sports may be higher for a few months or years, and then lower, and then higher again ... so may a person's sexual desire rise and fall at various times in his or her life. It is also not a need, exactly, in the sense that people can survive who have no sexual desire at all, whereas a person who never experiences hunger or thirst will probably die.

Emphasize that it is also very possible to experience desire and not act on the feelings, to simply enjoy the feelings.

Phase II: Arousal

*Sometimes though, people do go on. The second phase is **arousal**. If the person lets him or herself fantasize or begin sexual touch (alone or with someone else), desire becomes arousal. A number of changes begin to occur in the body.*

1. *The change people most notice is that blood gathers in the genital area.*

    - *In women, the extra blood fills spongy tissue in the clitoris, causing it to swell and become erect. And the blood puts pressure on the walls of the vagina, squeezing a clear fluid through, making the vagina much wetter.*
    - *In men, this extra blood fills spongy tissue in the penis, causing it to get larger and harder and stand out from the body (this is, of course, an "erection"). The blood also puts pressure on the Cowper's glands, causing some clear, slippery fluid to be released.*

2. *Also during this phase, in both sexes:*

   - *the muscles (especially in the pelvic area) tighten,*
   - *the nipples may become erect,*
   - *the areola (the dark area around the nipples) may become darker and larger, and*
   - *the pulse rate and blood pressure increase.*

3. *Some people's skin gets flushed, sort of like a rash.*

4. *In women:*

   - *the labia minora also swell and darken,*
   - *the uterus enlarges and is pulled up in the lower abdomen,*
   - *the vagina lengthens and widens, and*
   - *the clitoris eventually withdraws under its hood.*

   Point out that, just as its possible to have desire and not move to arousal, it is also possible to have arousal and not do anything with it ... except to enjoy the feelings.

Phase III: Release

*Whether or not people go on fantasizing or touching, they will reach the last phase of sexual response: release. "**Release**" can be rather fast or more gradual.*

*When it is fast, it begins with "**orgasm**" ... a three- to ten-second series of muscle contractions, triggered by the brain. When a woman has an orgasm, her uterus and the outer third of her vagina contract. When a man has an orgasm, the muscles in his abdomen and penis contract ... often forcing out semen. This is called "**ejaculating**" Usually, a man ejaculates when he has an orgasm, but not always.*

Then, with or without orgasm, the body returns to its resting state. This happens more quickly (within minutes or hours) if a person has had an orgasm. People often describe their feelings during this time as ones of peace and well-being. If a couple has been making love, this period of gradual return-to-normal can be a very close, important time for them. Without an orgasm, this return-to-normal stage takes hours or, in some cases, a couple of days.

In human beings, this 3-stage sexual response cycle is controlled partly by the body (hormones, nervous system, etc.) and, to a very great extent, by the mind (feelings, beliefs). So sexual problems are sometimes physical and sometimes emotional ... and sometimes both.

Ask the class: *How long do these three phases last?*

Our answer: It's extremely variable. When someone is infatuated, sometimes desire is a 24-hour a day state of being. At other times in your life, it may come and go or be absent all together for weeks or months at a time. Similarly, arousal may last for a moment or for hours. Release may happen within seconds, if a person has an orgasm, or take days, if not.

TRANSPARENCY 4: Common Concerns/Dysfunctions
Teacher's notes:

*For each problem, let me define it and explain how it might be caused by a simple misunderstanding about a perfectly normal process. I need to make clear, up front, though, that for each dysfunction, there **may** be causes that take more than accurate information to resolve.*

a. LACK OF (or inhibited) DESIRE

*In many cases, the problem is not that one person is not at **all** interested. It is that the two people have different **levels** of desire. So the "problem" can be simply that the couple thinks one of the two is normal ... with the implication that the other is **ab**normal. In a heterosexual couple, if the man has the lower libido (that is, if he is less interested in sex than his partner) both people may be afraid there's something wrong with them ... based on the myth that men always want sex and women rarely do. However, there certainly **are** other situations where the problem is more complicated than this.*

b. TROUBLE GETTING (or keeping) AN ERECTION

*Over half of men have problems with erection on occasion. It is only a problem if it worries the individual, or if it lasts for a long time (months). There is often a simple cause or a temporary lack of erection. Alcohol is probably the most common cause. A couple of beers, for instance, might prevent a man's body from responding. However, his **concern** can turn a temporary ebbing into a longer term issue. The problem may he perpetuated, simply because he is so worried about it. Again, of course, there **may** be more complex issues involved.*

c. RAPID EJACULATION

*This is sometimes called "premature ejaculation" but the term implies that there is a specific length of time a sexual experience should last, prior to ejaculation. That's not true. The problem is not how long an erection lasts, per se, but rather that the man, or the couple, **wants** to delay his release and he isn't able to. People sometimes reach orgasm more quickly than they or their partners would like. There can be a variety of reasons for this. If it is an ongoing problem for a person/couple, professional intervention is often able to resolve it. This and erection concerns are the two most common problems men bring to physicians and sex therapists.*

d. LACK OF (or delayed) ORGASM OR EJACULATION

*Sometimes it simply takes **longer** for a person to reach orgasm, than he or she thinks it "should" ... longer than it seems to in books or during masturbation. Each person has a different sense of timing. Some men and women have orgasms very quickly (i.e., 1-5 minutes) and others take longer (i.e., 60 minutes or more). All is within the range of normal.*

Sometimes the problem is that people just don't communicate with their partners about their sexual wants and needs. As they mature and learn more about their bodies, talking about sexual feelings and behavior with a partner may become more comfortable.

Then again, some people just don't have orgasms every time they have sex. Sex can be enjoyable, for a man or a woman, without an orgasm. And, in a woman, the problem may not even be that she's not having orgasms. She may be having them and not recognizing them ... if she has mythical expectations (rockets exploding and earth shaking, as may have been "observed" in erotic films or described by friends).

So, delayed orgasm, or none at all, is often a problem that can be "solved" by learning more about the body. However for some people, male and female, it is an ongoing problem, caused by more than lack of information. In women, this and inhibited desire are probably the two most common concerns reported to specialists.

e. PAIN WITH SEXUAL INTERCOURSE

*In women, the most common reason for discomfort or pain with intercourse is dryness (lack of natural lubrication in the vagina). Why might there be too little moisture? Perhaps the most common issue is **hurrying**. A woman's partner may become aroused more quickly than she does. It takes each person a different amount of time and a different amount, or type, of stimulation. The body cannot be rushed. Again, learning about the body, replacing myths with knowledge, can solve the problem, if this is the cause. There may, of course, be other causes of dryness, besides hurrying. The rectum has less natural moisture, for instance, so that dryness with anal sex is not a matter of hurrying.*

Another reason for a little pain, the first time a woman has vaginal penetration, could be the presence of an unstretched hymen. Some women have very little, if any, hymen at the opening to the vagina ... they were born with very little extra skin here, or have long since stretched it out of the way through sports, tampon use, or masturbation. But if there is still any unstretched tissue, there may be some discomfort with first intercourse.

*Sometimes, men **and** women can experience pain for reasons other than dryness or an unstretched hymen. We will address these reasons in a few minutes.*

TRANSPARENCY 5: Causes of Concerns/Dysfunctions
Teacher's notes:

1. ***MYTHS**, and **MISUNDERSTANDINGS** about bodies, along with confusion and communication problems ... all these can cause dissatisfaction with one's sexual response system. In fact, ignorance and miscommunication are the most common factors "to blame".*

   Have the class think of a couple of examples of myths and misunderstandings that might affect sexual response. For example: "Men want sex most of the time. Women don't want it as much." Ask the class how believing this myth might affect a person's sexual response.

2. ***FEELINGS** and **VALUES** influence our sexual response.*

   Again, the class may be able to suggest examples. Use Reference Sheet 2 for an idea or

two if the students draw a blank.

3. ***ALCOHOL*** *and some other* ***DRUGS*** *may also affect the sexual response system.*

   Again, elicit an example or two from the class. You can refer to Reference Sheet 3, if necessary.

4. *Finally,* ***MEDICAL FACTORS*** *sometimes cause dysfunctions.*

   Elicit examples and refer, as needed, to Reference Sheet 4.

4. Use the "Scenario Exercise" to give students an opportunity to apply their understanding of the concerns/dysfunctions and their causes. Divide the class in ten groups with two or three students per group. Their job is to complete the last section of their Worksheets cooperatively in these small groups. Provide each small group with one set of all four Reference Sheets and with one Scenario Card. There will be two groups working with each of the five scenarios. Allow five or six minutes for their small group work and ten to fifteen minutes for very brief verbal reports back to the large group.

5. Especially if you don't have enough time for the "Scenario Exercise", do take five minutes for a brainstorm of self-help solutions:

   If a person or couple is experiencing a sexual response problem, they ***may*** *be able to resolve it themselves, without professional help ... depending on its cause. What kinds of things might the person or couple try?*

   Answers might include:

   - A person could try eliminating all **illegal and over-the-counter drug use**, including use of alcohol.
   - He or she (or they) could think about possible **value conflicts**. Do they both truly feel the behavior is right? Even some married people have been so conditioned to believe that sex is dirty, that they truly can't let themselves want it.
   - A couple could talk over **feelings and stresses** they are experiencing, as individuals and as a couple ... talk with each other, if they can ... or with someone else, if they can't. And focus on the playful, affectionate aspects of the relationship, instead of "performance".
   - They might want to **read about, and try, specific exercises** for learning to delay ejaculation or for learning to have orgasms (both of which can be "learned").
   - A person should remember that it's OK (healthy, normal, to be expected) **not to be attracted to everyone** ... even people who others find attractive.
   - A couple should remember that it's OK (healthy, normal, to be expected) to have **differing levels of desire** from one another ... and from last week or last year. Try negotiating, with patience and respect for one another's feelings.
   - Making a "date" with each other for sex can sometimes help **rekindle desire** … even after many years together, anticipation may be just what's missing.

- A person needs to realize that he or she is no less a "**real man**" or a "**real woman**" no matter what his or her level of desire.
- Both people have to understand that **very many men** experience occasional inability to get or maintain an erection.
- As a man ages, it helps to remember that the **speed and firmness** of erections may decline naturally in middle and elder adulthood ... and that speed isn't the goal.
- He should also remember that it's normal for most men to be **unable to get an erection for some time after ejaculating** and that the duration of that "refractory period" increases with age.
- Both people have to understand that **penis size (and breast size, for that matter)** varies considerably, and that it's almost never related to either person's enjoyment.
- If a man is having trouble ejaculating sooner than he wishes, using a **condom** may help. And it may help to **keep making love**; after a premature ejaculation, his next erection may last longer.
- If dryness is causing pain with intercourse, **slowing down** may give a woman's body more time to lubricate. If slowing down and focusing on foreplay doesn't solve the problem, using water-based or silicone-based **lubricants** from a store is perfectly safe.
- A couple should keep in mind that **lovemaking is more** than sexual intercourse. Sensual massage – without the expectation that intercourse will follow -- can sometimes resolve desire and orgasm problems.
- It helps if they remember that it is OK (normal, healthy) **not to have an orgasm** every time one has sex. Sex is a shared experience, a way of being together, not a sport with a goal.

Discuss, also, how a person or couple might know "when it's time to see an expert". Again, elicit students' input.

Our suggestions are:

- If they've tried the above ideas with no success or have run out of ideas (not getting professional help at that point can "lock in" a problem with a sense of hopelessness and ill-will),
- If they are using any prescription medications (It is important to go back to the prescribing clinician – or better yet, to a pharmacist -- and discuss the possibility of its effecting sexual functioning. Perhaps the clinician can lower the dosage or change to a different drug. **But the patient should never just stop taking a medicine, or change dosages without the clinician's knowledge!**),
- If only one of the partners is willing to work on a shared problem, or if they can't figure out how to talk with one another without outside help.
- If they think the problem might stem from negative sexual experiences, especially exploitive ones such as child sexual abuse and rape. Healing and full recovery are very possible, but often not without professional help.

- If they already know of an illness, injury or congenital disorder that might be causing the problem.
- If they think the problem may stem from deeply-held attitudes and they think that only therapy will help.

6. Hand out the ***Sexuality and Sexual Response Resource List***. Have students take it home for future reference; it need not be discussed in class. There may also be some students who would like personal copies of the ***Reference Sheets*** to take home.

Sexual Response System Transparency 1:

Sexual Response System

The set of organs and structures which have to do with sexual feelings.

It includes parts of other systems:

the Reproductive System,
the Nervous System,
the Circulatory System and
the Musculo-skeletal System.

Sexual Response System Transparency 2:

Reproductive System

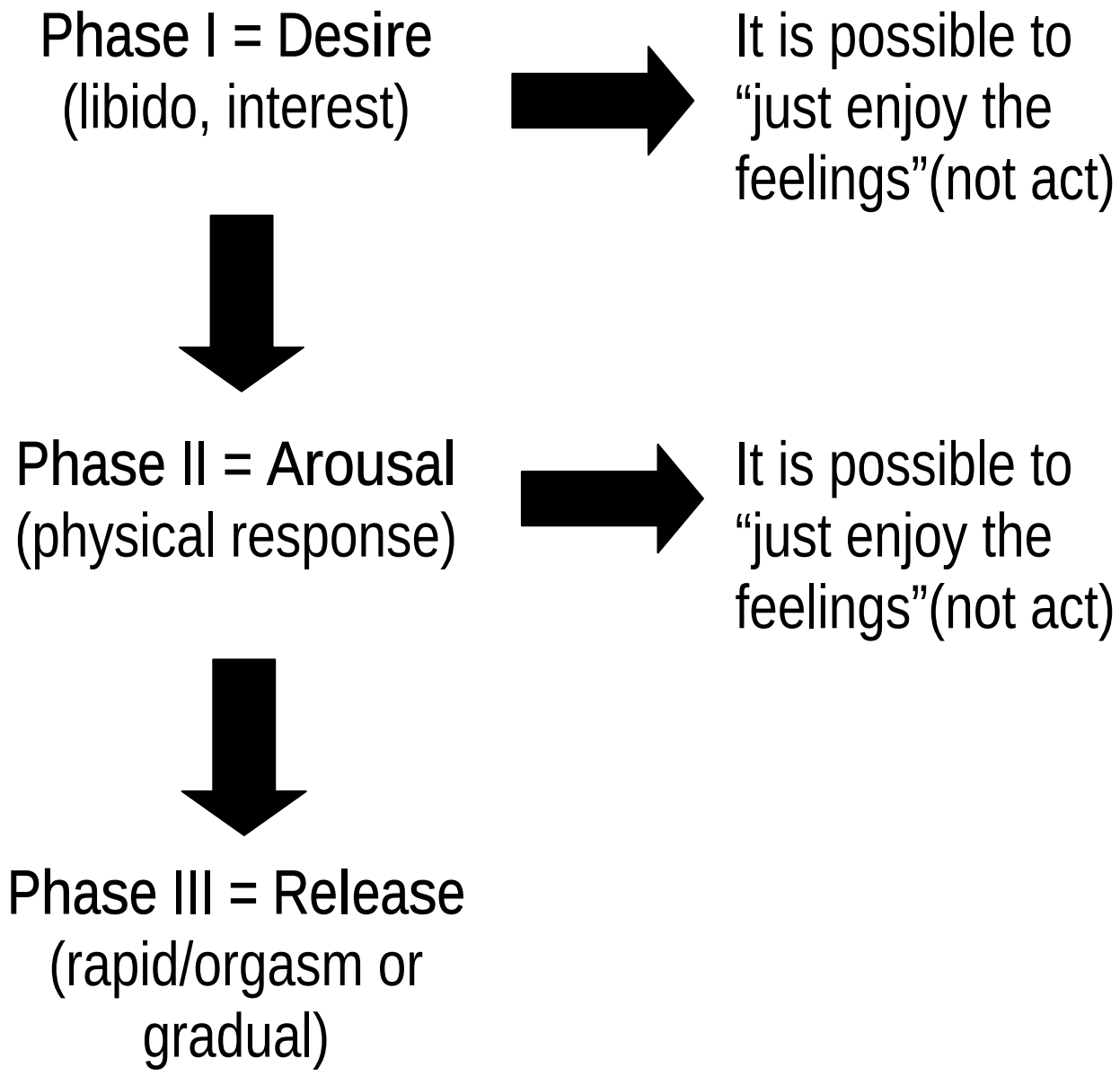
The set of organs and structures which have to do with creating babies.

It includes parts of other systems:

the Endocrine System,
the Musculo-skeletal System, and
in males, the Urinary System.

Sexual Response System Transparency 3:

Human Sexual Response



Sexual Response System Transparency 4:

Common Concerns/Dysfunctions

a. lack of (or inhibited) desire

b. trouble getting (or keeping) an erection

c. rapid ejaculation

d. lack of (or delayed) orgasm or ejaculation

e. pain with sexual intercourse

Sexual Response System Transparency 5:

Causes of Concerns/Dysfunctions

1. Myths and misconceptions
   "*Am I 'normal'?*"
   "Are we doing this 'right'?"

2. Feelings and values
   'I'm too angry [scared, tired, etc.]."
   "This goes against my beliefs."

3. Alcohol and other drugs
   "I only had a couple of beers!"
   "Could this medicine be affecting my sexual feelings?"

4. Medical factors
   "Why didn't anyone tell me this disease could affect my sex life!?"
   "This operation seems to have changed my sexual response."

Sexual Response System Worksheet

NAME _____DATE _____PERIOD _____

Sexual Response System: the set of organs and structures which have to do with sexual feelings…

At what ages is the reproductive system able to function?

_____

At what ages is the sexual response system able to function?

_____

Human Sexual Response: When it is healthy and functioning as it should, it consists of three phases…

Phase I = _____

Phase II = _____

Phase III = _____

It is possible to 'just enjoy the feelings" of desire or arousal, without having to act on them. True or false? _____

Common Concerns/Dysfunctions: At some time in their lives, many people have concerns about their sexual response. If these concerns become long-term problems that begin to interfere with a person's life, they may be called "dysfunctions". The most common concerns people talk with experts about are these:

a. _____

b. _____

c. _____

d. _____

e. _____

NOTE: Throughout this lesson, the word "intercourse" has been used to mean all forms of intercourse: oral, anal and vaginal, except where specified.

Causes of Concerns/Dysfunctions: In about half of all sexual concerns, education solves the problem. Why? Because the most common **cause** of sexual response problems is

1. _____

Other common causes of sexual response problems include…

2. _____
3. _____
4. _____

Scenario Exercise ____:

1. What is this person's or couples concern or dysfunction?
   _____ lack of desire
   _____ trouble getting or keeping an erection
   _____ rapid ejaculation
   _____ lack of or delayed orgasm or ejaculation
   _____ pain with intercourse

USE A SEPARATE SHEET OF PAPER TO ANSWER THESE LAST 3 QUESTIONS:

2. What myths or misconceptions might be causing this person's or couple's problem?

3. What else, besides myths and misconceptions, could be causing the problem? (Be specific.)

4. If you were a health care worker, or clergy person (but not a specialist), and this person or couple asked your advice, what would you suggest? Give at least 3 practical ideas of things for them to understand, think about, or try. If those ideas don't help, you can always send them to an expert.

Sexuality and Sexual Response Resource List

GENERAL BOOKS:

Contraceptive Technology, 18th edition: Hatcher, RA; et al.; Contraceptive Technology, Ardent Media, Inc., NY (2004)

Dr. Michael Carrera's Sexual Health for Men: Your A to Z Guide and *Dr. Michael Carrera's Sexual Health for Women: Your A to Z Guide*, Michael Carrera, Michael Friedman Publishing Group, New York, NY (1990)

For Women Only: A Revolutionary Guide to Overcoming Sexual Dysfunction and Reclaiming Your Sex Life, Berman, J; Berman, L; Henry Holt & Co., NY (2001)

The New Ourselves, Growing Older, Doress-Worters, PB; Siegal, DL; Simon & Schuster, NY (1994)

Our Bodies, Ourselves: New Edition for a New Era, Boston Women's Health Book Collective; Simon & Schuster, NY (2004)

Our Sexuality, 7th edition, Robert Crooks and Karla Bauer, Benjamin/Cummings Publishing, Redwood City, CA (revised 1999) -- an excellent college-level text

GENERAL WEB SITES, AGENCIES:

SEX, ETC., a web site by teens, for teens, from Answer at Rutgers University: http://www.sexetc.org/

The Facts of Life Line: (206) 328-7711 (Seattle area) Open 3-6 p.m., Monday through Thursday. They can answer questions and discuss your concerns ... from, "Should I see a health care provider about this problem?" or "Could this have anything to do with the medicine I take for my heart disease?" to "How can I talk to my partner (doctor, family, etc.) about this?" They can also recommend books on sexual health for people with specific concerns, religious faiths or disabilities.

The Sex Information and Education Council of the United States:
http://www.siecus.org

ON DISABILITIES AND SEXUALITY:

There are books and articles written specifically about sexuality for people with ostomies, hearing impairments, developmental disabilities, visual impairments, cerebral palsy, etc.

Annotated Bibliography: Sexuality and Disability, from SIECUS, the Sexuality Information and Education Council of the United States (2001):
http://www.siecus.org/pubs/biblio/bibs0009.html

Disability and Illness pages, The Sexual Health Network:
http://www.sexualhealth.com/channel/view/disability-illness/

Sexuality & Disability Webliography, Janet Freeman, Wellness & Disability Initiative/AIDS & Disability Action Program, BC Coalition of People with Disabilities (2002):
http://www.bccpd.bc.ca/i/pdf/WDI/Sex_DisabilityWebliog.pdf

ON HEALING FROM SEXUAL EXPLOITATION:

Breaking Free: A Self-Help Guide for Adults Who Were Sexually Abused As Children, Carolyn Ainscough and Kay Toon (1993): Fisher Books, 800/225-1514,
http//www.fisherbooks.com

The Sexual Healing Journey, Wendy Maltz (1992): HarperCollins, 800/242-7737,
http://www.harpercollins.com

ON ALCOHOL AND OTHER ADDICTIONS, RECOVERY, AND SEXUALITY:

"Intimacy" (each pamphlet costs $ 1-3), Hazelden Publishers, 1-800-328-9000, www.hazeldenbookplace.org

OTHE RESOURCES:

- your public library
- a college or university library
- a college or university bookstore
- your local medical society and/or psychological association
- your local family planning agency

SCENARIO CARD 1

A: ***"We used to have sex all the time. Now it's always like, 'Not tonight, dear. I have a headache.' What happened? Is it me?"***

B: ***"No. It's not you. I just can't ... it isn't working. I want to, but I get so embarrassed because ... I haven't been able to get an erection."***

1: What is this person's or couple's concern or dysfunction?

2: What myths or misconceptions might be causing this person's or couple's problem ... or contributing to it?

3: What else, besides myths and misconceptions, could be causing or contributing to the problem?

4: If you were a health care worker or clergy person (but not a specialist) and this person or couple asked your advice, what would you suggest? Give at least 3 practical ideas of things for them to understand, think about or try. If those ideas don't help, you can always send them to an expert.

SCENARIO CARD 2

A: "I don't feel excited about sex any more. I don't hate it. It just doesn't do much for me. I feel bad for you, but I don't want to pretend I feel something I don't."

B: "Maybe you just don't love me anymore."

A: "I do love you; it's not that. And I want to want it. I don't know what to do."

1: What is this person's or couple's concern or dysfunction?

2: What myths or misconceptions might be causing this person's or couple's problem ... or contributing to it?

3: What else, besides myths and misconceptions, could be causing or contributing to the problem?

4: If you were a health care worker or clergy person (but not a specialist) and this person or couple asked your advice, what would you suggest? Give at least 3 practical ideas of things for them to understand, think about or try. If those ideas don't help, you can always send them to an expert.

SCENARIO CARD 3

A: ***"I 'come' so fast. I'm sorry. I know that you're just getting into it, when it's over. I can't help it."***

B: ***"Maybe it's me. It takes me forever. Maybe there's something wrong with me."***

1: What is this person's or couple's concern or dysfunction?
2: What myths or misconceptions might be causing this person's or couple's problem ... or contributing to it?
3: What else, besides myths and misconceptions, could be causing or contributing to the problem?
4: If you were a health care worker or clergy person (but not a specialist) and this person or couple asked your advice, what would you suggest? Give at least 3 practical ideas of things for them to understand, think about or try. If those ideas don't help, you can always send them to an expert.

SCENARIO CARD 4

A: ***"Was it as wonderful for you as it was for me?"***

B: ***"Oh ... I can't lie to you. It was good, but I didn't have an orgasm. I don't think I ever do."***

1: What is this person's or couple's concern or dysfunction?
2: What myths or misconceptions might be causing this person's or couple's problem ... or contributing to it?
3: What else, besides myths and misconceptions, could be causing or contributing to the problem?
4: If you were a health care worker or clergy person (but not a specialist) and this person or couple asked your advice, what would you suggest? Give at least 3 practical ideas of things for them to understand, think about or try. If those ideas don't help, you can always send them to an expert.

SCENARIO CARD 5

A: "It hurts. I just can't have sex now, OK?"

B: "OK, but what's wrong? Is it something I'm doing?"

A: "I don't know"

1: What is this person's or couple's concern or dysfunction?
2: What myths or misconceptions might be causing this person's or couple's problem ... or contributing to it?
3: What else, besides myths and misconceptions, could be causing or contributing to the problem?
4: If you were a health care worker or clergy person (but not a specialist) and this person or couple asked your advice, what would you suggest? Give at least 3 practical ideas of things for them to understand, think about or try. If those ideas don't help you can always send them to an expert.

Response and Dysfunction Reference Sheet 1:

MYTHS AND MISCONCEPTIONS
which can affect the functioning of the sexual response system

MYTH 1: *"Men want sex most of the time. Women don't want it as much."*

☛ **FACT:** That's an overgeneralization. Each person is unique. Some have higher levels of desire than others, but it has nothing to do with being a "real" man or a "real" woman. Of course, desire is influenced by what we've been taught and some guys have been taught to expect to have a high level of desire. But that can just feel like one more pressure sometimes.

MYTH 2: *"Sex is better when both people have an orgasm ... and both at the same time."*

☛ **FACT:** Each couple is different. But sex is better, for most couples, when they don't have such high expectations of themselves, and of each other ... when they just relax. It is not a sport with a goal. It is a way of enjoying being together.

MYTH 3: *"The genitals are the most important sex organs."*

☛ **FACT:** The most crucial sex organs are the skin and the brain. Sadly, many people learn (from friends, from pornography, from pop culture) that only their genitals matter. They may find sex disappointing and frustrating. Some couples have to sort of "relearn" the value of massage and other ways of touching.

MYTH 4: *"Sex is better for men with larger penises and for their partners."*

☛ **FACT:** The size of the penis rarely has any relationship to either person's "performance" or enjoyment. But if a man believes the myth that penis-size matters, his worrying can **lead** to sexual problems. This is similar to the myth that the size of a woman's breasts has something to do with her level of desire. That's just not true, either.

MYTH 5: *"Most men lose the ability to have an erection as they age."*

☛ **FACT:** It may take them longer to get an erection than when they were younger. And they may need different kinds of stimulation (just a fantasy may no longer cause an erection, for instance). Some men have less firmness with age. But most men and women are able to have and enjoy sexual relationships for their entire lives.

MYTH 6: *"If you have a little experience, you can tell what the other person wants, without their having to tell you".*

FACT: Nobody is a mind-reader. And experience with other people (or with fictional characters in movies or books), doesn't tell you what this person likes or feels OK about, Only he or she knows what he or she prefers (gentler, less gentle, faster, higher, etc.) and this will vary with time and circumstances. It's important for each person in a couple to speak up about his or her feelings, and what he or she likes and dislikes.

MYTH 7: *"Most people can have another orgasm again right away after the first one."*

FACT: That's an overgeneralization. Many women can become aroused again fairly quickly and have a second orgasm. Most men cannot reach orgasm again right after ejaculating. This recovery time is called the "refractory period' and its duration increases with age. It is something to expect and not something to worry about.

MYTH 8: *"There is probably a medical cause if a man cannot get an erection."*

FACT: At least half of all men are sometimes unable to get an erection. Often it is a simple matter of being under stress or having had a couple of beers. Worrying a lot about it can make it happen again, because the brain is such an important part of sexual response. About half of all **long-term** erection problems are caused by something physical (alcohol or other drugs or medical factors) and about half are caused by psychological factors (myths, feelings).

MYTH 9: *"Women do not enjoy sex after a certain age."*

FACT: Unlike the reproductive system, the sexual response system can function all your life. Women do often have less vaginal lubrication after menopause, as their estrogen level declines, which can cause discomfort. They may find they need an extra lubricant, such as K-Y Jelly, Astroglide, Replens, or Slippery Stuff (which most drug stores carry next to the contraceptives). But most women continue to experience sexual desire and arousal as they age.

MYTH 10: *"Most women have orgasms with vaginal intercourse."*

FACT: Each person's body is unique, but many women need more direct stimulation of the clitoris. Some can only have orgasms with manual or oral stimulation. Others prefer indirect stimulation, and often do climax with vaginal intercourse.

Response and Dysfunction Reference Sheet 2:

FEELINGS AND VALUES

which can affect the functioning of the sexual response system

Note two important facts:

1. Each life experience affects each person differently.
2. This list is not meant to be complete. These are a few examples of how feelings and values may influence sexual response.

FATIGUE can cause desire, erection, and orgasm problems. During pregnancy, for instance, some women are simply too tired to feel desire. After the birth, both people's fatigue may cause response problems.

FEAR can cause a man to ejaculate more quickly than usual, or, in either gender,
can block orgasm altogether. It could be fear of being "walked in on", fear of pregnancy or a disease, or fear of sexual touch per se.

GUILT can impair desire, erection, or orgasm. It means the individual is doing something he or she really believes is wrong, something that conflicts with his or her sexual value system.

SIMPLY NOT FEELING INTERESTED can cause desire and arousal "problems", and can, in turn cause pain with intercourse (because of dryness). The person may not be interested in sex at all, or in this particular person, or people of this particular gender. He or she may just not be interested at this time, or because he or she is feeling pushed or forced into it.

STRESS in the relationship or elsewhere (job change, illness, death of a loved one), can cause desire, erection or orgasm problems. Extreme stress can also cause pain with intercourse.

ANGER at a partner which is not being expressed or heard, can also interfere with desire, erection or orgasm.

DISLIKE OR DISREGARD for one's partner can cause a man to ejaculate quickly or a woman not to lubricate (making intercourse painful for both partners). For instance, a man who considers his own gratification more important than his partner's, could ejaculate quickly. A woman's anger might prevent her from lubricating if she were committing a rape or being raped.

BOREDOM with the sexual relationship can cause inhibited desire, especially when all sense of playfulness and affection has declined (or wasn't present to begin with).

Finally, note that **NEGATIVE PRIOR SEXUAL EXPERIENCES** (especially if they were one's earliest sexual encounters), could lead to any of the feelings listed above. Harmful sexual experiences can include ones that are:

- dehumanizing ... such as with a stranger;
- hurtful, humiliating or fear-inducing ... such as molestation, incest or rape;
- or "just" disappointing or lonely ... such as with someone one isn't especially close to.

These kinds of experiences can associate sex, in the person's mind, with the feelings it once engendered. They can lead to dysfunctions in any of the three phases of sexual response.

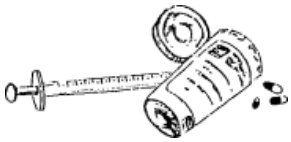
That doesn't mean such experiences can't be overcome. People can recover. It may take time and patience ... and, for many people, professional help.

Response and Dysfunction Reference Sheet 3:

EXAMPLES OF ALCOHOL AND OTHER DRUGS
which can affect the functioning of the sexual response system

Note two important facts:

1. Each drug affects each person differently. The same drug may cause a sexual response problem in one person and not in another. If you have concerns about a prescription drug, consult your health care provider. A pharmacist may be able to answer questions about prescription and over-the-counter drugs, as well as herbal remedies and supplements.
2. This list is not meant to be complete. These are a few examples.

DRUG / SUBSTANCE  **POSSIBLE EFFECTS ***

ALCOHOL.....EC, OC, LD

Moderate, recent use may decrease inhibitions, so that it appears to increase desire. However, even one or two beers can impair erection and lubrication and interfere with orgasm. Alcohol, even in small amounts, like many other drugs, reduces judgment. So, besides affecting sexual response, it can lead to sexual risk-taking and/or exploitation.

Prolonged use decreases testosterone in men. In both sexes it can lead to depression, chronic active hepatitis, and cirrhosis ... any of which, in turn, can impair all three phases of response. Besides affecting sexual response, it can cause infertility.

ANABOLIC STEROIDS, withdrawal from .....LD

During use, steroids may artificially enhance desire. Therefore during **withdrawal**, the user may notice a sudden loss of desire. Also, if the person has convinced him or herself that enjoyment or performance was only possible because of the drug's use, then giving it up may cause dysfunction.

AMPHETAMINES ** .....EC, OC

ANTI-ANXIETY DRUGS ** .....LD, OC, EC

ANTI-CHOLINERGICS (ulcer medicines) ** .....LD, EC

ANTI-CONVULSANTS ** .....LD, EC, OC

DRUG / SUBSTANCE — **POSSIBLE EFFECTS ***

ANTI-DEPRESSANTS & ANTI-PSYCHOTICS **.....EC, LD, OC, PI

ANTI-HYPERTENSIVE MEDICATIONS **.....EC, LD

ANTIHISTAMINES (many allergy medicines) **.....LD

APPETITE SUPPRESANTS **.....LD

BARBITURATES **.....LD

COCAINE, chronic use and withdrawal.....LD

Many early users report enhanced desire and orgasm. "In reality, nothing changes, but to their brains, the feelings seem real." *** Hence, most experience **withdrawal**-associated dysfunction (see anabolic steroids, above).

Chronic long-term use of cocaine in any of its forms can also inhibit desire.

MARIJUANA, chronic use and withdrawal.....LD, EC

Short-term users report differing effects on sexual response, from enhancement to impairment. It does contain the carcinogen benzopyrine, which can cause depression in **chronic users** ... and depression, in turn, can impair all three phases of sexual response. It can also affect levels of testosterone and estrogen, and may affect fertility in both sexes.

NARCOTICS **.....LD, EC, OC

Methadone, morphine, codeine and heroin, for instance, sometimes cause impairment in all three phases of sexual response.

HORMONAL CONTRACEPTIVES (birth control pills, patch, ring, etc.) **...LD, EC, PI

TOBACCO, chronic use.....EC, PI

Occasionally, the vasoconstrictive — vessel constricting — effect of nicotine can be sufficient in **chronic smokers and people who chew**, to lead to erection problems or vaginal dryness. Also, smoking leaves scratchy plaque deposits on blood vessels, which can cause erection problems.

* The letters indicate which effect(s) might be caused by a particular drug:
LD = Lack of Desire (not feeling aroused – turned on)
EC = Erection Concerns (trouble getting or maintaining one)
RE = Rapid Ejaculation (faster than desired)
OC = Orgasm or ejaculation Concerns (delayed or none)
PI = Pain with Intercourse (oral, anal, and/or vaginal)

** Some, not necessarily all, drugs in this category may cause sexual dysfunctions.
***Carrera/Spain Adolescent Sexuality Report, (1:2, p.2) March-April 1988

Response and Dysfunction Reference Sheet 4:

EXAMPLES OF MEDICAL FACTORS
which can affect the functioning of the sexual response system

Note two important facts:

1. Each medical problem, affects each person differently. Some medical problems may cause a sexual dysfunction in one person and not in another. Many people with chronic diseases and disabilities have full sexual function.
2. This list is not meant to be complete. These are a few examples. There are many other medical problems that can affect sexual response. A patient should discuss any concerns with his or her health care provider.

MEDICAL FACTOR **POSSIBLE EFFECTS ***

ALLERGIES ..... PI

A person, male or female, might be allergic to a particular brand of spermicide (birth control cream, jelly, foam, sponge, or lubricated condom). Or someone might be allergic to latex (as in the condom, diaphragm, dental dam, or cervical cap, itself). He or she may be allergic to a particular brand of soap or to vaginal deodorants (as in sprays, douches, and some tampons).

ARTHRITIS ..... PI

CEREBRAL PALSY ..... PI

CIRRHOSIS ..... LD

CUSHING'S SYNDROME ..... LD

CURVATURE OF THE PENIS, severe ..... PI

Mild curvature is not at all unusual, and is generally not painful; severe curvature is less common. It may have been caused by an injury to the ligaments or muscles on one side of the penis. It may be caused by Peyronie's Disease.

CYSTS OR TUMORS OF THE OVARY ..... PI

DEPRESSION ..... LD

DIABETES ..... LD, EC, OC, PI

MEDICAL FACTOR	**POSSIBLE EFFECTS ***
ECTOPIC (tubal) PREGNANCY	PI
ENDOMETRIOSIS	PI
HEPATITIS, chronic active	LD
HYPOPITUITARISM	LD
HYPOTHYROIDISM	LD
KIDNEY DISEASE	LD
LUPUS	PI, LD
With a chronic terminal disease, like lupus, desire may wax and wane.	
MULTIPLE SCLEROSIS	LD, EC, OC, PI
PARKINSON'S DISEASE	LD
PROSTATE SURGERY, some kinds	EC, OC
Prostate surgery sometimes effects ejaculation, even though a man may still have orgasms. Some kinds of prostate surgery can also cause erection problems.	
SEXUALLY TRANSMITTED DISEASES, some	PI
Some STDs on the genitals or in the vagina or urethra can make sex painful (e.g., trichomonas, yeast infection, genital herpes). Others may cause pain for women once they travel to the uterus, tubes, or ovaries ** (e.g. gonorrhea, chlamydia). Herpes or shingles on the penis can make it painful to touch.	
SPINAL CORD INJURIES, some	EC, OC
Note that desire is not usually affected by spinal cord injury. Sex may continue to be an important part of a person's life after a spinal cord injury.	
TUBERCULOSIS	LD

* The letters indicate which effect(s) might be caused by a particular medical factor:

LD = Lack of Desire
EC = Erection Concerns (trouble getting or maintaining one)
RE = Rapid Ejaculation (faster than desired)
OC = Orgasm or ejaculation Concerns (delayed or none)
PI = Pain with Intercourse (oral, anal, and/or vaginal)

** Infections in these organs are called "Pelvic Inflammatory Disease" or "PID".

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