

chapter 13

The Sexual Body in Health and Illness



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CHAPTER OUTLINE

Living in Our Bodies: The Quest
for Physical Perfection
Alcohol, Drugs, and Sexuality
Sexuality and Disability

Sexuality and Cancer
Additional Sexual Health Issues
Sexual Orientation and Health



woman that I am. I no longer see the woman who wanted breast implants and other superficial aspects of beauty. My beauty now flows from within, and all I had to acquire was love for myself and knowledge of myself, and it did not cost me anything.”

—21-year-old female

“It was never about food; it was always about the way I felt inside. The day that changed my life forever was January 29, 2007. It was the mortifying reflection of myself off the porcelain toilet I hovered over that made me see the truth. At that moment, I knew I could no longer go on living or dying like a parched skeleton. I had to hit rock bottom before I realized that what I was doing was wrong. I feel that, even if twenty people had sat me down at that time and told me I had an eating disorder, I would have laughed. I was blind.”

—20-year-old female

“Interestingly, I am writing this paper with a bald head. I used to have long, beautiful blonde hair. Chemotherapy took care of that little social/sexual status symbol. I was not at all prepared for losing my looks along with that much of my sexual identity. It has taken me by surprise to realize how much the way you look influences how people react to you, especially the opposite sex. The real lesson comes from the betrayal I feel from my body. I was healthy before, and now that I am sick, I feel as if my identity has changed. I always saw my body as sexual. Now after surgery, which left a large scar where my cleavage used to be, and with chemotherapy, which left me bald, I feel like my body is a medical experiment. My sexual desire has been very low, and I think it is all related to not feeling good about the way I look. Amazing how much of our identities are wrapped around the way we feel about the way we look. The good news for me is that my foundation is strong: I am not just what is on the outside.”

—26-year-old female

“On the weekend, I like to go out with my friend. When I drink alcohol in excessive amounts, I never have any problems performing sexually. But when I smoke marijuana, I have a major problem performing up to my standards.”

—19-year-old male

11 *The essence of beauty is the unity of variety.*

—William Somerset Maugham
(1874–1965)

THE INTERRELATEDNESS OF OUR PHYSICAL HEALTH, our psychological well-being, and our sexuality is complex. It’s not something that most of us even think about, especially as long as we remain in good health. On the other hand, we may encounter physical and emotional problems and limitations, many of which may profoundly influence our sexual lives. We need to inform ourselves about these problems so that we can help prevent or deal with them effectively.

In this chapter, we examine our attitudes and feelings about our bodies and look at specific health issues. We begin with a discussion of body image and its impact on sexuality. Next we look at the relationship between alcohol and other drugs and our sexuality. Then we turn to issues of sexuality and disability. We also discuss the physical and emotional effects of specific diseases such as diabetes, heart disease, arthritis, and cancer as they influence our sexual functioning. Finally, we address other issues specific to women or men and look at the impact that sexual orientation has on health and well-being.

As we grow emotionally and physically, we may also develop new perceptions of what it means to be healthy. We may discover new dimensions in ourselves to lead us to a more fulfilled and healthier sex life.

● Living in Our Bodies: The Quest for Physical Perfection

Health is more than the absence of disease and sexual health is more than the presence of healthy sexual parts. According to the World Health Organization (2006):

Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Sexual health has to do with how we function biologically, but it is also a function of our behavior and our awareness and acceptance of our bodies. In terms of sexuality, good health requires us to know and understand our bodies, to feel comfortable with them. It requires a woman to feel at ease with the sight, feel, and smell of her vulva, and to be comfortable with and aware of her breasts—their shape, size, and contours. Sexual health requires a man to accept his body, including his genitals, and to be aware of physical sensations such as lower back pain or a feeling of congestion in his bladder. A sexually healthy man abandons the idea that masculinity means he should ignore his body's pains, endure stress, and suffer in silence.

Our general health affects our sexual functioning. Fatigue, stress, and minor ailments all affect our sexual interactions. If we ignore these aspects of our health, we are likely to experience a decline in our sexual desires, as well as suffer physical and psychological distress. A person who always feels tired or stressed or who is constantly ill or debilitated is likely to feel less sexual than a healthy, rested person. Health and sexuality are gifts we must nurture and respect, not use and abuse.

Eating Disorders

Many of us are willing to pay high costs—physical, emotional, and financial—to meet the expectations of our culture and to feel worthy, lovable, and sexually attractive. Although having these desires is clearly a normal human characteristic, the means by which we try to fulfill them can be extreme and even self-destructive. Many American women and some men try to control their weight by dieting, but some people's fear and loathing of fat often combined with fear or disgust regarding sexual functions impels them to extreme eating behaviors. Compulsive overeating (binge eating) and compulsive overdieting (which may include self-starvation and binge eating and purging)—and combinations thereof—are the behaviors classified as **eating disorders**.

Most people with eating disorders have certain traits, such as low self-esteem, perfectionism, difficulty dealing with emotions, unreasonable demands for self-control, negative perceptions of self in relation to others, and, of course, a fear of becoming fat. Often, the person lacks adequate skills for dealing with stress.



Contrary to popular stereotypes, people of all shapes, sizes, and ages can lead healthy and happy sexual lives.

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“I wouldn't sue anyone for saying I had a big prick. No man would. In fact, I might pay them to do it.

—Joe Orton
(1933–1967)

“Muscles I don't care about—my husband likes me to be squishy when he hugs me.

—Dixie Carter
(1939–2010)

think about it

Body Image and Sexuality: Are They One and the Same?

*O, that this too too solid flesh would melt;
Thaw and resolve itself into a dew!*

—William Shakespeare, *Hamlet* (1564–1616)

Most Americans would agree that the way one feels about one's body has a powerful effect on self-esteem and the ability to enjoy life, including one's sex life.

Researchers have confirmed this by associating positive body image with a pleasurable sex life (Satinsky, Reece, Dennis, Sanders, & Bardzell, 2012). Others have associated body image with several aspects of better overall adjustment, functioning, and well-being, including higher self-esteem and optimism, more proactive coping styles, higher levels of attractiveness, higher educational achievement, fewer disordered eating patterns, and more negative attitudes toward cosmetic surgery (Swami, 2009; Swami, Hadji-Michael, & Furnham, 2008; Woertman & van den Brink, 2012; Wood-Barcalow, Tylka, & Augustus-Horvath, 2010). Contrary to this, body dissatisfaction has been linked to eating disorders, sexual aversion, sexual avoidance, risky sexual behavior, and sexual problems (Reissing, Laliberte, & Davis, 2005).

Just why does body image have such a significant effect on individuals' attitudes and behaviors? From what experiences or images do negative feelings about our body arise? Evolutionary theorists report that women's physical attractiveness is important because it gives male sexual partners information about their health and potential reproductive success (Buss & Schmitt, 2011). In Western cultures, this often translates to a woman's appeal as a sexual partner being dependent on her visual appearance. Men, on the other hand, may use age preference as a marker for reproductive success, with women in their mid-20s being most desirable ("Evolutionary psychology," 2014). Two authors (Bancroft & Graham, 2011) have postulated that a man's experience is dominated by the pursuit of sexual pleasure, whereas a woman's is dominated by a sense of being desired and of emotional intimacy. Desirable body image may be one component of this pursuit.

Media images of women's bodies often present an ideal that is not representative of most women: tall, slim-hipped, long-legged, large-breasted, and many pounds lighter. Men, on the other hand, are presented as tall, buff, hairless, and angular. Because we know that sexual attraction and desire are influenced by complex individual, bio-

logical, behavioral, and social factors, it's difficult to determine exactly how the media influence attitudes or behaviors. Additionally, because there is no universally objective, ideal body shape, size, or look, just as there is no "right" way a body should move or respond, body image is inseparable from a particular society's understanding of the social constructs of beauty, including gender, age, and race. While none of us are born evaluating our bodies, we soon learn to, which in turn will often determine the way in which we interpret what we see in the mirror and how we regard a potential partner. As a result, the beauty ideal established and reinforced by the media often leads both men and women to feel not only bad about themselves but often critical when their beloved does not measure up. The internal clashes between the idealized and the real may bring repressive or destructive behaviors into the bedroom and relationship.

The literature underscores just how closely body image and sexuality are related. In a review of 57 studies of evidence regarding the association between sexuality and body image among healthy women, the overall finding was that body image issues can affect all domains of sexual functioning, including sexual desire, arousal, orgasm, and satisfaction (Woertman & van den Brink, 2012). Particularly salient in this review was the impact of awareness and self-consciousness or negative body evaluations on the individual: during sexual activity, they interfered with both sexual responses and experiences.

With so much research dedicated to negative body image, it's interesting to note the results of findings when body image is examined in the context of sexual health among young women. A group of researchers in the Netherlands explored the sexual health of university women, aged 18–35, who had been or were sexually active, in order to assess whether positive body esteem impacts a woman's sexuality. Their online survey provided questions about body image, its affect during sexual activity, sexual frequency, and levels of sexual self-esteem (van den Brink, Smeets, Hessen, Talens, & Woertman, 2013). Data from 319 participants revealed some interesting findings:

- Overall, the women's level of body dissatisfaction was minimal. Instead, the majority reported neutral or mildly positive body evaluations with 30% of the sample clearly reporting positive evaluations.

- Those who were body-satisfied had lower body mass indexes (BMIs) and reported less body image investment, less overweight preoccupation, and less body self-consciousness during sexual activity.
- With regard to sexual health, body-satisfied women reported better sexual functioning, higher sexual self-esteem, and higher frequency of sexual activity with a partner.

In this case, we may need to determine which cultural factors (having American versus Dutch parents, sexuality education, conservative versus sex-positive views, etc.) contribute to body satisfaction and sexual health.

One outcome of body image is its relationship to sexual desire. It may be interesting to note that problems with sexual desire are among the most common sexual difficulties presented in therapy (Hock 2007). Although there are still limited data, the overall findings indicate that positive body image experiences are associated with higher levels of sexual desire (Woertman & van den Brink, 2012).

While research will continue to explore the connections between body image, well-being, and sexuality, clinicians who work with individuals with distorted body image and often-associated eating disorders must take into consideration the complexity of the issues and be

able to provide individualized, prolonged treatment. What we can most likely anticipate is that as long as an overly thin woman or extremely buff man represents the American ideal, there will continue to be negative consequences in the bedroom. The impact of these will depend in part on the ability of men and women to detach from defining themselves or others by their bodies and to avoid or limit contact with sources that perpetuate false or unrealistic ideals.

Think Critically

1. How would you evaluate your body image? From what sources have you drawn your ideals?
2. Which gender do you feel is most impacted by issues related to body image? Why do you think this is true?
3. What influence does body image have on sexual self-esteem? Sexual health? Sexual functioning? What measures might you take to begin to improve those areas of your body image where you personally feel uncomfortable?

The American Psychiatric Association (2013) states that a primary goal for those experiencing eating disorders is to have an accurate diagnosis which can help define a treatment plan. Eating disorders are frequently present with other psychiatric disorders, such as depression, substance abuse, and anxiety disorders (National Institute of Mental Health [NIMH], 2010).

Although many studies of eating disorders have singled out White middle-class and upper-class women, these problems transcend ethnic, socioeconomic, gender, and age boundaries. The median age for the onset of eating disorders is about 12 to 13 years old (Swanson, Crow, LeGrange, Swendsen, & Merikangas, 2011). Most research suggests that eating disorders are equally common among White females and Latinas, more frequent among American Indian females, and not as common among African American and Asian American females. Among minority racial/ethnic groups, the females who are younger, have more body weight, are better educated, and identify with middle-class values are at higher risk for eating disorders than their peers (Insel & Roth, 2010).

While body image and eating disorders have been discussed extensively in the heterosexual population, until recently little has been known about how prevalent these are in gay men, lesbian women, and transsexual people. Findings from a study of over 56,000 heterosexual, gay, and lesbian individuals revealed that all women, regardless of sexual orientation, are similar in their level of body satisfaction; that is, they adhere to cultural ideals of attractiveness, including a high preoccupation with their weight, low evaluation of their appearance, and the experience of negative effects of their body image on their quality of life and sex life (Peplau et al., 2009). In contrast, the majority of men, both gay and heterosexual, reported being satisfied with their bodies. Nonetheless, a greater



The doll, Lammily, has replaced Barbie as the 'new normal.' With brown hair, shorter legs, thicker waist, and less makeup, kids can appreciate her for her positive body image.

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percentage of gay men than heterosexual men were dissatisfied. Among those with gender dysphoria, those transitioning from male to female (MtF) reported to be at an enhanced risk of developing eating disorders and body image dissatisfaction (Vocks, Stahn, Loenser, & Legenbauer, 2009).

● Alcohol, Drugs, and Sexuality

In the minds of many Americans, sex and alcohol or sex and “recreational” drugs go together. Although experience shows us that sexual performance and enjoyment generally decrease as alcohol or drug consumption levels increase, many people cling to the age-old myths.

Alcohol Use and Sexuality

The belief that alcohol and sex go together, although not new, is certainly reinforced by popular culture. Alcohol advertising often features beautiful, scantily clad women. Beer drinkers are portrayed as young, healthy, and fun-loving. Wine drinkers are romantics, surrounded by candlelight and roses. Those who choose Scotch are the epitome of sophistication. These images reinforce long-held cultural myths associating alcohol with social prestige and sexual enhancement.

It is well known that alcohol use among college students is very common. Of those college students who drink alcohol, 43% reported binge drinking (five or more drinks) the last time they “partied” or socialized (American College Health Association, 2014.13a). Drinking is associated with sexual risks. In fact, most risky first-time sexual encounters involve being inebriated (George et al., 2009). In highly charged sexual situations, intoxication has been reported to increase drinkers’ willingness to engage in unprotected intercourse by fostering their belief that they are aroused.

Because of the ambivalence we often have about sex—“It’s good but it’s bad”—many people feel more comfortable about initiating or participating in sexual activities if they have had a drink or two. This phenomenon of activating

behaviors that would normally be suppressed is known as **disinhibition**. Although a small amount of alcohol may have a small disinhibiting, or relaxing, effect, greater quantities can result in aggression, loss of judgment, poor coordination, and loss of consciousness.

Alcohol affects the ability of both men and women to become sexually aroused. Men may have difficulty getting or maintaining an erection, and women may not experience vaginal lubrication. Physical sensations are likely to be dulled. Chronic users of alcohol typically experience desire and arousal difficulties. Researchers have determined that drinking a six-pack of beer in less than 2 hours can affect testosterone and sperm production for up to 12 hours. This does not mean, however, that no sperm are present; production is slowed, but most men will remain fertile when drinking alcohol.

Researchers are not sure if alcohol use causes risky sexual behavior, but it is possibly part of a risky health behavior problem.

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However, ingestion of large amounts of alcohol by both men and women can contribute to infertility and birth defects.

Alcohol use has also been found to be associated with numerous dangerous consequences such as unwanted sexual intercourse and sexual violence. The disinhibiting effect of alcohol allows some men to justify various types of sexual violence they would not otherwise commit. Men may expect that alcohol will make them sexually aggressive and act accordingly. In drinking situations, women are viewed as more sexually available when impaired. Thus, males may participate in drinking situations expecting to find a sexual partner. Additionally, a woman who has been drinking may have difficulty in sending and receiving cues about expected behavior and in resisting assault. Alcohol use is often a significant factor in sexual violence of all types. Studies of college students have shown that alcohol consumption by either the perpetrator or the person raped, or both, increases the chance of sexual assault. They also show that the higher the amount of alcohol consumption by either person up to a point when alcohol impairs performance in men, the more likely the sexual victimization to the woman will be severe. This is particularly true for intoxicated men who have hostile attitudes toward women (Abbey, 2012).

Drinking alcohol has long been known to be associated with sexual risk taking. For example, when college students were asked if, within the past 12 months, they experienced unprotected sex while drinking alcohol, 16% reported they had (American College Health Association, 2014). However, alcohol use among young people is just one component of an overall risk behavior pattern and not the cause of sexual risk behavior. Additionally, impulsivity/sensation seeking, sociability, and usual drinking pattern provide a broader explanation for sexual risk taking than acute alcohol effects (Velez-Blasini, 2008).

Other Drug Use and Sexuality

Substances that purport to increase sexual desire or improve sexual function are called **aphrodisiacs**. In addition to drugs, aphrodisiacs can include perfumes and certain foods, particularly those that resemble genitals, such as bananas and oysters. Ground rhinoceros horn has been considered an aphrodisiac in Asia, possibly giving rise to the term “horny” (Taberner, 1985). Research, both personal and professional, inevitably leads to the same conclusion: One’s inner fantasy life and a positive image of the sexual self, coupled with an interested and involved responsive partner, are the most powerful aphrodisiacs. Nevertheless, the search continues for this elusive magic potion, and many people take a variety of drugs in an attempt to enhance their sexual experiences.

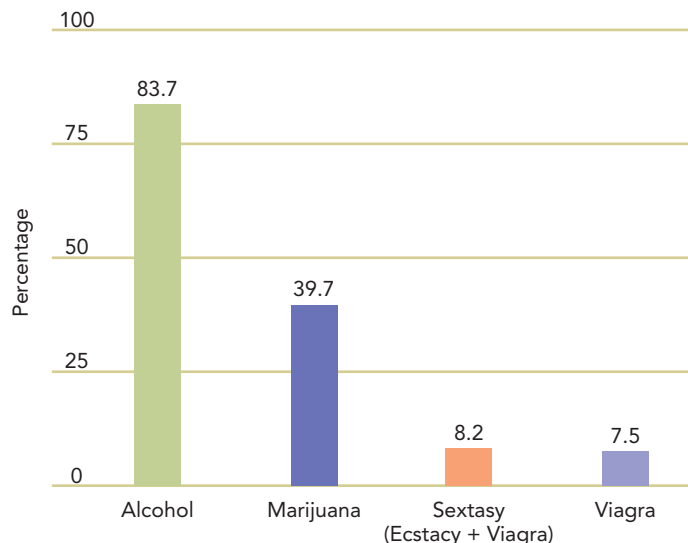
Studies have examined the prevalence of the use of drugs as an aphrodisiac. A sample of 1,114 sexually experienced individuals aged 18–39 years was studied to determine if the participants had ever used a drug to enhance their sexual experience. Among the 28% who reported ever using a drug to improve sexual functioning, several drugs were commonly cited (see Figure 1). When considering this self-report, it is important to realize that the “placebo effect” of aphrodisiacs has been estimated at 33% (American Cancer Society, 2014.13a).

Most recreational drugs, although perceived as increasing sexual enjoyment, actually have the opposite effect. Many prescribed medications have negative effects on sexual desire and functioning as well, and users should read the information accompanying the prescription or ask the pharmacist about any sexual side effects. Although some recreational drugs may reduce inhibitions

• **FIGURE 1**

**Most Commonly Cited Drugs Used
by a Sample of 18- to 39-Year-Olds
Who Reported Ever Using a Drug to
Improve Sexual Functioning.**

(Source: Foxman, Sevgi, & Holmes, 2006.)



and appear to enhance the sexual experience, many also cause problems with fertility and sexual desire and functioning. They can also interfere with fertility and have a serious impact on overall health and well-being.

Marijuana users often report that its use during sexual encounters increases stimulation and sensations. The effects of marijuana, however, are in large part influenced by the expectations of its users; therefore, no definitive statement can be made about how marijuana affects sexual encounters. Specific information about its effects in a relationship can be found by looking at the role it plays in a couple's life. In some cases, marijuana or any drug can become either an aid or a crutch to help people deal with situations or behaviors they find uncomfortable. Long-term marijuana use can also cause or contribute to low motivation to achieve and to low sex drive.

The substance amyl nitrate, also known as "poppers," is a fast-acting muscle relaxant and coronary vasodilator, meaning it expands the blood vessels around the heart. Medically, it is used to relieve attacks of angina. Some people attempt to intensify their orgasms by "popping" an amyl nitrate vial and inhaling the vapor. The drug causes engorgement of the blood vessels in the penis, vagina, and anus. It also causes a drop in blood pressure, which may result in feelings of dizziness and giddiness. The most common side effects are severe headaches and fainting, and, if allowed to touch the skin, the drug can cause burns.

Another drug widely considered to be an aphrodisiac is cantharides, or "Spanish fly." This substance is produced by drying and heating certain beetles' bodies until they disintegrate into a powder. There have not yet been controlled studies to confirm its aphrodisiac effect. Taken internally, the substance causes acute irritation and inflammation of the genitourinary tract, including the kidneys, bladder, and urethra, and it can result in permanent tissue damage and death. This substance is banned in the United States.

LSD and other psychedelic drugs (including mescaline and psilocybin) have no positive effects on sexual response. They may actually cause constant and painful erections, a condition called priapism.

Cocaine, a central nervous system stimulant, reduces inhibitions and enhances feelings of well-being. But regular use nearly always leads to sexual function difficulties in both men and women, as well as an inability to have an erection or orgasm. Male cocaine users also have a lower sperm count, less active sperm, and more abnormal sperm than nonusers. The same levels of sexual impairment occur among those who snort the drug and those who smoke or “freebase” it. Those who inject cocaine experience the greatest sexual function difficulties.

MDMA (Ecstasy or Molly) is a hallucinogenic amphetamine that produces heightened arousal, a mellowing effect, and an enhanced sense of self, as well as distortions in sensory and time perception. It is an illegal drug with no legitimate use. Many of these tablets also contain a number of other drugs or drug combinations that can be harmful. In spite of this, 7% of college students report using it (American College Health Association, 2014). The drug has been associated with dehydration due to physical exertion without breaks for water; heavy use has been linked to paranoia, liver damage, and heart attacks. Because users feel increased empathy, ecstasy can lower sexual inhibitions. However, men generally cannot get erections when they are high but are often very sexual when the effects of the drug begin to fade.

The use of methamphetamine, often referred to as “crystal,” “Christina,” or “Tina,” is increasingly becoming associated with casual sex. Prized as an aphrodisiac and stimulant used to prolong sexual arousal without orgasm, methamphetamine can be snorted, inhaled, swallowed, or injected. The sharp increase in sexual interest caused by crystal use can lead to dangerous behavior. And methamphetamine use may increase the user’s susceptibility to HIV infection and progression through the use of contaminated needles, increased risky sexual behaviors, and poor medication adherence (“NIDA topics in brief,” 2011). Some men, in an attempt to enhance sexual functioning, mix recreational drugs such as methamphetamine, amyl nitrate, and ecstasy with Viagra or other prescription drugs used for erectile problems. The combination of methamphetamine or amyl nitrate and erection-enhancing prescription drugs such as Viagra and Cialis has sometimes resulted in a phenomenon known as a “sexual marathon,” during which sexual activity can be prolonged over hours or even days.

Aside from the adverse physical effects of recreational drugs themselves, their use is associated with greater risk for acquiring STIs, including HIV infection (“Lancet HIV,” 2014). Addiction to cocaine, especially crack cocaine, has led to the widespread bartering of sex for cocaine. This practice, as well as the injection of cocaine or heroin, combined with the low rate of condom use, has led to epidemics of STIs, including AIDS, in many urban areas.

Current interest in nutrition, natural healing, and nutritional supplements, coupled with the accessibility of the Internet, has helped fuel an industry that is selling products to stimulate or improve sexuality. Such herbs as *avena sativa*, cayenne, yohimbe, and damiana are claimed to increase sexual stamina, performance, and/or sensation. Additionally, lotions such as Zestra, a blend of botanical oils and extracts that promises to enhance sexual arousal for women, are available. There is no current evidence to support any of these medicinal aids as effective at improving sexual functioning. However, if some individuals do benefit, it may be because they *believe* that the products work. It is important to be aware that many of the herbs mentioned previously can have side effects ranging from mild to severe.

The use of recreational drugs has become an all too common part of the party scene.

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Though media may be portraying more disabilities in movies, such as *The Theory of Everything*, people with disabilities still remain neglected, and if they are seen, misrepresented.

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● Sexuality and Disability

A wide range of disabilities and physically limiting conditions affect human sexuality, yet the sexual needs and desires of those with disabilities have generally been overlooked and ignored. Nearly 20% of people in the U.S. have a disability, with more than half of them reporting it severe enough to impose a limitation on their life (U.S. Census Bureau, 2012.13a). Certainly, a disability or chronic condition does not inevitably mean the end of a person's sexual life. In 1987, Ellen Stohl, a young woman who uses a wheelchair, created a controversy by posing seminude in an eight-page layout in *Playboy*. Some people (including some editors at *Playboy*) felt that the feature could be construed as exploitive of people with disabilities. Others, Stohl among them, believed that it would help normalize society's perception of individuals who have disabilities. She said, "I realized I was still a woman. But the world didn't accept me as that. Here I am a senior in college [with] a 3.5 average, and people treat me like I'm a 3-year-old" (quoted in Cummings, 1987). Though Stohl's layout in *Playboy* occurred almost three decades ago, even today we rarely see media depictions of people living with disabilities or chronic illness as having sex lives.

Among the most significant issues facing those with disabilities as well as those who care for them is the belief that people with disabilities are less sexual than those without disabilities. In fact, sexual expression is a component of personality, which is separate from erectile function or fertility status. Other common myths about disability and sexuality include (Klein & Meier, 2013):

- Sex means sexual intercourse.
- Among those who have disabilities, talking about sex is not natural, proper, or necessary.
- Sex is for younger people who are able-bodied.
- Sex should be spontaneous.
- A firm penis and an orgasm are requirements for satisfying sex.

Because of the complexity of physical, psychological, and emotional changes that may occur as a result of a disability, it's important to educate the person with a disability about sexuality, as well as to involve and communicate with those who support him or her. Issues related to desires, needs, and sexual function should be explored and addressed in a comfortable and nonjudgmental setting.

Physical Limitations and Changing Expectations

Many people are subject to sexually limiting conditions for some or all of their lives. These conditions may be congenital, appearing at birth, such as cerebral palsy (a neuromuscular disorder) and Down syndrome (a developmentally disabling condition). They may be caused by a disease such as diabetes, arthritis, or cancer or be the result of an accident, as in the case of spinal cord injuries.

In cases in which the spinal cord is completely severed, for example, there is no feeling in the genitals, but that does not eliminate sexual desires or exclude other possible sexual behaviors. Many men with spinal cord damage are able to have full or partial erections; some may ejaculate.

However, the effects on sexual response are generally associated with the degree and location of the injury. Nearly 40% of quadriplegic men are able to experience orgasm and ejaculation (Ducharme & Gill, 1997). Those who are not

11 I get the feeling people think that because I am in a chair there is just a blank space down there.

—Anonymous quote in the book *The Ultimate Guide to Sex and Disability*

capable of ejaculation may be able to father a child through electroejaculation sperm retrieval and intrauterine insemination of the man's partner. In this procedure, the prostate gland is electrically stimulated through the rectum, causing erection and ejaculation. Many women with spinal cord damage injuries are able to have painless childbirth, although forceps delivery, vacuum extraction, or cesarean section may be necessary. Since sexuality is still a relatively new target of pharmacological research, little is known about the impact of these kinds of treatments on sexuality-related outcomes. Research from clinical reports and practice finds that medication or treatments for neurological diseases, including spinal cord injuries, have varied effects on both sexual functioning and sexual well-being (Verschuren, Enzlin, Dijkstra, Geertzen, & Dekker, 2010).

Women with spinal cord injuries experience many of the same sexual responses as other women, including (in about 50% of women with such injuries) the capacity to experience an orgasm (Sipiski, Alexander, Gómez-Marín, & Spalding, 2007). People with spinal cord injuries (and anyone else, for that matter) may engage in oral or manual sex—anything, in fact, they and their partners find pleasurable and acceptable. They may discover a wide variety of erogenous areas, such as their breasts, thighs, necks, ears, or underarms.

To establish sexual health, people with disabilities must overcome previous sexual function expectations and realign them with their actual sexual capacities. A major problem for many people with disabilities is overcoming the anger or disappointment they feel because their bodies don't meet the cultural "ideal." They often live in dread of rejection, which may or may not be realistic, depending on whom they seek as partners. Many people with disabilities have rich fantasy lives. This is fortuitous because imagination is a key ingredient in developing a full sex life. Robert Lenz, a consultant in the field of sexuality and disability, received a quadriplegic (paralyzed from the neck down) spinal cord injury when he was 16 (Lenz & Chaves, 1981). In the film *Active Partners*, he says:

One thing I do know is that I'm a much better lover now than I ever was before. There are a lot of reasons for that, but one of the biggest is that I'm more relaxed. I don't have a list of do's and don'ts, a timetable or a proper sequence of moves to follow, or the need to "give" my partner an orgasm every time we make love. Sex isn't just orgasm for me; it's pleasuring, playing, laughing, and sharing.

Educating people with physical limitations about their sexuality and using a holistic approach that includes counseling to build self-esteem and combat negative stereotypes are increasingly being recognized as crucial issues by the medical community. Important tasks of therapists working with people who have disabilities are to give their clients "permission" to engage in sexual activities that are appropriate to their capacities and to suggest new activities or techniques. Researchers suggest that nonpenetrative sexual behaviors should be affirmed as valid and healthy expressions of the individual's or couple's sexuality. Clients should also be advised about the use of vibrators, artificial



All individuals, including those with physical and mental limitations, have a need for touch and intimacy.

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penises and vaginas, and other aids to sexual enhancement. Certainly, with proper and adequate support, people with disabilities can have full and satisfying sex lives.

Vision and Hearing Impairment

Loss of sight or hearing, especially if it is total and has existed from infancy, presents many difficulties in both the theoretical and the practical understanding of sexuality. A young person who has been blind from birth is unlikely to know what a person of the other sex actually “looks” (or feels) like. Children who are deaf often do not have parents who communicate well in sign language; as a result, they may not receive much instruction about sexuality at home, nor are they likely to understand abstract concepts such as “intimacy.” Older individuals who experience significant losses of sight or hearing may become depressed, develop low self-esteem, and withdraw from contact with others. Because they don’t receive the visual or auditory cues that most of us take for granted, people with hearing or vision impairments may have communication difficulties within their sexual relationships. These difficulties often can be overcome with education or counseling, depending on the circumstances. Schools and programs for children who are sight- and hearing-impaired offer specially designed curricula for teaching about sexuality.

Chronic Illness

Diabetes, cardiovascular disease, and arthritis are three of the most prevalent diseases in America. Although these conditions are not always described as disabilities, they may require considerable adjustments in a person’s sexuality because they, or the medications or treatments given to control them, may affect libido, sexual capability or responsiveness, and body image. It is important to acknowledge that the partner’s sexuality may also be affected by chronic illness. Additionally, many older partners find themselves dealing with issues of disease and disability as well as those of aging.

There may be other disabling conditions, too numerous to discuss here, that affect our lives or those of people we know. Some of the information presented here may be applicable to conditions not specifically dealt with, such as multiple sclerosis or post-polio syndrome. We encourage readers with specific questions regarding sexuality and chronic diseases to seek out networks, organizations, and self-help groups that specialize in those issues.

Diabetes **Diabetes mellitus**, commonly referred to simply as diabetes, is a chronic disease characterized by an excess of sugar in the blood and urine, due to a deficiency of insulin, a protein hormone. About 29 million people in the United States, or 9.3% of the population, have diabetes (Centers for Disease Control and Prevention (CDC), 2014.13a); of these, nearly 28% are undiagnosed. Nerve damage or circulatory problems caused by diabetes can cause sexual problems. Men with diabetes are often more affected sexually by the disease than are women. Estimates of the prevalence of erectile dysfunction vary widely, ranging from 20% to 75% (National Diabetes Information Clearinghouse [NDIC], 2012). Some men with diabetes experience problems with sexual desire, difficulty getting an erection, and not experiencing orgasm. Heavy alcohol use, obe-

sity, age, smoking, and poor blood-sugar control also increase the risk of erectile problems.

Diabetes can affect a woman's sexuality as well. Female sexual function difficulties have been found to occur in 18–42% of sexually active women with diabetes (NDIC, 2012). Some women with diabetes may have less interest in being sexual because of frequent yeast infections. High blood-sugar levels can make some women feel tired or irritable, resulting in reduced sexual interest. Also, intercourse may be painful because of vaginal dryness.

Problems with sexual functioning in men and women with diabetes are also associated with fear of failure, reduced self-esteem, and problems with acceptance of the disease. While it may be difficult to discuss these feelings with a partner, it's important not to give up. Finding someone on your health care team to talk with may also be helpful.

Cardiovascular Disease Obviously, a heart attack or stroke is a major event in a person's life, affecting important aspects of daily living. Following an attack, a person often enters a period of depression in which the appetite declines, sleep habits change, and there is fatigue and a loss of libido. There is often an overwhelming fear of sex based on the belief that sexual activity might provoke another heart attack or stroke. Sexual function difficulties are common in cardiac patients and, in men, may precede cardiac symptoms; over 50% of men with coronary artery disease have erectile problems (Jackson, 2009). The partners of male heart attack patients also express great concern about sexuality. They are fearful of the risks, concerned over sexual function difficulties, and apprehensive about the possibility of another attack during intercourse. Most people can start sexual activity again 3 to 6 weeks after their condition becomes stable following an attack if the physician agrees (National Institute on Aging, 2008). In general, the chance of a person with a prior heart attack having another one during sex is no greater than that of anyone else.

LAMENT OF A CORONARY
*My doctor has made a prognosis
That intercourse fosters thrombosis,
But I'd rather expire fulfilling desire
Than abstain, and suffer neurosis.*
—Anonymous

Arthritis About one in five Americans has some type of arthritis, most of them older women, but the disease may afflict and disable children and adolescents as well (CDC, 2013.13a). Arthritis is a painful inflammation and swelling of the joints, usually of the knees, hips, and lower back, which may lead to disfigurement of the limbs. Sometimes, the joints can be moved only with great difficulty and pain; sometimes, they cannot be moved at all. Arthritis is a leading cause of disability in Americans and a major cause of work limitation in the United States. The cause of arthritis is not known.

Sexual intimacy may be difficult for people with arthritis because of the pain and stiffening that accompanies it. Oral sex, general pleasuring of the body, and creative sexual positioning have definite advantages for those with arthritis. Applying moist heat to the joints or sharing a shower or bath with a partner prior to sexual activity can help.

Developmental Disabilities

Developmental disabilities are a diverse group of severe, lifelong, chronic conditions attributable to mental and/or physical impairments that begin during the developmental period and result in major lifestyle limitations. People with developmental disabilities most often have problems with major life activities such



as language, mobility, learning, self-help, and independent living. The sexuality of those who have developmental disabilities has only recently been widely acknowledged by those who work with them. The capabilities of individuals with developmental disabilities vary widely. People with mild or moderate disabilities may be able to learn to behave appropriately, protect themselves from abuse, and understand the basics of reproduction. Some manage to marry, work, and raise families with little assistance.

Sexuality education is extremely important for adolescents who have developmental disabilities. Some parents may fear that this will “put ideas into their heads,” but it is more likely given the combination of explicit media and Internet images and the effects of increased hormonal output, that the ideas are already there. It may be difficult or

Though most people support the right of consenting adults to have access to sexuality education and a sexual life, few acknowledge the needs and rights of those with disabilities to have the same.

impossible to teach more severely affected people how to engage in safer sexual behaviors. There is ongoing debate about the ethics of mandatory birth control or sterilization for those who have developmental disabilities. These issues are especially salient in cases in which there is a chance of passing the disability to a child.

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The Sexual Rights of People With Disabilities

Although many of the concerns of people with disabilities are becoming more visible through the courageous efforts of certain groups and individuals, much of their lives still remains hidden. By refusing to recognize the existence and concerns of those with physical and developmental limitations, the rest of us do a profound disservice to our fellow human beings and, ultimately, to ourselves. The United Nations General Assembly (1993) noted that states “should promote their [persons’ with disabilities] rights to personal integrity and ensure that laws do not discriminate against persons with disabilities with respect to sexual relationships, marriage, and parenthood.” The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000 explicitly states that individuals with intellectual disability have the fundamental right to engage in meaningful relationships with others (U.S. Department of Health and Human Services, 2000).

The sexual rights of persons with disabilities should be the same as those for persons without disabilities and include the following:

- The right to sexual expression.
- The right to privacy.
- The right to be informed about and have access to needed services, such as contraceptive counseling, medical care, genetic counseling, and sex counseling.
- The right to choose one’s marital status.
- The right to have or not have children.
- The right to make one’s own decisions and develop to one’s full potential.

● Sexuality and Cancer

Cancer is not a single disease; it is more than 300 distinct illnesses that can affect any organ of the body. These various cancers grow at different speeds and have different treatment success and failure rates. Most cancers, but not all (e.g., leukemia), form solid tumors.

All cancers have one thing in common: They are the result of the aberrant behavior of cells. Cancer-causing agents (carcinogens) are believed to scramble the messages of the DNA within cells, causing the cell to abandon its normal functions. Tumors are either benign or malignant. **Benign tumors** usually are slow growing and remain localized. **Malignant tumors**, however, are cancerous. Instead of remaining localized, they invade nearby tissues and disrupt the normal functioning of vital organs. The process by which the disease spreads from one part of the body to another, unrelated part is called **metastasis**. This metastatic process, not the original tumor, accounts for the vast majority of cancer deaths.

Women and Cancer

Because of their fear of breast cancer and cancer of the reproductive organs, some women avoid having regular breast examinations or Pap tests. If a woman feels a lump in her breast or her doctor tells her she has a growth in her uterus, she may plunge into despair or panic. These reactions are understandable, but they are also counterproductive. Most lumps and bumps are benign conditions, such as uterine fibroids, ovarian cysts, and fibroadenomas of the breast.

Breast Cancer Excluding cancer of the skin, breast cancer is the most common cancer in women and the second leading cause of cancer deaths in women (American Cancer Society, 2014.13b). It is predicted that in 2015 about 231,840 new cases of invasive breast cancer will be diagnosed, with about 40,300 women dying from the disease (American Cancer Society, 2014.13c). Experts estimate that in the United States about one of every eight women (12.4%) born today will be diagnosed with breast cancer at some time during her life (American Cancer Society, 2014.13c). In spite of these staggering numbers, the incidence of female breast cancer actually declined in 2000, then dropped by about 7% from 2002 to 2003. This was thought to be due to the decrease in use of hormone therapy during and following menopause. Death rates have also been falling since 1989, especially among women younger than 50, with the decreases believed to be the result of earlier screening, increased awareness, and improved treatment.

The most significant risk factor for breast cancer is age. Other factors that increase a woman's risk of developing breast cancer include inherited changes in certain genes, personal or family history of breast cancer, dense breasts, beginning to menstruate before age 12 or starting menopause after age 55, a first full-term pregnancy after age 30, never having been pregnant, obesity after menopause, race and ethnicity, and alcohol use. Studies have shown that using combined hormone therapy (progestin and estrogen) after menopause also increases the risk of acquiring and dying from breast cancer. While much research has looked for links between breast cancer and other factors, including diet and vitamin intake, chemicals in the environment, tobacco smoke, night work, and breast implants, the results of these studies still prove to be inconclusive (American Cancer Society, 2014.13b).

The 5-year survival rate from breast cancer varies greatly, depending on many factors, including the grade of the cancer and the presence of hormone receptors

on the cancer cells. Those who are diagnosed in the earliest stages (1 and 2) have a 93–100% survival rate; however, these rates drop for each stage of diagnosis (American Cancer Society, 2014.13d).

Studies have found that lesbian and bisexual women have higher rates of breast cancer than heterosexual women (American Cancer Society, 2014.13e). Factors more likely to affect lesbian and bisexual women include not having had children and not having breastfed, not having used oral contraceptives, and being older when they first give birth. At the same time, bisexual and lesbian women also tend to get less routine health care than other women, including colon, breast, and cervical cancer screening. Additionally, they have lower rates of health insurance, may fear discrimination, and may have had negative experiences with health care providers. Missing routine cancer screenings, for example, can lead to cancer being diagnosed at a later stage when it is harder to treat. It is especially important for lesbian and bisexual women to find providers who are accepting and culturally and medically competent.

Detection Breast self-exam (BSE), a method of checking one's own breasts for lumps or suspicious changes, has been widely advocated as a technique that can help women find early variations in their breasts. This implies that finding a lump early will save lives; however, no study to date has found that BSE reduces breast cancer deaths (National Cancer Institute, 2014a). As a result of earlier data, in 2003 the American Cancer Society revised its breast cancer screening guidelines to suggest that BSE be optional; however, the technique can be used to help a woman become familiar with the way her breasts normally look and feel. The screening guidelines from the American Cancer Society and the National Cancer Institute are listed in Table 1.

Another test that has widely been used to detect breast cancer is **mammography**, or the use of X-rays to detect breast tumors before they can be seen or felt. The American Cancer Society (2014.13f) recommends that women aged 40 and older have a mammogram each year and continue to do so even if they are in good health. They suggest that women at increased risk (e.g., having family history, genetic tendency, past breast cancer) should talk with their doctors about the benefits and limitations of mammography screening as well as other detection tests (e.g., magnetic resonance imaging, or MRI) or of having more frequent exams. At the same time, it's important to note that a committee convened by the National Institutes of Health has declined to recommend universal screening with mammography for women; however, the agency did acknowledge that screening mammography may lead to a decrease in breast cancer mortality (National Cancer Institute, 2014a). Helping guide this recommendation were results from one of the largest and longest-running studies of mammograms ever conducted, the Canadian National Breast Cancer Screening Study (Miller, Wall, Baines, Sun, To, & Narod, 2014), which reported that the screening tests do not improve a woman's chances for surviving breast cancer. More specifically, "annual mammography in women aged 40–59 does not reduce mortality from breast cancer beyond that of physical examination or usual care when adjuvant therapy for breast cancer is freely available." The researchers also found that only 20% of cancers detected via mammography and treated with often-dangerous chemotherapy, surgery, or radiation therapies actually posed a threat to the women's health. With this much controversy, the American College of Physicians recommends that women consult with their doctors before undergoing routine mammography as the risk of false-positives and other issues can cause anxiety and possible harm.

TABLE 1 • Screening Guidelines for the Early Detection of Breast Cancer: American Cancer Society and U.S. Preventive Services Task Force

American Cancer Society	U.S. Preventive Services Task Force
Self-Breast Exam (BSE)	
Women in their 20s—optional	Recommends against teaching BSE
Clinical Breast Exam	
Women in their 20s and 30s—periodic/regular health exam, preferably every 3 years	Insufficient evidence to assess benefits and harms
Starting at age 40—yearly exam by health professional	
Mammogram	
Ages 40 and over—yearly and continued testing as long as a woman is in good health	Ages 40–49: Individual choice
	Ages 50–74: Screening mammography recommended every 2 years
	Ages 75 and older: Insufficient evidence to assess benefits and harms*
MRI	
Not recommended if lifetime risk of breast cancer is less than 15% (based on risk assessment tools)	Insufficient evidence to assess balance of benefits and harms*
Insufficient evidence for yearly MRI if lifetime risk is between 15–20%	
Mammogram and MRI	
Yearly only for women who are at high risk for breast cancer based on certain risk factors	Insufficient evidence to assess balance of benefits and harms*

SOURCES: American Cancer Society. (2014.13f). American Cancer Society recommendations for early breast cancer detection in women without breast symptoms. Available: <http://www.cancer.org/cancer/breastcancer/moreinformation/breastcancerearlydetection/breast-cancer-early-detection-ac-recs>; U.S. Preventive Services Task Force. (2009). Breast cancer screening. Available: <http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/breast-cancer-screening?ds=1&s=breast%20cancer> (Last visited 5/7/15).

*U.S. Preventive Services Task Force. (2015). Breast cancer screening draft recommendations. Available: <http://screeningforbreastcancer.org/?ds=1&s=breast%2520cancer%2520screening> (Last visited 5/7/15).

Early detection is an important part of preventive care. The earlier breast cancer is found, the better the chances that treatment will be effective and the breast can be saved. The goal is to discover cancer prior to symptoms appearing. Most physicians believe that early detection of breast cancer saves thousands of lives each year.

It is important to recognize that most breast lumps—75–80%—are *not* cancerous. Many disappear on their own. Of lumps that are surgically removed for diagnostic purposes (biopsied), 80% prove to be benign. Most are related to **fibrocystic disease**, a common and generally harmless breast condition, not really a disease at all, or they are fibroadenomas, round, movable growths, also harmless, that occur in young women. Because some benign breast lumps can increase a woman's chance of developing breast cancer, it is important that any breast lumps be checked by a health care provider.



Angelina Jolie's announcement in 2013 that she had a preventive double mastectomy raised awareness and controversy about breast cancer and the issues around genetic testing, risk, prophylactic surgery, and body image. Preventive mastectomy should only be considered after a woman has received genetic and psychological counseling.

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Treatment Most women with breast cancer undergo some type of surgery to remove the primary tumor. Other reasons for surgery include finding out whether the cancer has spread to the lymph nodes under the arm, restoring the breast's appearance, and relieving symptoms of advanced cancer. Common breast cancer surgeries described by the American Cancer Society (2014.13g) include the following (see Figure 2):

- **Lumpectomy.** This procedure involves the removal of only the breast lump and some normal tissue around it.
- **Partial (segmental) mastectomy.** This surgery involves the removal of more of the breast tissue than with a lumpectomy.
- **Simple, or total, mastectomy.** This operation involves the removal of the entire breast, but not the lymph nodes from under the arm or muscle tissue from beneath the breast.
- **Modified radical mastectomy.** This surgery involves the removal of the entire breast and some of the lymph nodes under the arm. This is the most common breast cancer surgery.
- **Radical mastectomy.** This operation involves the removal of the entire breast, lymph nodes, and chest wall muscles under the breast. Because the modified radical mastectomy has proved to be just as effective, with less disfigurement and fewer side effects, radical mastectomy is rarely done now.

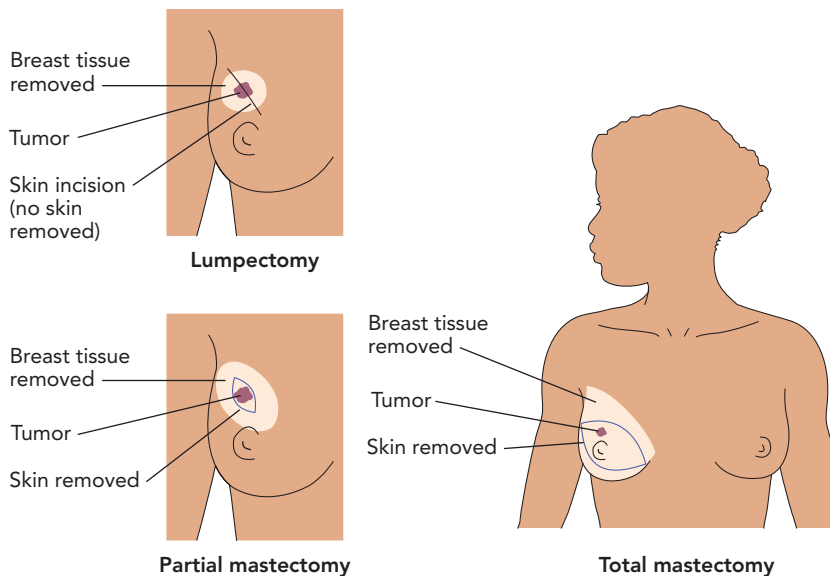
Surgery may also be combined with other treatments such as chemotherapy, hormone therapy, or radiation therapy.

Additional treatments for cancer are external radiation and chemotherapy. The female hormone, estrogen, promotes the growth of breast cancer cells in some women. For these women, several methods, including the use of the drug tamoxifen, can block the effects of estrogen or lower its levels (American Cancer Society, 2014.13g).

• FIGURE 2

Types of Surgical Treatment for Breast Cancer.

(Source: Reprinted by the permission of the American Cancer Society, Inc. from www.cancer.org. All rights reserved.)



Sexual Well-Being and Adjustment After Treatment Sexuality is one aspect of life that may be profoundly altered by cancer. In fact, it is widely recognized that changes to sexual well-being following diagnosis and treatment of breast cancer can be one of the most problematic aspects of life with the impact lasting for many years following successful treatment. The largest study of sexual well-being in the context of breast cancer published to date found that 33% of women report a negative impact on their sexuality. In spite of this significant number, the authors speculate this to be a “significant underestimate” of women’s actual experience. Still, only 25% of breast cancer patients reported that they had discussed sexual well-being with a health professional (Ussher, Perz, & Gilbert, 2012).

For most women, there is little preparation for the many distressing changes that may occur as a result of breast cancer diagnosis and treatment, including decreases in the frequency of sex, sexual arousal, interest, and desire, as well as in sexual pleasure, satisfaction, and intimacy. These may be due to a range of factors, including tiredness and pain, psychological distress and body image, and medically induced menopausal changes, such as vaginal dryness and hot flashes. While these changes are not inevitable, worries about the impact on the body and concern about body image are quite common (Fobair et al., 2006).

Relationship context and partner reaction, along with the complexity of the woman with breast cancer’s own responses, are matters to be addressed both personally and in a health care setting. Psychologically, the loss of a breast may symbolize for a woman the loss of sexuality; she may feel scarred and be fearful of rejection. However, even when a partner is supportive, that validation does not always alleviate the negative feelings that a survivor may



Surviving cancer can deepen one’s appreciation of life. Notice the tattoo along this woman’s mastectomy scars.

© Steve Wisbauer/Photographer’s Choice/Getty Images

have about herself and her sexuality. While both negative and positive accounts of the impact of cancer on sexual relationships have been reported, in a meta-analysis of distress in couples coping with cancer, one researcher summed up the literature by concluding that further research is needed on “just how much cancer intrudes upon and organizes the daily lives of couples” (Hagedoorn et al., 2008, p. 24).

Many women with breast cancer have adjusted well. However, there is still a need to not only understand how various cancer treatments affect sexuality but also to provide support to those with cancer-related sexual function problems. Realizing that there are alternative ways of expressing one’s sexuality can be valuable. The woman and her partner can decide what is satisfying and pleasurable. And, of course, being comfortable with her own sexuality can enhance a woman’s self-esteem and make coping with cancer easier.

Cervical Cancer and Cervical Dysplasia **Cervical dysplasia**, also called **cervical intraepithelial neoplasia (CIN)**, is a condition of the cervical epithelium (covering membrane of cervix). Although this is not cancer, it is considered a precancerous condition. Most cases occur in women aged 25–35, although it can develop at any age (“Cervical Dysplasia,” 2014). Most often cervical dysplasia is caused by the human papillomavirus (HPV), a common virus that is spread through sexual contact. There are several factors that may increase a woman’s risk of cervical dysplasia including having sexual intercourse before age 18, giving birth before age 16, having multiple sexual partners, having another illness, using medications that suppress the immune system, and smoking. Most of the time there are no symptoms. Without treatment many cases of severe cervical dysplasia lead to invasive cancer; the risk of cancer is lower for mild dysplasia. Early diagnosis and prompt treatment cure nearly all cases of cervical dysplasia; however, the conditions may return.

It may take 10 or more years for cervical dysplasia to develop into cancer. The more advanced and dangerous malignancy is invasive cancer of the cervix (ICC), also called **cervical cancer**. The American Cancer Society (2014.13i) estimates about 12,900 new cases of invasive cervical cancer will occur in 2015 and that 4,100 women will die from this disease. As previously stated, the most important risk factor for cervical cancer is infection by the sexually transmitted human papillomavirus (HPV). It’s important to note, however, that most women with HPV do not get cervical cancer because the infection usually goes away on its own, without treatment. Additional risk factors include age (most newly diagnosed cases are found in women under 50), HIV infection, which makes women more vulnerable to HPV, chlamydia infection, poor diet, many sexual partners, a mother who was given diethylstilbestrol (DES) during pregnancy, having sexual intercourse at an early age, long-term use of oral contraceptives, being overweight, having a compromised immune system, cigarette smoking, family history, and low socioeconomic status. When detected and treated in its early stages, the disease is both prevented from spreading to other organs and cured. Unusual discharge, bleeding, spotting, or pain or bleeding during sex may be signs of cervical cancer (American Cancer Society, 2014.13i).

In June 2006, the U.S. Food and Drug Administration approved a vaccine, called Gardasil, that would protect thousands of women each year from cervical cancer. Later, in 2014, the FDA also approved Gardasil 9, which protects against additional HPV strains. The vaccine, the world’s first cancer vaccine

and a major medical advance, works to prevent against the strains of HPV most likely to cause cancer.

Detection The most reliable means of early detection of cervical cancer is the **Pap test** (or Pap smear). This is a simple procedure that can not only detect cancer but also reveal changes in cells that make them precancerous. A Pap test can warn against cancer even before it begins, and the use of the Pap test has resulted in dramatic decreases in cervical cancer deaths in the United States. Newer, liquid-based Pap tests do not find more cancers or precancers than conventional tests but do lower the chance that the test will need to be repeated and have the benefit that the same sample can be used for HPV testing.

The Pap test is usually done during a pelvic exam and takes about a minute. Cell samples and mucus are lightly scraped from the cervix and examined under a microscope. If anything unusual is found, the physician will do further tests. Unfortunately, the test is not as effective in detecting cancer in the body of the uterus, which occurs in women most frequently during or after menopause.

The American Cancer Society (2014.13i) offers the following guidelines for early detection of precancerous changes of the cervix:

- *Cervical cancer screening (testing) should begin at age 21.* Women under age 21 should *not* be tested.
- *Women between ages 21 and 29* should have a Pap test every 3 years. HPV testing should *not* be used in this age group unless it is needed after an abnormal Pap test result.
- *Women over age 65* who have had regular screenings in the previous 10 years should stop cervical cancer screening as long as they haven't had any serious precancers found in the last 20 years. Women with a history of precancers should continue to have testing for at least 20 years after the abnormality was found.
- *A woman who has had a total hysterectomy* (removal of the uterus and cervix) should stop cervical screening unless the hysterectomy was done as a treatment for cervical precancer or cancer. Women who have had a hysterectomy without removal of the cervix should continue cervical cancer screening according to the preceding guidelines.
- *Women of any age* should *not* be screened every year by any screening method.
- *Women who have been vaccinated against HPV* should follow the preceding guidelines.

Some women—because of their history—may need to have a different screening schedule for cervical cancer.

To make the Pap test more accurate, women should not schedule the appointment during their menstrual period. Additionally, for 48 hours prior to the test, they should not have intercourse, douche, or use tampons, birth control foams, jellies, or other vaginal creams or vaginal medications. Coverage for cervical cancer screening is mandated by the Affordable Care Act.

Diagnosis and Treatment If a woman has certain symptoms that suggest cancer or if the Pap test shows abnormal cells she will have a test called a colposcopy. This test itself causes no more discomfort than any other speculum exam, has no side effects, and can be done safely even if a woman is pregnant. If an

think about it

Female Genital Cutting: Mutilation or Important Custom?

In African countries, some parts of Asia, and the Middle East, and among certain immigrant communities in North America and Europe, female infants, girls, or young women may undergo female genital mutilation/cutting (FGM/C). An estimated 100 to 140 million girls and women worldwide have undergone FGM/C and more than 3 million girls are at risk each year on the African continent alone (Population Reference Bureau, 2014). FGM/C is often performed on girls between ages 4 and 12, however in some cultures it is practiced as early as a few days after birth or as late as just prior to marriage. In the late 1970s, several international organizations, including the World Health Organization, began using the term “female genital mutilation” to refer to this procedure emphasizing that the act violates girls’ and women’s human rights, alters or causes injury to the female genital organs, and has no health benefits. The United Nations Children’s Fund and the United Nations Population Fund use the less judgmental expression “female genital mutilation/cutting” (World Health Organization, 2014.13a). For the sake of this discussion, we will use the less judgmental “female genital cutting” as well.

One type of FGC is clitoridectomy, or female circumcision: having their clitoris slit or cut out entirely and all or part of their labia sliced off. The sides of their vulvas or their vaginal openings may be stitched together—a process called infibulation—leaving only a tiny opening for the passage of urine and menstrual blood. These surgeries are generally performed in unsanitary conditions, with a knife, a razor, or even a tin can lid or piece of broken glass, without medical anesthesia; antiseptic powder or concocted pastes may be applied. FGC has no known health benefits. On the contrary, the effects of the devastatingly painful operations include bleeding, infections, infertility, scarring, the inability to enjoy sex, and, not uncommonly, death. Upon marriage, a young woman may experience considerable pain and bleeding as the entry to the vagina is reopened by tearing her flesh. In childbirth, the old wounds must be reopened surgically, or tearing will result. Women who have undergone FGC and their babies are more likely to die during childbirth (World Health Organization, 2014.13a).

This ancient custom, practiced mainly in Africa, is difficult for outsiders to understand. Why would loving parents allow this to be done to their defenseless daughter, and even hold her down during the procedure? As with many other practices, including male circumcision in our own culture, the answer is “tradition.” Persons who



Female genital mutilation/cutting is common in many African and Middle Eastern countries.

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conduct circumcisions and contribute to childbirth needs in communities mostly carry out the practice. However, health care providers perform more than 18% of all FGC, with an increasing trend toward medicalization in many countries (WHO, 2014.13a). Beyond tradition, the surgery is practiced for several reasons, including as a way of controlling women’s sexuality, often resulting in impaired sexual enjoyment.

Though progress has been made in curtailing FGC through international responses and resolutions, research shows that if practicing communities themselves decide to abandon FGC, the practice could be eliminated very rapidly (WHO, 2014.13a). However, strongly held customs are hard to change, and there are still many places where it continues.

Think Critically

1. Which is the better term: *female genital cutting* or *female genital mutilation*? Why?
2. Should female genital cutting be eliminated worldwide or should it be permitted in countries where it is an important custom?
3. Does FGC violate the human rights of girls and women? If so, in what ways? If not, why?

abnormal area is seen on the cervix, a **biopsy**, or a surgical remove of the tissue for diagnosis, will be done. A biopsy is the only way to tell for certain if abnormal cells are precancer, true cancer, or neither. Several types of biopsies are used.

Treating women with abnormal test results can prevent cervical cancer from developing. Thus, if a doctor sees an abnormal area during the colposcopy, he or she will be able to remove it with any one of a variety of procedures. A woman will need follow-up exams to make sure that the abnormality does not return; however, if it does, the treatments can be repeated. Rarely will surgery be required to remove the cervix. The varieties of treatments available are almost always effective in destroying precancers and preventing them from developing into true cancer (American Cancer Society, 2014.13i).

11 *The patient must combat the disease along with the physician.*

—Hippocrates, Aphorisms
(460–370 BCE)

Ovarian Cancer Ovarian cancer is the fifth-ranked cause of cancer death in women. The American Cancer Society (2014.13j) estimates that there will be about 21,290 new cases of ovarian cancer in the United States in 2015 and that about 14,180 women will die from the disease. The odds of a woman getting ovarian cancer during her lifetime are about 1 in 73. The risk of getting ovarian cancer and dying is 1 in 100. Evidence links pregnancy, breastfeeding, tubal ligation or hysterectomy, and use of oral contraceptives or the birth control shot with a lower risk of ovarian cancer, perhaps because each gives the woman a rest from ovulation and eases the hormonal fluctuations that occur within the ovaries.

Factors that increase risk include age (about half of all ovarian cancers are found in women over 63), use of the fertility drug clomiphene citrate, more monthly periods, a family history of ovarian cancer, not having children, estrogen replacement therapy, smoking and alcohol use, breast cancer, obesity, and poor diet. Ovarian cancer is hard to diagnose because there are no symptoms in the early stages; it is not usually detectable by a Pap test. Diagnosis is done by pelvic examination and needle aspiration (removal of fluid) or biopsy. Treatment involves surgical removal of the tumor and ovary, often followed by radiation or chemotherapy. Follow-up care is especially important. If ovarian cancer is found early, the chances of survival are much greater. Though 94% of women will survive at least 5 years if the cancer is found and treated before it has spread outside the ovary, only 20% of ovarian cancers are found at this stage (American Cancer Society, 2014.13j).

Uterine (Endometrial) Cancer Nearly 53,000 new cases of cancers of the uterus were estimated for 2014, with 8,000 women in the United States dying from uterine cancer (American Cancer Society, 2014.13k). More than 95% of cancers of the uterus involve the endometrium, the lining of the uterus. Certain women appear more at risk for developing endometrial cancer than others, including those who are over age 55, are obese, have used estrogen therapy or the drug tamoxifen, have a history of infertility, are diabetic, have menstruated before age 12, or experienced menopause after age 52 (American Cancer Society, 2014.13k).

Hysterectomy The surgical removal of the uterus and ligaments in order to treat some cancers or severe gynecological problems is called a **radical hysterectomy**. The cervix and an inch or two of the deep vagina around the cervix are also removed. If a woman is under the age of 40, the surgeon will often try to leave an ovary or part of one. If a woman is between 40 and 50 when she

has surgery, doctors weigh the benefits of removing both ovaries to prevent ovarian cancer against the costs of causing sudden early menopause. A somewhat less complicated procedure is a hysterectomy, which involves the removal of the upper part of the uterus and cervix. This is most often used to treat endometrial cancer. The ovaries and fallopian tubes are not removed unless there is some other reason to do so (American Cancer Society, 2013.13a).

Certain conditions make a hysterectomy necessary: (1) when a cancerous or precancerous growth cannot be treated otherwise, (2) when noncancerous growths on the uterus become so large that they interfere with other organs, such as when they hinder bladder or bowel functions, or cause pain or pressure, (3) when bleeding is so heavy that it cannot be controlled or when it leads to anemia, and/or (4) when severe infection cannot be controlled in any other way. If a woman's physician recommends a hysterectomy, she should have the opinion confirmed by a second physician.

Removal of the ovaries can result in lowered libido because testosterone, the sex-drive hormone, is mainly produced there. Furthermore, the absence of ovarian estrogen can cause menopausal symptoms such as vaginal dryness and thinning of the vaginal walls. A hysterectomy alone is unlikely to cause sexual function problems. In fact, a radical hysterectomy does not alter a woman's ability to feel sexual pleasure. A woman does not need a uterus or cervix to have an orgasm. Getting educated and participating in therapy or self-help groups can be very useful for post-hysterectomy women who wish to improve the quality of their sexual lives and relationships.

Vaginal Cancer Vaginal cancer is rare. The American Cancer Society (2014.13l) estimated that there were about 3,170 new cases of vaginal cancer in the United States in 2014, with about 880 women dying from this cancer. Although the exact cause of most vaginal cancers is not known, established risk factors include age (almost half of cases occur in women who are 70 and older), mother's use of DES when pregnant, HPV infection, previous cervical cancer, and smoking. Symptoms include abnormal vaginal bleeding, vaginal discharge, a mass that can be felt, and pain during intercourse. Treatment options, based on the type of cancer and the stage of the disease when diagnosed, are surgery, radiation, and chemotherapy in combination with radiation for advanced disease.

Men and Cancer

Generally, men are less likely than women to get regular checkups and to seek help at the onset of symptoms. This tendency can have unfortunate consequences where reproductive cancers are concerned, because early detection can often mean the difference between life and death. Men should pay attention to what goes on in their genital and urinary organs, as well as in the rest of their bodies.

Prostate Cancer Prostate cancer is the most common form of cancer, excluding skin cancer, among American men; it causes the second highest number of deaths among men diagnosed with cancer (lung cancer is first). The American Cancer Society (2014.13m) estimates that there will be about 220,800 new cases of prostate cancer in the United States in 2015, with about 27,540 deaths. One man in 7 will get prostate cancer during his lifetime, but only 1 man in 38 will die from this disease.

Risk factors for prostate cancer include aging, a family history, being African American, a high-fat diet, and obesity. Prostate cancer is more common in North America and northwestern Europe than in Asia, Africa, Central America, and South America. For reasons still unknown, African American men are more likely to have prostate cancer, to have a more advanced disease when it is found, and to die from it than men of other races. Prostate cancer occurs less frequently in Asian American and Hispanic/Latino men than in non-Hispanic White men. About two thirds of prostate cancers are found in men over age 65.

Researchers have tried to determine if there is an association between risk for prostate cancer and ejaculation frequency. A longitudinal study of 29,342 men from the National Cancer Institute revealed that high ejaculations frequency—21 or more ejaculations per month—had a decreased risk of prostate cancer compared with men who reported 4 to 7 ejaculations a month throughout their lifetimes (Leitzmann, Platz, Stampfer, Willet, & Giovannucci, 2004). In theory, high ejaculation frequency may decrease the concentration of potentially irritating or harmful substances in the prostate. Further study is needed to investigate possible protection mechanisms.

Detection Various symptoms may point to prostate cancer, a slow-growing disease, but often there are no symptoms or symptoms may not appear for many years. Although the symptoms in the following list are more likely to indicate prostatic enlargement or benign tumors than cancer, they should never be ignored. By the time signs do occur, the cancer may have spread beyond the prostate. When symptoms do occur, they may include:

- Urine flow that is not easily stopped, weak urinary stream, or the need to urinate more frequently
- Difficulty in getting an erection
- Blood in urine or semen
- Continuing pain in the lower back, pelvis, hips, or other areas from cancer that has spread to bones
- Weakness or numbness in the legs or feet, or loss of bladder control from cancer pressing on the spinal cord

It is important to be aware that other diseases or problems can cause these symptoms.

Like breast cancer screening, guidelines for the detection of prostate cancer are somewhat controversial (see Table 2). With organizations such as the U.S. Preventive Services Task Force (2012) and the American Urological Association (2013), each having slightly different recommendations, it may be difficult for men and their health care providers to decide if prostate screening testing is needed and if so which tests will be conducted. According to evidence reviewed by the National Cancer Institute (2014b), screening with digital rectal exam (DRE) or with prostatic-specific antigen (PSA) will detect some prostate cancer that would have caused problems. However, the organization acknowledges that it is not clear whether early detection and treatment lead to any change in the natural history and outcome of the disease. Based on solid evidence, screening leads to some degree of overtreatment, including radical prostatectomy (removal of the prostate gland) and radiation therapy, both of which can result in permanent side effects in many men.

Updated guidelines from the American Cancer Society (2014.13m) recommend a more individual approach, suggesting that men have a chance to make

TABLE 2 • Screening Guidelines for the Early Detection of Prostate Cancer: American Cancer Society and U.S. Preventive Services Task Force

American Cancer Society	U.S. Preventive Services Task Force
Following a discussion with their doctor, men should make an informed decision about screening. This discussion should take place: ■ at age 50 with average risk; ■ age 45 at high risk; ■ age 40 for highest risk	There is evidence that PSA-based screening programs result in cases of asymptomatic prostate cancer and that these cases will either have a tumor that will not progress or will progress so slowly that it would have remained asymptomatic for the man's lifetime.
Digital Rectal Exam (DRE)	
Can be done as a part of screening	No recommendation
Prostate-Specific Antigen (PSA)	
For men who wish to be screened	Not recommended for any age; screening results in overdiagnosis
Men who do not have a 10-year life expectancy	
No testing	No recommendation

SOURCES: American Cancer Society. (2014). American Cancer Society recommendations for prostate cancer early detection. Available: <http://www.cancer.org/cancer/prostatecancer/moreinformation/prostatecancerearlydetection/prostate-cancer-early-detection-ac-s-recommendations>; U.S. Preventive Services Task Force. (2012). Final recommendation statement: Prostate cancer screening. Available: <http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/prostate-cancer-screening> (Last visited 5/7/15).

an informed decision with their health care provider. It also recommends that doctors stop giving the digital rectal exam (DRE) because it has not clearly shown a benefit, though it can remain an option.

A blood test, called the **prostate-specific antigen (PSA) test**, can be used to help diagnose prostate cancer. At the same time, research shows that PSA poses dilemmas, particularly because levels of PSA can be elevated in men with a benign condition called **prostatic hyperplasia**, when the prostate gland enlarges and blocks the flow of urine. Additionally, the test cannot distinguish between aggressive and mild forms of the disease.

Some research has shown that many, and probably most, tumors discovered during the screenings are so small and slow growing that they are unlikely to do any harm to patients. Prostate cancer develops slowly over many years and most cases are not life-threatening. Other research has shown that when dangerous tumors are found, the mortality rates are usually the same among men who had regular screenings and those who did not see a physician until they developed symptoms. However, if a young man gets prostate cancer it will probably shorten his life if it is not caught early. For an older man or one in poor health, prostate cancer may never become a major problem because it often grows so slowly.

Detection Depending on the stage of the cancer and age of the man, treatment may include surgery, androgen deprivation therapy, radiation therapy, chemotherapy, or a combination of any of these. Some men may simply undergo active surveillance. If the cancer has not spread beyond the prostate gland, all or part of the gland may be removed by surgery. Radical surgery has a high cure rate,

11 *Oh, to be seventy again [at the age of 91, upon seeing a young woman].*

—Oliver Wendell Holmes, Sr.
(1809–1894)



Testicular Self-Examination

Most doctors agree that a man increases the chances of early cancer detection by performing a monthly testicular self-exam. However, doctors still debate whether a man should perform this exam. What they do agree upon is that it is important for a man to know what his own testicles feel like normally so that he will recognize any changes. The best time to perform the examination is after a warm shower or bath, when the scrotum is relaxed.

1. Stand in front of a mirror and look for any swelling on the scrotum.
2. Hold the penis out of the way and examine each testicle separately. With your thumb on top of the testicle and two fingers underneath, gently roll the testicle to check for lumps or areas of particular firmness. A normal testicle is smooth, oval, and uniformly firm to the touch. Don't worry if your testicles differ slightly in size; this is common. And don't mistake the epididymis, the sperm-carrying tube at the rear of the testicle, for an abnormality.
3. If you find any hard lumps or nodules, or if there has been any change in shape, size, or texture of the testicles, a sudden collection of fluid in the scrotum, a dull ache in the lower back or pain in a testicle or the scrotum, consult a physician. These signs may not indicate a malignancy, but only your physician can make a diagnosis.



Most testicular cancers can be found at an early stage.

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SOURCE: American Cancer Society. (2015.13a). Testicular self-exam. Available: <http://www.cancer.org/cancer/testicularcancer/moreinformation/doi-havetesticulercancer/do-i-have-testicular-cancer-self-exam> (Last visited 5/7/15).

but it often results in incontinence and erectile difficulties. Because prostate cancer often spreads slowly, some men may never need treatment. The premise of watchful-waiting is that cases of localized cancer may advance so slowly that they are unlikely to cause men, especially older men, any health problems during their lifetime.

Sex counseling should be an integral part of treatment for men who have had prostate cancer surgery. The American Cancer Society (2014.13m) also suggests several options for erection-enhancing drugs—Viagra, Levitra, Stendra, or Cialis—for those who experience erection difficulties after surgery. These drugs will not work, however, if important nerves are removed or damaged during surgery.

Since the exact cause of prostate cancer is unknown, it is not possible to prevent most cases of the disease. But many risk factors can be controlled. The American Cancer Society (2014.13m) suggests eating less red meat and fat and eating more vegetables, fruits, and whole grains, which may also lower one's risk for some other types of cancer and diseases. Some evidence shows that taking the drug Proscar or Avodart might help reduce the risk of prostate cancer,

but it's not clear if the benefits outweigh the risks. The American Cancer Society (2014.13m) recommends that men thinking about taking these drugs to reduce their risk of prostate cancer discuss it with their doctors.

Testicular Cancer According to the American Cancer Society (2013.13b), about 8,820 new cases of testicular cancer were estimated to be diagnosed in 2014, with an estimated 380 deaths. The chance of a man developing testicular cancer in his lifetime is 1 in about 270. Because treatment is very successful, the risk of dying from this cancer is 1 in 5,000. The exact cause of most cases of testicular cancer is unknown, but risk factors include age (the average age at the time of diagnosis is about 33), undescended testicle(s), a family history of testicular cancer, HIV infection, cancer of the other testicle, and race and ethnicity. A man who has had cancer in one testicle has about a 3% chance of developing cancer in the other testicle. This is usually a new cancer. The risk of developing testicular cancer in the United States is about 4 to 5 times greater for White men than for African American men and more than 3 times that for Asian American men. The risk for Hispanics is between the risks for Asians and non-Hispanic Whites (American Cancer Society, 2013.13b).

Detection Most cases of testicular cancer can be found as a result of signs or symptoms. The first sign of testicular cancer is usually a painless lump or slight enlargement and a change in the consistency of the testicle or the testicle becomes swollen or large. Some types of testicular cancers have no symptoms until the advanced stage. Although the tumors that grow on the testes are generally painless, there may be low back pain. If the tumor is growing rapidly, there may be severe pain in the testicles. Because of the lack of symptoms and pain in the early stage, men often do not go to a doctor for several months after discovering a slightly enlarged testicle.

The examination of a man's testicles is a valuable part of a general physical examination and the American Cancer Society includes testicular examination in its recommendations for routine cancer-related checkups. Whether a man should perform a regular testicular self-examination is debated, though. The American Cancer Society (2013.13b) believes that it is important to make men aware of testicular cancer and to remind them that any testicular mass should be immediately evaluated by a physician. Some doctors recommend monthly testicular self-examination by all men after puberty. The American Cancer Society (2013.13b) believes that for men with average testicular cancer risk there is no medical evidence to suggest that monthly examination is any more effective than simple awareness and prompt medical attention. However, whether to perform this examination is a decision best made by each man. Men with certain risk factors, such as previous testicular cancer or a family history should consider monthly self-examinations and discuss the issue with their doctors. Most often ultrasound and blood tests are used as diagnostic tools for testicular cancer.

Treatment Testicular cancer is a highly treatable form of cancer. The three main methods of treatment are surgery, radiation therapy, and chemotherapy. After the affected testicle is removed, an artificial one may be inserted in the scrotal sac. Radiation treatment or chemotherapy may follow.

Although the cure rate for all types of testicular cancer is very high, provided the disease has not widely metastasized, the man's fertility is often a major concern. Since boys and men usually develop cancer in only one testicle, the remaining testicle usually can make enough testosterone to keep a man healthy and able to reproduce. If the other testicle needs to be removed because the cancer is in both testicles or if it has spread, the man will need to take some form of testosterone therapy for the rest of his life. However, testicular cancer or its treatment can make a man infertile. Thus, before treatment starts, men who might wish to father children may choose to store sperm in a sperm bank for later use. Advances in assisted reproductive methods such as in vitro fertilization have also made fatherhood possible, even if a man's sperm counts are extremely low. In some cases, if one testicle is left, fertility returns after the testicular cancer has been treated. This typically occurs at about 2 years after chemotherapy has stopped (American Cancer Society, 2013.13b).

Penile Cancer Cancer of the penis affects only 1 out of every 100,000 men and accounts for less than 1% of cancers in men in the United States. The American Cancer Society (2013.13b) estimated that about 1,640 new cases of penile cancer were diagnosed in 2014, with an estimated 320 deaths from it. Although it is very rare in North America and Europe, it is more common in parts of Africa and South America, where it accounts for up to 10% of cancers in men. Risk factors include HPV infection, smoking, having AIDS, being treated for psoriasis with ultraviolet light and a drug called psoralen, and age. Nearly two thirds of cases are diagnosed in men over 65. For reasons not entirely clear, men who are circumcised as babies have less than half the chance of getting cancer of the penis than those who are not.

Many cases of penile cancer can be detected early on. Men should be alert to any unusual growths on or other abnormalities of the penis. If such changes occur, men should promptly consult a physician. Treatment options include surgery, radiation, and chemotherapy. Most early-stage penile cancers can be completely cured by fairly minor surgery with little or no damage to the penis. Removal of all or part of the penis is rare except for late-stage cancer. Adult men can lower their risk of penile cancer by avoiding the things that are known to increase the risk.

Breast Cancer in Men Breast cancer is about 100 times less common among men than among women. The lifetime risk of a man getting breast cancer is 1 in 1,000. However, an estimated 2,350 new cases of breast cancer are estimated to occur in 2015 in men in the United States, with about 440 deaths (American Cancer Society, 2014.13n). As is the case for women, most breast disorders in men are benign. Known risk factors include aging (the average age is about 68 at diagnosis), family history of breast cancer for both male and female blood relatives, heavy alcohol use, inherited gene mutation (responsible for some breast cancers in women), Klinefelter syndrome, radiation exposure, liver disease, physical inactivity and obesity, and estrogen treatment (for prostate cancer, for example). Symptoms of possible breast cancer include a lump or swelling of the breast, skin dimpling or puckering, nipple retraction (turning inward), redness or scaling of the nipple or breast skin, and discharge from the nipple. Diagnosis involves clinical breast examination, mammography, ultrasound, nipple discharge examination, and biopsy. Male breast cancer is treated

with surgery, radiation therapy, and chemotherapy. The survival rate is very high following early-stage detection and are about the same for both men and women when looking at each stage of breast cancer (American Cancer Society, 2014.13n).

Anal Cancer in Men and Women

Anal cancer is fairly uncommon, although the number of cases has been increasing for many years. The American Cancer Society (2014.13o) estimated that about 7,270 new cases of anal cancer will be diagnosed in 2015, with about 1,010 deaths. Women get anal cancer slightly more often than men. Most anal cancer may be due to high prevalence of HPV infection. In fact, women with a history of cervical or precervical cancer have an increased risk of anal cancer. Additionally, risk factors include having numerous lifetime sex partners, history of receptive anal intercourse particularly under age 30, HIV infection, anal warts, and smoking. Pain in the anal area, change in the diameter of the stool, abnormal discharge from the anus, and swollen lymph glands in the anal or groin areas are the major symptoms of anal cancer. Bleeding occurs in more than half of the cases of anal cancer and is usually the first sign of the disease. The digital rectal examination for prostate cancer will find some cases of rectal cancer. Like many other cancers, surgery, radiation therapy, and chemotherapy are the major treatments for anal cancer (American Cancer Society, 2014.13o). Because the majority of anal cancers are linked to HPV and HIV, condoms will provide some protection against the virus. As previously discussed, vaccines are available to protect against certain HPV infections as well as help prevent anal cancers and precancers in both men and women.

● Additional Sexual Health Issues

In this section, we discuss two disorders of the female reproductive system, toxic shock syndrome and endometriosis, as well as some other sexual health issues.

Toxic Shock Syndrome

Toxic shock syndrome (TSS) is caused by the *Staphylococcus aureus* bacterium, a common agent of infection. This organism is normally present in the body and usually does not pose a threat. Although the earliest cases of TSS involved women who were using tampons, today less than half of the cases are associated with their use. Toxic shock syndrome can also occur with skin infections, burns, and after surgery and can affect children, postmenopausal women, and men (“Toxic shock syndrome,” 2012). Women of all ages can get TSS, but those under age 30 are at higher risk because they may not have developed antibodies to the disease. TSS can occur in men—for example, from skin wounds and surgery—but it is uncommon.

It is recommended that all women who use tampons reduce the already low risk by carefully following the directions for insertion, choosing the lowest-absorbing one for their flow, changing the tampon more frequently, and using tampons less regularly (“Toxic shock syndrome,” 2012).

TSS can be treated effectively if it is detected. The warning signs are sudden fever (102°F or higher), diarrhea, low blood pressure, a rash that peels after 1–2

weeks, and problems with the function of at least three organs. Additionally, there may be vomiting, fainting or nearly fainting, and muscle aches and headaches. Early detection is critical; otherwise, TSS can be fatal. Women should talk with their health care provider about any new information regarding prevention.

Vulvodynia

One condition that has received little attention from the general public is **vulvodynia**, defined as chronic vulvar pain or discomfort of the vulva (“Vulvodynia,” 2013). The specific cause of the pain is unknown; however, it tends to be diagnosed when other causes of vulvar pain, such as infections or skin diseases, are ruled out. Additionally, the condition may be associated with any number of factors, including injury or irritation of the nerves in the pelvic region, elevated levels of inflammatory substances in the vulvar tissue, or pelvic floor muscle weakness or spasm. Though the exact number of women with vulvodynia is unknown, it is estimated that 9–18% of women between the ages of 18 and 64 may experience vulvar pain during their lifetimes (Arnold, Bachmann, Rosen, & Rhoads, 2007). Because many women either do not seek help or are unable to receive answers from their doctors, many are without treatment. However, once diagnosed, a variety of treatment options are available, including topical medications; drug treatments, including pain relievers, antidepressants, or anticonvulsants; biofeedback therapy; physical therapy to strengthen pelvic floor muscles; and surgery to remove the affected skin and tissue in localized vulvodynia.

Endometriosis

Endometriosis is a disease in which tissue that normally grows inside the uterus instead grows outside the uterus (“Endometriosis,” 2013). It is one of the most common gynecological diseases, with its primary symptoms including pain and infertility. Most lesions or patches of endometriosis occur in the pelvic cavity, either on or under the ovaries, on the fallopian tubes, behind the uterus, or on the bowels or bladder. Interestingly, the size and location of the lesions are not related to the severity of the pain or its location. Because some women have endometriosis but may not have symptoms or have it diagnosed, it’s difficult to know how many actually have the condition. Estimates suggest that 6–10% of women of reproductive age, or 5 million women in the United States, have the disease. Factors that may increase the risk of endometriosis include a relative who has had the disease, menstrual periods that started before age 11, shorter monthly cycles (less than 27 days), and menstrual cycles that are heavy and last more than 7 days.

Symptoms of endometriosis include pain (usually pelvic pain, which can be very intense), very painful cramps or periods, heavy periods, intestinal pain, pain during or after sex, and infertility. Some women do not have symptoms and may not find out they have the disease until they have trouble getting pregnant. It is usually diagnosed by imaging tests (e.g., ultrasound); however, surgery is the only way to be sure of the diagnosis. There is currently no cure for endometriosis, but there are ways to minimize the symptoms caused by the condition, and endometriosis-related fertility often can be treated successfully using hormones and surgery (“Endometriosis,” 2013).

Prostatitis

Prostatitis is a frequently painful condition that involves inflammation of the prostate and sometimes the area around the prostate (“Prostatitis,” 2014). It is the most common urinary tract problem for men younger than age 50 and the third most common among men older than age 50. There are currently four types of prostatitis, one of which is chronic, two are bacterial, and one is asymptomatic and inflammatory. The factors that affect a man’s chance of developing prostatitis differ depending on the type; however, men with nerve damage in the lower urinary tract due to surgery or trauma and men with a history of lower urinary tract infections are more vulnerable to this problem.

Symptoms of prostatitis vary and depend on the cause, but many include frequent and urgent need to urinate and pain or burning when urinating, often accompanied by pelvic, groin, or low-back pain. Prostatitis can be difficult to diagnose because the symptoms often are similar to those of other medical conditions such as bladder infections, bladder cancer, or prostate enlargement. Digital rectal exam and urine, semen, and blood tests are used to diagnose prostatitis. A biopsy may also be taken. Treatment depends on the type of prostatitis and can include anti-inflammatory drugs, antibiotics, and/or pain medications.

A man does not necessarily need to avoid sexual intercourse if he has prostatitis. Prostatitis is usually not made worse by sexual activity, although sometimes men with prostatitis will experience pain during ejaculation or sexual intercourse. If sex is too painful, a man may consider abstaining from sexual activity until the prostatitis symptoms improve (Mayo Clinic, 2014.13a).

● Sexual Orientation and Health

Research specifically focused on sexual orientation did not begin until the 1950s. Then the origins of sexual orientation and the psychological functioning of gay, lesbian, bisexual, and transgendered (GLBT) individuals were the focus of inquiry. During the 1970s, studies of GLBT people as psychologically healthy individuals emerged, and some of the research of the 1980s examined issues related to the development of GLBT individuals across their life span. With the advent of HIV/AIDS occurring in the United States in the 1980s, research priorities shifted to the biology of the disease and preventive means to stop it. Even as this continues, it is apparent that the study of sexual orientations and sexual well-being is relatively new and still emerging.

As discussed elsewhere, the inclusion of sexual orientation in CDC survey data collection finally allows evidence to be submitted that might influence research decisions and funding about special and unique health needs of sexual minorities (Ward, Dahlhamer, Galinsky, & Joestl, 2014). Data reveal significant differences in health-related behaviors, health status, and health care access and utilization among U.S. adults aged 18–64 who identified as straight, gay, lesbian, or bisexual (GLB). Specific health behaviors that show disparities between those who identified as GLB as compared with those who identified as straight included a higher incidence of smoking and alcohol consumption among the GLB population. Additionally, a higher percentage of those who identified as bisexual experienced serious psychological distress in the past 30 days

compared with their straight counterparts, while a higher percentage of bisexual women were obese. Regarding health care access, a higher percentage of those who identified as lesbian and bisexual indicated they did not have a usual place to go for medical care, with bisexual adults having the highest rates of failure to obtain needed medical care in the past year due to cost (Ward et al., 2014).

Among these disparities, discrimination causes many GLBT people to avoid seeking medical care, and when they do get treatment, evidence shows that GLBT people are often not treated with the respect or cultural competence that other patients receive and deserve (Human Rights Campaign, 2015). For example, 56% of GLB people and 70% of transgender and gender nonconforming people had at least one of the following experiences when attempting to access health care: being refused needed care; health care professionals refusing to touch them or using excessive precautions; health care professionals using harsh or abusive language; being blamed for their health status; or health care professionals being physically rough or abusive (Lambda Legal, 2010). Among those diagnosed or living with HIV, it is estimated that in 2015 half of all Americans living with HIV will be over the age of 50, yet one of every six new HIV diagnoses is in a person over age 50. In addition to suffering other medical ailments, only half of those older Americans who have HIV are in care, and only a third of them have suppressed viral loads (SAGE, 2013).

Seeking to address these and previously reported disparities between the GLBT and straight populations, the U.S. Department of Health and Human Services' *Healthy People 2020* initiative now includes the goal of improving the health, safety, and well-being of gay, lesbian, bisexual, and transgendered persons. In the meantime, there are still enormous challenges that remain for LBGT communities in accessing quality, nondiscriminatory health care services. These barriers often result in poorer health outcomes and have serious and even catastrophic consequences to both individuals and society.

Final Thoughts

In this chapter, we've explored issues of self-image and body image as they interact with our society's ideas about beauty and sexuality. We've considered the effects of alcohol and certain drugs on our sexuality. We've looked at physical limitations and disabilities and cancer and other health issues. Our intent is to provide you with information in order to help assist you in identifying potential problems and making responsible decisions around your own health and well-being as well as to stimulate your thinking about how society deals with certain aspects of sexual health. We encourage you to learn more about your own body and your own sexual functioning. If things don't seem to work right, if you don't feel well, or if you have questions, consult your physician or other health care practitioner. If you're not satisfied, get a second opinion. Read about health issues that apply to you and the people you're close to. Because we live in our bodies, we need to appreciate and respect them. By taking care of ourselves physically and mentally, we can maximize our pleasures in sexuality and in life.



Summary

Living in Our Bodies: The Quest for Physical Perfection

- *Sexual health* is a state of physical, emotional, mental, and social well-being related to sexuality. As such, it requires us to know, understand, and feel comfortable with our bodies.
- Our society is preoccupied with bodily perfection. As a result, *eating disorders* have become common, especially among young women. Eating disorders reduce a person's health and vigor; are carried out in secrecy; are accompanied by obsessions, depression, anxiety, and guilt; lead to self-absorption and emotional instability; and are characterized by a lack of control.

Alcohol, Drugs, and Sexuality

- Drugs and alcohol are commonly perceived as enhancers of sexuality, although in reality this is rarely the case.
- Researchers are beginning to believe that alcohol use among young people is just one component of an overall risky health behavior pattern—not the cause of sexual risk behavior—and that other factors are powerful causes of risk.
- Some people use alcohol to give themselves permission to be sexual. Some men may use alcohol to justify sexual violence. People under the influence of alcohol or drugs tend to place themselves in risky sexual situations, such as exposing themselves to sexually transmitted infections.
- Substances that purport to increase sexual desire or improve sexual performance are called *aphrodisiacs*. It's important to note that the placebo effect may account for approximately 33% of reported response to an aphrodisiac.

Sexuality and Disability

- A wide range of disabilities and physical limitations can affect sexuality. People with these limitations need support and education so that they can enjoy their full sexual potential. Society as a whole needs to be aware of the concerns of people with disabilities and to allow them the same sexual rights as others have.

- Chronic illnesses such as diabetes, cardiovascular disease, and arthritis pose special problems with regard to sexuality. People with these diseases and their partners can learn what to expect of themselves sexually and how to best cope with their particular conditions.

Sexuality and Cancer

- Cancer in its many forms occurs when cells begin to grow aberrantly. Most cancers form tumors. *Benign tumors* grow slowly and remain localized. *Malignant tumors* can spread throughout the body. When malignant cells are released into the blood or lymph system, they begin to grow away from the original tumor; this process is called *metastasis*.
- Other than cancers of the skin, breast cancer is the most common cancer among women. Although the survival rate is improving, those who survive it may still suffer psychologically. *Mammograms* (low-dose X-ray screenings) are the principal method of detection, though some are challenging its risks versus benefits. Surgical removal of the breast is called *mastectomy*; surgery that removes only the tumor and surrounding lymph nodes is called *lumpectomy*. Radiation and chemotherapy are also used to fight breast cancer.
- *Cervical dysplasia*, or *cervical intraepithelial neoplasia (CIN)*, the appearance of certain abnormal cells on the cervix, can be diagnosed by a *Pap test*. It may then be treated by *biopsy*, cauterization, cryosurgery, or other surgery. If untreated, CIN may lead to cervical cancer.
- New cases of ovarian cancer have been slowly decreasing since 1991. Pregnancy, breastfeeding, birth control, tubal ligation, and hysterectomy are considered factors that lower the risk of ovarian cancer.
- Several vaccinations, the most common one known as Gardasil and Gardasil 9, guards against strains of the STI human papillomavirus (HPV) that cause cervical cancer and genital warts and are available for males and females.
- Nearly all cancers of the uterus involve the endometrium, the lining of the uterus. Uterine cancer is treated with surgery (hysterectomy), radiation, or both.

- A *radical hysterectomy* is the surgical removal of the uterus and its ligaments in order to treat some cancers or severe gynecological problems. A hysterectomy is required when cancerous or precancerous growths cannot be treated with less invasive procedures, when noncancerous growths interfere with other organs, when heavy bleeding or severe infection cannot be otherwise controlled, and when severe infection cannot be otherwise controlled.
- Prostate cancer is the most common form of cancer among men, excluding skin cancer. If detected early, it has a high cure rate. It is recommended that men discuss with their doctor the risks and benefits of prostate cancer screening. Surgery, radiation, hormone therapy, and chemotherapy are possible treatments.
- Testicular cancer affects relatively young men with the average age of diagnosis being 33. If caught early, it is curable. Self-examination is recommended by some doctors for early detection.
- Penile cancer affects only 1 in 100,000 men in the United States, with most early-stage cancers being completely cured. Men can develop breast cancer, but this cancer is 100 times more common among women.
- Anal cancer is uncommon, although it has been increasing in both men and women in recent years.

Additional Sexual Health Issues

- *Toxic shock syndrome (TSS)* is a potentially fatal disease caused by the *Staphylococcus aureus* bacterium. The disease is easily cured with antibiotics if caught early.
- *Vulvodynia* is a chronic vulvar pain or discomfort of the vulva. At this time, there is no cure for vulvodynia.
- *Endometriosis* is a disease in which tissue that normally grows inside the uterus instead grows outside the uterus. It is a major cause of infertility. Symptoms include intense pelvic pain and abnormal menstrual bleeding. Treatment depends on a number of factors. Various hormone treatments and types of surgery are employed.
- *Prostatitis* is the inflammation of the prostate gland. Antibiotics and pain medications are the primary treatment for prostatitis. No evidence has been found that prostatitis increases the risk of prostate cancer.

Sexual Orientation and Health

- The inclusion of sexual orientation in CDC survey data collection finally allows evidence to be submitted that might influence research decisions and funding about special health needs of sexual minorities.
- Discrimination causes many LGBT people to avoid seeking medical care, and when they do many are often not treated with respect or cultural competence.

Questions for Discussion

- Is there too much emphasis on body perfection in our society? Have you had friends who took extreme measures to make their body fit the cultural ideal? How have you dealt with pressure to have a certain body?
- How comfortable are you in discussing your sexual and reproductive health with your doctor? If you feel uncomfortable, why do you think you feel that way?
- Do many of your peers use alcohol as a “sexual lubricant,” hoping that its use will lead to sexual activity? Do you know of individuals who regret being sexual while under the influence of alcohol? What, in your opinion, is the role of alcohol in dating?

Sex and the Internet

Cancer and Sexuality

The American Cancer Society (ACS) has an extensive website that provides detailed information on prevention of and risk factors for, detection and symptoms of, and treatment for the various cancers, including those of the reproductive system. The impact of cancer of the reproductive structures on sexuality also is discussed. Go to the ACS website (<http://www.cancer.org>) to research this issue. After getting on the website, select a specific type of cancer, and answer the following questions:

- What are the risk factors for the cancer?
- How can that type of cancer be prevented?
- What are some of the methods used to treat this form of cancer?
- What are the sexuality-related outcomes of the cancer and its treatment?

Suggested Websites

National Breast Cancer Foundation

<http://www.nationalbreastcancer.org/>

Aims to help women by providing information and help and inspiring hope to those affected by breast cancer.

National Cancer Institute

<http://www.cancer.gov/>

Supports and disseminates research and information that help expand our understanding of cancer: its screening, causes, treatments, and prevention.

National Coalition for Sexual Health

<http://nationalcoalitionforsexualhealth.org/>

Aims to improve sexual health and well-being by encouraging conversations about sexual health and promoting high quality sexual health information and health services.

National Eating Disorders Association

<http://www.nationaleatingdisorders.org/>

Dedicated to providing education, resources, and support to those affected by eating disorders.

Services and Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders (SAGE)

<http://sageusa.org/>

The country's largest and oldest organization dedicated to improving the lives of lesbian, gay, bisexual, and transgender (LGBT) older adults, including quality-of-life issues related to health and wellness.

Testicular Cancer Resource Center (TCRC)

tcrc.acor.org

Devoted to helping people understand testicular and extragonadal germ cell tumors.

Zero—The End of Prostate Cancer

www.zerocancer.org

Contains information on prostate cancer, outreach, and advocacy.

Suggested Reading

Aggleton, P., & Parker, R. (eds.). (2012). *Routledge Handbook of Sexuality, Health and Rights*. New York: Routledge.

Provides an overview of emerging and controversial issues in the field of human sexuality, including sexual health and human rights.

Cash, T. F., & Smolak, L. (eds.). (2011). *Body Image: A Handbook of Science, Practice and Prevention*. New York: Guilford Press. A comprehensive volume of specific topics that address the complexity of body image experiences.

Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities; Board on the Health of Select Populations. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: Institute of Medicine. Assesses the state of science on the health status of the LGBT populations, identifies research gaps and opportunities, and outlines a research agenda for the National Cancer Institute.

Katz, A. (2009). *Woman, cancer, sex*. Also: *Man, cancer, sex*. (2009). Pittsburgh: Hygenia Press. Both books explain the changes that many women and men with cancer experience and offer practical and compassionate advice on how to handle these changes.

McRuer, R., & Mollow, A. (eds.). (2012). *Sex and Disability*. Durham, NC: Duke University Press. This collection of essays considers how sex and disability come together and how disabled people negotiate sex and sexual identities in an ableist and heteronormative culture.

chapter 14

Sexual Function Difficulties, Dissatisfaction, Enhancement, and Therapy



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CHAPTER OUTLINE

Sexual Function Difficulties: Definitions, Types, and Prevalence

Physical Causes of Sexual Function Difficulties and Dissatisfaction

Psychological Causes of Sexual Function Difficulties and Dissatisfaction

Sexual Function Enhancement

Treating Sexual Function Difficulties



Student Voices

when sexual desire is so high that I can't control myself. Why is this?"

—19-year-old male

"My friend has a problem that seems to occur once every few months. He suddenly becomes not able to get erect. It seems like it happens very suddenly."

—18-year-old male

"I have not experienced any sexual function difficulties. On the other hand, I have been with my boyfriend for 3 years and I only had two orgasms. I enjoy having sex with him

—21-year-old female

"When having a sexual experience with a new partner, I sometimes have a sense of guilt about past relationships. This can make performing in the new situation really difficult."

—21-year-old male

"I always had a really low sex drive with past boyfriends. I never understood why until I started dating my current boyfriend. The key is communication! We're open with each other and honest about what we like and dislike. Now my sex drive is through the roof!"

—20-year-old female

II *When sex is good, it's 10% of the relationship. When it is bad, it's 90%.*

—Charles Muir

II *When our innermost desires are revealed and are met by our own loved one with acceptance and validation, the shame dissolves.*

—Esther Pevel
(1958–)

THE QUALITY OF OUR SEXUALITY is intimately connected to the quality of our lives and relationships. Because our sexuality is an integral part of ourselves, it reflects our excitement and boredom, intimacy and distance, emotional well-being and distress, and health and illness. As a consequence, our sexual desires and activities ebb and flow. Sometimes, they are highly erotic; other times, they may be boring. Furthermore, many of us who are sexually active may sometimes experience sexual function difficulties or problems, often resulting in disappointment in ourselves, our partners, or both. Studies indicate that many men and women report occasional or frequent lack of desire, problems in arousal or orgasm, and pain during intercourse or noncoital sex. Here are the “real-life” facts that illustrate that not all couple sex matches media portrayals of couples always having great sex (McCarthy & McCarthy, 2003, 2009):

- Less than 50% of happy, sexually satisfied couples described having similar desire, arousal, orgasm, and pleasure during a particular sexual episode.
- For about 25% of the sexual experiences, one partner described the sex as positive, whereas the other considered it as “OK.” However, these experiences were good for nourishing the intimacy of the relationship. Sometimes one partner “went along for the ride.”
- Fifteen percent of sexual experiences were considered unremarkable even though there were no sexual function problems. If the couple had to do it over again, they probably would have chosen something else to do.
- Five to 15 percent of the sexual experiences were dissatisfying or represented a sexual function problem.

Later in this chapter, we discuss the prevalence and predictions of sexual function difficulties found in five nationally representative studies to illustrate the commonality of sexual problems. The widespread variability in our sexual

functioning suggests how “normal” at least occasional sexual difficulties are. Sex therapist Bernie Zilbergeld (1999) writes:

Sex problems are normal and typical. I know, I know, all of your buddies are functioning perfectly and never have a problem. If you really believe that, I have a nice piece of oceanfront property in Kansas I’d like to talk to you about.

In this chapter, we look at several common sexual function difficulties, their causes, and ways to enhance your sexuality to bring greater pleasure and intimacy.

● Sexual Function Difficulties: Definitions, Types, and Prevalence

Most of the literature concerning sexual difficulties or problems with sexual functioning deals with heterosexual couples; thus, most of the discussion in this chapter reflects that bias. Unfortunately, too little research has been done on the sexual function difficulties of gay, lesbian, bisexual, or transgender individuals and couples (Institute of Medicine, 2011). In general, heterosexual individuals, gay men, and lesbian women seemingly experience similar kinds of sexual function problems, yet further research is needed on sexual function difficulties among varied populations.

Defining Sexual Function Difficulties: Different Perspectives

The line between “normal” sexual functioning and a sexual difficulty or problem is not always clear. Enormous variation exists in levels of sexual desire and forms of expression, and these differences do not necessarily indicate any sexual function difficulty. It can be challenging to determine exactly when something is a sexual function problem, and so we must be careful in defining a particular sexual function difficulty as a problem. Some people have rigid and possibly unrealistic expectations for their own or their partner’s sexual expression and may perceive something wrong with their behavior that need not be considered a “sexual function problem.” Still, people sometimes experience difficulties in sexual function that are so persistent that they would benefit from sex therapy (Strassburg & Mackaronis, 2014).

Health care providers, including sex therapists, need to be aware of different types of sexual function difficulties that can interfere with sexual satisfaction and intimacy. Therefore, a structure to diagnose and address difficulties can be valuable. However, there has been some debate among sexuality and mental health professionals about which terms accurately describe sexual function problems and how to classify these difficulties (West, Vinikoor, & Zolnoun, 2004). Though categories such as “dysfunction,” “disorder,” “difficulty,” and “problems” have been used, this chapter presents alternate classification models.

The standard medical diagnostic classification of sexual function difficulties is found in the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (APA, 2013), which uses the terms “dysfunction” and “disorders.” Because the *DSM*’s is the most widely used classification system, the discussion of various sexual function difficulties in the professional literature is largely based on the *DSM* and uses the terms “sexual dysfunction” and “sexual disorders.” Thus, the *DSM* terminology is quoted often in this chapter, particularly in the context of the *DSM* categories of sexual dysfunction.

“Most of sex is psychological—most of it is between our ears and not between our legs.

—Joy Browne
(1944–)



Couples can experience sexual function difficulties that may lead to dissatisfaction, as well as frustration, with their sex lives.

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An alternative term to “sexual dysfunction” is **sexual function dissatisfaction**. Sexual dissatisfaction is a common outcome of a difficulty in sexual functioning. In contrast to the broad medical focus of the *DSM* term, this term reflects an individual perception. That is, a person or couple can experience some of the *DSM* dysfunctions yet be satisfied with their sex lives. The difficulty in functioning might be considered a “dysfunction” only when the two people are dissatisfied and decide they may have a problem. The “dissatisfaction” concept is a fundamental tenet of the classification system for women’s sexual problems of the Working Group for a New View of Women’s Sexual Problems (2001). The system begins with a woman-centered definition of sexual function problems as “discontent or dissatisfaction with any emotional, physical, or relational aspects of sexual experience”—a definition that could also be applied to men. Furthermore, according to the World Health Organization’s (2010.14a) International Classification of Diseases and Related Health Problems (ICD-10), “sexual dysfunction” includes “the various ways in which an individual is unable to participate in a sexual relationship as he or she would wish.”

An advantage of the term “sexual function dissatisfaction” is that it acknowledges sexual scripts as individual and avoids an overarching definition of what is “normal” versus what is dysfunctional (i.e., pathological). Adopting this subjective and personal view might help people be more comfortable with their own sexuality and less likely to feel “sexually flawed.” We favor the terms “sexual function difficulties” and “sexual function dissatisfaction” and use them in this chapter whenever possible. However, in citing reports or research related to sexual difficulties, we often utilize the terms used therein.

Two alternate classifications of sexual function difficulties and dissatisfaction, based on medical and feminist models, illustrate different perspectives on the origins and causes of sexual problems: the *DSM-5* and the Working Group for a New View of Women’s Sexual Problems.

The Diagnostic and Statistical Manual of Mental Disorders The fifth edition of the APA’s *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* (2013) labels sexual function difficulties as disorders and characterizes them according to the four phases of Masters and Johnson’s sexual response cycle. The *DSM-5* defines **sexual dysfunction** as “a clinically significant disturbance in a person’s ability to respond sexually or to experience sexual pleasure.” The *DSM-5* sexual dysfunctions/disorders are presented in Table 1. More specific diagnostic criteria are presented in the discussion of each dysfunction/disorder. Several changes in the categories of sexual dysfunctions were made in the *DSM-5* from the prior edition. Some existing categories were combined and new, gender-specific diagnoses were added. All dysfunctions require the symptoms to be present for at least 6 months (except for dysfunctions caused by substance or medication use) and cause significant distress to the individual. The disorders could occur at any time during sexual activity, meaning that the person could have more than one disorder, as often occurs.

The *DSM-5* states that “sexual response has a requisite biological underpinning, yet it is usually experienced in an intrapersonal, interpersonal, and cultural context.” That is, sexual response and function occur as an interaction of

TABLE 1 • DSM-5 Sexual Dysfunction/Disorders

Female sexual interest/arousal disorder	Absent/reduced sexual thoughts, fantasies, initiation and receptivity and absent/reduced arousal and pleasure during sexual activity
Male hypoactive sexual desire disorder	Persistence or absence of sexual thoughts, fantasies, and desire for sexual activity
Erectile disorders	Difficulty with erections during partnered sexual activity
Female orgasmic disorders	Difficulty in experiencing orgasms or reduced intensity of orgasms during sexual activity
Premature (early) ejaculation	Experiencing “early” ejaculation following vaginal penetration
Delayed ejaculation	Marked delay in or inability to ejaculate usually during partnered sexual activity
Genito-pelvic pain/penetration disorder	Difficulties related to genital and pelvic pain and vaginal penetration during intercourse
Substance/medication-induced sexual dysfunction	A specific substance presumed to cause the sexual dysfunction

SOURCE: *Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition: (DSM-5)*. Arlington, VA: American Psychiatric Association.

biological, sociocultural, and psychological factors, including those related to the sexual partner; the relationship; individual vulnerability, psychological problems, or stressors; culture or religion; and medical issues.

For each sexual dysfunction, the *DSM-5* has subtypes based on the onset of the dysfunction and the context in which it occurs. Lifelong dysfunctions are those sexual problems present from the first sexual experience; acquired patterns develop only after a period of relatively normal functioning. A *generalized pattern of dysfunction* refers to sexual problems that are not limited to certain types of situations, stimulation, or partners. A situational sexual dysfunction is one that occurs only with certain types of situations, stimulation, or partners. In most instances, the dysfunction, whether generalized or situational, occurs during sexual activity with a partner. Acquired and situational dysfunctions typically are more successfully addressed in sex therapy (APA, 2013).

Although the *DSM-5* is the most widely used categorization of sexual disorders, it largely reflects a psychiatric medical model and has been criticized. It generally presents problems only in the heterosexual context, and it focuses on genital events in a linear sequence of desire, arousal, orgasm, and so on (Basson, Wierman, van Lankveld, & Brotto, 2010).

A New View of Women's Sexual Problems In recent years, more attention has been directed to increasing our understanding of female sexual desire and function difficulties (Basson et al., 2010; Katz-Wise & Hyde, 2014; Wood, Koch, & Mansfield, 2006). The Working Group for a New View of Women's Sexual Problems (2001), a group of clinicians and social scientists, offers a classification system called A New View of Women's Sexual Problems. This system classifies women's sexual function difficulties based on women's needs and sexual realities. The Working Group contends that the widely utilized *DSM* framework for sexual dysfunctions does not adequately address the totality of factors impacting female sexuality—specifically, situational factors. This contention was based on the fourth edition of the *DSM* (APA, 2000). The more recently published *DSM-5* (APA, 2013) stresses that five factors—sexual partner factors; relationship factors; individual vulnerability factors, psychological problems, or stresses; culture and religion factors; and medical factors—must be considered in the assessment and diagnosis of sexual function problems in

that they may be relevant to the cause of the problem and/or the treatment of the dysfunction. These factors are nearly similar to the four categories of possible underlying factors of female sexual dissatisfaction identified by the Working Group. Even though the *DSM-5* now addresses nonphysiological aspects of female sexuality and this “new” Working Group perspective was published over a decade ago, the Working Group’s contribution remains an important addition to our understanding of female sexual response and pleasure.

The Working Group claims that a physiological framework for sexual dysfunction has shortcomings as applied to women:

- *A false notion of sexual equivalency between men and women.* Early researchers emphasized similarities in men’s and women’s physiological responses during sexual activities and concluded that their sexual problems must also be similar. The few studies that asked women to describe their own experiences found significant differences.
- *The unacknowledged role of relationships in sexuality.* The Working Group states that the relational aspects of women’s sexuality, which are often fundamental to sexual function satisfaction and problems, have not been adequately addressed. It contends that the reduction of “normal sexual functioning” to physiology implies, incorrectly, that sexual dissatisfaction can be treated without considering the relationship in which sex occurs.
- *The leveling of differences among women.* The Working Group contends that women are dissimilar and the varied components of their sexuality do not fit neatly into the categories of desire, arousal, orgasm, and pain.

The Working Group suggests a women-centered definition of sexual function problems “as discontent or dissatisfaction with any emotional, physical, or relational aspect of sexual experience,” which may arise in one or more of four categories underlying the dissatisfaction:

- *Sociocultural, political, or economic factors.* These include inadequate sexuality education, lack of access to health services, a perceived inability to meet cultural norms regarding correct or ideal sexuality, inhibitions due to conflict between the sexual norms of the subculture or culture of origin and those of the dominant culture, and a lack of interest, time, or energy due to family and work obligations.
- *Partner and relationship problems.* These include discrepancies in desire for sexual activity or in preferences for various sexual activities, inhibitions about communicating preferences, loss of interest due to conflicts over commonplace issues, and inhibitions due to a partner’s health status or sexual problems.
- *Psychological problems.* These include past abuse; problems with attachment, rejection, cooperation, or entitlement; fear of pregnancy and sexually transmitted infections (STIs); and loss of partner or good sexual reputation.
- *Medical factors.* These include numerous local or systemic medical conditions, pregnancy, STIs, and side effects of drugs, medications, and medical treatments, including surgery.

Prevalence and Cofactors

National studies have been conducted on the prevalence of sexual function difficulties and factors related to them. We will briefly describe the major findings of five such studies conducted in Britain, Denmark, Portugal, and the United States.

Looking at the results of these studies will provide an overview of how common and universal certain sexual function difficulties are and the factors related to the problems. The prevalence of sexual function difficulties and their cofactors are generally in the same range from study to study. Differences in prevalence may reflect varied study methodologies, such as how sexual function problems are defined or perceived by the respondent, and variations in the period of time assessed (e.g., the problem may have occurred in the past year, in the past month, or at the last sexual event), which may make it difficult to compare the data from one study to the other. Note that the following studies are cross-sectional, which means it is not possible to determine causality—some of the factors identified in the studies (e.g., sociodemographic factors, relationship difficulties) may have caused the sexual function problems and dissatisfaction, whereas other factors may be a consequence of sexual function problems.

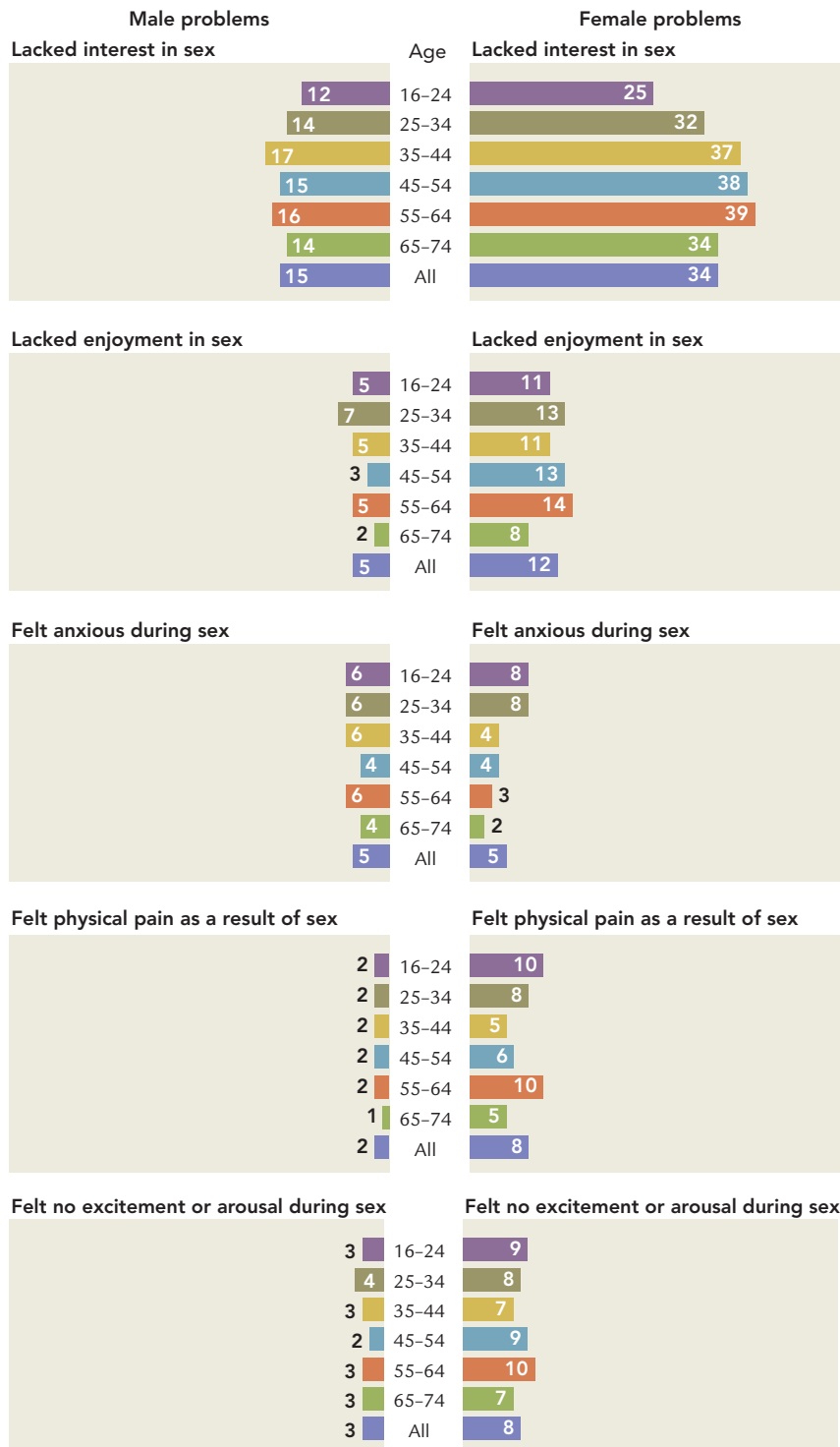
From a nationally representative study, called the third National Survey of Sexual Attitudes and Lifestyle (Natsal-3), 4,913 men and 6,777 women aged 16–74 years who lived in Britain (England, Scotland, and Wales) and who were sexually active in the past year were interviewed concerning their sexual function (Mitchell et al., 2013). “Sexually active” was defined as vaginal, oral, or anal intercourse with an other-sex or same-sex partner or partners. A major strength of this study was that it defined partners as either other-sex or same-sex and its assessment of factors related to sexual problems. Figure 1 presents the percentage of individual sexual function problems and dissatisfaction lasting 3 months or more in the past year by gender and age group. Sexual response problems persisting at least 3 months in the preceding year were common, even among the younger study participants. More than 40% of men and 50% of women reported one or more problems. For men, the most frequently reported problems were lack of interest in sex (15%), reaching climax more quickly than desired (15%), and difficulty in getting or keeping an erection (13%). For women, the most commonly reported problems were lack of interest in sex (34%), difficulty in reaching climax (16%), an uncomfortably dry vagina (13%), and lack of enjoyment (12%). As shown in Figure 1, for the youngest participants (16–24 years) the most commonly reported problem for men was reaching climax too soon (17%) and for women it was lacking sex interest (25%) and difficulty reaching climax (21%). Despite these difficulties, only 10% of both men and women reported distress about their sex lives (defined as sexual thoughts, sexual feelings, sexual activity, and sexual relationships). The most frequently reported issue within relationships was an imbalance in level of sexual interest between partners. The study found that low sexual function was associated with several factors:

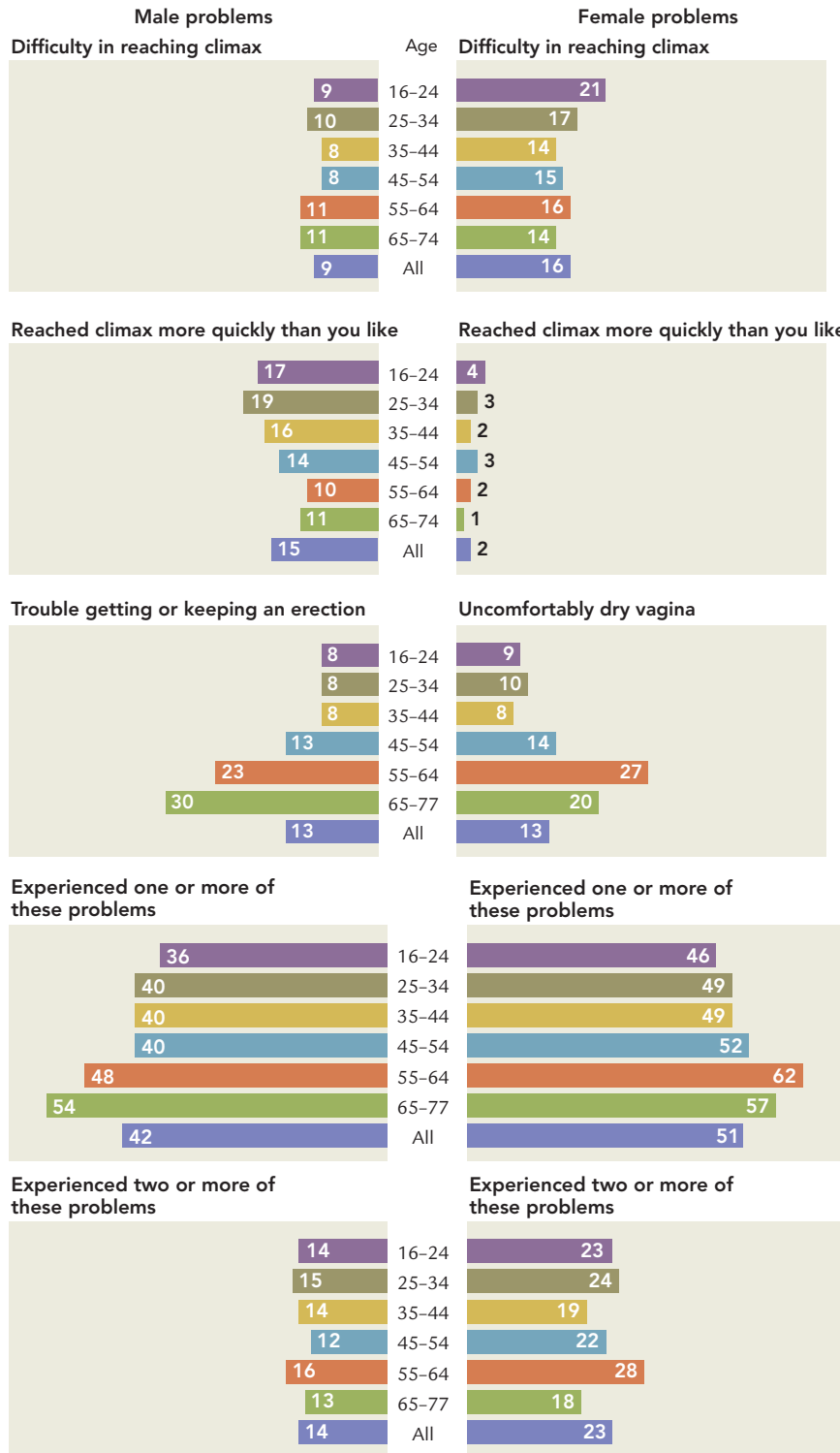
- Increased age
- Depression
- Self-reported poor health status
- Experiencing the end of a relationship
- Inability to talk easily about sex with a partner
- Not being happy in the relationship
- Engaging in fewer than four sexual episodes in the past 4 weeks
- Having had same-sex partners
- Paying for sex (men only)
- Higher number of lifetime sexual partners (women only)
- Negative sexual health outcomes such as experience of nonvoluntary sex

• **FIGURE 1**

Percentage of Sexually Active Men and Women in Britain, Aged 16–74; Reporting Selected Sexual Problems Lasting 3 Months or More in the Past Year.

(Source: Adapted from Mitchell et al., 2013.)



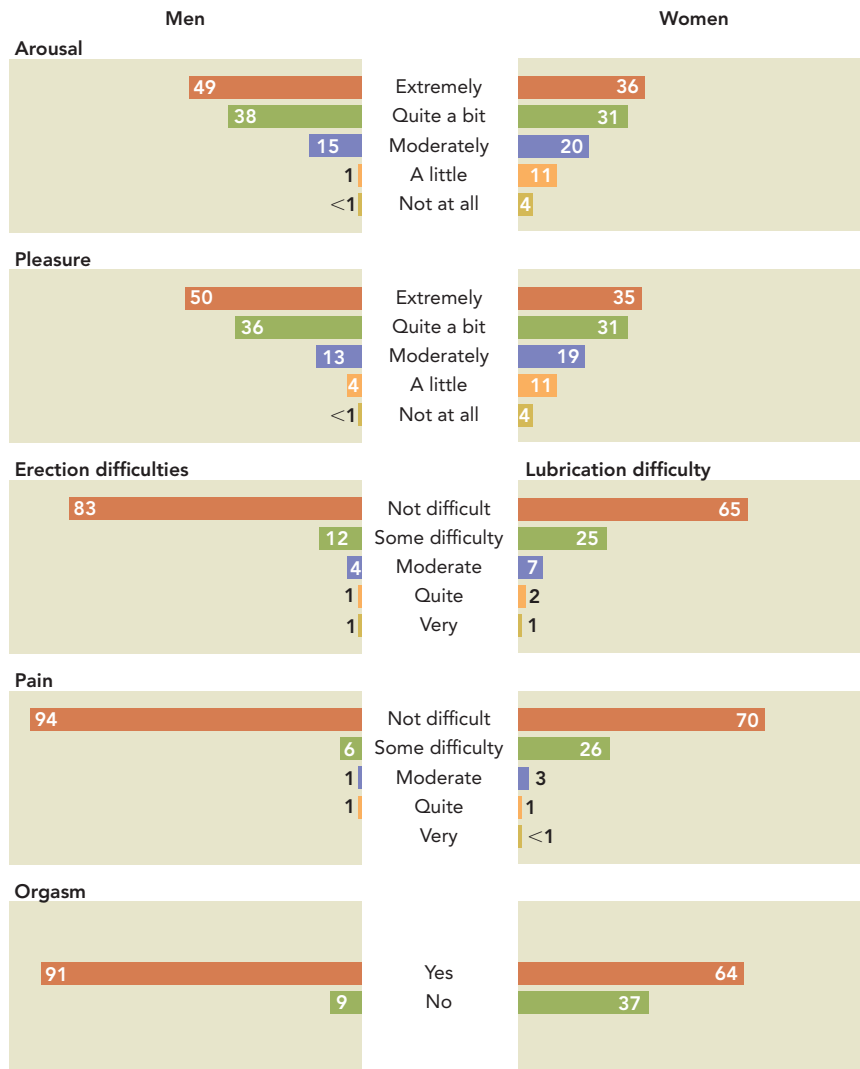


In Denmark in 2005, a study of sexual dysfunction and sexual difficulties was conducted examining 4,415 Danes aged 16–95 years as part of the Danish Health and Morbidity Program (Christensen et al., 2011). Overall, 11% of both men and women reported at least one sexual dysfunction (a frequent sexual difficulty that was perceived as a problem) in the past year, and another 68% of men and 69% of women reported infrequent or less severe sexual function difficulties. The highest prevalence of sexual dysfunctions was in men above 60 years and women below 30 years or above 50. Further, economic hardship was associated with sexual dysfunctions, particularly among women.

An online study of 1,009 heterosexual women and 390 lesbian women in Portugal assessed self-perceived sexual function problems and their associated distress levels over the past 6 months (Peixoto & Nobre, 2014). To determine the prevalence of sexual difficulties and dissatisfaction, the researchers selected a novel approach: They chose only those women who reported moderate to extreme distress from their sexual problem. Using this data analysis control, they found that for lesbian women, 10% reported sexual pain, 7% reported orgasmic difficulties and lack of desire, and 6% reported sexual arousal difficulties. For heterosexual women, 13% reported sexual pain, 12% reported orgasmic difficulties, 10% reported lack of sexual desire, and 9% reported sexual arousal difficulties.

The National Survey of Sexual Health and Behavior The National Survey of Sexual Health and Behavior (NSSHB) assessed several measures of sexual functioning among a random sample in the United States. Data from 3,900 adults aged 18–59 years who reported about their last partnered sexual event were analyzed. Participants were asked to evaluate that sexual event relative to pleasure, arousal, erection/lubrication difficulty, and orgasm (Herbenick et al., 2010.14a). The degree to which the participants reported their experiences for each of the five measures is shown in Figure 2. The NSSHB found that most men and women—even those in their 50s—evaluated the experience of their last sexual event as high on a scale measuring pleasure and arousal. For men, age was associated with greater erection difficulties, greater pain during sexual activity, and less likelihood of experiencing orgasm. For women, older age was associated with more problems with lubrication and a greater likelihood of experiencing orgasm. The study also found that men with a relationship partner reported greater arousal, greater pleasure, more frequent orgasm, fewer problems with erectile function, and less pain during their last sexual event than those whose last sexual event was with a nonrelationship partner. For women, those whose last sexual event was with a relationship partner reported greater problems with arousal and lubrication yet greater likelihood of their partner experiencing orgasm than women whose last sexual event was with a nonrelationship partner.

The National Health and Social Life Survey: Sexual Dysfunction Findings The National Health and Social Life Survey (NHSLs), using a U.S. national sample of 1,749 women and 1,410 men aged 18–59, found that self-reported sexual dysfunctions are widespread and are influenced by both health-related and psychosocial factors (Laumann, Paik, & Rosen, 1999). According to the NHSLs, sexual dysfunctions were more prevalent among women (43%) than men (31%) and were generally most common among young women and older men (Figure 3). Sexual dysfunctions were associated with poor quality of



• **FIGURE 2**
Percentage of Self-Reported Sexual Functioning at Most Recent Partnered Sexual Event Among U.S. Adults Aged 18–59, 2009.
 (Source: Adapted from Herbenick et al., 2010.14a.)

Note: Percents are rounded; hence, the total may exceed 100%.

life (i.e., lower emotional satisfaction and happiness), although females appeared to be impacted by this factor more than males. Those who experienced emotional or stress-related problems had more difficulties.

Disorders of Sexual Desire

The number-one sexual function problem of American couples is inhibited sexual desire. Discrepancies in sexual desire, discussed in the “Practically Speaking” box “Sexual Desire: When Appetites Differ” is the most common complaint that leads couples to sex therapy. More than one half of married couples experience inhibited sexual desire or desire discrepancy at some time in their marriage. Inhibited sexual desire causes more stress in a marriage than any other sexual function problem (McCarthy & McCarthy, 2003; Northrup, Schwartz, & Witte, 2012).

Defining low desire is tricky, often subjective, as there is no norm level of sexual desire; further, any such definition is often based on an assumption that there is an optimal level of sexual desire (Hall, 2004; van Lankveld, 2013).

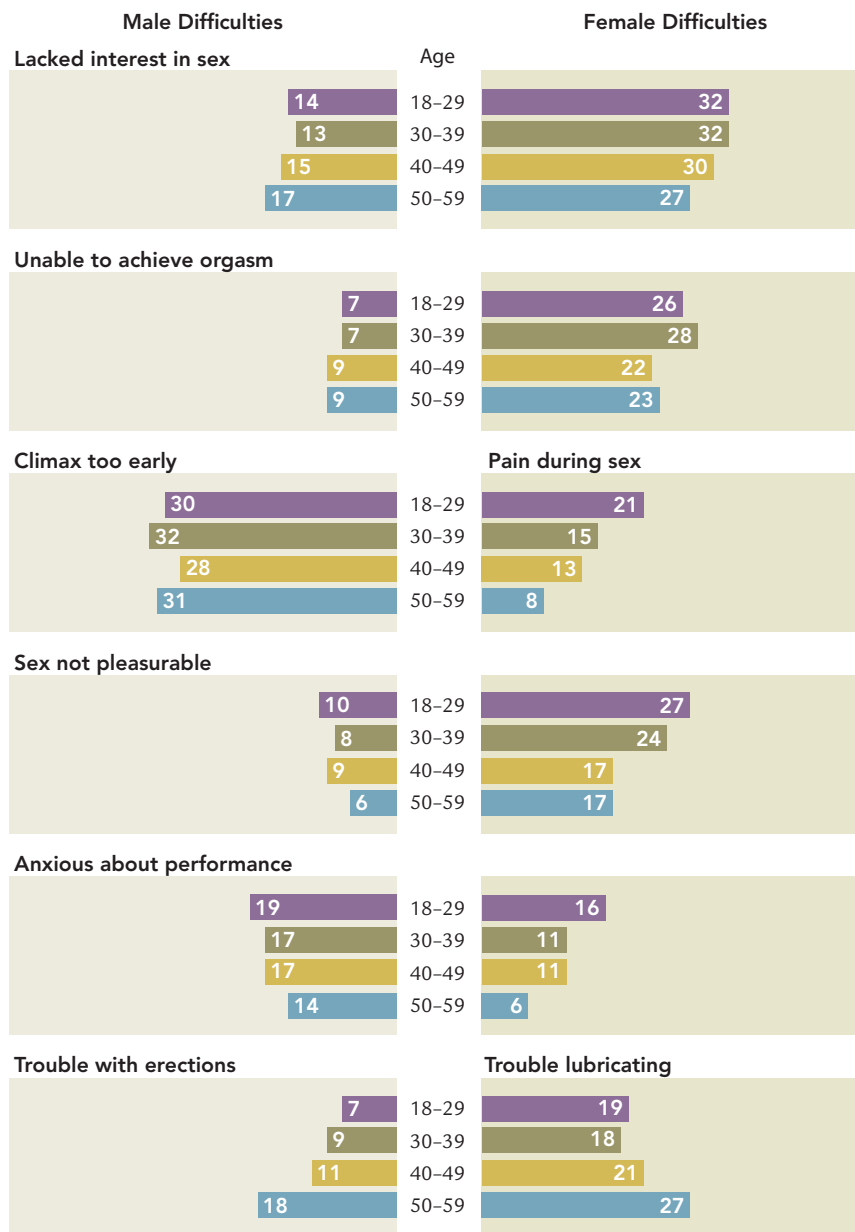
“Sexual desire is a fragile, mysterious appetite.”

—Michael Castleman
 (1950–)

• **FIGURE 3**

Percentage of Self-Reported Sexual Function Difficulties in the Past 12 Months Among U.S. Adults Aged 18–59, by Gender and Age.

(Source: Adapted from Laumann et al., 1999.)



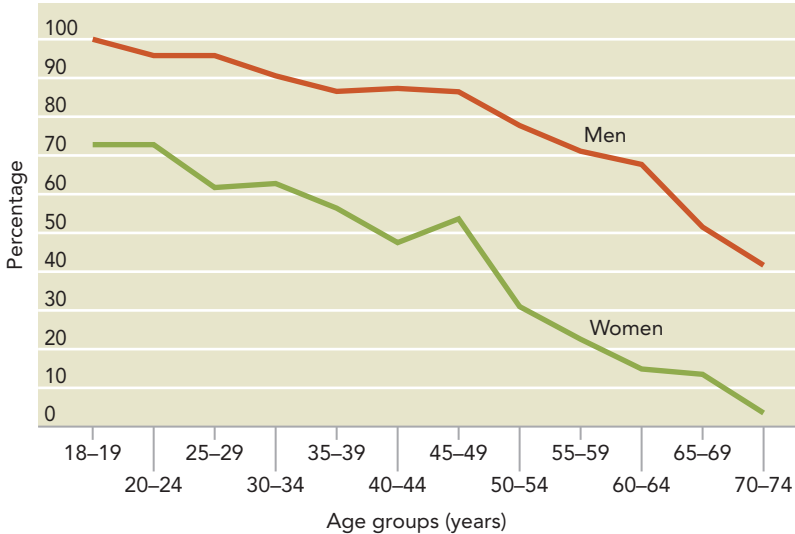
If you have a comfortable compatible love without sexual sparks, you don't have enough. If you have sexual heat but not friendship, you don't have enough. Neither lust nor love by itself is enough. You have to have passion.

—Carol Cassell
(1936–)

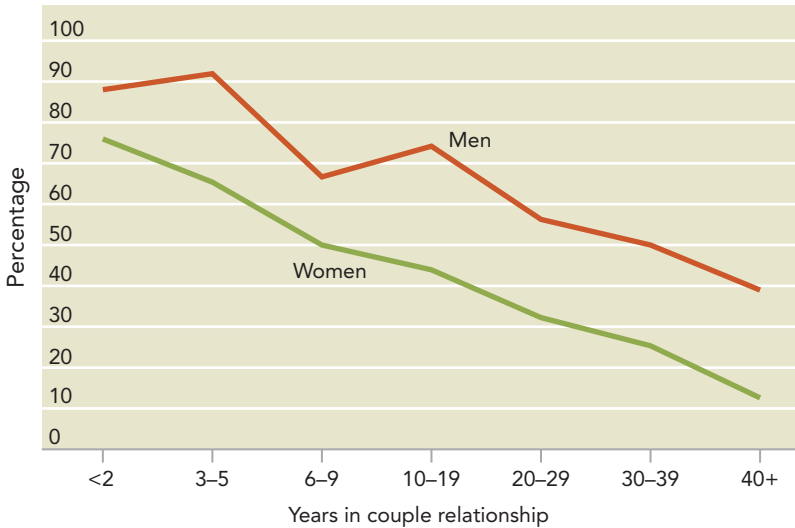
Certainly, sexually “normal” people vary considerably in their sexual interests, fantasies, and desires and occasionally experience a lack of desire (see Figures 1 and 3). Research has found that men reported more sexual desire than women. Persons in a same-sex relationship reported a slightly higher sexual desire than those in other-sex relationships (Holmberg & Blair, 2009; Laumann, Paik, & Rosen, 1999; Michell et al., 2013). Low sexual desire is most often acquired; that is, the person felt sexual previously but no longer experiences desire. The good news: It is often transitory. People with lower sexual desire often reluctantly participate in sex when it is initiated by a partner. A study of 63 persons aged 18–24 in a committed heterosexual relationship found that 17% of all sexual

activity was rated as compliant/obliging with no difference between men and women being compliant (Vannier & O’Sullivan, 2010). Most often, lower sexual desire develops in adulthood in association with psychological distress resulting from depression, stressful life events, or interpersonal difficulties. The loss of desire, whether ongoing or situational, can negatively affect a relationship (APA, 2013; Brotto & Smith, 2014). Anger within a relationship can also diminish sexual desire. Over time, if the anger is not resolved, it may develop into resentment or hatred that colors every aspect of the relationship. Most people cannot experience sexual desire for someone with whom they are angry or whom they deeply resent. Drugs, hormone deficiency, and illness can also decrease desire.

One should note that beyond any individual, situational, or relationship factors that can result in low sexual desire, sexual desire declines for most people through time. For example, a Finnish study of 2,650 adults found that feelings of sexual desire decreased as the individual aged (Figure 4) and as a relationship continued through the years (Figure 5) (Kontula, 2009; Kontula & Haavio-Mannila, 2009).



● **FIGURE 4**
Percentage of Finnish Adults Who Indicated That They Feel Sexual Desire at Least a Few Times a Week.
(Source: Kontula, 2009.)



● **FIGURE 5**
Percentage of Finnish Adults Who Indicated That If They Could Choose Freely They Would Like to Have Intercourse at Least Twice a Week.
(Source: Kontula, 2009.)

Gay men and lesbian women may experience lower sexual desire for a number of reasons, one of which could be that they are having difficulty with their sexual orientation (Margolies, Becher, & Jackson-Brewer, 1988; Reece, 1988).

Two female sexual function disorders listed in prior *DSM* editions—hypo sexual desire disorder and female sexual arousal disorder—were combined in the *DSM-5* into a single diagnosis, **female sexual interest/arousal disorder** (APA, 2013). For a diagnosis of this disorder, at least half of six disorders must occur that deal with absent/reduced interest in sexual activity, sexual/erotic thoughts or fantasies, sexual excitement/pleasure during sexual activity (75–100% of the times), sexual interest/arousal in response to sexual cues, and genital or body sensations during sexual activity (75–100% of the times) and no/reduced initiation of sexual activity or being unreceptive of partner's initiation. Further, the indicators must occur for at least 6 months and cause significant individual distress. The *DSM-5* states that sexual desire and arousal frequently coexist and often simultaneously characterize the complaints of women experiencing this disorder. Desire discrepancy within a partner relationship in which a woman has a lower sexual desire does not meet the criteria for this disorder, nor does common short-term changes in sexual interest or arousal that may be adaptive to events in a woman's life, such as having a child or the stress of unpaid bills.

The lack of sexual pleasure is a common complaint of women with low sexual desire. This disorder is frequently associated with problems experiencing orgasm, pain during sexual activity, low frequency of sexual activity, and couple discrepancies in desire. Unrealistic expectations and norms regarding the “normal or appropriate” level of sexual interest or arousal, poor sexual techniques, relationship problems, lack of accurate information, and mood disorders are also associated with this disorder (APA, 2013). A study of 741 women of mean age 48 years verified many of these associations. This study found that sexual desire was lower among older, postmenopausal women; those being in the current relationship for a long time; and those whose partner experienced a sexual dysfunction, suggesting that a sexual difficulty in one partner is likely associated with sexual difficulties in the other partner (McCabe & Goldhammer, 2012).

The term “frigid” was once used to describe this problem, but this pejorative and value-laden term is no longer used by professionals. This difficulty can occur when a woman desires sex but has difficulty maintaining arousal, resulting in vaginal dryness and tightness and subsequent discomfort if intercourse is attempted. Thirty-five percent of women in the NSSHB reported at least some difficulty with lubrication (see Figure 2), a problem shown to increase with age (see Figure 3). Female sexual arousal disorders are often accompanied by sexual desire and orgasm disorders, as well as sexual avoidance and stress in sexual relationships. If there are no physiological or substance use reasons for poor lubrication, this disorder is diagnosed as psychological in origin (APA, 2000). However, the lack of vaginal lubrication may be misleading, as some women reporting dryness indicate the presence of sexual excitement and arousal. These women often use supplemental lubricants. Further, some women report their clitoris engorged and their vagina lubricated but they did not feel psychologically aroused. Given these experiences, many sex therapists believe that sexual arousal is much more of a psychological process in women than in men (Keesling, 2006).

Also new to the *DSM-5* is a separate disorder for men, **male hypoactive sexual desire disorder**, defined as both low/absent desire for sexual activity and deficient/absent sex-related thoughts or fantasies that persist for a minimum duration of 6 months and cause significant individual distress (APA, 2013). Male

hypoactive sexual desire disorder may be associated with erectile and/or ejaculatory difficulties. Men with this disorder may not initiate partnered sexual activity and are minimally responsive to partner initiation of sex. Desire discrepancy within a partner relationship in which the man has a lower sexual desire does not meet the criteria for this disorder. The *DSM-5* states that there is a normative decline in sexual desire as men age and that mental health, alcohol use, self-directed homophobia in gay men, interpersonal and relational problems, lack of healthy attitudes and lack of accurate knowledge, and trauma from early life experiences may account for low desire.

The repeated inability to obtain and maintain erections during partnered sexual activities is called **erectile disorder** by the *DSM-5* (APA, 2013). The problem must have been present for at least 6 months, must occur in the majority of occasions, and must cause significant personal distress (i.e., at least 75% of the time). Many men experiencing erection difficulties may have low self-esteem, low self-confidence, decreased sexual satisfaction, reduced sexual desire, and a decreased sense of masculinity. Acquired erectile disorder is likely to continue in most men. According to the *DSM-5*, about 20% of men fear erection difficulties on their first sexual episode, with about 8% reporting problems that hindered penetration during their first sexual episode.

At one time, this disorder was called “impotence,” but like “frigid,” this value-laden and pejorative term is no longer used. This very common male sexual difficulty was treated primarily by therapists before the introduction of Viagra and other prescription erection-enhancing drugs. Sexual anxiety, fear of failure, high performance standards, concerns about sexual performance, and low sexual desire and excitement, as well as specific medical conditions and medications, are often associated with erectile disorder (APA, 2000, 2013; Hall, Shackelton, Rosen, & Araujo, 2010).

Eighteen percent of the men in the NSSHB reported at least some difficulty with erections during their most recent partnered sexual event (see Figure 3). The prevalence of erectile disorder increases with age, with more than twice as many men 50–59 reporting problems with erections as men 18–29 in the NHSLs (see Figure 3) and with nearly four times as many men aged 65–77 reporting problems with erection as men aged 16–44 in the Natsal-3 (see Figure 1). However, it is important to note that, like female arousal disorders, male erectile disorders are not an inevitable consequence of aging. But the health problems that often accompany aging increase the disorder’s prevalence. The prevalence of erectile difficulty has been directly correlated with certain diseases, such as hypertension, diabetes mellitus, and heart disease; certain medications, such as cardiac drugs and antihypertensives; cigarette smoking in association with treated heart disease and treated hypertension; excessive alcohol consumption; suppression and expression of anger; obesity; and depression (Bancroft, 2009; Nusbaum, 2002).

The diagnosis of erectile disorder is usually psychologically based. Men who have erections while sleeping or masturbating obviously are physically able to have erections, meaning that an erectile disorder during two-person sexual activity has a psychological origin. As with the other sexual dysfunctions, erectile disorder is a diagnosable problem in the *DSM-5* only when the man or his partner is dissatisfied and distressed by the occurrence (Schwartz, 2000).

Sex therapist and author Barbara Keesling (2006) gives some cautions relative to expectations of erections. She notes that men’s concept of an adequate erection varies considerably from person to person, and that a man does not necessarily have an erection problem if he doesn’t have reflex or spontaneous

“Thou treacherous, base deserter of
my flame,
False to my passion, fatal to my fame,
Through what mistaken magic dost
thou prove
So true to lewdness, so untrue to love?
—John Wilmot, Earl of Rochester
(1647–1680)

Sexual Desire: When Appetites Differ

Surprising how the most common sexual problem is not low libido, rapid ejaculation, or difficulty with orgasm: it is that people are not prepared for the extent of individual differences in human sexuality.

—Sandra Pertot
(1950–)

How much sexual desire is “normal” and what can couples do when one partner has more—or less—desire than the other? Sex therapist and clinical psychologist David Schnarch (2002) observes:

Couples frequently argue about low desire, but their real issue is *difference* in desires. Neither partner's desire need be particularly low or high. Disparity in sexual desire is couples' most common sexual complaint.

For most long-term relationships, sexual passion subsides, but not always at the same rate for each partner. Differences in sexual desire may impact the couple relationship. For example, one study of 1,054 married couples found that higher individual sexual desire discrepancies among married persons may erode the well-being of the relationship. In this study, husbands were more likely than wives to report large discrepancies between desired and actual frequency of sexual contact with their spouse (Willoughby, Farero, & Busby, 2014). Most sex therapists believe that differences arise because, for example, one or both partners may be fatigued, ill, under the influence of alcohol or other drugs, or consumed with the tasks of daily living. Or there may be problems with the sexual relationship of the couple, such as anger or imbalance of power between the partners.

Clinical psychologist and sex therapist Sandra Pertot, in her book *When Your Sex Drives Don't Match* (2007), presents another perspective on why couples experience variation in sexual desire. She contends that the sexual issues, including very common desire discrepancies, typically do not represent individual pathology or relationship problems but, instead, reflect the fact that there are different sexual types, which she labels “libido types,” such as sensual, erotic, stressed, detached, and disinterested. Interestingly, she states that “people are different just because they are, not because there is anything wrong with them” and encourages an acceptance of different libido types as one way to minimize misinterpreting each other's sexuality.

Michael Castleman (2004), an award-winning medical writer, notes in his book *Great Sex: A Man's Guide to the Secret Principles of Total-Body Sex* that the partner who desires more sex often may experience an array of feelings; such as rejection, confusion, and anger, may feel unloved and unattractive; and may be labeled a “sex fiend.” The person who wants more sex may stop initiating sex just to see how long it will take his or her partner to ask for it; often this takes a long time, making the high-desire partner even more frustrated or angry. The partner with the lower-desire may feel guilty, confused, and resentful of perceived constant demands for sex and may believe that the other partner doesn't love him or her but just wants sex. Castleman notes that “as goodwill erodes, it becomes harder to ask about sex. Couples often slip into two modes: bickering and silence.” He continues by noting that both partners may have more power than they realize—the power to drive each other crazy. Another unfortunate outcome of persistent desire differences may be the decline in nonsexual affection: Holding hands, hugging, or cuddling on the sofa, for example, often becomes more infrequent.

Castleman notes that there is no magic formula for resolving sexual desire differences, but here are some suggestions he offers for dealing with libido differences in couples:

- *Count your blessings.* The higher-desire partner may want sex more often than the lower-desire partner. But at least the lower-desire person wants sex sometimes. Isn't some sex better than none? Because differences in sexual desire occur in most long-term relationships, adapting to the change is the key.
- *Don't try to change your partner's libido.* In a couple with desire differences, each partner may hope that the other person will change and acquire a compatible level of desire. But it is difficult for a person to do that. Sexual desire can change, but this must come from within the person.
- *Consider your choices and negotiate.* A couple having chronic difficulties with sexual desire has three choices: (1) break up, (2) do nothing and live in misery, or (3) negotiate a mutually agreed compromise. Couples wanting to live comfortably with each other have no choice other than to compromise by being flexible, showing good faith, and being willing to invest in the happiness of the relationship.

- *Schedule sex dates.* Certainly there is some excitement when sex occurs spontaneously. But scheduling has an advantage of eliminating sexual uncertainty for couples facing major desire differences. Both partners know when sex will occur: The higher-desire person then may not make as many sexual advances, and the lower-desire person will not have to experience repeated requests.
- *Cultivate nonsexual affection.* Once sex dates are scheduled, nonsexual affection has less chance of being misconstrued as having sexual expectations. Being held and touched is one of the most important ways to nurture a relationship, and knowing that it has no sexual connotations may provide a great relief.
- *Savor your solution.* Once a couple negotiates a mutual compromise, the relationship often improves and resentments slowly fade. The lower-desire person may become more comfortable, which often improves

that person's responsiveness. There may still be some desire differences; the ability to compromise means that the couple has found a workable solution for their relationship.

Because fluctuations in individual sexual desire are a normal part of life, as are differences in desire between partners, individuals may choose masturbation as an acceptable and pleasurable outlet for sexual desire. As is true for all areas of sexual functioning, the important thing to remember, when sexual appetites differ, is that communicating openly and honestly and appreciating what a person brings to the relationship pave the way to resolution and fulfillment. Cultivating sexuality by planning for sex, using one's imagination, learning to be playful, recognizing your partner's mystery, and respecting his or her privacy can all increase desire. If given sufficient attention, desire often returns (Perel, 2006; Pertot, 2007).

erections from viewing a partner's body, for example. Many men, even young men, almost always need direct stimulation to have an erection. Also, she says that "it's probably also unrealistic to expect that your erection will maintain the same level of rigidity throughout the course of a sexual encounter." During any particular sexual encounter, a man's erection can vacillate between several levels of rigidity depending on the amount of stimulation.

Another sexual function difficulty related to desire is called **sexual aversion disorder**, the aversion to any form of partnered sexual activity. This problem is considered to be uncommon and was dropped from the *DSM-5*, since clinicians rarely used this diagnostic category (Brotto, 2010; Lehmiller, 2014). However, we have chosen to include a discussion of this problem, given that this type of behavior does occur and represents a serious issue to those who experience it.

For those experiencing sexual aversion, the possibility of sexual contact may cause anxiety, disgust, or fear, and some sufferers create covert strategies (e.g., traveling, sleeping, or being heavily involved with work) to avoid sex (APA, 2000). A mere kiss, touch, or caress may cause a phobic response out of fear that it might lead to something sexual. Sometimes, these responses are internalized; other times, they can lead to panic attacks and physiological responses such as sweating, nausea, vomiting, and diarrhea. For people with this disorder, the frequency of sexual contact with a partner is rare and can lead to severe relationship stress. Sexual aversion often results from severely negative parental attitudes during childhood; sexual trauma, such as rape or sexual abuse, especially in women; consistent sexual pressure from a long-term partner; a history of erectile difficulties in men; and/or gender identity confusion.

Barry McCarthy and Emily McCarthy, in their book *Rekindling Desire: A Step-by-Step Program to Help Low-Sex and No-Sex Marriages* (2003), write about what they call "no-sex marriages," the extreme of desire problems that they define as having sex less than 10 times a year. They state that couples in a no-sex marriage experience a cycle of anticipatory anxiety, negative experiences, and eventually avoidance of sex—a cycle that they did not plan for in their marriage. According to the McCarthys, about one in five marriages is a no-sex marriage. The longer the couple avoids sexual contact, the more difficult it is to



think
about it

Is Intercourse Enough? The Big “O” and Sexual Behaviors

Many of us measure both our sexuality and ourselves in terms of orgasm: Did we have one? Did our partner have one? If so, was it good? Did we have simultaneous orgasms? Did it occur through oral sex, vaginal or anal intercourse, or a combination of these and other means? The questions go on. It's obvious to most people that orgasms are an erotic and intimate component of most relationships.

As we look at our sexuality, we can see some pressure to be successful lovers. Men talk of performance anxiety. Both men and women tend to evaluate a woman's sexual self-worth in terms of her being orgasmic. For men, the significant question about women's sexuality has shifted from “Is she a virgin?” to “Is she orgasmic?” While these questions will continue to trouble some, a more significant question arises between men and women: In sexual encounters, is penile-vaginal intercourse sufficient to stimulate orgasm? Scholars are quick to acknowledge, “That depends.” Personal and relationship factors, anxiety and shame about one's sexuality, trust, sleep, stress, comfort with one's body, and the type of sexual stimulation received, to name a few, all play important roles in sexual satisfaction, including orgasm.

Because male orgasm is closely tied to reproduction, evolutionary scientists have never had difficulty explaining it; it ensures reproduction. In the same vein, scientists have for decades searched for an evolutionary function for female orgasm but have not been as successful. Possibly, one effect of orgasm is to increase a suction in the uterus to draw up ejaculated semen, thereby increasing the retention of sperm (Komisaruk, Whipple, Nasserzadeh, & Beyer-Flores, 2010). Since women can have sexual intercourse and become pregnant without experiencing orgasm, perhaps there is no evolutionary function for orgasm (Lloyd, 2005). However, as philosopher and professor Elisabeth Lloyd acknowledges, evolution does not dictate what is culturally important.

Data from a national study help answer the question of whether one aspect, vaginal intercourse between heterosexual couples, is enough or if other sexual behaviors are necessary for men and women to experience orgasm during partnered sex. The National Survey of Sexual Health and Behavior (NSSHB) assessed sexual behaviors during the most recent partnered event of a probability sample of 3,990 U.S. adults aged 18–59

(Herbenick et al., 2010:14a). The NSSHB found that during the most recent sexual event:

- A wide variety of sexual behaviors occur during any sexual behavior. Of these, 33% of men and 39% of women reported having engaged solely in penile-vaginal intercourse.
- Men reported that they had an orgasm more frequently if the sexual event included penile-vaginal intercourse.
- Women reported that they were more likely to have had an orgasm if they gave or received oral sex, had penile-vaginal sex, or received anal sex.
- Both men and women were more likely to experience orgasm if they engaged in a wider array of sexual behaviors.

Another study, the Australian Study of Health and Relationships, also assessed behaviors during the participants' most recent sexual encounter (Richters, de Visser, Rissel, & Smith, 2006). In a representative sample of 5,111 Australians aged 15–59, the researchers found that of the 95% of men and women reporting having vaginal intercourse:

- About 8 in 10 reported manual stimulation of the woman by the man.
- About 7 in 10 reported manual stimulation of the man by the woman.
- About one quarter reported cunnilingus and fellatio.
- Less than 1 in 10 reported anal intercourse.
- Almost all men (95%) experienced orgasm in encounters that included vaginal intercourse, whereas orgasm for women was less likely (50%) among those who reported having only vaginal intercourse.
- For women, the rate of orgasm (70%) was higher among those reporting intercourse plus receiving manual stimulation or intercourse plus cunnilingus, although orgasm did not necessarily occur during these practices. Orgasm was even more likely for those who had vaginal intercourse and had received both manual and oral stimulation.

The researchers cautioned that we should not assume that everyone having a sexual encounter wants to experience an orgasm; that is, not everyone needs to have an

orgasm to be physically and emotionally satisfied. They note that a woman may have an intercourse-only encounter (a “quickie” or “freebie”) with her male partner to oblige the man. Further, some nonintercourse events may be a man obliging the woman; that is, the man might provide manual and oral stimulation of the woman, although he is not interested in experiencing orgasm himself. Likewise, for some, tenderness, intimacy, and affection may be more important determinants of intimacy and gratification than having an orgasm.

While the question “Was it good for you?” may initiate a dialogue, the statement “Orgasm is good for us” acknowledges a fact. Though it’s apparent that orgasm feels good, some of us may not recognize that orgasm is indeed good for our health. Sexual activity not only burns quite a few calories and boosts the metabolism but also improves immune function, helps you sleep better, and relieves menstrual cramps and stress. In fact, substantial connections between women’s sexual satisfaction and all three aspects of their well-being (relational, mental, and physical) have been reported (Holmberg, Blair, & Phillips, 2010).

The idea that women fake orgasm is familiar, probably because there is considerable pressure on them to do so. What is less well known is that some men also pretend orgasm. Research on pretending orgasm can provide interesting insights into sexual scripts and their functions and meanings for both sexes. Professor Sandra Caron (2013) found that 28% of college men and 69% of college women at one U.S. university reported faking orgasm, saying they weren’t just doing it—they were performing it. Frequently reported reasons for pretending orgasm (reported by both sexes) were that orgasm was

unlikely, they wanted sexual activity to end, and they wanted to avoid negative consequences (hurting their partner’s feelings) and obtain positive ones (pleasuring their partners) (Muehlenhard & Shippee, 2009).

When we measure our sexuality by orgasm only, we discount activities that do not necessarily lead to orgasm such as touching, caressing, and kissing. In other words, we may ignore erotic pleasure as an end in itself. Still, the question about intercourse—“Is it enough?”—troubles many. Part of the joy of sexuality is to listen, learn, and acknowledge the multitude of factors that contribute to fun and meaningful sexual expression, which may or may not include orgasm.

Think Critically

1. How important is experiencing orgasm? Does this vary by sex? age?
2. Are you interested in providing sexual stimulation other than intercourse? Are you (or would you be) comfortable and willing to request or introduce a variety of sexual behaviors into your relationship?
3. Can a person experience physical satisfaction and not experience an orgasm during sex? Do women and men feel the same way about this?
4. If you are sexually active, have you ever faked an orgasm? Why or why not?

break the cycle and the more they blame each other. Further, the more shameful they feel, the harder it is to break the cycle. The McCarthys note, however, that motivated couples can reestablish desire through self-help and therapy.

As with heterosexuals, gay men and lesbian women may enjoy certain activities, such as kissing or mutual masturbation, but feel aversion to other activities. For gay men, sexual aversion often focuses on issues of anal eroticism (Reece, 1988; Sandfort & de Keizer, 2001). For lesbian women, it may focus on cunnilingus (Nichols, 1987), which is often their preferred activity for reaching orgasm.

Interestingly, the *DSM-5* does not include a “hyperactive sexual desire disorder,” implying that its authors, mental health professionals, do not believe that high sexual desire is a mental disorder. This is contrary to the view of the general public and some professionals who espouse the concept of sexual addiction. Sexual desire exists on a continuum, with some people having very low desire and others having very high desire. Most people seem to be somewhere in the middle, however.

Orgasmic Disorders

According to the *DSM-5*, a difficulty experiencing orgasm and/or markedly reduced intensity of orgasmic sensations in women is called **female orgasmic disorder**. For a diagnosis, these symptoms must occur on almost or all

(about 75–100%) occasions during sexual activity with a minimal duration of about 6 months. The experience of an orgasm via clitoral stimulation not during intercourse does not meet the criteria for a clinical diagnosis of female orgasmic disorder (APA, 2013). Orgasmic difficulties are the second most common sexual function difficulty (after low sexual desire) treated by therapists (Keesling, 2006). The most common sexual functioning problems of women in the Natsal-3 study (see Figure 1) were lacking interest in sex (34%) and difficulty experiencing orgasm (16%) (Mitchell et al., 2013). Female orgasmic disorder has also been called anorgasmia, inorgasmia, pre-orgasmia, inhibited female orgasm, and the pejorative “frigidity.” Most female orgasmic disorders are lifelong rather than acquired problems; once a woman learns how to have an orgasm, it is uncommon for her to lose that capacity (APA, 2000).

Female orgasm is not universal; a slight minority never or rarely have them. The NSSHB found that 37% of women reported not having an orgasm at their most recent partnered sexual event (see Figure 2). About 10% of women do not experience orgasm throughout their lifetime (APA, 2013). No relationships were found between certain personality traits or psychopathology and orgasm among women in the NHSLS study (Laumann et al., 1999).

Women use a wide variability in the type and intensity of stimulation that results in orgasm. Clitoral stimulation is required by many to experience orgasm, and a relatively small proportion of women indicate that they always experience orgasm during penile-vaginal intercourse. The age of first orgasm for women is more variable than for men—it may occur anytime from the prepubertal period to well into adulthood. Women’s reports of having experienced orgasm increase with age, as shown in the Natsal-3 data (see Figure 1) and the NHSLS data (see Figure 3). Many women learn to experience orgasm as they try a wide array of stimulation and become more knowledgeable about their bodies. Orgasm consistency (i.e., usually or always) among women is higher during masturbation than during partnered sexual behavior (APA, 2013).

Some women who enjoy sexual activity with partners have difficulty experiencing orgasm with them, thereby sometimes causing dissatisfaction or distress within the relationship. Many women with female orgasmic disorder have negative or guilty attitudes about their sexuality, relationship difficulties, and physical and mental health problems and are influenced by sociocultural factors such as gender role expectations, and religion. Inadequate sexual stimulation is also a factor in this disorder (APA, 2000, 2013). Keesling (2006) states that “the number-one reason why some women have difficulty with orgasm is lack of experience with self-touch.” As described in the “Think About It” box “Is Intercourse Enough? The Big ‘O’ and Sexual Behaviors,” studies have found that women were more likely to experience orgasm during partnered sex that included a wider variety of sexual behaviors than intercourse.

Women differ on their views of how important orgasm is to their feeling satisfied during partnered sex. Some women have wondered “Why all this fuss about having orgasm during sex?” and have questioned whether women need to have orgasms during partnered sex to feel sexually satisfied. Overall, satisfaction with sexual activity in women is not strongly correlated with experiencing an orgasm. Many women report high levels of satisfaction during sexual activity despite never or rarely ever experiencing orgasm (APA, 2013).

A recurring and continuing (for at least 6 months) pattern of ejaculation during partnered sexual activity within about 1 minute following vaginal penetration and before the individual desires, and that causes interpersonal distress, is

called **premature (early) ejaculation** in the *DSM-5* (APA, 2013). Even though premature (early) ejaculation may occur in nonvaginal sexual activities, a specific time duration criterion has not been created for those activities. Studies have shown that premature ejaculation is one of the most common sexual function difficulties in the male general population. The prevalence of men who experienced premature ejaculation reported in studies varies: Men in the Natsal-3 study reported between 10% and 17% reached climax more quickly than desired (see Figure 1), and the NHSLS found between 30% and 32% men reported climaxing earlier than desired (see Figure 3). Using the *DSM-5* criteria of early ejaculation being within about 1 minute of vaginal penetration, only 1–3% of men would be diagnosed with this disorder (APA, 2013; Rowland, 2012a).

As with many sexual difficulties, there is a problem with definitions: What is premature ejaculation? The definition may vary among individuals, populations, and cultures. Some sex therapists have defined it according to how long intercourse lasts, how many pelvic thrusts there are, and how often the woman experiences orgasm. Therapist Helen Singer Kaplan (1974) suggested that the absence of voluntary control at orgasm is the key to defining premature ejaculation. Actually, many males with premature ejaculation report a lack of control over the moment of ejaculation (APA, 2013). Some sex therapists suggest that the term “involuntary ejaculation” is the more accurate term, given that the treatment focuses on acquiring voluntary control over something that has been involuntary (Castleman, 2004). Early ejaculation is a problem when the man or his partner is dissatisfied by the amount of time it takes him to ejaculate. Some couples want intercourse to last a long time, but others are not concerned about that.

Couples often are confused, bewildered, and unhappy when the man consistently ejaculates too early, although women seem to be increasingly more disturbed by the disorder than men are. The woman may be sexually dissatisfied, while her partner may feel that she is too demanding. He may also feel considerable guilt and anxiety. They may begin to avoid sexual contact with each other. The man may experience erectile problems because of his anxieties over early ejaculation, and he may withdraw from sexual activity completely. Other factors may contribute to early or involuntary ejaculation in men, such as inexperience in negotiating with a sexual partner, inadequate understanding of sexual response in both women and men, unwittingly training themselves to ejaculate quickly during masturbation, inability to relax deeply during sexual intercourse, nonsensual lovemaking, and a narrow focus on the penis and a partner’s genitals during sex (Castleman, 2004; Rowland, 2012b).

Most men with early or involuntary ejaculation can delay ejaculation during self-masturbation for a longer period of time than during coitus. With sexual experience and aging, many males learn to delay ejaculation, but others continue to ejaculate early and may seek professional help (APA, 2000, 2013). This disorder often occurs in young and sexually inexperienced males, especially those who have primarily been in situations in which speed of ejaculation was important so as for example, to avoid being discovered. It is the number-one sexual function complaint of young men.

What about premature, or early, orgasm among women? This phenomenon is not typically considered a sexual function difficulty by women or their partners and is not listed as a sexual dysfunction disorder in the *DSM-5*. The prevalence of early orgasm is rarely reported by women: Between 1% and 4% of women in the Natsal-3 study (see Figure 1) indicated that they reached climax more quickly than they liked (Mitchell et al., 2013). Some women who have

orgasms very quickly may not be interested in continuing sexual activity; others, however, are open to continued stimulation and may have repeated orgasms.

The persistence and recurrent (at least for 6 months) marked delay or inability to ejaculate that causes personal distress is identified in the *DSM-5* as **delayed ejaculation**. The inability or difficulty in ejaculating occurs despite adequate sexual stimulation and the desire to experience ejaculation. The diagnostic criteria state that this difficulty must be experienced during nearly all occasions (about 75–100%). The complaint from the man or his partner usually comes from this problem occurring during partnered sexual activity. Prolonged thrusting to experience orgasm to the point of exhaustion or genital discomfort often occurs, resulting in the couple ceasing attempts. Some men report that they began to avoid partnered sexual activity because of repeated difficulties in ejaculating. Ejaculation and orgasm are two separate events that usually occur at the same time, but not always. Given this, a man experiencing delayed ejaculation may have an orgasm (full body experience) but is unable to ejaculate at all or have delayed ejaculation. In the most common form of delayed ejaculation, the man cannot ejaculate during intercourse but can from a partner's manual or oral stimulation.

How often delayed ejaculation occurs is difficult to ascertain because there is no consensus as to what constitutes a reasonable time or number of penile thrusts to experience ejaculation or what is unreasonably long for most men and their partners. Clinicians report that it is the least commonly reported sexual function complaint. Only 75% of men report always ejaculating during sexual activity; of the remainder, less than 1% complain of difficulty in ejaculating that lasts more than 3 months. Around 1 in 10 men of the Natsal-3, HSSHB, and NHSLs studies reported difficulties with experiencing orgasm (see Figures 1–3). The *DSM-5* states that men in their 80s report twice as much difficulty in ejaculating than men younger than 50 years. Age-related decreases in fast-conducting peripheral sensory nerves and in sex steroid secretion may be related to increased occurrence of delayed ejaculation in men older than 50 years.

As with other sexual function disorders, delayed ejaculation may occur as an interaction of biological, sociocultural, and psychological factors, including those related to the sexual partner; the relationship; individual vulnerability, psychological problems, or stressors; culture or religion; and medical issues. Anxiety-provoking sexual situations can interfere with a man experiencing an orgasm, or a man may not be able to have an ejaculation in situations in which he feels guilty or conflicted. Often, the individual can overcome this disorder when he and his partner are able to comfortably discuss the issue, when the situation or partner changes, or when he engages in a fantasy or receives additional stimulation (APA, 2013).

Sexual Pain Disorders

The *DSM-5* combined the conditions **vaginismus** (muscle spasms around the vagina) and **dyspareunia** (painful intercourse) from the *DSM-IV-TR* into one category, **genital-pelvic pain/penetration disorder**, with four diagnostic categories: (1) marked difficulty having vaginal intercourse/penetration, (2) marked vaginal or pelvic pain during a vaginal intercourse or penetration attempt, (3) marked fear or anxiety about vaginal or pelvic pain in anticipation of, during, or as a result of vaginal penetration, and (4) marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration. Diagnosis of genital-pelvic pain/penetration disorder is based on persistent and recurrent difficulty with any one of the

four symptoms and the fact that the symptoms cause significant interpersonal distress. These issues may occur in conjunction with other sexual function difficulties, such as low sexual desire, and partner difficulties, such as problems with erections and ejaculation. Like most sexual function difficulties, factors related to the partner, the relationship, individual vulnerability, religion/culture, and medical issues may be relevant to experiencing genital-pelvic pain/penetration disorder.

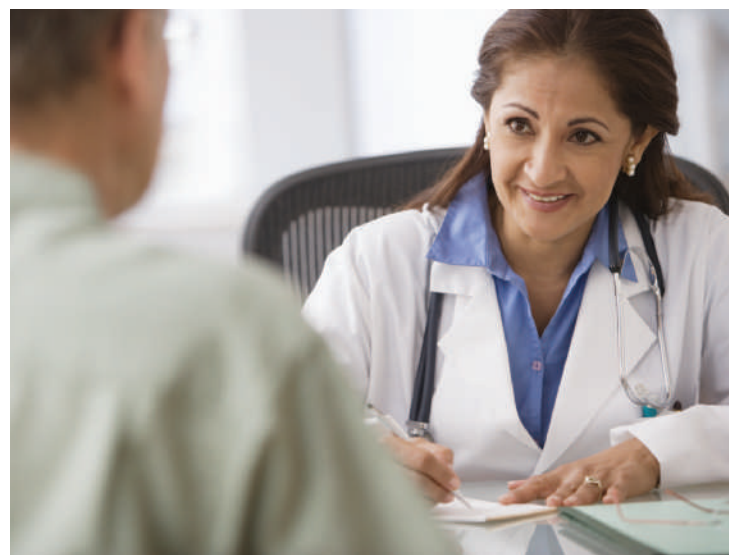
The diagnostic vaginal intercourse/penetration category of the genital-pelvic pain/penetration disorder represents a range from a total inability to experience vaginal penetration in any circumstance (e.g., intercourse, gynecological examinations, tampon insertion) to an ability to easily experience penetration in one situation but not another. Women experiencing the marked vaginal or pelvic pain report mild to severe pain associated with intercourse that can be characterized as burning, cutting, shooting, or throbbing, for example. The pain may continue after intercourse and may occur during urination. Many women experience pain occasionally during intercourse, but much fewer men report pain (see Figures 1–3). Persistent pain among women may indicate difficulties that need to be addressed. Marked anxiety about genital or pelvic pain in association with intercourse is frequently reported by women who have regularly experienced pain during intercourse. This reaction may result in avoidance of intercourse or vaginal penetration.

The tensing or tightening of pelvic muscles represents an involuntary spasm of the outer third of the vagina (the pubococcygeus muscle); that is, the muscles around the vaginal opening go into involuntary spasmodic contractions, preventing the insertion of a penis, finger, tampon, or speculum. The most frequent clinical issue is when a woman is not able to experience intercourse or vaginal penetration with a partner, although this disorder may also occur during gynecological examinations. This difficulty is found more often in younger women than older women (APA, 2000, 2013).

Another type of pain associated with sex that is not included in the *DSM-5* is **anodyspareunia**, pain occurring during anal intercourse. Gay men sometimes experience this, often due to lack of adequate lubrication. The depth of penile penetration into the anus, the rate of thrusting, and anxiety or embarrassment about the situation often are associated with anodyspareunia (Rosser, Short, Thurmes, & Coleman, 1998). A study of 404 men who have sex with men found that 55 (14%) experienced anodyspareunia; these men reported their pain as lifelong, experienced psychological distress as a result, and avoided anal sex for periods of time (Damon & Rosser, 2005). Among heterosexual women, a substantial proportion experience pain at initial and subsequent anal intercourse (Stulhofer & Ajdukovic, 2011). A study of 1,265 women, aged 18–30, who reported two or more episodes of anal intercourse, found that nearly one half (49%) had discontinued their first episode because of pain or discomfort, although a majority of women subsequently continued anal sex. Of the 505 women who reported two or more anal intercourse episodes in the past year, nearly 1 in 10 reported severe pain. More than two thirds of these women reported that their pain level remained unchanged from their first anal intercourse experience. The researchers hypothesized that the inability to relax was the major cause of the pain.

Discussing sexuality and becoming educated about one's sexual functioning with a qualified health care professional can sometimes help resolve questions, issues, or problems.

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Substance/Medication-Induced Sexual Dysfunction

The *DSM-5* added a category of sexual disorder, called **substance/medication-induced sexual dysfunction**. Sexual dysfunction can occur with intoxication use of numerous drugs such as alcohol, opioids, sedatives, antidepressants, hypnotics, antipsychotics, stimulants, hormonal contraceptives, illicit/recreational drugs, and other unknown substances. The prevalence of substance/medication-induced sexual dysfunction is not known, although some research has been conducted. For example, studies have shown that 25–80% of persons taking certain antidepressants report sexual side effects. About one half of persons taking antipsychotic medications report experiencing sexual side effects, including difficulties with sexual desire, erection, lubrication, ejaculation, and orgasm. Difficulties with sexual functioning appear greater in persons abusing heroin (about 60–70%) than in individuals who abuse amphetamines and ecstasy (APA, 2013). Many persons using prescription medications do not realize that the drug may impair sexual functioning. One should inquire about this possibility from a health care provider or pharmacist.

Other Disorders

Two other disorders not mentioned in the *DSM-5* because they are based on physical conditions are Peyronie's disease and priapism. These conditions can also cause other difficulties in sexual functioning.

Peyronie's Disease A condition in which calcium deposits and tough fibrous tissue develop in the corpora cavernosa within the penis is known as **Peyronie's disease**. This problem occurs primarily in older men (usually for no apparent reason) and can be quite painful. The disease results in a curvature of the penis, which, in severe cases, interferes with erection and intercourse. Medical treatments can alleviate the source of discomfort, and sometimes the condition disappears without treatment. A study involving 4,432 men in Germany found the prevalence of Peyronie's disease was 3.2% (Schwarzer et al., 2001). For the record, rarely are penises perfectly straight; most curve to one side.

Priapism Prolonged and painful erection, occurring when blood is unable to drain from the penis, is called **priapism**. Lasting from several hours to a few days, this problem is not associated with sexual thoughts or activities. Rather, it results from certain medications, including some antidepressants, erectile dysfunction medications, and excessive doses of penile injections for producing an erection. Medical conditions such as sickle-cell disease and leukemia may also cause priapism.

● Physical Causes of Sexual Function Difficulties and Dissatisfaction

Until recently, researchers believed that most sexual function difficulties and dissatisfaction were almost exclusively psychological in origin. Current research challenges this view as more is learned about the intricacies of sexual physiology, such as the subtle influences of hormones. Our vascular, neurological, and endocrine systems are sensitive to changes and disruptions. As a result, various illnesses and disturbances to these systems may have an adverse effect on our sexual functioning. Some prescription drugs, such as medication for hypertension

or for depression, may affect sexual responsiveness. Chemotherapy and radiation treatment for cancer, and pain from cancer, can affect sexual desire and responsiveness (American Cancer Society, 2015.14a).

Physical Causes in Men

Diabetes and alcoholism are leading causes of male erectile difficulties; together, they account for several million cases. Diabetes damages blood vessels and nerves, including those within the penis. Other causes of sexual function difficulties include lumbar disc disease and multiple sclerosis, which interfere with the nerve impulses regulating erection. In addition, atherosclerosis causes blockage of the arteries, including the blood flow necessary for erection. Spinal cord injuries and prostate-cancer treatment may affect erectile abilities as well. Alcoholism and drug use are widely associated with sexual difficulties. Smoking may also contribute to erection difficulties (Gades et al., 2005; Rowland, 2012a). One study found that men who are heavy smokers are 50% more likely to experience erectile problems than nonsmokers (National Center for Environmental Health, 1995). Bicycle-induced sexual difficulties can occur as a result of a flattening of the main penile artery, thereby temporarily blocking the blood flow required for erections. Diseases of the heart and circulatory system may be associated with erectile difficulty. A four-country study of 2,400 men found that “erectile dysfunction was associated with diabetes, heart disease, lower urinary tract symptoms, heavy smoking and depression and increased by 10 percent per year of age” (Nicolosi, Moreira, Shirai, Bin Mohd Tambi, & Glasser, 2003).

Physical Causes in Women

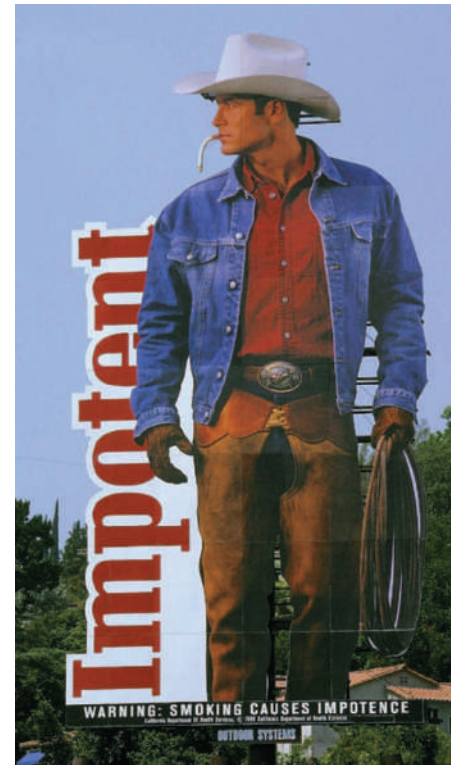
Organic causes of female orgasmic disorder include medical conditions such as diabetes and heart disease, hormone deficiencies, and neurological disorders, as well as general poor health, extreme fatigue, drug use, and alcoholism. Spinal cord injuries may affect sexual responsiveness. Multiple sclerosis can decrease vaginal lubrication and sexual response.

Genital pain during intercourse may result from an obstructed or thickened hymen, clitoral adhesions, infections, painful scars, a constrictive clitoral hood, vulvodynia, or a weak **pubococcygeus** (pew-bo-kawk-SEE-gee-us) (PC) muscle, the pelvic floor muscle surrounding the urethra and the vagina. Antihistamines used to treat colds and allergies can reduce vaginal lubrication, as can marijuana. Endometriosis and ovarian and uterine tumors and cysts may affect a woman’s sexual response.

The skin covering the clitoris can become infected. Women who masturbate too vigorously can irritate their clitoris, making sexual interactions painful. A partner can also stimulate a woman too roughly, causing soreness in the vagina, urethra, or clitoral area. And unclean hands may cause a vaginal or urinary tract infection.

● Psychological Causes of Sexual Function Difficulties and Dissatisfaction

Sexual function difficulties and dissatisfaction may have their origin in any number of psychological causes. Some difficulties and dissatisfaction originate from immediate causes, others from conflict within the self, and still others from a particular sexual relationship.



Men who smoke are more likely to experience erection problems (“impotence”) than men who do not smoke.

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Immediate Causes

The immediate causes of sexual function difficulties and dissatisfaction include fatigue, stress, ineffective sexual behavior, and sexual anxieties.

Fatigue and Stress Many sexual function difficulties and dissatisfaction have fairly simple causes. Individuals may find themselves physically exhausted from the demands of daily life. They may bring their fatigue into the bedroom in the form of sexual apathy or disinterest. “I’m too tired to make love tonight” can be a truthful description of a person’s feelings. What these couples may need is not therapy or counseling but temporary relief from their daily routines.

Long-term stress can also contribute to lowered sexual drive and reduced responsiveness. A person preoccupied with making financial ends meet, raising children, or coping with prolonged illness, for example, can temporarily lose sexual desire.

Ineffective Sexual Behavior Ignorance, ineffective sexual communication, and misinformation prevent partners from being effectively sexual with each other. Ineffective sexual stimulation is especially relevant in explaining why some women do not experience orgasm in sexual interactions, as discussed earlier and in the box “Is Intercourse Enough? The Big ‘O’ and Sexual Behaviors.”

Some individuals have not learned effective sexual stimulation behaviors because they are inexperienced. They may have grown up without easily accessible sexual information or positive role models.

Sexual Anxieties A number of anxieties, such as performance anxiety, can lead to sexual function difficulties and dissatisfaction (Bancroft, 2009). If a man fails to experience an erection or a woman is not orgasmic, he or she may feel anxious and fearful. And the anxiety may block the very response desired.

Performance anxieties may give rise to **spectatoring**, in which a person becomes a spectator of her or his own sexual behaviors (Masters & Johnson, 1970). When people become spectators of their sexual activities, they critically evaluate and judge whether they are “performing” well or whether they are doing everything “right.” Some sex therapists suggest that spectatoring is involved in most orgasmic difficulties.

Performance anxiety may be even more widespread among gay men (Sandfort & de Keizer, 2001). Sex researcher Rex Reece (1988) writes: “Many gay men move in a social, sexual milieu where sexual arousal is expected immediately or soon after meeting someone. If response is not rapidly forthcoming, rejection is very likely.”

Excessive Need to Please a Partner Another source of anxiety is an excessive need to please a partner. A man who feels this need, sometimes labeled as trying to be the “delivery boy,” may want a speedy erection to please or impress his partner. He may feel that he must “give her orgasms” through his expert lovemaking or always delay his orgasm until after his partner’s orgasm. A woman who experiences this anxiety may want to have an orgasm quickly to please her partner (Castleman, 2004; Salisbury &

The demands of work and child rearing may create fatigue and stress which can create sexual apathy for one or both partners.

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Fisher, 2013). She may worry that she is not sufficiently attractive to her partner or that she is sexually inadequate.

One result of the need to please is that men and women may pretend to have orgasms. (Meg Ryan famously demonstrated faking an orgasm in a deli in the film *When Harry Met Sally*.) Women fake orgasm most often to retain their mate (Kaighobadi, Shackelford, & Welling, 2012) or to avoid disappointing their partner or hurting his feelings. According to sex therapist Kathryn Hall (2004), these women “are buying into the myth that men are really concerned only with satisfying their own ego.” Both men and women also fake orgasm to present a false image of their sexual performance. Unfortunately, faking orgasm miscommunicates to the partner that a person is equally satisfied. Because the orgasmic problem is not addressed, negative emotions may simmer. The wisest decision is never to pretend to experience feelings, interests, or pleasures that do not happen (Hall, 2004).

“In the 1990s a feminist joke asked, ‘Why do women fake orgasm?’ and answered ‘Because men fake foreplay.’ In the masculinist version, the question was ‘Why do women fake orgasm?’ and the answer, ‘Because they think men care.’”

—Angus McLaren

Conflict Within the Self

Negative parental attitudes toward sex are frequently associated with subsequent sexual function difficulties and dissatisfaction. Much of the process of growing up is a casting off of the sexual guilt and negativity instilled in childhood. Some people fear becoming emotionally intimate with another person. They may enjoy the sex but fear the accompanying feelings of vulnerability and, so, withdraw from the sexual relationship before they become emotionally close to their partner (Hyde & DeLamater, 2014). And among gay men, lesbian women, and bisexual individuals, internalized homophobia—self-hatred because of one’s homosexuality—is a major source of conflict that can be traced to a number of factors, including conservative religious upbringing (Frost & Meyer, 2009).

Sources of severe sexual function difficulties include childhood sexual abuse, adult sexual assault, and rape. Guilt and conflict do not usually eliminate a person’s sex drive; rather, they inhibit the drive and alienate the individual from his or her sexuality. He or she may come to see sexuality as something bad or “dirty,” rather than something to happily affirm.

Therapists Robert Firestone, Lisa Firestone, and Joyce Catlett (2006) provide an alternative perspective on the decline of sexual passion in long-term relationships and marriage. They believe that the decline cannot be attributed to the reasons usually given, such as familiarity, gender differences, economic hardships, and other stressors, but rather to changes in the relationship dynamics, the emergence of painful feelings from childhood, and fears of rejection that cause partners to retreat to a more defended posture. Many men and women have difficulty in maintaining sexually satisfying relationships “because in their earlier relationships, hurt and frustration caused them to turn away from love and closeness and to become suspicious and self-protective.” In advising couples in longer-term relationships, the therapists note:

To sustain a loving sexual relationship, individuals must be willing to face the threats to the defense system that loving another person and being loved for oneself evoke. To be able to accept genuine affection, tenderness, love, and fulfilling sexual experiences as part of an ongoing relationship, they must be willing to challenge their negative voices, modify the image of themselves formed in the family, and give up well-entrenched defenses, which would cause them a great deal of anxiety.

“Pleasure is the object, duty, and the goal of all rational creatures.”

—Voltaire
(1694–1770)

Relationship Causes

Sexual function difficulties do not exist in a vacuum, but usually within the context of a relationship. All couples at some point experience difficulties in their sexual relationship. Sex therapist David Schnarch (2002) writes that “sexual problems are common among healthy couples who are normal in every other way—so common, in fact, that they are arguably a sign of normality.” Most frequently, married couples go into therapy because they have a greater investment in the relationship than couples who are dating or cohabiting. Sexual function difficulties in a dating or cohabiting relationship often do not surface; it is sometimes easier for couples to break up than to change the behaviors that contribute to their sexual function problems.

Sex therapist Esther Perel, in her book *Mating in Captivity* (2006), presents a provocative view of desire difficulties in marriage, one that is counter to often-held perspectives among sex therapists. She contends that eroticism thrives on the unpredictable and that increased intimacy often leads to a decrease in sexual desire. Perel states that love is fed by knowing everything about one’s partner, while desire needs mystery, and that love wants to shrink the distance between the two people, while desire is energized by it. She continues by declaring that “as an expression of longing, desire requires elusiveness.” Perel contends that couples may be more successful in maintaining and cultivating sexual desire by enriching their separate lives instead of always striving for closeness. The challenge for many couples is balancing separateness with togetherness, as both are important components of a loving relationship.

If sexual function problems are left unresolved, disappointment, rage, anger, resentment, power conflicts, and hostility often become a permanent part of couple interaction.

“As with singers in a harmony, a harmonious sex life is not necessarily one in which you are both wanting and doing exactly the same things in the same way, but one that is characterized by blending the strengths that you each have to create an agreeable and pleasant sex life.

—Sandra Pertot
(1950–)

● Sexual Function Enhancement

Improving the quality of a sexual relationship is referred to as **sexual function enhancement**. There are several sexual function–enhancement programs for people who function well sexually but who nevertheless want to improve the quality of their sexual interactions and relationships. The programs generally seek to provide accurate information about sexuality, develop communication skills, foster positive attitudes, provide sexual homework for practicing techniques discussed in therapy, and increase self-awareness (Castleman, 2004).

Developing Self-Awareness

Being aware of our own sexual needs is often critical to enhancing our sexual functioning.

What Is Good Sex? Sexual stereotypes present us with images of how we are supposed to behave sexually. Images of the “sexually in charge” man and the “sexual but not too sexual” woman may interfere with our ability to express our own sexual feelings, needs, and desires. We follow the scripts and stereotypes we have been socialized to accept, rather than our own unique responses. Following these cultural images may impede our ability to have what therapist Carol Ellison calls “good sex.” In an essay about intimacy-based sex therapy, Ellison (1985) writes that we will know we are having good sex if we feel good about ourselves, our partners, our relationships, and our sexual behaviors. Further, we will feel good about sex

before, during, and after being sexual with our partners (Hall, 2004). Good sex does not necessarily include orgasm or intercourse. It can be kissing, cuddling, masturbating, performing oral or anal sex, and so on. Sex therapist and clinical psychologist Marty Klein (2012) states that culture dictates a hierarchy of sexual behaviors, with some activities being superior to others. In Western culture the pinnacle of heterosexual sexual behavior is intercourse; it is considered to be the most enjoyable, natural, and intimate sexual behavior. Below intercourse in the hierarchy are other forms of genital sex (touching of the genitals) with a partner, such as oral sex, anal sex, and hand jobs, then followed by masturbation and intimate behaviors not involving touching the genitals, such as touching of the breasts. Kissing is the ultimate expression of intimacy for some people; for others, it is considered boring or a turnoff. One limitation of the concept of sexual hierarchy is that it can minimize the intimacy and pleasure of behaviors “lower” on the hierarchy, and it implies that intercourse must occur in order to have successful sex. With an emphasis on and even a frequent expectation for good sex, one might ask if there is a cost to this approach to couple sex. See the “Think About It” box “Good Enough Sex: The Way to Lifetime Couple Satisfaction” for an alternative model to good or “perfect” partnered sex.



Good sex involves the ability to communicate well nonverbally—through laughter and positive body language and facial expressions—as well as verbally.

© Jonnie Miles/Getty Images

Discovering Your Conditions for Good Sex Zilbergeld (1999) has suggested that to fully enjoy our sexuality we need to explore our “conditions for good sex.” There is nothing unusual about requiring conditions for any activity. Of conditions for good sex, Zilbergeld (1999) writes:

In a sexual situation, a condition is anything that makes you more relaxed, more comfortable, more confident, more excited, more open to your experience. Put differently, a condition is something that clears your nervous system of unnecessary clutter, leaving it open to receive and transmit sexual messages in ways that will result in a good time for you.

Each individual has his or her own unique conditions for good sex. This might include factors such as feeling intimate and emotionally close with one’s partner, feeling trust toward one’s partner, being physically and mentally alert, and embracing one’s own sexual desire and eroticism (Ogden, 2008; Zilbergeld, 1999). If you are or have been sexually active, to discover your conditions for good sex, think about the last few times you were sexual and were highly aroused. Then compare those times with other times when you were much less aroused. Identify the needs that underlie these factors and communicate these needs to your partner.

“When adults experience passions, it’s usually not in response to incredible sex or the perfect body—it’s in response to giving themselves permission to let go emotionally.”

—Marty Klein
(1950–)

Doing Homework Exercises Sexual function–enhancement programs often specify exercises for couples to undertake in private. Such “homework” exercises require individuals to make a time commitment to themselves or their partner. Typical assignments include the following exercises:

- **Mirror examination.** Use a full-length mirror to examine your nude body. Use a hand mirror to view your genitals. Look at all your features in an uncritical manner; view yourself with acceptance.

think about it

“Good Enough Sex”: The Way to Lifetime Couple Satisfaction

Sex provides a buffet of experiences: at times, sex is enthusiastic, cheerful, erotic, gratifying and at other times uninspiring.

—Metz and McCarthy
(2011)

Renowned sex therapists and authors Michael Metz and Barry McCarthy, in their book *Enduring Desire: Your Guide to Lifetime Intimacy* (2011), challenge the current cultural models of “perfect sex” and “perfect intercourse” with an alternative concept for long-term, committed couples, the “Good Enough Sex” (GES) model. They contend that prevailing beliefs that sex should always be perfect are toxic and can lead to disappointment and disillusionment. Unrealistic expectations about sex precipitate a sense of failure as “great sex” in committed relationships, particularly, is uneven and variable. Metz and McCarthy state that the GES model with its physical, psychological, and interpersonal dimensions is not a cop-out that leads to mediocre, boring, or mechanical sex but rather a “roadmap to a lifetime of terrific, meaningful sex, a guide to help you feel sexually satisfied, not in a fantasy world but in real life.” They note that research suggests that regular, variable, and flexible couple sex that is fully integrated into real life is the best couple sex. The GES model does not lead to disappointing compromise or feelings of “selling out” but rather to feelings of relief, affirmation, and inspiration; it seeks *realistically great sex* grounded on a realistic appreciation that variations in couple sex over time are both healthy and necessary.

The GES approach works best when one develops realistic, flexible, accurate, and positive beliefs about GES’s three dimensions, what great sex is and is not, and what sex can be for “oneself.” GES partners embrace concepts such as:

- Sexual satisfaction varies from one experience to the next.
- Achieving high-quality sex is a lifelong process.
- Sexual function difficulties are opportunities for increased cooperation and intimacy.
- Satisfied couples cooperate as an intimate team.
- Quality sex is flexible: You adapt to the inevitable variability and difficulties.

- Sex fits real life, and real life should be brought into the sexual relationship.
- The best sex involves being intimate and erotic partners.
- Quality sex is cooperative relationship sex.

There are numerous benefits of “Good Enough Sex.” One feels self-assured and proud of being a sexual person knowing that positive, realistic expectations decrease embarrassment and shame about one’s body and sexuality. A person will view sex as a normal, real, and positive part of an honest and genuine life. One adopts beliefs that sex is “decent” and wild and that passionate couple sex is “good.” One accepts that sex is variable and creates flexible ways to integrate variability into the couple’s life situation to enhance mutual pleasure. Partners form an intimate team to discover the meanings of sexuality and to balance eroticism and intimacy. Metz and McCarthy state that “no longer bound by shame, no longer having to be different than who you are, no longer anxiously fearing failure, and no longer pursuing perfection, you feel self-assured, confident, and content.”

Think Critically

1. In what ways does society stress “perfect sex”?
2. Do you think by adopting the “Good Enough Sex” approach one would be settling for mediocre and boring sex? Explain your response.
3. Is the “Good Enough Sex” approach realistic for college-age students? Why or why not?
4. If you have been in a sexual relationship, have you experienced “great sex” and “uninspiring sex”? If so, how did you deal with that? Is the “Good Enough Sex” approach a good way to deal with the variability of sex?

SOURCE: Metz, M. E., & McCarthy, B. W. (2011). *Enduring desire: Your guide to lifelong intimacy*. New York: Routledge.

- *Body relaxation and exploration.* Take 30–60 minutes to fully relax. Begin with a leisurely shower or bath; then, remaining nude, find a comfortable place to touch and explore your body and genitals.
- *Masturbation.* In a relaxed situation, with body oils or lotions to enhance your sensations, explore ways of touching your body and genitals that bring you pleasure. Do this exercise for several sessions without having an orgasm; experiencing erotic pleasure without orgasm is the goal. If you are about to have an orgasm, decrease stimulation. After several sessions without having an orgasm, continue pleasuring yourself until you have an orgasm.
- *Sexual voice.* Each person has his or her own erotic “sexual voice,” which is enhanced by discovering, nurturing, and integrating into the couple’s sexual style. Traditionally, many women have been dependent on the male partner’s eroticism and his sexual lead; the woman was not supposed to have her own erotic voice (McCarthy & McCarthy, 2009). Women who develop their own sexual voice open themselves up to a more satisfying and rewarding sexual experience with a partner.
- *Kegel exercises for women and men.* Originally developed to help women with controlling urination, Kegel exercises involve exercising a muscle in the pelvic floor called the pubococcygeus (P.C.) muscle. The Kegel exercises basically involve tightening the P.C. muscle as one does to stop the flow of urine. These exercises can aid in increasing one’s sexual awareness and functioning. (See the “Practically Speaking” box “Kegel Exercises for Men and Women” to learn about why and how to do these exercises.)
- *Erotic aids.* Products designed to enhance erotic responsiveness, such as vibrators, dildos, G-spot stimulators, artificial vaginas and mouths, clitoral stimulators, vibrating nipple clips, explicit videos, oils, lubricants, and lotions, are referred to as **erotic aids**. They are also called **sex toys**, emphasizing their playful quality. Vibrators and dildos seem to be the most common sex toys and are usually considered “women’s toys.” But, of course, they can be for either gender and can be used alone or with a partner. Two national studies of men and women in the U.S., aged 18 to 60, assessed lifetime use of vibrators: 44.8% of men had incorporated a vibrator into their sexual activities during their lives and 52.5% of women had ever used a vibrator (Herbenick, Reece, Sanders, Ghassemi, & Fortenberry, 2009; Reece et al., 2009). You may wish to try using a sex toy or shower massage as you masturbate with your partner or by yourself. You may also want to view erotic DVDs, go online to find sexually explicit images, or read erotic poetry or stories to yourself or your partner.

Intensifying Erotic Pleasure

One of the most significant elements of enhancing our physical experience of sex is intensifying arousal. In intensifying arousal, the focus is on erotic pleasure rather than on sexual functioning. This can be done in a number of ways.

A vibrator can be a valuable aid in increasing sexual arousal and experiencing an orgasm.

© H.S. Photos/Alamy



Kegel Exercises for Women and Men

Kegel exercises were originally developed by gynecologist Arnold Kegel (KAY-gul) to help women with problems controlling urination. They were designed to strengthen and give women voluntary control of a muscle called the pubococcygeus, or P.C. for short. The P.C. muscle is part of the sling of muscle stretching from the pubic bone in front to the tailbone in back, also called the pelvic floor. Because the muscle encircles not only the urinary opening but also the outside of the vagina, some of Kegel's patients discovered a pleasant side effect—increased sexual awareness. Many report that the sensations are similar for men and women. If you are a man, the exercises can be valuable to you for improving erectile function and learning ejaculatory control. In fact, a British study found that erection function improved significantly in men after 3 months of Kegel exercises (Dorey, Speakman, Feneley, Swinkels, & Dunn, 2005). So, men, when reading the directions, just substitute your genitals in places where the directions talk about “vagina” and so on.

Why Do Kegel Exercises?

- They can help you be more aware of feelings in your genital area.
- They can increase circulation in the genital area.
- They may help increase sexual arousal started by other kinds of stimulation.
- They can be useful during childbirth to help control the strength and duration of pushing.
- They can be helpful after childbirth to restore muscle tone in the vagina.
- They can help men improve erection function and control the timing of ejaculation.
- If urinary incontinence is a problem, strengthening these muscles may improve urinary control.

Identifying Your P.C. Muscle

Sit on the toilet. Spread your legs apart. See if you can stop and start the flow of urine without moving your legs. That's your P.C. muscle, the one that turns the flow on and off. If you don't find it the first time, don't give up; try again the next time you have to urinate. (For the British

study cited previously, the researchers instructed the men to tighten their pelvic floor as if they were trying to prevent intestinal gas from escaping or to try retracting the penis and lifting the scrotum and testicles.)

How to Do the Exercises

- *Slow Kegels:* Tighten the P.C. muscle as you did to stop the urine. Hold it for a slow count of three. Relax it.
- *Quick Kegels:* Tighten and relax the P.C. muscle as rapidly as you can.
- *Pull in—push out:* Pull up the entire pelvic floor as though trying to suck water into your vagina. Then push or bear down as if trying to push the imaginary water out. (This exercise will use a number of stomach or abdominal muscles as well as the P.C. muscle.)

At first, do 10 of each of these three exercises (one set) five times every day. Each week, increase the number of times you do each exercise by five (15, 20, 25, etc.). Keep doing five “sets” each day.

Exercise Guidelines

- You can do these exercises anytime during daily activities that don't require a lot of moving around—for example, while driving your car, watching television, sitting in school or at your computer, or lying in bed.
- When you start, you will probably notice that the muscle doesn't want to stay “contracted” during “slow Kegels” and that you can't do “quick Kegels” very rapidly or evenly. Keep at it. In a week or two, you will probably notice that you can control the muscle quite well.
- Sometimes, the muscle will start to feel a little tired. This is not surprising—you probably haven't used it very much before. Take a few seconds' rest and start again.
- A good way to check on how you are doing is to insert one or two lubricated fingers into your vagina. Men can place a finger into their rectum to feel the anus contract. Because it may be a month or so before you notice results, be patient.

Finally, always remember to keep breathing naturally and evenly while doing your Kegels.

Developing Bridges to Desire Sex therapist Barry McCarthy and author Emily McCarthy (2009) state that sexual desire is the core element of a healthy sexuality and that developing and maintaining sexual desire is important to a satisfying couple sexual style. Couples prefer to experience the fun and energizing effect of spontaneous sex that is common in the romantic/passionate sex/idealization phase of a new sexual relationship in which sex occurs nearly every time the couple get together. But for couples past the 6-month to 2-year passionate sex phase, especially those with demanding jobs, kids, mortgages, and so on, most sexual encounters are planned and many couples begin to experience lower sexual desire. This occurs because couples are not able to transfer from the passionate sex stage to an enduring intimate and erotic couple sexual style. The key is to integrate intimacy and eroticism by “building bridges to desire.”

The McCarthys state that “bridges to desire require ways of thinking, anticipating, and experiencing a sexual encounter that makes sex inviting.” The most important bridge to desire involves couples anticipating a sexual encounter in which the partner is involved, giving, and aroused. Each partner and the couple should be creative in developing and maintaining bridges to desire. Even though individual bridges are important, discovering unique, mutual bridges can be a valuable couple resource. The more varied the bridges, the easier it is to maintain desire. Further, the more bridges to desire, the more ways to connect and reconnect through touch. One way to develop a bridge to desire is for each partner to inform the other partner what his or her two favorite ways to initiate a sexual encounter are and two favorite ways to be invited for a sexual encounter. Revealing your thoughts on how your partner can be a better lover may enhance sexual pleasure for both of you. (See the “Think About It” box “My Partner Could Be a Better Lover If . . . : What Men and Women Want from Their Sexual Partners” which lists the top things both men and women want from their partners.)

Sexual Arousal Sexual arousal refers to the physiological responses, fantasies, and desires associated with sexual anticipation and activity. We have different levels of arousal, and they are not necessarily associated with particular types of sexual activities. Sometimes, we feel more sexually aroused when we kiss or masturbate than when we have sexual intercourse or oral sex.

The first element in increasing sexual arousal is having your conditions for good sex met. If you need privacy, find a place to be alone; if you need a romantic setting, go for a relaxing walk or listen to music by candlelight; if you want limits on your sexual activities, tell your partner; if you need a certain kind of physical stimulation, show or tell your partner what you like.

A second element in increasing arousal is focusing on the sensations you are experiencing. Once you begin an erotic activity such as massaging or kissing, do not let yourself be distracted. When you’re kissing, don’t think about what you’re going to do next or about an upcoming test. Instead, focus on the sensual experience of your lips and heart.

Alternatives to Intercourse Waiting, delaying, and facing obstacles may intensify arousal. This is one of the pleasures of sexual abstinence that may be forgotten soon after you begin intercourse. Renowned sex therapist and author Lonnie Barbach (2001) suggests that sexually active people may intensify



Some individuals and couples use erotic aids such as vibrators, dildos, videos, oils, lubricants, and lotions to enhance their sexual pleasure and responsiveness.

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“The best aphrodisiac is an involved, aroused partner.

McCarthy and McCarthy
(2009)

“License my roving hands, and let them go,
Behind, before, above, between,
below.

—John Donne
(1572–1631)



think
about it

My Partner Could Be a Better Lover If . . . : What Men and Women Want from Their Sexual Partners

Most desire is unspoken.

—Northrup, Schwartz, and Witte
(2012)

“I wish my partner was a better lover.” How often have you thought that? Most of us have wished that at one time or another, but we have been afraid to tell our partners. We are afraid to make a request, fearing that our partner will interpret the request as an attack on his or her sexual skills, which may result in anger and even more sexual and emotional problems. So many people remain silent. Actually, for many people their sexual needs and desires are hidden and are unspoken. This can leave them frustrated, and disappointed, feeling “short-changed” and resentful.

After seeing this box title, you may be curious: What do men and women want from their sexual partners? Research has addressed that. An Internet study of over 77,000 individuals around the world asked respondents to select from a long list of choices the top two things they feel that are missing from the sexual relationship (Northrup et al., 2012). Here are the top three choices of what a partner could do to be a better lover:

What Men Want from Their Partners

1. *Sexual diversity (30%).* Even though these men were not necessarily unhappy, many complained that sex with their partners was always predictable. They wanted to mix things up a little bit with new foreplay behaviors and intercourse positions or their partner initiating sex more frequently.
2. *Less passivity (22%).* These men wanted their partners to express more passion. They wanted to expand their usual bounds of sexual excitement.
3. *Sexual noises (16%).* More partner feedback, positive reinforcement, and encouragement were desired by these men. They would like more sexual noises from their partners, like those that let them know that their partners are experiencing enjoyment during sex.

What Women Want from Their Partners

1. *Foreplay (25%).* These women stated that they do not get enough foreplay. They want to be touched more often and for longer periods of time.
2. *Romance (20%).* More romance and loving passion were desired by these women.
3. *Less predictability (19%).* These women wanted less predictability and more diversity in sexual behaviors. They wanted more spontaneous and fun sex.

The researchers note that “it is amazing how constrained sexual intimacy can be, even when we have the security of a truly loving relationship.” Even couples who have been together long-term may be hesitant and embarrassed to ask for and explain what they desire and want. Unfortunately, culture has taught many of us that “wild abandon sex” is shameful and even wrong. The researchers conclude by noting that “if you keep your intimate sexual thoughts a secret, your sexual relationship has no chance to improve.” In a novel way, the researchers continue by proclaiming that squeamishness and prudishness make chilling bedfellows. So be brave and tell your sex partner what you are thinking, and welcome your partner declaring his or her desires.

Think Critically

1. Are the results of this study surprising or what you thought? Explain.
2. Will the findings help you be a better lover? If so, in what way?
3. Do you believe you could tell a partner what would make him or her a better lover? If not, why? If so, how would you do this?
4. What are your thoughts about the idea that “wild abandon sex” is shameful?

SOURCES: Northrup, C., Schwartz, P., & Witte, J. (2012). *The normal bar: The surprising secrets of happy couples and what they reveal about creating a new normal in your relationship*. New York: Harmony.

arousal by placing a ban on partnered sexual activity for a period of time. During this time, explore other ways of being erotic or sexual, such as showering together, giving or receiving an erotic massage without genital stimulation, sharing one's sexual fantasies, or dancing together sexually.

“Sex is more about imagination than friction.”

—Erica Jong
(1942–)

Changing a Sexual Relationship and Managing Sexual Difficulties

In his book *Resurrecting Sex* (2002), David Schnarch, a prominent sex therapist and clinical psychologist, discusses common sexual function difficulties of couples and provides practical suggestions for addressing them. Schnarch says that every couple has sexual function problems at some point, although most couples do not anticipate that they will end up experiencing sexual dissatisfaction. In a statement that might seem surprising, he notes, “If your sexual relationship stays the same, you are more likely to have sexual dysfunctions (and be bored to death).” Schnarch declares that changing the sexual relationship is necessary for couples having sexual function problems and suggests 22 ways to “resurrect sex.” His concepts and strategies for resolving sexual function difficulties include the following:

1. Put some effort into the nonsexual aspects of the relationship. Focus on the tasks of daily living that you share.
2. Expand your repertoire of sexual behaviors, “tones,” styles, and meanings. Push yourself to try sexual behaviors that might seem to be a stretch. Resurrecting sex means doing things differently.
3. Address any issues you and your partner have swept under the carpet. Trying to be intimate and sexual when you are angry, frustrated, or resentful often does not work.
4. Deal with unresolved personal issues. They can hinder your arousal and make you vulnerable to sexual difficulties.
5. Do not become overly concerned with possible unconscious meanings of your sexual problems, and don't get sidetracked playing amateur psychoanalyst. No personality traits or life experiences invariably result in sexual function difficulties. Pay attention to your specific situation, and focus on what is actually happening to you.
6. Recognize that changing a sexual relationship typically involves embracing a deeper connection. Given that many couples do not achieve much emotional connection through sex, this can be a challenge. Intimate, deep connection during sex requires a sensory and emotional bond with your partner.

Schnarch guarantees one thing: To resurrect or improve an intimate relationship, you have to change the current relationship. He notes that this is no small task. Rather, it involves, for example, raising your level of stimulation, accepting new truths about you and your partner, becoming closer, and changing yourself in the process. Resurrecting sex requires being able to make positive changes without taking out frustrations on your partner, even if you think he or she deserves it.

Biomedical and behavioral interventions are effective for treating some individuals experiencing sexual function difficulties. However, sometimes treatment



think about it

Sexual Turn-Ons and Turn-Offs: What College Students Report

What turns college men and women on and off sexually? Are there gender differences and similarities? Sex researcher Robin R. Milhausen conducted an online study of 822 heterosexual students (440 women and 382 men) aged 18–37 from Indiana University who were randomly selected to participate. She contends that a greater understanding of factors that turn on and turn off men and women can be valuable in increasing sexual well-being and improving sexual relationships. Here are the study's major findings.

Some Important Factors Men and Women Agreed On

Factors that *enhance sexual arousal* for both men and women were:

- A good sense of humor, self-confidence, and intelligence
- Feeling desired as a partner
- Spontaneous and varied sex (e.g., not the same activities every time, having sex in a different setting)
- Fantasizing about and anticipating a sexual encounter
- Doing something fun together

Turn-offs for both men and women were:

- A lack of balance in giving and receiving during sex
- A partner who is self-conscious about his or her body
- Worrying about getting a bad sexual reputation
- Worrying about STIs
- Using condoms

Some Important Factors Men and Women Disagreed On

- Women were more concerned about their sexual functioning (e.g., being a good lover, worrying about taking too long to become aroused, feeling shy or self-conscious).
- Being in a relationship characterized by trust and emotional safety was considered more important to sexual arousal for women than for men.

- More women than men indicated that “feeling used” was a big turn-off.
- Men more often considered a variety of sexual stimuli (e.g., thinking about someone they find sexually attractive, “talking dirty,” thinking and talking about sex, being physically close to a partner) as enhancers to sexual arousal.
- Women more often considered partner characteristics and behaviors (e.g., partner showing talent, interacting well with others, doing chores) as enhancers to sexual arousal.
- Women more often considered elements of the sexual setting (e.g., a setting where they might be seen or heard while having sex) as inhibitors to sexual arousal.
- Women were more aware of the role of hormones in sexual arousal.
- Women more often considered elements of the sexual interaction (e.g., partner not sensitive to the signals being given and received during sex, being uncertain how her partner feels) as inhibitors of sexual arousal.
- More men than women *disagreed* that “going right to the genitals” during sex would be a turn-off during sex.

Think Critically

1. Were you surprised by any of the findings? Which one and why?
2. Are some of the results similar to what you would consider sexual turn-ons and turn-offs?
3. Have you learned anything from this study that you might use in your future sexual encounters?
4. Do you think the results would be similar for gay and lesbian couples?

SOURCES: Milhausen, R. R. (2004). *Factors that inhibit and enhance sexual arousal in college men and women*. Doctoral dissertation. Indiana University, Bloomington, IN; Milhausen, R. R., Yarber, W., Sanders, S., & Graham, C. (2004, Nov.). *Factors that inhibit and enhance sexual arousal in college men and women*. Paper presented at the annual meeting of the Society for the Scientific Study of Sexuality, Orlando, FL.

TABLE 2 • Strategies to Cope With Sexual Difficulties

Coping Category	Examples of Strategies from the Data
Changing circumstances to fit goals	
Seek to alter circumstances	■ Seek to solve the problem medically (e.g., with Viagra) or psychologically ■ Close down a relationship and begin a new one
Changing goals to fit circumstances	
Engage flexible stance toward the importance of sex	■ Relegate sex in relation to other priorities ■ Focus on other aspects of the relationship ■ Focus on other priorities
Lower expectations	■ Accept a trade-off between being with someone you love and having the perfect physical sexual experience ■ Expect to have “good” sex less often
Engage flexible definitions of “good-enough” sex	■ Shift from viewing excitement as most important to viewing intimacy as most important
Living with a gap between goals and circumstances	
Normalization	■ Come to see your experience as normal ■ Compare your experience favorably with others
Avoidance	■ Avoid sexual activity ■ Avoid initiating sexual relationships ■ Avoid thinking about the problem

SOURCE: From Mitchell, R., King, M., Nazareth, I., & Wellings, K. (2001). Managing sexual difficulties: A qualitative investigation of coping strategies. *The Journal of Sex Research*, 48, 325–333. Reprinted by permission of The Society for the Scientific Study of Sexuality.

fails, resulting in individuals having to find ways to cope with and adjust to the difficulties. Little research has been conducted on how to do this. An interview study of 32 individuals living in Portugal and who experienced varied sexual function difficulties was conducted to identify the range of coping responses to their sexual problems (Mitchell, King, Nazareth, & Wellings, 2001). Three broad coping approaches, along with strategies, were identified (see Table 2): changing circumstances to fit goals, changing goals to fit circumstances, and living with a gap between goal and circumstances either by normalizing one’s experience or by avoiding the problem. The findings revealed that the participants negotiated the meaning and significance of sexual experience within themselves and in response to outside factors, notably their sexual partner. The third approach, of living with a gap between goals and circumstances by normalizing one’s situation or by avoiding the problem, may seem too unlikely to result in a mutually successful resolution, although in certain circumstances it may be effective. In commenting about the study results, the researchers stated:

Where treatment fails or is not possible, adaptation will be much more likely where patients are encouraged toward more flexible definitions of good-enough sex and flexible prioritization of sex. Our use of the concept of good-enough sex was validated by participant descriptions of normality less than perfect. (p. 332)

● Treating Sexual Function Difficulties

There are several psychologically based approaches to sex therapy, the most important ones being behavior modification and psychosexual therapy. A systematic and meta-analysis review of available studies of psychological interventions for sexual dysfunctions from 1980 to 2009 found that they are effective options for treating sexual dysfunctions. Evidence varies across the different sexual function difficulties but good efficacy exists for female sexual interest/arousal disorder (Fruhauf, Gerger, Schmidt, Munder, & Barth, 2013). William Masters and Virginia Johnson were the pioneers in the cognitive-behavioral approach; one of the most influential psychosexual therapists is Helen Singer Kaplan. Medical approaches may also be effective with some sexual function problems.

Masters and Johnson: A Cognitive-Behavioral Approach

The program developed by Masters and Johnson for the treatment of sexual function difficulties was the starting point for contemporary sex therapy. They not only rejected the Freudian approach of tracing sexual function problems to childhood; they also relabeled sexual function problems as sexual dysfunctions rather than aspects of neuroses. Masters and Johnson (1970) argue that the majority of sexual function problems are the result of sexual ignorance, faulty techniques, or relationship problems. They treated difficulties using a combination of cognitive and behavioral techniques, and they treated couples rather than individuals.

Couples With Difficulties Cognitive-behavioral therapists approach the problems of erectile and orgasmic difficulties by counseling the couple rather than the individual. They regard sexuality as an interpersonal phenomenon rather than an individual one. In fact, they tell their clients that there are no individuals with sexual function difficulties, only couples with sexual function difficulties. Sex therapist Sandra Pertot (2007) states that “even people with secure, happy personal histories can end up with unsatisfying sexual relationships, because it is how your individual sexuality interacts with your partner’s that defines what is a problem and what isn’t.” In this model, neither individual is to blame for any sexual dissatisfaction; rather, it is their mutual interaction that sustains a difficulty or resolves a problem. Masters and Johnson called this principle “neutrality and mutuality” (Masters & Johnson, 1974).

“Full nakedness! All joys are due to thee,
As souls unbodied, bodies unclothed must be,
To taste whole joys.

—John Donne
(1572–1631)

Sensate Focus A common therapeutic method is **sensate focus**, the focusing on touch and the giving and receiving of pleasure (see Figure 6). The other senses—smell, sight, hearing, and taste—are worked on indirectly as a means of reinforcing the touch experience. To increase their sensate focus, the couple is given “homework” assignments. In the privacy of their own home, the partners are to take off their clothes so that nothing will restrict their sensations. One partner must give pleasure and the other receive it. The giver touches, caresses, massages, and strokes his or her partner’s body everywhere except the genitals and breasts. The purpose is not sexual arousal but simply sense awareness.

Specific Treatment Techniques Sex therapy utilizes different techniques for treating specific problems. Treatment techniques for four major problems are briefly described in this section.



• **FIGURE 6**
Sensate Focus

Female Orgasmic Disorder After doing sensate focus, the woman's partner begins to touch and caress her vulva; she guides the partner's hand to show what she likes. The partner is told, however, not to stimulate the clitoris directly because it may be extremely sensitive and stimulation may cause pain rather than pleasure. Instead, the partner caresses and stimulates the area around the clitoris, the labia, and the upper thighs. During this time, the partners are told not to attempt to have an orgasm because it would place undue performance pressure on the woman. They are simply to explore the woman's erotic potential and discover what brings her the greatest pleasure.

Here is a special message to partners of women who have difficulty experiencing orgasm during sex: Support her to have an orgasm any way it happens for her. Sexual partners do not give each other orgasms—lovers are traveling companions experiencing their own erotic journey (Castleman, 2004). Sex therapist and author Marty Klein, speaking to partners of women with orgasmic difficulties, states that “you can create the environment in which your lover feels relaxed enough and turned on enough to have one [orgasm]. But, she creates her own orgasm. You don't *give* it to her” (quoted in Castleman, 2004). In support of Klein's contention that a woman creates her own orgasm, a study of 2,371 women revealed that many women do things during sex beyond getting specific physical stimulation to aid them in experiencing orgasm (Ellison, 2000). The most frequent activities of these women are shown in Table 3. For example, 9 in 10 women indicated that they positioned their body in a way to get the stimulation they needed.

Erection Difficulties When the problem is erection difficulties, the couple is taught that fears and anxieties are largely responsible and that the removal of these fears is the first step in therapy. Once these are removed, the man is less likely to be an observer of his sexuality; he can become a participant rather than a spectator or judge.

After integrating sensate focus into the couple's behavior, the partners are told to play with each other's genitals, but not to attempt an erection. Often, erections may occur because there is no demand on the man; however, he is encouraged to let his penis become flaccid again, then erect, then flaccid, as reassurance that he can successfully have erections. This builds his confidence, as well as his partner's, by letting him know that the partner can excite him.

Therapists also try to dispel many of the erection myths. Although the majority of difficulties with erections are caused by a combination of factors, such as

“The penis, far from being an impenetrable knight in armor, in fact bears its heart on its sleeve.

—Susan Bordo
(1947–)

TABLE 3 • Women's Most Frequent Activities to Facilitate Orgasm During Intercourse^a

Activity	Percentage
Positioned my body to get the stimulation I needed	90
Paid attention to my physical sensations	83
Tightened and released my pelvic muscles	75
Synchronized the rhythm of my movements to my partner's	75
Asked or encouraged my partner to do what I needed	74
Got myself in a sexy mood beforehand	71
Focused on my partner's pleasure	68
Felt/thought how much I love my partner	65
Engaged in a fantasy of my own	56

^aFrom a list of 14 possible answers, the answers that were chosen by at least one half of the women who responded to the sentence "In addition to getting specific physical stimulation, I often have done the following to help me reach orgasm during sex with a partner."

SOURCE: C.R. Ellison, *Women's Sexualities: Generations of Women Share Intimate Secrets of Sexual Self-Acceptance*. Read File Publications, 2006. Copyright © 2006 by Carol Ellison. All rights reserved. Used with permission.

relationship difficulties, cardiovascular problems, and depression, becoming more knowledgeable and realistic about erections is an important step to overcoming difficulties (Rosen, Miner, & Wincze, 2014). Common erection myths include the following (Castleman, 2004):

- *Erection is something that is achieved.* Penises don't become erect through work, but from just the opposite. The more sensual the lovemaking, the more likely an erection will occur.
- *Men are sex machines, always ready, always hard.* A man can really enjoy sex, but if certain conditions are not met, his penis might not become aroused. Instead of thinking of sex as performance, think about it as play that occurs best when both partners are able to relax.
- *During a sexual encounter, you get only one shot at an erection.* Erection changes during a sexual encounter are very common. If an erection subsides during sex, the man shouldn't tense up and decide it is over but instead breathe deeply, keep the faith, and ask the partner to provide stimulation that is sensual.
- *I blew it last time; I will never get it up again.* It's a mistake to overgeneralize from a single sexual episode to a lifetime of erection difficulties. Overgeneralizing can cause stress, sometimes resulting in a self-fulfilling prophecy.
- *If I can't have an erection, my partner can't be sexually satisfied.* Certainly there are numerous ways of providing sexual stimulation to a partner without an erection. How many people who care about their partners would leave him if he has erection problems? Most would want to help him resolve them.

Early Ejaculation Cognitive-behavioral therapists treat early or rapid ejaculation by using initially the same pattern as in treating erection difficulties. They concentrate especially on reducing fears and anxieties and increasing sensate focus and communication. Then they use a simple exercise called the **squeeze technique**

(see Figure 7). The penis is brought manually to a full erection and stimulation continues. Just before he is about to ejaculate, his partner squeezes his penis with thumb and forefinger just below the corona. After 30 seconds of inactivity, the partner arouses him again and, just prior to ejaculation, squeezes again. Using this technique, the couple can continue for 15–20 minutes before the man ejaculates.

Some sex therapists suggest that a man can learn ejaculatory control by increasing his ability to extend the plateau phase of his sexual response cycle, largely through learning to delay ejaculation during masturbation. They encourage men to learn their plateau phase well and, when the “point of no return” is reached during masturbation, the man should stop stroking his penis but not cease caressing completely. This “start-stop” technique can be done by the man himself or by a sexual partner. He should also strengthen his P.C. muscle, so that he can squeeze it to delay ejaculation at the point of no return. Then he returns to masturbation and repeats the cycle several times. For a man to learn ejaculatory control, sex therapists recommend masturbation several times a week for about 30–60 minutes per session. After several weeks, many men are able to hold themselves in the plateau phase for as long as they want. Further, if a man can learn to last 15 minutes, he can probably last as long as he’d like (Castleman, 2004; Keesling, 2006).



• **FIGURE 7**
Squeeze Technique

Delayed Ejaculation One way in which delayed ejaculation is treated is by having the man’s partner manipulate his penis. The partner asks for verbal and physical directions to bring him the most pleasure possible. It may take a few sessions before the man has his first ejaculation. The idea is to identify his partner with sexual pleasure and desire. He is encouraged to relax to keep the P.C. muscle from tightening and to feel stimulated, not only by his partner but also by the partner’s erotic responses to him. After the man has experienced orgasm through manual stimulation, he can then proceed to vaginal or anal intercourse. With further instruction and feedback, the man should be able to function sexually without fear of delayed ejaculation.

Sex therapist Barbara Keesling (2006) states, “Ejaculation will happen when it happens,” and it will happen when the man focuses on the sensations that allow ejaculation to occur rather than trying to make it happen.

Kaplan: Psychosexual Therapy

Helen Singer Kaplan (1974, 1979, 1983) modified Masters and Johnson’s behavioral treatment program to include psychosexual therapy. The cognitive-behavioral approach works well for arousal and orgasmic difficulties resulting from mild to midlevel sexual anxieties. Such severe anxieties may manifest themselves in female sexual interest/arousal disorder, male hypoactive sexual desire disorder and sexual aversion disorder.

Other Nonmedical Approaches

Both cognitive-behavioral and psychosexual therapy are expensive and take a considerable amount of time. In response to these limitations, “brief” sex therapy and self-help and group therapy have developed.

PLISSIT Model of Therapy One of the most common approaches used by sex therapists is based on the **PLISSIT model** (Annon, 1974, 1976). “PLISSIT” is an acronym for the four progressive levels of sex therapy: **p**ermission, **l**imited

information, specific suggestions, and intensive therapy. About 90% of sexual function difficulties can be successfully addressed in the first three levels; only about 10% of patients require extensive therapy.

The first level in the PLISSIT model involves giving permission. At one time or another, most sexual behaviors were prohibited by important figures in our lives. Because desires and activities such as fantasies or masturbation were not validated, we often question their “normality” or “morality.” We shroud them in secrecy or drape them with shame. Without permission to be sexual, we may experience sexual difficulties and dissatisfaction. Sex therapists act as “permission givers” for us to be sexual.

The second level involves giving limited information. This information is restricted to the specific area of sexual function difficulties. If a woman has an orgasmic disorder, for example, the therapist might explain that not all women are orgasmic in coitus without additional manual stimulation before, during, or after penetration.

The third level involves making specific suggestions. If permission giving and limited information are not sufficient, the therapist next suggests specific “homework” exercises. For example, if a man experiences early or involuntary ejaculation, the therapist may suggest that he and his partner try the squeeze technique. A woman with orgasmic disorder might be instructed to masturbate with or without her partner to discover the best way for her partner to assist her in experiencing orgasm.

The fourth level involves undergoing intensive therapy. If the individual continues to experience a sexual function problem, he or she will need to enter intensive therapy, such as psychosexual therapy.

Self-Help and Group Therapy The PLISSIT model provides a sound basis for understanding how partners, friends, books, sexuality education films, self-help exercises, and group therapy can be useful in helping us deal with the first three levels of therapy: permission, limited information, and specific suggestions. Partners, friends, books, sexuality education films, and group therapy sessions under a therapist’s guidance, for example, may provide “permission” for us to engage in sexual exploration and discovery. From these sources, we may learn that many of our sexual fantasies and behaviors are very common.

The first step in dealing with a sexual function difficulty can be to tap your own immediate resources. Begin by discussing the problem with your partner; find out what he or she thinks. Discuss specific strategies that might be useful. Sometimes, simply communicating your feelings and thoughts will resolve the dissatisfaction. Seek out friends with whom you can share your feelings and anxieties. Find out what they think; ask them whether they have had similar experiences and, if so, how they handled them. Try to keep your perspective—and your sense of humor.

Medical Approaches

Sexual function difficulties are often a combination of physical and psychological problems. Even people whose difficulties are physical may develop psychological or relationship problems as they try to cope with their difficulties. Thus, treatment for organically based problems may need to include psychological counseling. The combined medical and psychological intervention has

Four prescription drugs—Viagra, Cialis, Stendra, Levitra—have revolutionized the treatment of male erection difficulties.

© Studio Works/Alamy



several advantages, such as greater treatment efficacy and patient satisfaction (Althof, 2010).

Vaginal pain caused by inadequate lubrication and thinning vaginal walls often occurs as a result of the decreased estrogen associated with menopause. A lubricating jelly or estrogen therapy may help. Vaginitis, endometriosis, and pelvic inflammatory disease may also make intercourse painful. Lubricants or short-term menopausal hormone therapy often resolves difficulties. Loss of sex drive and function, low energy and strength, depressed mood, and low self-esteem may sometimes occur from testosterone deficiency. The sex lives of people with significant testosterone deficiencies may be helped by testosterone supplements.

Most medical and surgical treatments for men have centered on erection difficulties. Such approaches include microsurgery to improve a blood flow problem, suction devices to induce and maintain an erection, a prosthesis implanted in the penis and abdomen, and drugs injected into the penis. Because these methods are not practical or pleasant, they became virtually obsolete with the introduction of an erection-enhancing drug, Viagra, in 1998 by Pfizer. Viagra, the trade name for sildenafil citrate, is the first effective and safe oral drug for the treatment of male erection difficulty, whether caused by psychological or medical conditions.

Viagra revolutionized the treatment of erection difficulties, representing the beginning of a pharmacological approach to treating sexual difficulties. Medical literature shows that Viagra is effective and well tolerated, even for men who have taken the drug for a long period of time, and can improve the sexual satisfaction of both the man and his partner in couples with male erection difficulties (Heiman et al., 2007; Padma-Nathan, Eardley, Kloner, Laties, & Montorsi, 2002). In 2003, two other drugs were approved by the FDA for the treatment of erection problems: GlaxoSmithKline and Bayer's Levitra (vardenafil HCl) and Eli Lilly's Cialis (tadalafil). These three drugs are one of the most popular groups of drugs in pharmaceutical industry history. In April 2012, the U.S. Food and Drug Administration approved another erection-enhancing drug, Stendra (avanafil). About 100 million men globally have sought medical help for erectile dysfunction and the drugs are now commonly used as first-time therapy for ED (Rosen et al., 2014). The National Survey of Sexual Health and Behavior found that 3% of U.S. men aged 18–59 had used an erection medication the last time they had sex. Use was greater for men in the 50–59 age group (8%) than the younger age groups (e.g., 18–24, <1%) (Herbenick et al., 2010.14a). Viagra and Levitra are effective for a few hours, whereas Cialis is effective for 24 to 36 hours. Among the several benefits of the erection-enhancing drugs is that they are often effective in treating erection difficulties that occur as a result of prostate-cancer treatment and surgery, including complete removal of the prostate (American Cancer Society, 2015).

Erection-enhancing drugs allow the muscles in the penis to relax and penile arteries to dilate, thus expanding the erectile tissues that squeeze shut the veins in the penis. They are taken before sex; the amount of time the effects last varies depending on the drug. The drugs do not increase sexual desire, nor do they produce an erection itself; there still must be sexual stimulation. After sex is over, the erection goes away. The primary psychological role of the erection drugs is to eliminate the anticipatory and performance anxiety surrounding intercourse, which will usually, in itself, result in erections and increased confidence. Some men take the drugs as a “quick fix” for a temporary problem or as “insurance,” even though they may not really need them. Because Viagra increases pelvic blood flow, many women began using it when it was first released in hopes of increasing sensation and orgasm. These experiences, and the results of medical research,

“The penis used to have a mind of its own. Not anymore. The erection industry has reconfigured the organ, replacing the finicky original with a more reliable model.”

—David Friedman
(1949–)

though, have yielded mixed results as insufficient vasocongestion probably does not solely account for orgasm difficulties in women. Efforts to create an effective drug (e.g., Flibanserin) for female sexual difficulties, particularly low sexual desire, continue but to no avail (Angier, 2007; Bancroft, 2009; Landau, 2014).

The U.S. Food and Drug Administration notes that these drugs are safe for most men if used according to the directions, except for men taking nitrates (often prescribed for chest pain) and those having poor cardiovascular health. Headaches, visual disturbances, and flushing sometimes occur, and in rare cases extended and painful erections occur (Ashton, 2007; Reitman, 2004). Some men are using the erection drugs casually, as party drugs or as insurance against the effects of alcohol and for a desired increase in “prowess” (Harte & Meston, 2011). The mixing of street drugs and an erection-enhancing drug is dangerous. And people should never use someone else’s erection-enhancing drug; they should always get their own prescription from a doctor.

Some experts caution people not to over-rely on medical approaches to solve sexual function difficulties (see the “Think About It” box “The Medicalization of Sexual Function Problems”). Sex therapist and clinical psychologist Julian Slowinski (2007) states that “a man’s sexual functioning is determined and affected by the health of his body and lifestyle, his personal emotional state, the quality of his relationship, and the influence of life and environmental stress.” Most sexual function difficulties can be resolved through individual and couple therapy. The optimal approach in the use of drugs is in concert with psychotherapy.

Numerous homeopathic products, often known as “natural sexual enhancers,” are being sold on the Internet and at health-food stores, convenience stores, and drugstores, promising to “spice up your sex life,” “rekindle desire,” and “improve sexual performance.” Supported by unsubstantiated claims and personal testimonials, these capsules, herbal erection creams, sprays, lubricants, gels, and tonics promise greater sexual arousal and rock-hard erections. These products are not regulated by the U.S. Food and Drug Administration, may or may not contain ingredients listed on the label, and instead may contain ingredients that could be harmful to people, especially those with medical conditions. Conclusive evidence of the effectiveness of the natural sexual enhancers treating male and female sexual function problems has not been established. In short, there aren’t any natural “magic bullets” that turn you into an instant, perfect love machine. As suggested throughout this book, enhancing your emotional and physical health, as well as your relationship with your partner, is usually the best path to sexual fulfillment.

Gay, Lesbian, and Bisexual Sex Therapy

Until recently, sex therapists treated sexual function difficulties as implicitly heterosexual. The model for sexual functioning, in fact, was generally orgasmic heterosexual intercourse. There was virtually no mention of gay, lesbian, bisexual, or transgender sexual concerns.

For gay men, lesbian women, and bisexual individuals, sexual issues differ from those of heterosexuals in several ways. First, although gay men and lesbian women may have arousal, desire, erectile, or orgasmic difficulties, the context in which they occur may differ significantly from that of heterosexual individuals (Institute of Medicine, 2011). Problems among heterosexuals most often focus on sexual intercourse, whereas the sexual dissatisfaction of gay men, lesbian women, and bisexual people focuses on other behaviors. Gay men in sex therapy,



think
about it

The Medicalization of Sexual Function Problems

Since the early 1980s, a number of pharmacological therapies have been introduced for treatment of men's sexual function problems. The erection-enhancing drugs—Viagra, Levitra, Cialis, and Stendra—enable some men suffering from hypertension, diabetes, and prostate problems to get an erection by increasing the flow of blood to the penis, provided there is sexual stimulation. However, the pills do not cure fractured relationships, make people more sensual lovers, enlarge penises, end age-related sexual limits, or address the complexity of all sexual problems (Marshall, 2012; Moynihan & Mintzes, 2010; Reitman, 2004; Slowinski, 2007). One problem with the erection-enhancing drugs is that they reinforce the widespread, but mistaken, belief that an erection equals a satisfying sexual experience for both men and women. It perpetuates the notion, fed by many erotic videos, that sticking an erection into an erotic opening is the only thing sex is about (Castleman, 2004). Sex therapist Marty Klein says that “it’s possible to have a rock-hard erection and still have lousy sex” (quoted in Castleman, 2004). The pills often help individuals postpone or avoid self and couple analysis. Some experts contend that the erection-enhancing pills have, thus, medicalized sexual problems, resulting in the prevailing medical model that promotes a specific norm of sexual functioning: correct genital performance (Tiefer, 2001). The medical solution would be to take a pill for an erection problem, thus taking the focus off the individual and the dynamics of the relationship (Bancroft, 2009; Tiefer, 2001, 2004). However, the best use of Viagra (and Levitra, Cialis, and Stendra) is in the context of a comprehensive assessment and intervention by a sex therapist that focuses on the physical, emotional, and relational aspects of the male (McCarthy, 1998; Slowinski, 2007).

The “Viagra phenomenon,” the most recent event in the medicalization of male sexuality, has both positive and negative consequences: It enables millions of men to have reliable erections, but it also calls for a similar pill that would increase female sexual response. John Bancroft, senior research fellow at The Kinsey Institute, in speaking about pharmacological approaches to female sexual function problems, contends that the term “sexual dysfunction” commonly used in medicine is misleading and dangerous; portraying sexual difficulties as dysfunctions “encourages physicians to prescribe drugs to change sexual function when the attention should be paid to other aspects of the woman’s life” (quoted in Moynihan, 2002). Bancroft (2002, 2009) stated that a

Viagra-type drug might influence female sexual response and enjoyment but treatment should not separate sexual expression from other factors that influence sexual functioning in women, such as fatigue, stress, or threatening behavior from their partners.

Leonore Tiefer (2004), a sex therapist and psychiatry faculty member at New York University School of Medicine, says that innumerable professional and scientific conferences have been held on female sexual dysfunction, enthusiastically backed by drug companies. She contends that this is an effort to sell female sexual function problems as a new medical disorder solvable by medical treatments. In response to this, she and other experts developed a perspective of female sexuality, The New View of Women’s Sexual Problems, described earlier in this chapter, to challenge the medicalization of women’s sexuality.

Tiefer (2012) states that with increasing emphasis on the search for sexual desire and orgasm, satisfaction may become more elusive; sexual discontent will become universal and therapies infinite. In looking ahead to the future of medicalization of sexual function problems, she contends that the marketplace is always at work for new solutions. She notes that:

However, as the growth of alternative sexualities expands, the paradigm of problems and therapies may shift away from medicalization and biomedicalization toward a multisexualities diversity model. Society and people will continue to need various kinds of help, but perhaps in the next era they won’t turn—or first turn—to medicine or a model centered on health or illness to lead the way. (p. 317)

Think Critically

1. Do you think that the sexuality of men and women is being medicalized?
2. Do you think it would be easier to take an erection-enhancing drug than seek therapy for erection difficulties?
3. Should a drug like Viagra be developed for women?
4. Are people over-relying on drugs to solve their sexual function problems?



Seeking Professional Assistance

Just because something is not “functioning” according to a therapist’s model does not necessarily mean that something is wrong. You need to evaluate your sexuality in terms of your own and your partner’s satisfaction and the meanings you give to your sexuality. If, after doing this, you are unable to resolve your sexual function difficulties yourself, seek professional assistance. It is important to realize that seeking such assistance is not a sign of personal weakness or failure. Rather, it is a sign of strength, for it demonstrates an ability to reach out and a willingness to change. It is a sign that you care for your partner, your relationship, and yourself. As you think about therapy, consider the following:

- What are your goals in therapy? Are you willing to make changes in your relationship to achieve your goals?
- Do you want individual, couple, or group therapy? If you are in a relationship, is your partner willing to participate in therapy?
- What characteristics are important for you in a therapist? Do you prefer a female or a male therapist? Is the therapist’s age, religion, or ethnic background important to you?
- What are the therapist’s professional qualifications? There are few certified sex therapy programs; most therapists who treat sexual function difficulties come from various professional backgrounds, such as psychiatry, clinical psychology, psychoanalysis, marriage and family counseling, and social work. The American Association of Sexuality Educators, Counselors, and Therapists certifies sex therapists and has a list of

certified persons with contact information, by state and country, on its website (<http://www.aasect.org>). Because there is no licensing in the field of sex therapy, it is important to seek out those trained therapists who have licenses in their generalized field.

- What is the therapist’s approach? Is it behavioral, psychosexual, psychoanalytic, medical, religious, spiritual, feminist, or something else? Do you feel comfortable with the approach?
- If necessary, does the therapist offer a sliding-scale fee, based on your level of income?
- If you are a lesbian, gay, or bisexual person, does the therapist affirm your sexual orientation? Does the therapist understand the special problems gay men, bisexual individuals, and lesbian women face?
- After a session or two with the therapist, do you have confidence in him or her? If not, discuss your feelings with the therapist. If you believe your dissatisfaction is not a defense mechanism, change therapists.

Most sex therapists believe that their work results in considerable success. Not all problems can be resolved completely, but some—and often great—improvement usually occurs. Short-term therapy of 10 or fewer sessions helps some people, although most require therapy for 4 months or longer (McCarthy & McCarthy, 2009). Much of therapy’s success depends on a person’s willingness to confront painful feelings and to change. This entails time, effort, and often considerable amounts of money. But ultimately, the difficult work may reward partners with greater satisfaction and a deeper relationship.

“Impulse arrested spills over, and the flood is feeling, the flood is passion, the flood is even madness: It depends on the force of the current, the height and strength of the barrier. . . . Feeling lurks in that interval of time between desire and its consummation.”

—Aldous Huxley
(1894–1963)

for example, most often experience aversion toward anal eroticism (Reece, 1988; Sandfort & de Keizer, 2001). Lesbian women in sex therapy frequently complain about aversive feelings toward cunnilingus. Female orgasmic difficulty, however, is not frequently viewed as a problem (Margolies et al., 1988). Heterosexual women, in contrast, frequently complain about lack of orgasm.

Second, lesbian women, gay men, and bisexual individuals must deal with both societal homophobia and internalized homophobia. Fear of violence makes it difficult for gay men, bisexual individuals, and lesbian women to openly express their affection in the same manner as heterosexuals. As a consequence, lesbian women, bisexual individuals, and gay men learn to repress their expressions of feelings in public; this repression may carry over into the private realm



It is important for gay, lesbian, and bisexual people with sexual difficulties to choose a therapist who affirms their orientation and understands the special issues confronting them.

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as well. Internalized homophobia may result in diminished sexual desire, creating sexual aversion and fostering guilt and negative feelings about sexual activity.

Third, gay men must deal with the association between sex and HIV infection that has cut a deadly swath through the gay community. The death of friends, lovers, and partners has left many depressed, which, in turn, affects sexual desire and creates high levels of sexual anxiety. Many gay men are fearful of contracting HIV even if they practice safer sex. And HIV-positive men, even if they are practicing safer sex, are often afraid of transmitting the infection to their loved ones.

These unique lesbian, bisexual, and gay individuals' concerns along with those who identify as gender non-conforming or transsexual require that sex therapists expand their understanding and treatment of sexual function problems. For example, if the therapist is heterosexual, he or she needs to have a thorough knowledge of sexual orientation issues and the special needs of gay, lesbian, bisexual, and gender non-conforming individuals. Therapists further need to be aware of their own assumptions and feelings about varied sexual orientations and gender identities.

Final Thoughts

As we consider our sexuality, it is important to realize that sexual function difficulties and dissatisfaction are commonplace. But sex is more than orgasms or certain kinds of activities. Even if we have function difficulties in some areas, there are other areas in which we may be fully sexual. If we have erection or orgasmic problems, we can use our imagination to expand our repertoire of erotic activities. We can touch each other sensually, masturbate alone or with our partner, and caress, kiss, eroticize, and explore our bodies with fingers and tongues. We can enhance our sexuality if we look at sex as the mutual giving and receiving of erotic pleasure, rather than a command performance. By paying attention to our conditions for good sex, maintaining intimacy, and focusing on our own erotic sensations and those of our partner, we can transform our sexual relationships.



Summary

Sexual Function Difficulties: Definitions, Types, and Prevalence

- The line between “normal” sexual functioning and a sexual function difficulty is often not definitive.
- Difficulties in sexual functioning are often called sexual problems, sexual disorders, or *sexual dysfunctions*.
- The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* classifies four types of sexual dysfunctions: sexual desire problems, orgasmic disorders, sexual pain disorders, and substance/medication-induced sexual dysfunction. According to a woman-centered classification system, sexual function difficulties arise from cultural and relational factors, as well as psychological and medical problems.
- A sexual function difficulty can be defined as a disappointment on the part of one or both partners.
- Several national studies show that many men and women experience, on occasion, sexual function difficulties. Numerous factors, such as personal and relationship problems, aging, personal health, socioeconomic issues, unrealistic expectations, and attitudes toward sexuality, impact sexual functioning.
- *Female sexual interest/arousal disorder* is the absent/reduced sexual thoughts, fantasies, initiation and receptivity and absent/reduced arousal and pleasure during sexual activity. This disorder is frequently associated with problems of experiencing orgasm, pain during sexual activity, low frequency of sexual activity, poor sexual techniques, and relationship problems. Lack of sexual interest is the most common female sexual function difficulty.
- *Male hypoactive sexual desire disorder* is the persistence or absence of sexual thoughts, fantasies, and desire for sexual activity. This disorder may be associated with erectile and/or ejaculatory difficulties.
- *Erectile disorder* is the difficulty with erections during partnered sexual activity. Many men experiencing erection difficulties may have low self-esteem, low self-confidence, decreased sexual satisfaction, reduced sexual desire, and a decreased sense of masculinity.
- *Sexual aversion disorder* is a consistently phobic response to sexual activities or the idea of such activities.
- *Female orgasmic disorder* is the difficulty in experiencing orgasms or reduced intensity of orgasms during sexual activity. Orgasmic difficulties are the

second most common female problem treated by therapists.

- *Delayed ejaculation* is inability or difficulty in ejaculating despite adequate sexual stimulation or desire to experience ejaculation.
- *Premature (early) ejaculation* is, according to the *DSM-5*, a pattern of early ejaculation during partnered sexual activity within 1 minute following vaginal penetration and before the individual desires. Some debate exists on how long intercourse should take place to be classified as having premature/early ejaculation. Early ejaculation is fairly common in the general population.
- *Genito-pelvic/penetration disorder* is difficulty related to genital and pelvic pain and vaginal penetration during intercourse. The category represents a total inability to experience vaginal penetration in any circumstance (e.g., intercourse, gynecological examination, tampon insertion), to being able to easily experience penetration in one situation but not another.
- *Substance/medication-induced sexual dysfunction* is the difficulty in sexual functioning that can occur with intoxication or soon after or during withdrawal of numerous drugs including prescription and illicit/recreational drugs.

Physical Causes of Sexual Function Difficulties and Dissatisfaction

- Health problems such as diabetes and alcoholism can cause erectile difficulties. Some prescription drugs affect sexual responsiveness.
- Coital pain caused by inadequate lubrication and thinning vaginal walls often occurs as a result of decreased estrogen associated with menopause. Lubricants can resolve the difficulties.

Psychological Causes of Sexual Function Difficulties and Dissatisfaction

- Sexual function difficulties may have their origin in any number of psychological causes. The immediate causes of these difficulties lie in the current situation, including fatigue and stress, ineffective sexual behavior, sexual anxieties, and an excessive need to please a partner. Internal conflict caused by religious teachings, guilt, negative learning, and internalized homophobia can contribute to dissatisfaction, as can relationship conflicts.

Sexual Function Enhancement

- Many people and all couples experience sexual function difficulties and dissatisfaction at one time or another. Differences in sexual desire are the most common complaint among couples. The widespread variability of sexual functioning suggests the “normality” of at least occasional sexual function difficulties.
- *Sexual function enhancement* refers to improving the quality of one’s sexual relationship. Sexual function–enhancement programs generally provide accurate information about sexuality, develop communication skills, foster positive attitudes, and increase self-awareness. Awareness of your own sexual needs is often critical to enhancing your sexuality. Enhancement of sex includes the intensification of arousal.
- There has been a dramatic increase in over-the-counter, natural sexual enhancers, but none have been scientifically shown to be effective.

Treating Sexual Function Difficulties

- Masters and Johnson developed a cognitive-behavioral approach to sexual function difficulties. They relabeled sexual problems as dysfunctions rather than neuroses or diseases, used direct behavior modification practices, and treated couples rather than individuals. Treatment includes *sensate focus* without intercourse, “homework” activities, and, finally, “permission” to engage in sexual intercourse. Kaplan’s psychosexual therapy program combines behavioral activities with insight therapy.
- The *PLISSIT model* of sex therapy refers to four progressive levels: *permission*, *limited information*, *specific suggestions*, and *intensive therapy*. Individuals and couples can often resolve their sexual function difficulties by talking them over with their partners or friends, reading self-help books, and attending sex therapy groups. If they are unable to resolve their difficulties in these ways, they should consider intensive sex therapy.
- Viagra was introduced in the United States in 1998 and was the first effective and safe oral drug for treatment of male erection difficulty. Subsequently, three other prescription drugs, Levitra, Cialis, and Stendra, have been approved by the U.S. Food and Drug Administration. These drugs do not increase sexual excitement but rather facilitate blood engorgement in the penis.

- Some sexuality professionals claim that drug companies have exaggerated and “medicalized” sexual function difficulties to promote sales.
- There are three significant concerns for gay men, bisexual individuals, and lesbian women in sex therapy. First, the context in which problems occur may differ significantly from that of a heterosexual person; there may be issues revolving around anal eroticism and cunnilingus. Second, they must deal with both societal homophobia and internalized homophobia. Third, gay men must deal with the association between sex and HIV/AIDS and other sexually transmitted infections.
- In seeking professional assistance for a sexual problem, it is important to realize that seeking help is not a sign of personal weakness or failure but rather a sign of strength.

Questions for Discussion

- Do you think that sexual function difficulties should be determined by a medical group such as the American Psychiatric Association or by what the individual and/or couple decides is dissatisfying?
- If you have been sexual with another person, have you ever experienced sexual function dissatisfaction or difficulty? After reading this chapter, do you think that this experience is actually a “sexual dysfunction” or possibly a dissatisfaction based on an unrealistic expectation of what sex should be like? Did you talk to your partner about the disappointment?
- What do you consider to be a satisfying sexual experience with a partner? Did the information in this chapter cause you to reevaluate what you consider “good sex” for you and a partner?
- If you had a sexual function difficulty, how comfortable would you be in seeking help from a sex therapist?
- If you or your male partner were having difficulties with erections, would you seek prescription drugs (Viagra, Levitra, Cialis, or Stendra) to deal with the problem? Is it possible for a man and his partner to have good sex without an erection?

Sex and the Internet

Sexual Difficulties

The website WebMD provides information on various health issues, including sexual function difficulties. Go to this site (<http://www.webmd.com>) and find the “Search” box. Type in various sexual function difficulty terms, such as “sexual dysfunction,” “erectile dysfunction,” “premature ejaculation,” “female orgasmic disorder,” and “sexual pain.” Review the information for each topic.

- Is the information given appropriate for nonmedical people?
- What new information is provided?
- Are there links to other sites that provide sexual information?

Suggested Websites

American Family Physician

<http://www.aafp.org>

Provides information about both female and male sexual function difficulties.

New View Campaign

<http://www.newviewcampaign.org>

Promotes an alternative view of female sexual function difficulties, challenges the pharmaceutical industry, and calls for further research on these difficulties.

Cleveland Clinic

http://my.clevelandclinic.org/disorders/sexual_dysfunction/hic_sexual_dysfunction_in_males.aspx

Provides an overview of sexual dysfunction in both men and women and a discussion of diseases and medications that affect sexual function.

Women’s Sexual Health

<http://www.womenssexualhealth.com>

Addresses the questions and concerns of women and their partners concerning female sexual function difficulties and includes a “Physician Locator” to help them find local physicians who treat these difficulties.

Suggested Reading

Binik, Y. M., & Hall, K. S. K. (2014). *Principles and practice of sex therapy* (5th ed.). New York: Guilford Press. A multidisciplinary perspective on the causes and treatment of sexual dysfunctions that integrates current research with clinical

practice. All chapters are authored by internationally recognized experts.

Cassell, C. (2008). *Put passion first: Why sexual chemistry is the key to finding and keeping lasting love*. New York: McGraw-Hill. Written for women (but can be valuable to men, too), this book helps the reader understand the significance and role of sexual passion within a relationship with emphasis on increasing couple intimacy.

Castleman, M. (2004). *Great sex: A man’s guide to the secret principles of total-body sex*. New York: Rodale. An exceptionally easy-to-read and practical book for men in which the author quotes well-respected sex therapists throughout the book to show therapists’ suggestions for various sexual function problems.

Keesling, B. (2006). *Sexual healing: The complete guide to overcoming common sexual problems* (3rd ed.). Alameda, CA: Hunter House. A greatly expanded edition of the classic book on the healing power of sex that offers more than 125 exercises that help with a wide range of sexual function difficulties.

Klein, M. (2012). *Sexual intelligence: What we really want from sex—and how to get it*. New York: HarperOne. Presents a very sex-positive, realistic, and healthy perspective on enhancing sexual pleasure for individuals and couples.

McCarthy, B. W., & McCarthy, E. (2009). *Discovering your couple sexual style*. New York: Routledge. Focuses on helping couples enhance intimacy and sexual satisfaction by providing relevant sexual information, exercises, and practical tools.

Metz, M. E., & McCarthy, B. W. (2011). *Enduring desire: Your guide to lifelong intimacy*. New York: Routledge. A superb guide on creating and maintaining a satisfying sex life across ages of a long-term relationship.

Moynihan, R., & Mintzes, B. (2010). *Sex, lies & pharmaceuticals*. Vancouver, British Columbia: Greystone Books. Explores the causes of women’s sexual dissatisfaction and the global efforts of drug companies to medicalize women’s sexual problems.

Ogden, G. (2008). *The return of desire: A guide to discovering your sexual passions*. Boston: Trumpeter. Written by an experienced sex therapist, this book is a wise guide that focuses on women and enhancing their sexual desire and passion.

Perel, E. (2006). *Mating in captivity*. New York: Harper. Presents a provocative perspective on intimacy and sex in exploring the paradoxical union of domesticity and sexual desire.

Pertot, S. (2007). *When sex drives don’t match*. New York: Marlow & Company. Presents 10 libido types and how they affect a couple along with rational ways for couples to work through differing sex drives.

Schnarch, D. (2002). *Resurrecting sex*. New York: HarperCollins. Deals with the sexual problems of couples and offers frank talk about sex, intimacy, and relationships.