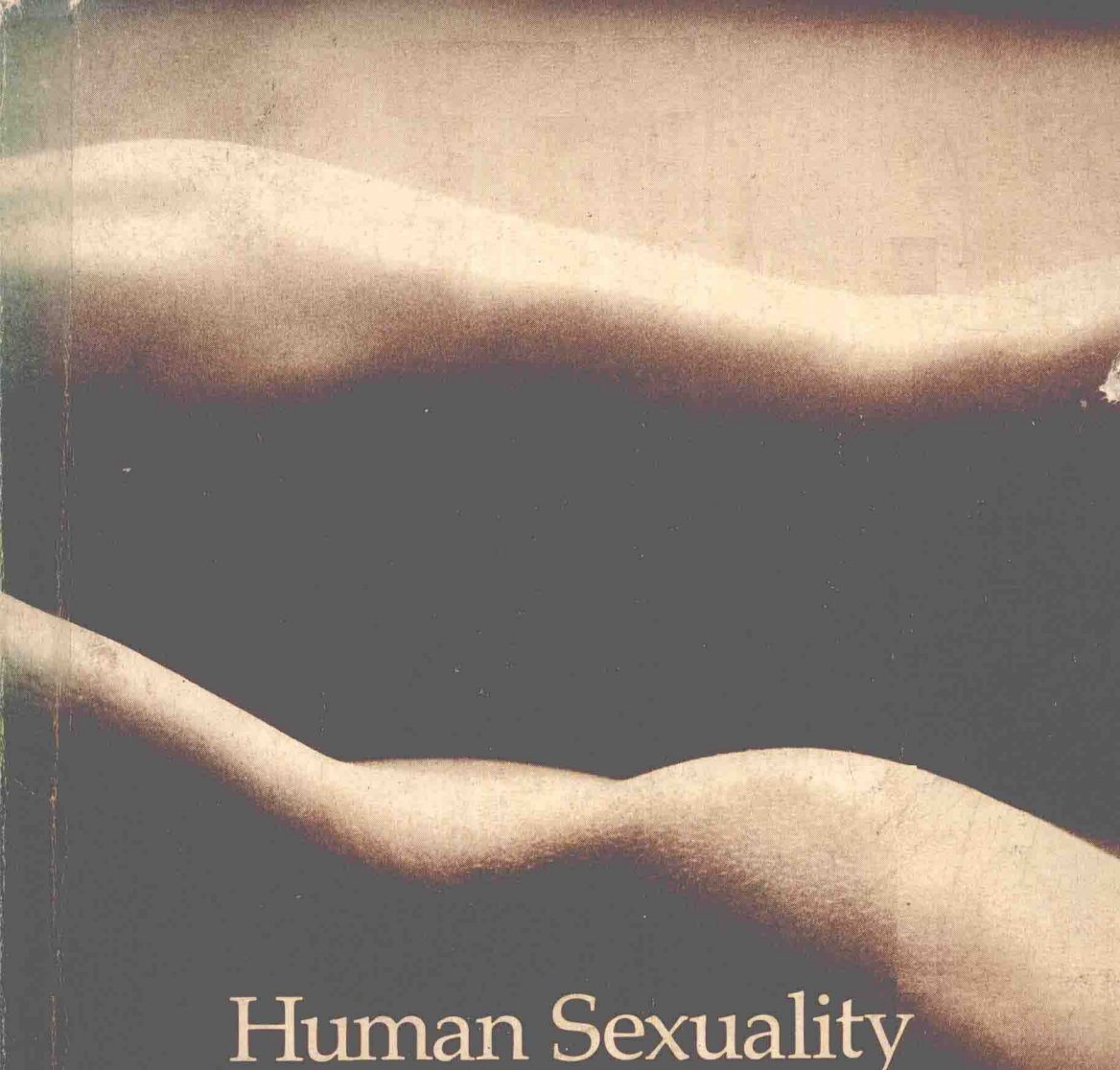

Human Sexuality

IN HEALTH AND ILLNESS

Nancy Fugate Woods

THIRD EDITION

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IN HEALTH AND ILLNESS

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THIRD EDITION

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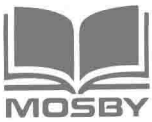

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Preface

Human sexuality is a complex phenomenon, pervading every aspect of our being. It is a source of pleasure, even peak experiences. Sexuality can also be a source of great pain. It is vulnerable to the vicissitudes of stress and strain of daily living and illness.

Sexuality is multidimensional. Sexual health is reflected in the integration of biologic, intrapersonal, social, and cultural aspects of our being. Unit I examines human sexuality as a multidimensional phenomenon. Human sexual behavior, how it is influenced by social and biologic processes, variability in expression of sexual behavior, and the development of sexuality throughout the life span are considered. In Unit II sexual health and health care, including assessment of sexual health, sex education, counseling, and therapy, are discussed. In Unit III clinical aspects of human sexuality are examined.

This text views human sexuality in health and illness from a multidimensional perspective. Several life events influence sexuality. Pregnancy and lactation change a woman's biology, her image of herself, and her social relationships. Abortion, a crisis situation, may have some sequelae affecting a woman's sexuality and that of her partner. Sexual assault has the potential to negatively influence a woman's future sexual functioning, her concept of herself as a woman, and her social relationships. Fertility and infertility raise important sexual issues.

Hospitalization and illness warrant certain changes in life-style, one of which is altered sexual behavior patterns. Chronic illnesses such as diabetes, renal disease, cancer, arthritis, and heart disease; surgery that alters body image; spinal cord injury; stroke; and drug abuse or drug therapy are each capable of interfering with normal sexual functioning.

Sexually transmitted diseases are becoming increasingly prevalent in society. Their identification, treatment, and prevention constitute an important contemporary public health problem. Changes in the life patterns of individuals with developmental disabilities have brought sexual issues to the fore. Health professionals are asked to help the developmentally disabled embrace their sexuality at the same time that they are striving to become integrated in a world oriented to the nondisabled.

Throughout the book an attempt has been made to review current literature dealing with each topic; to examine the area in view of its biologic, psychologic, and social ramifications; and to suggest guidelines with which the health care practitioner can intervene with clients in certain life situations that threaten sexual integrity. Case examples are presented in review questions to help both students and practitioners apply the theories, principles, and research findings discussed in each chapter.

The guidelines for practice presented here are general in their orientation. Not every principle will be applicable in every situation or to each client. Practitioners will find it necessary to modify their approaches to their individual clients, to the context in which they practice, and to their own comfort and style of providing care.

Nancy Fugate Woods

Human Sexuality

IN HEALTH AND ILLNESS

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I

Human sexuality: an overview

1

Human sexuality: a holistic perspective

Human sexuality is a highly complex phenomenon. Sexuality pervades human beings, influencing their self-images and feelings. It influences their relationships with others. In addition, sexuality involves the biologic basis for experiencing sexual pleasure, giving and receiving sensual pleasure, and is a powerful force in a person's ability to bond to another person. Sexuality is concerned with the biologic, psychologic, sociologic, spiritual, and cultural aspects of life.

The purposes of this chapter follow:

1. To review the physiologic components of the human sexual response cycle
2. To consider the psychologic components of the human sexual response
3. To discuss psychosocial and cultural factors influencing sexuality

Physiologic aspects of human sexual response

Little knowledge about the physiologic aspects of human sexual response existed until the publication of Masters and Johnson's classic volume in 1966.[17] Masters and Johnson sought to determine what physical phenomena developed as humans responded to sexual stimulation and what psychosocial factors influenced how they responded. Their method of study consisted of direct observation and measurement of the changes that occur during the sexual response.

In the monitoring of the human sexual response cycle Masters and Johnson[17] recorded two principal physiologic changes: vasoconstriction and myotonia. Vasoconstriction is defined as congestion of blood vessels, usually venous vessels, and is the primary physiologic response to sexual stimulation. Myotonia, increased muscular tension, is a secondary physiologic response to sexual stimulation. These two changes are responsible for the phenomena observed during the sexual response cycle.

Phases of the cycle. To facilitate description of their observations, Masters and Johnson arbitrarily chose to divide the cycle into four phases: excitement, plateau, orgasm, and resolution. The excitement phase develops from any source of bodily or psychic stimuli, and if adequate stimulation occurs, the intensity of excitement increases rapidly. This phase may be interrupted, prolonged, or ended by distracting stimuli.

The plateau phase is a consolidation period that follows excitement if adequate stimulation is maintained. Sexual tension becomes intensified to the level at which the person may experience orgasm. Like excitement, this phase may also be affected by distracting stimuli.

Orgasm, the involuntary climax of sexual tension increment, involves only a few seconds of the human sexual response cycle during which vasocongestion and myotonia are released. There appears to be greater variation of intensity and duration of orgasm among females than among males. Although the total body is involved, the sensual focus during orgasm is usually in the pelvic area.[17]

During the resolution phase the person undergoes involutional changes that restore the preexcitement state. Females may, if adequately stimulated, begin another sexual response cycle immediately before sexual excitement totally resolves. However, for males a refractory period during which they cannot be restimulated is superimposed on the resolution period. Unless orgasm has been overwhelming, sexual tension dissipates slowly. Usually the length of the resolution periods parallels the length of the excitement phase.

Masters and Johnson[17] described only one sexual response pattern for males, although it is highly unlikely that it is invariant. In this pattern, illustrated in Fig. 1-1, excitement proceeds rapidly, followed by a short plateau period, orgasm, and a resolution period. Although Masters and Johnson state that the variety of patterns for females is almost infinite, they described the three most prevalent patterns (Fig. 1-2). In pattern *A*, the female experiences multiple orgasms, with a fairly rapid resolution period. Pattern *B* depicts a nonorgasmic cycle in which several peaks are noted in the plateau phase and a longer resolution period occurs. Pattern *C* shows a cycle in which the female's excitement is first interrupted or distracted, an intense orgasm occurs, and resolution is very rapid.

A very important finding from the work of Masters and Johnson[17] is that human sexual response is a total body response rather than merely a pelvic phenomenon. Changes in

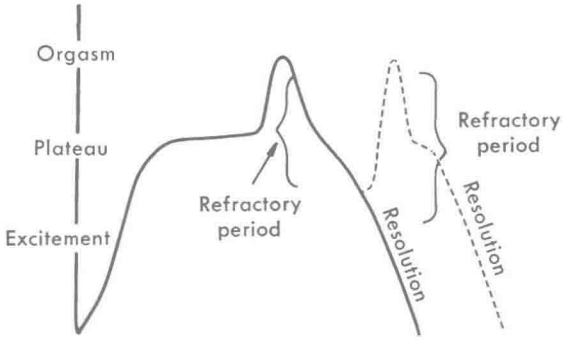

Fig. 1-1. Male sexual response cycle. (From Masters, W., and Johnson, V.: Human sexual response, Boston, 1966, Little, Brown & Co.)

the cardiovascular and respiratory function and reactions involving skin, muscle, breasts, and the rectal sphincter are observed during the sexual response cycle.

Excitement phase. During the excitement phase of the human sexual response cycle the clitoral glans becomes tumescent, or enlarged, and the clitoral shaft increases in diameter and elongates. The appearance of vaginal lubrication, caused by vasocongestion and likened to a sweating process, occurs within 10 to 30 seconds after initiation of sexual stimulation. The vaginal barrel expands about 3.75 to 4.25 cm in transcervical width and lengthens 2.5 to 3.5 cm. In addition, the vaginal wall develops a purplish hue because of vasocongestion. Partial elevation of the uterus may occur if it lies in the anterior position. Irritation of the corpus uteri may also occur.

In the nulliparous woman, flattening and separating of the labia majora occur as in an apparent effort to open the entrance to the vagina. In the multiparous woman the labia majora move slightly away from the introitus because of a vasocongestive increase in their diameter. The vaginal barrel is lengthened approximately 1 cm as a result of the thickening of the labia minora. No changes have been observed in Bartholin's glands during this phase.

In the male there is rapid erection of the penis, which may be partially lost and regained during this phase. At this time there is also the possibility that distracting stimuli may interfere with erection.[17]

Tensing and thickening of the scrotal skin occur with elevation of the scrotal sac. Both testes are partially elevated toward the perineum as the spermatic cords shorten.

During this phase vasocongestion causes both penile erection and vaginal lubrication. Thickening of the scrotal skin, elevation of the scrotal sac, elevation and flattening of

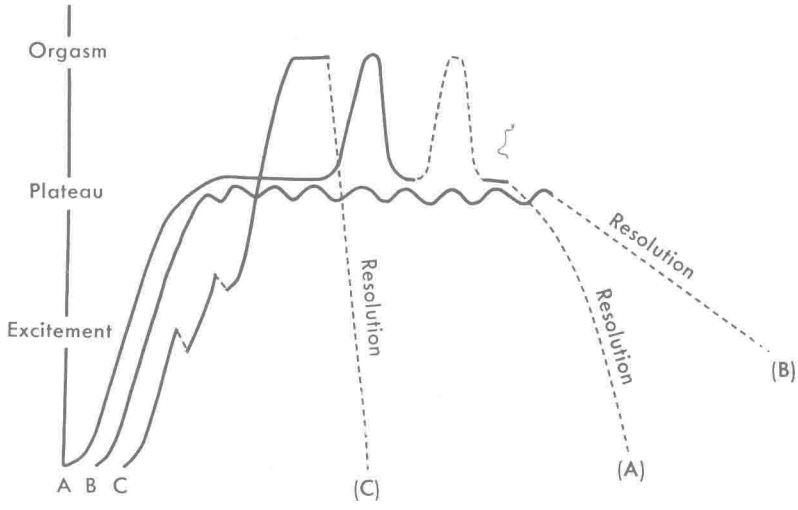

Fig. 1-2. Female sexual response cycle. (From Masters, W., and Johnson, V.: Human sexual response, Boston, 1966, Little, Brown & Co.)