THE WORLD OF PSYCHOLOGY: THERAPEUTIC, RELATIONAL, TEACHING

Sex and Sexuality

The Good, the Bad, and the Ugly

A Sex Therapist's Perspective

Ami Rokach, PhD

NOVA

The World of Psychology: Therapeutic, Relational, Teaching

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With Contribution by Sybil Chan

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To my beloved Natalie, and to ‘Jane’ who shared her experiences with me

Heartfelt thanks to Sybil Chan for assisting with editing the manuscript
A.R.

Contents

Prologue:	**An Introduction and Sneak Peek into | What to Expect**	ix
Chapter 1	**Religion, Culture, and the Evolution of Sexuality**	1
Chapter 2	**How Is Research in Human Sexuality Conducted?**	21
Chapter 3	**How Do We Respond to Sexual Stimulation?**	31
Chapter 4	**Our Sexual Behaviors, and How They Are Formed**	55
Chapter 5	**Belonging, Love and Intimacy**	89
Chapter 6	**Communicating about Sex**	123
Chapter 7	**Sexual Orientation: Whom Do We Prefer as a Sexual Partner?**	137
Chapter 8	**Can Psychological and Medical Conditions Affect Sexuality?**	157
Chapter 9	**The ‘Bad’: When Things Don’t Go the Way They Should**	189
Chapter 10	**The ‘Ugly’: Unlawful Sexual Behaviors**	237
Chapter 11	**Sexual Variations: It’s Different, But Not Always ‘Bad’**	255
Chapter 12	**The Ins and Outs of Sex Therapy**	277
Chapter 13	**Sexuality and Relationships**	313
Epilogue		335
Index		337
About the Author		343

Prologue: An Introduction and Sneak Peek into What to Expect

Within our culture, the topic of sexuality has been traditionally considered as taboo and hidden from the public. Up until the sexual revolution, countless societies all over the world mainly understood sex as inserting a penis into a vagina in the context of marriage. Its main purpose was to bring children into the world, rather than for pleasure. In some cultures, other forms of sexual stimulation, not to speak of adult toys, is seen as sinful and may result in incarceration!

Instead, open discussions of sex related matters including everything from mutual masturbation to oral, vaginal, and anal stimulation has been introduced into our lives. For example, masturbation is now recognized as a natural, health activity. No longer is it seen as a cause of blindness or of hair to grow in the palm of our hands. We can see here that conventional beliefs about sex have diversified and expanded in the past two decades This includes newer forms of sexual expression including the phenomenon of 'sexting' that has become widely popular in our online world. Well, mainly to the lives of the younger generation. Can you imagine the change?!

The fixation of sex in American culture is also not a new concept. Some suggest that we are deeply ambivalent about sexual pleasure and intimacy. In many cases, parents are worried whether their teens are 'doing it', and teachers are not free to develop sexual education curriculums without the scrutiny of it being checked, evaluated, and sometimes censured. Americans seem to be concerned about a variety of issues ranging from unintended pregnancy, sexually transmitted diseases, sexually active youth and the right to marry for gay and lesbian individuals. Sexual literacy is essential if we want to achieve healthy intimate relationships and be able to prevent disease and unwanted pregnancies in the future. And although America prides itself on its progressive development, it is clear that the same cannot be said for its understanding of sexuality.

Sexual activity is a complex process which relies on a working tandem of genetics, psychological factors, social influences, and cultural norms which affect all of us. The evolution of social communities, which then developed into societies and cultures, has seen a preoccupation with the immorality of sex. Take, for instance, the Christian perspective of sex. For ages, members within this community have struggled to accept sex as a normal activity, and basically saw it as a necessary evil which is needed in order to procreate. In other cultures, sexual perspectives are more extreme. Sexual affection or open sexuality is often prohibited and may forbid women from showing their bodies publicly in fear that they will seduce men. In this light, men are perceived as sex-driven beings that harbour a burning desire to fornicate all the time.

Unfortunately, this is not dissimilar to traditional medical and psychological approaches to sexuality as well. This can be seen through the emergence of the sexual revolution through the advent of 'The Pill', and the ground-breaking research of Dr. Kinsey, and Dr. Masters and Ms. Johnson. Their epitomal work in the second half of the 20th century helped free society in many respects related to endorsing more liberal, sex-positive attitudes. Their contributions have introduced an incredible variability of sexual experiences which may exist in our relationships and lives. And thanks to their astonishing work, we can now recognize the importance of sexuality in establishing and maintaining healthy relational intimacy.

Sex is a significant part of the human relationship. Lately, it has begun to be of interest to researchers in the field despite its long-lasting fascination by the public. It is commonly believed that long relationships will inevitably see a passionless, sexless end that will become stale for both partners. However, some of the material and research that is covered in this book shows that it does *not* have to be that way. We believe that long relationships can build on the extensive knowledge that partners have of each other, and be rich with relational experiences, sexually fulfilling intimacy, and romantic love.

In fact, sexual intimacy is an incredibly important factor that drives happy and successful relationships. As Dr. Dean Ornish wrote in his remarkable from 1998 book called 'Love and Survival', our survival depends on the healing power of love, and the intimacy it enhances. To fulfill our need to belong, we desire to be in intimate relationships and seek close human connections with others. But…you need to know how to do it. We'll talk about what it takes to achieve such a relationship in later chapters.

The book that you are holding discusses not only sex, intimacy, and love, but also the different types of non-harmful sex which is uncommonly practiced by a minority of people. This includes sexual behaviours considered to be "abnormal," such as watching porn, having fetishes, crossdressing, and more. But as with all things, there are other and more harmful behaviors such as sexual abuse, pedophilia, and rape (the "ugly"), that will also be covered later in this book. We will explore the negative effects that are usually left on victims and its implications for their later relationships.

This book begins with a review of the history of sexuality; how humanity has evolved in the way that sexuality is perceived, and its approaches in the 21st century. We will explore an angle of sexuality research that most lay people may not be familiar with including its methodologies and conclusions that can be drawn from it. We will review the various ways that sex-related research is conducted in North America This will largely cover Dr. Kinsey's survey questions, Dr. Master's and Ms. Johnson's experimental work observing and measuring bodily responses to sexual stimulation and the importance of the language in sex research.

We will also identify how commonly recognized sexual behaviours (the "good"), contribute to fulfilling sexual relationships. This includes processes related to mate selection, how men and women differ in patterns of sexual desire and the influential role that culture plays on sexual behavior. We will also be exploring the ways in which sexual pleasure is achieved (aside from partnered sex) through masturbation and sexual toys. We will then discuss about sexual dysfunctions (the "bad") that are commonly experienced by older adults, but by younger folk as well.

Later on, we will also explore the purpose and expression of love and its relationship to intimacy. This will also include how love and intimacy have been defined in the literature, and the effect of the internet on romantic relationships. Men and women may not be from different planets, but they do have some different needs and preferences that, if considered, will enhance our relationships to one another.

The belief that "You should know how I feel and what I want" no longer holds water. Mind readers are not easily found in our midst. Instead, good and healthy communication is of prime importance to a successful relationship – especially in the context of sex and intimacy. Therefore, we have devoted a chapter to examine how good (and not so good) communication affects our relationships, our sexual satisfaction, and the intimacy between partners.

However, people are not invincible. They may suffer, at any age, from psychological, medical, or psychiatric problems which may have a huge impact on their lives, relationships,

and sexuality. We will explore those effects and how certain treatments can help reduce these problems.

In turn, we will also dive into an uncommon genre of sex that is typically not recognized by the mainstream. These sexual variations called 'paraphilias' play a huge role in affecting people's lives. As such, we will be bringing them to your awareness in hopes of making them more accessible to the public. Although, a clear distinction must be made to dissociate the harmful and non-harmful paraphilias shared by common lay people vs. sexual offenders. We will talk in depth about who these offenders are, their niches and their 'perversions'. We will also explore whether treatments can cure them, or at least help them control their behaviors and the various modalities that are used in this process.

Lastly, we will discuss sexual dysfunctions that are experienced by both men and women. This includes a variety of sexual desire disorders, orgasmic disorders, pain-related sexual dysfunctions, and sexual dysfunctions related to childhood sexual abuse. Such circumstances can impose significant impacts to a person's or a couple's love life. These effects on their well-being and sexuality will ultimately be explored in this book as well.

An Important Point

This volume is not intended to be just another book which introduces human sexuality simply through pictures, drawings, and instructions of "how to." Rather, I assume that you may already know 'something' about sex and sexuality, and thus, are looking for a different approach to the topic. Instead of describing human sexuality, this book is a compilation of much that is not covered by other books in the field. It examines various issues, concerns, and points of view that may be of particular interest to readers who are curious about sexuality. And especially, about dimensions which are not usually accessible to the general public. At the end of each chapter, I have included additional sources if you are interested in exploring any of the topics we have covered in further detail.

It is a pleasure that we can describe and explain normal and abnormal sexual behaviors in this book. We aim to reduce negative attitudes and stigmas associated with sex by enriching and empowering our readers with knowledge.

Our goal is to encourage an openness towards sexuality and sex-related topics in a way that has slowly emerged within the past 50 years. Here is a joke that I would have been unable to include here, had the book been published then.

*

A poor wanderer arrives at a farm and asks the farmer whether he can get something to eat, and actually if he can get a job on the farm. The suspicious farmer says, "And what can you do"?

The wanderer claims that he can understand animal talk, to which the astonished farmer replies "Let's try you out, and if you can do what you said you can, I will hire you."

They approach the barn where the cows stand, and the wanderer listens, as the farmer looks inquisitively at him. "The cows complain that you do not give them water after they eat, and they are unhappy." The farmer smiles and says that he will pay more attention to it.

They then proceed to the chicken coop. The wanderer listens and says, “The chicken complain that their food is unhealthy and that you neglect to clean their cages.” The farmer is amazed, and takes the wanderer to the last stop, the sheep pen. As the wanderer starts to listen to them, the farmer says “Listen, they are lying, and I will never do it again.

The wanderer got the job.

I hope that you enjoy the book and find it enriching.

Ami Rokach, PhD

Chapter 1

Religion, Culture, and the Evolution of Sexuality

> While sex has been around since the beginning of time, the ways in which we think about and perceive the act have changed tremendously. In the 1980s, an African man walked into my Canadian clinic and requested sex therapy for erectile difficulties. When it became clear to him that we would have to discuss various issues that may have contributed to his difficulties, he pointed out that he came to get "a pill to make it hard." At the time, it was unheard of. But now, we can easily purchase Viagra that does the trick.

When talking about sexuality and sexual expression, it is interesting to review how it has evolved. We will be discussing the status of sexuality in different religions, the influence of culture on sexual behaviors, and global perspectives of sex overtime.

Religion's View of Sexuality

The Hebrew Bible was written approximately between 800 and 200 B.C.E. Its content was based on ancient traditions and included clear messages regarding sexuality and its place in human life and society. In these scriptures, sexuality is viewed as fundamentally positive and healthy. The Genesis account of creation reports that "God created man in his own image, in the image of God he created him; male and female he created them" (Genesis 1:27); which indicates that sexual differentiation is not an afterthought or an aberration, but what God ends up referring to as "good."

Judaism

A quick look at how various religion's view sexuality suggests that Judaism views sexuality as a gift given to humans that should be utilized responsibly. Humans, a-la-the-Bible, are commanded to procreate within marriage.

There are three main themes in the Hebrew scriptures regarding sexuality. First, sex is seen not as just another biological function but is perceived as an expression of deep intimacy between two people. It is echoed by the story of Adam and Eve which states that "…a man leaves his father and cleaves to his wife and the two become one flesh" (Genesis 2:24). The use of sexual imagery in describing both marital and divine human relationships testify to the positive view of sex in the Hebrew Bible.

Second, the Hebrew scriptures clarify that sexuality could never be separated from its social consequences. Israel began as a small group of nomadic tribes which struggled to stay alive in the near-desert of the Arabian Peninsula. Bearing a greater number of offspring could increase a family's chances of survival. This was particularly beneficial if they were boys so that they could grow up and become herdsmen and warriors for these tribes. As such, tribes

were often small and close-knit. This meant that social conventions relating to sex and sexuality was heavily regulated to prevent jealousy over sexual partners, which could have undermined the group's cohesion. Consequently, the Hebrew Bible discusses these issues as laws regarding the cohabitation of people often includes the regulation of sexual practices as well.

Lastly, Hebrew scriptures view sexuality as an aspect of national and religious loyalty. When the Israelites settled in what is now known as the state of Israel during 1200 to 1000 B.C.E., they came into contact with the original inhabitants of the land (the Canaanites). They saw that the Canaanites prayed to the gods to enhance the growth of their crops which was often encouraged through ritual sex. In response, religious Hebrew leaders began to forbid these sexual acts to dismantle traditional Canaanite culture. These sexual regulations included the prohibition of nakedness, cultic prostitution, and other similar Canaanite practices. Both themes are present in this passage from Leviticus 20:10–19:

> "If a man commits adultery with his neighbor's wife, both adulterer and adulteress shall be put to death. The man who has intercourse with his father's wife has brought shame on his father. They shall both be put to death; their blood shall be on their own heads…A man who has intercourse with any beast shall be put to death, and father's daughter or his mother's daughter, and they see one another naked, it is a scandalous disgrace. They shall be cut off in the presence of their people….If a man lies with a woman during her monthly period and brings shame upon her, he has exposed her discharge and she has uncovered the source of her discharge; they shall both be cut off from their people. The menstrual taboo is typical of many societies. It should be noted that all societies have had laws regulating sex and that the Hebrew laws, made sense in their historical context and were humane for the time. The Hebrew scriptures highly regard married love, affection, and sexuality. And the Song of Songs, part of the Hebrew Bible, is an enthusiastic celebration of sexual romance, with no reference to having children."

Christianity

In but three centuries, Christianity grew from an obscure Jewish sect to the dominant religion in the West. During those days, it was believed that the body and spirit were in opposition to each other. The philosophy of dualism had suggested that our purpose of life was to transcend the physical world in order to become purely spiritual. Judaists began to reject the excesses of Roman life, and adopt more dualistic and anti sex notions by the time of the early Christian Church. Christianity, just like Judaism, is one of the few major world religions that insist on monogamy. By establishing the standard of monogamy, Christianity heavily influenced the principles of equality between men and women. This can be shown through its oppositional beliefs towards practices like divorce. Thus, leaving men with the power of simply divorcing their wives at will, but yielding no similar power to their wives.

Because Jesus said almost nothing on the subject of sex, it is difficult to understand what the sexual ethic of the Gospels are. Jesus, who followed Hebrew prophets, urged his followers to strive for ethical perfection. He spoke fiercely against instances of pride, hypocrisy, injustice, and the misuse of wealth (John 4:1–30, John 8:53–9:11, and Luke 7:36–50). However, he did not emphasize sexual conduct.

In contrast, some interpretations suggest that St. Paul held a surprisingly positive outlook on sex. He tried to reconcile the rampant sexual activities of the Gentiles with the more reverential attitude of the Jews. Paul understood that human sexuality had profound interpersonal and spiritual implications (1 Corinthians 5–8). And when Paul referred to sexual practices as instances of impurity (Romans 1:24–27), he was viewing them as social taboos, not moral evils. Thus, negative beliefs towards sex in Christian traditions may not be rooted in the Bible, but in the philosophies that shaped its early values. As the Church became the official religion of the Roman Empire, devoted Christians revolted against its corruption by moving to the desert to become monks and hermits. Here, they began to fast, pray, and practiced celibacy. And since the early 12th-century, it was instituted that all clergy in the West remain celibate; a departure from early Church practice.

The Protestant, which rose in the 16th century, proposed modest changes regarding sexual ethics. Its radical emergence shook the theological foundations of the Catholic church. The Protestant churches did not require clerical celibacy and dictated that sex was acceptable only within marriage and the family. The Protestant Reformation, led by Martin Luther, also gave rise to Puritanism which led them to use civil law to try and regulate human behavior in an attempt to suppress immorality. In turn, we often mistake the "Puritan" era with the "Victorian." Queen Victoria reigned in England for about 60 years (1839–1901), and made her disgust of sexual expression very clear. Consequently, strict standards regarding the public display of decency and purity were enforced, while pornography and prostitution were still quite popular. The 20th century sexual revolt seemed to have been initiated as a response to the Victorian era.

Islam

Apparently and contrary to Catholicism, Islamic law not only permits but encourages contraception. Islam is the closest faith to the Judeo–Christian heritage. It was founded by the Prophet Muhammad, who lived in what is now Saudi Arabia from 570 to 632 C.E. Apparently, traditional Islam views sexuality very positively. In fact, intercourse within marriage was seen as the highest achievement of human life. However, sex outside marriage is viewed as a sin. These directives reinforce double standards that are marked by male dominance, and tolerates extramarital affairs by men. An adulterous wife, however, may be subjected to an honor killing. In Iran, religious law is enacted in civil law where sexual offenses are punished more strictly, and women have less freedom. Interestingly, in Egypt and Syria, Western values were adopted to some extent to create more pluralistic beliefs about sexual values.

Hinduism

In general, Hinduism refers to a complex series of mythology and religious practices founded on the Indian subcontinent. And in Hinduism, one can see almost every approach to sexuality that humans have yet invented. Hinduism holds that there are four possible approaches to life: Kama, the pursuit of pleasure; Artha, the pursuit of success and material wealth; Dharma, the pursuit of the moral life; and Moksha, the pursuit of liberation through the negation of the self in a state known as nirvana. Kama is the most known as the Kama Sutra of Vatsyayana, a masterpiece of erotic hedonism and pleasure, originated from it. In contrast, Dharma and

Moksha prohibits all passions including sex. Instead, it requires its followers to pass out of the cycle of continual rebirth to absorption into the godhead.

Buddhism

Buddhism originated out of Hinduism following the philosophy of Gautama (560–480 B.C.E.), the Buddha. Buddha hardly referred to sexuality, as he focused on achieving enlightenment and escape from suffering. The two traditions of Buddhism, Theravada and Mahayana, differ greatly in its philosophies. The ethics of Theravada include the strict avoidance of any desires that bring joy while Mahayana emphasizes the love of others. Today, most believers live ordinary lives while the monks cultivate ascetic wisdom. Tantric Buddhism (which is practiced particularly in Tibet and India) claims that sexual unions epitomize the essential unity of all things by the joining of female energy (shakti) and male energy (shiva). Thus, sexual expression is perceived as leading to spiritual enlightenment.

A Brief Cultural Overview of Sexuality

Since the mid 1900s, all regions of the world were drawn into tighter economic and political relations. It appears that imperialism and economic change had a major impact on sexual behaviors and values. During this period, Eurocentric beliefs towards sex and sexual behaviours played an important role in setting trends in various locations. For instance, sexual practices endorsed in the west began to spread in Europe. The use of pornography began to rise and attitudes towards promiscuity began to waver.

Additionally, European imperialism and colonialism brought men and their families to countries which were under colonial rule. European men were fearful of Asian and African sexual immorality. They believed that strict rules and practices needed to be enforced to reduce the ‘lustful control’ of these native women. As a result, rampant sexual violence towards these women led to increased and unprecedented levels of venereal disease, which affected virtually every part of the world.

Consequently, leaders in the 20th century tried to reconcile these contradictory trends of sexual behaviour. However, putting the genie back in the bottle was almost impossible. In Africa, and particularly in Kenya, women were forced to undergo circumcision (which we now refer to as female sexual mutilation), as a way to curb their sexual pleasure and sexual appetite. This cruel technique is still practiced in various African Muslim countries, like Somalia, Sudan, Ghana, Nigeria, and Ethiopia for instance.

As part of our cultural tours, let’s examine how China handled the surge in sexuality during this time. Many Westerners often highlighted the effeminacy of Chinese men who are seen by Westerners as quite unkind to women. There was significantly less criticism of Chinese women, mainly because they were sheltered and did not come in contact with Westerners. Chinese women were seen as very docile and controlled by their culture which aimed to reduce female independence through practices such as foot binding. Marital ages in China remained far below those practiced in the West, with men marrying at 21, and women at 17. The Chinese widely practiced arranged marriages, but less so in the 20th century with the rise of the younger

generation which resisted that practice. Infanticide remained in China as a leading form of birth control. Girls were mainly victims of this practice which led to great distortions in the gender ratios of some regions.

Interestingly, homosexuality was tolerated by Muslim culture in the Middle East. It actually became a drawing feature for European and American authors such as Oscar Wilde and T. E. Lawrence. They often traveled to these areas to experience and write about the sexual freedoms evident there. Additionally, the Muslim culture also tolerated polarizing sexual practices such as polygamy, abortion and birth control. And while the Sahria frowned upon the act of coitus interruptus, it condoned other methods of birth control. Importantly, the treatment of women reflected the relationship of a master and a servant; including sexual use and abuse.

Latin America

Since most of Latin America is Catholic, it adheres to the Catholic Church's emphasis on marital sex and reproduction. In Chile, Argentina, and Uruguay, artificial contraception was heavily prohibited, and those who dared to abort were jailed. Most legal systems made divorce difficult, as marriage was perceived to help control male sexual impulses. However, since there was a wide chasm between the church's rules and people's behaviors, the rape and exploitation of women persisted.

Russia and Japan

With the industrial revolution, Russia and Japan experienced dislocation and increased prostitution which the West had already experienced before them. Both countries saw a sexual revolution similar to that of its Western counterpart. However, Japan began to Westernize its sexual beliefs and to adopt "honorable sexual behaviors," while Russia did nothing of the sort.

Russia

The peasants which formed most of the Russian population in the 19th century was significantly influenced by the Orthodox Christian church. In response to this, attempts to regulate premarital sex were conducted to reduce population size. And while a strong emphasis was put on female virginity, early age marriages were the solution for the needs of sexual behavior. Urbanization ultimately reduced the peasant population and distinctly affected their sexual practices and norms. Rates of premarital sex soared and with it, came larger waves of illegitimate offspring to be produced from extramarital sex. Boys were commonly introduced to sex in brothels which sprung up all around the country, and venereal diseases were rampant, as was homosexuality. The use of pornography spread and the emergence of sexually explicit advertisements appeared. Voices started to demand that abortion needed to be decriminalized. As such, the fascination with sexual violence and homosexuality grew.

Following the 1917 Russian revolution, laws against sexual deviancy were appreciably relaxed. Abortions, homosexual activities, and divorce were decriminalized and consequently proliferated. Sexual pleasure became a valued and sought-after activity, and consequently, adultery increased. As the communists established their grip on Russia, concern was also

expressed about the rising rate of divorce, abortions and venereal diseases. Many Russians remained deeply anxious about masturbation, homosexuality, and extramarital sex. Stalin's regime endorsed a Victorian approach to sexuality. Sexual education was deeply influenced by Victorian values, and the political system spoke against eroticism and sexuality. It disagreed with pornography, made divorce more difficult to attain, and instilled the understanding that talking openly about sexuality was taboo. Sexual sublimation and control were practiced as enhancing one's productivity, creativity, and solidarity in socialistic beliefs. However, despite the communist leaders comparing their "pure" society to the decadent West, extramarital sex, abortion, and prostitution continued to be practiced.

Japan

We have heard that in Japan there are geisha houses, which unlike what the Westerners assumed, are not brothels. The women there are trained to satisfy men's wishes and erotic needs without engaging in sexual acts. Once the Western world began to criticize Japan's sexual tolerance, the Japanese official response was swift. Regulations of geisha houses stiffened, and erotic art was banned, and homosexual intercourse was declared illegal. Women were urged to remain faithful to their husbands and direct their sexual interests towards childbearing and rearing. However, Japanese art and literature continued to display considerable interest in sexual themes.

The growing city population in industrialized Japan became more interested in sexual pleasure, specifically for men. Male dissatisfaction in these Japanese relationships often resulted in declining rates of sex but growing rates of divorce. However, sexually suggestive fashion began to spread amongst women during this time. In turn, greater "pleasure zones" started to populate up in cities, including dance halls and prostitution. Although following this urbanization of modern Japan, women were abducted and forced into prostitution in China or other parts of Asia. Later, Japan reversed its stern view of prostitution and 'comfort women'. These women, who were initially Korean and then Japanese, were used to entertain the Japanese soldiers who fought in Korea, and later the allied soldiers there.

Sexual Behaviors

All types of human behaviour, especially those that are sexual in nature, are significantly influenced by the culture to which they belong. Anthropologists often refer to culture as the sum of traditions. It encapsulates the ideas and values that are passed down from generation to generation, mainly via language sculpt the behavior that the group practices and values. Research indicates that all societies regulate sexual behavior in some way, although the exact regulations vary greatly from one culture to the next. Some prohibitions can be found in all cultures, including sex between blood relatives, incest, as well as rape or forced sexual relations. Most of us assume that sexuality is identical all over the world. However, it is obvious that wide variations in sexual behaviour, preference and values among cultures exist. We will examine some of the more interesting ones.

Sexual Techniques

Kissing is one of the most common sexual techniques practiced across the world, but not all cultures share the same openness to this practice. When the Thonga of Africa first saw Europeans kissing, they laughed and said, "Look at them; they eat each other's saliva and dirt." It is noted that kissing has some variations. Cunnilingus (mouth stimulation of the female genitals) is fairly common in our society, and it occurs in a few other societies as well, especially in the South Pacific. On the island of Ponape, coitus has an interesting foreplay where the man places a fish in the woman's vulva and then gradually licks it out prior to coitus. While in other societies, inflicting pain on one's partner is part of the sexual process. The Apinaye woman of the Brazilian highlands may bite off bits of her partner's eyebrows; noisily spitting them aside. Ponapean men, on the other hand, may tug at the woman's eyebrows, occasionally yanking large pieces of hair.

The frequency of intercourse for married couples varies considerably from one culture to the next. The lowest frequency was observed among the Irish natives of Inis Beag, who engage in intercourse perhaps only once or twice a month. At the opposite extreme, the Mangaians have intercourse several times a night, at least among the young who can still perform at that frequency. Similarly, the Santals of southern Asia copulate as frequently as five times a day during the beginning of their marriage. The frequency of intercourse in the United States is about in the middle compared with other societies.

Sexuality in Different Societies

One of the most sexually repressed societies in the world lives in the Inis Beag, which is a small island off the coast of Ireland. The people of Inis Beag seem to be completely unaware of practices such as French kissing, mouth stimulation of the breast, masturbating the partner's penis, oral sex, or homosexuality. There is no sex education to the inhabitants as parents are embarrassed to discuss sexual topics with their children. Menstruation and menopause are very frightening to the island's women as they have no idea why these physiological changes happen. In their ignorance, they believe that menopause can produce insanity. Men on this island see intercourse as not a healthy activity, and will not engage in sex the night before they are to do a job that takes great energy. These men do not initiate sex during menstruation as a woman is considered dangerous to the man during these times. These islanders abhor nudity, and so only babies are allowed to bathe while nude. Adults bathe with their clothes on, and wash only the parts of their bodies that extend beyond their clothing—specifically, their face, neck, lower arms, hands, lower legs, and feet. Premarital sex is not practiced, and following their wedding, foreplay is generally limited to kissing and rough fondling of the buttocks. The husband invariably initiates the activity. The male-on-top (missionary) is the only position used while both partners keep their underwear on. The man falls asleep immediately following orgasm, while the woman does not orgasm since it is considered deviant for a woman to reach orgasm.

In distinct contrast to Inis Beag, we find Mangaia, an island in the South Pacific where sex, for pleasure, is of principal interest. The Mangaian boy starts masturbating at the age of eight. When he is 13 years old, he undergoes a rite of passage ritual in which a super incision is made

from the top of his penis along its entire length. This ritual initiates him into manhood. Interestingly, the expert who performs the super incision provides the boy with instructions about how to perform oral sex on a woman, how to kiss and suck breasts, and how to bring his partner to orgasm several times before he has his own. Two weeks following the operation, once their incision has healed, the boy has intercourse with an experienced woman. She demonstrates and instructs him regarding various acts and positions and trains him to hold back until he can have simultaneous orgasms with his partner. Following that, the Mangaian boy feels ready for sexual relations and actively seeks out girls with the purpose of having coitus every night. The girl, who has also been instructed by an older and more experienced woman, expects demonstration of the boy's virility as a proof of his desire for her. As well, partners who does not move during sex are quite despised. It was found that by the age of 18, the Mangaians typically have sex most nights of the week, with about three orgasms per night. Women in Mangaia learn and develop their ability to achieve orgasms, and the man is seen as responsible to help the woman reach it.

Chinese historical approaches to sexuality were also characterized by open, positive attitudes about human sexuality during the first 4,000 years of its history. Erotic literature was commonly created and consumed by the Chinese. In fact, the oldest sex manuals in the world come from China, dating from approximately 200 B.C.E. Sadly, the most recent 1,000 years have been characterized be sexual repression and censorship.

Around 300 B.C.E. we find the philosophical concept of yin and yang in China. According to the yin-yang philosophy, all events and 'things' are composed of two elements: yin, and yang. Yin is associated with the female, and yang, with the male. For many centuries, yin came to symbolize negative, passive, and destructive elements while the yang was seen as the positive, active, and constructive element. This philosophy sees the harmonious interaction between the male and female principles as vital; creating positive cultural attitudes toward sexuality.

There are three major religions of China, namely Confucianism, Taoism, and Buddhism. Out of those three, only Taoism advocates for the cultivation of sexual techniques in its practice. However, in 1422 and later in 1664, bans on erotic literature were instituted. A person found printing a banned book could be beaten and exiled. In 1949, the communist government who founded the People's Republic of China, imposed a strict ban on all sexually explicit materials. However, that did not stop citizens from slyly accessing these materials via X-rated videotapes that were smuggled into China from Hong Kong and other countries. In response, the government reacted harshly, and in 1985, enacted a new antipornography law at the despise of its people.

Furthermore, the expression of sexuality in Chinese history has had a complicated past. Nearly 2,500 years ago, male homosexuality was at its Golden Age as homosexual partners were often expressed in historical writings. But since 1949, this has not been the case. Other forms of sexual expression were also severely repressed. Married couples could not hold hands in public, and prostitution and other variant sexual behaviors were illegal and harshly punished. A moderate sexual liberation began in the 1980s and continues today as inspired by the nation's increased access to sexual media. Holding hands in public is now tolerated, and sex education is largely included in high school curriculums. Although, this may not apply in rural, conservative areas where most Chinese live.

Masturbation

Attitudes toward masturbation are greatly influenced by one's culture. Some societies tolerate or even encourage masturbation during childhood and adolescence, whereas others frown upon the practice altogether. Regardless, many individuals, both female and male, universally practice it. For example, it is known that the African Azande woman uses a wooden root in the shape of a phallus for masturbation, although that practice is not typically condoned by her husband, and may result in the woman being beaten severely if she is caught in the act. In contrast, the Lesu of the South Pacific, displays a very open acceptance of masturbation; condoning women to masturbate even in the presence of others.

Pre and Extra Marital Sex

Societies differ considerably in their rules regarding premarital sex. The Marquesans of Eastern Polynesia are probably at one extreme, where prepubescent boys and girls have already participated in various sexual experiences, though they first engage in intercourse in their thirties. And daughters with many lovers before marriage are highly regarded by their mothers in this culture. In contrast, the Egyptians of Siwa are very oppressive. They remove the girl's clitoris at age 7 or 8 in order to decrease her potential for sexual excitement and intercourse. The culture does not tolerate any premarital sex at all. One method of eliminating premarital sex is getting the girls to marry at the young age of 12. In general, these two cultural perspectives about sex are fairly typical of their local region's attitudes. According to one study, 90% of Pacific Island societies permit premarital sex, as do 88% of African and 82% of Eurasian societies. However, in the Mediterranean countries, extramarital sex is only second to incest in the cultural taboo that is applied to it.

Attitudes toward Homosexual Sex

Various cultures display a wide range of attitudes toward same-gender sexual expression. At one extreme are those societies that vehemently oppose such sexual behavior. On the other, includes those that seem to tolerate this practice up until puberty or adolescence. In Europe, attitudes toward homosexuality may vary widely. For example, people in: Denmark, the Netherlands, Sweden, Austria, Belgium, France, Germany, Great Britain, Greece, Italy, and Spain have the most positive attitudes; while those inhabiting: Belarus, Bulgaria, Estonia, and Russia, display more negative attitudes. The most negative attitudes toward homosexuality can be found in: Croatia, Lithuania, Poland, Portugal, Romania, and Ukraine.

Disease

The increase in sexual promiscuity readily contributed to the spread of sexually transmitted diseases. In the United States, sexual herpes was spreading in the 1980s. But with the new emergence of AIDS (or Acquired Immune Deficiency Syndrome), its focus was directed

elsewhere. This threatening disease is easily transmitted through the exchange of bodily fluids which often resulted in painful symptoms ending in death. It was most prominent among homosexuals and drug users due to the re-use of non-sterile needles. The Western world experienced immense panic during this time and resulted in several cultural shifts in response. This included: religious leaders advocating sexual caution; opposition against the sexual revolution; abstinence against homosexuality; and increased use of condoms. AIDS, thus, exacerbated social tensions. Americans criticized the African Americans while the indigenous attacked the Nepalese.

1995 saw the introduction of antiretroviral medications that did not prevent or cured AIDS but were effective in preventing HIV (or the Human Immunodeficiency Virus) from turning into the fatal AIDS condition. However, in poorer countries, this medication was not widely available and left some babies to get the virus through their infected mothers. Africa, Russia, and China were also slow to react to the AIDS phenomenon and prostitutes within these spaces carried the disease and infected their customers. Around 20 million people worldwide were diagnosed with AIDS by the early 21st century. The development of medications to combat HIV in the West, along with increased condom usage, helped stop the growing spread of this condition. Thus, rates of sexual activity had slowly returned to their pre-AIDS level and sexual expression and pleasure were once again emphasized following this movement.

Sex and Violence

Sex and violence have been bedfellows since the beginning of humanity. In many societies, it is believed that the man rules, and therefore, can do whatever he pleases with the woman. This includes the use of violent behavior if she does not do what he pleases. In the past two decades, violence towards women has increased, and amongst the factors that account for that increase is the approach that ‘anything goes in sexuality’. For instance, men became intimidated seeing modern women becoming more independent and decided that violence would help keep them in line. In Pakistan, women who wore western dresses or advocated for more open sexual behavior were subjected to “honour killings” by their families who suffered minimal punishment for this practice. Attacks on prostitutes, and rape in general became more frequent. Rape within the marriage also increased, as women were expected to avail themselves to the demand of their husbands at any given time. This is supported by recent statistics from India that indicates that between 6% and 59% of women report having been raped by a husband or an intimate partner. In other cultures, like in Rwanda and Haiti, war time rapes occurred frequently in 2001 and were predicated on the belief that raping women of a different ethnicity would dishonor those women’s group.

Sexual violence was also not unscathed in the United States. Women were empowered to report violations and cast aside the traditional shame that is casted on victims of sexual violence. As a corollary of that, the #MeToo campaign highlighted the need to treat women respectfully and to not impose any unwanted sexual behaviors on others if they do not clearly consent. Admitting greater accountability and enforcement are now the rule, rather than the exception. New legal regulations and guidelines were now created in order to reduce the increase the exploitation and violence of women across all spaces.

The Evolution of Sexual Reproduction

In the southwestern deserts of the USA live a species of whiptail lizards who have given up on sexual reproduction, since they reproduce clones of themselves. Living in such a harsh environment where a male may not be found, females must go through the mating motions with other females, who also mount them, in sort of a pseudo copulation in order to facilitate the cloning process and egg development. However, in general, sexual reproduction is the norm for plants and animals, including humans. Human sexual reproduction extends back at least a billion years, and its benefits include weeding out harmful gene mutations and diversifying gene pools to create novel combinations that may be effective for survival. Additionally, sexual reproduction enables the creation of adaptive immune systems which may be beneficial if the organism is challenged by an unpredictable pathogen.

Sexual Differences

If adaptive cost-benefit ratios favor sexual reproduction, how does it lead to distinctly different sexes? Experiments with fruit flies suggest that females invest in their eggs much more than males in their sperm. Males simply need access to a female in order to reproduce, while females typically need more to sustain themselves during this process (i.e., food and a non-hostile environment). Usually, males compete to gain the female's attention to copulate. However, females also need to compete amongst themselves to successfully find a mate with the scarce number of males available in the group. Thus, the empirical foundation of sex differences is observed. The reproduction rate of the female sex is typically lower to that of males due to their need for greater resources like food. While males (whose reproductive rate is higher) are most closely related to competition as a basis for reproduction.

Sexual Selection

Charles Darwin discussed the process of intrasexual and intersexual selection in his classic book on the origin of species. Intrasexual selection involves competition among males to court and copulate with a female while simply choosing a female is understood as intersexual selection. In many species, we may see female-female competition as a form of sexual selection. Differences in body size between the sexes are seen as part of the mating system. For instance, in species where one male mates with several females, there are extreme body size differences between the sexes. In species where multiple males live and mate with multiple females, the males are characterized by smaller body sizes and sexual dimorphism. Species who mate with one female (like humans) show no sex differences in body size.

This can be seen in many different species. For example, in the Jacana birds, the females deposit their eggs with the males who then provide the bulk of parental care. Thus, the females in that species tend to be larger and more colorful than the males to help them win the competitions with other females. Their colorful feathers have been developed in order for them to attract the males who are essential in caring for their eggs.

Mating Strategies

It seems that all organisms face budget constraints. Challenged by limited energy and time, the organism has to channel those resources towards *growth, maintenance, and reproduction*. Human *growth*, which relates to growing up and being able to survive, tends to end around adolescence, but other species have different growth trajectories. *Maintenance* refers to investing in a strong immune system which actually protects and keeps the organism alive. *Reproduction* includes courtship and mating, followed by caring for the eggs and the offspring. In mammalian populations, males invest more effort in growing than females to prepare for competitions for mate selection. Female thus place a considerable investment in mating and then parenting in these relationships. Their mating strategies are geared to assure that the female and her offspring may survive for a long time. As such, they seek males who can protect them, provide food and have optimal genetic traits to increase their survival for their families. As we can see from this brief review, males and females have their own agendas within the mating process.

Cultural Influences on Human Sexual Behavior

While the days of emperors, harems, and eunuchs are all but over, occasional polyandrous and arranged marriages remain mainly in Muslim countries. In an interesting cross-cultural survey that was taken some 50 years ago on 849 societies (including hunter-gatherers, horticulturalists, pastoralists, and others), it was found that the vast majority allowed polygyny. Generalized polygyny – in which a man has more than one wife – was the rule in about 30% of these societies. In the remaining societies, less than 20% had multiple wives, as monogamy was the dominant practice.

If we examine marriage arrangements, it appears that in many Islamic cultures, a wealthy man may commonly have several wives. It takes only a wealthy man to do it, since he is the one to provide for them economically, look after their children, and divide his resources, equally, amongst all his wives. Historical figures may provide several examples to that ’rule’. This includes the Incan emperor who had access to hundreds of potential sexual partners; the Moroccan emperor Moulay Ismael Bloodthirsty, who is said to have fathered 888 children from numerous women; and the Egyptian pharaoh Ramses the second who had sex with many secondary wives and mistresses in addition to his supreme wife. Nowadays, this practice is not as popular, though it still exists and is being practiced mainly in rural and poorer communities.

As for women’s expression of sexuality, varies widely according to the society they belong to. In some, female sexuality is openly practiced, while in others (mainly in Arabian countries) they may be cloistered and asked to be hidden under clothing or veils. These women are commonly chaperoned when they go out to protect them from potential sexual harassment by men. They are taught to avoid being lured into sexual relationships with a men who are not their husband, and are guarded by male family members as a result. Other attempts to control women’s sexuality can be found in the European chastity belts during the Renaissance period, or through women’s genital mutilation which is still practiced in some regions of the world.

How Does Culture Influence Sexuality and Intimacy?

A large-scale study which investigated mate preferences among more than ten thousand participants from 37 societies found that women look for men who have loving characteristics. This included those with high emotional stability and dependability. Globally, these traits were regarded as those that would contribute to a successful long-term relationship.

Let’s look at what the genders prefer and value in several cultures. In Indonesia, China and India, men mostly value chastity in a woman. In the Netherlands, France, and Sweden, that chastity was much less important to men. In Nigeria and Iran, men’s industriousness and ambition were important to women much more than in European countries. Age preferences in a mate varied as well. Women seemed to prefer older and more established men, while men preferred younger women. That is quite consistent with scientific reproduction patterns. And so, while older males may have the resources to look after the woman and their offspring, young females have a higher reproductive potential due to their fertility. Research also indicated that women experience their first sexual intercourse at an earlier age than men depending of course on the society they live in. In the USA, 40% of young men and women had their first intercourse by age sixteen, with a whopping 85% of them have had sex by age twenty-one.

Contexts of Sexuality

A sexual researcher wrote in 1935 that masturbation can be found anywhere and performed by both sexes especially when their mate is not available. Dr. Duffy, a sex researcher, examined the 1848 annual report of the Massachusetts Lunatic Asylum and discovered that 32% of its admissions were due to “self-pollution,” or masturbation, as it is commonly referred to now. In the context of sexuality, it is interesting to examine the places in which people have sex. We would naturally assume that bedrooms will be the answer, but a 2001 study found otherwise. Emerging American adults in colleges reported having sex clubs, cars, and twin beds within dormitories, not to mention parks, beaches, and any place where some privacy was afforded to them. Another interesting question is when do people have sex? Since weekdays are usually filled with work and other obligations in America, sex usually takes place on the weekends. Specifically, on Sunday mornings (according to the Kinsey institute).

In terms of sexual positions, missionary is by far the most common with the couple facing each other while the woman is on her back and the man is above. Not only is it practiced most frequently in the United States, but also by the Chagga of Tanzania, and the Miao of China. Another common sexual position is the “Oceanic” position, so called after the islands of Melanesia, Micronesia, and Polynesia. In this position, the man squats or kneels in front of a lying woman. This position can offer increased stimulation of the clitoris and the vulvar area. Another position involves the woman-on-top which provides women the greatest sexual pleasure. They can control the rhythm, the movements, and the depth of penetration, thus enhancing their sexual pleasure and orgasm. The Masai and the Kwaitul societies prefer the position of a man and a woman lying beside each other during intercourse as well as the position where the woman is entered by the man from behind.

Non-Relationship Sexual Pleasure

In Las Vegas, one can find the Erotic Heritage Museum, which offers probably the largest assemblage of sexual images, films, and paraphernalia. It houses a large collection of many phallic-shaped objects in glass cases, which actually served as dildoes from past centuries. In ancient Rome 3,000 years ago, a woman would squat over the wooden dildo once she got married in order to deflower herself. This was so that she would not harbour any resentment towards her husband as a result of pain during the first penetration of their time together. In Africa, the Azande used bananas for a similar purpose as well to facilitate masturbation. In contrast, the Kagaba in Colombia and the Mehinaku in Brazil saw male masturbation as an awful waste of semen that is frowned upon. This shares similarities to the view of the Bible which prohibits masturbation. But since the sexual revolution of the 1960s, masturbation is now seen as a natural occurrence in most Western societies. Moreover, even women in the USA are now taught how to masturbate, as a means to help them achieve sexual orgasm as well.

Prostitution, often termed the "oldest profession," is commonly offered by women to men. It has been around since the beginning of time. It has been evidenced in the human remains of the people of Pompei as well as in Europe, China, and in America. In Thailand, young men were initiated into sex work in order to earn money. Prostitutes also vary in their lifestyles. Some prostitutes are single, while others are in romantic relationships. Some supplement their income from their day work, while others need the money to support their habits and, occasionally, addictions. Attitudes and behaviors regarding prostitution vary around the world despite its service having been commonplace throughout centuries – especially during times of war. Although, statistical research suggests that men across the world still seek out prostitution services but varies from culture to culture. In southern Africa, 11-14% of men engaged in such sex; similar rates (11%) were found in China and Hong Kong; East and West Africa reported 10%; Caribbean men reported 6-7%; and in Latin America, North America, and Europe, it is about 3%. Interestingly, I once saw a couple for marital therapy. The man complained of wanting more sex, and his wife was simply not interested. In responding to his complaints, she suggested that he go to a prostitute and get whatever he wishes from her. Presumably, prostitutes can supplement limited, or lacking sexual relations at home.

Bestiality or zoophilia are also an additional source of non-relationship sexual expression. Kinsey reported that 8% of American men and 3.6% of women reported having had some sexual experience with non-humans. It can be mostly found on farms, where men who lack a human sexual partner will have intercourse with an animal, mainly a cow, but also camels, sheep or dogs. Bestiality has been reported in many societies, such as within Indian sculptures, as well as Greek mythology.

The Pleasure Theme of Sexuality in the Last 60 Years

Although the Church described sexual relations mainly as a means for procreation, the salient theme of Western sexuality in the last 60 years clearly indicates that sex is for recreation and pleasure. Public culture became steadily more sexualized. Consequently, birth rates dropped dramatically in most regions, as an emphasis of sexual pleasure intensified. Premarital sex became more common and other forms of sexual expression including adultery, homosexuality, and divorce were reconsidered. And although past centuries highlighted the importance of

virginity, it has now declined with the introduction of ‘the Pill’; a new birth control method which introduced dramatic changes in sexuality, relationships, and parenthood. In addition, vasectomies for men and tying the Fallopian tubes of women also became very reliable birth control methods for couples. Consequently, the number of unwanted children dropped sharply, and birth rates have dropped significantly lower than it was in the agricultural age.

While these major changes in the approach to sexuality were taking place in the West, it was a different situation in Japan. Japan’s leadership, having been quite concerned about the Pill’s effect on promiscuity, only began to approve of its use in 1999. This was after an exhaustive three-decade campaign of women’s right groups within the nation. In Russia, the government encouraged abortions as a preferred method of birth control rather than through contraceptive devices and pills. It was reported that by 1990, a Russian woman had an average of three abortions in her reproductive life. And as a consequence of the American sexual revolution, condoms became more widely accessible in the country but were touted as un-masculine by 1991.

South Korea was greatly influenced by the sexual movement in the USA. They saw a reduction of abortions following this time, and an increased use of contraceptives like the Pill or condoms. This was in stark contrast to the Chinese, who prior to 1970, encouraged citizens to have as many offspring as they could. The result of this philosophy lead to the implementation of the ‘one-child-per-family’ policy, which resulted in many unsafe abortions throughout the 1970s. Parents who could only have one child and typically abandoned or killed newborn girls in favor of boys. Gradually, and mainly in urban centers, artificial devices made some headway in China. By the 1990s, married couples were using IUDs, the Pill and sterilization quite widely. Unmarried Chinese couples relied mainly on the rhythm method and on abortions.

Latin American and the Middle Eastern nations adopted contraception quite readily. Egyptians relied heavily on IUDs and the Pill, while in Turkey, 71% of married women used IUDs or condoms, with the pill being less popular. In strict Islamic countries, fundamentalists frowned upon the use of contraceptives and called abortions child murder. In contrast, attempts to reduce the Muslim population commonly called for family planning. Bahrain, a Muslim country, offered its citizens free access to birth control, and educated women about their right to exercise birth control. In Catholic Latin America, impediments for women exercising birth control were put up. Colombia was an exception, where the government openly discussed about family planning and introduced contraception and sterilization. In contrast, Chilean and Guatemalan citizens were met with laws prohibiting the practice of abortion and made contraceptives unavailable to the general public. Despite this, abortion was the preferred method of birth control as alternate options were limited and scarce. In Communist Cuba, abortions were outlawed, as they were in Nicaragua. In Mexico, attitudes regarding contraception were complex and secretive. Since they were not encouraged to use birth control, men and women often lied to each other about their contraceptive use. Men typically concealed it from their wives, while women used birth control pills without their partner’s knowledge. In sub-Saharan Africa, change came slowly due to its lack of sex education. Males commonly resisted condoms since it reduced their sexual pleasure, while women relied heavily on herbal contraceptives.

But by the mid 20th-century, stark changes towards sex and sexual attitudes began as sexual themes became more explicit in graphic and provocative fashion. The pursuit of increased sexual pleasure was now the goal. Sexual acts, talking about sexuality, and reading about sex

became more widespread and accepted than in any other time in human history. “The vagina monologues” is but one example.

The sexual tide eventually swept away Victorianism, communist ideology, and pushed back older religious restrictions. Media innovations, first via video stores, and now of course the internet, made it easy to view sexual movies and other material. Religious organizations attempted to stem the tide, but it was impossible to do. Sexually explicit magazines could now be found in many global newsstands. And starting in 1991, pornography became more accessible than ever before with the development of the internet. By 2016, it was estimated that about 50 new pornographic films were produced daily in the United States. Another estimate suggested that Americans spent $3,000 *every second*, on pornography, and over 40% of all internet use involves pornography. Never before was pornography so widely consumed with such great graphic imagery.

Sexual culture sold and helped sell other goods, such as automobiles and many other products. You can commonly find adverts including sensual women standing by products in sexy poses illustrating a fantasy for men who buy such material. Women’s magazine included sexual advice and promulgated sexualization of the female’s body. Books such as D.H. Lawrence’s *Lady Chatterley’s lover* which previously were hard to come by, as well as magazines like *Playboy* and the even more sexually explicit franchise, *Penthouse*, were now readily available legally. Hollywood followed suit, by including openly sexual acts and sexual scenes in movies. In Western Europe, sexuality even became easily available to teenagers, as by the 21st century, daily tabloids did not shy away from displaying pictures of bare breasted women on its covers. In the Netherlands and in Sweden, sex shops were opened and frequented by people within and outside those countries.

Additionally, dress styles also became more daring as showing cleavage and wearing skin-tight clothing featuring female bottoms have become quite acceptable. In Western Europe, nude beaches became popular, and even for those women who are dressed in a bathing suit, much skin is shown. And since our bodies are now being publicly displayed, people can now flock to plastic surgeons for breast enlargements or reduction; nose reshaping; fat suction; and even penile augmentation or buttocks enlargement as well.

In their attempts to promote sexual pleasure, sex manuals now promoted sex without love, beside the more traditional philosophy of love leading to sex. Masturbation was now not only accepted but touted as a healthy expression of sexuality. The Kinsey report of the 1950s helped the public become aware of the great variability in people’s sexual preferences. And the religious commitments, neither in Europe nor the USA, were able to curb that sexual freedom. These American induced changes influenced the rest of the world greatly. New pornographic novels, sex manuals, medical discussions of sexology, and translation of sexual material from the West became common practices in China. Sexualized adverts were now being used in conservative nations. Pornography expanded, and in 1990, the Interpol reported that Japan became the world’s largest source of child pornography, which was promptly outlawed in 1999. Latin America was also greatly influenced by the USA, with magazines educating women how to please a man and how to win his love. Costume changes were striking, and in places like Brazil, women adopted body-exposing costumes for everyday activities and even more for when they went to the beach. In Russia, the fall of the Soviet Union and its greater openness to the West created an explosion of sexual eroticism. And although the Middle East, Cuba and North Korea were not partaking in the sexualization of public culture, civilians in these nations are still able to obtain sexual products from private vendors. In general, the presence of

sexuality in mass consumerism steadily gained traction, with some regional adjustments and differentiation based on individual standards of living.

Below is a brief summary of the sexual themes globally.

1. Change and continuity of sexual attitudes and behaviors were observed throughout the world. Homosexuality was no longer seen as a mental disorder and gained more public acceptance. Polygamy began to decline or was even abolished in certain countries. Sexual freedom was increased, and sex outside marriage became more prevalent, either via romantic engagements or with the help of prostitutes. Women's sexual slavery was outlawed, and matrimonial age was increased in order to protect girls from being wedded to older men, usually against their will.
2. Birth control methods in earlier periods were mainly through coitus interruptus. In the case of African women, many proceeded to shove grass or a piece of cloth into their cervix in order to prevent pregnancy. Needless to say, these were not reliable methods. It took the advent of 'the Pill' in the 1960s to get that issue under control in a safe and easily accessible way.
3. Previously, Venereal diseases (VD) were widespread, including the dreaded Syphilis and Gonorrhea which resulted in ailments and eventually death. Medicine did not know how to address these maladies and abstinence was the preferred way of staying sexually healthy. However, the emergence of antibiotics starting in the 1930s helped change and reduce mortality rates from VD.
4. In older days, homosexuality had been treated as a mental disorder; one that is shameful and unacceptable. The penal code for homosexual intercourse was evident in the West, and all the European colonies, such as large parts of Africa, the Caribbeans, as well as in Canada, New Zealand, and Australia. In the Middle East, the reaction to homosexuality was even harsher and possibly leading to the killing of men who were involved in it – lasting to even this current day and age.

Sexuality in the 21st Century

Sexuality in the 21st century has become more public than it has ever been before, with the media and the internet serving as major vehicles for sexual expression. Presently, sexuality is seen in all media outlets much more than ever before. Sexuality is now an all-encompassing term that includes gender identities and roles, social orientation, eroticism, pleasure, intimacy, and sexual reproduction. The internet helps make people much more aware and attuned to sexuality, and sexual experimentation is encouraged. There is also a wealth of information on the internet in regard to sexual health, behavior, transmission, and treatment.

Among these changes that we saw in the 21st century, we can name changes in birth control practices, sexual behaviors, and same-sex relationships and marriages. Interestingly, it was observed that contemporary sexuality could lead to a certain level of fatigue or disengagement. For instance, many Japanese under 40 avoid dating, marriage, or even more casual engagements with sex, as it is seen as too demanding socially and sexually. A 2012 poll found that 45% of Japanese women and 25% of men were uninterested or even despised sex. Many opted for a

single life with a pet. In the United States, people in their twenties may have fewer partners and even fewer sexual encounters than their counterparts 15 years ago did.

Sexual Freedom and Problems

Changes provoke reactions, and the culture of sexuality experienced a sort of "culture war" or conflict within the USA and other countries after 1960. Sexually related diseases became more rampant as the exploitation and trafficking of women increased considerably as well. In response, the creation of the "Me Too" movement became a social concern in hopes of reducing these numbers.

As far as commercialized sex, it is noted that prostitution expanded and gained popularity and accessibility overtime. Greater search for sexual pleasure without a romantic commitment became more commonplace over the years. Interestingly, the vitality of prostitution was kept by middle aged men who were looking to complement their marital sex, and much less by the younger generation. In India, red light districts expanded, and urban dislocations brought hundreds of thousands of Chinese prostitutes into the big cities. In Africa, some women served as concubines for wealthy men and for some foreigners. In Pakistan, the Islamic religion forbade prostitution, did little to stop youthful, good-looking women to congregate in brothels right below the leading mosque in Lahore. In Japan, bathhouses with private rooms continued to provide sexual relief to interested men despite laws that forbade it. Several Western countries, headed by the Netherlands, openly recognized prostitution, and so sex workers could advertise, unionize, and get proper medical attention to protect their health. Sadly, in Sudan, prostitutes were punished by death. And as we can see all over the world, tremendous growth of the sex industry introduced newer and more innovative types of prostitution regardless of prohibitory policies and legislations.

Between 1991 and 2008, it is reported that 500,000 women from Ukraine, and 400,00 from Moldova have been trafficked to work as prostitutes. Thailand became a center for prostitution, especially after servicing American servicemen during and after the Vietnam War. Likewise, prostitution in the Balkans increased in service of the United Nations peacekeeping forces. By 2005, a report suggested that as many as 600,000 to 800,000 women were trafficked each year, raising billions of dollars for the criminals who were involved in it. Destinations of sex trafficking included Western Europe, North America, Japan, and the United Kingdom. Hotels in Ukraine also offered sex tours, with American agents serving as the mediators between tourists and sex workers. The internet also made advertising for paid sex much easier and widely available all over the globe. Japan saw various clubs offering sexual stimuli over the phone and schools for girls were opened in order to teach them how to please older men.

Sex and the Media

The media seems to shape not only how we perceive our world, ourselves, and others, but it also contributes to creating societal norms including those of sexuality. The media dictates what is "normal" and what is "not normal" when it comes to sexuality. It may not reflect reality, but it clearly helps us shape the way we perceive it. And as western changes in the 20th century would indicate, sexuality in advertising became common. Even nonsexual products were

advertised with aspects of sexuality including lux soup that was touted to "keep romance aflame" or pinup girls who were used, in the 1940s and 1950s, to sell various products.

For a long time, films refrained from showing nudity though sexual themes and innuendos. But that is not the same today. At the beginning of the 21st century, sex scenes and nudity were included in movies quite freely. And the internet continues to serve as a global hub that provides easy access to sexual material for people to consume within the privacy of their own homes. As such, it is safe to say that sex has definitely changed across the evolution of society overtime.

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> A teacher is teaching a class and sees that Johnny isn't paying attention. So she asks him, "If there are three ducks sitting on a fence, and you shoot one, how many are left?" Johnny says, "None." The teacher asks, "Why?" Johnny says, "Because the shot scared them all off." The teacher says, "No, two, but I like how you're thinking." Johnny asks the teacher, "If you see three women walking out of an ice cream parlor, and one is licking her ice cream, one is sucking her ice cream, and one is biting her ice cream, which one is married?" The teacher says, "The one sucking her ice cream." Johnny replies, "No, the one with the wedding ring, but I like how you're thinking!"

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Chapter 2

How Is Research in Human Sexuality Conducted?

> Dr. William Masters and Virginia Johnson stand far and above all other sex researchers. The TV series “Masters of sex” illustrated their work, relationship and actual research. In the 1950s, Masters decided to research sexuality; not by simply asking people what they did, but through direct observation. He faced severe repercussions from the university he taught at and had difficulty finding assistants and participants. Virginia Johnson helped him throughout his several years of research. They contributed, tremendously to our understanding of sexuality.

Sex Research in North America: Let’s Take a Brief Tour Along the Centuries

While sexuality was quite successful at “coming out of the closet” and gaining public recognition during the 1960s, it was not always the case. Since Colonial days, people in North America were bitterly divided regarding passionate love and sexual desire. They were in disagreement about whether these were the delights of life, or whether they constituted threats to social order, morality, or homosexuality. Preachers in the New England colonies condemned sexual lust as “unclean” and declared that they posed a danger to the body and soul. The congregations were encouraged to control these desires that “lie lurking in the heart.” In those days, sinful sex resulted in terrible punishments such as flogging, hanging, having one’s ears cut off, or having one’s tongue bored through with a hot iron. Unsurprisingly, male masturbation was also strongly discouraged, as it was thought to cause ailments ranging from impotence to memory loss or even death.

The Protestant hegemony was starting to be challenged in the late eighteenth to early nineteenth century. Those referred to as the ‘Shakers’ did not recognize marriage and required that their community members remain celibate. This obviously brought their numbers to steady decline. The Mormons rejected and still oppose romantic love, courtship, and contraception to this day. Another group called ‘The Oneidans’ promoted the concept of “complex marriage” where the community had the power to regulate sex and reproduction. This group practiced religious perfectionism in a communal society founded by John Humphrey Noyes in 1848 near Oneida, New York (hence, their name).

And as the 1900s ushered in, we could see more attacks on sexuality, sexual behaviors, and the release of sexual information. In 1915, anti-vice activist Anthony Comstock dedicated himself to upholding Victorian morality. His official title was that of the ‘United States Postal Inspector’ and ‘Secretary of the New York Society for the Suppression of Vice’. He opposed many forms of ‘illicit material’ including: obscene literature, abortion, contraception, gambling, prostitution, and quack medicine. His efforts to eradicate anything considered to be obscene, lewd, or lascivious extended to filtering US mail and other forms of literature such as

political tracts, anatomy textbooks, information about birth control and more. Most American churchgoers at this time applauded his actions. In contrast, those found to endorse this information were punished for their activism. This can be seen in the case of Dr. William Sanger, a New York City physician, who was jailed for handing out pamphlets advertising birth control methods.

In light of this brief review of the history of sexuality in America, it is clear that American sexual culture is complex and pluralistic. It is made up of significantly diverse sexual communities, behaviors, identities, and politics which encompass a diverse range of polarizing opinions on the subject.

What Changed Since Those Early Days?

When reviewing the revolutionary changes that have occurred in America since the Colonial period, we note a growing rejection of the tradition of life as "a veil of tears." This pursuit of happiness included an avoidance of pain as desirable goals including the story of love, sexuality, and family life were rising in popularity. Societal shifts from a male-centric and patriarchal ideology also began to include the equality of other gender and minority groups. We now see sex as not just a way to procreate, but as a legitimate and valuable activity in promoting pleasure and intimacy.

But while historic philosophers like Hippocrates, Aristotle, and Plato commonly theorized about topics related to sex, the scientific study of this field only began in the mid-nineteenth century. Here, we saw the first publications of books related to sexual behaviour by notable physicians such as Dr. Heinrich Kaan and Dr. Richard von Krafft-Ebing. Their main contributions to this field was unlike previous writings that described sexual "aberrations" and dysfunctions as moral failings. Rather, they reconceptualized them as medical and mental issues.

In the beginning of the 20th century, Dr. Sigmund Freud developed a monumental psychological approach to sexuality. However, his theories were based on theoretical underpinnings and centered mostly around his own patients; a small and non-representative group. That is when sex research began to move into the laboratory. Dr. John Watson was the first psychologist to study sex in the laboratory. His research in the field led to the eventual divorce from his wife as it cemented his romantic relationship with his research assistant, Rosalie Rayner. Goes to show that one has to be quite mindful with whom s/he does research with. Watson was even the pioneer in developing scientific instruments that could record human sexual responses. With his mistress and lab assistant, Miss Rayner, he conducted sexual experiments and recorded these findings. Watson faced a lot of professional and personal disapproval for his conduct and was even asked to resign his post at Johns Hopkins University. However, those who followed Watson's research, like Kinsey and then Masters and Johnson, were willing to stand against the prevailing social norms and declare sex as a worthy topic of scientific inquiry.

But like Watson, researchers who dared to study sexuality were often confronted with criticism, hostility, a lack of funding, and even risked their careers as academic institutions and professional journals refused to recognize their research as acceptable or legitimate. As a result, the scientific study of human sexuality remained almost completely underground until the 1940s and 50s when Kinsey entered the limelight. Dr. Alfred Kinsey, an entomologist who

studied the behavior of insects, was asked by the university to teach a course on marriage and sexuality. Unable to find much information about current sexual behavior, he started his own research on the topic which later became known as the Kinsey Report. It included hundreds of interviews with people of all walks of life, which reflected people's sexual behavior, preferences, values, and fantasies. It was around this time (in the 1950s and 60s) that the husband and wife duo Dr. William Masters (a gynecologist) and Virginia Johnson (who started as his assistant) brought a renewed sense of objectivity to the study of sex.

Masters and Johnson sought to conduct the most elaborate and scientifically grounded observational research on sex to date. As diligent researchers, their work was strictly conducted in labs with the utmost professionalism and most technologically advanced equipment of their time. Their lab served as an observational ground to view and measure people masturbating, getting sexually excited, and having sexual intercourse. They developed a glass penis that had a light and camera in its tip to film and show the inside of the vagina and the physical processes involved in sexual stimulation. Their work unveiled many facts about sexuality which negated currently held beliefs about sex and has guided the field of sexuality to this day. Their discoveries were incredibly important in the development of the field of sex therapy and has helped numerous couples throughout the world to improve their sex lives. They published their research results in books, since most academic journals deemed their research as "pornographic." And since those early publications, societal and cultural attitudes toward sex have gradually become more progressive and sexuality research has come to achieve greater levels of scientific and popular acceptance.

But still to this day, there are politicians in the U.S. who threaten to rescind federal funding from research projects that focus on sexuality or relationships, despite the fact that panels of scientific experts may have already deemed them to be worthy of research. Studies of sexual and gender minorities, sex workers, pornography, and the sex lives of older adults are particularly prone to political criticism as topics that are "inappropriate" for government grants. It is disheartening that the openness towards sexuality and sex research may still be frowned upon by some.

Sexology aims to increase our understanding of all aspects of human sexuality. It includes a myriad of topics such as why different sexual orientations exist, the frequency of specific sexual practices across cultures, the discussion of rape and other sexual crimes, and lastly, therapeutic interventions which can help treat sexual problems. Given the array of overlapping fields involved in this discipline, sexologists could be psychologists, sociologists, anthropologists, physicians, biologists and various others professionals.

Sex Research in America at Present

The National Center for Health Statistics (NCHS) in the U.S. carried out the National Survey of Family Growth (NSFG) on almost 13,500 people from all walks of life to learn about marriage, divorce, contraception, infertility, and the health of women and infants. It was found that 98% of females and 97% of males aged 25-44 had sexual intercourse, 89% of females and 90% of males had oral sex with another-sex partner, and 36% of females and 44% of males have experienced anal sex in their lives. Examining the number of sexual partners for males aged 15-44, it was found that they had about five female partners while women had 3.2 lifetime

male partners. Five percent of men and 12.5% of women aged 15-44 had same-sex contact during their lifetime.

The Centers for Disease Control and Prevention (CDC) conducts a survey every two years to explore the sexual behavior of young adults. Results highlighted several interesting findings. For example, 39% percent of females and 43% of male young adults reported having had sexual intercourse in their lives. Following this, 9% of females and 14% of males reported having had four or more sexual partners during this time. Interestingly, 15% of females and 12% of males did not use any method of contraception to prevent pregnancy during their last intercourse. It was also found that 69% of students reported experiencing unwelcomed sexual activity through being kissed, touched, or physically forced to have sexual intercourse with someone in the past 12 months. In terms of sexual orientation, 89% percent of students (85% female and 93% male) identified as heterosexual while 2% female and 2% of male identified as gay or lesbian, 6% (10% female and 2% male) identified as bisexual, and 3% (4% female and 3% male) were not sure of their identity.

The most expansive and nationally representative study of sexual and sexual-health behaviors in the U.S. is known as the National Survey of Sexual Health and Behavior (NSSHB). This study, which was published in 2010, examined internet reports from 5,865 American adolescents and adults aged 14–94. Adults were shown to have a large variability of sexual repertoires and behaviors in this sample. For example, both men and women reported having participated in both solo and partnered behaviors throughout their life course with active and pleasurable sex lives. Masturbation was common among all age groups, and especially among men and women aged 25-29 years old. Vaginal intercourse was the most frequently reported sexual behavior, although oral and anal sex were also well-established sexual behaviors among both genders.

Some Examples of Sex Surveys

Kinsey and his team interviewed 5,300 men and 5,940 women in their study of sexuality and intimate relationships. These reports initially shocked the American public as it unveiled how common extramarital sex, masturbation, and homosexual sex were during a time where these behaviors were believed to be deviant. Kinsey's study was fundamental in showcasing how prevalent and diverse sexual behaviors could be amongst common people. Other outstanding findings included: 92% of men and 62% of women having had masturbated before, 37% of men and 13% of women having at least one sexual experience with a member of the same sex, and that up to 69% of men having at least one sexual experience with a prostitute in their lifetime.

Alternatively, the well-known observational research on sexuality was that conducted by Masters and Johnson. Their results were based on observing the sexual behavior of 694 men and women who ranged from 18 to 89 in age. Masters and Johnson were interested in understanding how men's and women's bodies responded to sexual stimulation. They explored this curiosity by asking their participants to engage in sexual activities in their lab, including masturbation, sexual intercourse, and simulated intercourse while various pieces of technology recording the changes that happened to their participants during these activities.

Another method of research, known as case reports, is also common in the field of sexuality and sex research. This method focuses on the intensive study of one or limited participants to

gather as much detail about their experience revolving around a specific topic. For example, a sexologist might perform a case study on someone with a sexual dysfunction, someone who has an unusual sexual desire, or is a sex worker. This may also bleed into longitudinal sex research which is conducted over a long period of time with the same people. The purpose of this method is to measure changes and developments that have occurred for the person(s) overtime.

The Stigma of Sexual Research; Yes, It Does Exist

Stigma exists in workplaces. Not only in offices or factories, but apparently in academia as well. In the Western culture, sex is considered as a "special case" evoking inconsistent attitudes. On the one hand, we see sexuality as a taboo topic and yet consider it as the essence of the modern self; a social domain of desire and danger. Having faced controversy, sexuality research has struggled for academic legitimacy since the beginning of sex research. Sex researchers are met with snide comments, uncomfortable jokes, assumptions made about their sexual identities, behaviours and even harm to their professional reputations. For instance, people who research about prostitution, or adultery, are also asked whether they have experienced it themselves. Needless to say, entering the field of sexual research requires guts, the ability to withstand academic 'attacks', and the possibility of not getting one's articles published by professional journals.

What Are the Implication of Sex Research to Participants and Researchers?

Several physical, emotional, psychological, and professional risks exist for sex researchers involved in the field of sex research. Researchers may be subjected to physical threats or abuse by participants, especially during studies involving highly sensitive topics. For instance, research about BDSM may expose researchers to psychological trauma caused by threats or actual physical harm when placed in situations where they may be accused of improper behavior. Other studies may also pose risks of members being infected by sexually transmitted infections as well. As such, sex researchers often work in pairs and develop safety plans with opportunities for counselling or debriefing to occur to minimize these risks.

As recently as 2017 sexuality researchers have reported that they are not valued or taken seriously as academics, and may even be accused of inappropriate or unethical conduct, and their character, motivations, and methods are more deeply scrutinized than researchers in other fields. As far as participants are concerned, they are seen by professional bodies as vulnerable to psychological harm or distress. It was observed that sexually non-normative participants such as sex workers, queer folks, or kinksters are often automatically deemed as "vulnerable" in a way that suggests that they are engaging in shameful practices. In reality, researchers reported that many of their research participants enjoyed answering questions about their sexuality and sexual practice. Therefore, it can be said quite confidently that whether discussing sexuality is "distressful" largely depends on the norms or taboos of the people involved and the sexual subcultures they circulate within.

Doing Sexuality Research with Children

There is heightened governance to research practices involving children and adolescents – especially in the context of sex research. The study of sexuality, however, actually encompasses much more than simply sexual practices. Young people may benefit from greater access to sexual knowledge as it helps them with the understanding of their bodies, desires and sense of self. These beliefs have a great impact on their health and overall well-being. And truthfully, youth exposure to sex and sex-related content is not uncommon in our modern world. Children and young people are surrounded by messages coming from the world of advertising, popular culture, family rituals and everyday practices that give them messages on what being sexual is. With this knowledge, they commonly adopt components of these cultural practices as their own and adopt them within their own lives. Thus, the media becomes an important alternative source of information on the topic of sexuality and sexual expression for these youth. Sexuality is viewed as the exclusive realm of adults, and children are construed as the asexual, naive, and innocent beings who are vulnerable and in need of protection, which places additional restrictions and limitations on researchers.

Consequently, approaches to examining the topic of children and sexuality have become strict, limited, and quite rigid. Institutions are hesitant about the ethicality of studying young participants in a discipline that is deemed as quite "adult" in nature. As such, sexuality research involving individuals under the age of 18 is considered 'high risk' and may result in greater scrutiny by academic committees with a stricter regulation of projects than usual.

Dr. Breanne Fahs, a researcher on female sexuality, noticed a grave limitation in qualitative (as well as quantitative) research in the field of sex. She noticed that researchers may be prone to missing the aims of their studies as the questions that are raised may be misinterpreted by participants. Thus, generating data that may cast doubt on the validity of their findings. Researchers must, therefore, be aware of those differences and take them into account when interpreting their results. Another important variable is the choice of language that may affect the research results. For example, there is a difference of whether a researcher asks about fellatio, oral sex, blowjobs, or "going down on someone" when referring to this action, just like how participants may interpret the words "sex" and "satisfaction" completely differently. We will describe some further examples of challenging topics below:

Research on Alcohol and Sexuality: Issues and Approaches

Research in the area of sexuality may touch on various topics, populations, and related variables. Since alcohol consumption has been shown to be related to problematic sexual behavior, it makes sense for us to increase our understanding of the relationship between alcohol and sexuality.

Since the beginning of the 21st century, there has been a considerable growth (1000% to be exact) in the volume of alcohol–sexuality research over the past three decades. The most notable were topics included in studies on adolescent communities and gay/bisexual samples. Research found that intoxicated participants were more ready and willing to engage in unsafe sex compared to those who are sober.

Challenges Related to Sex Research

Virginity – Research revolving virginity and the loss of virginity is a good example of how women construct virginity and premarital sex in diverse ways. It may differ in the ways in which the researcher refers to it, as it may not always include penile-vaginal intercourse. Interestingly, there are women who believe that virginity cannot be lost through rape.

Oral sex – is another example of a topic that is subject for misunderstanding unless very specific and pointed questions are asked. Researchers may receive answers to unrelated questions if they are not careful about their inquiries. For example, women have been socialized to view oral sex more as 'giving' rather than 'receiving' which encourages them to prioritize their partner's need over their own. This may encourage participants to discuss a variety of problematic behaviors such as faking orgasms, engaging in unwanted sex even if it may be unpleasant or painful, or even submitting to sexual violence. Research has found that women give oral sex much more than receiving it. For women who receive cunnilingus, it was reported that they are thus more assertive, skillful, and gratified than those who did not receive oral sex. Therefore, oral sex narratives reveal the complicated position around entitlement and emotional/sexual labor for women in these relationships.

Relating to sexual violence – exploring women's experience with sexual violence frequently opens up discussions of their reactions to these events. These women may not prefer to label these experiences as rape, partly due to the cultural stigmas against those who have been raped. Thus, the researcher is placed in a sensitive position that posits them as responsible for ensuring the confidentiality and dignity of the women in these studies. They must navigate how to understand the contexts of these events without sacrificing the integrity of the responses from these participants. As such, the questions raised in these studies greatly impact the quality of data collected from these women.

For instance, when inquiring about their first sexual experience, women in one study ended up addressing their early sexual traumas, which occurred prior to the age of consenting or wanting. This included details related to nonpenetrative sexual experiences, including experiences like 'dry' humping, masturbation or being fingered. Respondents also reported non-orgasm directed sexual experiences, such as kissing, being seen naked and loss of virginity. That, obviously, created chaotic results which may have been unreliable for researchers in the context of their original research goals.

Another example includes studies that inquire about women's worst sexual experiences. When asked this question, researchers encountered women who did not see coerced sex "…as really rape." In these circumstances, the sexual trauma and coercion either became obvious, for some women, or, in other cases, obscured, hidden, or minimized. Thus, these answers deviated from the initial goal of the research. Consequently, researchers must be mindful about how the questions that they pose might twist, flip flop and circulate differently than they intended.

We would think that after so many years and decades of sexual research, we may know all there is to know about this topic. Apparently, not so. I would like to close this chapter by some examples of recent research results in the past two years relating to sexual issues.

In 2019, more than half of American women struggled to talk about what they wanted sexually. It appears that 55% of women in the U.S. found it difficult to communicate to their partner how they wanted to be touched and what turned them on sexually. This is important as research has found that just being able to say the word 'clitoris' may lead to better overall sex. And as we know, the clitoris is key to improving sexual pleasure for people who have them.

This suggests that using specific sexual language (such as ‘clitoris’) requires people to be comfortable with discussing the topic of sexuality with others, and may thus enhance their sexual pleasure.

Greater sexual satisfaction and less faked orgasms can also be seen in those who are able to communicate their sexual desires. This is significant as 55% of people who experience a “bad orgasm” feel physically pained and less likely to engage in sexual relations.

Research has also confirmed what is commonly known for those in long-term relationships. People in such relationships (whether it on marriage or cohabitating terms) have significantly less sex than others who are single. However, and that is an important ‘however’, it was found that commitment and good sex were definitely linked. Having good sex once per week was associated with couples feeling more committed to each other the following week. The reverse was also true.

Another finding that may be intuitively obvious involves the negative relationship between trauma and sexual pleasure. People with more traumatic experiences in childhood, tend to have less satisfying sex lives in adulthood due to the psychological distress of these previous experiences.

Alternatively, research has also indicated that up to 58% of men and women between ages 55 and 74 are not satisfied with their sex lives. Some of the top reasons for not having sex were not having a partner to have sex with, having a partner with a medical condition making sex impossible, and having a partner dealing with sexual dysfunction. In a study of over 2,000 women, researchers found that nearly a quarter of women had experienced pain during their last sexual encounter. Those women who experienced little to no pleasure during the sexual experience were also three times more likely to not tell their partner about the pain.

Research examining the links between personality and sexuality also found open-mindedness was most associated with cheating behavior. In other words, people who are more open to new experiences tend to be more likely to cheat as well, although we must remember that open-mindedness is also correlated with being more welcoming, more creative, more sexually liberated. And the last study which I will briefly describe may bring hope to couples, as it was found that sexual desire is buildable. Experiencing sexual desire today makes you more likely to experience sexual desire and have better sex tomorrow.

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Reporter: “Excuse me, may I interview you?”
Man: “Yes!”
Reporter: “Name?”
Man: “Johnny”
Reporter: “Sex?”
Man: “Three to five times a week.”
Reporter: “No no! I mean male or female?”
Man: “Yes, male, female... sometimes camel.”
Reporter: “Holy cow!”
Man: “Yes, cow, sheep... animals in general.”
Reporter: “But isn’t that hostile?”
Man: “Yes, horse style, dog style, any style.”
Reporter: “Oh dear!”
Man: “No, no deer. Deer run too fast. Hard to catch.”

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Chapter 3

How Do We Respond to Sexual Stimulation?

> My mentor, Dr. Steve, was a pioneer sex therapist in Canada during the 1960s. He told me about a couple (a lawyer and his wife) who sought his help due to repeated painful intercourse experienced by the wife. He counseled them and recommended some cream to ease penetration but nothing helped. Desperate to find out why he cannot succeed in easing the couple's suffering, during a meeting with the couple, he drew a woman's body and asked the man to show him where he penetrates his wife. As incredible as it may sound, the man pointed to the belly button and complained that as hard as he pushed, he was unable to get in. This serves as an extreme example as to why we cannot assume that everyone knows what the sexual parts are, where they are located, and what their function is.

In order for us to know what our body is going through and how it reacts to sexual stimulation, we need to look closely at our bodies. What are its sexual parts, how do they react to stimulation, and what is their role in sexual activity? As books from the last five decades have openly discussed this issue with accompanying drawings and pictures of the various sexual 'parts', we will do so only briefly.

Female Genitals

The *external female genitalia*, or vulva, consist of the: mons pubis, the clitoris, the labia majora, the labia minora, the vulvar vestibule, and the urethral and vaginal openings. Let's explain those unusual names to our sexual parts.

- *The mons pubis* – is the round and fatty pad of tissue that covers the point where the left and the right side of the pelvis meet. It is sensitive to touch.
- *The clitoris* – is the exceptionally sensitive organ which has approximately the same number of nerve endings and receptors as the glans penis. It is found at the upper meeting point of the two vulval folds and exists solely as a mechanism for female sexual pleasure. It is essential to enhancing female sexual responses and is the most common way that women achieve arousal and orgasm during masturbation. The clitoris is composed of the glans and the shaft. The glans is a small, knob-like tissue that is smooth, round, and somewhat transparent. The shaft runs back along the two sides of the corpora cavernosa (i.e., erectile tissue) which extends back and cannot be seen from the outside. Both of these parts are covered by the clitoral hood.
- The *labia majora*, or as it is sometimes referred to as the "outer (large) lips" are pads of fatty tissue which are lateral to the labia minora, the urethra, and vaginal opening. The labia majora extends downwards from the mons pubis on each side of the vulva. Its skin is typically darker than that of the thighs and is richly supplied with nerve

endings. It serves to provide padding and protection for the sensitive labia minora, clitoris, and vaginal opening.

- The *labia minora*, or the “inner lips” are hairless folds of skin located between the labia majora. They extend upward from the clitoral hood to meet the vaginal opening between the folds of skin located at the back of the vulva called the fourchette. The labia minora contains oil glands, sweat glands, hood vessels, and many nerve endings which are important in sexual stimulation and arousal. It serves to protect highly sensitive areas like the vulval vestibule, vagina and urethral openings from mechanical irritation, dryness and infections.
- The *vulvar vestibule* is the ‘teardrop’ shaped area located inside the labia minora that precedes the vulva. This area is filled with nerve endings and blood vessels that are highly responsive to sexual stimulation.
- The *urethral opening* is situated between the clitoris and the vaginal opening. It includes the tube that transports urine from the bladder so it can be expelled by the body. It is generally not sensitive to sexual stimulation.
- The *vaginal opening* is a highly sensitive region located in the outer part of the vulvar vestibule below the urethral opening.

Unlike the external genitalia, the *internal female genitalia* are not observable from the outside. It consists of the: vagina, Bartholin glands, the vestibular bulbs, the Skene’s gland, the cervix, the uterus, the ovaries, and the fallopian tubes.

- The *vagina* is actually a canal that starts from the vaginal opening and extends into the body to connect with the *cervix* (the entrance to the uterus). Its size in an unaroused woman varies between 7.5 to 12.5 cm, but may lengthen by an additional 10 cm when sexually stimulated. It consists of three layers of tissue starting with the *vaginal mucosa*.
- The *vaginal mucosa* is the outer entryway of the vagina that is soft and moist like a mouth. It is sensitive to the touch and releases secretions after mechanical stimulation (either by hand or a sexual toy). This helps the vagina maintain a healthy and slightly acidic chemical balance. When the woman is sexually aroused, the mucosa releases a clear, slippery lubricant, which is associated with increased blood flow to the vaginal walls. This contributes to sexual pleasure as it reduces friction through lubrication during penetrative sex.
  - The middle layer of the vagina is a muscular portion that helps to facilitate tightening and contraction during orgasm. It contributes to providing enhanced sexual pleasure for the user and their partner(s). It is located in the lower third of the vagina.
  - The deepest layer of the vagina is made of fibrous tissue that resists expansion and helps keep the vagina in place within the pelvis.
- The *Bartholin glands* are a small pair of glands which lie inside the labia minora on both sides of the vagina. It was previously believed to provide lubrication within the vagina, but that was quickly corrected after Masters and Johnson who discovered other structures responsible for this. As such, their function is still unknown.

- The *Vestibular bulbs* are composed of erectile tissue similar to those found in the penis. They fill with blood upon sexual arousal and are a part of the clitoris.
- The two *Skene's glands* are located on the anterior wall of the vagina. Recent research suggests that they are the female equivalent to the male's prostate gland and are thought to contribute to the sensitivity of the *G-spot*.
- The *G-spot's* (Grafenberg spot) existence is fiercely debated in the scientific world. Some women are sure they have it and enjoy the enhanced sexual stimulation that touching the G-spot is assumed to bring, while others do not seem to have it. Regardless, it can be said that the G-spot seems to be a highly sensitive zone and is located on the front of the vaginal wall, about five cm from the vaginal opening. Those who have a G-spot experience highly pleasurable sensations from stimulation of that area and reported that ejaculation follows their orgasms, similar to the male's ejaculation.
- The *cervix* is the lower third part of the *uterus*. It is situated at the top of the vagina and contains mucus secreting glands.
- The *uterus* is where the fetus is held during pregnancy.
- The two *ovaries* are situated one on each side of the uterus. They produce estrogens which influence the development of physical sex characteristics and progesterone which regulates the menstrual cycle. Progesterone also prepares the lining of the uterus for pregnancy. The ovaries produce ova, or eggs, which are used for fertilization. An upwards of one million immature eggs are available in the ovaries upon birth. They are released overtime each passing menstrual cycle and alternate between each ovary.
- The *fallopian tubes* are approximately 10 cm long. They are located on each side of the pelvic cavity. Their function is to transport the ova from the ovaries to the uterus.

The Clitoris: Anatomical and Psychological Issues

Some people call it "the love button" or "the little man in the boat," but the clitoris, the pivotal organ of female sexual responses, is far from being little. Most people assume that the part we can see is all there is to the clitoris. However, using Magnetic Resonance Imaging (MRI), it was shown that there is much more to the clitoris than meets the eye. The clitoris is actually a wishbone-shaped structure that is about 3 1/2 inches (9 cm) in length and 2 ½ inches (6 cm) in width. We can easily observe the part that protrudes from the top of the vulva which is called the glans. However, the rest of the glans extend interiorly back into the clitoral body. It then splits downward into two leglike parts. The *crura*, which are composed of erectile tissue, are located near the vagina and urethra. This finding helps to confirm that the main reason why sexual intercourse is exciting is probably due to the stimulation of the bulbs of the clitoris adjacent to the vaginal walls. Recent findings also suggest that the G-spot may exist in areas where the clitoral extensions of the crura are adjacent to the vagina, and thus, receives special stimulation through the vaginal wall.

From ancient times to the present day, the anatomy of the clitoris has been discovered, repressed, forgotten, denied, or shrunk and rediscovered many times. These recent discoveries of clitoral anatomy call for a rethinking of our understanding of the female body and sexuality from every perspective, since what you see is not always what you get, literally.

Why Was the Clitoris Treated the Way It Was?

The Greek physician, Hippocrates (460 B.C.), called the clitoris “columella”; the little pillar. About 500 years later, Galen, an Italian physician, denied the existence of the clitoris. He believed that female genitalia were the reverse copy of male genitalia. As he believed that the male penis corresponded to the uterus, he asserted that there was no place for the clitoris. In 1559, a Paduan surgeon named Renaldo Columbo claimed to have discovered the clitoris. He aptly described it as “the seat of women’s delight…If you touch it, you will find it rendered a little harder and longer to such a degree that it shows itself as a sort of male member.” Yet, not all contemporaries accepted the clitoris. Vesalius, the famous surgeon of Padua, disagreed forcefully. He insisted that the clitoris did not exist in healthy women and could only be found in hermaphrodites.

By 1844, German anatomist, Georg Ludwig Kobelt, provided a comprehensive and accurate description of clitoral anatomy in his book *The Male and Female Sex Organs in Humans and Some Mammals, in the Anatomic Physiological Relation*. Kobelt accurately reported that the clitoris is much larger than what we can observe from the exterior, and already then, so many years ago, described it as a wishbone-shaped structure that extends internally which may lengthen up to ten centimeters. He claimed that due to this extended internal structure, the clitoris can respond to stimulation of the external vaginal labia, the vagina itself, and the anus. Here, we can see how precise and thorough Kobelt’s description of the vagina was, even in the mid-1800s.

The suppression and rediscovery of the clitoris continued its cyclical pattern into modern times. For example, in the 1901 edition of Gray’s Anatomy, there is a drawing of the female pelvis in a cross section which shows a small protrusion labelled the “clitoris.” There are only minimal details in this illustration about the clitoris, but at least it is there. The next edition of Gray’s Anatomy which was published 47 years later featured an analogous illustration of female genital anatomy but with the protrusion and the label “clitoris” gone. The clitoris was entirely erased by a male! But unfortunately, that pattern is well known. The clitoris disappears, and then, from time to time, some pioneers revive it, adopting a new worldview or a new technology. One explanation for this suggests that the gender of the anatomists which described the clitoris has impact on its relevancy in science. Most anatomists are, or were, men. And had it been up to women to write anatomy textbooks, it is probably less likely that they would not have left out the clitoris.

Another theory behind the inconsistent recognition of the clitoris in medical history is that of ‘clitoris envy’. This hypothesis was proposed when comparisons of the female clitoris were made against the male penis. The main function of the clitoris was to provide sexual pleasure to women – a phenomenon that cannot be compared with the penis as it used several different purposes in men such as urination, fertilization and sexual pleasure. This may have discouraged male anatomists from acknowledging the clitoris and thus, tactfully exclude existence in science.

Male Genitals

External male genitalia consist of the penis and scrotum, with the testes located inside the scrotum. We will examine some of those parts below:

- The *penis* is essential to sexual pleasure, reproduction, and urination In it are blood vessels, rubbery tissue, and three spongy tissues. Unlike some mammals, men do not have any bones in their penis. The penis can be divided into three sections: the roots, the shaft, and the glans.
  - The roots of the penis extend internally and attach to the bars of the pubic bone.
  - The shaft, which starts at the base of the penis and ends at the rim of the glans, is the main external part. It is covered with loose skin when the penis is non-erect.
  - The glans is an acorn shaped tip of the penis. It is sensitive to stimulation, and in uncircumcised males, it is partially or fully covered by the foreskin.
  - Three cylindrical spongy bodies run along the length of the penis.
    - The two large ones, lie together on the upper part of the shaft.
    - The third one lies below with the urethra running through its middle. This third spongy body expands at the head of the penis and forms the glans.
  - Inside the penis are many tiny irregular spaces which are richly supplied by blood vessels and nerves, which upon stimulation become engorged with blood and cause a penile erection.
- The *scrotum* is the loose pouch of skin that contains the testes and is situated below the basis of the penis.

Internally, the male's sex organs include the: testes which are located inside the scrotum, the seminiferous tubules, the epididymis, the vas deference, the seminal vesicles, the prostate, and Cowper's glands.

- The *testes* are the male's reproductive glands, similar to the function of female ovaries. They secret androgens, which are male sex hormones, and also produce sperm. Each testicle is suspended in the scrotum by the spermatic cord, and are surrounded by a layer of muscle which lifts the testes when it contracts. This helps the testes lift and lower to maintain a constant temperature, as overheating may cause damage to the sperm.
- The *seminiferous tubules* are the site of the germination, maturation, and transportation of the sperm cells within the male testes.
- The *epididymis* is a c-shaped structure that covers parts of each testicle. It is actually a 'holding place' where immature sperm is held until they mature.
- The *vas deference* is a thin duct into which the mature sperm is drained from the epididymis. It then carries the sperm into the prostate gland where the sperm mixes with fluids. Upon ejaculation, these fluids are secreted by the seminal vesicles into the urethra and then ejected out of the body. The seminal vesicles are two tubular glands located near the prostate and at the end of the vas deference. They secrete an alkaline fluid containing a multitude of chemicals which forms up to 70% of the ejaculate.

- The *prostate gland* lies below the bladder and secretes a milky, alkaline fluid which provides a safe environment to maintain the sperm.
- *Semen* is made up of fluid from the seminal vesicles and the prostate gland. A man releases about one teaspoon of semen in each ejaculation, though the amount may vary between men. A single ejaculate may contain between 200 and 500 million sperm. Yet, despite their very large number, sperm may account for only 1% of the ejaculate, while the rest of the fluid is made up of fructose, ascorbic and citric acids, and water.
- The *cowper's* glands are two pea-sized structures that lie beside the urethra and below the prostate. During sexual arousal they secrete a small amount of clear and slippery 'pre-ejaculate' fluid which counteracts the acidity of the urethra and prepare the urethra for the flow of sperm.

In general, erogenous zones may also include the: scrotum, anus (and surrounding perineal area), buttocks, wrists, ears, neck, armpits, breasts, and the nipples.

While we now have an idea about our sexual apparatus, we cannot aspire to understand human sexuality and offer treatment for sexual problems without clarifying what the sexual response cycle is and how it acts. The *sexual response cycle* refers to the sequence of events that occurs during sexual arousal and engaging in sexual activities, such as intercourse or masturbation. While it is mainly based on physiological processes, it also involves psychological, cognitive, emotional, and experiential components, which originate in the brain. Several models described the human sexual response cycle, and we will briefly review the main ones. The biological characteristics of sexual arousal include changes in our genitalia such as the erection of the penis and tumescence, as well as the engorgement of the clitoris with blood and vaginal lubrication. Additionally, there is a heightened awareness of pleasurable erotic sensation with the changes in our subjective state that we call 'sexual arousal'. It seems that the interplay of psychological and somatic processes involves the entire body from excitement to orgasm, ultimately ending in the refractory period.

The Intricacy of Human Sexual Response Cycle

In 2001, Dr. Rosemary Basson, a sex researcher and theoretician noted that solitary or shared sexual experiences may help to fulfill a number of different needs, which sexual hunger is but one of them. And while sexual hunger is the major reason for masturbation, its presence is not central in sexual activity with one's partner, though it may be precipitated by it. Some other reasons that people engage in sexual activity includes the enhancement of emotional closeness, bonding, commitment, and desire to increase one's attraction to one's partner. Basson believed that sexual desires are rooted in the reasons described above not only increases arousal but can increase the willingness to receive or provide further stimulation. Let's examine the various factors which affect the processing of sexual stimuli, and which were reviewed by Basson.

Psychological factors – can have significant effects on our arousal and enjoyment of sex. For instance, non-sexual distractions or the recall of previous negative sexual experiences (or traumas) may inhibit one from sensing arousal. Thus, blocking the neurological signals that allow genital and other somatic arousal responses to occur in order for sexual activity to take place. Distressed arousal, rather than absent arousal, is known to occur by those who

experienced sexual abuse in their past. This may lead to the person's dissociation or attempts of distraction to avoid or even prevent the sexual stimuli from taking place.

Biological factors – Depression is considered the most common biological factor that inhibits sexual arousal. Fatigue is also another common biological factor that reduces sexual responsiveness. It may result from a lack of sleep or as a result of various medical conditions, such as renal failure, multiple sclerosis, or from a stressful lifestyle.

Emotional and physical satisfaction – 'enhanced emotional intimacy' is an integral part in the sexual response cycle that Basson proposed. Such emotional intimacy occurs when the outcome of the sexual encounter is both physically and emotionally rewarding. For women, it does not necessarily need to include orgasm. But for others, it may need to involve the experience of separate orgasms or sometimes a very prolonged arousal of orgasmic intensity in order to feel the enhanced emotional intimacy. Men, on the other hand, need orgasmic release for satisfaction and only rarely achieve multiple orgasms. For either gender, a sexual encounter reduces physical tension, but the ultimate positive reinforcer for the person is the ongoing wish to increase emotional intimacy.

What if Emotional and Physical Satisfaction Do Not Happen?

Painful and disappointing sexual experiences do not enhance emotional intimacy. Rather, the woman who may be the one to experience such pain, may end up feeling confused, resentful, or even abused. Thus, the very "power" that drives her cycle is weakened. When her partner displays misunderstanding and a lack of empathy, coupled with the invalidation of her pain, it can seriously and negatively affect the couple's intimacy. As a result, the woman may begin to avoid sexual stimuli as it is now connected to negative physical and emotional outcomes.

Combining the traditional and alternative cycles – Dr. Basson suggested that the traditional human sex-response cycle which was described by Masters and Johnson and later updated by Dr. Helen Singer Kaplan (which we will review a bit later) often supplements the intimacy-based cycle. Especially in their younger years, men are more likely to report the influence of intimacy-based desire as being secondary to the more "traditional" or biologically-based sexual desire in attraction. Clearly, when sexual stimuli are processed as a way to allow for sexual arousal, the conscious experience of arousal alters the functioning of the brain to initiate genital changes that form sexual responses. In men, the genital engorgement with blood serves as a further sexual stimulus. When they are deprived of such enjoyment, seen in those with erectile dysfunction (ED), they are not only deprived of the further stimulus, but now recognize their unsatisfactory erectile response as a negatively distracting event. Women are commonly not aware of genital engorgement so that this stimulus, which may be produced by the genitals, is absent. And so, if genital congestion does not occur alongside their poor associations of these sexual events, it may increase physical discomfort in women.

The emotional experience – Despite the physiological responses to sexual stimuli, negative emotions related to these sexual events will create a negative feedback that will turn off the "sexual centres" of the brain. Men with chronic situational erectile dysfunction experience negative emotions upon attempting sexual activity, which diminishes their motivation for trying it again in the future. It appears that the way we think about sexuality, and the cultural beliefs, attitudes, and inhibitions that we have learned overtime significantly affects our sexual responses and excitement.

The sex response cycle discussed above emphasizes the role of shared sexual interactions in enhancing emotional closeness. Thus, Dr. Basson proposed that lacking an initial sense of sexual needs (which many women complain about), may develop later during interaction. That may be reassuring to the 33% of North American women who perceive that they have low sexual desire, since it may be conceived as "normal" to be able to respond to the sexual stimuli but rarely sense inborn sexual hunger. The cycle which we have discussed highlights the necessary integration of mind and body throughout the sexual experience. The extensive feedback to the mind, which includes emotions, a sense of physical and genital arousal, as well as mental excitement, constitutes ongoing stimuli to be processed and modulates the ongoing sexual response.

The Masters and Johnson's Model of Sexual Response

Masters and Johnson were the first researchers who objectively investigated, rather than inquired about, the sexual response cycle of more than 350 women and 300 men who experienced more than 10,000 cycles of arousal and orgasm in a laboratory setting. They measured each person's heart rate, blood pressure and respiration rate, and also directly observed changes in the genital and non-genital areas of the body. Amongst the changes they recorded were those occurring inside the vagina during arousal, orgasm and during what was termed "artificial coition" where they provided the female participants with a clear, phallic-shaped dildo that contained a tiny surgical camera. Based on their findings, they drew a four-phase model of sexual responses based mainly on vasocongestion (the pooling of blood in a bodily organ) and the increased muscle tension in a bodily area during sexual arousal.

Phase 1: Excitement – This phase signals the beginning of sexual arousal. The fundamental process that occurs during this phase is the pooling of blood in the sexual organs, resulting in erections for males and vaginal lubrication in females. It occurs fairly quickly and can be triggered either by direct sexual stimulation, or by sexually related thoughts, pictures, or even oral descriptions. During this phase, the labia majora in females separates from the vaginal opening and the labia minora swells and darkens. The inner two thirds of the vagina expand significantly, and the vaginal walls, which usually touch each other, open to accommodate the entry of a penis, while the cervix and the uterus elevate to enhance sperm deposit. Non-genital changes that also occur include: nipple erection in both genders, females' breasts swelling and visibly enlarging, increased blood pressure and heart rate, and a sex flush – a pink or red blush on the chest of mainly women.

The second phase: Plateau – Here, we find a dramatic surge of sexual tension in both men and women. The process that started in the excitement phase continues, increases and reaches its peak in the next phase – orgasm. Heartbeat, blood pressure and muscle tension increase in both sexes. In males, the testicles are elevated as does the uterus in females. At that point, the clitoris becomes hyper sensitive, and may retract under the clitoral hood as continued stimulation may feel too intense, uncomfortable or even painful. The lower third of the vagina begins to engorge with blood and causes it to provide increased muscle tension of the pelvic floor.

Orgasm, the point desired most by both males and females, is the third phase which occurs following increased effective stimulation. It is the shortest stage and usually lasts a few seconds. During this stage, involuntary muscle spasms occur in the pelvic floor and elsewhere in the

body such as in the anal sphincter. Males ejaculate during orgasm, and females experience contractions of the lower base of the vagina and the uterus, as well as rectal pressure.

Resolution – is the final phase of the sexual response cycle. During this phase, the sexual response cycle returns to its unaroused state. Some processes, such as heartrate, blood pressure and sex flush, resolve quickly, while clitoral engorgement and penile erection take longer. If no orgasm occurred this phase will take longer to complete.

Helen Singer Kaplan's Model

Singer Kaplan developed a three-stage model of sexual response including desire (which describes the physiological and psychological state of the person about to engage in sex), excitement (which is similar to the Masters and Johnson stage), and orgasm. The strength of this model stems from its inclusion of desire as the initial stage of sexual response, acknowledging the importance of the psychological elements in this process. Research demonstrated that strong positive or negative emotions may significantly affect sexual arousal differently.

Sex Differences in Sexual Response

Males and females respond differently during the resolution phase, as described by Masters and Johnson. Males usually experience a refractory period following orgasm. This period is characterized by the span of time after having an orgasm during which a person is not sexually responsive. The refractory period can have both mental and physiological effects. It may last from a few minutes for youngsters to several days or longer depending on the person's age and frequency of previous sexual activity. Females do not have a refractory period and can readily experience multiple orgasms. Kinsey's research showed that up to 14% of women regularly experience multiple orgasms. Masters and Johnson suggested that women's capacity for multiple orgasms may be related to masturbation, and not necessarily to intercourse. Although there is very little research on it, we know that some males may experience multiple orgasms as well. Interestingly, some men who had their prostate gland removed due to cancer may also experience multiple orgasms. But since there is no gland, these will be "dry" orgasms.

The orgasm variability – Orgasm varies significantly between males and females. While in young boys the frequency increases from 5% to 100% during ages 10 to 15, women experience a much more gradual increase in the following 25-year span starting at age 15. Stimulation is also different between the sexes. Almost 90% of women are orgasmic from either direct or indirect sexual stimulation, but sexual intercourse alone does not result in orgasm for most of them. In contrast, almost 100% of men regularly experience orgasm from sexual intercourse alone. A sexual researcher under the pseudonym A.E. Narjani proposed that women whose distance between the clitoral glans and urethra is less than 2.5 cm have a higher likelihood of orgasm as a result of sexual intercourse. Research confirmed that suggestion and showed that due to the short distance between the two areas, the movements of intercourse do contribute to enhanced ability to reach orgasm by intercourse. Following orgasm, men's desire decreases quicker than women's and occurs similarly to genital temperature which was raised during excitement and orgasm.

Is There Proof for the G-Spot?

During the first half of the 20th century, it was believed that the vagina is primarily meant for reproduction, and was not intended for sexual pleasure. Apparently, research demonstrated that the frontal vaginal wall had low sensitivity to stimuli, low density of sensory receptors, and no nerve endings which would enhance the belief that it is not meant for pleasure. But starting in the 1950s, researchers began to discover the importance of the vagina, particularly the frontal wall, and its role in sexual pleasure and orgasm. The German gynecologist Dr. Ernst Gräfenberg was the first to describe an area of heightened sensitivity in the frontal part of the vagina. It is also interesting to see similar findings described in the Kamasutra which was produced in the 11th century. In the Western culture, Dr. Regnier de Graaf, a Dutch physician, pointed to an erogenous zone in the vagina that was associated with the male prostate gland in the 17th century.

Gräfenberg, explaining what came to be known as the G-spot, described a 1–2 cm area located in the front wall of the vagina that was quite close to the bladder and urethra. In some women, it was especially sensitive to direct stimulation. A study in 1985 demonstrated this as manual stimulation of the back and frontal wall of the vagina can similarly elicit an orgasmic response. This is further supported by another study which found that vaginal stimulation to both walls of the vagina led to increased erotic sensitivity in participants. An orgasmic response was elicited by the stimulation of these zones in 89% of the subjects. However, it is currently still unclear, as to whether or not there is a connection of female ejaculation and the G-spot.

Although, the Skene's glands, which are believed to be located along the supposed G-spot, raises the possibility that they may actually be the anatomical structure of the G-spot. A study surveying 1,230 women aged 22-82 in North America found that 40% reported ejaculating at the moment of orgasm. It further found that 82% of those who reported having a G-spot also reported experiencing ejaculation with orgasm. Consequently, it was suggested that the G-spot is a system of glands and ducts located within the frontal wall of the vagina and may possibly play a role in the stimulatory phase of sexual responses and orgasm.

How Do Our Genitals Respond during Sexual Activity?

The fundamental function of genital responses in humans is to enable the entry of a penis into the vagina, with the aim of depositing semen in the vagina. It is so programmed, not only for reproduction purposes, but also for the sexual pleasure which it produces. We will explore the purpose of the genital vasocongestion or blood gorging, which may differ between males and females.

Males' Genital Response

The principal and most crucial response of the male is the erection of their penis. It is the subject of much male concern and self-observation. And with failure in achieving an erection, come fears of sexual dysfunction. In addition to penile erection, the testes enlarge during sexual activity and are elevated. If stimulation is intensified or prolonged, the testes are pulled up to the perineal floor (which is the area between the penis and the anus) and further increases in

size. Masters and Johnson suggested that the testes are elevated in order for the full force of ejaculation to occur.

Penile Erection

It is obvious that penile erection is needed for the penis to gain entry into the vagina and for semen disposition to be possible. The erect penis is also a stimulator of the vagina and the main tactile erotic area for the male. The stiffness of the erect penis depends on blood filling the erectile tissues. Tough tissue which is situated around the corpora cavernosa (two masses of erectile tissue forming the bulk of the penis) contains the increased pressure that produces the erection, based on an internal hydraulic system inside the penis. Traditional physiological explanations maintained that erection is the result of arterial blood flowing into the penis while the parasympathetic nervous system creates arterial dilation. The sympathetic nervous system, which helps relax the body after it tenses, was assumed to be responsible for the reversal of erection, or detumescence. However, it appears that erectile process is more complex than that. Several needs must be attained such as having enough pressure produced for the rigidity of the penis, slower blood flow exiting the penis and increased filling of the erectile tissue. Entrapment of the blood by compression of the penile veins is the favoured explanation at present. Reduction of venous outflow is present in the early development of an erection.

Genital Response in Women

The consequences of erotically induced blood congestion in sex organs of females are more complex and more extensive than it is in the male. Current understandings of this process work include the congregation of various veins (which surround the lower part of the vagina) as well as the bulbs of the clitoris becoming engorged during intercourse. Once the sexual stimulation intensifies, the woman reaches the plateau phase and exhibits congestive swelling of their vulva which results in the reddening of the labia minora. The clitoris, which erects to a significant degree, now retracts under the clitoral hood. As for the deeper parts of the female genital anatomy, the uterus becomes engorged with blood and rises to the pelvis. Additionally, the vaginal canal elongates with ballooning of the upper two thirds of the vagina. As sexual stimulation occurs, slow contractions of the vaginal vault may be observed, while no changes were observed in the labia, the vaginal wall or lining. And just like how a male's erection facilitates entry into the vagina, the vagina has a part in easing that entry as well. The congested and 'pouting' labia invites entry of the penis while, at the same time, the vaginal secretions lubricate the vaginal barrel. The orgasmic platform (i.e., the narrowing of the outer third of the vagina) provides erotic stimulation to both the man and the woman. The elevated uterus that was mentioned earlier, seems to pull the cervix out of the way to prevent discomfort for the woman from the deeply thrusting penis. We can now understand that if vaginal entry is attempted without these genital responses, pain may result.

As we can see, nature has taken care of these processes with the intention of having all parts working in harmony in order for sex to be pleasurable. So, while these genital responses aid reproduction, do they also contribute to a woman's sexual pleasure? In the male, the progression towards sexual pleasure is quite clear: penile erection, orgasm, and ejaculation, all naturally essential for reproduction. It appears that a woman can be impregnated without feeling sexual pleasure. However, most women do experience such pleasure to, at least, some extent. As we mentioned previously, the sole function of the clitoris is to enhance the woman's sexual

pleasure during sexual activity. It is hypersensitive and is said to contain as many nerve endings as the glans penis. The woman can, indeed, reach orgasm during coitus.

Vaginal Response

The lining of the vagina is commonly moist. This moisture is produced by fluid from the uterus as well as mucous secretions in the cervix which originates in the vaginal wall. A smart plan by nature resulted in variations of the cervical fluid's amount and consistency through the ovarian cycle. Periods closer to ovulation increases the volume and consistency of this substance to a watery texture. This facilitates easier sperm entry into the uterus. However, during the luteal phase of the cycle (i.e., after ovulation or the release of the egg by the ovaries before the beginning of the period), the volume of cervical fluid is reduced and thickens to 'plug' the cervical canal. Thus, reducing the likelihood of sperm to enter. In contrast, sexual stimulation helps ease copulation through the development of fluid appearing on the inner lining of the vagina. This lubricating coat, similar to what Masters and Johnson described as the 'sweating' of the vagina, makes movement easier and less painful for the woman.

Interestingly, theoreticians have speculated about the differences between clitoral and vaginal orgasms. Freud believed that there are distinct differences between the clitoral and the more "mature" vaginal orgasm. However, this has been debunked by research from Masters and Johnson. Instead, conversations concerning the existence of a female G-spot has been the topic of interest in modern day sex research. In fact, Kinsey had indicated that 11% of women reported a specific point in the frontal vaginal wall as being sensitive to sexual stimulation. However, there is currently no definitive answer about the existence of the G-spot.

Vaginal Stimulation Can Cause an Analgesic Effect

Studies conducted on rats indicated that pressure on the vaginal wall and cervix of female rats induced sexual receptivity in rats that previously were non-responsive. Interestingly, when a painful stimulus was introduced, the researchers noticed that the rats became immobilized and suspended their response to the painful stimuli. And when penile intromission replaced the vaginal probe, the results were similar. Amazingly, the pain-blocking effect of penile insertion has been estimated to be at least five times more powerful than that of a standard analgesic dose of morphine! Studies in women, showed a similar analgesic effect of self-induced pressure on the anterior vaginal wall or clitoris. And while more research is needed on the analgesic effects of vaginal stimulation, it is possible, that it may reduce pain during childbirth.

Orgasm

As much as it may be the focal point of sexual stimulation, orgasms remain as the most mysterious phenomena due to its subjective nature. Once the male reaches sexual maturity, the event is marked by ejaculation. While in females, it is usually not. Thus, it is not uncommon to find women who are unsure whether they have reached orgasm.

Orgasms are a very pleasurable occurrence, and in addition to its relaxing effect, it reinforces future sexual activity. Understandably, not reaching orgasm is a cause of concern for

those who cannot reach it. Kinsey and colleagues aptly described this process "…as the individual approaches a peak of sexual activity he or she may suddenly become tense, momentarily maintain a high level of tension, rise to a new peak of maximum tension and then abruptly and instantaneously release all tensions and plunge into a series of muscular spasms or convulsions through which he or she returns to normal or even subnormal physiological state."

Various writers, theoreticians and researchers attempted to capture the essence of orgasm. A review of about 300 publications revealed that orgasm is an increase in sexual arousal, and during its peak, the following takes place: an intense feeling of pleasure; some degree of altered state of consciousness; sensations that are felt in the genital area and which may spread to other parts of the body, and muscle contractions. Following orgasm, or the post orgasmic state, those manifestations (in both men and women) return to a non-arousal state which suggests that it is an active process resulting in a 'refractory period' when further sexual arousal will not occur.

Gender Differences in Orgasms

Statistics suggest that while 75% of men orgasm every time in sex they have with a partner, only 29% of women consistently orgasm during sexual interactions. Since an orgasm is believed to indicate sexual satisfaction for those who experienced it, does that necessarily mean that women are simply more difficult to please? The question then arises: why do men orgasm more frequently than women do?

A point which is so very clear, but demands to be emphasised and repeated, involves the understanding of another's wants, needs and familiarity of their body parts for good and satisfying sex to occur. The penis and vagina are known to all, but the clitoris, the most powerful predictor of a woman's orgasm, is less known. Its hidden placement and lack of reproductive function remains a mystery to men and women alike. This is consistent with research about it from the past (as we described previously) as having been simply ignored altogether. That, naturally, must be remedied. It has more nerve endings than the sensitive head of the penis, and thus should be a major part in female sexual arousal and pleasure.

It may not be surprising that men and women differ in the quantity of their orgasms. But what about the quality? While men's orgasm can be identified by the ejaculate, women do not ejaculate. Researchers explored whether there is a qualitative difference between men and women's orgasms based on gender. They asked college men and women to describe their orgasms. They found that both genders described them very similarly, suggesting that the belief that men experience orgasms differently than women is an erroneous one. We should remember that sex, and even 'mind-blowing' sex, does not have to include orgasm, and a lack of one does not mean that the partner does not enjoy sex. Sexual satisfaction varies between different people, at different times, and at different situations.

Male's Responses during Orgasm

Ejaculation is the forceful expulsion of semen through the urethra, though in some men it may just drip out. And while most men ejaculate during orgasm, the ease at which they are able to reach orgasm and its intensity may vary considerably between males. Research found that only

75% of men are always ejaculating during sexual activity. Prior to ejaculation, there is the point of no return, or ejaculatory inevitably, where the man knows that ejaculation is imminent, and cannot be stopped or controlled. Ejaculation occurs 3-5 seconds after that point.

Female Orgasmic Responses

Unlike men, women are much more variable in their orgasmic behaviors. Men typically begin to experience orgasms and ejaculation close to the onset of puberty while women may experience it between puberty to adulthood. In fact, Kinsey found that around 23% of young girls experienced orgasm by age 15, 53% by age 20, and 90% by age 35. Approximately 9% of women from Kinsey's research reported never reaching orgasm. Like men, women vary at the ease in which they achieve orgasm. Some can experience orgasm just from fantasizing alone or from the stimulation of their breasts while others require very specific stimulation of their genitals. And unlike males, only 29% of women reported always experiencing orgasm during sexual activity. The duration of their orgasm also varies and usually lasts approximately 20 seconds. The subjective experience of orgasm typically lasts only a few seconds, while the muscles surrounding the outer third of the vagina contract rhythmically in a series of five to eight contractions shortly thereafter. Synchronous contractions of the anal sphincter and uterine muscles are evident in some women as well.

How Does Orgasm Actually Feel?

Somatic feelings that we undergo during orgasm are determined by specific genital responses. So, as ejaculation is characteristic of the male, in females we find vaginal or uterus contractions. As such, reports concerning the subjective experience of orgasm found no clear gender difference. Some descriptions of experiencing orgasm imply altered consciousness while others reported a loss of control not unlike that of an epileptic fit.

Sexual Arousal in Women: Clitoris and Orgasm

Approximately 90% of women reach orgasm from some form of sexual stimulation, though most women do not routinely experience it solely from sexual intercourse. Almost 100% of men routinely experience orgasm from sexual intercourse.

Orgasms are the culmination of sexual arousal and an orgasmic peak which serves to motivate individuals to engage in sexual intercourse. But even if orgasm is not reached, sexual arousal in itself is rewarding, and thus serves to increase our motivation to engage in it. In males, sufficient sexual arousal leads to ejaculation and orgasm. We can quite confidently conclude that it is possible for orgasm to occur in all male mammals. However, it is still unclear as to whether humans are the only mammals that experience female orgasms after heightened sexual arousal.

There is disagreement regarding the specific sexual stimulation that triggers orgasm in women. Women can reach orgasm through vaginal stimulation, direct and indirect clitoral

stimulation as well as stimulation of the internal areas surrounding the vagina. Another variation to note is that there are women who experience orgasm solely from sexual intercourse, while others require additional stimulation to the external parts of the clitoris if they are to reach orgasm during sexual intercourse. Sadly, some women never experience orgasm during intercourse under any conditions. These striking sex differences between male and female orgasms are not new to researchers. Some women may reach orgasm as easily and routinely as men, while others cannot.

The Psychological Components of the Orgasmic Experience

What Are the Orgasm's Functions?

It is obvious that male orgasms are intended for reproductive purposes in addition to sexual pleasure. In women, it is less obvious and not related to procreation. Consequently, it is interesting to mention the known orgasmic functions of this process:

- Orgasm serves as a reward, via the pleasure, for enabling intercourse to occur.
- It brings coitus to an end.
- Contractions of the muscles around the vagina stimulate the male to ejaculate intravaginally.
- It enhances the bonding of the couple, since the male is inducing the orgasm for both of them.
- Uterine contractions lead to the 'upsucking' of semen into the uterus.

Researchers suggested that in women, orgasm was not needed for reproduction and was just an 'add on' to sexual activity. When asked how orgasms were important to their happiness, 83% of women claimed that it allows them to feel closer to their partner, 79% wanted to see their partner sexually satisfied, 61% said that it allowed them to have open communication with their sexual partner, and 29% said that it was important for them to have an orgasm.

Females

One of the major questions about female orgasm is whether there is more than one kind of orgasm that occurs during intercourse (i.e., vaginal vs. clitoral). Kinsey challenged Freud's notion that clitoral orgasms are an indicator of sexual immaturity in contrast to the insensitivity of the vaginal walls. Moreover, it is a biological impossibility to see both types as distinct from each other. Masters and Johnson found that every orgasm must involve direct or indirect stimulation of the clitoris which led to the understanding that there is only one kind of female orgasm. An intriguing explanation was offered to suggest that women who mainly experience vaginal orgasms are more prone to anxiety than women who can orgasm by clitoral stimulation. It was suggested that women who rely on vaginal intercourse, prefer it that way since they are threatened by the intensity of clitoral stimulation and orgasm.

How Can Women's Pleasure Be Enhanced?

It should be clearly understood by both sexual partners that the responsibility for the woman's orgasm rests with both of them. This requires an understanding of what each party needs, choosing intercourse positions where the clitoris will be stimulated, and having open communication their needs and desires. The degree of stimulation, the location surrounding the clitoris, or even the pressure put while stimulating it may bring about different sensations for different women during this process. This is why it is so important to clarify it openly. Communication is thus of the utmost importance. Masturbation may be one of the best ways for the woman to learn what brings her pleasure. The benefits of masturbation include: improving orgasm consistency and frequency during intercourse, sexual desire, and even ways of treating the female sexual orgasm. Kinsey found that women who masturbated prior to marriage had a better chance of experiencing orgasm in the first year of marriage than those who did not.

The Orgasm Gap, and How to Address It

In a long-term relationship, partners can learn each other's desires and if they care, attempt to provide it sexually. In a single hookup, that is impossible to achieve for either gender. Both men and women need penile and clitoral stimulation to orgasm. But it is much more common to see fellatio rather than cunnilingus in a sexual hookup. Another reason for the gap in casual encounters is communication. Since childhood, women are taught that talking about sex is unacceptable, slutty, or un-lady like. In return, and especially in casual sexual encounters, they will not talk about their sexual needs, adjustments, pain, or wishes. They may not be sufficiently stimulated when intercourse is attempted, while men usually are.

But what may help reduce the orgasm gap in casual sex is for both genders to know their body (possibly through masturbation) and what they exactly want for full sexual pleasure. It may help for the person to ask themselves the following questions prior to the sexual encounter: what kind of sexual behaviors are appealing to me? What behaviors are clearly off-limits? If the partner suggested something new, would I agree to try it? Will I say 'no' to situations that I have not considered prior to our sexual encounter? This can help people prepare these questions ahead of time and address what feels good to them or what they would like to try in these situations.

In contrast, long-term partners may feel freer to voice what they need, like, or do not like sexually. Research found that cunnilingus is very helpful in assisting woman to reach orgasm, and since women feel more capable to ask for it in long-term relationships, they can orgasm more frequently than in casual encounters. Foreplay also has a key role in the woman's orgasm. Often, long-term partners enjoy sex even without an orgasm, which may not be the absolute goal of these sexual encounters.

However, sexual activity in these long-term partnerships commonly declines over time partly because men and women become desensitized to their partner's behaviors and cues that they became used to. Therefore, keeping communication open, telling one's partner what "works," experimenting with sexual behaviors, and describing what one prefers to one's partner, may revive their sexual relationship.

The Refractory Period

Orgasm is followed by a state of calm, along with a return of physiological manifestations. This includes the swelling of bodily tissues caused by increased vascular blood flow to pre-sexual levels. These changes can occur without orgasm as well, although they take much longer to resolve and may be accompanied by discomfort. The refractory period in males means that no amount of sexual stimulation could, for a specified time, bring about another orgasm. As a man ages, his refractory period becomes longer. While it may take minutes for a young male, in the older man, the refractory period may be hours or even days. In their lab, Masters and Johnson observed that females can reach another orgasm in a matter of minutes and suggested that they do not have the refractory period like men do. In contrast, Kinsey reported that only 14% of women reported experiencing multiple orgasms on a regular basis. The refractory period, at least in the male, has an obvious reproductive benefit. Too many frequent ejaculations would cause a decline in sperm count and thus, make the man become less fertile.

Female Ejaculation

Some women pass fluid during orgasm. And in thinking that it is urine, it causes them concern and embarrassment. It is conceivable that in some cases it is, indeed, urine which they expel. However, that fluid has mostly been reported to only include prostatic acid phosphate. This raises the possibility that remnants of prostatic tissue may be found in some women and may account for the fluid. It may be reassuring to those women who eject fluid during orgasm that it may not be urine that is expelled but actual ejaculation.

How Do We Respond to Sexual Stimuli?

Not surprisingly, research has indicated that both men and women can produce genital responses at will in response to sexual thoughts, fantasies, audio or visual erotic stimuli, or pornography. Smell, or as it is referred to as ‘pheromones’ are considerably important in the sexual behavior of most animals. In the animal kingdom, urinary and vaginal odours indicate that the female is in oestrus, a recurring period of sexual receptivity and fertility in many female mammals that is attractive to the male. As of yet, it is still unclear how olfactory stimuli influences sexual arousal and its precise effect on human sexual responses. However, in light of the very active market of scents, perfumes, deodorants, and scented creams, anecdotal evidence about the effects of olfactory cues on some people has suggested that it has a profound role in human arousal. Interestingly, the maintenance of the relationship may be motivated by smells which the partners find appealing, and thus, should not be ignored.

How Do Hormones Play during Sex?

Hormones are powerful chemicals that are produced by the endocrine system. This involves a collection of glands which produce hormones to regulate several bodily functions including our

metabolism, growth and development, sexual function, reproduction, sleep, and mood. Hormones are secreted directly into the blood system and thus, rapidly affect areas close and distant from their source. The most important sex hormones are testosterone (which is mainly produced by males) and estrogens and progesterone (which are mainly produced by women).

In males, the pituitary gland and testes produce hormones. The testes produce the "male" hormone called testosterone. This chemical has several important functions in stimulating the secondary male characteristics, such as maintaining the genitals and their capability to produce sperm, as well as stimulating the growth of muscles and bones. *In females,* the ovaries produce estrogen and progesterone. Estrogen stimulates the growth of the breasts, uterus and vagina, enlarging the pelvis, and maintaining the mucus membranes of the vagina. In adult women, the levels of estrogen and progesterone fluctuate according to the phases of the menstrual cycles, pregnancy, and menopause.

It is well known that many animal species regulate their sexual hormones and activity according to the yearly seasons when they may be fertile. This ensures that they are only available for mating during specific seasons. And although humans can have sex year-round, birth records indicate peaks during some seasons. It appears that the highest number of births occur during late summer and early autumn. This suggests that sexual activity and conception peak during the darkest winter months, while sex occurs much less frequently in late winter and early spring. That provides evidence of the importance of the seasons in regulating the production of sex hormones, emphasizing the connection of the environment, the brain, and the reproductive system.

Visual stimuli are also a major importance in eliciting sexual interest, desire, and arousal. Our Western culture is aware of it and makes regular use of that fact. Generally, erotic films are known to be more powerful in arousing men's sexual response than fantasies are. What is considered sexually attractive to men and women is quite complex and reflects the different criteria of males and females.

Touch is, naturally, an important source of erotic stimulation as well. Erotic touch on the genitals can produce erection in the male, and blood pooling in the female's labia area. Although, tactile stimulation of other areas in the body can also be intensely erotic.

Taking One More Look at Women's Sexual Response

Since the 1990s, we have seen a surge of empirical research on women's sexual response. Prior to the mid-1990s, women's sexual responses were viewed as complementary to men. Research by Masters and Johnson as well as others had believed that models of female sexual responses, desires, and expressions were identical to those of men. More recently, however, this genderless perspective on sexuality has been challenged as inadequately capturing women's unique experiences.

Examining different *models of sexual response*, we find the original conceptualization and clinical work of Masters and Johnson to state that sexual responses emerge from internal drives, not unlike hunger or thirst. Other researchers expanded on what Masters and Johnson described, and together, created the tri-phasic manner in which both genders experienced sexuality: sexual desire as the instigator of a sequence of events leading to arousal and eventual orgasm. It appears that women view the distinction between sexual *arousal* and *desire* as artificial, as was found through measures which reported an inability to separate desire from items of arousal. A

newer model of sexuality, the Incentive Motivation Model (IMM), proposed that sexual desire and arousal are reciprocally-reinforcing, meaning that sexual desire emerges after sexual arousal is experienced, and arousal is the experience that reinforces sexual motivation. For example, feelings of sexual arousal may represent an awareness of genital changes resulting from sexual stimulation, perhaps combined with a conscious evaluation that the situation is indeed sexual. Sexual desire, on the other hand, may represent the experience of a willingness to behave in a sexual way, and takes place when feedback from physical changes goes beyond the threshold of perception.

Do Men and Women Experience Intercourse Differently?

Attitudes, behaviors, sensations, drives, emotions, and cognitions all constitute the experience of sexual intercourse. Research has repeatedly demonstrated that men and women differ in their attitudes, behavior, and physiological responses. However, little research was done to explore gender differences of subjective experiences of sexual intercourse. To date, most research has neglected to explore the totality of the sexual intercourse experience.

Evolutionary psychology is a branch within the discipline of psychology, that attempts to learn about humans from an evolutionary perspective. Within the field of sex research, theoreticians have attempted to explain how gender relates to sexuality, as well as to predict differences in the experience of heterosexual intercourse between males and females. They suggest that the differences found between genders in sexual desires, attitudes or behaviors may have contributed to the obligatory parental investment of each offspring. Men will aim to succeed in short term mating. However, short-term and long-term success in mating requires solving some problems that men and women faced during the process of evolution. Historically, men needed to engage in many brief affairs with fertile women, but did so while minimizing commitment and investment in those women until the right one is found. On the other hand, women who searched for a mate, had to assess the quality of the man's genes and their ability to provide immediate resources to look after the family for the long-term. When aiming for a long-term mating strategy, men had to ensure of their paternity and be certain that the offspring were theirs. Women needed to identify men who would be willing and able to invest resources in them and in their offspring on a long-term basis. Both genders needed to identify a mate with good parenting skills who would be willing to form a committed relationship.

Evolutionary theories predicted that men and women need to cope with different sets of problems to succeed in short- and long-term mating – especially in the experience of sexual intercourse. For instance, women may use the sexual encounter as a way to assess and evaluate their partner's characteristics and value. This experience may also reveal their intentions, earnestness, and ability to be committed to them for long-term relationships. In turn, it makes sense that women will place greater emphasis than men on interpersonal aspects during sexual intercourse. Another approach suggested that women and men rarely receive the same socialization about sexuality. As men grow up, they usually receive more positive reinforcement for engaging in casual sex. They are permitted to openly express their sexual needs and focus on physical pleasure, while women receive positive reinforcement for restricting their sexual expression to committed relationships. Therefore, men and women

exhibit different sexual desires, attitudes and behaviors, as well as experience their sexuality differently.

Regardless of the perspectives reviewed above, it is generally agreed that women adopt a more emotional-interpersonal orientation to sexuality, whereas men develop a more recreational orientation toward their sexuality. Women are occupied with the relational aspect during intercourse, which she interprets as a sign of love and a confirmation of the romantic relationship she has with the man. Men, on the other hand, emphasize the pleasure and satisfaction derived from the sexual act itself. When motivation for sex was examined, research indicated that women were motivated to engage in sexual activity seeking love, commitment, intimacy, and closeness. For men, sexual motivations included the need for gratification, fun and physical release.

A recent study indicated that heterosexual intercourse is a complex experience which includes three different stages. The first one focuses on the romantic relationship with the sexual partner and reflects the person’s emotional and cognitive transactions that he or she has with the partner during the act. This may include things such as feelings of being loved and esteemed by the partner, feeling love towards the partner, and focusing on their needs and reactions during coitus. The second stage is the worry-centered pattern, which reflects people’s possible negative reactions to the sexual act. What we mean here are the negative and immoral meanings that this activity may have for some people. Personal vulnerability, the lack of a partner’s sexual competence or even the lack of sexual adequacy in oneself all encapsulate the interfering thoughts one may have. In the third stage, the pleasure-centered sexual experience consists of feelings reflecting the orgasmic cycle of excitement-pleasure-relief-satisfaction. Interestingly, that occurs together with a sense of power, strength, and cognitive/emotional dissociation from the environment while focusing one’s attention on reaching the orgasm. It is said that during the moment of orgasm, the person is completely dissociated from the environment to such a degree that even a mother to a newborn child will not hear its cry during orgasm.

Examining the genders’ experience of intercourse, evolution would suggest that women would be more selective in choosing their mate, since they are the ones who are mainly responsible for their offspring and need a mate who is ready to establish a long-term relationship. Having to make such an important decision, sexual activity and intercourse become a sort of an evaluation procedure for finding the right male to be with. Men, as compared with women, reported being more centered upon their partner’s needs, thoughts, and reactions. They tended to be more preoccupied with pleasing their partner and being less able to give up control. In other words, for men, sexual intercourse is just that: an opportunity to enjoy a pleasuring experience for themselves and for their partner.

What Is Sexual Arousal?

Dr. Erick Janssen, a sex theorist and researcher, posed the question of what men’s sexual arousal actually is. He responded by writing that, “In short, we don’t know. Although its main indicators (including, for men, penile erection) may be well recognized, we do not know what is necessary or sufficient to label someone as being sexually aroused. Most men may be capable of having erections. Most men may know what it feels like to be sexually aroused. But despite

the generally high correlations between erections and subjective arousal, men do not always report feeling sexually aroused when they have an erection, nor do they always experience an erection when they feel aroused." And, indeed, erections may occur during times where no sexual stimuli are present, such as in non-erotic sleeping periods. For instance, it was found that men can get erections in response to rape films without being subjectively aroused. The opposite was also observed where men experienced sexual arousal without erections, such as in strip clubs, for example. These findings underscore the complexities involved in establishing the necessary and sufficient conditions for sexual arousal.

Sexual Arousal and Emotion

Emotion theorists attempt to understand how feelings come about. Some suggested that sexual arousal fits the definition of an emotion. It involves feelings, bodily reactions, and prepares the person for action, just like other emotions do. It interacts with other positive and negative emotions in a complex manner. Positive emotions may facilitate sexual arousal in men. There exists a complicated relationship between negative states and sexual arousal in men. A negative mood induction resulted in reduced genital responses in men, although it did not impact subjective sexual arousal. Several studies have indicated that genital arousal can be facilitated by anxiety in sexually functional men.

Sexual Arousal and Genital Feedback

Emotion theorists were intrigued by the question of how the body and mind, specifically feelings, interact, which is relevant to sexual arousal. For example, the association between genital responses and subjective sexual arousal are higher in men than in women. This has led researchers to speculate that in men, subjective sexual arousal is informed by feedback from their genitals.

Sexual Arousal and Desire

Another aspect of sexual arousal is its connection to sexual desire. Traditionally, sexual *desire* has been seen as a motivational state which directs behavior, while sexual *arousal* has been seen as an emotional state. Yet, there is considerable overlap in these approaches. Emotions are most commonly defined as action influencers. Both sexual arousal and sexual desire are considered by some as emotional states which prepare the person for action. So, how different or similar are the subjective experiences of arousal and desire? It was found that men do not, commonly, separate desire from arousal as perhaps was once assumed. And as we mentioned previously, desire can be experienced without genital response, as erections may occur in the absence of desire. Research found that men who watched a rape film, experienced higher levels of sexual *arousal* than women. However, levels of *desire* in response to the film were low and did not differentiate between men and women. As such, desire could be described as the conscious endorsement of arousal reaching the conscious awareness of the person. This notion

is consistent with the idea that desire is an experience that follows, instead of precedes, the activation of sexual arousal.

The Way People Define Sexual Desire and Sexual Arousal

How Experts Define Sexual Desire and Arousal

Sexual desire has been broadly described by some researchers as the sum of forces that lead us toward sexual behavior. Others see sexual desire as a psychological state experienced by the individual as an awareness to want sexual activity or orgasm. These two examples exemplify that most expert definitions of sexual arousal are generally broad. Thus, arousal includes a range of mental and physical processes that include processing relevant stimuli, arousal in a general sense, and genital response. That view of arousal addresses mind, body and motivations toward reaching the goal of orgasm.

There is some indication that there is a circular relation between desire and arousal, such as desire feeding into arousal feeding into desire. In a focus group study, women aged 18–84 years reported desire as preceding arousal, and at other times, said that it followed arousal. Others reported that they perceived sexual arousal without any experience of sexual interest/desire. In contrast, there exists a paucity of studies on men's experiences of sexual desire. Men reported that they did not consistently or easily distinguish between sexual desire and arousal. And so, it appears that there is diversity in women's and men's experiences of sexual response and that no one model fully captures this diversity.

Women's Sexual Desire

Diminished sexual desire is the most common reason motivating women to seek sexual counseling. Yet, our understanding of this aspect in female sexual functioning is limited and continues to be a challenge in both clinical and basic areas of sex research.

The importance of intimacy's role in women's sexual responses have been well documented by researchers. It was argued that while men tend to approach sex as a way to experience intimacy, women experience desire and engage in sex in order to deepen intimacy. However, some researchers argued that excessive emotional closeness may be detrimental to sexual desire.

For instance, intimacy in the form of fusion between partners kills desire. In light of those findings, some researchers encourage the introduction of '…a healthy distance and individuation…'and suggest that distance can facilitate sexual desire. Desire can be sharpened by withdrawal or abstinence. Fantasy, hope, and promise may also stimulate desire. In addition, physical distance, openness to novelty, and curiosity have been linked to sexual desire as well.

A key to female sexuality is to be desired by another person. And thus, seduction by a partner is a prerequisite for the development of desire. Sexual fantasies provide support for the need of external affirmations. For women, the reception of such themes like having sex with a stranger, center around the confirmation of their sexual value and attractiveness. Research of 662 premenopausal women about their sexual desire showed that decreased desire in long-term

relationships have often been attributed to increased intimacy between partners. Thus, leading to overfamiliarity and sexual disinterest.

What to Do When Each Partner Has a Different Level of Sexual Desire?

Research has shown that high sexual desire and satisfaction in a relationship are linked with relationship satisfaction, love, and commitment for both men and women. It has been consistently shown that sexual activity and the relational well-being of a couple are closely related. In that, higher sexual satisfaction contributes to increased relational well-being. Greater sexual activity has also been found to be positively related to sexual satisfaction in relationships, particularly for men. Additionally, sexual desire is positively correlated with marital satisfaction and fewer negative partner interactions. Therefore, when one's desire for one's partner is low, it indicates that the quality of the relationship is deteriorating and that the couple is experiencing stressful times with psychologically ill effects.

Sexual desire is often assumed to precede sexual involvement in the sexual response cycle, although engaging in sex without desire is not uncommon. Thus, it was suggested that sexual desire forms the motivation to exhibit sexual behavior and is linked to feelings of romantic love. Consequently, some researchers proposed that sexual desire and not sexual frequency needs to be seen as predicting the relational stability.

Gender Differences

Strong and consistent gender differences have been found in relation to sexual behavior and attitudes. On average, men report higher levels of sexual desire than women who complain of low desire during sex therapy. Researchers have suggested that sexual behavior, the dynamics of the relationship, and the length of time of the relationship are interconnected and influence one another. Discrepancies between sexual frequency and desire may affect relationships in a variety of ways based on the duration of that relationship. Not engaging in sexual behavior as frequently as desired will likely be associated with lower relationship satisfaction and stability. While on the other hand, having high sexual desire for a partner and low frequency sets up an incentive for improving the relationship.

It was postulated that women's sexual desire is linked with feelings of love, desire, and intimacy. Women with high sexual desire may also have high levels of passionate love and attachment to a given partner. Consequently, high sexual desire may motivate some women to invest more resources into the relationship. Thus, enhancing future sexual contact, and increasing the intimacy and closeness in their relationship.

*

A guy and girl had a sex poem competition.

Guy: "Two times two is four, four plus five is nine. I can put mine in yours, but you can't put yours in mine."

Girl: "Two times two is four, four plus five is nine. I know the length of yours, but you won't know the depth of mine."

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Chapter 4

Our Sexual Behaviors, and How They Are Formed

> I worked, as a psychologist, in a Canadian jail for almost three decades. Many of the prisoners, or residents as we called them, were jailed for sexual offences. I remember conducting an initial interview with a 40 plus old man who recently came from an African country. He was sentenced to 18 months. I asked him, as I did with all incoming residents, to describe his crime. With great surprise at his jail sentence, he informed me that it was the responsibility of the father, in the country form which he came, to deflower his daughter and guide her in sexual matters. This was so that she would be properly ready for marriage. This interesting case brings to mind that human sexual behavior is influenced by various factors, and among them culture, religion, personal beliefs, and one's personality.

We All Want a Fulfilling Sexual Relationship

The success of sexual relationships depends on, both, the physiological and the social relationship. A relationship that is characterized by intimacy, commitment, psychological comfort, and good communication which contribute significantly to a sexually satisfying partnership. Let's briefly examine the various factors that enhance sexual relationships:

Intimacy – The 'ingredients' of intimacy include mutual care, respecting one's partner, and responsiveness to each other's needs. It is commonly seen as the foundation of a satisfying sexual relationship. So, while we can have sex without intimacy, intimacy gives it depth and meaning beyond just a physical release.

Commitment – Masters, Johnson, and Robert Kolodny, the famous sex researchers, concluded that commitment is the most important factor in a sexually satisfying relationship. When a couple is committed, it appears that both men and women exhibit better sexual responses. Committed individuals feel free and safe to give themselves completely to their partner, which ultimately enhances their intimacy and sexual relationship.

Psychological comfort – An important but commonly ignored factor in successful relationships. Being uncomfortable with a partner can easily disrupt and even prevent one's sexual response. A lack of commitment driven by distrust contributes to a lack of psychological comfort.

Good communication – Communication has been hailed as the cornerstone of a good and satisfying sexual relationship. Clearly communicating what is arousing to a partner, how stimulation should be carried out, and what is the desired position and frequency of sexual activity can greatly enhance sexual satisfaction.

Knowledge of the sexual response cycle – and realizing that men's cycle is different from that of women can greatly enhance their sexual satisfaction. They can learn about their partner's state and whether anything additionally needs to be done to enhance the partner's arousal or satisfaction.

Emphasis of 'other enjoyment' – Self-centredness is not part of a satisfying sexual relationship. Rather than watching oneself and how they perform, they are focused on pleasing their partner when it is their turn to please, stimulate, and express their desire.

Good mental and physical health – Our sexual response is significantly affected by our physical and mental health. Good sex can happen when our health is high and we are feeling in shape. Health problems, like chronic pain, can make sexual activity undesirable or non-enjoyable. Illnesses, such as diabetes in men may cause erectile problems, while women who are diabetic may suffer vaginal dryness and discomfort. Emotional health, which is equally important, involves how we think, cope and adapt to change. It focuses on our dominant emotions. Having a chronic mental health problem and distrust towards others may lead to a loss of interest in sex and a lowered ability to respond to others sexually.

Do Men and Women Differ in Their Sexual Behavior?

Women's Genital Touching

For more than a century, scientists have attempted to understand and describe women's sexual pleasure, her orgasm and whether there are various 'types' of orgasms that women may have. Along these years, scientists and theoreticians went from considering vaginal orgasm as 'mature', to understanding that clitoral stimulation is required for female orgasm. This stark progression has opened up the discussion of the female orgasm – even offering various descriptions of different stimulations that are likely to facilitate orgasm from both genital and non-genital stimulation.

Additionally, there has been an emphasis on understanding what women subjectively feel when experiencing sexual pleasure and orgasm. Previous research has often focused on the stimulation of particular body sites such as the clitoris, "g-spot," "a-spot," breasts/nipples, where vibrators can be placed, or what penile-vaginal intercourse positions can add to the woman's stimulation. A study which addressed the gap between what is known theoretically and what we have discovered empirically about women's orgasm explored women's experiences related to orgasm and sexual pleasure. They focused on detailed aspects of genital touch and stimulation. It was discovered that some kinds of genital touching or stimulation were more often preferred than others. Interestingly, most women preferred a relatively small number of touch techniques, indicating that communication is of the utmost importance for enhancing sexual pleasure rather than touch. Women gave varied responses regarding the location, pressure, shape, and pattern of genital touch. Most women preferred light to medium pressure, though about 10% preferred firm pressure. Locations for the most effective touching areas was identified as directly on or around the clitoris. Regarding the "shape" or style of touch, most women preferred an up-and-down, circular, or side-to-side motion. All in all, the women preferred from 13 to 15 different patterns of stimulation during partnered genital touch.

As far as orgasming during penile-vaginal penetration, it was found that many women can, in fact, reach orgasm just from vaginal penetration. However, added clitoral stimulation increases the percentage of women who can orgasm. When asked about the quality of their orgasm, more than three-quarters of women reported that some orgasms feel better than others, indicating that adding clitoral stimulation improves the quality of their orgasms. However most

women reported that better orgasms were directly affected by spending time building arousal, being familiar with their partner, and emotional intimacy. The duration of sexual activity is less important to women than to men. Thus, it is important that clinicians and sex therapists discuss with clients the dimensions of clitoral stimulation. This will help men become aware that sexual pleasure for the woman is closely related to these dimensions.

Recent Data on Americans' Sexual Behavior

A recent study explored sexual behavior, sexual attraction, and sexual orientation among 10,416 American women and men aged 15–44 years old in the United States. This comprehensive report yielded the following results:

Sexual behavior – It is encouraging to learn that 94% of women and 92% of men had vaginal intercourse, 86% of women and 87% of men had oral sex, and 36% of women and 42% of men had anal sex. Regarding same-sex sexual behavior, almost triple the number of women aged 18–44 (17%) have had same-sex contact compared with men (6%) at the same ages. Interestingly, percentages reporting specific types of sexual experience with opposite-sex partners generally increased with age in both men and women.

Sexual attraction – 92% of men compared to 81% of women claimed that they were attracted “only to the opposite sex.” Similar patterns of sexual attraction by age were seen for both women and men.

Sexual orientation – Among adults aged 18-44, 92% of women and 95% of men said they were heterosexual or straight. One percent of women and 2% of men said that they were homosexual, gay, or lesbian. Six percent of women and 2.0% of men said that they were bisexual.

Sexuality and Culture

The Influence of Culture on Sexual Behavior

It is known that biology and evolution play a role in sexual desire and behavior. In particular, testosterone levels highly influence sexual desire. Evolution had to make sure that we would want to procreate, as that is how the human race can survive and thrive as a species. However, our society requires us to live by the rules in order to get along and make communal life possible. Social norms and standards dictate how we should behave, and those are significantly influenced by our culture and era. Social messages emphasize men as being big, dominant, and sexually charged by attractive women. As such, many are aware of the social expectations placed onto men regarding the ways that they should perform. Recent research found that men's close male friendships are actually closer and more intimate than we commonly think of them.

Almost every aspect of sexual behavior may be affected by cultural norms; and we are not just talking about sex. It ranges from displays of affection to sexual initiation – indeed, everything from the when to the what and how of sexuality. Ethnic groups expect people to marry within their race, class, and religion. And when they do not, the family may react

negatively. Sex norms, practices, and preferences are strongly influenced by culture, class, race, and gender.

Sexuality examined from a cultural perspective is filled with paradoxes and contradictions. It is not uncommon that sexual values, beliefs, traditions, and norms contradict one another, even in the same culture. Take for example the dictation, by some cultures, that women are to be virginal until married and sexually ignorant so that they can be taught and sexually molded by their husbands. The men in those cultures are expected to be sexually experienced, and full of sexual prowess and power. One may wonder, however, that since women are supposed to be virginal until they marry, with whom are those men supposed to gain all the experience and knowledge that they are expected to have? This is but one example of a norm which is difficult to understand, explain, and probably follow. The patriarchal worldview that gave rise to such norms has encouraged to the normalization of abuse against women worldwide.

Religion, more than any other institution, has shaped sexual norms, practices, and beliefs. It is said that Islamic cultures are ‘sex-positive’, while Christianity traditionally depicted sex as sinful. Christians (and Orthodox Jews) have viewed celibacy as ideal unless the individuals were married. Marriage was simply a ‘permission to sin’, and was primarily intended just for procreation. In contrast, cultures in the East, while patriarchal, have celebrated and rejoiced in human sexuality, but mainly about heterosexuality. The positive Muslim attitude towards sexuality is evident in the Koran, where Mohammed (the chief prophet) teaches his followers that intercourse preserves human health. Their folktales include explicit sexual instructions and sex manuals that still circulate to this day in the Muslim world. Eastern cultures allow and condone books about sexuality, and few have not heard of the Indian *Kama Sutra*, the Hindu guide to lovemaking. In Jewish culture, a healthy marriage includes a fulfilling sexual relationship where the husband is obligated to provide his wife with sexual satisfaction. Sexual fulfillment for both partners are also encouraged, so much so that Judaism sees a refusal to engage in sex possibly leading to annulling the marriage.

Consequently, the Chinese have never equated sex with committing a sin or feeling guilty. In ancient China, sexual activity was regarded as an indispensable activity to reach the harmony of the two opposing forces; the yin and the yang. Moreover, appropriate sex methods were seen as a way of achieving immortality. The Taoist handbook on sex focused on the man’s role of pleasing his woman, and taught men how to refrain from losing their semen while giving their sexual partner as much pleasure as they could. It’s enlightening, especially in the Western culture, to review the terms that Taoists used to describe women’s genitals as metaphors of beauty, sweetness, artistry, rareness, and fragrance. Sexual frustration was seen as something to avoid, as it was believed to threaten women’s health. As we can see, most religions (aside from Christianity) shared the belief that God created humans with sexual organs desires for procreation and pleasure as well.

Although, changes in approaches to sexuality exist even within the same cultural group. For example, Orthodox Jews are required to practice a high degree of segregation between genders, and even as much as a handshake is prohibited. Once a woman is menstruating, partners are not allowed to sexually touch each other until her period has ceased and that she has visited a mikvheh, or cleansing bath. Sexual activities may only occur once her period is over. Non-Orthodox Jews do not practice such rituals and lean towards a high degree of reciprocity between the genders. Roman Catholics also differ markedly amongst themselves. While the Irish have a long history of sexual repression, Italians are much more sexually expressive. Italian women are used to, and accept, sexually flirtatious comments, and even

some sexual touching by men. Naturally, this behavior would not be tolerated by Irish or German Catholics.

Sexual stereotypes clearly affect our perception of that culture. Such stereotypes include that Latinos are “hot blooded” or passionate, that African Americans are highly sexed, and that Asian women are exotic or submissive. The Hopi Indians viewed women’s sexual desire very differently from the West. They saw women’s sexual desire as an engine that can bring about cosmic harmony, while Europeans saw not divinity, but depravity. Europeans, who equated sex with shame, saw hell where the Pueblos saw pleasure. Spanish Catholic priests maintained that those very women who were “promiscuous” and “Lascivious” were incarnations of the devil. In reviewing American stereotypes, African American women were seen as equally strong and unshakable, but also lesser than their Caucasian counterparts due to years of slavery and discrimination. This has affected many African American women by making them hesitant in allowing themselves to be vulnerable in intimate relationships. And since these women are also hypersexualized, they are vulnerable to sexual harassment, sexual violence, and abuse.

The double standard is also affected by culture. For instance, it is condoned for Mexican American men to have multiple sex partners while women are expected to be faithful. A young Latina who is in love is expected to be submissive and thus, give in to her boyfriend’s sexual demands. In more extreme cases, female circumcision or more precisely, female genital mutilation is an illustration of a double standard which has been considered normal in parts of the Middle East and Africa for centuries. That cruel and barbaric procedure is, basically, a clear violation of human rights, and has serious repercussions on the emotional, social, sexual, and physical well-being of girls and women. The culture dictates the age of circumcision. In some places it is done during infancy, but more commonly just before puberty, and in other areas even later.

On the other hand, the Japanese segregates boys and girls from an early age until marriage. Another Japanese “invention” are the geishas. Geishas were highly talented women who were trained as hostesses and entertainers, as well as sexual partners for men. They were intended to fill the void of prohibited female company, meaning that men could still have sex when, formally, they were not supposed to associate with women. The general suppression of emotion as is seen in the Japanese culture results in couples who have very little experience relating to each other and have mainly less than satisfactory relationships. Japanese culture has also cultivated an extensive sexual fantasy world which includes the use of ’love hotels’ that mainly men can use to play out their specific sexualized fantasies without emotional involvement.

The Effect of Culture on Love, Sex and Intimacy

Falling in love is a universal experience. However, and as we may well know, families and even communities do not always agree with couples’ choices. Love influences what we deem as desirable, whether we will be involved in monogamous relationships with an opposite sex member, and the sorts of sexual activities we will engage in (i.e., vaginal-penile intercourse). Generally, families support their children’s choices if they conform to cultural dictates: marry within your class, your race, and your religion, and marry someone of the opposite sex. In Western culture, women are encouraged to marry someone who is taller, older, smarter, and of higher social status. But in other cultures, women essentially have no say about who they will marry or even when it will happen. For instance, Nigerian girls who may be 14 or even younger

are chosen to marry, have sex with and relocate with their older husbands without negotiation from their parents. In Asian Indian cultures, marriages are traditionally arranged by parents and love is not usually a variable to be considered.

Cultural differences between partners may also present problems for the couple. In Japanese culture, the man is expected to be very attentive and romantic while he courts his future wife, but when married, begins to focus on his job more than his spouse. Consequently, a woman who is not Japanese may be shocked to marry a Japanese man and find that he hardly has any time for her after the marriage. In contrast, the Irish have a reputation of speaking freely, but experience difficulties in intimate relationships. In that culture, romance is not a central concern, and partners tend to resign themselves to emotionally distant marriages.

Interestingly, abortion was recently legalized in Ireland while emotionless marriages were not. Here we see another paradox of sexuality, gender, and culture. Imagine a marriage between an Irish woman, who is used to distance when there is a conflict in the marriage, and an Italian man who is used to freely expressing his feelings and concerns. Obviously, that union could become unsuccessful and dissatisfying.

Similarly, beliefs related to marital infidelity are also dictated by culture. As such, some cultures may not talk about these issues, others may tolerate it and some may even classify it as a punishable offence resulting in death. Paradoxically in many cultures, men's' infidelity is tolerated, while women who do the same are seen as sinners; part of the double standard.

To practice effective sex therapy, the therapist must be aware and insightful into the interface between culture and sexuality. Our roots affect us, including our sexual behavior, our beliefs, attitudes, and practices. These factors play a significant role in our lives, as well as in our sexuality and romantic relations. Therefore, they need to be examined during sex therapy, especially of marriages where partners are from different cultures and religions.

Gender and Sexual Behavior

While the genders are basically quite similar in their sexuality, differences do exist between males and females. These differences are in masturbation, attitudes about casual sex, the use of pornography, the consistency of orgasm during sex, and one's sex drive.

Masturbation – Both men and women masturbate, but differ in their frequency. Kinsey and his research team reported that 92% of males had masturbated to orgasm at least once in their lives, as compared with 58% of females. Moreover, women began masturbation at a later age than men did. Virtually all men said they had masturbated before age 20, but a large percentage of women reported masturbating for the first time at age 25, 30, or 35. This gender difference still appears in recent studies despite the many years that has passed since Kinsey's research.

Attitudes regarding casual sex – Another substantial gender difference is related to attitudes towards casual sex such as a "one-night stand," where there is no emotionally committed relationship between the partners. It was found that men are much more approving of such sexual behavior than women. One study has gained legendary status researching that attitude held by men. Female and male research assistants, who were confederates of the experimenters, approached opposite-gender people and invited them to engage in casual sex. Apparently, women did not agree to participate in such behavior, whereas 70 percent of men did. Evolutionary theorists explain that it may serve as evidence of men's selection to have sex

with many partners, and women's selection to be choosy. However, socialization explanations are equally plausible, as girls are taught to be weary of men approaching them in fear of being raped. Boys are not given that message. Several other experiments support these socialization explanations.

Use of pornography – This is the third substantial gender difference. Men report using significantly more pornography than women. A plausible explanation may be that in our society, most erotic and sexually arousing media has been geared for the male gaze. That is based on assumption that women are not interested in such things. Research indicates that both genders are interested in porn, whether they admit it or not. Much insight into the responses of males and females to erotic materials was provided by a 1975 experiment. The participants in that study were sexually experienced university students whose responses were examined while they listened to tape recordings of erotic stories. The respondents provided self-ratings, but in addition, were also subjected to a collection of physiological measures as well. Men were fitted with a penile strain gauge that measured the blood engorgement of their penis, while women's physiological arousal was similarly measured by a photometer which measured their physiological arousal. That research yielded two important results: (1) The great majority of both males and females responded most strongly, both physiologically and in self-ratings, to the erotic and erotic-romantic tapes. (2) Women were sometimes not aware of their own physiological arousal.

To summarize, this study indicates that, contrary to public belief, both genders are quite similar in their responses to erotic materials but women may be unaware of their own physical arousal. Similarly, recent studies using fMRI brain scans to examine gender differences in response to erotic materials have indicated that the brain regions that fire are the same in women and men.

Orgasm – Men experience orgasm during sex more frequently than females do. It was found that 91% of men and only 64% of women had an orgasm during their most recent sexual encounter. The gap is narrower for orgasm achieved during masturbation, but here as well, men are more frequently able to reach orgasm (80%) than women (60%).

Sex drive – Various sources, as is popularly believed, indicated that men have a stronger sex drive than women do. Men are known to think about sex much more frequently and have more sexual fantasies on a daily basis. They desire more sexual partners and want to have intercourse more frequently as well. A study that examined gender differences in the preferred number of partners across 52(!) nations worldwide corroborated these results. A 2012 study regarding the number of times per day that each gender thinks about sex found that men thought about sex, on average, 19 times a day compared with 10 times a day for women. Furthermore, an important study published in 2000 regarding female sexual systems found that:

- Women show more changes in their sexual activity over time than men do.
- Women, more than men, are influenced by religious teaching and education.
- Jailed women, much more than jailed men, are more likely to engage in homosexual activities.
- Women are more likely to change sexual orientation than men are.
- Men initiate sex more often than women do in relationships.
- Men masturbate more often than women.
- Men seem to have less problems with sexual desire, as compared to women.

- Men watch pornography more often than women.
- Men reach orgasms more reliably and easily than women.

What Is Responsible for Those Gender Differences?

There are several current theories which offer predictions about possible gender differences and attitudes about sex. Amongst them are theories grounded in evolutionary psychology, cognitive social learning theory, and social structural theory. *Evolutionary theory* suggests that in order to ensure successful reproduction, it is necessary for men to maximize the number of viable offspring who pass on their parents' genes to successive generations. In turn, this increases their search for appropriate females to with whom to mate. *Sexual strategies theory* suggests that women focus on ensuring the survival of each offspring by choosing a mate who will provide resources for their family. Since women cannot give birth to a large number of offspring, it stands to reason that they will look for a specific male who can ensure their survival. Men, on the other hand, aim to pass on their genes and would prefer many short-term sexual liaisons in the hope of spreading their genes to as many women as possible.

In terms of sexual *attitudes*, evolutionary psychology predicts that men would be more accepting of attitudes requiring little sexual commitment than women. This includes attitudes toward premarital sex, extramarital sex, attitudes casual sex, and general sexual permissiveness. Sexual strategies theory views women as looking for men with immediate resources in short term mating. But when selecting a man for a long-term relationship, they search for one with potential for future earning and resources. Men are much less choosy regarding the women they have sex with within the short term, but for the long-term, become more sexually exclusive.

Cognitive social learning theory stipulates that learning occurs by observing others' behaviors and modeling after them. Although people can rarely observe others' sexual behaviors directly, they are subjected to the sexual behaviors and attitudes that seen shown in general media. This places a great influence on our attitudes towards sex and sexuality. Research found that increased exposure to media is associated with more sexually permissive attitudes and behaviors. Hence, cognitive social learning theory postulates that women will, across time, imitate the sexual permissiveness portrayed by the media, and end up decreasing the gender gap for sexual behaviors and attitudes.

Social structural theory proposes that any psychological gender difference is the consequence of gendered divisions of labor and disparities in power. Men, who are physically stronger than women, were historically designated to work out of the home to become the "breadwinners" of their household. On the other hand, women looked after their offspring and were known as "homemakers." The breadwinner commonly has more power and status than the homemaker, providing men with more power over women. They were the ones to control family resources and have more influence than their mate. Consequently, this theory suggests that women are perceived as less valuable than men and serve as only the objects of male sexual satisfaction. Thus, more dominant men may devalue women as sexual objects and use them for casual relationships without committing to a long-term one. And as women hold less power than men, they must also rely on them for the provision of goods, and thus, seek long-term relationships powerful men. Therefore, social structural theory proposes that gender differences in sexuality are a result of gender differences in power.

To conclude, the three theories presented are not mutually exclusive. Evolutionary psychology, cognitive social learning theory, and social structural theory all agree that gender differences are evident for specific sexual behaviors. Namely, that men are typically more sexually active and more sexually permissive than women. Cognitive social learning theory and social structural theory propose that cultural attitudes and norms regarding gender empowerment may influence these behaviors in men and women.

Sexual Expression

Sexual attractiveness is an important component in sexual expression. The two characteristics that both men and women universally consider as the most important for sexual attractiveness were youthfulness and good health, as according to a 1951 study. In addition to that, other aspects may be attributed by one's culture. This may be explained from an evolutionary perspective. Theorists suggested that all animals, including humans, desire to reproduce, and consequently, adopt reproductive strategies. The goal is to choose a healthy mate who can reproduce and care for the offspring. Men appear to prefer young women who are likely to be fertile and be able to look after their children. Our ancestors looked for certain physical characteristics that indicated a woman's health and youthfulness, which are still influential to this day. These traits included having full lips, clear and smooth skin, good muscle tone, clear eyes and a high energy level. Women, on the other hand, prefer men who are slightly older than they are. This is because an older man is likely to be more stable, mature and have greater resources and protection to invest in children. In America, as various studies indicate, economic security and employment are much more important for women than for men. Women also prefer men who are healthy, strong and physically fit as they are more likely to be good providers.

Scent is also another significant factor in sexual attraction. The other person's smell—that is, his or her natural body scent mixed with the lingering smells of the day—plays a major role in drawing people together and finding optimal partners. Body odor was found to be a manifestation of our immune system, and thus it aids the search of people trying to connect with others who are most genetically compatible with them. Interestingly, in both sexes, there is a close correlation between body odor that others find attractive, and symmetrical features in one's face which are said to increase one's attractiveness.

Examining the ages of sexual attraction, females tended to prefer slightly older men for their mate. Men preferred to have sex with younger women in their youth, but gradually consider sex with those their own age or older as they age. It should be noted, though, that men's potential interest in younger women does not likely result in sexual activity, especially as they age.

Autoeroticism – includes sexual activities that involve only the self. Autoeroticism does not involve others. It includes masturbation, sexual fantasies, erotic dreams, viewing sexually explicit material by oneself, and using vibrators and other sex toys by oneself. Autoeroticism has traditionally been condemned by society and has encouraged deeply negative and inhibitory attitudes toward sexuality in general. Research found that those who engage in such activities appear to be more open to sexual experimentation, such as oral or anal sex, and are more likely to have a partner.

Sexual fantasies and dreams – Both genders fully engage in sex fantasies. Ninety four percent of males and 76% of females engage in sex related thoughts. Erotic fantasy is probably the most universal of all sexual activities. Fantasies are used to enhance and enrich our masturbatory experiences. Some fantasize during intercourse, and others, during interpersonal experiences. Nearly everyone has experienced such fantasies, but they are usually not openly discussed. Many people have "forbidden" sexual fantasies that they never act on. It was discovered that fantasizing about one's partner increases desire for that partner. That could result in displays of more love, affection, and support. Interestingly, sexual fantasizes about someone who is not your partner, will not, according to research, enhance or harm your romantic relationship. A study examining the sexual fantasies of 85 men and 77 women aged 21–45 found significant gender differences:

a) Men's fantasies, in contrast to women's, were more sexually explicit and more likely to involve multiple partners. Women's fantasies focused more on emotional-romantic themes and included only a single partner.
b) Men more often fantasized about dominance, and women fantasized more about submission, although that does not indicate that it is what they want.
c) While men focused on satisfying the woman, women tended to be more self-centered and focused on themselves rather than their partner's desires.

How We Feel and How It Affects Our Sexual Activity

How we feel is closely related to our sexual functioning. Negative emotions play a major role on sexual difficulties in men and women. Laboratory studies of subjective arousal during the viewing of erotic clips have shown that positive emotions increase as does subjective sexual arousal in men and women. Another study found that following an enhancement of a good mood in the study participants, there was an increase in both physiological and subjective arousal in men but not in women. Regarding negative emotions and their effect on sex, it was found that negative affect was unrelated to subjective and genital arousal in men during the viewing of explicit sexual films. However, other studies have shown a significant correlation between anxiety (negative affect) and subjective sexual arousal in both genders.

Research on women's responses found that women who experienced sexual dysfunction reported *less* positive emotions like pleasure and *more* negative emotions, such as sadness, during sexual activity. Similar results were found for men. Intuitively, it is safe to assume that men and women afflicted with sexual problems experience more negative emotions, and less positive ones, during sexual activity. This is especially true for men and women with sexual desire problems. This may include men with erectile disorders, and women who are persistently sexually aroused or suffer from dyspareunia, or painful intercourse.

Sexually dysfunctional men and women reported significantly higher levels of negative emotions during sexual encounters. It stands to reason that psychological interventions aimed to increase positive feelings while lowering negative ones should be considered as part of sex therapy.

Solitary Sexual Behaviors

Asexuals

Some people are sexually inactive – either on a temporary or a continuous basis. To some, they are referred to as 'asexual', meaning that they do not desire any partnered sexual activity. While they may still masturbate and have sexual fantasies, they are not interested in engaging in any sexual behavior. Asexuals do desire relationships and intimate behaviors, such as cuddling, but sex does not interest them. Some asexuals intentionally refrain from sex similarly to the practice of celibacy like that of priests and nuns. This includes refraining from partnered sex and engaging in masturbation or engaging in non-sexual behavior in order to replace sexual activity.

One might choose to become celibate in order to focus on personal growth due to physical and psychological health concerns which could stem from previous traumatic sexual experiences. Involuntary celibacy may also occur for those who are away from their loved ones (i.e., military deployment), or for those afflicted with physical or psychological disabilities. Although, truth be told, some of the most common solitary sexual behaviors occur within one's brain. Those are sexual fantasies that almost everyone engages in. A sexual fantasy can be an elaborate story, or it can be a fleeting thought of some romantic or sexual activity. It can involve bizarre imagery, or it can be quite realistic.

Fantasy content differs between the sexes. First, men's sexual fantasies are more sexually explicit than those of women. They may inject images of their own, or their partner's, anatomy for enjoyment. On the other hand, women's fantasy contain more emotional and romantic content. Next, men are known to usually include several sexual partners at the same time (e.g., threesomes, gangbangs) in their fantasies. It is known that sexual fantasies enhance sexual arousal or compensate for a less than ideal situation. It may be an expression of one's hidden desires or include things that the person cannot or won't do in real life. In general, people who fantasize more often tend to report being more sexually satisfied. And although most fantasies are relatively harmless and represent a healthy sex life, some are potentially problematic and even dangerous to others. Some fantasies could negatively impact the relationship, depending on how bizarre they are. Fantasies about sexually assaulting children could result in acting out on them, which would naturally be harmful to others.

Sex Toys

Humans have been making and using sex toys since the Stone Age. Currently, 45% of men and 53% of women report that they have used a vibrator. Dildos, Ben Wa balls, and various other devices designed to aid in sexual pleasure have a surprisingly long, and quite interesting, history.

Interestingly, the world's first vibrator was invented as a helpful device for treating women's hysteria, as the movie by that name showed. Hysteria was among the most common medical disorders diagnosed in women. It included a wide range of symptoms from nervousness and insomnia to a loss of appetite for sex and the "tendency to cause trouble for others." Hysteria was seen as originating from insufficient or unsatisfying sex, for which physicians would provide a 'pelvic massage' that actually brought the woman to orgasm. It is

quite tiring to stimulate a queue of women for about 20 minutes each, and so a creative physician invented a vibrator, which allowed the physician to "treat" more women simultaneously. As electricity started making its way into people's homes, vibrators thus made their way into homes long before vacuum cleaners, electric irons, and television sets. Modern vibrators are battery operated, and some are optimized for clitoral stimulation, others for G-spot or anal stimulation.

Masturbation, being a solo form of self-stimulation focusing on one's genitals, is largely aided by fantasies. They may vary in terms of the motion, speed, and amount of pressure applied, as well as whether they incorporate pornography. It seems that men are more likely to masturbate than women, and do so with greater frequency. But why do people masturbate? Research pointed out that they commonly do so for a variety of reasons, and among them are for: tension relief, pleasure, relaxation, and the unavailability of a sexual partner. Unlike what was believed and preached in past centuries, we now know that masturbation is associated with enhanced physical and psychological health, with higher self-esteem among women and a lower risk of prostate cancer in men.

Partnered Sexual Behaviors

Some of the most common partnered sexual activities include kissing, sexual touching, oral sex, anal sex, and vaginal intercourse. A US national survey found that by the time people reached their mid-twenties to early 30s, 97% have had oral, vaginal, or anal sex previously, while only 3% reported having no sexual experience at all. It seems that people first kissed when they were 15, and their first intercourse occurred when they were around 17. Partnered sex often continues for the rest of our lives, assuming that our health and access to a partner will allow it.

Kissing – Kissing in Western society is one of the most socially accepted and common sexual behaviors to exist. Although across 168 different cultures, kissing was present in less than half (46%) of the cultures that were studied! It was found that kissing was least likely to be observed among cultures in Africa, Central and South America, and Oceania. In contrast, it is frequently practiced in North America, Asia, Europe, and the Middle East. Thus, we can conclude that kissing is by no means universally practiced.

Touching – Touch is the predominant sexual sense for most of us, and it only stands to reason that it would be an integral part of sexual activity. Sexual touching usually only focuses on primary and secondary erogenous zones. But it should be noted that almost any part of the body can be involved, because nerve endings are present throughout our skin. Touch is so central in sexuality, that sexual pleasure and even orgasm can be derived from touch even if the genitals are not directly stimulated.

Oral sex – involves stimulation of the genitals with the mouth. Apparently, when asked, about three quarters of adults reported that they have engaged in oral sex within the past year. Oral sex is negatively associated with age or education, meaning that the older or more educated the person is, the less oral sex they will engage in. At least, statistically. Oral sex is also influenced by ethnicity and culture. For instance, white Americans engage in it more than African Americans or Hispanics, and at some parts of the world, like in Sub-Saharan Africa, oral sex is seen as an unnatural and unclean activity that is not practiced widely. *Cunnilingus* is the term that describes the stimulation of the vulva by a partner's mouth, and *fellatio* is the

term for when it is done to the penis. *Anilingus* is the stimulation of the anus and anal area by one's partner's mouth. As a result, couples vary in terms of how they prefer to deal with male and/or female ejaculate. Some find ejaculation inside the mouth to be exciting, while others dislike it. Amazingly, oral stimulation alone may be enough to bring men and women to orgasm. In fact, about one in ten men and one in five women report that oral sex is their preferred route to climax.

Vaginal intercourse – Freud maintained that vaginal orgasm was the "right and mature" way to experience sex. It is considered the most common form of partnered sexual activity. Like all other behaviors, vaginal intercourse may be performed in a variety of positions. The four basic positions are man-on-top (i.e., "missionary"), woman-on-top, side-by-side, and rear-entry (i.e., "doggy style"). Research indicated that men tend to prefer the woman-on-top position, while woman prefer the man to be on top.

Anal sex – Although reported as the least practiced form of sexual activity, anal sex has begun to gain popularity with about one in four 20 to 30-year-olds having practiced it in the past year. Similar to masturbation and oral sex, anal sex is more common among those who are younger and more highly educated. White and African American men practice it in similar percentages, though women are less likely to report that they have tried it. Unlike public perception, anal sex is practiced mainly by straight couples, and much less by same sex ones. While anal sex obviously includes penile-anal penetration, it also involves inserting a finger or sex toy into the anus during masturbation or partnered sex, or engaging in 'rimming' which involves orally stimulating the anus.

Same sex behaviors – Possibly unbeknownst to the general public, it appears that sexual activity of gays and lesbians are strikingly similar to the sex practiced by heterosexuals, with the exception of penile-vaginal intercourse. Statistically speaking, lesbian couples practice sex less often than gay men, but have more sexually satisfying relationships than them. And while it is believed, by the general public, that gays prefer mainly anal sex, it is actually oral sex and mutual masturbation that has been shown to be practiced by them the most. In a large study examining the sexual practices of gay men, it was found that over 1,300 unique combinations of sexual behaviors were reported. Around sixty-three percent of participants in that study reported engaging in somewhere between five and nine different sexual activities during their most recent sexual encounters. This included activities such as kissing (75%), oral sex (73%) and mutual masturbation (68%). Interestingly, anal sex (37%) was the least practiced sexual activity reported in this study. Similarly, bisexuals engage in a diverse range of sexual activities, including vaginal intercourse, giving and receiving oral sex, engaging in mutual masturbation, and some receptive or insertion-style anal sex.

Myths about Men's Sexuality and How They Affect Their Behavior

Some of the myths about men tell the tale of a hyper-masculine body coupled with a voracious sexual appetite and ability for amazing sexual performance.TV shows, movies, and song lyrics seem to reinforce stereotypes about men's sexual desire being high and unwavering. Let's examine the myths that surround men's sexuality and explore whether they are based on fact or fantasy.

One of the most prevalent myths about men is that they need and want more sex than they actually have. This leaves the impression that men are constantly searching for a sex partner and sexual activity. That may actually be quite true until the age of 25, after which a whole slew of life changes may negatively impact their sexual desire. It appears that high sex interest in men relate to and stem from their testosterone levels, which are high when boys reach puberty. By the age of 30, it gradually decreases and may be completely absent by age 65. At that point, they are said to no longer be interested in sex.

However, we note that various life events may negatively impact men's desire besides aging. Having children, for instance, is one of the main ones. Historically, men would have simply captured the woman's heart, inseminated her, and leave the woman to take care of their child. But now, men are expected to share the load of raising their children right when they're born. This starts with being present in the delivery room, helping with bedtime routines, taking the kids to their extracurriculars, picking them up after school, and many more activities. The weight of these responsibilities coupled with simply the thought of knowing that their children are around can significantly dampen men's sexuality.

Apparently, becoming an adult is not easy. In fact, famous sex researcher Dr. Sarah Murry wrote, in 2019, that "…the older we get, the more and more responsibilities pile on. Maybe we get a pet. Or we start paying a mortgage instead of rent, or at least we start paying more expensive rent on our own or with a partner instead of split between five roommates. We get a car. We have a job. We need to pay more bills and those mounting responsibilities impact on us multiple levels – including our sexual desire." Those mounting responsibilities can have a sex killing effect on some men's desire to engage in sexual activity.

Although, and as we all know, relationships change. In the beginning, we may become obsessed with our partners by staying with them and talking to them too much of the time. Sexual desire is quite high and rampant at this stage. Pop culture refers to this period as the 'Honeymoon phase." As the relationship continues beyond several months, things start to change. There comes a noticeable decrease in our sexual desire, and when tired, the desire to sleep may outweigh any desire we may have to engage in sex. Sex now takes a backseat to our social involvements, attending to our work, or to our hobbies. This stage, termed as companionate love, is supposedly the healthy progression from a permanent passionate love to daily living. The lust that we had for our intimate partner subsides, and a calmer friendship of sorts takes place.

Another myth that many take as the truth is that men's desire is mainly influenced by the woman's physical appearance. That myth is simplistic, as it disregards men's deeper thoughts and the complexity of his sexuality. Research on men's sexuality found that although we think that the woman's looks is the most important factor, their sexual desire is more influenced by their emotional and romantic connection with them. Looks matter, but they are not the only thing that does. Apparently, for men, being in the woman's presence, going on a walk with her, or just communicating with her leads to a deeper relationship and increased desire. Men's motivating factor in having sex is providing sexual pleasure to their partner, and it appears that if she is not experiencing pleasure, it may significantly affect the man's enjoyment of sex. Apparently, men would rather not have sex than do it with a partner who is not into it, does not enjoy it, or fakes satisfaction or orgasm.

Additionally, the myth of the male body being sex-crazed by pornography is nothing short but the product of our society. Pornography is a multibillion-dollar industry which sees thousands of new videos being uploaded daily! It is mostly heterosexual males who consume

these porn videos, since the assumption is that it is driven by their high sex drive The consumption of porn is a private endeavor and done mainly by men. Indeed, watching porn and sharing it with their partners could deepen their mutual understanding, reveal their sexual preferences, and increase their intimacy. Since it is not uncommon that couples have different desire levels, men use porn occasionally to masturbate and relieve their need for sexual release. To summarize, men are not as sex crazed as we assumed they are. They want to have sex as a way of connecting to another human. And thus, watching porn is not a problem, but our assessment of it as bad is problematic.

Alternatively, another common myth about men is that women, and only women, are desirable, while it is men who do the desiring. That is not so. But what does desire look like? That may include hearing their partner tell them about how attractive they look and validating their physical appearance. It may also include the active engagement of their partners being present during their sexual activity. According to reports, men were not able to believe in these words, but felt them and described it as being a huge aphrodisiac for them during sexual activity.

Men are also expected to be the initiators of sex, and that it is the most common pattern of initiation. That myth is so deeply ingrained in our culture that we simply accept it without questioning whether it is indeed so. It can be discussed that the socialization of this belief may stem from the idea of the ‘good girl’ being the one who does not seek or agree to sex. Men, being the sex-crazed ones in the relationship, are perceived as the ones to ‘chase’ the ‘gatekeeping’ women in these partnerships which extends into adulthood. The man is expected to knock at her door, and *she* decides whether or when to let him in. However, recent research in sex initiation may reveal a new pattern in this traditional line of thinking. In 2005, researchers asked men about their role in sex initiation and whom they would want to initiate it. Seventy-two (!) percent indicated that they wanted an equal amount of initiation between themselves and their sexual partner. Apparently, research indicated that men find it really sexy when a woman approaches them out of nowhere, wearing something really sexy, or even – as some put it – by grabbing them below the belt. Women may be unaware or simply forget that men need to be seduced, romanced, and cared about through women’s sexual initiation.

For ages, women were encouraged to reject men’s advances since they’ve been told that men want only one thing. However, sexual rejection is hard for both genders and brings about negative feelings for men and women. Rejection affects their self-esteem and lowers their interest in sex. Moreover, men who have been rejected frequently simply avoid approaching women and experience decreased sexual desire. We grew up with the myth that men are always ready and willing to have sex. However, that is not so. Physical illness, exhaustion, and medical complications are amongst the reasons that may cause men to refuse sex. And not only women, but men as well, engage in sexual compliance – meaning having sex without desire, just as much as women do.

Sexuality in Later Life: Do the Elderly Have Sex?

An examination of sexual functioning amongst the elderly is important since, in the USA and other Western countries, they are a sizable segment of the population. According to research, this group is projected to double in size by 2050. Moreover, life expectancy has increased

appreciably which makes this topic more important to discuss. Potential sexual activity in later life is predicted to increase significantly, along with the new stages in later life such as “empty nest” and retirement. Since regular sexual expression contributes to better physical and psychological well-being associated with aging, it behooves us as a society to understand sexuality in later years, and maybe even encourage it. Aging, alongside its associate changes, is only one of three influences which impacts sexual functioning. The other ones are psychological influences such as attitudes and knowledge, and relational factors such as the quality and satisfaction of the relationship. It is noted that until recently, literature on sexuality and aging was mainly focused on sexual interest, the ability to have sexual intercourse, and on erectile dysfunction among other sexual dysfunctions that the elderly may experience. But in order to have a comprehensive understanding of sexuality in later years, we need to consider a range of sexual activities, including solo and partnered masturbation and oral sex.

Sexual Behavior

How do older adults behave sexually? Solo masturbation is common among older American men and women. Forty six percent of the oldest men (over 70) and 33% of the oldest women report engaging in solo masturbation as a form of sexual relief. Men, more than women, report giving and receiving oral sex, though it declines with age. Fifty eight percent of men and 51% of women aged 50-59 reported vaginal intercourse which declines for women over 70, mainly due to the loss of a partner. Thus, it is clear that sexual activity remains a significant part of life for those 67 and older. Being in good health and having a sexual partner seems to be central for continued sexual activity.

Health and Sexual Activity

Physical changes during aging may affect sexual functioning. In women, the most noticeable changes are related to declined ovarian functioning during menopause. It is often followed by vaginal dryness, aches and itching in the vulva and vagina and burning – leading to painful intercourse, if it is attempted. Up to 60% of postmenopausal women experience these conditions, which may lead to lowered sexual interest, although some women report greater excitement and desire after menopause.

The analogous change in men is expressed via a very gradual decline in testosterone production. As a result, men may experience slower and less firm erections, decreased likelihood of orgasm, and a refractory period which gets longer as men age. However, it appears that it is the meaning of those changes, rather than the changes themselves, which may impact sexual functioning. These changes serve as reminders that we are biologically aging and for those who live in an ageist society it may be stressful, thus, affecting their sexual functioning. Studying women aged 39-56, they reported experiencing declines in their sexual desire and frequency due to feeling less physically attractive than they were ten years earlier regardless of their age. For some, unfortunately, womanhood is significantly related to motherhood, and the women’s inability to reproduce following menopause may result in their view that they no longer need to engage in sexual activity.

Physical Health and Sexual Activity

Research indicated that older men and women who report their health as excellent or good are more likely to be sexually active than those who report their health as fair or poor. The American Association of Retired Persons survey indicated that older people's health is positively correlated to their sexual activity, meaning that the healthier they are, the more sex they have. Examining the effects of illnesses yielded similar results that were found in two surveys conducted in Finland. For instance, it was found that diabetes mellitus and hypertension are associated with sexual dysfunction among older men and women. Although, contrasting results from an Australian study involving 474 women aged 40-79 suggested otherwise. Various medical conditions which were reported by these women including breast cancer, diabetes mellitus, hypertension, and osteoarthritis showed no increase in sexual distress because of ill health. All in all, it appears that medical illness does not have a major influence on declining sexual desire or behavior in later life.

Does Mental Health Affect Our Sexuality?

Sexual functioning is significantly influenced by mental health, in our youth, adulthood, and old age. Anxiety was found to be related to sexual difficulties among men and women. Increased anxiety was associated with the lack of sexual interest, increased anorgasmia, and for women, the lack of pleasure from sex. Depression was found to be associated, for men, with erectile dysfunction and anorgasmia.

The Effect of Medications on Sexual Behavior

Older adults often take various medications for their health. The instructions on some of them specifically state that they affect sexual functioning, and others affect it indirectly. It was suggested that increasing the use of multiple medications, with the exception of drugs for erectile dysfunction, is a major reason why older people stop engaging in sexual activity. In the AARP study which was mentioned earlier, men and women 50 and over, were asked what medications they used on a daily basis. About 47% reported taking blood pressure medication, with 41% of men and 36% of women reported taking medication to lower cholesterol. Thirty nine percent of men and 43% of women reported taking medication to relieve pain. And as they get older, the consumption of these drugs continued, and with it, the side effects of these medications which usually hamper sexual response and performance.

Sexual Desire

The literature on sexual functioning, as well as popular belief, hold that sexual desire is important. But as we know, sexual desire declines with age with 76% of men aged 45-59 reporting that they desired sex fewer times per week. But at age 60-74, it declined to 43%, with

only 17% of those men aged over 75 desiring sex at that frequency. Among women, the comparable percentages were 36%, 11%, and 4%, respectively. Studying the connection of sexual desire to sexual problems in men aged 45-74 revealed that 13% of men aged 45-54, 12% aged 55-64, and 30% aged 65-74 replied that there was clearly a connection between the two. Another study found that among men, sexual interest was stable across age groups while for women interest declined significantly after the age of 60. Clearly, desire does not always decline as men and women age, suggesting that other variables may play a role as well. In fact, research has found a link between sexual desire and activity. A study of healthy older women found that sexual desire and the frequency of arousal, lubrication, and orgasm were greater in women who were active on daily basis. An association was also reported between desire and increased masturbation.

Women may experience problematic low sexual desire, which was referred to as hypoactive sexual desire and can cause significant distress. Approximately 15% of the male population in the U.S. aged 18 to 59 complained of persistent low sexual desire, a much lower number than for women. Causes for low sexual desire in men may stem from certain medications, surgeries they may have undergone, or due to illness. However, other causes such as an attempt to camouflage issues like erectile dysfunction or premature ejaculation can also have similar effects due to the embarrassment associated with these conditions.

When researchers explored the reasons why North American men and women want sex, they found 237 rationales. There were some differences between the genders, but interestingly, eight out of the top ten reasons for men and women were identical. A sign that the gender gap is narrowing was provided by research where men reported only slightly more sexual experiences with more sexual partners, and more positive attitudes towards sexuality than women did. One exception was noted, however, as men reported engaging in more masturbation than women.

Sexual Dysfunctions

Since the literature commonly addresses sexual dysfunctions in older adults, we will discuss about issues related to desire, arousal, orgasm, sexual pain and the use of lubricants.

Hypoactive sexual desire disorder (HSDD) is a serious disorder that is defined as the persistent deficiency, or even absence, of sexual fantasies, thoughts, or desires for sexual activity. Those afflicted by it report feeling high personal distress as a result. Studies on American and European women indicated that a lack of desire increased with age, but perhaps, not linearly. The percentage of women distressed by this condition declined from two-thirds of those aged 20-29 to 37% of women aged 60-70 in the USA and 22% of women of the same age in Europe. Thus, it may be concluded that HSDD is not associated with age, but with other issues.

Problems of sexual arousal is another issue faced by older people. Research on women of different age groups revealed that the percentage of women who encountered great lubrication difficulties increased from 17% among women aged 45-54, 28% among women aged 55-64 and 27% among women over the age of 65. For men in their late fifties to mid-eighties, *erectile dysfunction* is the most common and bothersome disorder. It was found that men aged 50-59 were three times more likely than those aged 18-29 to experience erectile difficulties. Based on American and Australian data, it was suggested that the incidence of erectile problems was

significantly related to age. And while only 2.5% of those aged 45-59 experienced impotence, 16% of those 60-74 years old experienced erectile dysfunction, going up to 38% of those 75 and over. These findings suggest a clear correlation between advanced age and difficulties to reach and maintain an erection. As such, it is quite plausible that men who experience erectile dysfunction bypass penile penetration and their sexual activity is less affected by it.

Orgasmic difficulties are reported by 22%-26% of women aged 18-59. It does not get worse with age, apparently. Men aged 18-59 experienced orgasmic difficulties to a significantly lesser extent than women, with only 7%-9% of them reporting difficulties in achieving climax. The age trend in men is highly significant. In women, orgasmic dysfunction is not correlated with age; in contrast to what was found about men.

Pain during intercourse. Only 4% of men reported experiencing pain during intercourse, and that did not vary with age. Among women, about 12% to 19% experienced pain during intercourse, and that did not vary with age as well.

Sexual activity is commonly coupled, and requires a certain amount of sexual and emotional intimacy for it to be satisfying. In such relationships, partners find, and offer instrumental and emotional support and that feeling may strengthen as people become older. Statistics from the U.S. Census Bureau in 2010, indicated that 67%-72% of men at the age range of 45-64 are married, while 63% of women are married at the two decades beginning with age 45, while only 40% of women aged 65 and over are married. Married people, of both genders, seem to engage in sexual activity more than single individuals, including the divorced or widowed, particularly at older ages. Especially among women, sexual activity declines with age.

A major influence on sexual activity is the satisfaction that one gets from their relationship and the quality the union. Spousal support and relationship happiness are essential to more frequent and satisfying sexual episodes, with the reverse of it also being correct. Rating one's marriage as happier is associated with more frequent sexual intercourse. It was observed that increased satisfaction of one's relationship was associated with more frequent hugging, kissing, oral sex, and vaginal intercourse. However, it was surprisingly also correlated with reduced sexual interest and a lack of sexual pleasure.

Research which examined data from 5,440 marriages and 462 cohabiting couples concluded that dissatisfaction, which may be destructive to the relationship, was associated with infrequent sexual activity. Most couples report less sexual activity as they age. That reduction is replaced with emotional attachment and other ways that the couple expresses their love, connection, and commitment. Interestingly, older women reported that emotional closeness results in more frequent arousal, lubrication, and orgasm, which indicates what truly "speaks" to them.

To summarize, men and women frequently remain sexually active into their 80s. Men report experiencing a greater incidence and frequency of sexual activity and intercourse than women. There is little evidence that physical changes associated with aging necessarily lead to reduced sexual activity. Men commonly experience difficulties with sexual arousal and erection as they age while women are more likely to report at least occasional orgasmic difficulty as they age.

Human Mating and Sexual Selection

In the USA and the Western world, heterosexual competition for mates mostly entails attracting members of the opposite sex. A corollary of that, however, involve the multibillion-dollar industries which capitalize the importance of beauty, fashion, and physical fitness in mate selection. Genes must be propagated, and sex is the way to do it. Sexual courtship has thus been central in human evolution and remains central in modern human life. Consequently, the preferences of each sex places important selection pressures on the other.

Sexual Selection in Humans

It is known that just like in the animal kingdom, women invest more in their offspring than men do. Men have higher reproductive variance when compared to women, and are thus larger, more muscular, and die sooner. These factors all correlates to an effectively polygynous mating system, which is one where the male lives and mates with multiple females but each female only mates with a single male. Contests are the dominant mode of sexual selection in men. Just like in the animal world, men's large size enables them to inflict damaging blows, verbal or physical, and attempt to get the woman they desire. It was found that men have 80% greater arm muscle mass and 50% more lower body muscle mass than women which translates into large differences in strength and speed. Certainly, size, strength, speed, and aggression in men lead to greater physical prowess. Interestingly, even men's facial features may partake in getting the mate they desire and to threaten rivals of a similar stature. For instance, beards and eyebrow hair grow at puberty in males and are related to testosterone levels which play a role in aggression and dominance. Male faces with beards are rated as more dominant than the same faces clean-shaven. And similarly, deep, low pitched voices increase men's apparent size and threatening stance.

As such, it appears that female mating strategies would prefer traits to attract men, rather than physically monopolize them. These preferences appear to be culturally pervasive, as those with resources and a willingness to invest in their partners are most desirable. Men are perceived to be providers partly since it increases their chances to attract females and provide for them with protection from rape or harm to the family. In a similar vein, women seem to also value the odors, faces, and voices of men whose external features are symmetrical. They prefer masculine men who are more average in height. Although, research has indicated that men with high testosterone levels are more likely to have extramarital sex. Thus, it stands to reason that masculine and symmetrical men should make better sires than long-term mates. Women's sexual preferences aim to recruit genetic benefits from men who may not be the women's long-term partners. Evidence of sperm competition and moderate rates of paternity out of the union, across human societies support this possibility.

As far as men's apparatus, research showed that men's penises are longer and thicker, both relatively and absolutely, than those of chimpanzees and gorillas. They could have evolved to indicate to women that the owner has good mate quality. And indeed, women report greater satisfaction with larger penises. Thus, it appears that penis size does matter and may affect a man's ability to stimulate orgasm in women. Sperm retention may be stimulated by the female orgasm and encourage additional copulations. But it may also be that penis size may advertise

vigor to other men. Females fuel male dominance competitions by indicating that they prefer dominant male behavior in short term/sexual mating contexts. To summarize the research on men, Dr. Puts concluded that many male traits are probably not generally preferred by females, and those that are, appear better designed for contests than for mate attraction.

Women compete for men's protection and provision of resources, but operate differently than men. While men emphasize women's physical attractiveness across societies, women 'got the message' and utilize that same preference when attracting males. Women who are interested in pursuing men appear to be chaste and faithful. This is believed to increase attractiveness as targets of investment, and tend to put down other women's attractiveness to make their rivals less appealing to men. Women compete to look attractive and to emphasize anatomical traits that are valued by men. And since female reproductive value peaks at sexual maturity occurring in the mid-twenties, it is quite clear why men, all over the world, prefer young women. Women's traits that enhance a youthful appearance include slender or thin facial features, reduced body hair, and body fat distributions which reflect fertility. Women have fat deposits that concentrate on their breasts and hips as they approach sexual maturity, which suggests that these traits are involved in mating.

Sexual Fantasies and Their Function

What are sexual fantasies, and what role do they play in relationships? What do they tell us about people's desires, their relationships, and their past experiences? Do men and women have different fantasies? For a long time before the 1950s, sexual fantasies were viewed negatively and taken to be pathological especially if a woman engaged in them. This is believed to be related to the social climate that did not accept women's sexual desire or wish for pleasure at the time. By the 1960s, however, an openness to sexuality changed the value and purpose of sexual fantasies for providing a healthy outlet that, had they been acted on, could jeopardize the relationship.

Research showed that sexual fantasies are associated with increased sexual interest, desire and positive attitudes about sexuality. While men report engaging in sexual fantasies more frequently than women, both genders experience them. Sexual fantasies have been defined as any mental imagery that is sexually arousing or erotic to the individual. Research has typically found that sexual fantasies can enrich the sex lives of individuals, but it is interesting to explore what it does to the sex lives of couples.

Fantasies in couples may serve several purposes. First, they may indicate what people may want in their relationships; or what they want in partnered sex. Secondly, it allows people to fantasize about partnerships outside of their current relationships without harming it. These fantasies, if shared with one's partner, may enhance communication about sexuality, what turns them on and how to achieve it. Research found that women mostly fantasize about a future or former male partner. In turn, those in committed relationships reported experiencing less frequent sexual fantasies than single people. An inability to have sexual fantasies is now connected to sexual dysfunctions, and possibly to relational problematic issues. Partners replacing fantasies can contribute to the ever-declining excitement and novelty in long-term relationships. This may decrease the couple's intimacy by removing the togetherness from the act, and replacing it with individual pleasure.

And while a lack of fantasies in coupled relationships may be problematic, a lack of experiencing fantasies altogether may also indicate trouble. For instance, a relationship that includes a history of infidelity could be harmed by fantasies of having sex outside of the marriage or relationship. What types of sexual fantasies are employed by men and women? Research indicates that, overall, males fantasize about power and dominance, while women do about submissiveness. In my research, I found that some women fantasized about being raped, though they clearly do not want it to happen in real life. That may be their way of fantasizing about engaging in sexual relationships and acts which they feel prohibited to do in real life, but in the fantasies, they are 'forced' to engage in it.

What Is the Function of Sexual Fantasies?

Sexual fantasies have several important functions. Firstly, they provide concrete images and specific content to our sexualized drives. However, if the fantasies revolve around people whom we have no chance to meet or engage with, we will end up feeling frustrated and unfulfilled. We can imagine perfection, but we rarely find it in real life. Additionally, sexual fantasies allow us to plan for anticipated situations, where we may want to rehearse ahead of time and how to behave. Third, sexual fantasies provide escape from dull or oppressive environments. And fourth, having fantasies and acting them out may bring novelty and excitement into our relationships. For example, some research has indicated that there are women who can orgasm solely through fantasy. Fantasies can take place during partnered sexual activity, or when practicing sex solo. *During sexual activity,* fantasies may allow us to transform our partner into someone more desirable, like a Hollywood movie star. In that respect, research indicated that 98% of men and 80% of women reported having extradyadic fantasies about someone outside of their relationship. Contrary to the feeling of those people as being "mentally unfaithful," sex and relational therapists suggest that such fantasies are quite normal and certainly typical. As I mentioned earlier regarding my own findings about women's sexual fantasies, other researchers have also found that some women, and not a small number of them, report fantasizing about being forced into various sexual acts. Researchers saw it as a wish to be involved in a variety of sexual activities. *Erotic dreams* have been reported by almost all men and women. These sexually related dreams may result in nighttime orgasms in both men and women, or ejaculation in men.

Masturbation – People masturbate for various reasons. They may do it to relax, get relief from sexual tension, or when they are far from their partner. People may masturbate during a particular time (i.e., when they serve in the army, are in jail, etc.) or throughout their life. While in past centuries masturbation was frowned upon and children and adolescents were cautioned about its destructive properties, it is now considered an important means for us to learn about our bodies. Masturbation allows us to learn what pleases us, how to move our body, and what our natural rhythm looks like. This activity has no harmful physical effects and is actually recommended by sex therapists as a means of overcoming specific sexual or relational problems since it can be practiced alone or in the presence of one's partner.

What is the prevalence of masturbation? National research in the U.S. indicated that it is practiced by people of all age groups, sexual orientations, and ethnicities. It can be seen as a typical and pleasurable part of an individual's and a couple's sexuality. A study which explored masturbation among college students found that a whopping 98% of men and 64% of women

masturbated frequently, with men averaging 36 times and women 14 times in the past 3 months. It was also found that the more one is educated, the greater one's masturbation's frequency becomes. Exploring the percentage of women who masturbate, it was found that 72% of women masturbated in the preceding year during 25-29 years of age, while only 33% of those aged 70+ group engaged in such practices. Interestingly, masturbation was more common among women who experience more frequent vaginal intercourse, oral and anal sex with sexual partners in the past year. Women who masturbated were also more likely to orgasm than those who did not masturbate. And when asked about the reasons that they masturbated, women mentioned that it gave them sexual pleasure and greater appreciation for their bodies without the aid of a partner.

In contrast, men masturbate quite frequently depending on their age group. Eighty four percent of men aged 25-29 and 40% of those 70+ have reported masturbating on a regular basis. Most men recognize masturbation as part of a healthy sexual development, and like women, engage in unique manners of masturbation. Though, most involve some type of direct stimulation to the penis with the hand. Other parts of the body may be stimulated, such as breasts, testicles or the anus, but it ultimately depends on the individual.

Most people continue to masturbate even while they are sexually involved with a partner, though significantly less frequently. Interestingly, about 57% of married men and 37% of married women masturbate as opposed to about 48% and 69% of formerly married and never-married men and women, respectively. Masturbation seems to be happening even in addition to a satisfying sex life, when one's partner may be away or unwilling to have sex, or as a way to release tension.

Sexual Fantasies from an Attachment Theory's View

It is scientifically and intuitively clear that, both, the attachment and sexual systems are distinctive systems that serve different evolutionary goals. One provides protection from danger by maintaining proximity to a caregiver vs. gene reproduction by sexual intercourse, respectively. And while they may occur independently of each other, we may expect that the attachment system can influence one's sexual system later in life due to its earlier development. As such, research has indicated that sexual fantasies are, partly, shaped by attachment processes.

Attachment Orientation and Its Relation to Sexual Interactions

Dr. Bowlby was a British psychiatrist who observed children's interactions with their caregivers and how they evolved in order to maintain proximity to them. He referred to these caregivers as attachment figures. Attachment figures are the picture of the world that the infant has. They represent the world for him or her. The quality of repeated interactions with the attachment figures, particularly in times of distress, gradually shapes the lifelong patterns of the child's interpersonal relationships over the entire life span. Attachment figures are considered consistently available and responsive to the child's if they can support their need for closeness, intimacy, protection and nurturance. This establishes a stable, secure relationship with the caregiver. But when attachment figures are not reliably available for a variety of

reasons, the infant cannot attain a sense of attachment security and develops serious doubts about their self-worth and others. As a result, the individual may adopt one of two alternative strategies for dealing with these insecurities, namely through either the hyperactivation, or deactivation of the attachment system. Hyperactivation strategies, which characterize anxious attachment, aim to get the attachment figure to pay attention to the infant for comfort and relief which persists through adulthood. In contrast, the main goal of deactivation strategies, which are mostly utilized by avoidant attachment individuals, is the pursuit of distance and control in close relationships. The infant avoids closeness for fear that ‘people will eventually move away from me or abandon me’.

The difference between secure and insecure attachment as far as sexual relationships are concerned, is that attachment security enhances mutually intimate and satisfying engagements while attachment insecurity interferes with the functioning of the sexual system in intimate relationships. Importantly, the nature of this interference differs between avoidant and anxious attachment.

A major interference can be found in highly avoidant people. These individuals habitually seek physical and emotional distance from their partners whilst experiencing discomfort in close, intimate relationships that are integral to intimate sexual interactions. This discomfort may lead to an avoidance of affectionate sexual activities which may commonly lead to sex such as cuddling, kissing or intimate sexual positions. They may develop negative emotions and thoughts about the situation. Avoidant individuals also tend to engage in sexual intercourse for relatively relationship-irrelevant reasons, such as to impress peers, and to reduce stress. Thus, it is hardly surprising that highly avoidant people are more likely to engage in relatively emotion-free sex in the context of casual, short-term relationships, which may provide them the needed distance that they desire from a sexual partner. Generally, highly avoidant individuals tend to detach intimacy from sexual behavior and, consequently, find themselves having a sex life relatively devoid of relationships.

Highly anxious people, on the other hand, tend to use sex as way to get closer to others in order to serve their unmet attachment needs. They tend to have sex as a strategy to avoid a partner’s rejection and to induce a partner to love them more. They may also find themselves engaged in unwanted, but consensual, sexual behaviors. Highly anxious individuals may display an ambivalent approach to sex, where they may experience, both, wanting sexual intimacy but feeling aversively towards it.

Sexual Fantasies

The obscure nature of sexual fantasies gave rise to a debate about the underlying functions of sexual fantasies, and about what guides their content. Freud, the father of psychology, argued that sexual fantasies originate in its unsatisfied wishes. Others disagreed and suggested that sexual fantasies are an integral part of healthy sexuality and may reflect sexual activities or issues troubling the person. Research into the nature of sexual fantasies attempted to settle this debate. It was found, contrary to what Freud believed, that people who suffer from sexual difficulties are those who fantasize less during general daydreaming, masturbation, and sexual intercourse. People with more active and satisfying sex lives engage more frequently in sexual fantasies that reflect the type of sexual experience they have. Thus, one’s sexual fantasies are

not generated to compensate for what is lacking, but may serve as compensation for a lack of enjoyable sexual stimulation.

For example, it was found that younger, unmarried women are more likely to fantasize about their current partner, whereas married women are more likely to report fantasies involving partners with whom they are not romantically or sexually involved with. And the longer the relationship persists, the more the person fantasizes about those who are extradyadic. These fantasies may be the person's way to compensate for relationship burnout or sexual boredom. In fact, research has indicated that both men and women tend to experience sexual fantasies somewhat differently. Women tend to adopt a more emotional-interpersonal orientation to sexuality, while men see sexual activity as more recreational and aimed to serve their sexual needs. Consequently, men are more likely to have sexual fantasies than women; fantasies which focus on explicit sexual acts and physical gratification whereas women are more likely to fantasize about emotional or romantic content.

As we have mentioned above, research has indicated that avoidant men and women tend to be quite 'stingy' regarding their expressions of intimacy during sexual interactions. Although, this was more pronounced for men. Those who display attachment anxiety tend to engage in abundant sexual activity, including unrestricted and risky sexual behaviors. Anxiously attached men tend to restrict their sexual expression which may be related to their concerns about harming their relationships.

A study which explored the fantasy lives of men and women with different attachment styles found that, for both genders, more anxiously attached individuals fantasized more about sex-related themes than those with lower attachment anxiety. Their fantasies often included themes of submission. Interestingly, more anxiously attached women were more likely to report unrestricted and extra-relational sex related fantasies, whereas more anxiously attached men reported more romantic fantasies. Results of that research indicated that more anxiously attached individuals fantasize about being highly desirable and often represent themselves as affectionate and helpless.

People with stronger anxious attachments fantasize more about sex than less anxious individuals. This begs the question of what themes are explored in the sexual fantasies of highly anxious people in committed relationships? Highly anxious people tend to be obsessed with their romantic partners. They tend to exhibit clingy, intrusive, and controlling patterns of relational behaviors. They are especially likely to have romantic fantasies in which they saw themselves as affectionate, passionate, and pleasing. They use sex in order to care for their partners, which is simply an indication of their need to maintain closeness as a way to reduce their anxiety.

In contrast, highly avoidant people fantasize primarily about intimacy and the concerns it causes them. They were found to be less likely to desire intimacy, and represent themselves as affectionate. However, those who were not involved in a romantic relationship perceived the mates that they longed for as more aggressive and alienated while perceiving themselves as humiliated. These fantasies may also reflect the typical sexual motivations and corresponding experiences of highly avoidant people.

Deviant Sexual Fantasy in Adult Males

Previous research has addressed the deviant sexual fantasies of sex-offending people but has only just begun to do the same in nonoffending populations. A 2020 study examined these 'odd' and 'socially unacceptable' fantasies in 318 nonoffending adult males from the general population aged 18–76 years. It showed that normative sexual fantasies do not progressively decline with age. More specifically, those in the 31–50 years age group had the most normative sexual fantasies, followed by younger participants aged 18–30 years. But just like the normative ones, deviant sexual fantasies progressively decline with age. A potential explanation for this involves the decrease of sexual arousal in adult males. General sexual interest declines in older adult males, with testosterone levels peaking in early adulthood and then gradually decreasing to lower sexual arousal in males.

Overall, it was found that deviant sexual fantasies were infrequent across all age groups, particularly in comparison to normative sexual ones. This finding, they noted, is in line with current literature about sexual fantasies across adulthood. This supports the belief that sexual fantasies are infrequently endorsed by adult males in the general population and is quite uncommon compared to normative sexual fantasies.

Sex in the 21st Century

Numerous cultural shifts have occurred in the last several decades. For instance, internet use has expanded dramatically and have significantly increased opportunities to view pornography and meet sexual partners online. In Western countries, civil liberties for gay men and women have become a hot political issue and seem to be affecting, in a positive way, sexual attitudes of many voters. Research from 2005 examined studies that were conducted between 1943 and 1999 and found that sexual behaviors and attitudes reported by participants became more liberal across time.

Internet and Sexuality: How Are They Connected?

Sexual online content has become widespread. There is a substantial divergence between the forms of sexuality which manifest on the internet and in other contexts depicted in various media. In addition to pornography with employed actors, the rise of enhanced amateur pornography has surged. Some may refer to this online sexuality as "virtual pseudo-sexuality." Online dating services have become a popular and successful method for meeting real-world sexual partners in fast and uncomplicated ways. The internet may have a positive or negative effects on its users, depending on how it is used. As such, internet sexuality refers to a variety of sexual phenomena, such as sex education, sexual contacts, and (naturally) pornography. This is related to online services and applications such as websites, online chat rooms, and peer-to-peer networks, referred to as 'cybersexuality'.

Internet sexuality includes the following areas of behavior:

Pornography – Internet users have free access to commercially available pornography. That pornography is created by professional studios but also by amateurs. There are some viewers who particularly prefer amateur sex videos.

Sex shops – Internet users may obtain information and discretely order sexual aids and toys online. Online sex shops sell, among others, vibrators, condoms, aphrodisiacs, sexy lingerie, and erotic magazines.

Sex work – The internet serves to publicize offline sex work, such as brothels, sex tourism, or escort services. Online broadcasts of live sex shows may also be done through video calls where the client meets a sex worker for a fee.

Sex education – There is an abundance of information regarding sexuality available on the internet. Conventional sex education materials, such as brochures, are widely available on the internet. Other multi-media learning modules like peer advice from online forums, and sexual field reports in online diaries are available as well.

Sexual contacts – are those who were exclusively found for computer-mediated sexual exchanges. These online sex contacts may end up with real-world, offline sexual encounters. It may consist of fleeting engagements that can lead to long-term relationships as well. By using specific online dating platforms, internet users can initiate offline sexual relations far more easily than they may do so in the 'real world'.

Sexual subcultures – The internet affords sexual minorities, who are out of the mainstream, an easy and inexpensive way to connect with others and garner social support through internet friendships in exchange for information. Online platforms for sexual subcultures may include special supplies for activities such as pornography, sex shops, sex work, sexual education, and sex contacts tailored to the sexual preferences of the user. These are all lawful and non-harmful activities. By contrast, the harmful and unlawful activities expose internet users to the enormous quantity of online sexual content. They may exhibit addictive or compulsive usage patterns which can be harmful for themselves or others, such as sexual harassment or being exposed to unwanted sexual content.

Pornography on the Internet

Explicit, free of charge, and potentially stimulating portrayals of sexual activity exist on the internet in the form of photos, video clips, and texts. Pornographic material is also exchanged in peer-to-peer networks, online forums, and online chat channels. Online pornography includes soft- and hard-core pornography, illegal material such as child pornography, and teen sex which is 'barely legal'. Specialized websites offer violent pornography and animal pornography. It is relatively easy to find free of charge because it is legal in several countries. One of the reasons that online pornography is so widespread is that it is characterized by anonymity, affordability, and accessibility which are described as a 'Triple A-Engine'. It is said that only one percent of all cyber material is pornographic, but that small percentage actually represents many millions of files.

The use of pornography is now common throughout the world. A Norwegian study found that the majority of the population between 18 and 49 years of age (96% of men and 73% of women) has used pornographic magazines, video, films, or internet content at least once in their lives. Online pornography was used in even larger numbers by younger individuals and homosexual/bisexual men and women. A Canadian study found that 72% of males and 24% of female students aged 20 years used online pornography within the previous 12 months. And with the help of computer technology, even blind people can use screen readers to help them consume pornography. It was discovered that pornography is usually consumed by people who are either lonely, or in moments of solitude. When asked about the reasons they consume pornography, the answers provided included curiosity, sexual stimulation, masturbation, and for the enhancement of their sex life with partners.

What Are the Effects of Online Pornography?

Online pornography carries with it certain risks, among them being: cyberporn addiction or victimization through illegal online pornography and negative role models in mainstream internet porn. Research indicated that internet addiction afflicts 2% of all internet users in the United States. For males, an intensive preoccupation with online pornography can negatively impact the quality of heterosexual relationships, both sexually and emotionally. Used in the workplace, online pornography can impair performance and potentially result in employee dismissal. Financial difficulties may befall those who end up paying for online pornography. Child pornography is criminally persecuted all over the world, since it is indisputable that they are abused when being forced into the production of this content.

Psychological treatment has been used to help those compulsive users of illegal online pornography. Traditional mainstream pornography, even without excessive use, may be communicating a sexist portrayal of women, unrealistic body images and unrealistic standards of sexual performance. Thus, creating insecurities related to sexual performance in its viewers. However, whether users imitate online pornographic images depends on numerous factors, including interpersonal communication and consent.

Sex work on the internet – Offline sex tourism, prostitution, and even strip clubs are now widely marketed on the internet, appearing as if it is a normal and acceptable behavior. The internet is believed to play a role in forced prostitution and the sexual trafficking of children and women. Sex work has also developed *online* with live sex shows being broadcasted using webcams. The women involved in those acts feel much safer doing it online than on the street, as they previously did. However, some of these women may have been lured or forced into online sex work under the pretense of it being safe and unproblematic.

Sex education on the internet – Institutions, companies, groups, and individuals use the internet to obtain and provide information about sexuality. Forty-five percent of females and 68% of males occasionally search for sex information online. The wide variety of content, as well as the confidentiality with which it can be obtained, are the main reasons indicated for engaging in such online searches. It must be emphasized that the quality of online sex information cannot be assured, and that there are many questionable sites disseminating incorrect information.

Online sex – is commonly accompanied by the self-masturbation of partners who seek to stimulate one another sexually by exchanging explicit images, and/or video. Contact between them may be fleeting or more enduring. Cybersex may offer sexual and emotional intimacy without the risks that may be present in offline sex such as physical violence, unplanned pregnancy, and the transmission of STDs. Doing it online may assist people in overcoming inhibitions, and encouraging open communication, due to the anonymity it offers. On the internet, there is no need to hide one's sexual inclinations and preferences that are otherwise concealed in the real world. Cybersex allows participants to hide physical handicaps or deformities which they are uncomfortable with, and older people can be made to look younger, and adolescents, older.

The degree to which online sex is experienced as satisfying and meaningful depends on the participants involved. Women, for instance, seem to have a stronger preference for cybersex than men. Cybersex is associated with three forms of risks: *Suffering from acute psychological afflictions* due to the compulsive preoccupation with online sex. Cybersex may be perceived as *betrayal* (Cyber infidelity) by one's partner and may lead to a crisis in the couple's relationship. If cybersex is not initiated on mutual consent, it may result in what can be perceived as online sexual harassment or sexual solicitation among adults, adolescents, and even children.

Online Use for Offline Sex: Advantages and Disadvantages

The internet can also be used to seek *offline sex*. A British survey indicated that 7% and 5% of heterosexual women, 14% and 10% of heterosexual men, and 47% and 44% of gay men had used the internet to search for offline sex partners within the past 12 months. Individuals actively participating in sex with online partners were noted in single women between 34 and 65 years old, and homosexual/bisexual men. Communication on the internet is achieved via e-mail, instant messenger, webcam, or Skype, which allows for the matching of physical attractiveness, sexual preferences, or preferred safe-sex practices to occur. Sometimes, prior to meeting in the real world, potential partners engage in online sex in order to test their sexual compatibility. The internet enables sexual contact among people who live in geographic isolation, as well as among people who have little access to typical locations where sexual partners can be met. However, that may lead to dangerous meetings. The internet also plays a role in sexual crimes against minors by family members and acquaintances. Its easily accessible platform helps set safe spaces for individuals of similar creeds and sexual orientations to meet. It can ameliorate social isolation while facilitating social networking to help communicate practical information.

Research has indicated that sex contacts initiated via the internet are quite prevalent and popular despite the dangers it may pose to people's safety and psychological well-being. They may result in sexual harassment, sexual abuse, addictive overuse and infidelity. There may also be a potential spread of STDs involved as well when moved to offline contact. As far as sex shops are concerned, there may be some opportunities such as the removal of taboos regarding sex toys like vibrators, but also risks, such as unregulated online sales of prescription medications like Viagra, which may actually be harmful to its users.

Hooking Up

Hooking up is a term used to describe casual sexual encounters (ranging from kissing to intercourse) between two people with no clear mutual expectation of further interactions or a committed relationship. It is different from Friends with Benefits (FWB) who may engage in casual sex without the emotional commitment. It was found that between 50-80% of young adults engage in hooking up. Individuals who are less thoughtful about relational encounters and transitions may slide into hooking up without much thought about the potential outcomes, be it positive or negative.

Alcohol is thought to “grease” the slide into hooking up by lowering inhibitions and altering the decision-making process. Due to the masculine norms and pressures placed onto men, they may engage in hooking up more often than women do. Women hookup more if alcohol is involved. This may promote riskier and more frequent sexual behavior to unfold as a result. It was suggested that hooking up may serve as a means for a distressed individual to feel better about themselves or to achieve an intimate, albeit brief, connection with another person. And indeed, a 2003 study of adolescents found that in virgins aged 12-21, those who displayed depressive symptoms and delinquent behaviors tended to engage in casual sex behaviors, which may not involve penetration.

A large-scale 2011 study examined hookup patterns of 856 U.S. university students. It was found that 57% of young adults hooked up and, of those, nearly 55% engaged in penetrative hook ups. Overall, it was found that the best predictor of future hooking up behavior was previous hooking up behavior, especially if it was a positive experience. It appears that in young adults, alcohol use increases the likelihood that the physical exploration will include penetrative encounters.

It was hypothesized that young adults’ loneliness may be associated with a greater likelihood of hooking up due to a desire to be more connected to others. It was also found that young adults who struggled with depressive symptoms and greater feelings of loneliness at the beginning of the semester, reported much less depression and loneliness once they engaged in penetrative hook ups. This may suggest that hookups are used as a means to cope with stresses which youngsters, and especially college students, tend to face.

Why, We May Wonder, Has Hooking Up Become the Norm on College Campuses?

To answer that question, we need to look at shifts in intimacy throughout the 20th century. Prior to the 1920s, men and women would practice the art of courting through specialized procedures. This would involve the young man being invited to call on a young woman at her home whilst meeting her parents and introducing himself to the family. The family would then decide whether the young couple were appropriate partners for marriage. If the parents did not like him, they could veto the relationship and decide that it cannot go any further.

Cinemas, dance halls and increased access to private cars during the 1920s also allowed young people to escape the watchful eye of parents, and so “dating” became the norm. Youngsters met their dates to have fun without focusing on the ‘end goal’ of marriage. Strict codes ensured that the couple heeded social norms. That included choosing partners on the basis of social desirability. The dating script began to shift with World War II, which restricted

the number of available bachelors to date, and "going steady" with one person became the norm. Sexual commitment became an acceptable part of dating and some couples even gave each other a memento to wear as a signal to others that the person was 'taken'. The ultimate goal was to find a suitable marriage partner.

However, the feminist movement of the 1960s changed the dating scene again. Campus students joined parties and event groups to find suitable dating partners or for casual sex. This was made possible due to the development of birth control pills. This greater permissiveness of sexual attitudes and norms led to changes in behavior such as increased premarital sex. Students became active agents of their own sexuality. These changes carried over to our present hookup culture. Young adults are attending colleges in greater numbers. Thus, the campuses become a fertile ground where they can experiment with sexual behavior and freely interact with the opposite sex without any restrictions from parents. Recent statistics indicate that rates of hooking up on college campuses range from 53% to 76% of the student population, with significantly more male participation.

Some students hookup with "randoms," although the majority of students' hookup with friends, classmates, or other students with whom they are familiar with and may do so several times during a semester. Different people have various expectations of hooking up. Freshmen entering college seem to participate in hooking up with the hope that these encounters may lead to an exclusive romantic relationship. However, when it is understood that it may not lead to a permanent relationship, they lower their expectations and disassociate love from sex in order fit in with peers. Once they leave college, students become more serious about relationships and their partner's marriage potential.

Sexting and Sextortion

Sexting is composed of the words 'sex' and 'texting' which is used to convey sensual messages that are expressed and displayed through a variety of sexual behaviors. It is typically transmitted through photos, and or videos via digital technology, including cell phones, emails, and the internet. It is effortless to send, receive, and forward, and that is what contributes to its popularity. Sexting material can be circulated within a matter of seconds over the internet and through cellphones where the control over what has been sent could be lost forever the moment it has been sent.

Texting is mainly practiced by adolescents and emerging adults. Emerging adults enter a volition phase while discovering their independence. They often fail to realize the dangers that posting those 'fleshy' pictures or videos online may have for their future, and that others may view them without their consent or control. Additional risks involved may include sending sexual material to individuals they know little about or to complete strangers who may demand of more lustful imagery. Sexting could lead to sexual victimization, where individuals may be pressured into performing acts that they have never considered engaging in before, hence 'sextortion'.

Victims of sextortion have traditionally been blackmailed with the use of their own sexually-explicit material. These sexual images and/or videos may be used as blackmail to extort the individual with threats of hurting the person, or to inflict damage to his or her property. And while most sextortion remains hidden, due to its embarrassment, it is not

uncommon for youngsters to be badgered after their explicit photos and videos are forwarded to others. This may result in severe harassment, suicide, or legal cases that are implicating adolescents who are criminally charged for child pornography.

Females, commonly, sext to gain the interest of another person whereas males may sext to lure in or arouse females to engage in additional sexual activities. Fifty-percent more females than males are asked to send sexting materials and are more disturbed by the request of transmitting indecent pictures and videos. Sexting may also be encouraged during the beginning of a relationship to maintain the closeness and 'spark' between partners. Other motivations could be related to seeking attentiveness through flirtatiousness or a desire to increase one's social status.

Engaging in sexting behaviors resulting in negative outcomes may exacerbate the turmoil that adolescents and emerging adults are known to experience. When sexually explicit material is being potentially circulated over the internet, it may leave the person feeling demeaned and tarnished. That may result in self-mutilation related to anxiety, depression, decreased self-esteem, and social isolation. Cyberbullying as well as other forms of harassment have been associated with several conditions such as anxiety disorder, affective disorder, psychotic disorder, somatic disorder, conduct disorder, and substance abuse. Sexting has also been associated with a higher likelihood of being sexually active and engaging in riskier sexual behavior, such as having unprotected sex and consuming alcohol and drugs prior to sexual activity. Regarding attitudes towards sexting, it was found that previous sext users had a more positive attitude towards this practice.

Clearly, sexting may have negative and dire consequences. Research findings highlight the need for professionals working with children, adolescents, and emerging adults in clinical and school settings to be aware of the issue. And as sexting behavior appears to be related to sexual activity and risk behaviors, awareness of the practice of sexting might indicate the need for inquiry and signal the possibility of sexting being part of a broader set of behaviors.

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> Little Sally came home from school with a smile on her face, and told her mother, "Frankie Brown showed me his weenie today at the playground!" Before the mother could raise a concern, Sally went on to say, "It reminded me of a peanut." Relaxing with a hidden smile, Sally's mom asked, "Really small, was it?" Sally replied, "No, salty." Mom fainted.

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Chapter 5

Belonging, Love and Intimacy

Several years ago, I saw Jim and Anna for marital therapy. The couple, in their mid forties, complained that they were unsatisfied in their marriage; that their love had dried up, and that they were wondering whether they were headed for divorce. We engaged in marital therapy, examined their connection and commitment issues, and discovered that they, actually, still cared for each other. They, then, asked how to revive their marriage and reignite their love. I responded by "date each other," to which they replied in a tired look saying "roses, movies, presents"? No, I said. I asked them what is the bottom line of dating? What is it trying to do? They did not know, like many others whom I've asked since. Married couples are together since there is an agreement between them, and overtime, they start to take each other for granted. Dating, and all we do while we date, actually aims to get the other person to WANT to be with us. Not just to be with us, but to want to do so. That is the very basis of love and relationships.

Longing to Belong

Humans are fundamentally social creatures whose quality of life depends on others. We have a need for social interactions and flourish with its use. But upon facing social disconnection, our psychological, physiological and even spiritual well-being is negatively affected. To put it quite simply, we yearn to belong. Our whole survival depends on it. And like animals, humans cannot simply survive on their own. Dr. Ornish, a famed cardiologist, observed that our experiences of isolation often lead to illness and suffering, while love, intimacy, community and connection heals and nurtures us. Research has pointed out that those in mutually nurturing relationships report higher satisfaction than those who are in non-caring ones. Everyone desires to be socially accepted and valued, and lack thereof is known to cause stress and suffering. Moreover, since social connection is so important to us, there may be an "internal gauge" which is referred to as the 'socio-meter' that helps us constantly monitor the environment for clues of our inclusionary status. Highlighting the importance of social connections and belonging, Ornish asserted that "…Our survival depends on the healing power of love, intimacy, and relationships. Physically. Emotionally. Spiritually. As individuals. As communities. As a culture. Perhaps even as a species."

Over several centuries, the church has understood the centrality of belongingness and used ex-communication, the church's most severe social reprimand, as a way to punish those who they thought deserved punishment. In jail, unruly criminals may face solitary confinement. Similarly, research has shown that we actually respond the same way when reacting to physically and socially painful events. Take, for instance, a situation where we may be interpersonally rejected. In such cases, one may experience a sort of numbness (that is similar to physical analgesia as an initial response to trauma) that protects us from distressing emotional reactions. Eventually, this analgesic effect will fade away and the social (or in the

other case, physical) effects will be experienced. Needs for belonging which remain unfulfilled may lead to social isolation, alienation, and loneliness. It is, generally, the discrepancy between the *need to belong* and the degree to which that need is satisfied that is crucial in ushering the experience of loneliness.

Why Do We, Actually, Yearn so Much to Belong?

Ours was dubbed the age of relationships. We highly value the importance, uniqueness, and availability of the different ways we relate to others. We often believe that we know how to conquer the barriers against closeness that we ourselves have erected. In this day and age, relationships appear to be the main or even, the only avenue, by which self-esteem can truly be affirmed. Suzzanne Gordon's 1976 book about loneliness observed that "…to be alone is to be different, to be different is to be alone, and to be in the interior of this fatal circle is to be lonely. To be lonely is to have failed." This explains the stigma which is often associated with loneliness that causes people to deny it – especially to themselves but also to others. However, a paradox is created. While we yearn for closeness, our present lifestyle creates and reinforces isolation, making loneliness even more difficult to cope with.

A social support network formed by friends and acquaintances can offer various kinds of support which can be grouped into three categories: *Instrumental support* – which involves the provision of material and practical help, like helping you move, or loaning you a lawnmower; *Informational support* – giving information which could aid the receiver to cope with difficulties or current problems. This includes such things as informing you who is the best doctor for what you need, or which store has what you are looking for; and *Emotional support* – expressing empathy, care, and reassurance when it is needed during hard times. As research has indicated, such support can buffer the negative impact of stress on our psychological distress, and lower depression, and anxiety. In general, people who are part of a social network are, naturally, subjected to social influence and such influence may, for instance, direct them towards taking care of their health. By abiding by those messages from their support network, one may get a sense of identity, stability, belonging, and self-worth. Social isolation, and the loneliness that may follow, may serve as a stressor which may decrease one's sense of control and self-esteem, which has been shown to suppress immune function and interfere with practiced health behaviours.

What is, then, a community which we want to belong to? It is viewed as a network of significant relationships that are characterized by caring, mutual valuing, and commitment. Those that form that network are committed to each other and interact on an ongoing basis. Being a part of that network provides the members a feeling of fitting in; of belonging and of being of value to others. And although today's society is not as cohesive, close knitted, and involved in its members' lives as it has been in yesteryears, the longing to belong still exists as it is an integral part of being human. In our digital age, Facebook has provided a partial answer to this paradox. It shows our desire to belong and be connected, but with a preference of doing it 'the long-distance way' via the internet versus the face-to-face interaction that was such an accepted part of life in the pre-internet days.

Since infancy, we have very little capacity for self-regulation, and our internal biological states such as heart rates, hormone levels, and nervous system activity, depend completely on the infant's relationship with their caregivers. Those emotional and social relationships remain central after we mature as well. Our species did not evolve as solitary creatures but as social animals who depend on the emotional connections with family and the tribe. These connections are an integral part of our neurological and chemical makeup. Research demonstrated that social support helps reduce physiological stress, and people who are more isolated are more prone to illness. Mortality risk is negatively correlated with social integration, meaning that mortality drops when there is meaningful social connection present.

Love, Attraction, and Intimate Relationships

People need to be part of an intimate, lasting and caring relationship with a partner who is close and deeply concerned about them. To fulfill that need, people establish close contact with others and partake in intimate relationships. When they are part of a close and emotionally intimate relationship, people live longer, healthier, happier and more fulfilling lives.

Philosophers' View of Love

Jean-Luc Marion, the philosopher, observed that it is love or the act of loving that makes one his own person. He further stated that "I do not become myself when I simply think, doubt, or imagine, because others can think my thoughts [. . .] nor do I become myself when I will, desire, or hope [. . .] But I become myself definitely each time and for as long as I, as lover, can love first." Love can actually be one way of living in a world that we did not chose or create, while simultaneously being socially inclined and take an active stance toward the future. That is best done in concert with the one who cares about us. Thus, love was conceptualized as a tension between activity and passivity, such as listening vs. speaking or gratitude vs. nonsatisfaction. Love, as we may know from personal experience, just happens. But it can also evaporate. And yet, innumerable philosophical and scientific attempts to understand love and to explore its peculiar forms have been made since the beginning of time.

We do not freely choose our existence, but are sort of thrown into a world that is already there. In that world, there are limits to our freedom. In that vein, we cannot voluntarily choose to love another person. The one we fall in love with is given to us by a world that is not interested in explaining itself. The person we end up loving does not necessitate a decision or responsibility. Clearly, we cannot be forced to love someone, which can be seen as an expression of personal freedom, since our ability to make choices and take responsibility is an integral part of living. We are unsure, as of yet, whether this responsibility is primarily for the individual's existence or, alternatively, for the loved one.

Martin Buber, the philosopher, observed that we cannot act for the one we love without it affecting us, such is the connection between the two people. That means that taking responsibility always includes the loved one. As we may have experienced, being in love and intimate with another exposes us to each other's most vulnerable state. Some call love "risky" as it calls upon us to be responsible for something that we have not chosen but rather have

fallen into, and that may significantly affect us and the one we love. Thus, falling in love has been described as a form of 'dementia' of one's former existence, since it was claimed that we cannot fall in love if we are even partly satisfied with what and who we are.

There is a philosophical debate as to whether we fall in love in response to the other person's qualities, or whether love, in fact, creates the value we ascribe to the person that we are drawn to. From an existential perspective which considers human nature to be open-ended, flexible and capable of an enormous range of experiences, love is related to the one we fall in love with as he or she were *prior* to our meeting. Love, as those who experienced it know, consists of a focused attention to that person's attractive qualities, which places the object of our love in their most favorable light. And even though love carries the risk of being narcissistic and idealizing, it should first and foremost consist of focusing on the loved one's good qualities. Loving is therefore both a response to an existing situation, as well as a cocreation of something new.

Love also intensifies selfhood. In love, I become who I am by allowing both myself and the loved one to become who we are, rather than who I thought we were, meaning being truly ourselves. Falling in love is not a passive experience, since we actively respond to the one we love. In love, we respond to the loved one with belief that it will endure, persist and include a commitment to fidelity. Love affords us the realization of the 'we-ness' in a common and shared future. The decision to establish a relationship with the loved one is an expression of our personal freedom, since we may fall in love with or without realizing or wanting it, but entering a love relationship is solely based on our free will. The result is the combination of our wills, but it is also *my* responsibility. I choose the other, and by making that choice, I exclude all other people from the range of possible love companions. Love is exclusive, and by it I declare that 'I want you' and consequently do not want all the others. And even though love involves a certain appreciation of the qualities of the beloved, it is actually a situation where the beloved becomes valuable merely by attaching and committing himself to him/her. Hence, beginning a process that cannot be stipulated, nor predicted in advance, but still includes a commitment to be with the loved one.

How Does Love Affect Us?

As we discussed earlier, humans have a fundamental need to attach and belong. They thrive when they are intimately connected to significant others. Feelings of intimacy can emerge in any social interactions, and progress to emotional and physical intimacy. A key component of intimacy is the extent to which their partners understand, validate, and care for them. The response from one's partner provides the person with a validation of the self, resulting in feelings of acceptance, warmth, belonging, and trust which are known to contribute to the development of emotional and physical well-being. Research has demonstrated that physical symptoms of ill people decrease if they are involved in an intimate and loving relationship which may also contribute to their vitality. Loving and affectionate newlyweds who were observed during lab interactions were found to more satisfied with their marriage. Brain imaging studies show that intimacy, acceptance, and romantic love are associated with effects that impact neural activity and our health. And apparently, being accepted (vs. rejected) by a potential romantic partner increases activation in opioid receptors, including endorphins and dopamine. These chemicals are related to feelings of reward and positive affect, with its

hormones affecting regions that are involved in pain and mood regulation. And additionally, thinking about one's romantic partner leads to increases in blood glucose levels (which, arguably, may not be suitable for diabetics). Another piece of evidence regarding the importance of closeness, which has received quite a lot of attention, is touch. Physical touch and intimacy are essential to our well-being and can positively influence our health. Research has shown that couples who held hands or hug experience a decrease in somatic symptoms.

Overall, it is well accepted now that close relationships significantly enhance positive emotions and positively impact our well-being and resilience. Love may serve as a very fundamental dimension linking connection and relatedness to well-being. Generally, love is perceived as an emotion, a type of a thinking pattern, and as a motivational state that encourages us to act. To summarize the varied and multi-faceted research on love, it should be noted that love is referred to as self-organized; meaning that it cannot be created or imposed from the outside. Love is dynamic, adaptive and context dependent.

How Was Love Seen in Ancient Times?

"What 'tis to love?" asked Shakespeare in *As You Like It* and, indeed, since the time of the ancient Greeks, there have been literally hundreds of theories that aimed to describe and explain love; that emotion that 'we know when we feel it' but find hard to define.

Early Buddhist and Greek writings are responsible for our present-day notions of love. The *Buddhists* conceived of two forms of love: a) self-love, which they saw as the unfortunate kind of love, and b) the creative spiritual attainment, which to them was the "good" kind of love. This was the "love of detachment," which focused on accepting people the way they are and not expecting them to change so we could bestow our affection on them. That is considered the best love to a Buddhist.

There were three kinds of love for the *Greeks*: phileo, agape, and eros. Phileo is based on friendship and is commonly found between family members, friends, as well as between lovers. In our modern day, we may refer to it as affection or fondness. Agape love is focused on the well-being of others. It is, thus, a spiritual and not a sexual kind of love. It is altruistic and requires nothing in return. Such love is given without the expectation of being reciprocated. Eros is sexual love which seeks gratification and sexual expression. In the days of Plato, this kind of love was reserved for marriage between a man and a woman, and even more so for homosexuals who experienced the highest form of love which was aimed at a partner without expecting offspring or marriage.

However, love in the 1100s was influenced by economic, political, and family structure. During those times, love was independent of marriage but was based on the adoration of physical beauty. It could, interestingly, occur between married partners or unmarried people. Thus, romantic love was mainly found in extramarital relations rather than between spouses – kind of the opposite of what we expect these days. Only in medieval times did marriage start to be based on love.

Intimacy and love are experienced universally in all cultures and by all people. But although universal, relationships and intimacy are influenced by the times and the culture in which they occur. Below is a brief overview of the interesting relational patterns in the U.S.:

a) Fewer people got married in the dawn of the 21st century than ever before, though many lived and resided together. While in the 1960s, 94% of people married at some point in their lives, only 85% of today's young adults are expected to marry. In light of separation, divorce, widowhood, and those who never married, only 52% of the adult population in the Western world is presently married.
b) As most readers can gauge, people marry now at an older age. On average, women are 26 and men are 28 years old when they first marry. Up to 46%(!) reach their mid-30s without being married.
c) In the 1960s, it was rare, but often shameful, when babies were born out of wedlock. Now, it is not uncommon for unwedded or single parents to have a child. Additionally, it has been reported that in the first two decades of the 21st century, up to 41% of children were born to unwed mothers up from 28% in the 1990s; the highest rate ever recorded in the Western world.
d) Half of all marriages now end in divorce. Marriage was once a sacred institution which was expected to last until people were separated by death. But now, can be interpreted as an attempt to be together until it is no longer convenient, pleasant or possible. It is like a common ship that hits an iceberg and the couple either drowns or jumps to safety, each swimming in a different direction.
e) Up to 40% of children live in a single parent home. As they grow up, they witness a variety of adults come and go through their homes, affecting them in enumerable ways – good, bad, and sometimes harmful.
f) While in the 1960s, for example, 75% of mothers stayed home during their children's pre-schooling years, only 40% of them do so now. This day and age, most mothers work, and the "latchkey kids" of yesteryear are seen again in growing numbers.

What affects intimate relationships, cohabitation, and parenting? There is a close connection between cultural standards and intimate relationships. Cohabitation is a relatively recent development in relational arrangements and is supposed to help the couple adjust to each other in preparation of their life together when wedded. Research, in fact, indicates the opposite. If a subsequent marriage takes place after cohabitation, it has an increased chance to end in divorce.

In the Western world, the emphasis on personal expression and fulfillment where people are encouraged to focus on themselves, does not bode well with intimate connection with another person. Some researchers opined that this trend, among others in Western societies, may increase loneliness. That may include the increasing number of those living alone, and the number of divorces and prevalence of temporary, unstable cohabitation. Social relations, thus, seem to be more fluid and unstable, making people more vulnerable to loneliness.

Dr. James Lynch, a cardiologist who wrote about loneliness and the broken heart, observed that mortality rates for divorced, single, and widowed people were consistently higher for people of all races, genders and ages in the U.S. This finding is striking since death rates in unmarried individuals may be as high as ten times(!) the rate of married individuals of comparable ages. As if to confirm the above finding, a large-scale study of men, found that those who later experienced myocardial infarctions reported a higher incidence of dissatisfaction with their marital lives and did not feel supported by their partner. Ornish, a noted physician who created a special program and diet to deal with cardiac problems, described a very large-scale research study that looked at 10,000 married men with no prior

history of heart related complaints. What he and his team found was that in general, men who suffered from significant risk factors such as elevated cholesterol, high blood pressure, age, diabetes, or electrocardiogram abnormalities were found to be 20 times more likely to develop chest pain (angina) over the next five years. Astonishingly, the men in that study were asked a simple question, “Does your wife show her love?” Men who received that love had suffered from significantly less angina, even when they had high levels of the risk factors we mentioned previously. Men who were in a loveless marriage showed a substantial increase in angina.

Love and Attachment

Dr. Bowlby, the noted British psychiatrist, and Dr. Harlow, the American psychologist, described infants as innately relationship-seeking. And in order to survive, they naturally seek closer proximity to their caregivers. Bowlby observed that the infant’s caregivers (who may be its parents or significant others), or attachment figures as Bowlby termed them, need to provide a “safe haven” during times of need in which an infant can explore comfortably. Other researchers extended Bowlby’s conceptualization of attachment figures into adulthood and observed that adult romantic bonds are actually emotional attachments which are significantly influenced by the bonds the infant had with his caregivers.

Apparently, love in infancy as well as in adulthood is expressed similarly in activities such as crying, clinging, and a desire to be comforted by a partner or primary caregiver. This is associated with the expectation of experiencing happiness upon a reunion. In both kinds of relationships, when the partner (or primary caregiver) is not available or does not respond to the other person’s search for proximity, the one seeking closeness may become “obsessed” with getting it and become hypersensitive to signs of rejection or disapproval.

Attachment is classified mainly into three types which serve to illustrate the three *intimate* adult attachment versions:

- *Secure* – The person feels relatively comfortable being close to others and is able to depend on them. They are not worried about being abandoned or about someone getting too close to them. Either way, they feel comfortable in relationships.
- *Avoidant* – The individual is uncomfortable being close to others and has great difficulty trusting that they will not disappoint them and leave, and thus finds it difficult to allow themself to depend on them.
- *Anxious* – This person would like others to get closer to them, even closer than what they are comfortable with. They are worried that their partner doesn’t really love them and may not be committed to them. Such an individual desires closeness with their partner, and that may arouse discomfort in the partner.

Drs. Cindy Hazan and Phillip Shaver and other researchers who applied attachment theory to romantic relationships illustrated the *general* adult attachment versions, and provided examples of the way the person may think or behave:

- *Secure* – I find it relatively easy to get close to others and am comfortable depending on them and having them depend on me. I don't worry about being abandoned or about someone getting too close to me.
- *Avoidant* – I am somewhat uncomfortable being close to others; I find it difficult to trust them completely. I am nervous when anyone gets too close, and often others want me to be more intimate than I feel comfortable being.
- *Anxious* – I find that others are reluctant to get as close as I would like. I often worry that my partner doesn't really love me or won't want to stay with me. I want to get very close to my partner, and this sometimes scares people away."

Romantic relationships, love, and sex are significantly affected by attachment to one's partner, the caregiving behavior that they both display, and their sexual relationships. Research has demonstrated that people with a secure attachment style enjoy higher levels of relational stability and greater satisfaction with their dating and marriage journeys. They also report higher levels of intimacy and commitment.

As we stated earlier, adults in their romantic relationships tend to display the same attachment style that they displayed during infancy. Securely attached adults perceived their loving relationships to be friendly, warm, and supportive. Intimacy was the central theme of their romantic relationships, and they believe that love can be maintained over a long period of time. Avoidant attachment style individuals reported having romantic relationships which were described as not warm or friendly and lacking in emotional involvement. In their time of not wanting to experience closeness which they may then lose, love fades over time, and the kind of love depicted in novels and movies is simply unrealistic. Anxiously attached people characterized their romantic involvement as containing strong physical attraction, a desire to merge and unite with their partner, and proneness to fall in love somewhat indiscriminately. They described their lovers as untrustworthy and unsupportive, and rejection brought in them intense bouts of jealousy and anger.

The Nature of Love

The question about the nature of love is probably as old as humanity. Writers, philosophers, poets, and sculptors have attempted to describe and capture its meaning for centuries but have only recently begun to invite social scientists to join this conversation. Many people experience love together with sexual activity and feelings of sexual desire. Love is one of the main reasons for people to have sex. Love is elusive, and although we are supposed to know what it is and when we feel it, those caught in its spell cannot define it. Love may, at times, be confused with lust and infatuation. Research has concluded, without a doubt, that a person responds with their entire body when they feel desire. When one is around an object of their desire, adrenaline – or epinephrine – is released in their brain and that causes the person's heart rate to increase, his pupils dilate, the sweat glands are stimulated, and the brain becomes increasingly more alert. This reaction is exactly how people describe the feeling and energy of being "in love."

Love is expressed and experienced differently by women and men. With respect to the expression of love, surprisingly little psychological research has focused on the expression "I love you," even though these three small words appear to be a critical demarcation in

relationships. These expressions of affection are thought to be decisive moments for the advancement of romantic relationships. As we know, women and men differ in their expression of emotions. Women are faster at perceiving others' emotions and have more confidence than men when expressing affection, liking, and love to the opposite sex. This view may also explain why men, who are not known for their ability to express emotions, may experience intimacy, parenting, and relationship problems. Although women, relative to men, are making more careful assessments of their partners before committing sexually and emotionally to a relationship. No other differences between the genders were found, indicating that women are not greater fools for love than are men as the common societal stereotype. In fact, research indicated that both sexes are equally as pragmatic and as foolish about love.

Dr. Zick Rubin was the first psychologist to write extensively about love. He defined it as an attitude that causes one to think, feel, and act in specific ways towards the love object. He further suggested that love has three components: intimacy, need/attachment, and caring. Other theoreticians have differentiated between compassionate and passionate love. They state that while compassionate love is characterized by friendly affection and brings about caring, trust, honesty, and respect (which we commonly may feel towards our friends and family), passionate love is characterized by emotional extremes, physiological arousal, and sexual attraction.

Dr. Robert Sternberg, an American psychologist, proposed what is known as the triangular theory of love, with intimacy, passion, and commitment as its pinnacles. *Intimacy* is composed of the feelings of attachment and closeness in a relationship, where we feel comfortable to share secrets with another person. *Passion* involves the feelings of sexual and romantic attraction. *Commitment* includes a willingness in the short-term to create and maintain a relationship with eventual long-term plans to continue that relationship. Sternberg's interesting illumination of the concept of love was in his description of eight different kinds of love resulting from the various combinations of these three elements:

- *Non-love,* which is the absence of any three 'ingredients' of love. It indicates a lack of connection; an indifferent relationship.
- *Liking/Friendship* results from the presence of intimacy without passion or commitment. This type is found in friendships.
- *Infatuated love* is passion without intimacy or commitment, commonly referred to as "puppy love." Romantic relationships often start out as infatuated love and become romantic love as intimacy develops over time. Without developing intimacy or commitment, this kind of love may disappear quickly and suddenly.
- *Empty love* includes commitment without intimacy or passion, making one wonder whether it is love at all. Couples who may have been together for many years may find themselves in empty love if the couple does not guard against it.
- *Romantic love* is passionate and intimate but has no commitment. This could be considered as a romantic affair.
- *Companionate love* is intimate and committed but without passion. It is akin to what we may observe in long term relationships where the couple is committed, close to each other emotionally and are intimate, but non-passionate.
- *Fatuous love* has passion and commitment but no intimacy. We can see it at what was termed 'Love at first sight'.

- *Consummate love* is the complete form of love, representing an ideal relationship which people strive towards, and possibly not many achieve.

Dr. Beverley Fehr, who conducted many studies about love and relationships, wanted to find out what ordinary people think about love. She asked lay people what love was to them. She found that the features that were listed frequently included honesty, trust, and caring. Interestingly, dependency, sexual passion, and physical attraction were listed infrequently. She concluded that lay people perceive love to encompass both compassionate and passionate styles which were described above. More specifically, she observed that lay people regarded compassionate love as central to love, whereas passionate kinds of love were considered as less central or important to them.

To conclude, let's look at an eloquent definition of love that was offered by two researchers. They exclaimed that "To love someone romantically is…to experience a strong desire for union with someone who is deemed entirely unique. It is to idealize this person, to think constantly about him or her, and to discover that one's own life priorities have changed dramatically. It is to care deeply for the person's well-being, and to feel pain or emptiness when he or she is absent."

Romantic love, which is what most of us think about when we hear the word 'love', has a unique constellation of emotions, behaviors, and motivations. It evolves when an individual regards another as special or even unique. The lover then intensely focuses on the preferred person, magnifying his or her better traits and minimizing or even ignoring flaws. Love was described as including extreme energy, euphoria, sleeplessness, impulsivity, and mood swings, which act as strong motivators for the person experiencing it to win the beloved's heart. Once won over, the lovers become emotionally dependent on their relationship, and commonly reorder their daily activities in order to maximize their closeness to the love object. They may also experience separation anxiety when they part.

Rejected lovers, a pain that few of us 'missed' experiencing, may bring about depression, rage, and despair. It may even encourage engagement in extraordinary and even inappropriate efforts to win back their sweetheart. Romantic love has been said to be involuntary, meaning it is difficult to control, and impermanent. Romantic love evolves over time and when asked about their love after several years of marriage, most of those who manage to stay married report reduced passion in their relationship. Moreover, research demonstrated that the decrease in romantic love may be rapid. Sadly, with only two years into the marriage, married couples are 50% less affectionate to their partner than they were before they were married. For couples who are fortunate and married, their passionate love into compassionate love; a love that may last a lifetime.

Love as a Tool to Enhance Commitment

Elementary economics clearly indicates that a person who may be holding valuable resources does not give them away indiscriminately. That, of course, makes intuitive sense. It poses an interesting question, however, which asks how one knows whether their partner is going to be there through thick and thin? Through sickness and health? It was hypothesized that love is, in part, a solution to that quandary. It could be that the person was chosen as a mate for "rational" reasons, but *commitment* can be maintained when one is blinded by an uncontrollable love that

cannot be helped and cannot be chosen. A love for only one specific person and no other. And when that happens, commitment is almost assured. It ensures that you will not leave when someone more desirable comes along.

Dr. Ornish, the famed physician, highlighted the evolutionary fact that humans are 'touchy-feely' creatures. In fact, the past thousands of years has shown that those who learned to care for and love each other were more likely to survive than those who did not. He suggested that in our individualistic cultures, we have neglected caring for each other, and that may negatively affect our survival. He maintained that love is not only soul nourishing but can heal us physically as well.

Love Is Found All Over the World

fMRI (functional magnetic resonance imaging) research discovered that the brains of people who reported that they were in love seemed to deactivate brain centers responsible for assessing others and making moral judgments. That research supports the claims that love is blind which purports that when we are in love, we tend to overlook the loved one's faults. Secondly, love is universal and is part of human nature; thus, it can be traced to our neural connections in the brain.

Love is universal, and humans have the capacity to feel love, regardless of their culture, gender, or age. An interesting example of the universality of love can be found in the attempt of the Oneida society. In the nineteenth century, romantic love was believed to be fictitious and as a deceit which was invented to cover up sexual lust. The Shakers, or in their more formal name the 'United Society of Believers in Christ's Second Appearing', was a Protestant sect founded in England in 1747. They sought to banish love since they saw it as undignified and a threat to the larger society. They did not succeed. The Mormons, in the nineteenth century, viewed love as a disruption in one's life and sought to banish it. Not surprisingly, romantic love persisted and flourished, hidden from the harsh eyes of the group's elders. Apparently, suppressing or prohibiting love can only enhance it. People may attempt to control their feelings or their expression of them, but cannot completely erase them. Love is universal and transcends cultural and geographical borders. A saying I heard suggests that love does not make the world go round, but it makes the ride worthwhile.

Love in Various Cultures

While love is universal, the way it is expressed is not. Love, the emotion, is experienced identically in the U.S. and say, in China. It is noted that romantic and compassionate love are also recognized as distinctly unique across cultures, although there are some interesting cultural nuances. Americans for instance, when asked about falling in love, emphasize the similarities between themselves and their partner, and frequently, the latter's good looks. Chinese people, on the other hand, when talking about the one they love, describe their partner's desired personality, their opinions, and their own physical arousal when addressing their feelings of love. Romantic fantasies – which color love in warm tones with the hope that it will last forever – are more common in America, while the Chinese tend to view it in less 'cozy' tones.

Finally, in Western society, love is a requirement for marriage which cannot be said in the East. College students in China are commonly guided by their parents when they seek a partner to marry, whereas in America the one who plans to marry makes that choice.

There are similarities, but also differences, in which various cultures view love. For instance, in individualistic cultures like ours, where the individual is empowered to look after his or her needs first, people focus mainly on achieving their personal goals. Collectivistic cultures where the community is held in high importance, such as in India or China, value communal goals, group membership, and personal sacrifice for the good of the community. As far as love is concerned, individualistic cultures hail passionate love as a basis for marriage much more than collectivistic cultures do, and thus arranged marriages are much more common in those collectivistic cultures. Exploring undergraduate students who studied in Toronto about their love styles indicated that students from Asian backgrounds (Chinese, Japanese, Korean, Indian, Pakistani) were more likely to describe love in terms of friendship, more so than students from European backgrounds. Similarities exist between cultures in regard to passionate love. It was, shown repeatedly that love is a universal phenomenon. An interesting research study was conducted that asked 9,000 people from 33 cultures what characteristics they found desirable in a potential mate with significant similarities which were found cross-culturally. Almost all participants indicated that dependability, emotional stability, intelligence, kindness, and understanding were seen as highly desirable. And so, regardless of their culture of origin, humans describe and behave in choosing and being with a mate similarly.

How Do Men and Women Differ in Love?

Love exists and seems to have a clear evolutionary goal, as we previously noted. In addition, love feels good and is invigorating, so it is something that (a) people wish to feel, but (b) can be exploited and ruthlessly manipulated. It has been observed, and may not surprise us, that some men deceive women about the great depths of their love and intention to commit to the relationship to gain sexual favors. While men may use "love" to get sex, women are said to be using sex as a means of getting love.

Along the years, both men and women have developed defenses to protect against deception, and those behaviors were described as the "arms race" of strategies to deceive, and to counter that deception. Men appear to place a greater premium than women on physical appearance. Evolution may help us understand why. Physical appearance has been providing the man, along history, with information about the woman's youth and health – giving him an idea as to the chances of having healthy children with her. Women, too, value physical appearance since it sends a message about the man's youth and his reproductive ability, which is of high importance to women. The physical features that support the "attractiveness-fertility" links include clear and smooth skin, slim build, lustrous long hair, symmetrical features, relatively small waist and relatively large breasts. Women, on the other hand, seek qualities that cannot be seen on the man, such as his ambition, his industriousness, his ability to produce, and the chances of his status to increase. All of these qualities are related to understanding whether he would be an appropriate provider for her and her children.

Cultural stereotypes also indicate that women generally love men more than they are loved in return. However, there is little research to support this stereotype. As far as passionate love is concerned, sometimes women are found to be more passionate, while other studies find that

it is actually men who are more passionate. Men, somewhat surprisingly, tend to have a more romantic or passionate view of love than women do. As for compassionate love, results are clearer cut. Here, the cultural stereotype that holds that women are more loving, and nurturing is supported.

The Way We Select a Mate

What do people want when they come to select their mate? Researchers which observed the inhabitants of New Zealand, Canada, the Pacific Islands, African hunter-gatherer cultures, the USA and around the world, found that they all seek the same qualities in a potential mate. These qualities can be divided into three groups of traits: (1) intelligence, warmth, and trustworthiness (2) attractiveness, and (3) status with having the resources to achieve it. Although there are gender and cultural differences which rank the importance of each set of traits differently there is a general consensus regarding what is most valuable in seeking a mate across all societies. The *minimum* criteria for either a long or short-term relationship as chosen by both men and women were emotional stability, agreeableness, and intellect. People in Western culture do not differ from other cultures in what they consider to be beautiful and sexy. Dr. Cunningham found that universally attractive women have: large, wideset eyes, a small nose and chin, prominent cheekbones, high eyebrows, large pupils, and a warm smile. A man's face was found to be attractive if he had a relatively angular appearance, large, wide-set eyes and a large chin, combined with an expressive smile.

Mating Strategies

Mating strategies are a set of behaviors that a person uses, even unconsciously, to attract and retain a mate. There are two main mating strategies: short-term strategies, in which sex and mating is sought at a relatively young age in life, while tending to have more sex partners in adulthood. The second approach describes a process by which those who are interested in sex and mating later in life tend to begin their sexual history at an older age with fewer partners in adulthood. People with an unrestricted willingness to engage in sex out of marriage usually adopt short-term mating strategies, while others adopt long-term ones. Research has indicated that those unwilling to engage in extramarital sex prefer mates who, like themselves, value intimacy and commitment, are trustworthy, and faithful. To attract such mates, these men emphasize and accentuate their positive qualities; especially those valued by women who seek long-term relationships. Those willing to engage in extramarital sex prefer physically attractive mates and as the research shows, are more likely to cheat on their partners. When attempting to attract a woman, these men use competitive tactics, and show an increased openness to sexual contacts expressed in flirtatious glances, smiles or head tilts, when they meet an attractive individual.

To summarize, men place more value on attractiveness, sexual variety (meaning, sex with a variety of partners), younger women, and tend to emphasize their potential as caring mates who are able to provide for their family. Women are less impressed with attractiveness or sexual variety but search for status and resources seen in typically older men. They are not usually interested in casual sex, and emphasize their attractiveness to attract males.

What Is, Intimacy, Actually?

In Western culture, we highly value intimacy since satisfying intimate relationships are associated with many benefits, including emotional well-being and happiness, social support, and improved physical health. Intimacy is a complex concept which includes knowledge about one's own partner through mutual caring, interdependence, trust, and commitment. Partners in an intimate relationship have extensive personal, confidential, and private knowledge about each other. That may include their histories, feelings, and desires that they may not share with others. Intimate partners care about each other and are more affectionate more with each other than with others. Their lives are intertwined as they constantly affect each other in meaningful ways over long periods of time. Intimate couples often think of themselves as "us" and see themselves as very similar in various respects. Intimacy, naturally, means that partners can trust the other person knowing that it is safe to open up and that their partner will be there to support and respond to their needs. Finally, intimate partners are committed to their relationship which they expect to last for many years, and are therefore ready to invest time, effort, and the resources in order to build and maintain it.

While many complain after years of togetherness that "love went out the window," there are other couples whose love continues even 10, 20 or more years into their relationship or marriage. These are the same people who, when looking at a picture of their beloved partner, experience the same activation of the brain's reward centers when they were activated during their falling in love stage. While it seems that passion may decline over time, intimacy and commitment actually increase with age. That indicates that compassionate love is more stable than romantic love. Let's examine the concept of love along the decades and centuries.

Historically, there was a "double standard" as far as sexuality was concerned. Traditionally, older adults interpreted "passionate love" to mean sexual love. In the Victorian era for instance, men loved sexually but women did not. Older women actually prefer talking and uttering love words, to the sexual act itself. Men are said to view such sexual activities like caressing one's body, masturbation, and intercourse as the most important aspects of sexual activity. Throughout history, and until recently, women depended on men for their economic survival and thus, had to control their emotional yearnings to focus on pleasing the man who had a promising financial potential. Men were able to marry the woman they desired and loved, since they did not need to engage in all those "calculations." And so, while women passively waited for the right match, men were free to initiate a relationship with those they loved. In the 21st century, however, women depended less on marriage for status and financial well-being in exchange for academic and occupational freedom. As such, they began to engage with men that they were attracted to.

At times, intimacy is sometimes seen as a sexual bond that is also viewed as a search to discover oneself in relationships with others. Others associated intimacy with caring for each other, opening oneself to the other person, and marveling at the closeness, which is accompanied by empathy. Showing our inner world to our partner and feeling safe doing so results in a symmetrical reaction from them. Dr. Sternberg, whom we mentioned earlier and who proposed a model of love, considered intimacy to be one of the three factors of love, apart from passion and engagement. It creates a sense of support and closeness between partners.

Intimacy, according to Dr. Sternberg, includes (in addition to the various traits that we outlined above) also experiencing happiness in being with that person from whom one can give and receive emotional support. Women, who were socialized to open up and share, showed a greater need than men to share their experiences. Intimacy in a relationship is more important for women than men and affected their satisfaction with the relationship.

The Effects of Intimacy on Our Health

Because human beings have an innate need for attachment and belonging, they thrive when they feel intimately connected to those who are significant to them. When a person is understood, accepted, validated, and cared for, it frequently results in that person feeling acceptance, belonging, and trust – which positively affects their health. For example, research found that when people feel more understood and appreciated in social interactions they feel greater vitality, report fewer physical symptoms and are, generally, more satisfied with their lives. Brain imaging studies show that intimacy, acceptance, and romantic love are associated with brain activity that has implications for health. For example, being positively responded to by a potential romantic partner causes an increased activation in opioid receptors related to reward, positive affect, and a pleasant feeling. Love as we know is rewarding, and additionally, it boosts our energy and metabolic resources. For instance, when people were instructed to think about their romantic partner, their body responded with increased blood glucose levels and that they felt emotionally better. Intimate physical touch like holding hands or hugging, may significantly and positively affect health. Furthermore, increases in intimacy, even from one day to another, may bring about decreases in physical complaints and pain.

What Is the Meaning of Passion?

Passion is generally at the core of romantic relationships. Passion is defined as a strong tendency towards an activity that one loves, finds important and meaning from. Ultimately, this leads to a greater investment of time and energy. Theoreticians opined that there are two types of romantic passion, namely harmonious and obsessive, that has different influences on how a couple may engage with each other. Harmonious passion involves a flexible form of engagement. That occurs when individuals freely and deliberately engage in their beloved activity, with no internal pressure. Thus, their behavior is flexible, and they decide when and how they want to practice their passionate activity. These people experience positive outcomes both during and after their activity. Obsessive passion, the other type, is seen when the person feels controlled by the passion, and can take a disproportionate place in their lives that causes them to possibly neglect other important life aspects. Romantic passion is a part of conflict resolution strategies that people use within their romantic relationship which is specifically in relation to the type of their attachment: secure, anxious, and avoidant attachment styles. Additionally, they influence communication patterns and conflict resolutions used by couples. It was suggested that one's attachment style could play a key role in the type of romantic passion that one develops.

Romantic Passion

The dualistic conceptualization of passion also applies to romantic involvements. Accordingly, romantic passion is a strong yearning towards one's romantic partner with whom one has an important relationship. Altogether, this involves the investment of significant time and energy in their relationship. However, obsessive results in a situation in which a person may feel that their romantic relationship controls them and interferes with other important aspects of their life. Conversely, experiencing harmonious passion that is expressed for one's beloved partner leaves the individual feeling no pressure in the relationship. They hope that this freedom will be in harmony with the rest of their life's aspects. A series of three studies revealed that harmonious passion leads to greater relationship quality than obsessive passion does. Additionally, it was found that one's type of romantic passion may even predict relationship length and positively affect well-being.

Attachment and Romantic Passion

Let's examine how attachment styles influence romantic passion. Researchers suggested that the internalization of a particular attachment history, particularly threats to one's self-esteem, insecurities, and anxiety, significantly affect the development of passionate love. Individuals with secure and anxious attachment styles wanted more passion in ideal love than avoidant individuals, which seems obvious, as they needed a reinforcement of the love that they yearned for. Examining the effects of two love styles, Eros, which includes physical attraction, commitment, and love, and Mania, the possessive and dependent love, it was shown that both share some similarities with harmonious and obsessive passion, respectively. Eros was similar to harmonious passion as the more mature perspective on love, whereas Mania shards some sense of immaturity with obsessive passion. Research indicated that Eros was related to a secure attachment style whereas Mania was associated with an anxious attachment style.

Research findings suggest that attachment styles seem to represent an important determinant of romantic passion. Firstly, harmonious passion was associated with a secure attachment style. Secondly, an anxious attachment style, which is characterized by fear of being abandoned by one's romantic partner, was linked to obsessive passion. It can be understood, then, that anxious people will continuously endeavor to prevent abandonment by investing heavily in their romantic relationships. The results of this may reflect a rejection of pursuing any other activities or relationships as the romantic partner becomes the center of their life, which may feel to their partner like being smothered. Finally, it was found that having an avoidant attachment style, defined as an unwillingness to rely on anyone and feel uncomfortable with intimacy as being negatively associated with harmonious passion. One is increased when the other is decreased.

How Do We Keep Sexual Passion Alive?

I am sure that we are in agreement that, at any age and with whoever our partner is, we would like to keep sexual activity as fresh and lively as possible as our relationships progress.

However, maintaining sexual satisfaction over a long period of time may not be easy. Maintaining passion over time is considered an elusive goal, achieved only by a small number of couples in long-term relationships. Some of the strategies that couples employ in order to keep their sex lives from fading include communicating their desires to their partners, trying new sexual positions and activities, and consulting sexual self-help magazines, or videos. In cultures where kissing is part of the romantic-sexual repertoire, it enhances arousal and feelings of closeness before, during, and after sex acts. Research found that both men and women experience higher sexual satisfaction when they engage in more frequent kissing, cuddling, touching, and caressing. It was also found that the extent of foreplay and length of sexual encounters also contribute to sexual satisfaction. As such, it was found that for women, more foreplay through genital stimulation and oral sex accompanied by loving, intimate words increased the likelihood of orgasm.

Affection Following Sexual Activity

Sexuality is a key factor in shaping happiness and satisfaction in romantic relationships, and so, both men and women are more satisfied when their sexual activity is increased. This association has also been well documented in non-Western countries such as China. It is quite clear that, both, the frequency and quality of sexual interactions contribute to the quality of romantic relationships and decrease the chance that the couple will break up.

As such, research has shown that engaging with one's partner after sex is important for bonding and intimacy. Both genders enjoy and feel loved during cuddling, caressing, and shared verbal intimacy with their sexual partner once sexual activity is over. Kissing is considered a prominent way to display affection in a romantic relationship and positively affects their relationship quality, physical health and emotional closeness. In an interesting study published in 2009, couples were randomly assigned to one of two groups to determine relationship satisfaction after kissing. One group was asked to increase the frequency of their kissing, while no such instructions were given to the other group. Results showed that only the 'kissing couples' had lower stress levels and higher relational satisfaction as a result. Another study followed couples' relationship and post-sex behavior which showed that cuddling, caressing and intimately talking after sex increased their intimacy and bonding. A researcher suggested that post-sex affection may be interpreted as nurturing, and thus have a positive effect on the couple. Research has also indicated that for short-term couples, men preferred post-coitus activity to either continue with sex or engage in eating, drinking or smoking, to a higher degree than women did. In long-term relationships, however, both men and women value affection and intimacy with a long-term partner after sex. In general, women value post sex affection more than men.

The Effect of the Internet on Romantic Relationships

The internet is a very powerful tool as it allows people to connect and relate to one another in ways that they were never able to do previously. They can exchange instant messages or texts throughout a day, e-cards, and share links and music with a few short clicks of the computer

mouse. Such easy and instant communication benefits long distance relationships and enhances intimacy and problem resolution. However, the internet, may also create problems for its users. For example, miscommunications about the intentionality of a message disrupt a couple's communication on and off line. Secondly, being continuously connected to one's partner may be experienced by some as being 'smothered' and may result in wanting to have some distance and some private time alone. In addition, the rise of cybersex may arouse distress within a relationship – leading to the eventual breakup of a partnership. Research found that cybersex was, indeed, a major factor in decreased desire for relational sex through the negative comparisons of one's self and an online partner with feelings of betrayal – eventually leading to separation and divorce.

It was found that most of the articles in the professional literature address exploring internet-related problems focused on porn use. What contributes to internet-related intimacy problems were termed by as: *anonymity, accessibility, and affordability*, *approximation*, *ambiguity*, and *accommodation.* Here is a brief explanation of what they indicate:

Anonymity – Anonymity refers to the concept that the internet user is in control of how they present themselves. While in face-to-face relationships, our identity can be revealed through non-verbal communication or our physical appearance, online users can change their ethnicity, gender, or age, to present a person that they are actually not. And so, seeking sex on the internet may end up being more successful simply because of those changes that one can make in their presentation to potential partners.

Accessibility – The internet is very accessible. It may be accessed from homes, workplaces, internet cafés or cellphones. So, that accessibility makes it easy for those involved in an affair, for instance, to almost unlimited opportunities to send each other, any time of the day, erotic emails, and initiate sexual encounters. Infidelity is closely related to opportunity, and the internet offers it abundantly. Needless to say, the internet may and often does, interfere with one's primary offline relationships.

Affordability – Online relationships are very affordable, since the only cost is paying for the internet service, and that is immeasurably less expensive than paying for dinners, movies, or other outings. In addition, if one is involved in an affair, being discovered by one's partner is reduced as there is likely no receipts for outings, dinners, or other activities to be found. Even tracking time spent online may not indicate whether a person was involved in online sex.

Approximation – It seems that what is watched on the internet approximates the real world. For instance, one can engage in particular sexual acts on the internet that cannot be done in the real world, thus, blurring the difference between fantasy and action. As far as homosexual behavior is concerned, research indicated that interactions established via the internet may provide a safe space for experimentation with homosexual behavior. However, research has concluded that internet infidelity is often perceived as betrayal, and may negatively affect the primary relationship.

Acceptability – It appears that many behaviors that are perceived as inappropriate in society, are acceptable on the internet. A study conducted in 2005 involving 1,835 participants found that they used the internet for the pursuit of online sexual activities.

Ambiguity – Online behavior may not be easy to define as problematic. Some may consider viewing porn online as problematic behavior, while for others, consider it as problematic when it involves the emailing or messaging of sexually explicit or sexually charged material. On the internet, it becomes easier to 'cross the line', more so than in real life situations. To clarify, some may view exchanging sexual conversations or words with someone other than their

partner on the computer as unfaithful, while for others, viewing porn would be deemed as being unfaithful. Women, apparently, view online sexual activities as more problematic than men. Different people have different ideas as to what is considered appropriate, in contrast to inappropriate online behavior. And so, for people who define infidelity in only physical terms, internet sexual behavior may not seem like infidelity because of the lack of physical contact it provides.

Accommodation – For many who seek companionship online, there may be a conflict between one's ideal and real self. For instance, a person may be restricting their behavior and feeling in their day-to-day life, but online, may feel free to behave differently. For those who perceive their lives as structured, confined, or constrained, the internet may provide them an opportunity to change his or her online persona. Men who went online seeking sexual activities reported to researchers that their online behaviors differed from their real everyday life. In couples where minimal social media usage is used, behaviors of such are particularly vulnerable. People can express their emotions more openly and honestly online than in the everyday world, as internet connections may be more open, honest, and enhance a sense of deeper intimacy, trust, and acceptance.

What Contributes to Sexual Satisfaction?

Research indicated that more frequent vaginal intercourse, oral sex, and orgasm contribute to sexual satisfaction. However, the "honeymoon effect" of declining sex frequency can begin after a relatively short time together, and the initial passionate love may turn into companionate love.

From research that was conducted, it appears that sexual satisfaction and frequency of sex both decline with age. However, sexual satisfaction declines slower overtime. The consistency of reaching orgasm plays a role here. People who orgasm more frequently report more sexual satisfaction, which seems quite understandable. Aside from changes in sexual frequency, some sexual behaviors affect both sexual satisfaction and orgasm frequency. Oral sex (both fellatio and cunnilingus) is apparently part of the sexual repertoire of U.S. men and women in relationships and add to the couple's sexual and relationship satisfaction. Recent research suggests that sexual satisfaction affects relationship satisfaction and vice versa. In other words, couples who enjoy more pleasurable sex, experience more relational satisfaction. Constructive communication is clearly one way to promote sexual satisfaction. Speaking openly about our sexual desires and fantasies and sharing with our partner our likes and dislikes enhances our sex lives and the pleasure that they bring us.

A large U.S. sample of men and women who were involved in intimate relationships for three or more years indicated that, in general, most people felt that their sexual satisfaction and passion declined over time, though if properly nurtured, can last for decades. Nearly two-thirds of sexually satisfied respondents of that study reported that their sex lives were as passionate as in early days together. The authors further indicated that previous research may have asked only partial questions, and their results may not reflect actual behavior. For example, "…anal intercourse is widely studied because it entails health risks, whereas prevalence of anal stimulation is virtually unknown. When asked just about the past year, twice as many of our respondents had engaged in anal stimulation as anal intercourse (30% vs. 14%). Some couples' active efforts to keep sex lively focus on quality and variety over quantity, but we cannot know

the extent to which this is true unless we ask a broader spectrum of questions." To conclude, some researchers suggested that what can help revive and enhance passion in romantic relationships is to not neglect foreplay, setting up "date nights" for romantic getaways, wearing lingerie, giving massages, and talking about fantasies which can spice up a sex life, coupled with love expressions following sex. It is, indeed, possible to keep passion alive.

Evaluating Marital Success

Before evaluating what a successful marriage is, we first need to define it. A successful marriage is defined by its durability, approximation of ideals which the couple had, its fulfillment of their needs, and satisfaction from the union. However, before we expand on those terms, we must remember that a durable marriage does not necessarily indicate that it is a good one, or what the person hoped for upon marriage.

Durability – As was mentioned above, marital durability is not necessarily closely correlated with satisfaction. Durability alone, while important, cannot indicate whether the marriage is a successful one.

Approximation of ideals – When translated to everyday language, it refers to a marriage that may be judged as successful if it fulfills the couple's expectations or approximates their ideals. However, at times, people may harbor unrealistic expectations which may impede marital satisfaction.

Fulfillment of needs – Here we examine whether the marriage sufficiently contributes to the person's psychological needs for love, affection, and approval.

Sexual needs – Whether the marriage fulfills both physical and psychological sexual needs. It should be mentioned that each partner may be able to, *partly*, fulfill the other person's needs, since it is unrealistic to expect that one person can meet all the requirements of another. Friends, hobbies, and recreational pursuits may help married people meet some of those needs.

Satisfaction – This criterion deals with the extent to which couples are content and fulfilled in their relationship. Marital success is the extent in which both partners are satisfied, and that the marriage has met their reasonable expectations and mutual needs.

Characteristics of a Successful Marriage

Based on many research efforts, the following 12 characteristics were compiled to understand the traits of a successful marriage. They include a mixture of personal and relational characteristics, which together, institute qualities that were judged to be important to marital success.

Communication – Numerous studies have found that good communication is one of the most important requirements of a good marriage. Couples who communicate effectively report that they address their difficulties, work to eliminate them, and end up understanding their partner better. Communicating effectively allows the couple to exchange feelings, ideas, facts, attitudes, and beliefs in such a manner that the message is clearly and accurately received by the other partner. Although they must, be careful not to say critical, hurtful things in a cold and unfeeling way since that may worsen a relationship and create tension and alienation.

Admiration and respect – We all want to be accepted and appreciated. Two people who like each other can create a satisfying marriage if they admire and support each other. They should be proud of each other's achievements, and build each other's self-esteem to fill their emotional needs. Partners who can meet those needs are emotionally secure people, who enjoy appreciating and giving compliments.

Companionship – People, usually, get married for companionship. Successfully married couples spend sufficient quality time together, where they enjoy being together and share common interests or have similar desires and activities which they like. Indeed, it is important that couples attend to relationships and devote time and effort to improve them. Research shows that women prefer to talk and think about their relationships, whereas men commonly prefer to share time together.

Although, with all that togetherness, couples also need some separate private time to themselves in order to maintain a healthy relationship with their partner. Dr. Gottman, the noted sex and marital researcher, found that friendship is of utmost importance for women in improving their sex, romance, and passion in the marriage. For men, on the other hand, conflict reduction could improve those very same ingredients. Couples need to have fun in their marriage to acquire shared fond memories. These memories contribute to their continuous commitment to the marriage in order to increase passion and contribute to marital satisfaction. When both partners want a close relationship, they can 'work' on it and create it. But if only one desires it, this may create tension and conflict in the partnership.

Spirituality and values – Shared spirituality, morality, and values contribute to a successful marriage, since they all similarity make daily life go smoother. Couples who share spiritual activities and have similar beliefs and values are more satisfied with their marriage. Religious couples reported that religion contributes to their marriage in that they derive social, spiritual, and even emotional support from their faith to increase their social circle with like-minded friends.

Commitment – A sincere desire to make the marriage work and a readiness to invest time and effort to ensure that it does are essential to a successful marriage. Apparently, commitment, more than satisfaction or investment, is the strongest predictor of a relationship that lasts. Commitment has three components: psychological attachment, a cognitive orientation to remain in the relationship for the long term, and an intention to persist. Since relationships evolve and develop over time, it is highly recommended that the couple periodically defines their levels of commitment and trust. Naturally, marital success is more attainable if the commitment is mutual. When we speak of commitment, it behooves us to wonder commitment to whom and to what. The meaning of commitment:

- *A commitment of the self to oneself.* That means a desire to grow, to become a good marriage partner, and to evolve.
- *A commitment to each other*. Pledging to care and be with each other.
- *A commitment to the relationship, to the family, and to the marriage*. A commitment to the spouse, the children, and their union. Couples need to be in an interdependent relationship where their commitment to their partner does not result in a lost sense of self. Marital rituals are social interactions which are scheduled moments that are mutually decided on, repeated, and coordinated to have positive emotional

significance. It may enhance the marital success and satisfaction that the couple derives from it.

Affection – It is common for married people to expect that their need for love and affection would be fulfilled in their marriage. Since people's needs for affection are not identical, the couple needs to decide when and how they will express their feelings for each other. For instance, some people wish to be kissed and hugged many times a day, while their partner may be satisfied with an occasional hug. Similarly, the desire for intercourse may differ from one to the other. It was noted that words that express warmth, endearment, and approval, can do 'wonders' in raising a bruised ego or raise low spirits. They are just as important as physical contact and sexual intimacy. And while romantic love is fulfilling, sexual and affectional needs are even more important later in the relationship.

The ability to deal with crises and other stresses –Daily hassles are a part and parcel of any union. Stress may have a negative impact on the marriage. Research has found that when a couple habitually interacts in a positive interaction, it can buffer them from the negative effects of stress. The couple's ability to solve their problems and manage stress distinguishes marital success from marital failure. Consequently, couples in successful marriages have a greater tolerance to stress and are more emotionally mature than those who are in non-successful marriages.

Although, depression may be the result, or the cause, of marital dissatisfaction. People who experience depression typically exhibit reduced energy levels, appear removed and non-caring, and unmotivated to engage with others. Their spouse may try to 'pick up the slack', but eventually becomes exhausted and resentful.

Responsibility – Meaning personal accountability for one's behavior. It refers to taking responsibility for providing, contributing and alleviating their partner's stress as much as possible. Successful partners enjoy the knowledge that there is an equal division of labor.

Unselfishness – In the Western world, we try to find happiness through self-gratification and narcissism. Such goals in the marriage lessen each partner's responsibility for the success of the union. And obviously, if each looks mainly after his or her own needs, the result is marital instability and disharmony.

Honesty, trust, and fidelity – are of prime importance in successful relationships. They bind people together since they promote trust and enhance intimacy which cannot be developed without it. On the other hand, partners who feel vulnerable in the relationship will tend to become guarded and defensive. Breaking that trust may threaten the relationship, damage the intimacy, and may be difficult to repair.

Empathy and sensitivity – mean to know what the other person is experiencing *and* letting him or her know that we know. That shows a perception that is sensitive, and an expression of what was perceived, as caring enough to attend to what is going on with the other partner.

Adaptability, flexibility, and tolerance – successful couples are adaptable and flexible. They recognize individual differences in the attitudes, values, habits, and ways of doing things with an understanding and acceptance of them. They understand that their preferences or wishes are not the only ones that need to be taken into account and fulfilled. Thus, they learn to attend to their partner accordingly. Such an approach requires a high degree of emotional maturity.

Differences in Love and Relationships between Men and Women

We may all recall Dr. Gray's popular book, published in 1992, 'Men are from Mars, women are from Venus'. His assertions regarding how the genders operate was incredibly significant as differences are noted in almost all respects regarding the way they think, feel, behave. But Gray's book actually exaggerated those differences. This book and other similar ones do not take into account the complexity of social and cultural variables that shape love and romantic relationships across cultures. Let's, briefly, examine them.

Love as a Basis for Marriage

In Western culture, people will marry exclusively only if they are in love. Research found that a whopping 90% of participants in higher education (i.e., prior to marrying) indicated that they would not marry unless they were in love. There are, naturally, some cross-cultural differences regarding the issue of love and marriage. While the percentage of people who would marry only out of love is so very high in the U.S., it was indicated that Brazil had similar results to those in the U.S. (86%). Although, in India, the picture was entirely different. There, only 24% expected that marriage would follow falling in love. In Thailand, the percentage stood at 34%, and in Japan, it was 63%. No gender differences were found. Clearly, culture affects our expectations, and thoughts relating to our marital union.

Maintaining a marriage is also perceived to be dependent on love. A cross-cultural study which aimed to understand whether love is necessary to maintain a marriage was carried out in the U.S., Japan and Thailand. In two of those three countries, people were more likely than in the U.S. to endorse the statement, "If love has completely disappeared from a marriage, I think it is probably best for the couple to make a clean break and start new lives." No gender differences were found in that study.

Romantic Attitudes

These relate to such beliefs as love at first sight, or that there is only one true love; that true love lasts forever, and that love can overcome any obstacle. Interestingly, in the United States, men were found to be more romantic than women.

'Cracks' in the Couple's Bliss

What happens when the marriage does not deliver on its promises, or a divorce or death separates the partners? Widowhood or divorce are commonly followed by a decline in social integration and support, a changed economic status, or unhealthy behaviors. Compared to married people, widowed individuals reported less happiness or life satisfaction but complained more regarding somatic problems and depressed mood. Marital disruption due to a partner's death or divorce increases loneliness especially for men who are left alone, as women are more

socially connected. Dating, following death or separation from a loved one, may counteract loneliness and its effects on well-being to some extent, but not entirely so.

Romantic relationships have also been found to influence physical health, and even play a role in CHD (coronary heart disease). Smoking, hypertension, elevated blood lipids, glucose, dietary fat and caloric intake, have all been studied. However, what are the psychosocial factors that may affect and create cardiac problems? The following features seem to predict the development and progression of CHD. They include qualities of personal relationships, characteristics and events affecting social environments, and aspects of emotional well-being and personality traits. Intimate relationships are a central element of psychosocial risk for CHD. Being married or involved in an intimate relationship has been shown to reduce this risk. These relationships are important for our physical health, not just for their presence, but mainly for their quality.

Love and Loneliness Are Not Supposed to Go Together

Marriage is commonly associated with decreased loneliness. However, changes in financial security, health, and companionship may exacerbate loneliness in intimate relationships. Affection, conversation, openness, and honesty are mostly important and valued by women, while men seek an attractive mate, sexual fulfillment, and recreational partnership. Loneliness may set in when there is incongruence in what the couple wants and expects in their marriage. It was found that increased intimacy and communication can lead to decreased loneliness. It suggests that loneliness in marriage is alleviated by time spent together and open and honest communication.

Marriage has been known to be one of the strongest protective factors against loneliness, particularly for older adults. It has protective benefits concerning our psychological, emotional, and physical health, partly as a result of married couples' greater access to economic and social resources. However, these marital benefits are very dependent on the quality of the couple's relationship – which may be supportive or actually harmful. Research indicated that insensitive behavior and an unsatisfying sex life with a spouse are related with increased loneliness for married people whose marital support is lacking. Married women were found to be more influenced by marital quality than their husbands. And alternatively, women are both more likely to spread their loneliness to others and to be influenced by the loneliness of their social partners than men are.

In a previous publication, I wrote that loneliness is not separate from love. That being in a loving relationship, where we expect to be cared for, and for our lover to share their experiences with us but which they don't, could also be terribly lonely. You may wonder how someone who is loved can feel lonely?! In 2010, relationship researchers Drs. Gordon and McKinney wrote that much of heavy romance is actually the lovers' attempt to sustain the intensity of the relationship. In their opinion, partners do so by introducing some sort of crisis such as jealousy, bouts of anger or withdrawal from their partner. If that is what the lovers do to keep the flame alive, then they may end up withdrawing emotionally from one another and feel hurt, alienated, and lonely when their plan to ignite things faults.

Other theoreticians conceived the intensity of romantic love as increased by a mixture of sexual attraction and its continuous gratification, reduced feelings of loneliness, and excitement related to exploring the characteristics and body of their partner. Sadly, as time passes, sexual

attraction wanes and attachment anxieties which were previously reviewed, may lead to conflict or mutual withdrawal. Familiarity replaces novelty, and lovers may find themselves experiencing such distress as boredom, disappointment, or loneliness. Exploring how different attachment styles influences people in their romantic relations in adulthood, it was discovered that the anxiously attached need continuous demonstrations of love and support from their romantic partners. They tend to see conflicts with their partners as 'catastrophes in the making', which intensify their emotional and behavioral reactions to any signs that may indicate their partner's unavailability or disinterest. Consequently, the partner of the anxiously attached may feel engulfed by the partner's desire for intense closeness and hypervigilance. These feelings are unpleasant and may cause the partner to seek shelter or actually withdraw to stop the torrent of attempts by the partner to get closer.

Avoidant type individuals tend to deactivate their emotional involvement and commitment. Their attempts at intimacy are plagued by their fear of being unlovable, which may result in feeling frustrated or ignored. In contrast, securely attached individuals do not suffer those effects of a less-than-healthy attachment style and as previously mentioned, will commonly enjoy a satisfying relationship.

The Wear and Tear of Love

Various pitfalls, stumbling blocks, and hazards such as hurt feelings, ostracism, jealousy, lying, and betrayal may harm emotional relations and the feelings of love. We want and need to be loved by our intimate partners, and hope that our partner considers our intimate relationship valuable, important and as close as we perceive it to be. It is painful to discover that our partner may perceive it as less valuable than we would like. There is thus a
dissonance created between what we envision it to be, and what our partner apparently sees in it. That may result in us experiencing pain, anger, hurt, and loneliness.

The "cold shoulder" that partners sometimes give to their loved one may cause them to experience ostracism, which is utilized to punish the other, to assist the person in remaining calm, or to help the ostracizer cool down after a conflict. However, ostracism is very painful because it threatens our basic need to relate to the person who is supposed to be our best friend. The "silent treatment" not only threatens our need to belong, but may also damage our feelings or self-worth, and reduce our perceived control over the interactions. Usually, the one who is ostracized does not necessarily know why he or she received the 'cold shoulder'. And if it lasts for long, may result in having to work hard to regain their partner's regard, or start looking somewhere else.

Jealousy is an age-old relationship spoiler which is known to cause hurt, anger, and fear. Hurt may arise out of a concern that our partner may not value us enough to honor their commitment to the relationship. It reflects the fear that we are about to be abandoned and lose the relationship to end up lonely. The anger that follows may even turn to violence, which may, in some cases, be fatal (see the "Fatal Attraction" movie of yesteryear). Jealousy can be of one of two types: *Reactive jealousy*, which is aroused in reaction to an actual threat to the relationship, or *Suspicious jealousy*, which may occur without any indications that the relationship may be threatened. When one displays suspicious jealousy, it may result in mistrustful vigilance and spying on one's partner, as the jealous partner feels that they must find out whether there is a basis for their suspicion. At times, a reactive jealousy to, say, a

partner's affair, may end up with suspicious jealousy thereafter, which may be expressed also in future relationships. It appears that men react more strongly to a woman's sexual involvement with another man, while woman feel more jealous and threatened if their partner forms emotional attachment to another woman. Interestingly, men and women seemed to react similarly when the partner was engaged emotionally or sexually with a same sex person.

Deception, which is a behavior that creates an untrue impression of a partner's behavior or wants, can also spoil a good and loving relationship resulting in intense loneliness. Lies are commonly used to ward off embarrassment or guilt, to benefit the liar, or to desperately seek a partner's approval. Research indicated that men are more likely to lie about their income or to claim that they are committed to a relationship when they are not, while women may promise, but not provide, sex. They may fake pleasure during sex, or engage in the well-known practice of faking an orgasm.

Betrayals are probably the most hurtful of relationship spoilers, and they are the ones most closely related to loneliness. Betrayals were defined as hurtful actions by people we trusted and from whom we did not expect such behavior. Common examples are sexual and emotional infidelity as well as lying. Interestingly, any behavior that our partner may exhibit and which may violate the norms of kindness, loyalty, respect, which are expected in such intimate relationships are also considered to be betrayal. It was found that betrayal of some form occurred in half of all intimate relationships. It was even suggested that betrayal is actually common in close relationships. However, that is still up for debate.

Men and women do not differ in their tendency to betray others. Men, however, are likely to betray their romantic partners and business associates, while women betray their friends and family more often than men do. But what is the ultimate price of betraying someone? Betrayers were found to be unhappy, resentful, vengeful, and suspicious. They are jealous and cynical and do not trust others much. They are lonely and miserable.

Loneliness in loving or intimate relationships can be divided into personal and situational ones:

Personal

a) The anxious or avoidant attachment types cannot just "throw" themselves into loving and being loved, and trust that their lover truly values, respects, and loves them. The anxious type is constantly searching for indications that their lover is untrustworthy, or that they are not committed to their union. That takes away from their ability to bask in their love and friendship as they feel anxious and lonely; being convinced that it is but a matter of time before they will be abandoned.
   The avoidant type, on the other hand, may fall in love, but soon thereafter withdraws emotionally and does not allow the emotional guard to come down. The result is that they feel isolated and lonely, which makes their relationship neither fulfilling, nor reminiscent of true love.
b) Those who cannot love. Individuals who fear intimacy; who cannot allow themselves to be exposed and vulnerable prevents them from getting intimately close to others or falling in love, leading to loneliness and a feeling of disconnection and alienation.

Situational

a) That may occur in a love relationship which includes perversion; a twisted way of loving. Abusive relationships are one such example. Abusive relationships have a repeated cycle of tenderness followed by abuse that leaves the loved and loving partner confused, wounded, and lonely, and stuck in that relationship. Since love is inherently related to tenderness, caring, giving, and even sacrificing, a physical, sexual, or emotional abusive relationship, hurts doubly. Love, by its very nature, makes us vulnerable and lowers our defenses. When that love brings with it pain and hurt, it may be quite devastating.

b) Romantic relationships are dynamic. Partners change and evolve over time, and so does their relationship. Romantic relationships may change to compassionate love or may even be replaced by other feelings that are not as intimate and binding as love is. If both romantic partners change at about the same speed as their lover, then they are on the same trajectory and their relationship may continue to be satisfying. If their personal growth is bidirectional, however, meaning that they grow at different rates and in different directions, they may end up feeling isolated from the one they love and feel left behind, resentful, and lonely.

c) Relationships are never smooth sailing, and may include disappointments, anger, unfulfilled wishes, and possibly a love returned by our partner which may not provide us with what we need. Thus, lovers may find themselves lonely, longing for more and waiting to be closer and understood.

d) *Cybersex* – As previously mentioned, online technologies may significantly and adversely affect our romantic relationships. The internet can facilitate infidelity via cybersex which results in the partner feeling betrayed. They may experience rage, devastation, feeling sexually inadequate, and losing sexual desire. Cybersex was a major contributor to divorce and separation for 22% of couples who faced those breakups.

The ideal romantic love was described as a situation where '…the one I love, loves me back since out of all the people she could love, she chooses to love me, because I may have qualities that others do not. When those feelings seem to change, when I stop feeling so valued and special to my partner, it may lead to my feeling neglected, unappreciated, and thus, lonely'.

What's in Marital Satisfaction and Dissatisfaction

An interesting study which was conducted at the beginning of the 21st century on a sample of 10,000 persons showed that those who are married reported having the highest psychological well-being across all samples. Remarriage resulted in a decrease in depressive symptoms, while divorce or separation led to a higher level of depression. Amongst the benefits of marriage are better physical health and longevity, and better mental health and happiness. Examining the effects of marriage cross-culturally, it was found that married people reported more life satisfaction and positive emotions with less negative emotions than divorced or separated people in all the cultures that were surveyed. The benefits of marriage were found to stem from

both providing emotional support and encouraging healthier behaviors and lifestyle, in addition to its economic benefits.

Unsatisfactory marital unions, however, are known to affect our physical and mental health negatively. Marriage and other intimate relationships are a primary source of social connection and support that are associated with reduced risk of coronary heart disease (CHD) development. A disruption in one's marriage and eventual divorce may lead to mortality, coronary atherosclerosis, and reduced survival in those who suffered from CHD. Greater conflict and worries may increase the chances of CHD and result in poor clinical outcomes.

Clearly, a partner's behavior influences the internal experiences and overt actions of the other, along with affecting the partner's physiology. Criticism and blame from a partner which are quite negative evoke defensive, angry, and quarrelsome responses, which is commonly expressed physiologically. In contrast, a partner's affection and warm support are experienced positively, and may reduce unhealthy physiological responses.

Marriage, Divorce, and Their Effects on the Immune System

Epidemiological studies commonly indicate that marriage is good for health, while divorce has negative effects on mental and physical well-being. Apparently, it is not just the marriage, but the couple's behavior which are important. And as such, even married couples who behave in negative and unloving ways can be subject to depression and impaired health.

Newlyweds, almost without exception, are scorers of high marital satisfaction. As such, researchers explored their behaviors to observe how they behaved when they agreed with one another and when they fought. If hostility was directed towards them, they reacted in a hostile and negative fashion. And those hostile behaviors produced persistent changes in the participants' endocrine and immune functions. Women, more than men, during and following marital conflict, showed changes that were apparent considering these couples' usual pristine physical and mental health. Older couples who were also examined for the effects of hostile interchange found that those men and women averaging 67 years of age with 42 years of partnership had poorer immune responses across several immune markers. This study illustrated that stressors from problematic relationships can continue to elevate stress hormones throughout the lifetime.

It is apparent that both stress and depression can cause imbalances to the autonomic nervous system. This enhances our sympathetic nervous system which speeds up our bodily functions (i.e., heart rate, blood pressure, etc.) while lowering parasympathetic activation which is supposed to bring it back down and increase our calmness. Heightened inflammation, which has been recently associated with cardiological problems, was also shown to be related to troubled marriages. It was discovered that cohabiting couples' gut microbiotas are similar to each other, much more than the microbiotas of strangers. Apparently, the physical interaction that partners engage in, like hugging, kissing and sex, ensure that microbial transfer takes place. That, similarity, is also enhanced by their concordant health behaviors that significantly influence the microbiome such as diet, exercise, sleep, smoking, and alcohol consumption. If the couple's bodies are in so much sync, it is interesting to check how they respond to separation and divorce.

Compared to married couples, people who undergo separation or divorce have a higher risk of physical and mental illness. Men who had separated/divorced suffered more recent illness, had higher levels of depressive symptoms and were lonelier than married men. Just like separation, continued negative or even positive preoccupation with the former spouse may bring about mental and physical changes with prolonged stress related symptoms. However, when the marriage is non-satisfactory, divorce may, naturally, increase life satisfaction.

Better social integration has also been associated with more favorable immune profiles following marital separation. And while most people are resilient and recover from divorce, 10% become depressed with heightened risks for early mortality. Marital distress may also produce or increase one's depression, and that very depression may increase marital distress in addition to the harms that may be caused to a person's closest relationships. In general, depression increases the chances for inflammatory reactions and for sleep disturbances which act to stimulate depression, adiposity and increased inflammation.

The Influence of Intimacy on Heart Disease

Coronary heart disease (CHD) is the leading cause of death globally, annually taking the lives of more people in the United States than any other cause. Smoking, hypertension, elevated blood lipids, glucose, dietary fat, caloric intake, and inactivity are some of the biologic and behavioral risk factors. However, psychosocial factors like the quality of one's personal relationships and one's emotional adjustment and personality can predict the course of CHD. Research indicated that being involved in an intimate relationship or being married reduces risk for CHD, but it is not just the relationship that determines it but its quality. A good relationship helps avoid CHD, while bad relationships may hasten its appearance.

The Psychosocial Risk Factors for CHD

While MI (Myocardial Infarction) may be a sudden event, it actually takes decades for coronary atherosclerosis to form. The disease progression may begin in childhood or adolescence and proceeds at different ages that progresses at different rates depending on risk factors. CHD becomes apparent when the heart is deprived of blood in one or more of the blood vessels that bring blood to the heart. That progression is affected by a number of risk factors, such as the kind of intimate relationships that the person is in, their personality and emotional adjustment, as well as smoking, physical inactivity inflammation, and changes in blood platelet aggregation. Research has repeatedly demonstrated that social isolation and low levels of social support are associated with an adverse course of CHD. The chances for developing CHD have been shown to be reduced by good and supportive intimate relationships, while marital disharmony may increase those chances. Research has pointed out that greater conflict, worries, and demands in cohabiting relationships predict incident CHD, the severity of atherosclerosis and poor clinical outcomes.

How Do Personality, Social Environment, and Emotional Adjustment Affect CHD?

Anger, hostility, and antagonism lead, obviously, to marital difficulties, and possibly divorce. Constant anger and hostility as well as dominant and controlling interpersonal styles predict CHD development and how it will react to treatment. Depressive and anxious symptoms as well as disorders predict CHD development for reduced survival. Interestingly, research found that anxiety seems to affect CHD course less significantly. Low socioeconomic status (SES) and job-related stress can predict CHD. They are also related to lower marital quality and higher depression. Optimism, subjective well-being, and conscientiousness are associated with increased support in intimate relationships with reduced risk of CHD. Warmth evokes warmth in return, and hostility is usually met with hostile partner responses. Similarly, dominance invites deference, and deference invites dominance. Manipulations of marital conflict which were done as part of a research project, were found to evoke physiological responses which negatively influence CHD.

Designing Living Quarters to Create a Relatedness Experience

The Beatles' 'All You Need is Love' song, poignantly summarizes at least 60 years of psychological research into human well-being. Love, and the general feeling of being related to significant others, are crucial to people's life satisfaction and happiness. "Relatedness" prominently reflects many psychological theories of human needs, which see it as having regular intimate contact with people who care about you. Relatedness may be seen as a broad definition that subsumes such terms as connectedness, intimacy, love, belonging, closeness, or togetherness.

It was observed that in this day and age, fulfilling the need for relatedness is of prime importance but is also a challenge. The pressure of the job market in the global village forces employees to travel repeatedly and even to live apart from their partners and loved ones. The result are many long-distance relationships which are growing steadily each day. And although long-distance relationships are probably here to stay, they suffer from particular drawbacks, such as couples experiencing loneliness, which must be overcome to ensure the continuity of their relationship. Couples use such artifacts as wedding rings, clothing, pictures, and ornaments as a reminder to themselves and as a signal to others that they are in a relationship. Additionally, technology such as telephones, Skype, video recordings, e-mails, and Facebook afford the couple to stay in continuous contact. However, most available technologies may not reflect and in fact, neglect the emotional and subtle communication so salient in close relationships.

Dr. Hassenzahl and colleagues reviewed in their 2012 published work, 143 published artifacts to identify six strategies of how Interaction Designers, which is the practice of designing interactive digital products and services, attempt to create, or recreate, the experience of relatedness through technological artifacts. They extracted six common strategies which are commonly found in technological artifacts for relatedness:

- The first identified strategy is *Awareness*. This refers to knowing the environment we live in, our surroundings, and the presence and activities of others. Awareness devices

enable the exchange of continuous information, such as children's laughter, to create a feeling of relatedness which supports the partner being away an awareness of their loved ones. Self-disclosure, which is enhanced by that process, is at the heart of relationships and is related to feelings of controllability and vulnerability from each individual's perspective. Couples reveal themselves as the relationship develops, and thus, get to know one another.

Expressivity – means the explicit expression and reflection of emotions, feelings, and affections, in an enriched manner which could be playful and spontaneous. It often stimulates communication, which may take place in either a synchronous or asynchronous way. An interesting 'on-off' device involves a small disc in the computer's taskbar, which is connected to one's partner's computer. Clicking that disk lights up a red light on the partner's computer, and that is a message that their intimate partner thought and feels affection towards them. 'ComTouch' is another interesting example, which may be installed on a mobile phone which has extra buttons on its side. Pressure sensors enable users to squeeze the phone, and it is possible to intensify the vibrations it emits. That allows for a direct and immediate exchange of affection. Needless to say, such expressivity, is essential to close relationships. An important aspect of expressivity is reciprocity, which allows for others respond to them in a way like their own. Research demonstrated that couples who experience reciprocity have richer and more satisfying relationships. Expressive communication devices may, indeed, facilitate communication. But we should also remember that, in general, individuals vary in their ability to accurately express their emotions and to accurately identify the other's emotions. Men are better at expressing positive affection by, for instance, cooking dinner, while women prefer verbal expression of love, such as "I love you."

- *Physicalness* – Couples who have separated described physical contact as the most missed ingredient in their relationship. Consequentially, simulating mutual touch is an effective strategy for designing relatedness. We know that from a psychological perspective, physical intimacy is a critical aspect of relationships, especially for romantic relationships. It is so important that it was argued as being the most important of all nonverbal behaviors. And indeed, physical intimacy is one of the main, and most important direct ways to express feelings. Consequently, it is important to enable physical intimacy through communication devices. Although, such technologies have not been designed yet to emulate some of these necessary behaviours like kissing or hugging. We should also note that individuals in partnerships may not always feel comfortable being physically close and thus, resort to developing implicit rules and expectancies about when public intimacy is adequate and when it is not.
- *Gift giving* – This strategy means giving something without expecting something in return. There are two different models underlying gift-giving in a dating context: an "exchange model" and "agapeic love model." The exchange model indicates the function of the gift, in which the giver seeks control, and where monetary issues may play a role. Agapeic love, in contrast, emphasizes the spontaneous, idealistic nature of gifts, whereby the gift giver does not hold control and the gift is nonbinding. A carefully selected gift may signal intimacy and the importance of the relationship to the gift giver. The most basic psychological function of gift giving is a symbolic

communication with explicit and implicit meanings of love, and in intimate relationships they contribute to maintaining and enriching relationships.

- *Joint action* – Shared activities strengthen relationships by creating a shared experience through joint action. Creating new routines for the couple is one way of achieving it. One such way is installing a "Pillow Talk" in the couple's bedrooms if they live apart. This involves wearing a special touch activated ring that can communicate their movements to their partner.
- *Memories* – This strategy enables people to re-experience mutual memories without the necessary participation of the partner at the moment of re-experience. There is a necklace, for example, that features a microphone to record intimate sounds, such as whispers, automatically. Mementoes, such as collecting souvenirs, pictures, and other things that subsume and represent their past history, serve as reminders of earlier investments made into the relationship.

*

Wife: "How would you describe me?"
Husband: "ABCDEFGHIJK."
Wife: "What does that mean?"
Husband: "Adorable, beautiful, cute, delightful, elegant, fashionable, gorgeous, and hot."
Wife: "Aw, thank you, but what about IJK?"
Husband: "I'm just kidding!"

*

A guy and his wife are sitting and watching a boxing match on television. The husband sighs and complains, "This is disappointing. It only lasted for 30 seconds!" "Good," replied his wife. "Now you know how I always feel."

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Chapter 6

Communicating about Sex

> Sarah and Andy came to see me and felt that they were at the end of their rope. They were seriously considering a divorce, but hoping that their marriage can be saved. They were in their early 30s and were married for a mere three years. When we started to explore their situation, it became clear that their backgrounds, which were so different, did not prepare them to be together. Sarah grew up in a Jewish home while Andy was Catholic. Their main problem was their sex. It was infrequent, physically painful to Sarah and emotionally to Andy, and very frustrating to both of them. Sarah grew up in an orthodox Jewish home and Andy's parents were very religious Catholics. Neither was prepared for sexual activity and knew very little, if at all, about it. When they got married, they did not discuss – at all – what they expected, what they liked, or disliked. They simply attempted intercourse as they understood that activity. No communication whatsoever about what would make them feel good. As time went by, they became convinced that they were simply not meant to be together. As we started to train them to feel more comfortable sharing with each other their sexual wishes, concerns, and wants, their relationship had improved. Their overall general communication was also benefitting from it, and they were able to get to a point where they had satisfying sex, and a good relationship.

The Essence of Intimate Communication

Sexual intimacy is central to romantic relationships, and that has prompted researchers to explore the relationship qualities and characteristics that contribute to satisfying sexual experiences, which we mentioned earlier. Satisfying sexual encounters are essential to satisfying relationships. It was found that negative characteristics such as emotional distancing, or unresolved conflicts decreased sexual satisfaction whereas sexual self-disclosure and open communication about sex significantly contributed to sexual satisfaction. Because sexual intimacy and romantic relationships inherently integrate actions from both partners, it is important to understand how the behaviors and perceptions of husbands and wives are interdependent, meaning intertwined. Since romantic and sexual intimacy require action on both partners, research has revealed an array of dyadic effects in marital relationships. For example, a nagging or demanding partner, for instance, may cause the other one to retreat.

Research on couple communication and its relation to general romantic and sexual satisfaction revealed several interesting results. Relational uncertainty and indirect communication was found to significantly and negatively affect sexual satisfaction, which are influenced by conflict and jealousy in dating relationships. It is understood that sexual satisfaction is dependent on open and clear communication about sex, and that direct communication lets our partner know what will increase our sexual pleasure. While direct communication contributes, significantly, to spousal romantic and sexual satisfaction, indirect communication similarly affects their sexual satisfaction but in a negative way. Indirect sexual

communication contributes to a lower likelihood of having our sexual needs and preferences fulfilled. Dr. Theiss, a relationship researcher, published a study in 2011 which highlighted the ways in which husbands' and wives' sexual communication and sexual satisfaction are interdependent. Her results indicated that husbands create what can be termed as their relational culture – or the manner in which they interact and respond to one another. This defines their perceptions and behaviors within the relationship.

Interestingly, research indicated that a husband's indirectness has a stronger effect on his wife's sexual satisfaction than a wife's indirectness on her husband's satisfaction. This was because it was found that women's sexual satisfaction is closely linked to feelings of emotional closeness in the context of sexual intimacy. When a husband communicates indirectly about sex, it may indicate that he is unsatisfied sexually, is disinterested in sex, or may forewarn of early signs of relational distancing. Consequently, the woman may feel that her husband's indirectness denies her of the intimate connection that she needs and craves in order to be sexually satisfied. Husbands, in turn, show decreased sexual satisfaction when their wife is indirect, because it makes it difficult to clarify when sexual contact is desired or which sexual behaviors are enjoyed by her. It was demonstrated that sexual contact increases in frequency and in quality when wives are explicit about the kind of sexual contact they want and when they want it.

Communication and Relationships, in General

As was mentioned earlier, effective communication between partners includes a willingness to be open with the other person and for one to be honest with their own feelings in that partnership. When we look at distressed couples, it is apparent that their communication skills are less-than-appropriate and are conflicted and non-constructive, which significantly contribute to their relationship dissatisfaction. Happy couples experience less communication problems, indirect anger, and partner rejection in comparison to distressed couples.

Sexual Communication

Communication about sex is particularly important. Open discussion regarding sexual issues renders us vulnerable, which leaves many people finding it difficult to communicate with their partners about sexuality. To be able to discuss sexual issues and reveal our sexual desires and fantasies, it is imperative that we be willing to tolerate the feeling of being at risk and exposed to potential rejection, embarrassment, or humiliation. No question about it. For couples, effective communication all around is known to positively affect the partnership of these dyads, but openly discussing sexual matters enhances relationship satisfaction in a way beyond that of which general couple communication does. Research by Dr. Montesi from 2011 examined the associations between gender and both relationship and sexual satisfaction separately. It seems that the relationship between open sexual communication and overall relationship satisfaction was stronger for males than it was for females, as men highly value sexuality and speaking openly about their sexual likes, dislikes, and desires to their partners. For males, open sexual communication is most important, according to research, in the first year of the relationship and wanes over time. For women, on the other hand, open sexual communication contributed

more to relational satisfaction when the relationship was more than one year old; quite the opposite of men.

The Function of Sexual Communication

Couples' communication skills may have a large impact on sexual and relational satisfaction as much as reaching orgasm. Good sexual communication includes self-disclosure of sexual expectations, beliefs, and attitudes. Basically, how each partner feels about sexuality and what they wish to get from their sexual union.

When in sexual therapy, the therapist may inquire about the content of what the couple discusses regarding sexuality, since it may teach us of the couple's level of sexual knowledge, education, awareness, experience, the couple's attitudes toward sexuality, dynamics of perceived power in the sexual relationship, and emotional safety in discussing sexual problems. A couple's general communication may significantly differ from their sexual communication. That is, since being able to discuss and resolve issues in general may not generalize to doing so sexually, as discussing sex feels qualitatively different than other topic areas. That may be due to their background, religious upbringing, cultural norms, sexual education, sexual identity, history of sexual abuse or trauma, and or any sexual dysfunction problems they might have. Such experiences have been shown to increase anxiety or shame surrounding sexual conversations, making it difficult to discuss sexual issues. However, the evidence shows that increased disclosure about one's sexual preferences and desires positively affects sexual satisfaction and relationship quality, despite its difficulty to do so. Conversely, those who communicate less about sex, experience reduced sexual satisfaction. Sexual routines, roles, and expectations that remain undiscussed or un-negotiated may lead to greater sexual issues and conflicts as their relationships progresses. And while certain relationship factors are highly related to sexual satisfaction, higher general satisfaction does not always indicate that sexual functioning is going well. Although, couples that report lower communication satisfaction often experience more sexual problems.

With that said, the frequency of sex and ability to reach orgasm during sexual activities were found to be the most important predictors of sexual satisfaction for both genders. Women, as we know, are more interested in the relational aspects of sex, such as emotional closeness. However, experiencing orgasm is of high importance to them as well. A sign that many couples may lack about open and honest sexual communication is when a husband overestimates how frequently their wives reach orgasm. That may result in opposite perceptions of their relationship and sexual satisfaction. Some sexual researchers regard this as the fault of non-inclusive and often, restricted, sexual communication despite the use of medications, new positions, and sexual devices and toys. This was asserted in a study carried out by Dr. Jones and colleagues in 2018, which explored the relationship of 142 paired couples, who ranged in age from 20 to 83. All of whom were married, lived together, or were dating in heterosexual, committed relationships. The researchers found that the content of couples' sexual communication was significantly related with both relationship and sexual satisfaction regardless of how long they were together. As suggested by previous studies, the variety of sexual topics that the couple discuss indicates more positive relational processes, meaning the couple's manner of relating to each other, while actually engaging in such communication may

be more directly related to positive attitudes about sex. The content of their sexual communication was associated with men's sexual frequency, while women who increased their sexual communication reached orgasm more often. Importantly, they found that as men were sexually satisfied, their female partners tended to be relationally satisfied. Ultimately, it was suggested that to increase relationship satisfaction, men need to be attuned to their partners' communication needs, and women need to be mindful of their partners' sexual expectations. Open discussions about adding novelty items to their sex life, such as new sexual accessories or positions might help the couple increase sexual functioning and satisfaction.

What Are Sexual and Relational Satisfaction?

Achieving satisfaction in a romantic relationship is a complex process. Various factors may contribute to sexual and relationship satisfaction in the context of a romantic relationship. In fact, the overall happiness of a couple from their relationship is closely related to their sexual and relationship satisfaction. In the past, relational satisfaction was thought to reflect a relationship merely lacking dissatisfaction. It is now seen as including happiness that is more substantial than average levels of well-being. Sexual satisfaction has also been conceptualized in various ways. It was once described as being only dependent on the number of orgasms that a person has reached but is now seen as the achievement of 'satisfying' sex. Overall, it is quite clear that sexual and relationship satisfaction are heavily intertwined.

Communication is a complex process, especially when it relates to sexuality and the hurdles that need to be addressed and resolved. Couple communication refers to the ongoing exchange of verbal, emotional, and behavioral messages between the partners. Non-verbal behaviors, such as a raised eyebrow or silence are an integral part of that communication and is the cornerstone of intimate relationships. In fact, up to 80% of the information exchanged in interpersonal interactions are communicated non-verbally. In contrast, when open and safe communication does not take place, a deterioration in the relationship can be expected. Dr. Gottman, who conducted comprehensive studies regarding marital success and failures, identified four communicative behaviors that may lead to relational problems: criticism, contempt, defensiveness, and stonewalling. Criticism, which involves direct attacks on the person's character or personality, can cause long-term hurt feelings. Contempt such as eye rolling, name-calling, or mean humor, displays disrespectful attitudes towards one's partner and is even more impactful to the quality of their relationship. Defensiveness is expressed as a response to one feeling attacked by one's partner, and when drawn out, will lead to relational problems. Stonewalling occurs when one refuses to engage in a discussion and may leave even in the middle of a discussion. Overall, nonverbal communication gives us an opportunity to express feelings without words just by our body language such as body posture, voice qualities, and facial expressions.

Gender Difference in Couple's Communication

Although John Gray popularized the difference between the genders in his book *Men are from Mars, Women are from Venus*, he exaggerated and emphasized the dissimilarities between men and women. His approach minimized the many similarities between the sexes in terms of their

basic needs, motivations, and desires all while reinforcing traditional gender stereotypes. And while there are gender differences, many similarities shared between men and women tend to outweigh the small differences which exist between them.

For example, research found that men and women are quite similar in their social behaviors, despite the stereotype that predicts women to be passive and conciliatory while men as aggressive in social situations. In turn, it was shown that the context of the interaction, whether it was with a romantic partner or someone else, was what affected these types of 'gender differences' in communication rather than the gender. Further, it was found that in their communication, women are more likely to make demands while men are more likely to withdraw, a result of personality and socialization differences between men and women. Biologically, this lines up with evidence that suggest that men react with stronger physiological responses, such as increased heart rate, than women do, and consequently seek to withdraw from conflicts. As such, the socialization of men and women in relationships differ as well with women's identities being developed in the context of the relationship, while men's, in the context of separation. Therefore, *sexual communication* amongst couples must enable a way to share their likes and dislikes as a part of negotiating sexual behaviors which will suit both of them. This may mitigate challenges surrounding sexual incompatibilities that can impact the timing of sex, their personal preferences, and how long sexual activity should last. Research indicated that if sexual communication does not flow openly between the members of the union, their relationship will suffer. And as important as it may be for these partnerships, many find it difficult to speak about sexuality with their partners. Barriers to couples discussing sexual issues include concerns that such a discussion may highlight the different desires that each has, and may cause the other person discomfort and hesitation about remaining in the relationship. Such a discussion may also reveal if one has beliefs that it is immoral to discuss sex related feelings of shame and embarrassment, or simply a lack of experience in discussing sexuality.

How Do We Talk Effectively About Sexuality?

One's attitudes and sexual beliefs no doubt influences our sexual communication. Once a couple starts a discussion about sexual issues, it may be influenced by their effectiveness as listeners, and ability to accept without criticism whatever their partner brings up in the discussion.

It may be surprising to realize that 15% to 20% of married Americans have sex with their spouse less than once per month, which may suggest that their sexual activity is not satisfying. Achieving desired sexual outcomes requires effective coordination between partners in the activity itself, as well as what they expect and need in order to be pleasured. It is believed that married people are often less than fully effective in their communication about sex. Most sexual communication is nonverbal, but verbal messages are important as well.

Sexual Communication

Communication is a process by which we use symbols like words or gestures to establish human contact, share information, and reinforce or change our behaviors and those of others. It is often

influenced by cultural, social, and psychological contexts which makes it challenging when talking about sex and sexuality. To understand this, we must first identify what these contexts are and how they influence the manner in which we talk about sex with our partners.

The cultural context – here we mainly refer to the language that is used, and the values, beliefs, and customs associated with it. Since Western culture has traditionally viewed sexuality negatively, many sexual topics are considered taboos, with many traditional media outlets still censoring sexual topics are mentioned in their programming. This can be contradicting in a world where sexual content is served without filters on other sources like the internet. Altogether, these forms help shape the vocabulary which we use to talk about sexuality and describing sex. Those include the scientific or impersonal ones such as “sexual intercourse,” “coitus,” “copulation,” the moralistic ones such as “fornication,” euphemistic ones such as “doing it,” “hooking up,” “sleeping with,” and the taboo ones like “fucking,” “screwing” or “banging.” Oh yes, there is also “making love” which is sometimes used. We should also remember that gay, lesbian, bisexual, transgender, and queer subcultures also have their own sexual slang due to the societal oppression that is often applied to discussions or expressions of same-sex behavior.

Different ethnic groups also discuss sexual topics differently. AAVE or African-American Vernacular English is often characterized by emotional vitality, realness, confrontation, and a focus on direct experience. Individuals of Latino of Hispanic descent believe that men tend to be the initiators of sexual activity, and while both partners share responsibility for decisions regarding sexual activities and contraceptive use. Asian-Americans share a diverse group of demographic, historical, and cultural factors and traditions which make it difficult to generalize for brevity. However, the cultural characteristics which they do share include the primacy of the family and of collective goals over individual wishes. This reflects the emphasis that sex is appropriate only within the context of marriage, and prioritizes sexual restraint and modesty for couples and emerging adults. It is believed that their indirect or ambiguous communication helps form a more harmonious relationship which results on a reliance on nonverbal cues for communication. Sexual partners from Middle-Eastern backgrounds traditionally place men in dominant roles, and women in subordinate positions. Marriage is perceived as the only road to virtue while celibacy in marriage is not tolerated; nor is homosexuality. As such, diverse cultural understandings of sexual beliefs, practices and norms can be seen across different backgrounds.

The social context – addresses the roles we ‘play’ in society as members of various groups. Masculine and feminine roles are reserved for men and women respectively. Marital partners traditionally consist of husbands and wives, but has thankfully begun to allow gay, lesbian, and/or queer cohabiting roles to exist as well. Although, heterosexual couples tend to have a greater power imbalance than do gay and lesbian couples.

The psychological context – is what determines how we communicate. Being part of specific cultural groups, we tend to behave according to what is considered the ‘norm’ in these social aspects. Language taboos for example, may pressure us to reject or modify living practices that adhere to these spaces, such as traditional gender roles. Our personalities determine how we express our uniqueness while communicating. So, while speaking, we can be assertive, submissive, rigid or flexible – ultimately, giving us the choice to be sensitive or insensitive to these practices. Furthermore, our personal characteristics affect our ability to change, communicate, and manage conflict.

Sexual Communication

It is well known that communication is central in developing and maintaining healthy sexual relationships. During childhood and adolescence, we form our sexual identities from the knowledge and values that are communicated to us in the environment to which we belong. Once our relationship is established, communication is our tool to signal sexual interest, initiate sexual interactions, and maintain it.

Sexual communication is significantly influenced by gender roles that are often socialized to us by the media as well as discussions among peers and others who communicate personal, protective, informative, and diverse messages. Of 517 heterosexual college students, women were found to report their sexual communication as being centered around recreational, relational, heterosexual and procreational scripts to a larger degree than men did. Men received significantly fewer messages about the relationships than women. Their research also pointed out that men received more messages from their male friends focusing on recreational sex while women's conversations with their same-sex peers were more often conservative and dealt with their sexual and dating experience; focusing more on relationships and procreational sex. It appears that communications with other-sex peers, especially for men, was more comfortable than talking with same-sex peers.

Due to these cultural sex scripts, we know how to behave sexually in the beginning of a relationship. However, social media and other forms of online content has begun to challenge these ideals as more individuals have begun to communicate their sexual desires and needs on the web. What was termed "the halo effect" commonly occurs during the early stage of establishing a relationship. This is generally based on appearance, which then may cloud our perception and result in us overlooking less palatable behaviors of our partner.

Once a relationship is established, the way people regard their partnerships, and how they express themselves influence both their feelings and expectations about that union. The sexual script of partners within a developed relationship begins to change with time as they begin to interact and get to know each other better. Relational roles become less rigid, and partners start to adapt to the uniqueness of their loved one. They learn the likes and dislikes of each other and their wants and needs. Interestingly, much of this learning takes place nonverbally. Partners in established relationships express their sexual preferences and likes indirectly to avoid embarrassment or a loss of face. Consequently, if the couple wishes to achieve desired sexual outcomes, they need to coordinate and communicate events like planning sexual happenings, and develop a shared meaning and purpose regarding their sex life.

The process of articulating our feelings about sex can be very difficult for various reasons. First, most of us are not used to talking openly about it. Growing up, most parents do not discuss sex and sexuality with their children. Some equate talking about sex as being immoral, or "bad." And so, if the topic of sex is tabooed, then talking about it is not acceptable. We may refrain from talking about sexual feelings, fantasies, or desires that may concern, disgust or even repel our partners. We are also reluctant to discuss sexual difficulties or problems for fear that we will be seen as responsible for them. This further establishes the discussion of sex as a 'taboo' topic for most in many contexts.

Improving Our Sexual Communication

Self-disclosure – Opening up about ourselves may help to create an atmosphere of mutual understanding. What people know about us may be just part of the picture. Sharing who we really are helps makes us closer to one another and encourages the other person to open up as well. Traditionally, men are not as good as women in self-disclosing personal details about themselves. Since they have been taught to be ‘macho’, strong and silent, they find it difficult to express feelings of tenderness or vulnerability; though that may be changing in the last decade, at least for the younger generation. Women have been conditioned to express themselves, and thus find it easier to disclose their feelings. These differences can result in the distancing of partners which invites loneliness to settle in. It is the most painful loneliness when you feel alone while being with someone to whom you want to feel close with.

Trust – intimate relationships are mostly concerned with love and trust which are essential in every good partnership. Trust is a belief in the reliability and integrity of a person. Obviously, one cannot self-disclose without trust that his or her vulnerability will not be taken advantage of. The degree to which we trust a person influences how we interpret ambiguous or unexpected messages from him or her. When our interpretation may go either way, be it positive or negative, it influences the relationship.

Providing feedback – is another critical element in communication. Providing feedback requires active listening where we listen intently, question what is unclear, and for sure do not mock or criticize the other person. Constructive feedback, in particular, is most significant in strengthening relationships.

Research found that the more couples discuss their sexuality, the greater satisfaction they’ll have from their sexual activities and their relationship. Various ways that sexual communication is related to sexual and non-sexual satisfaction include:

a) *Sexual initiation* – Men in heterosexual relationships initiate sexual interactions more often than women who are likely to accepts such initiations, similar to men who would join a woman if she initiated sex. Refusing to join in are related to lower sexual and partnership satisfaction.
b) *Disclosure of likes and dislikes* – Increasing sexual satisfaction is related to partners disclosing what they like or dislike sexually. That will result in increased pleasure that they derive from the sexual activity. And the more pleasing the sexual interaction is, the more the couple will engage in it, which will increase their sexual and relational satisfaction.
c) *Sexual conflicts* – Sexual conflicts may be a frequent source of tension or problems in committed or even dating relationships. When they occur, they can severely harm the sexual and relational satisfaction of a couple’s union to each other. Such conflicts may involve disagreement about sexual frequency, an inconsideration a partner’s sexual needs, or not being willing to compromise regarding a specific sexual activity that one’s partner may or may not want to engage in.

The Effects of Affectionate Communication

Sexual activity entails various behaviors, such as oral, vaginal, anal intercourse as well as manual and oral stimulation. Communication about those activities, and especially affectionate

communication which includes hugging and cuddling, has several impacts on the people involved. As far as the relationship is concerned, affectionate communication is an investment in the relationship which may help reduce jealousy-evoking behaviors. Such communication may lower one's blood pressure, decrease cholesterol levels, and enhance cortisol recovery following stressful events.

Sexual Satisfaction and Intimate Behaviors in the Relationship

Research pointed out that those who are physically intimate are more satisfied from their relationship compared to those who are not physically affectionate. The affectionate couples engage more in sex and report greater relational stability than those who have sex more infrequently. While it seems clear, sex appears to have a positive effect on relationships since physical intimacy involving hugging, kissing, or holding hands brings the couple closer together and may bring about sexual activity. However, the opposite is also true, as sexual relations may also have negative effects on intimacy since less intimacy may 'insert' distance between partners. At times, relational partners transform their behavior to match each other's desires in order to achieve satisfying relational outcomes. For instance, partners may put their loved one's sexual desire and needs before theirs, which may be beneficial in the short run, but overtime, may not contribute to their intimacy. However, the overall impact of sex in relationships is largely positive and beneficial – especially for couples who are dating or married.

Sexual expression, love, and other intimate gestures have also been known to contribute to relational stability. The link between sexual behaviors and relationship quality has been well established in the literature. Research recommended that couples attempt to restore balance in sexual behaviors when discrepancies between their wishes occur, meaning, when each wants to practice it differently. In other words, when conflicts of interest arise, a partner may change their wishes and behavior in order to protect the relationship or cater to the needs of their partner. Research is somewhat unclear on how it affects the relationship quality. Some research indicates that sexually compliant individuals report feeling greater intimacy and more commitment, whereas other researchers found that subsuming one's preferences to accommodate one's partner results in decreased relationship satisfaction. The jury is still out on this issue.

Intimacy and the process of being 'intimate' as been described as a process which occurs when individuals interact with each other or coordinate their relational well-being. Physical components of intimacy include affectionate behaviors, physical closeness or touching, and sexual behaviors. Touch, as is easy to imagine, has been associated with lower conflict, and exchanging affection is positively associated with relationship satisfaction and commitment. Research by Dr. Burke and Dr. Young examined sexual transformations (i.e., changes in sexual behavior for the partner) and its association with intimacy and sexual behaviors. They hypothesized that the frequency of sex and feelings about sexual transformations would moderate the association between intimate behaviors and relationship satisfaction. Ultimately, it was found that individuals whose partners made more sexual transformations reported greater satisfaction from their relationship in general. Sexual activity in particular was also found to report greater relationship satisfaction as increased sexual behaviour contributed positively to the success of their relationship. These findings are in line with previous research which

indicated that more physically intimate behaviors from the partner, such as more hugs, cuddles, holding hands, were associated with greater relationship satisfaction, since these very behaviors are pleasant and rewarding to the partners. For individuals who evidenced fewer intimate behaviors from their partner, but experienced an increased frequency of sexual transformations by their partner reported greater relationship satisfaction for them. When partners have their physical affection needs met, they also report more love, liking, and satisfaction. Less satisfaction was found when those needs are not met.

Sexual Communication with Parents and Friends, and Well-Being

Romantic interactions and sexual behavior as correlates of sexual well-being were explored in adolescence and early adulthood. The researchers, Dr. Mastro and colleagues focused on how parents and friendships serve as potential social resources for talking about sex-related topics. They wondered how this communication could enhance sexual well-being. Sexual well-being is protective of sexual behaviors, thoughts and emotions that are associated with sexual behavior. The researchers explored how communication affected sexual well-being and examined sexual communication between adolescents and their parents and peers, while growing up.

Parents and peers are potentially essential sources of information and support during sexual development in adolescence. Parents discussing sexuality may provide important information that can guide sexual development and instill values and beliefs about sex which they subscribe to. Teens are known to discuss various topics with their parents, but often find communication about sex and sexuality difficult. This is largely due to their embarrassment, a lack of knowledge on sexual matters, or any negative feelings related to sex which they may have. Altogether, these factors naturally affect the frequency and quality of the sexual communication between parents and their children. In the study, adolescents whose parents attempted to discuss with them about sexual issues reported feeling uncomfortable, fearing that they were attempting to pry into their private affairs or that their parents may not accept and condone some of their behaviors. Thus, the way in which adolescents communicate with their parents about sexuality may be problematic.

Communication with friends provides support for initiating and pursuing romantic relationships, and for coping with difficulties that they may face. It is generally accepted that young people may gain more knowledge about sexuality from interactions with their peers than from any other sources. Research has demonstrated that risky sexual behavior is minimized following sexual communication with peers. However, talking about sex with peers seem to, also, make it easier for them to engage in sexual activity, as it appeared normative in their age group.

Greater communication about sex and sexuality during high school has also been believed to increase greater sexual well-being for individuals. For example, teens who communicated with their fathers about sex and sexuality were found to report more positive emotional responses to sex. When speaking to their mothers, greater safe-sex competence was shown across this sample. As an explanation for these differences, it was suggested that the emphasis and content of sex-related communication differs when it involves mothers as compared to fathers. Mothers, for instance, may emphasize how their child should avoid risks, while fathers may be more inclined to address the pleasurable and positive aspects of sex. Communication

with both parental figures and peers was found to decrease adolescent sexual risk behaviours; especially those who reported having 'higher quality' communication. These discussions and consultations may allow youth to feel more confident in asserting their sexual needs and consequently feel better about what they are doing or refraining from doing sexually, like risky behaviors.

Sexual Behavior and Communication

A study that was recently published (in 2019) suggested that increased use of emojis in text messages to potential romantic partners were related to more first dates and more sexual activity. The reported study, which surveyed 5,327 single students averaging 42 years of age, showed that about a quarter of those who text (28% to be specific) used emojis regularly while texting potential dates. Respondents reported that emojis made it easier for them to express emotions and enriched their messages. Apparently, those who used emojis were 'rewarded' with a larger number of first dates and more frequent sexual activity. Another research project studied 275 single students averaging 31 years found a positive correlation between emoji use and sexual activity as well as maintaining connection with partners beyond first date.

Pain and the Effect of Communication

Provoked vestibulodynia (PVD), which refers to a cutting and burning form of vulvar pain is localized to the vestibule and is provoked by touch – such as through the insertion of a tampon vaginal sexual activity. It's occurrence in the absence of a clear, identifiable cause makes it the most prevalent cause of genito-pelvic pain and penetration disorder. According to the American Psychiatric Association, it occurs mostly in premenopausal women and affects between 7% to 12% of women. Causes of PVD may be biomedical, psychological, or social in nature, and which may contribute to its onset and maintenance of the pain. Women afflicted with PVD tend to avoid affectionate or sexual contact with their partners for fear of the pain that it may cause them – thus, making PVD a major inhibitor in couples' intimacy and sexual satisfaction.

Women with PVD reported a reduced frequency of intercourse, lower sexual desire, and difficulties with arousal and orgasm, while their partners commonly experience erectile dysfunction as a reaction to the pain and difficulties that intercourse causes their partner. Needless to say, both men and women experience psychological distress from this condition, and can lead to feelings of sadness or depression. In fact, this dyadic context influences the severity of pain for women with PVD. For instance, a partner who responds supportively to the pain which the woman experiences help reduce their pain and enhance their sexual satisfaction and functioning. In contrast, negative partner responses, such as expressing hostility or annoyance, result in a women's increased pain and depressive symptoms from this condition.

In turn, sexual communication has been found to contribute to couples' sexual well-being via two pathways: one instrumental and the other expressive. Couples' instrumental communication addresses such issues like sexual preferences and is thought to facilitate change in their sexual behaviors. Sexual expressive communication enhances perceptions of intimacy, thereby contributing to greater sexual satisfaction in the couple. Instrumental and expressive

pathways could conceivably influence a women's pain and its associated impairments in a couple's sexual functioning. They can facilitate pleasurable activities that result in sexual desire and arousal. Increased communication in PVD couples contributes to greater intimate exchanges, greater sexual assertiveness, and increased sexual satisfaction.

In a 2016 study involving women with PVD, it was found that greater dyadic sexual communication was associated with the individuals' own higher sexual satisfaction and enhanced sexual functioning. When men communicated more, women reported greater sexual satisfaction and lower pain intensity. Similarly, a 2008 study involving the intimate partners of cancer patients found that open and constructive sexual communication was identified as the solution that successfully renegotiated their sexual relationship in the context of cancer. It appears that relational variables have a positive effect on individual patients' and partners' adjustment to illness, emphasizing the importance of considering both the individual and relational levels of the couple in these contexts. As such, couples addressing the woman's PVD may use communication to foster greater intimacy by conveying empathy around the impact of pain on their sexual relations. This facilitates greater emotion regulation in couples and additionally may reduce pain levels in the woman. Enhanced intimacy and dyadic coping efforts decreases the depressive symptoms of women with PVD who experience them, and alleviate their isolation, hopelessness, shame, and feelings of inadequacy.

Sexual Communication and Sex Toys Parties

Many people have questions about sexuality and may wish to enrich their sexual activities or minimize difficulties that they might be facing for the benefit of their relationships. Discussing those issues is not always available or is easy for these individuals, despite the availability of healthcare professionals, citing embarrassment, shame, or lack of time as their primary reasons. Considering that sexuality is a taboo topic in many cultures, individuals access information about sex in private ways, which may include reading sexually related materials, watching pornos, or consulting with partners or friends. To provide adults with accurate information that is relevant to their age, it is necessary to identify what sex information is available to a broad range of individuals. In the past, its teachings were done through beauty parlors, churches, or community organizations. But now, it is important to address a broader range of sexual topics to answer questions regarding sexual function, pleasure, relationship enhancement, sexuality in relation to health issues, and sexual communication.

Adult bookstores have been shown to provide sexual information to people. At least, to those who walk in. The sale of safer sex and enhancement products help facilitate the exchange of sexual information to those who purchase it. It is known that men are more likely to visit such establishments, leaving women as often being left out of the picture, unless they actively seek such information. Which usually, is unlikely.

Alternative sources of knowledge can be gained through the rising in-home sex toy party industry which has recently, and rapidly, expanded in North America, Australasia, and Western Europe. It is mainly targeted towards women and often, responds to their sexual enhancement using products such as vibrators or dildos to answer their desires for novelty, sexual pleasure, or to alleviate problems associated with sexual dysfunction. The industry that operates those in-home sex parties is similar to Tupperware and Mary Kay Cosmetics, two large companies

that respectively sell kitchen products and cosmetics which are sold in homes to women. Sex toy sales transactions occur through 'in-home parties' that are typically held in the home of a friend, co-worker, family member, or acquaintance of the facilitator – again as is common when Tupperware are selling their wares. The 'hostess' of those gatherings is the woman who organizes the party and invites other women to attend it, and the 'facilitator' is the company agent who is there to sell products. Products which are available in those gatherings include vibrators, dildos, male masturbation sleeves, anal toys, lubricants, massage products, sex games, and informational books. Less often, condoms and lingerie are included in the inventory. The toys are presented to the group, discussed as to how to use them and what their function is. Women who attend may later request to enter a private room (referred to as 'ordering room') with the facilitator, who will answer their questions and purchase a product without the leering eye of others. There is available data which indicates that most women purchase products which they hope will revive their sex lives or enhance them. These in-home sex toy parties increase women's access to sexual enhancement products and enable them to discuss bothersome issues with the facilitator. Given that female sexuality remains a taboo topic in many communities, and that the sale of some female sexual enhancement aids such as vibrators and dildos are not acceptable in some places, the sale and distribution of sex toys may represent both socialization and subversion. It was reported that facilitators encounter numerous questions about sexuality topics in these sessions. They may benefit from sexuality training and learning about local community resources which they could then share with the women. In turn, sexual health professionals may want to familiarize themselves with those who offer those parties in their community and offer to serve as a referral for clients with relevant sexual concerns.

*

Men look at a woman's behind and go "Wow, what an ass!"
Women look at a man's face and think the same.

*

If a man is talking in the forest, and no woman is there to hear him, is he still wrong?

*

When a woman says "what?" it's not because she did not hear you. She's giving you a chance to change what you said.

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Chapter 7

Sexual Orientation: Whom Do We Prefer as a Sexual Partner?

> Working as a psychologist in a Canadian jail for men, I interviewed incoming inmates to assist the classification committee with their rehabilitation plan. Interviewing some of them was nothing short of surprising. There were guys who lived on the street and reported earning money for food and drugs by prostitution and servicing homosexual men. In light of their homosexual activities, you'd think that they, too, were homosexual. Apparently, most of them were not. Sexual orientation has to do with a person's preference and the way s/he thinks of him or herself, rather than just their behavior. They liked women and preferred sex with women, but had it with men as a way to earn a living. The same can be said about women prostitutes who may be lesbian but still have sex with men.

What Is Sexual Orientation?

In 2011, researcher Dr. LeVay observed that "Sexual orientation has to do with the sex of our preferred sex partners. More specifically, it is the trait that predisposes us to experience sexual attraction to people of the same sex as ourselves (homosexual, gay, or lesbian), to persons of the other sex (heterosexual or straight), or to both sexes (bisexual)" (p. 1). Let's look at definitions of sexual orientation.

Dr. Lehmiller, a sex researcher who wrote, in 2018, a book on sexuality for university students, began his discussion of sexual orientation by declaring that there is no universally agreed-upon definition of this concept. Some researchers suggested that sexual orientation depends on a person's attraction, while others focus on one's behavior or their sexual identity. This, understandably, makes the literature on sexual orientation less clear. However, Dr. Lemiller chooses to describe sexual orientation as "…the unique pattern of sexual and romantic desire, behavior, and identity that each person expresses" (p. 358).

Four conceptually and empirically distinguishable phenomena are included under the rubric of sexual orientation. The first recognizes sexual behavior as sexual interactions between persons of the same sex (homosexual), the other sex (heterosexual), or both sexes (bisexual), and that would indicate one's sexual behavior. The second addresses the sexual identity of which a person thinks of him or herself: as a homosexual, bisexual, or heterosexual. Sexual attraction is the third phenomenon and addresses the degree that one is attracted to the same, both, and the opposite sex. The relative physiological sexual arousal that a person experiences to men versus women, is the fourth and last phenomenon.

Before we delve into what a sexual orientation is, let's sort out the difference between sexual identity, sexual interests, sexual behavior, and sexual orientation.

- *Sexual identity* is the way individuals define themselves sexually. It may or may not describe their actual sexual behavior, or which sexual stimuli arouses them.
- *Sexual interests* refer to what a person wants to do, regardless of whether they actually do it. Sexual interests imply that they sexually arouse the individual.
- *Sexual behavior* is what individuals actually do, even if it is different from their sexual identity or interests. The sexual behavior, as we pointed out above, may or may not be arousing to the individual, and may be used to arouse one's partner, done at the request of a partner, or as a prelude to other sex acts.
- *Sexual orientation* is a distinct type of an intense sexual interest, as defined above.

Dr. Moser, a well-known sex researcher, provided an astute an example to clarify the difference between a behavior and an orientation: "As individuals explore their sexuality, they are often presented with options that they can choose to experience. A woman may decide to investigate BDSM (Bondage and Discipline, Dominance and Submission, and Sadism and Masochism) at the urging of her current partner. The woman may like the attention her partner gives her, enjoy the newness of the experience, and find the new sexual acts exciting. If BDSM is not an orientation for her and she separates from the partner who urged her participation, she may stop engaging in BDSM with minimal sequelae. BDSM was a sexual interest, not an orientation. If BDSM was an orientation, she may choose to continue and seek new BDSM partners. In retrospect, she may recognize that she has had an interest in BDSM since puberty and that she feels more sexually fulfilled since exploring it" (p. 507). In addition to heterosexual and homosexual orientations, recently asexuality, pedophilia, and polyamory were added to the list.

Asexuality: Not Desiring Sex

Asexuality may be viewed as a sexual orientation on the continuum of *heterosexual*, *homosexual,* and *bisexual* orientations. *Asexuality* refers to a lack of sexual attraction or no interest in partnered sexual activity. That does not necessarily eliminate a desire to masturbate. Dr. Lehmiller, who we mentioned earlier, pointed out five interesting points about asexual individuals: First and foremost, being asexual is not the same as being celibate. While both avoid sexual activity, they do so for different reasons. Asexual people are simply not sexually attracted, those who are celibate make an informed choice to avert from those feelings for a period, or forever. Secondly, while it may intuitively be interpreted that way, asexuality is not a sexual dysfunction or a fear of sex. Being asexual does not necessarily mean that one is unresponsive to erotic stimuli or that asexuals have impaired genital function. It was shown that sexual women displayed increased positive affect while watching porn when asexual women showed no such emotion, indicating that they do not feel that sex is aversive, but that they simply do not want to partake in it. Thirdly, asexuals are not necessarily sexually inexperienced or are single. They may be involved in relationships that could include sex, although they simply do not desire it. This highlights the fact that while they may lack sexual attraction, they do not lack romantic attraction. And that may result in their participation in sex as a way to keep their partner. In fact, research has found that many self-identified asexuals masturbate, and some even have sexual fantasies but rarely. Lastly, there is a scientific

suggestion that asexuality is a distinct sexual orientation, since it was found that some of the same biological factors correlated with homosexuality are also correlated with asexuality. *Pansexuality* seems to be the opposite of asexuality and is the attraction to members of all sexes and gender identities, including transgender persons.

About one in 15 males and females are classified as having minimal sexual desire engaging in extremely low level of sexual activity. It should be noted that such low sexual activity may not necessarily indicate asexuality, but rather, the presence of late bloomers, purposeful abstainers, or those who simply did not have an opportunity for sexual activity. And although asexuality is commonly defined as a complete lack of sexual attraction, it may actually be a spectrum that includes the experiences of those who rarely but sometimes have sexual attractions, or 'demisexuals', who seek to be in a strong romantic bond before feeling sexual attraction. There is now a growing understanding that asexuality includes a whole range of heterosexual experiences which does not exclude all sexual activity. Some scholars suggested that asexuality is a unique sexual orientation where both males and females show minimal or low level of sexual expression and interest. If we adopt that view, asexuality, and the strength of one's attraction could represent a dimension of sexual orientation related to the issue of sex in one's target of attraction. Even many of those who self- identify as "heterosexuals" report minimal need for sexual interaction. Causes may include fluctuating feelings of connection to asexuality or a reluctance to recognize that they have a low level of sexual attraction. Generally, there is discrimination as well as low regard for asexuality compared to other sexual orientation groups, and that stigma could discourage people from acknowledging, first of all to themselves, that they may be asexual.

Characteristics of Sexual Orientation

The APA (the American Psychological Association) declared that *sexual orientation* refers to an enduring pattern of emotional, romantic, or sexual attractions to men, women, or both sexes. Additionally, it was noted that sexual orientation also refers to a person's sense of identity based on those attractions, related behaviors, and membership in a community of others who share those attractions. *Gender identity*, on the other hand, is one's internal and personal sense of being a man, woman or neither. For transgendered folk, this can look different as their birth-assigned sex and own internal sense of gender do not match. In such cases, individuals may choose to undergo sex reassignment surgery to fit their gender identity. We need to remember, though, that transgender reflects a gender identity and not a sexual orientation.

When endeavoring to understand these concepts, it is important to make the distinction between sexual orientation identity and sexual behavior. When the sexuality of American adults over 18 years of age was examined, it was found that 91.4% self-identified as heterosexual and had engaged exclusively in different-sex sexual behaviors. It is interesting to note that nearly 1% had exclusive same-sex behavior, but interestingly, these people did not identify themselves as lesbian, gay, or bisexual (LGB). Sexual orientation happens within a cultural context. And while there may be differences on how gays may be accepted in various countries, a global gay and lesbian culture has developed in Western societies. One reason for the discrepancy between identity and behavior is the societal stigma associated with LGB sexual orientation that is internalized by many sexual minorities.

Throughout history, the act of courting and seeking out sex involved having to find individuals that met one's personal needs. Once they realize what they desired, they are driven to spend significant time searching for partners which can help them engage in the sexual acts that they are interested in. In order to get what they are after, they are ready to risk a loss of established relationships, ridicule, discrimination, or being labeled as mentally ill or even be incarcerated for certain behaviors and in certain countries, in order to engage in and fulfill their desired sexual behaviors. Dr. Moser, whom we mentioned earlier, pointed out two characteristics of homosexual and heterosexual orientations, for those seeking to fulfill their sexual desires.

The first one is Lust – which is a strong and persistent attraction to potential partners, or specific sexual acts. It should not be confused with desire, which is an unfocused interest in pursuing sexual arousal and that may lead to engagement in a sexual act. Lust tends to continue even if one's physical state prevents sexual arousal or orgasm. Desire, on the other hand, is not dependent on any person, imagery, or object act.

The second is Fluidity. Sexual orientation evolves and changes in its preferences, just like how we become interested in those who are around our age, and not much younger or older.

Recent research indicated that the number of lesbian, gay, and bisexual adults is likely increase substantially. Most research about U.S. adults, suggests that at least 2% to 8% of the U.S. population is LGB. In large urban centers, 4.6% of women and 9.2% of men identified themselves as lesbian and gay respectively. It was not until the 1960s, with the civil rights movements, the Stonewall Inn riots, and the start of the gay liberation movement that younger gay men and lesbians began to emerge from the closet.

Bisexuality

While we may assume that bisexual-identified individuals exhibit both same-sex and other-sex attractions and sexual behavior, that is not always the case. Some individuals identify as bisexuals since they have experienced sexual activity with both, men and women. In other cases, individuals may be exclusively homosexuals, but if they periodically are involved sexually with both sexes, they may see themselves as bisexual. Research about bisexuality has become more popular in the past decade. That research has reflected the understanding that a noticeable proportion of non-heterosexual people are actually bisexual. Research indicates that the topic of bisexuality requires an open and thorough discussion and studying, much more that it received in the past. It was found, for instance, that some of those who identify as bisexuals actually be heterosexual or homosexual, but just identify themselves as bisexuals.

Homosexuality

Dr. Hyde and Dr. Delamater observed that "…sexual orientation is defined by whom we are sexually attracted to and also have the potential for loving. Thus, a homosexual is a person whose sexual orientation is toward members of their own gender; a heterosexual is a person whose sexual orientation is toward members of the other gender; and a bisexual is a person whose sexual orientation is toward both genders. The word homosexual is derived from the

Greek root homo, meaning "same" (not the *Latin* word homo, meaning "man")" (p. 324). The term homosexual is applied to both genders, though in general women who desire other women sexually are referred to as lesbians. The term lesbian, which is used to refer to female homosexuals, can be traced to the great Greek poet Sappho, who lived on the island of Lesbos (hence "lesbian") around 600 B.C. It is believed that by the age of five or six, or even earlier, the child's sexual orientation has been already determined.

What Contributes to Becoming Gay or Heterosexual?

There are various theoretical answers to this question, as well as the relevant evidence. We'll take a look at some of the main ones.

Biological theories – Some scientists believe that homosexuality is caused by biological factors, which may include genetic factors, prenatal (prior to birth) factors, and differences in brain structure.

Genetic factors – In order to explore the contribution of genetics to sexual orientation, two researchers, Dr. Bailey and Dr. Pillard recruited gay and bisexual men who had a twin or adopted brother and compared their gay and bisexual participants respectively. They reported some interesting results. For identical twins, the gay men group, 52% of the co-twins were gay. Among the nonidentical twins, only 22% of the co-twins were gay. The researchers, then, repeated the study with lesbians. Among the 71 lesbians who had an identical twin, 48% of the co-twins were also lesbian, and for those who had a nonidentical twin sister, only 16% of the co-twins were lesbian. The results which clearly showed that the rate of concordance is substantially higher for identical twins than for nonidentical twins, thus pointed out the genetic contribution to sexual orientation. However, it should be pointed out that genetic factors are not the only ones determining one's sexual orientation.

Prenatal factors – which are present before birth are another biological cause which is influenced by factors occurring during the pregnancy. More specifically, atypical hormones which the fetus may be exposed to in the womb, can lead to (for instance) a genetic female to have male genitals, or a genetic male to have female genitals. Such a process might also account for homosexuality. Any of the several biological variations during this period will produce homosexuality. One study which followed this line of reasoning found evidence that severe stress to a mother during pregnancy tends to produce homosexual offspring, an important note which may encourage expecting mothers to control their stress levels. Another interesting line of research explored the birth order of homosexuals and found that gay men are more likely to have a late birth order and to have more older brothers but not more older sisters. Other researchers have found that gays are 40% more likely than straights to be left-handed, and lesbians are nearly twice as likely as heterosexual women to be left-handed.

Hormonal imbalance – Research investigated the possibility that hormonal imbalances cause homosexuality. Studies have not found any hormonal differences between homosexual and heterosexual men. Much more research is needed in this area before we have some clear results.

Learning theory – Behaviorists, who are psychologists that believe that many of our behaviors are acquired through learning from and imitating others, emphasize the importance of learning in the development of sexual orientation. Bisexual behaviors, which are observed

in humans as well as animals, are a result of rewards and punishments which shape the individual's behavior into predominant homosexuality or predominant heterosexuality. People are, in their view, born sexual, not gay or straight. They acquire their sexual orientation only through learning. For instance, an early and unpleasant heterosexual experience may help change one towards homosexual behavior which may bring more pleasure. To illustrate, a girl who had a very unpleasant experience when she was raped at an early age avoids repeating it and chooses to protect herself by turning to the other gender. However, if an early sexual experience with the same gender is pleasant, the person may become gay. It should be pointed that the evidence on learning theory's explanation of sexual orientation is mixed and need to be accepted with "a grain of salt."

Sociological theory – For sociologists, labeling may explain homosexuality. The label "homosexual" may act as a self-fulfilling prophecy, especially if one is so labelled at an early age. Such a child will, naturally then, become aware of the slightest homosexual tendency in himself, and from there the self-convincing that he is actually a homosexual is a short way.

Considering these various theories, with none offering a proven cause of homosexuality, Dr. Hyde and Dr. Dalamater concluded that "It has generally been assumed that gays form not only a distinct category (which, we have already seen, is not very accurate) but also a homogeneous category, that is, that all gays are fairly similar. Not so. Probably there are many different kinds or "types" of LGBs. If this is the case, then one would not expect a single cause of homosexuality but rather many causes, each corresponding to its type" (2017; p. 341).

Homosexuality: A Drive Down Historical Memory Lane

Same-sex sexual activity appears to have existed throughout human history. Mesolithic rock art shows male-male sexual activity. Female-typical artifacts which were found in graves along with male skeletal remains, may indicate have been seen as evidence for transgender androphilic males in the prehistoric past. In ancient Egypt, we find the earliest written documentation of male-male sexual activity involving humans dated back to 1292– 1069 BCE. The story includes a sexual tryst between the pharaoh Neferkare and the military general Sisene. As already in the 7th century BCE, Sappho the Greek lyrical poet described romantic love and infatuation between females. Historical records indicate that at many times and in many places, androphilic males (those who like men) and gynephilic females (those who like women) have been recognized by others, as well as by themselves, as a unique class of individuals whose sexual orientation is dissimilar to the rest of the majority. In Plato's Symposium (c. 385–370 BCE), Aristophanes theorized that men who try to unite with other men, or women who do so with other women, are actually trying to reunite with a ancient conjoined same sex twin from whom they were separated. Indian ancient medical texts from the 1st Century contain typologies for same-sex attracted individuals that are strikingly similar to modern ones. Data shows that male same-sex sexual activity existed in most cultures, and the population prevalence rate, of about 1.5% to 5% of the population, appears to be similar to what we can find in contemporary cultural settings. At times, we may hear claims that male androphilia is "absent" in a particular culture, such as in the Middle East. These claims are false, as they are present in every culture. Although male-male sexuality may truly be absent in a small number of cultures, these exceptions do not invalidate the conclusion that homosexuality occurs in the

large majority of human cultures, just as female lesbian attraction does. However, it was suggested that romantic relationships between women have been more common historically and cross-culturally than relationships involving genital sexuality.

In Europe, recognizable centers of homosexual activity were traced as far back as the 11th-century court of King William II. Interestingly, same-sex-attracted individuals have more in common with each other, than with the culture which they came from.

Despite a lively debate, same-sex marriages have been legal in the United States since 2015. It seems that religion and conservative beliefs were the largest obstacles to this change. Churchgoing conservatives tend to view same-sex sexual relations as a violation of basic values which they disagree with, while liberals, who are generally more secular, see same-sex marriage as a civil rights issue.

The Shades of Sexual Orientation

Sexual orientation includes four overlapping components: attraction, sexual preference, sexual identity, and sexual behavior. *Sexual attraction* is defined as sexual arousal in response to same, or different gendered person. It may be expressed as a physiological or psychological arousal. Although sexual identity and sexual preference are essentially synonymous in Western societies, the concepts are actually different. *Sexual preference* has to do with the gender of the person one is attracted to. Sexual identity, on the other hand, is how one sees oneself. In the United States, about one in twenty men and one in six women experience same-sex attraction, though the actual numbers may be higher due to people's possible discomfort in admitting their homoeroticism. Some research indicated that both women who identify as heterosexual and those who see themselves as lesbian are aroused, to some extent, by both men and women. Men, on the other hand, were shown to be aroused to either males or females. True bisexuality, or the lack of a gender preference, is rare among men but somewhat more common among women. Homosexual behavior is both more common and more subject to cultural influence than is sexual preference. Between the late 1980s and early 2000s in the United States which is accepting of homosexuals, more people reported themselves homosexuals due to the increased social acceptance.

Religion and Homosexuality: Do They Go Together?

Religion is known to have a powerful influence on people's attitudes towards homosexuality. The more religious commitment people may have, the more likely they are to believe that homosexual activity is immoral. For example, Conservative Protestants are more likely than Catholics or Jews to perceive sex between individuals of the same sex as immoral. In other studies, research which explored the impact of parental religious identity on their child sexual attraction, identity and behaviour garnered mixed results. The researcher admitted that he expected that individuals who were reared in liberal religious backgrounds as well as individuals from secular backgrounds would be less likely to report homosexual attraction, identity and behavior than would be those who grew up in more conservative religious backgrounds. The expectation was that religious background would exert a greater influence on behavior and identity than on attraction. Results were inconsistent, though several patterns

that merit further study were identified. Individuals with a Jewish background appear to be much more likely than those with Protestant and Catholic backgrounds to admit having same sex feelings and identity. The effect of Jewish background on sexual orientation seems to be especially strong among women. Additionally, those with secular backgrounds ae more likely to admit having experienced homosexual attraction than those with Protestant or Catholic backgrounds, or admit to having engaged in homoerotic sex. Additionally, it was found that those with conservative Protestant parents appear unlikely to associate themselves with deviant sexual orientations which is what homosexuality is to them, though they do experience arousal to same sex people as Jews are, but tend not to admit it. Those who experience homoerotic arousal but will not admit that this is what it is, are less likely to act on it and more likely to ignore or suppress it. Dr. Felson ultimately concluded that if there is an effect of religious background on sexual orientation in the United States, it was only in the Jewish community. Although, the largest difference regarding sexual orientation was found between people with Christian backgrounds and those with a Jewish background. Dr. Felson, like other researchers, concluded that his findings support the idea that sexual orientation is primarily- but not completely- rooted in biological forces. Dr. Felson also found that the effect of Jewish background on sexual attraction was as significant as its effect on sexual identity or sexual behavior. It was suggested that most Jews are much more likely than most non-Jews to approve of homosexual behavior. Additionally, people from a Jewish background who know of the Jewish history, will find it easier than others to identify with a minority status, nonconformity, and victimhood.

Sexual Orientation and Neural Correlates

Neuroimaging, like MRI and fMRI, have a variety of advantages, including the potential for greater sensitivity in detecting responses to stimuli that are psychologically significant. fMRI has demonstrated a high degree of sensitivity and specificity in measuring sexual orientation even when erotic pictures were briefly presented. To clarify, genital arousal commonly only indicates a degree of increase or decrease along a single dimension of tumescence, which is the quality or state of being tumescent or swollen. Tumescence usually refers to the normal engorgement with blood of the erectile tissues, marking sexual excitation, and possible readiness for sexual activity. It, consequently, provides little qualitative information on the mental states underlying sexual arousal and desire. However, we need to remember that neuroimaging can pinpoint activity within various brain structures, and therefore suggest which psychological processes influence sexuality. Numerous studies have examined the neuroimaging links to sexual stimuli. Findings indicate that there are connections between mechanisms underlying a person's response to erotic stimuli and the mechanisms involved in responding to arousing and rewarding stimuli in general. Intuitively, these results make sense, since people who seek sexual activity expect that it will be rewarding and pleasant. In fact, a study involving 26 heterosexual men, 28 bisexual men, and 25 homosexual men indicated that heterosexual and homosexual men's responses to male and female erotic stimuli were quite dissimilar in brain activity when shown erotic stimuli.

Unraveling Sexual Identity

Biological sex variations – While most of us in the Western world think of biological sex as having the two categories of 'male' and 'female', sex is actually much more complex. For example, some people, who were known as *hermaphrodites*, are born with bodies and genitals that do not appear completely male or female, but rather, have features of both. They are now referred to as *intersexed*. It appears that being intersexed is more common than is believed to be, though they represent just 2% of live births.

Gender expression – It addresses the way one expresses one's gender. It is referred to as *transgender*, which is an umbrella term that is when one's gender identity or expression differs from social expectations for a given sex. Those whose gender identity and expression are consistent with their biological sex are often referred to as *cisgender*. For transsexuals, gender identity does not match their biological sex. So here, we may find a man who identifies himself as a female, or a female who sees herself as a male. Gender dysphoria is the term reserved for the persistent distress and discomfort that may result for incongruence between one's psychological gender identity and physical sex. Transexuals have a strong desire to exchange their own primary sex characteristics with the sex characteristics of the other gender; and they want very much to be the other sex and be treated accordingly.

Transsexualism is relatively rare, estimated at less than 1 in 10,000 in born males and less than 1 in 30,000 among those whose birth sex is female. Interestingly, research indicated that a majority of females who turned to male transsexuals, are attracted to women, while a majority of males who turned to female transsexuals report attraction to men, which indicates that once they changed to their desired gender, they are heterosexuals.

In most parts of the world, sex is viewed as a binary construct. That is, people tend to think that you can be either male with a penis, or female with a vagina, with nothing in between. People who violate these social norms are typically marginalized. Prejudice against transsexuals and transgender persons is also very common, unfortunately.

Cross dressing – also referred to as transvestism, is a subtype of transgenderism that involves the act of cross-dressing or wearing clothes of the opposite sex.

Occurrence of Non Heterosexual Orientation

Through a comprehensive literature review, it was suggested that precise statistics regarding sexual orientation are impossible to provide. There are several reasons for that uncertainty. First, regarding homosexuality and bisexuality—the behavior, identity, and sexual orientation of those in question tend to vary in frequency. For instance, people who identify as heterosexual (and may even be married) may still engage in homosexual sex and admit homosexual attraction – making it unclear as to where they belong. Different phenomena associated with homosexuality and bisexuality may vary over the life course, making it also challenging for research to determine whether participants are reflecting their current or their lifetime behaviors and attractions. Lastly, due to the stigma associated with those sexual orientations, some people may tend to underreport homosexual attraction, identity, or behaviors even in the most liberal nations.

It was Dr. Kinsey and his group who in 1948 published their ground breaking study on homosexuality in the United States. His results were quite surprising to readers, as they made homosexual behavior and attractions appear so common. He found that 37% of men admitted having had a homosexual experience, which occurred for most of them during their adolescence, perhaps as part of experimentation. The researchers also found that around 10% of the men had been more or less exclusively homosexual for at least 3 years during adulthood, while about 4% of the male respondents had been homosexual for their entire lives. Moving forward in the in the 1980s during the light of the AIDS epidemic, several large surveys of sexual behavior were conducted primarily in North America, Europe, and Australia. Results were generally consistent with previous research but provided lower percentages than Kinsey's 10%.

A recent survey of 34,557 U.S. adults explored their sexual identity and yielded rates of 96.6% heterosexual, 1.6% gay or lesbian, and 0.7% bisexual. Although, these were also found to gender identity as well as same-sex attraction. 1.8 to 11% of adults admitted to "any homosexual feelings." However, coming to understand the results, it is unclear what does it mean that an individual may have experienced a single same sex experience in their lifetime. Another unclear point was that while 11% admitted to a history of any homosexual attractions, only 3.3% of respondents said they were as attracted to the same sex as to the other sex. Quite a meaningful difference between these two numbers. That raises the question whether those who have had at least one or very few same-sex attractions are an intermediate between exclusively heterosexual and homosexual people on a continuum of sexual orientation? It appears that, at least at present, no number can provide an estimate of the prevalence of non heterosexual orientation. We can, however, reach several conclusions with a high degree of confidence regarding Western cultures. First, Dr. Kinsey seems to have overestimated the number of non- heterosexual attractions and experiences. Second, those with incidental homosexual feelings and contacts are much more common than those who are continuously show strong and persistent feelings regarding same-sex experiences. Thirdly, it appears that individuals with substantial homosexual feelings result in a minority of adults in Western developed nations and is smaller than Kinsey's estimation.

Men's and Women's Sexual Orientation

Men's and women's sexual orientations differ in more than one respect. For instance, women are more likely to report a bisexual orientation than saying that they are homosexual, while with men, the pattern is reversed. Women appear more likely than men to experience same-sex attraction in the context of close affectionate relationships, and we can see, over time, that their patterns of sexual attraction may change. Similar results were found when sexual attractions were assessed. The majority of both men and women reported that they were 'entirely heterosexual', with a higher percentage of men (93.2%) reporting it than women (86.8%). More women than men rated themselves as 'mostly heterosexual'. Less men were shown to report themselves as 'bisexual', with a slight rise in the frequency of 'mostly homosexual' and "entirely homosexual" ratings. It is clear that in the Western populations, exclusively homosexual attractions are rarer in women than in men whereas bisexual patterns of attraction are rarer in men than in women. The reason for it is as yet unclear.

The Historical Stigma Related to Sexual Orientation

In order to gain a better understanding of sexual orientation and the experience of the sexual minority that are not heterosexual, let's review the history of American healthcare providers' attitudes and actions regarding this group. During much of the 20th century, homosexuality's official designation in the United States was that of a mental illness, and it was, thus, stigmatized. But starting in the 1970s, a significant change in mental health awareness and professions began to shift as academics began to realize the importance of recognizing sexual orientation on a spectrum. It is important to note that the history of psychology's stance toward homosexuality and sexual minorities illustrates how institutions can recognize their mistakes, reverse their policies, and become agents for societal change. Sexual stigma is the stigma attached to any non-heterosexual behavior, identity, relationship, or community. Like other forms of stigma, it is fundamentally about power. It is also referred to as heterosexism which wants to ensure that non-heterosexuals have less power than heterosexuals by promoting the view that everyone is heterosexually oriented, and that heterosexual behavior and different-sex relationships are considered normal, natural, and unproblematic. That results in the impression that gay, lesbian, and bisexual people are essentially invisible in society at large, and has contributed to the ostracism, harassment, discrimination, and violence of non-heterosexual people across the Western world.

On the other hand, a historical perspective of sexual orientation reveals it to be a fairly recent construct. Although heterosexual and homosexual desires and sexual behaviors were always present in human societies, the meaning behind these acts were always determined by the culture and historical periods they were presented in. It was not until 1868, for example, that the word homosexuality was first introduced by the Hungarian writer Karl Maria Benkert. Heterosexuality came even later. Prior to that time, sexual orientations and behaviors were understood quite differently from the way we view them today. In the 19th century, the institution of marriage was mainly geared for securing wealth and property rights rather than as we perceive it now; a companionate relationship based on emotional intimacy and romantic love. Marriage in yesteryear did not include love since love and sexual desire were construed as opposites. Marriage was established to allow procreation in a socially condoned way in heterosexual marriages, whereas any other (improper) procreative acts were considered animalistic and condemned. Such were anal sex, referred to, by religious teachings and legal statutes, as sodomy as well as homosexual acts. Sodomy, included not only homosexual behaviors, but was also reserved for masturbation, sex with animals, pre- and extramarital heterosexual behaviors, and even sexual acts between a husband and wife that did not involve vaginal intercourse, but rather included oral or anal sex. It was not until the end of the 19th century where alternative forms of sexual attraction, behaviours and ideas were accepted as being normal in typical people. Love and sex came to be viewed as closely related to one another, and heterosexuality was described as their mature, healthy expression.

While Freud advanced the position that people start as bisexuals and then develop into hetero or homosexuals, American psychoanalysis believed otherwise. Homosexuality was believed to represent a phobic response to members of the other sex, which then ushered the view that homosexuality is a sickness. Following that, psychology and psychiatry viewed heterosexuality as normal and homosexuality, as disease. When the United States entered World War II, government personnel policies incorporated the illness model, not only

prohibiting sodomy and homosexual behavior, but also homosexuals in its entirety. However, their detection was quite sloppy, with many health care professionals looking the other way when recognizing homosexuals. As the World War II was coming to an end, anti-homosexual policies were vigorously enforced and resulted in witch hunts which occurred frequently, and the discharge of many gay men and women from the army. These "sexual psychopaths," as they were viewed in the armed forces, became socially ostracized in civilian life, were denied benefits under the GI Bill and often could not secure employment. The social atmosphere was so much against them that gay and lesbian civilians risked arrest almost anywhere they went, and moreover could be charged with disorderly conduct, vagrancy, and solicitation. Exploiting homosexuality's diagnostic status, many American states passed sexual psychopath laws that lumped homosexuals with rapists and child molesters, which sounds horrifying by today's standards. Their indefinite confinement in a psychiatric institution was enforced until they were declared 'cured'. State laws barred them from employment or even from getting professional licensure in very many occupations. During this era, it was not unhear of for psychiatrists and physicians to attempt to "cure" homosexuality, aiming to change homosexuals into heterosexuals, overwhelmingly unsuccessfully. When psychotherapy did not succeed in changing homosexuals, more drastic measures were employed such as hormone treatments, aversive conditioning with nausea-inducing drugs, lobotomy, electroshock, and castration. Sounds quite like the Middle Ages, but that actually happened a mere few decades ago. Many homosexuals who could not change their sexual orientation, attempted suicide. Again, it may be hard to believe, but up until the 1968 edition of the DSM – the American Psychiatric Association's bible of diagnoses, homosexuality was still listed as a mental disorder. Change came only when the mental health profession was pressured by those who suffered so terribly by it. By the 1970s, gay and lesbian activists directly confronted the psychiatric and psychological establishments – finally sparking the change in revising cultural views of homosexuality in psychology and psychiatry. In response, the American Psychiatric Association's finally removed homosexuality from its list of psychiatric disorders in 1973 with the American Psychological Association following suit closely thereafter. Following that major change, psychology and psychiatry changed focus, and aimed not to change the people's sexual orientation, but rather to help sexual minorities lead fulfilling and happy lives. Psychologists studied sexual orientation in well-designed studies and shared their scientific and clinical expertise about sexual orientation and sexual minorities with the courts, with legislative bodies, and with the general public. That change in attitude significantly influenced societal attitudes and provided a basis for reversing many of the antigay policies and laws.

Stigma Associated with an LGB Orientation

Nine out of 10 LGB children experience stigma and harassment in their schools, especially in spaces with ethnic minority communities. In a sample of Latino gay men for example, the vast majority had heard that homosexuals were not normal; as a consequence, most gays reported pretending to be straight to be accepted and not be laughed at. When being asked how they were treated socially, apparently about a quarter reported each of the following: having been hit or beaten, turned down for a job or career opportunity, and bothered by the police because of their sexual orientation. In a sample of South Asians, 70% reported that they experienced homo/trans/biphobia in the South Asian community. More than three fourths of them reported

living a double life hiding their true sexual orientation for fear of negative repercussions and as can be expected, most felt lonely and isolated.

What Is Sexual Fluidity?

Sexual fluidity is another recent determination of sexuality that points out the fluidity of sexual orientation which some refer to as erotic plasticity. Erotic plasticity is defined as the degree to which a person's sex drive and sexual behavior is "flexible" and responsive to cultural and situational pressures. Sex researchers pointed to men's sexual behavior which may fluctuate and vary less across time than does women's. For instance, more women, than men, engage in same-sex activity in jail, though they may not be lesbians. Likewise, same-sex activity among married wives of 'swinger' couples were shown to be more prevalent than with husbands. Research also found that women experience a great discrepancy between their sexual attitudes and behaviors (which may explain their engagement in same-sex behaviors), while with men that is not the case. Women are, consequently, far more likely than men to engage in sexual activity when they do not have the desire for it. It was also found that women's sexuality is more flexible and adaptable than men. Research indicated that while significant genital arousal in heterosexual men was shown in response to porn featuring women, heterosexual women showed strong levels of genital arousal in response to many kinds of porn – including lesbians, gay men, or heterosexual couples. It was also discovered that culture, education, and religion appear to have a stronger effect on female sexuality than on male sexuality. Catholic nuns, for instance, are more successful at maintaining vows of celibacy than are male priests. Another interesting finding is that female adolescents seem to adopt similar sexual attitudes and behaviors to those which their parents held. As such, these findings suggest that sexual fluidity appears to be especially common among women.

A study which interviewed 80 women at 16 to 23 years of age and provided an interesting insight into the condition of sexual fluidity in women. During the first interview at age 16, none of the women identified themselves as "heterosexual"; but instead, described themselves as "lesbian," "bisexual," or did not use any labels. However, over time, the women's sexual feelings toward women changed but only to some degree. Although, overall changes in sexual identity were common. In a two year follow up, approximately one-third of the women changed their sexual identities. Between the second and third interview, another quarter of them changed their sexual identities. And between the third and fourth interviews, another third of the participants changed their sexual identities. Generally, these changes were not dramatic ones, and were for example from "heterosexual" and "bisexual" but not from "heterosexual" to "lesbian," which would be a more dramatic change. These findings are consistent with the growing category of "mostly heterosexual" women, who perceive their main sexual orientation as heterosexual despite experiencing periodic same-sex attractions. An interesting, evolutionary related explanation for women's sexual fluidity was suggested by a researcher named Dr. Wallin in 1995. It was suggested that because women are capable of becoming sexually aroused at any point in the menstrual cycle for the purpose of procreation, sexual desires for the same sex came at no evolutionary cost, making it advantageous to have attraction to both genders for different purposes.

Do Facial Features Differentiate between Heterosexuals and Homosexuals?

Facial features play an important role in social perception. They can serve as an indicator of a person's age and sex, but also whether a person is, for example, aggressive or socially pleasant. Lately, facial features were researched for providing clues about sexual orientation. It is believed, for instance, that gay people can properly recognize each other at first sight, based on various nonverbal behaviors, including eye gaze which may indicate sexual interest or hair style. Research found that even a very short exposure to facial photographs allows people to infer the sexual orientation of people they do not know. It was further found that listeners could distinguish between the speech of homosexual and heterosexual speakers, and even from the way people walk. Interestingly, it was shown that those recognitions are not affected by the culture to which one belongs. A study even showed that it was very difficult to voluntarily conceal such nonverbal cues. Interestingly, feminine male faces receive higher ratings of homosexuality than masculine faces.

The Beginning of Sexual Attraction

Sexual orientations commonly appear at or prior to puberty, which means that they are completed before adulthood and before the hormonal 'explosion' of puberty. Some may deny what they suspect they feel and want, but eventually, figure it out and live in peace with their sexual orientation.

Studies have shown that both males and females recall first having feelings of sexual attraction at age ten, and whether they are attracted toward the same or the opposite sex. Dr. Savin-Williams found that homosexual men believed that their early sexual attractions were not necessarily a source of any distress. Same-sex attractions were often experienced as an obsession by those boys or adolescents who were around masculine men which they aspired to emulate. As time went on, these men recognized that their same-sex desires were rarely shared by others and should be hidden. Homosexual women, as we could expect, said that their same-sex attractions were emotionally based, and much less sexually related. Self-identifying as a lesbian or female bisexual often precedes the onset of homosexual activity, as the first erotic behaviors towards parties of the same sex commonly occur within a romantic relationship. Bisexual individuals recognize their same-sex attractions later than homosexual men and women. That may be due to the fact that bisexual identities usually follow after the establishment of a heterosexual identity.

Consequences of Sexual Orientation

We know from the news media that people will risk almost everything important to them to explore and experience the sexual acts that they desire. There are personal, emotional, and social consequences for denying one's sexual orientation. Alternatively, denying or repressing their sexual interests may backfire, as those who repress their desires may end up acting out on them, possibly at the wrong time and circumstance.

Sexual Orientation and Well-Being

Research about sex and sexual behaviour concluded that homosexual and bisexual men and women report having poorer psychological well-being than heterosexual men and women. Gender nonconformity, which means not behaving as is expected of one's gender can be observed throughout childhood and adolescence and has negative affects on one's well-being more so in males than in females. Let's take a closer look at sexual orientation and psychological well-being.

It has been established that there is an association between homosexuality and increased mental health risks such as anxiety, mood fluctuations, substance abuse disorders, and suicidal ideation and attempts, even at young ages. The ratio of problems in homosexual vs. heterosexual people is roughly 1 to 7.

Gender Nonconformity and Well-Being

Gender nonconforming children and adolescents frequently suffer mockery and rejection by peers and parents, particularly in young males. Extremely feminine boys are most vulnerable to these effects, and often experience great difficulties with, and rejection from their peers. Consequently, these individuals may experience long-term psychological distress and encounter difficulties in their relationships in adulthood. Research conducted about four decades ago, found that individuals who did not conform to their gender in childhood, was associated with feelings of isolation and suicidal thoughts. However, this was only prevalent in men.

Gender nonconformity may, in part, account for the decreased well-being of homosexual people. Among bisexual and homosexual men, gender nonconformity is expressed through having lower self-esteem, more eating disorders, increased depression and anxiety, and more suicidal attempts. Research indicated that in male youth, gender nonconformity, but not sexual orientation, was related to higher suicide attempts. Gender nonconformity and a same-sex orientation are related to psychiatric symptoms in both genders.

A study on 475 (52% males) high school seniors in the United States found that both childhood and adolescent gender nonconformity, for both males and females, were directly linked to well-being. Although not all homosexual and bisexual people are gender nonconforming, those who are commonly experience poorer psychological health. Similar conclusions can be made for heterosexual people who are gender nonconforming. Thus, whatever is causing gender nonconforming homosexual or bisexual people to suffer psychologically may also apply to heterosexual people as well.

Sexual Orientation Cross-Culturally

We can assume that in all cultures the vast majority of individuals are heterosexual, and only a minority of people are either homosexual or bisexual. Although the data that might speak to this issue are exceedingly limited, it appears to be consistent with this conclusion. Sexual identity and behavior, unlike sexual orientation, are far more susceptible to cultural variation.

Consequently, the ways in which many non-Western homosexuals and Western gay men and lesbians think about themselves and behave can differ in important respects. Sexual attractions can be considered a universal human phenomenon, though comparing sexual identity in various cultures is complicated, since different cultures may or may not have a notion of sexual identity and not all cultures permit individuals to pursue sexual behavior that aligns with their desires.

"Androphilia" and "gynephilia" are terms that point to basic human sexual attractions. Androphilia is sexual attraction and arousal to adult males, while gynephilia refers to sexual attraction and arousal to adult females. Consequently, homosexual men and heterosexual women are androphilic, while heterosexual men and homosexual women are gynephilic. It is true that same-sex-attracted individuals can differ in dramatic ways from one culture to the next; however, androphilic biological males or gynephilic biological females are terms that apply in any culture. But what does vary, significantly, between cultures is the manner in which same-sex sexual attraction is publicly expressed. For instance, on the Indian subcontinent, transgender male androphiles known as Hijra are known to bestow blessings from Hindu gods and goddesses for luck and fertility at weddings and are thus seen as religious entities. Similarly serving religious functions are the transgender androphilic males known as Bissu in Sulawesi, Indonesia, who are shamans which bless people for good health and are an integral part of weddings. In general, same-sex attracted individuals self-select to fill these roles, probably because it is socially condoned. Margaret Mead, the famed American cultural anthropologist, observed a meeting in which an Omaha minquga, meaning a transgender male androphile and a Japanese homosexual man (a cisgender – a person whose gender identity matches their sex assigned at birth – male androphile) instantly recognized each other when they visited her location. Within an hour of the Japanese man's arrival, the sole minquga in the tribe turned up and tried to make contact with him. In Western countries, within such relationships, partners treat each other as equals and do not have any special social roles.

Sexual Orientation: How Does It Start?

Across many different cultures, the non-heterosexuality of males and females in adulthood unveil itself during childhood through gender nonconformity, where the child behaves somewhat like the other sex. Childhood gender emerges at an early age, despite gender socialization which is prevalent in a given culture. But childhood gender nonconformity may persist into adulthood for some.

No specific theory of what causes people to be attracted to men, to women, or to both has been validated sufficiently to win the backing of all reasonable scientists. This does not mean that all theoretical musings are the same. In general, views on the causes of homosexuality can be divided between the pro and anti-homosexuality. The first, associated with positive attitudes toward homosexuality, simply points out that a small percentage of people are homosexual for reasons we simply cannot explain. The second, associated with negative attitudes toward homosexuality, sees homosexuality almost like a disease which may be socially contagious and can spread if we allow moral or legal prohibitions to be relaxed. Scientific evidence seems to support the first view much more strongly than it does the second. The evidence showcasing the prevalence of non-heterosexuality across cultures and during various eras, suggests that the frequency of homosexual orientation does *not* increase with social tolerance, although its

outward expression may do so. And so, just because a non-heterosexual orientation is accepted in a certain culture, does not mean that more people will become non heterosexual if they are not already so inclined. To reiterate, the fraternal-birth-order effect which some research found applies only to male sexual orientation. A research group headed by Dr. Bailey pointed out that it would be surprising if differences in social environment contributed to differences in male sexual orientation at all, though male homosexuals may feel more at ease acting upon their feelings if the culture they live in condones it.

Is It, at All, Relevant That We Know What Causes a Specific Sexual Orientation?

Researchers in the field of human sexuality constantly debate about that very question. It was pointed out that asking whether people *choose* their sexual orientation is not an appropriate question, since people believe different things about the causes of homosexuality, and more importantly about its consequences. Those who view homosexuality as having a negative influence on the psychological, moral, or social functioning of the individual, will disapprove of homosexuality and may attempt to restrict its expression. In contrast, people who do *not* believe the same will favor the rights of homosexuals to live openly and to enjoy the same rights as heterosexuals. These opposing beliefs become complicated when also recognizing the misinformed ideas surrounding sexuality and expression. For example, there is a belief, held by some, that homosexual people attempt to recruit others into homosexuality through conversion or 'reorientation'. Understanding the causality of homosexuality will help to address those issues and concerns.

OK, So Can Sexual Orientation Be Changed?

Not much is known, scientifically, about the possibility of changing people's sexual orientation. There are contrasting reports of success and harm which fuelled debates for many years regarding the possibility of changing sexual orientation. Historically, sexual reorientation has not only been a scientific one but a political, religious, and cultural issue. For centuries, non-heterosexual people have been taught by society to view themselves pejoratively, enhancing in them the belief that they are flawed, and thereby prompting them to seek a cure. Attitudes toward homosexuality and non-heterosexuality have shifted since the 1970s, and have contributed to counter the impact of false beliefs and the lack of accurate information about sexual diversity.

The Treatment of Non-Heterosexuals throughout History

Homosexual desires and behaviors have been described as sinful, criminal, and a mental illness. Interventions were then developed based upon these assumptions and attitudes towards sexual diversity. Throughout the decades, physicians, mental health professionals and the clergy tried and failed to change homosexuals. Many non-heterosexuals have voluntarily and involuntarily undergone interventions that have ranged from benign to even cruel and ridiculous approaches.

Some of such including treatments like spinal cord cauterizations, clitoridectomies which are the surgical removal, or partial removal of the clitoris, castration, ovary removal, and even lobotomies(!) in order to eliminate their unwanted sex drive. Additionally, convulsions and epileptic seizures were induced in those poor patients via electric shocks or drugs. Other methods that have been tried included radiation or steroid treatments to reduce homosexual urges brought on by a supposed hyperactivity of a gland secreting hormones in an attempt to "balance out" non-traditional gender expression. Behavioral interventions, which focus on changing behaviors without necessarily changing their underlying causes, have been used to generate heterosexual arousal and teach heterosexual skills. In the early nineteenth century the treatment even involved prostitution or marriage "therapies" in order to change the homosexual orientation of those who 'needed' that help. An obviously mistaken announcement was made by a writer named Dr. Ovesey, a mere 50 years ago who declared that "There is only one way that the (male) homosexual can overcome this phobia and learn to have heterosexual intercourse, and that way is in bed with a woman….Sooner or later, the homosexual patient must make the necessary attempts to have intercourse, and he must make them again and again, until he is capable of sustained erection, penetration, and pleasurable intra vaginal orgasm". Quite incredible!

In the 1970s, assertiveness and affection training, as well as dating skills were used as part of a process of physical and social reinforcement. Orgasmic masturbatory reconditioning, meaning the act of masturbating and reaching orgasm to images of women, were employed to extinguish homosexual arousal and condition heterosexual desire. A more severe approach involved aversion treatments which aimed to control arousal by punishing homosexual desires, joining other unbelievable yesteryear methods such as electric shocks, nausea-inducing liquids, shame and threats of beatings. More gentle approaches involved cognitive interventions which attempted to overcome "irrational" blocks and "anxieties" surrounding heterosexuality, thus, enabling the person to allow his heterosexuality to emerge. Even chiropractic services have been used as a possible intervention for this.

Is There Anything That Can Be Helpful in Sexual Reorientation?

The National Association for Research and Treatment of Homosexuality (NARTH), a well-established sexual conversion organization, indicated the following as necessary efforts for change to occur: "Efforts in masculinity (i.e., men have to feel manly and relate to other men); authenticity (e.g., getting out of the false self, facing real feelings in open relationships); need fulfillment (having those relationships, experiences, and opportunities that strengthen, nurture, and lead to joy and personal satisfaction); and surrender (letting go of everything that prevents change from happening and letting in the things that restore growth processes)" (In Beckstead, 2012, p. 3).

Currently there are still attempts to change sexual orientation, and some of the methods which are utilized include (1) helping the individual understand that their non-heterosexual orientation may stem from abuse, parental neglect and rejection, and inadequate gender roles; (2) reframing (which is a way of changing the way you look at something and, thus, changing your experience of it) homoerotic attractions as unmet needs and admiration; (3) avoidance of engaging in homosexual behaviors; (4) developing non-sexual, same sex relationships as a way to learning to relate to same-sex people in a manner which does not involve sexual feelings or

behaviors; (5) Attending support groups for validation, and for learning how to behave socially in a heterosexual manner; and (6) using religious practices such as praying, repenting, and focusing on God to provide answers, miracles, and support.

And so, instead of "repairing" non-heterosexuals to act traditionally heterosexual, there is now an attempt to educate the public about the importance for affirmation and acceptance. Additionally, non-heterosexuals are invited to develop competence in managing stigma and rejection effectively. The claims that were made in the past that environmental factors cause homosexuality were shown to be unfounded.

The American Psychological Association (APA) created a taskforce in 2009 to examine whether sexual reorientation can be successfully achieved. They found that aversive techniques rarely led to change in sexual orientation. In turn, behavioral changes observed outside of the laboratory were rare. However, what did occur was a reduction of arousal to all sexual stimuli, which many people may not voluntarily opt for. There is, quite clearly, no evidence that sexual reorientation can be achieved with any of the utilized methods known to us. It is still unknown if cerebral "plasticity," the ability of the brain to modify its connections or re-wire itself, is capable in helping to sexually reorient a person. As such, the aforementioned APA taskforce now recommends psychotherapeutic approached for reducing distress related to one's homosexual orientation, rather than changing their sexual orientation altogether.

Conversion therapy is the use of psychotherapy or behavioral therapy in an attempt to change homosexually oriented people to heterosexually oriented ones, or in general, change any sexual orientation to another. Psychiatrists and psychologists offered early forms of conversion therapy because homosexuality was viewed, for decades, as a form of psychopathology. Both that view and the practice of conversion therapy have drastically changed. And with it, comes opposition from the, American Psychiatric Association and the American Psychological Association for its ethically and scientifically inappropriate behaviour. Present-day conversion therapy is most likely offered by, and to, the religiously observant. Dr. Freund, a well-known Canadian sex researcher who originated the Plethysmograph, an instrument for recording and measuring variation in the volume of the penis, found that clients' claims of sexual reorientation were not supported by phallometric assessments. Other researchers also found that physiological arousal measurements did not support the positive reports of those who had participated in sexual-reorientation therapy.

Overall, there does not seem to be evidence that sexual orientation can be changed with therapy. It is now accepted by mental health professionals that no psychotherapeutic process can change a person's sexual orientation. Although an individual can choose not to engage in certain sexual *behaviors*, the individual's sexual orientation will not change. While sexual orientations evolve, people report fluidity of their sexual interests, it does not imply change of the person's orientation.

How Does Sexual Orientation Affect Mate Preferences?

In comparison to biological sex differences, differences in sexual orientation and mate preferences have not been covered much in the professional literature. Very few studies have focused on the mating psychology of individuals with a homosexual orientation, as if research assumed that they would simply mirror heterosexual mate preferences.

Online research which surveyed a very large number of homosexual and heterosexual participants found that homosexual men valued physical attractiveness just as heterosexual men do, while lesbians ranked attractiveness as not very important to them, like what heterosexual women indicate. However, differences in sexual orientation and mate preferences were found. Interestingly, heterosexual men and women ranked religion, parenting ability, and fondness for children more highly than homosexual men and women. That was said to make sense, since homosexuals may be less likely to focus on child rearing which they may not engage in, though lately that trend is changing. And with its prevailing negative attitudes toward homosexuality in general, many homosexuals tend to avoid engaging with many organized religions. Although there are similarities between homosexual and heterosexual men's and women's mate preferences, it cannot be assumed that they are identical, nor can we just assume the reverse.

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> A woman, on a blind date with a stockbroker, asked her companion what his favorite stage of human development is, what she should be doing in the stock market, what his sexual orientation is, and about his preferred way to end a conversation. His answers left her feeling very in sync with him. "Baby, buy, bi, bye."

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Chapter 8

Can Psychological and Medical Conditions Affect Sexuality?

> Joe and Marisa came to see me for sex therapy. They were at their wits end and were wondering whether their marriage would last. Joe was a banker in his 50s, and Marisa, a high school teacher in her late 40s. The couple had two adolescent children living at home. Their relationship was good; a marriage without too many struggles. They reached a point in life where they had what they needed, and looked forward to the time when the kids will leave home and they will be, once again, with each other and free to live as they wished. However, in the bedroom, things started to squeal, and Joe could not get an erection. Or if he got one, it waned in a matter of less than a moment. They tried to practice sex without penetration, or without using his penis for the act, but by the time they came to see me, they were frustrated, demoralized, and felt hopeless. One of the first things that I do when a couple seeks sex therapy, is to send the one with the symptoms to a urologist to rule out any physical condition that could account for the problem. For if that is the case, there is no need to engage in a lengthy psychotherapeutic adventure. The urologist sent Joe for a variety of tests, and when the urologist finally met him, he was told that he suffers from prolactinoma, a condition caused by a tumor of the pituitary gland. This tumor causes the pituitary to make too much of a hormone called prolactin. The fallout of that is, amongst other symptoms that men have, erectile dysfunction, a loss of interest in sexual activity, and visual disturbances. Both Joe and Marisa were relieved. So, now Marisa knows that Joe is still interested in her and loves her, but simply cannot "get it up." Joe, who once felt depressed at the sexual situation, now knows that his inability to get an erection is related to his medical condition, rather than to the fact that he "is no longer a man." Our therapy centered on teaching the couple the intimate connection of their medical issue and its effect on sexuality. I helped them rebuild their closeness, and encouraged them to see how fortunate they were that Joe's erectile problems alerted them to a hormonal problem, which was relatively easily 'fixed' with proper medication.

No question about it, medical illnesses impact our lives, our social functioning and even our sex lives. Among the most common chronic illnesses that have a significant impact on our sexuality are diabetes, neurological illnesses, cardiac disease, and cancer. Psychiatric illnesses, similar to physical ones, may affect our sexual interest and functioning directly, or due to medications and/or medical treatments that were prescribed. Sexual functioning is a biopsychosocial phenomenon where the body and mind affect each other, and both are influenced by the world around us – particularly by relational contexts within which we operate.

It is well known now, and confirmed by the U.S. Surgeon General, that sex is a basic human right and a fundamental part of healthy living even as we age. The Global Study of Sexual Attitudes and Behaviors which was conducted in 29 countries with a sample of 29,000 people found that over 80% of men and 60% of women described sex as 'extremely', 'very', or 'moderately' important. Estimates of sexual problems vary from 10% to 52% for men, and 25%

to 63% for women. However, this prevalence was shown to rise up to a staggering 90% when sampling medical and psychiatric patients. This reinforces the notion that sexual concerns, distress, and dysfunctions are extraordinarily widespread among ill people. The impact of sexual problems can vary in severity, as feelings of embarrassment, unhappiness, and frustration often lead to a loss of self-esteem or seriously damage these intimate relationships.

However, all medications have side effects. Some may result in sexual dysfunction, and precipitate increases or decreases of sexual desire, arousal and orgasm, negatively affect menstruation or fertility, cause breast disorders such as galactorrhea (a milky discharge from the nipples that is unrelated to the production of milk needed for breast feeding). And while galactorrhea itself isn't a disease, it could be a sign of an underlying problem. Other outcomes also include gynecomastia (a condition which results in the overdevelopment of breast tissue in men or boys which causes them to become larger or grow unevenly), and pain. Indirect effects may involve halitosis (bad breath), weight gain, nausea, bloating or dizziness, mood fluctuations, or perceptual distortions, all of which that can have a direct and negative effect on one's emotional readiness for sexual activity.

Psychotropic medications like antidepressants, anti-anxiety medications, stimulants, antipsychotics, and mood stabilizers are particularly problematic. About 85%(!) of people who are prescribed antipsychotics experience sexual difficulties. In a 1988 study, Dr. Angst compared the prevalence of sexual problems between non-depressed individuals, patients with untreated depression and treated samples on antidepressants. It was found that 26%, 45% and 63% of participants (respectively) were shown to experience problems related to sex and intimacy. Consequently, the research also found that many stopped taking those medications, despite needing to be on them partially due to these issues.

Some sexual dysfunctions may be early warning signs of physical illnesses, such as erectile dysfunction (ED) which may indicate cardiovascular problems, or follow stroke and diabetes. Sexual problems may affect the course of an illness and can precipitate or exacerbate depression; like in men who develop ED. In such cases, men may be prescribed PDE5 inhibitors such as Viagra or Cialis, to help with these issues. Thus, it is imperative that clinicians be able to openly discuss their patients' overall health and whether they can use recreational drugs in addition to sex related medications, since the mix may be harmful.

There is a wide variety of medical pathologies and psychological disturbances that interfere with sexual functioning and enjoyment. While the majority of sexual problems are not caused by medical conditions, we will briefly review those that are. The possible effects of a clinical condition on one's sexuality could be grouped into two main categories:

1. *The direct physical effects of the condition* – which involves a direct interference with the genitals, such as with vascular (blood vessel) impairment, neurological damage, or non-specific effects such as pain, fatigue, or lack of sexual desire.
2. *The psychological effects of a condition* –the individual feels sexually unattractive or develops low self-esteem. However, a more serious effect may be its harm on one's relationship, where sexual disability (as may happen following an accident) or a life-threatening illness, will have a significant impact on the relationship. Additionally, sexual activity may, in some cases, worsen a medical disability or illness. For instance, some individuals who experience ischemic heart problems, or for those with severe hypertension, can get into serious medical trouble as a result of a vigorous sexual session. Regarding the counseling that ill or handicapped people may need, it should

be mentioned and emphasized that they first need empathy and an understanding of their unique situation as they will eventually need to learn how it influences their sexuality. Mental health professionals, for example, can instruct couples on how they can help each other. But ways that require cooperation between a healthy and ill partner, such as assisted masturbation or doing other things that could enhance that person's sexual satisfaction will require experimentation rather than just verbal advice. Below, we will examine the variety of physical problems and illnesses that usually affect sexual functioning and desire in negative ways.

Men's Medical Conditions That May Negatively Affect His Sexuality

Andrology

Penial problems – this category relates to peronei's disease; a condition that interferes with erections and causes deformity to the erect penis, pain, and embarrassment to the affected man. This condition usually starts by inflammation leading to fibrosis and the formation of plaque, causing the penis to bend to the side of the lesion during an erection. While an upwards of 3.2% of men may suffer from it, this condition may resolve itself spontaneously or become a hindrance to sexual intercourse, but not necessarily to sexual activity.

Priapism – this is, what legend would make us believe, that some men may 'desire': a persistent erection. The reality is, however, not as fun as it is painful, very uncomfortable, and is considered a medical emergency which must be corrected commonly through surgery within 24 hours or it may result in permanent erectile damage.

Prostate disease –a benign prostatic growth (BPH) is experienced by the majority of men after their 40s. Many of these men will experience some narrowing or obstruction to their urethra, as well as a compression of their prostatic tissue – further inhibiting their desire. Malignant changes in the prostate are often less common, but dreadfully more serious. Surgery which may be employed to correct the situation, may interfere with their sexual functioning.

Pain during sexual activity – chronic pelvic pain syndrome (CPPS) is sometimes referred to as chronic prostatitis (CP) which affects around 30% of men at some point during their life. The affected men experience chronic or recurring pain in the testicular, or perineal regions, exacerbated by sexual activity.

Abnormal penile blood flow – Abnormalities of blood flow to the penis may result in ED, which then needs to be corrected surgically, as large volumes of blood is needed in the penis to result in an erection.

Cancer

The prevalence of sexual dysfunction in cancer patients is high. Depending on the location of the tumor or metastases, and its intensity, duration and treatment, all these factors can have profound effects on sexuality. That may be followed by fatigue, depression, anxiety, pain – common symptoms associated with chemotherapy and radiation. Sexual problems usually happen during the active treatment phase, but some sexual problems may linger after treatment

is completed. The after effects of cancer treatment may include decreased libido, dyspareunia (the persistent or recurrent genital pain that occurs just before, during or after intercourse), erectile dysfunction, and body image changes. Women who suffered from long-term breast or gynecological cancer reported experiencing profound sexual dysfunction in their relationships. Similar results were found in men undergoing treatment for prostate cancer, as 70% of participants reported having impaired sexual functioning. Radical prostatectomy involves the removal of the entire prostate and results in damage to the neurological and vascular bundles which are critical for managing an erection. It may damage the male's orgasm and could result in a lack of ejaculatory fluid after the removal of the prostate gland, which is where the fluid is produced. Chemical or surgical castration, which are sometimes involved in cases of testicular cancer or for sex offenders, may result in a loss of sexual desire, ED, difficulty reaching orgasm, and other features of feminization. Elderly and middle-aged men are also not excluded from these groups, as benign prostatic hypertrophy (BPH), have been shown to negatively impact the sexual functioning of 90% of men with this condition and additional bladder problems. Women who undergo vaginal or bladder surgeries due to cancer can be at risk for developing stenosis – (an abnormal condition which narrows the vaginal tract and shortens it due to the formation of fibrous tissue – contributing to sexual dysfunction or dyspareunia) or vaginal dryness; making sexual intercourse painful or even impossible.

Breast cancer – one in eight women will develop breast cancer at some point in their life. Breast cancer is curable, but may have a drastic impact on the sexual satisfaction of those who have it. The implementation of national screening programs have shown more cases of this disease in relatively young women than ever before. Its understanding in the medical world have become comparable to that of a chronic disease. And although treatment options have improved, they still constitute an assault on the body and mind.

Breasts, particularly in the West, are often perceived as a significant part of womanhood. Mastectomies, as a result, have far shown reaching impacts on a women's feelings and thoughts in these societies. Consequently, breast cancer survivors (whether they underwent radical mastectomy, or not) may experience long-lasting treatment-related side effects such as pain, depression, and reduced quality of life, which will likely affect their sexual lives. Young women afflicted with breast cancer commonly experience sexual dysfunction, as well as an early menopause. The physical outcomes of a breast surgery can lead to scars, asymmetry, sensory changes, and a disturbed body image where the woman may feel 'less of a woman' – and with being ashamed of the scars, may consequently lose her desire to engage in sexual activity. These physical therapies have major consequences for their physical health and in turn, have secondary consequences for sexuality and sexual well-being. Treatment-related symptoms may include chronic fatigue, pain caused by scar tissue or surgery, or even bodily changes resulting from surgery. Therefore, making it difficult, if not impossible, for a woman to enjoy sex.

It is now recognized that changes to sexual well-being can be the most problematic aspect of life after breast cancer, with its impact lasting for many years even with the successful termination of the cancerous disease. In fact, women afflicted with breast cancer showed lower levels of sexual satisfaction and experienced greater difficulties maintaining their sexual relationships. Some symptoms that were described included pain, decreased vaginal lubrication, nausea, hot flashes, night sweats, vomiting, decreased sexual desire, numbness of previously sensitive breasts and difficulty achieving orgasm. In addition, these women have often reported experiencing depression and a lower sense of sexual attractiveness that can lead

to sexual problems. As such, the quality of a partnered supportive relationship has been shown to be the most important predictor of sexual satisfaction in women with breast cancer.

However, breast cancer has also been linked to negative, indirect effects on partners of the afflicted women. Research now shows that partners of women with breast cancer reported decreases in their sex drive, fears of initiating sex with the woman, and feeling unwanted and unattractive because of the cessation of sex.

Psychological Factors Involved in Breast Cancer

Being diagnosed with cancer is traumatic and has been described as a violation of basic trust with one's body. Research has found that patients develop maladaptive thinking patterns related to the outcome of their diagnoses. Illness cognitions may significantly influence one's quality of life and could be problematic in relation to the expectations patients have of solving their own problems themselves.

Social Factors Related to Breast Cancer

Cancer is known to impact patients' relationships with their partners and their social functioning. That reduced social support may adversely affect their illness, and even their mortality; reflecting its importance as a necessary factor for healing. The quality our relationships are very closely linked to our quality of life, and when those relationships are not fulfilling and satisfying, it tends to negatively affect our sense of living and lead to significant stress. It was also shown that relationship stress and instability can have serious, negative consequences for the psychological and physical well-being of both partners and their children. A good, intimate and supportive relationship helps women to cope better with the impact of breast cancer on their sex lives. The degree to which women can discuss with their partner about the sexual issues, skills and changes needed to make sexual contact pleasant once again is of equal value to both partners. More specifically, it involves the woman being able to tell her partner what she wants and how to be sensitive to her sexual wishes and boundaries.

Results of a Dutch study that was published in 2013 indicated that the sexual activity of breast cancer women returns to its regular course once treatment has been completed. However, it harbours significant, qualitative differences than those of women in the general population. In general, the women who were treated for breast cancer were less satisfied with the quality of their sex lives and had more feelings of guilt about their sexual behavior. The researchers concluded that rehabilitation after breast cancer treatment is a long one, as reclaiming one's sex life after breast cancer is a difficult task. They also indicated that women who can talk readily about both their sexual wishes and their illness are more satisfied with their sexual lives. In contrast, women who find it hard to discuss these same wishes and desires experience more negative consequences and have more trouble resuming their sex lives.

Women who are reportedly more satisfied with their relationships view their sexual lives more positively and are more likely to cope with the negative and significant impact of breast cancer in a more positive manner. Relationships flagged by problems relating to dissatisfaction before the diagnosis tend to suffer more as a result of this news. The duality of the impact of cancer on relationships is thus highlighted. On the one hand, confronting cancer may strain a

relationship, but on the other, dealing with the disease together as a unit seems to be able to strengthen the relationship. Therefore, women who can develop a personal existential framework of meaning, such as believing that her life is worth fighting for and being able to draw on valuable personal experiences, can utilize it to improve her sex life as well as her relationship with her partner and others.

Vulvar vestibulitis syndrome (VVS) – this condition is characterised by severe pain when the vestibule is touched, or when vaginal entry is attempted. *Vulvodynia* describes a persistent, or intermittent, burning pain which may result from tactile stimulation, or simply be there without any specific cause.

Chronic pelvic pain – pelvic pain may cause various gynecological or intra-abdominal pathologies which can be exacerbated during intercourse. Endometriosis (which is tissue that is similar to the tissue that normally lines the inside of the uterus — the endometrium) —grows outside of the uterus and may cause pain especially with deep thrusting during intercourse. Prolapsed ovaries which result in pelvic inflammatory disease, may similarly cause pain.

The Impact of Gynecological Surgeries

Hysterectomy – is considered the most common major gynecological surgery, and is commonly done due to the prolapse of the uterus or uterine malignancy. Dysfunctional uterine bleeding and fibroids occurring in pre-menopausal women may be considered for such surgery. Its impact may range from physical (i.e., damage to pelvic floor) and/or psychological problems. The surgery may cause physical damage to the body, particularly to the nerve supply which is responsible for genital responses. It may also damage the pelvic floor muscles, related ligaments, as well as the ovaries overtime. Even if the ovaries are still left intact, changes in blood supply to the ovaries may eventually lead to ovarian failure. As a result, some women may feel de-feminized after a hysterectomy, and in some instances their partner may also react negatively to the surgery.

Vaginal repair – surgery is the main strategy to correct vaginal prolapse. If only the bladder is prolapsed, surgery may produce a cystocele, which occurs when the wall between the bladder and the vagina weakens and can cause the bladder to drop or sag into the vagina. That, naturally, interferes with emptying the bladder. Aging also adds to the progression of the prolapse which, in some cases, may result in a complete eversion of the vagina and descent of the uterus. Surgical repair may interfere with sexual functioning, either from undue narrowing or the presence of tender scar tissue. It was suggested that since they significantly impact sexual activity, such surgery should be avoided unless absolutely necessary. Researchers found that intercourse should resume about six weeks post-surgery, and should be done on a regular basis and form an important part of vaginal rehabilitation process.

Gynecological Malignancy

The four most common malignancies of the genital tract include the carcinoma of the endometrium, ovary, cervix, and vulva. Endometrial carcinoma is cancer that begins in the layer of cells that form the lining (endometrium) of the uterus and is sometimes called uterine

cancer. The significance of this type of cancer is due to its dependence on estrogen, as the removal of one or both ovaries are commonly associated in this practice and cause hormonal deficiencies that may consequently affect the woman's sexuality. It is either treated by surgery or radiotherapy. Some studies indicated that radiotherapy may cause soreness of the vagina, and more sexual problems than those that may follow surgery.

Vulval carcinoma – thankfully, vulval cancer is rare, and accounts for 3-5% of gynaecological malignancies, meaning that it afflicts approximately 27,000 people worldwide. However, its treatment is often much more severe, painful, and with long lasting effects on one's sexuality. A staggering 60% of female cancer cases were found to develop in the folds of skin around the vaginal opening termed labia, and in 13% the clitoris. The extensive surgery which is prescribed may include removal of all labial tissue and even the clitoris, depending on the extent of the malignancy. Research showed a distinct decrease of the woman's capacity for sexual arousal, although some women did retain orgasmic capacity, despite the extensive surgery. The impact of vulval cancer can be divided into physical, psychological, and sexual.

Physical Impact of Vulval Carcinoma

The major surgical treatment for precancer/cancer of the vulva directly impacts the women's bodily functions, such as the development of lower leg lymphoedema. This is a condition which produces an abnormal amount of protein-rich fluid in the leg that cannot be drained by the body's lymphatic system. That may cause women to curtail daily activities which results in a reduction in physical strength and in tiredness. Women reported a restriction in activities that involve sitting down for long periods as a result of the surgical removal of fatty tissue around the perineum – naturally affecting their careers and social lives. Those who underwent surgical procedures were noted to urinate in a 'spray' like fashion, often resulting in the dampening of their clothing or leakage on bathroom floors. It can easily be understood that the embarrassment one may feel in such instances may lead to a reduction in her social activity or possibly even withdrawing from others.

Psychological Effects of Vulval Carcinoma

Studies noted that diagnosis and surgery for vulval cancer resulted in depression, distress, and anxiety. Women reported a loss of self-confidence and self-esteem, with many feeling embarrassed by what the surgery had done to their bodies. Many also described feelings of not being the 'same' person any longer. Since those women felt that they could not discuss their surgery with anyone, except perhaps with their most intimate friend, many were left to bear these harmful feelings alone.

The Impact of Vulval Carcinoma on Sexual Function

Post-operative patients were shown to have a reduction in sexual functioning, as a 2000 study of women undergoing vulval surgery were left at risk of sexual dysfunction, regardless of the

extent of vulval surgery which was performed on them. Women experienced a loss of sensitivity in the genital area accompanied by persistent numbing, as well as dyspareunia. Additionally, those women reported a loss of libido which was followed by a reduction in their sexual activities. Some research has indicated that the post-surgery period may be positively correlated with the improvement of sexual functioning. Although, it is unclear as to what degree of that improvement is seen in this relationship. Seven out of ten couples, post-vulval surgery, remained sexually active and satisfied with their sexual relationship. This suggests that vulval surgery may have a significant effect on couples and their sexual involvement together, as the quality of the sexual relationship between the woman and her husband/partner may vary with time.

Negative emotions such as depression, anxiety and fear related to a woman's vulva may make her aversive to the idea of sex and sexual activity altogether. This lack of enthusiasm related to intimate activity has resulted in about half of men in these relationships reporting changes in mood and emotional disturbance after their partner's surgery. A study published in 1990 found that the majority of men found the experience of supporting their partners to be extremely stressful, leading to problems in their sexual functioning as well.

A Treatment Approach

The Mayo Clinic in Rochester, Minnesota is addressing the physical, medical, and psychological needs of women who were afflicted with vulvar cancer. Women undergoing major genital surgeries may sometimes be followed by chemotherapy and radiation treatments which have been found to have substantive effects on their sexual behavior and satisfaction. The treatment for vulvar and genital cancer results in the experience of serious pain that women endure when engaging in sexual activity. And so, Dr. Vencill who treats such women recalls having patients tell their experiences about remission, and the memories of surgeons warning them of the physical and emotional pain associated with these conditions. Most typically in those cases, vaginal intercourse may become painful and unenjoyable – making the couple feeling less apprehensive to try it.

Dr. Vencill, a clinician at the Mayo clinic, suggests that couples in these arrangements utilize other forms of intimacy including anal intercourse. From her experience, those who felt uncomfortable or afraid of pain which anal intercourse may cause, eventually learned to relax and take practical tips to make the experience more enjoyable. If cultural or religious attitudes prevented couples from engaging and enjoying alternate intercourse positions and strategies, they were addressed in therapy. Dr. Vencill helps patients disconnect touch from pain, and address such related issues as trauma, religious beliefs, and cultural dictates. In turn, these solutions offer a ray of hope to women who undergo major surgeries that result in pain and discomfort, and to their husbands who may not know how to support their wives and re-engage in sexual activity with them.

Prostate Cancer

Cancer of the prostate is the second most common cancer diagnosed worldwide (after breast cancer). Since the survival rate of prostate cancer is high, it is then the quality of life that

becomes important when discussing its challenges. Up to 85% of men diagnosed with prostate cancer frequently experience erectile dysfunction as a result of various treatment regiments. Challenges related to this often result in a loss of a man's social, emotional, and physical stability, especially since it may last for up to five years post-treatment.

Effects of Prostate Cancer

Prostate cancer affects more than just the man's erections. One's sexual interests, desire and levels of sexual activity are also negatively impacted. Research indicated that many men experience relational distress and disruption followed by changes to their self-confidence. The complementary strains related to a cancer diagnosis also result in heightened levels of stress and concerns in the relationship.

Sexual Rehabilitation

In 2009, a group of researchers compared eight interventions which focused on sexual rehabilitation for men with localized prostate cancer. They found that interventions that specifically focused on sexual rehabilitation were more effective than those that addressed various issues, including the sexual ones. The researchers wanted to examine which approach was the most effective. It was ultimately determined that a face-to-face format arranged by a therapist or a psychologist was the most effective treatment for this issue. What contributed to the success of this program involved taking a detailed sexual history, the explicit use of sex therapy techniques, teaching sensate focus (originated by Dr. Masters and Ms. Johnson, the famed sex researchers), and challenging negative thoughts related to sexuality, masculinity possible intimacy problems. It was reported that sexual satisfaction remained significantly improved even after six the intervention ended.

Cancer and Sexuality in Adolescents and Young Adults

Adolescent and young adult patients (AYA) are individuals aged 15 through 39 years assigned with a cancer diagnosis. A 2015 study conducted in Germany found that about 3% of all cancer diagnoses per year were among AYAs with breast cancer, melanoma, and hematological neoplasms as being the most prevalent diagnoses. With this in mind, it should be noted that AYAs are at a complex psychosocial stage in life when they are facing a serious disease. During that time, they are commonly starting a professional career, aiming to establish financial and social independence as well as a romantic relationship and family. However, a study published in 2014 showed that childhood cancer survivors were less likely to have a romantic relationship or get married than their peers do. Interestingly, a study involving men with testicular cancer found that whether patients were partnered versus unpartnered appeared to play an important role in adjustment outcomes. The romantic relationships of these people were associated with improved physical and emotional function, but also with new relational conflicts. Less

positively, it should also be noted that a negative body image, concerns regarding infertility, or feeling sexually unattractive may aggravate adverse effects of cancer.

In contrast, roughly 96% of AYAs reported feeling satisfied with their romantic and sexual experiences. However, dyadic changes are common in couples facing cancer. And although a majority of patients report having positive changes in their lives post-diagnosis, 13% of patients and 19% of partners experienced a lower quality of life and higher levels of anxiety and depression, as can be expected in light of a serious illness. It was found that couples in longer lasting relationships experienced lower levels of satisfaction. Age was also found to be important, as another study found that older couples reported lower relational satisfaction. Male cancer survivors, specifically, were found to have better sexual functioning than female patients their age. From this, researchers emphasize the great need of medical and mental health professionals in addressing the possible implications of cancer on sexuality, as it can be improved and strengthened with early intervention.

Can Sex Cause Cancer?!

Oral human papillomavirus (HPV), a sexually transmitted infection (STI), is the causing agent for the majority of oropharyngeal squamous cell carcinomas (OSCCs), which refers to cancer of the tonsil, base and posterior one third of the tongue, soft palate, and posterior and lateral walls of the neck and throat. There has recently been a significant increase in OSCC incidence as the percentage of OSCC caused by HPV has grown from 16% in the early 1980s to nearly 80% in the past decade. A 2015 study suggested that the incidence of HPV-positive OSCC is expected to exceed that of cervical carcinoma; the paradigm of HPV malignancies (also known as the most commonly transmitted infection known to man). The behavioral risk factors for HPV-positive and HPV-negative HNSCC are distinct, but show relationships between sexual behaviors and HPV-positive HNSCCs. The recent surge in HPV-OSCC has been attributed to the aging 1960s, 'sexual revolution', cohort which was known to have some of the youngest yet highest number of sexual partners than previous cohorts. As described, demographic variations in sexual behaviors highlight, at least partially, the epidemiology of both HPV-OSCC and oral HPV infection.

HPV is a DNA virus responsible for cancers of the anogenital tract – including the cervix, vulva, vagina, penis, anus and the oropharynx; causing an estimated 5% of the global cancer burden. It is a sexually transmitted disease which is actually common across many people (shown in the form of an anogenital HPV infection) at some point in their lives. Thus, it appears that in some circumstances, and regarding specific cancers, sexual activity may, indeed, relate to malignancies.

Sexual Behaviors

Various sexual behaviors have been shown to be associated with HPV-positive HNSCC including oral sex, vaginal sex, and oral-anal contact. Those with increased numbers of overall sexual partners throughout their lifetime are associated with a diagnosis of HPV-HNSCC – with earlier sexual debut bringing about increased chances for those malignancies.

Although, oral HPV infection apparently precedes HPV-OSCC as the natural progression from oral HPV infection to OSCC is still unclear. Oral HPV infections are relatively uncommon and usually clear up, but a subset of infections persist. Patients with these rare, persistent infections are presumed to be at an increased risk for progression to OSCC. An analysis of the American population detected a prevalence of oral HPV infections 6.9% in the general population, with a significantly higher prevalence among men than women (10% compared to 4%). It was found that anogenital infection is significantly more common than oral HPV infection for both genders, as 43% of healthy American women have a prevalent cervical HPV infection, with an estimated global cervical HPV problem of up to 12%. Oral HPV infections have also been found to be associated with surrogates for increased sexual exposure, including a history of anogenital warts. It is still unclear whether other forms of intimate activities such as 'French kissing' are prevalent to oral HPV infections. Although, research has indicated that in addition to smoking and HIV infection, oral sex, oral-anal contact, and open-mouth kissing did lead to increased risks for new infections.

The risk of both oral and genital HPV infection has mostly been explored in women. In fact, the prevalence of oral infection in women who also suffer from genital infection is almost five times more likely if they also have a comorbid cervical infection as well. It was suggested that it may take decades from the sexual transmission of oncogenic oral HPV infection to develop HPV-positive HNSCC. Rates of this increasing incidence of HPV-OSCC has shown to mostly affect young white men, while sparing African Americans and women.

Research observing distinct patterns of sexual behaviors between racial groups found substantial differences between Caucasian and African Americans. Caucasians, for instance, are more likely to engage in oral sex, with more partners, and at a younger age than African Americans. This may explain the white predominance of HPV-OSCC patients in the USA. Of those diagnosed with HPV-OSCC, younger individuals are likely to be infected with this virus and reflect a large proportion of those with HPV-negative OSCC globally. And while OSCC occurs six to eight more times in middle-aged individuals (ages 45–59) than younger adults (ages 30–44), the rate of OSCC has nearly doubled in the 35-to-44-year age group during the time period from 1973 to 2009. This follows the evolving sexual practices and norms of the past in recent decades and the decreasing age of youngsters beginning to have sex with more sexual partners.

Recent data has also revealed that the highest prevalence of oral HPV infection occurs in those aged 60–64 years, and a smaller peak in the 30–34 years age cohort. The peak at 30–34 years most likely indicates the tendency of those individuals to have participated in a greater number of sexual behaviors during young adulthood. However, what about the increased prevalence in older age? The peak at 60–64 years probably reflects the group of young adults during or after the sexual revolution of the 1960s having engaged in a variety of sexual activities. Alternatively, it is possible that they were already infected with the virus that got reactivated due to age-related immune suppression, as has been described for cervical HPV infection.

Studies have also shown that a significantly higher proportion of individuals with HPV-related HNSCC (73%) compared with HPV-unrelated HNSCC are men (62%). However, differences in the susceptibility to HPV infection should be recognized when exploring immune reactions which are elicited by HPV infection may vary depending on one's anatomic site (i.e., oral, anal, cervical, or penile). Research indicated that genital HPV infection and the

transmission of HPV from the cervix to the male genitalia occurs with significantly greater frequency than vice versa.

Counseling Patients with HPV-OSCC

A significant proportion of patients with HPV-OSCC are unaware that HPV is related to their cancer. Thus, often leaving them confused about the transmissibility of the virus. It seems that an overwhelming 84% of individuals neglected to discuss these matters with their oncologist. And while HPV-OSCC is often associated with sexual behaviors, a diagnosis of HPV-OSCC does not necessarily indicate promiscuity. HPV is a common infection among US adults. Its rates of infection are largely among those with increased numbers of sexual partners, but also reflects patients who have comparatively lower numbers of sexual partners – with some having reported never engaging in oral sex. Thus, highlighting the possibility of other causes for HPV-OSCC aside from oral sex.

Male partners of women with cervical cancer, which are almost always HPV-related, have a 2.4-to-2.7-fold increased risk for tonsil and tongue cancer. Similarly, it is disconcerting that this increased risk may also affect the partners of individuals with HPV-OSCC. It was shown that partners of individuals diagnosed with HPV-OSCC have a very low incidence of oral HPV infection comparable to that of the general population. Therefore, there is no reason to recommend altering sexual practices in relationships where one partner is diagnosed with HPV-OSCC.

Alternatively, research on those infected with HPV related genital lesions showed it to be associated with increased anxiety and concerns, depression, anger and shame related to decreased sexual activity as well as overall enjoyment and quality of life. These findings were mimicked in those afflicted with HPV OSCC – as patients often reported feeling guilty, embarrassed or helpless about their conditions and its effects in the bedroom.

Can HPV – OSCC Be Prevented?

Researchers, theoreticians, and clinicians suggest that the prevention of HPV-OSCC in the public can be achieved through proper education and medication interventions. To date, two vaccines have been developed in the USA to prevent HPV. These vaccines, which were originally developed for the prevention of cervical cancer, have shown a 98% efficacy against cervical lesions. And although its initial target groups were for women only, guidelines were revised to include men for the prevention of HPV-associated anal cancer.

Vaccination is currently recommended for boys and girls 11–12 years old with revaccinations up to 26 years old. It is intended to precede any sexual involvement in order to prevent sexually transmitted HPVs from occurring. General education taught to youth and adolescents has enforced negative stigmas involving STIs and vaginal intercourse – possibly leading to the engagement in oral sex which is seen as 'low-risk' in comparison. However, they must be cautioned that although oral sex is indeed associated with decreased infection rates of STIs, it is not a risk-free behavior. They should also be aware that in addition to oral HPV infection, oral sex has also been implicated in the transmission of gonorrhea, syphilis, chlamydia, and even HIV.

Sexuality as Practiced by Those with Congenital Disability

A review of the available research on congenital disability can provide us with information regarding the totality of the needs of those afflicted with the condition and examine how it affects their sexuality. Impacts to one's physical development, beliefs, values, social relationships, and feelings of physical attractiveness have often been cited in this field of academia. People with disabilities are sexual beings just like the rest of the population, while their difficulties in the engagement of sexual activities and intimacy may only differ in specific ways. For example, lower self-esteem has been associated with increased severity of disabilities.

A meta-analysis published in 2017 examined 1,377 articles about people with congenital disabilities. The research yielded six themes in regards to how people with congenital disabilities operate socially and sexually, including: social participation, social networks, relationships and sexuality, access to sexual health care and support services, body language and image, and sexual activities and dating.

a) *Social participation* – several factors affect the social involvement of those with physical disabilities. Amongst them are limited opportunities for socialization. Those with disabilities attempt to overcome the limited social opportunities with the help of support workers, friends, or family who help transport them and be "communication assistants." Unfortunately, this is often coupled be the risk of changing the dynamics of various social situations, as it can present a barrier to the person with the disability in meeting and interacting with others particularly if intimate interactions are sought.
b) *Social networks* – social support networks are a must for all of us. Such networks may be composed of friends, neighbors, and family – with the additional case of support workers in those with disabilities. The three core methods for helping disabled people develop and sustain their support networks include the use of buddy systems in schools, educational support for families, and social support throughout adulthood.
c) *Relationships and sexuality* – Relationships and sexuality have been identified as an essential aspect in strengthening the quality of life for adolescents with cerebral palsy. People with disabilities, who may miss out on socializing with others during adolescence, may not be familiar with social etiquettes and norms understood by those without disability. In one study observing the social lives of disabled youth, a participant said: "I wish I had been taught about women and having a girlfriend and being a parent. I think families should talk to their kids with disabilities about sex, bodies, HIV/AIDS, relationships, and love" (Collier et al. 2006; p. 69). At times, adults with complex communication needs can hinder social interactions if they are afraid of trying new activities, feel vulnerable in certain situations, or feel frustrated at their communication skills.
d) *Access to sexual health care and support services* – accessing health and support services for sexual health can be challenging for people with complex communication needs. It is not uncommon for them to be assisted by support workers in attempting to facilitate communication.
e) *Body language and image* – play, as we know, is an important aspect of social interactions as well as in maintaining sexual relationships. People with physical and

communication difficulties find it almost impossible to conform to the body image that is considered attractive in the Western hemisphere. Their difficulties in expressing themselves may stem from symptoms of their condition, including dysarthric speech (a form of physical disability where muscles used for speech are weakened and are unable to be controlled easily). Dysarthria often causes slurred or slow speech that can be difficult to understand. Challenges related to bodily communication may be misinterpreted, similarly to those occurring in people with cerebral palsy during instances of nervousness. Erratic or involuntary movements may change the course of various social situations in negative territories.

f) *Sexual activities and dating* – assistance with sexual activities may include support in preparation, positioning and even set-up for masturbation, should that be the preferred activity. Considerable trust between clients and their support workers is required for such intimate activities, as privacy must be maintained.

Sexuality and Obesity

The adverse effects of obesity on health-related quality of life are well documented. Sexual functioning is an integral part of a good quality of life and research has addressed its relation to obesity. Various studies have examined the links between obesity and erectile dysfunctions (ED), female sexual functioning, and whether weight loss positively affects sexual functioning. Findings indicate that obesity is associated with ED, and weight loss is positively correlated with improved sexual functioning in both men and women.

Obesity and Concurrent Illnesses

A series of studies on sexual functioning has been conducted in individuals with obesity-related concurrent illnesses including chronic binge eating, diabetes, obstructive sleep apnea, and prostate cancer. In most of these studies, an association between obesity and impairments in sexual functioning were often found as intuitively expected. This was shown in women with polycystic ovary syndrome; a hormonal disorder common among those of reproductive age. Women with PCOS may have infrequent prolonged menstrual periods with excess male hormone (androgen) levels. The ovaries may develop numerous small collections of fluid (follicles) and fail to regularly release eggs with their BMI (Body Mass Index). This value is derived from the mass and height of a person and appears to have only a modest or limited impact on their sexual functioning. In contrast, men with high BMIs and type 1 diabetes were found to be at increased risk for erectile dysfunction, but not in type 2 diabetes. Alternatively, BMI was also shown to have little relation with ED in men with prostate cancer.

Mental Health and Psychological Disorders

Given the mind-body nature of sexuality, it stands to reason that sexual problems occur concurrently with most psychiatric disorders. Proper sexual functioning is central in

maintaining a satisfying intimate relationship. However, about 54% of women and 31% of men in the USA have reported facing dysfunctions related to sexual behaviour – with the most common challenges being decreased sexual desires in women, and premature ejaculation and/or erectile dysfunction in men. The prevalence of sexual dysfunctions is even higher in those suffering from mental illness, and particularly for those treated with psychotropic medications. Sexual dysfunction has been reported in as many as 30%-60% of patients with schizophrenia treated with antipsychotic medications, up to 78% of individuals with depression treated with antidepressants, and up to 80% in patients suffering from anxiety disorders.

Although, speaking about sexual functioning becomes a complex manner as it involves a wide array of hormones including androgens (a hormone that regulates the development and maintenance of male characteristics), estrogens (a sex hormone responsible for the development and regulation of the female reproductive system and secondary sex characteristics), progesterone (a sex hormone involved in the menstrual cycle and pregnancy), prolactin (a protein best known for its role in enabling mammals females to produce milk), oxytocin (a hormone and neuropeptide which plays a role in social bonding, reproduction, childbirth, and the period after childbirth), cortisol (the body's main stress hormone), and pheromones (a secreted or excreted chemical factor that triggers a social response in members of the same species).

Depression

About 10% of the population suffers from depressive episodes with severe impairments in their quality of life and functioning – including, among other effects, decreased libido. Depressed individuals have reported facing difficulty in maintaining sexual arousal or achieving orgasm during intimate periods, with age and cognitive impairment having strong correlations to the reduction of sexual interest. Especially for men with severe depression, the rate of ED has shown to affect a whopping 90% of them.

To understand the relationship between sex and depression, researchers compared the sexual activity of depressed people to that of medically sick non-depressed patients. Their findings indicated that 63% of depressed patients reported having decreased sexual activity, while only 39% of the non-depressed participants had that complaint. Reduced libido was also shown in 83% of depressed males, and 53% of depressed females. In another study examining gender differences in severities of depression and sex, the loss of sexual interest in both genders was shown across all samples, although having a larger precedence in women. A project which explored a group of depressives found that 31% of people experienced a loss of sexual interest while 22% reported increased sexual interest! Those perplexing results were less evident in women, where only 9% of them reported having increased sexual interest and while 35% having experienced significant decreases in sexual interest.

However, this association between depression and lost sexual appetite is not surprising. Most people who experience sad or depressive feelings are typically not interested in sex or sexual behaviours. In people with untreated depression, 50% reported having sexual disinterest or arousal problems. The incidence of ED may approach 100% in older men with severe depression. Depressed men who may continue being sexually active despite having lost their sexual appetite, may experience a lack of confidence regarding their performance. And for women, similar results have been shown.

Two sex researchers, Dr. Atlantis and Dr. Sullivan, found in 2012 that "…those with depression had a 50% to 70% increased risk of developing sexual dysfunction, and those with sexual dysfunction had a 130% to 210% increased risk of developing depression… (Additionally) Diabetes and CVD are frequently associated with comorbid depression, and all three conditions predict lower urinary tract symptoms, which could interfere with sexual function" (p.1503).

Comparatively, depression and sexual dysfunction are both syndromes that are associated with failures of functional systems that can form positive feedback cycles in one's pathology. For instance, depressed people afflicted with diabetes frequently neglect their self-care and live in a way that may risk their health – resulting in medical complications. Those complications could further exacerbate their depression, diabetes and significantly contribute to sexual dysfunction. Similarly, depression was found to disrupt the sympathetic nervous system which is responsible for discerning between stressful or frightening situations. These inflammatory response systems could lead to type 2 diabetes and adversely affect sexual functioning. Sexual dysfunctions brought about by depression may also cause withdrawals from social life – impacting one's performance anxiety and further sexual aversions that may intensify one's depression.

The treatment of depression is typically a long one, as medication such as selective serotonin reuptake inhibitors (SSRIs) is commonly prescribed to those that suffer from it. SSRIs have been known to cause impairments in sexual functioning, as it specifically inhibits orgasm and lowers sexual desire that may result in feelings of dissatisfaction from sexual activity. The prevalence of antidepressant induced sexual dysfunction was found to account for 39% of depressed populations in the UK, and 27% in France. In a large American clinical sample, findings showed that its prevalence ranged from 22% to 43% across participants. Other common side effects of this medication also result in the deterioration of one's quality of life – leading to the termination of treatment altogether. Clinical experiences would indicate that when appropriate, it is advisable to switch to medications that cause less sexual dysfunction (bupropion, mirtazapine, nefazodone, reboxetine) for those diagnosed with depression. In fact, findings have shown that ED can be significantly improved with sildenafil (Viagra) and probably also with its two compatible drugs, tadalafil and vardenafil (Cialis and LeVitra).

Anxiety

Anxiety enhances fears related to sexual performance, resulting in problems with sexual interest, arousal, or orgasm. A study found that up to 74% of men suffering from social phobia report premature ejaculation compared with 21% in the general population. People suffering from panic disorder also showed very high sexual aversion rates, as they were more likely to encounter sexual problems. Premature ejaculation was the most common sexual problem in men with social phobias. And given the emphasis on the performance anxiety of men and women during intercourse, it is apparent that anxiety disorders will closely affect sexual performance, pleasure, and satisfaction in one's life. For instance, individuals who are concerned about the strength and sustainability of their erection, commonly experience anxieties regarding their sexual performance. These fears of poor or faulty performance can often predict a self-fulfilling prophecy that ends up reflecting what they were most concerned about. The self-esteem of patients with ED may sink due to erectile problems, having an impact

on not only the man himself, but his sexual partner as well. This may result in behaviors such as avoiding intimacy and temper outbursts, which may then increase the likelihood of ED becoming more pronounced and result in a vicious cycle of failure and escalating anxiety. This situation can be treated relatively easily with short-term therapeutic interventions intended to relieve anxiety.

About 15% of the population experience anxiety disorders which include generalized anxiety disorder, panic disorder, obsessive compulsive disorder (OCD), social phobia (SP), and posttraumatic stress disorder (PTSD). Studies have demonstrated that people with high levels of anxiety have a higher rate of sexual dysfunctions, with social phobia being one of them. The main component of Social Phobia (SP) is an extreme fear of behaving in an embarrassing manner in public, which may be followed by ridicule. Here, we find a combination of performance and interpersonal anxiety existing in about 7% of the population, as this type of anxiety is often accompanied by sexual dysfunction. It was proposed that sexual dysfunction, especially in those with reduced erectile capability, is a result of fears or anxieties related to the performance or criticism of others; a similar projection of SP. People with SP have reported facing sexual difficulties 33% of the time, with a majority involving challenges related to, premature ejaculation. Interestingly enough, men suffering from SP reported only moderate impairments in sexual satisfaction, while women suffered from severe impairments in desire, arousal, sexual activity and subjective satisfaction.

Exposure to extremely traumatic events such as war, traffic accidents, or rape may lead to the development of post-traumatic stress disorder or PTSD. PTSD significantly affects emotional, social, occupational, and sexual functioning, and is common for those with this disorder. In one study, over 80% of PTSD patients experienced ED and premature ejaculation, with significantly poorer sexual functioning in all domains of sexual activity (i.e., desire, arousal, orgasm, activity, and satisfaction). PTSD sufferers who were prescribed Viagra doses of 50mg brought about significant improvement in erection functionality and at the same time, improved desire, orgasm, and sexual satisfaction. In conclusion, it is clear that the role of anxiety in affecting impairments to sexual functioning are closely aligned and should not be overlooked during treatment.

Sexual Dysfunction in Patients with Eating Disorders

Research and clinicians have indicated that patients suffering from anorexia nervosa (AN), an eating disorder characterized by an abnormally low body weight and an intense fear of gaining weight, also experience sexual dysfunction and immaturity. They often show low sexual interest with an inhibited rate of sexual behaviors, a disgust towards sex, and a fear of intimacy. It is known that those suffering from AN are characterized by a profound disturbance of their body image. Consequently, it is one of the most researched conditions relating to eating disorders and sexuality in women. Research on women aged 24 years old found that 63% of participants had irregular menstruations, secondary amenorrhea, or the absence of menstruation altogether. Twenty percent of the patients had not experienced intercourse and 80% reported having sexual disturbances. In comparison, the control group comprised of women without AN reported having a satisfactory partner relationship 92% of the time.

In a study examining formerly anorexic women, it was shown that these individuals are less likely to be in a romantic/erotic relationship and were significantly less likely to have

engaged in masturbation than other women. However, groups showed no inherent differences with regard to the frequency of orgasm or intercourse they experienced. Thus, it can be seen that even after recovery, eating disorder patients struggle with the acceptance of their sexuality and often have high rates of inhibited sexual desire, sexual aversion, and anorgasmia, or difficulty reaching orgasm after ample sexual stimulation. The psychosexual therapy of patients with eating disorders is complicated due to basic issues of control, which stem from their childhood experiences with their significant others. The general treatment approach involves education about sexuality and a desensitization of these individuals to their own body.

Patients with personality disorders – are known to have deeply ingrained, inflexible, and maladaptive patterns of relating to and perceiving both the environment and themselves. For instance, those with borderline personality disorder (BPD) are characterized with being intense and unstable, haunted by fear of abandonment, and vacillate between idealization and devaluation. They were found to exhibit impulsivity, and inappropriate intense anger. It consequently stands to reason that these disturbed relational characteristics may interfere with their sexual functioning and capacity for intimacy. They may experience sexual difficulties such as promiscuity or avoidance. In those with borderline personality disorder, 65% of women and 43% of men reported having avoided sexual intimacy due to fears of becoming symptomatic as a result of relationship volatility. Although, only very few studies exist which specifically address the sexual relationships of patients with personality disorders.

A recent study examined a large sample of 290 BPD patients and followed them for six years. Sixty-one percent of BPD patients reported having some type of sexual relationship difficulty versus 19% of other personality disorder patients. Sixty-five percent of BPD women and 43% of male BPD patients reported either becoming dissociated, feeling suicidal, or practicing self-harm behaviours as a result of having consenting sex, or avoiding sex for fears of suffering from challenging symptoms. It was hypothesized that sexual trauma originating from childhood or adulthood predisposes many avoidance behaviours related to sexual intimacy due to a recurrence of trauma related memories evoking BPD symptoms. It is possible that addressing the fears of these patients may help improve the quality of their interpersonal adult relationships, including their sexual relationships.

Bipolar disorder (also referred to as manic depression) – involves a hypomanic phase which reflects a period of increased energy, exhilaration, and irritability commonly associated with bipolar disorder. Sexual activity may escalate to inappropriate or even harmful levels in these patients and put them at increased risk for sexually transmitted diseases. Impulsive sexual behaviors may also result in distresses related to the person and their inner circles, as offences to personal, cultural, or religious beliefs may occur as well.

Schizophrenia

Given the seriousness and the significant influence that this mental illness has, it is surprising that not much research has been conducted in this area of psychology. Schizophrenia is a serious mental disorder where people interpret reality abnormally, and may therefore result in some combination of hallucinations, delusions, and extremely disordered thinking and behavior. Sexual functioning is usually impaired, and schizophrenics are typically much less interested in sexual activity than the general population. Schizophrenics also experience

significantly more dysfunctions of arousal, performance, and orgasm. Thus, contributing to their low sexual satisfaction.

Antipsychotic medications often compound these problems due to their significantly negative sexual side effects. It was found that sexual dysfunction was more common, both pre and post psychotic breakdown, in the schizophrenic women that were studied. Of these women, 60% reported never having experienced an orgasm. Results for schizophrenic men also showed interesting findings, as hallucinations from this population commonly involve sexual content. Thirty percent reported that their hallucinations involved genital change, and 20% involved sex change. Similar results were shown in women. It was suggested that the continuation of sexual interest combined with bizarre sexual ideas, may account for the psychotic sexual behavior or attacks that schizophrenics are occasionally involved in. Most schizophrenics do not have sexual relations, but those who do, engage in unprotected sex and are thus at high risk of contracting sexually transmitted diseases.

To conclude, the rate of sexual dysfunction in patients suffering from psychiatric disorders like schizophrenia, depression, anxiety disorders, eating disorders, and personality disorders is significantly high. The psychotropic medications which are often prescribed for those patients commonly increase their sexual dysfunction and further contribute to their poor prognoses. It seems that the new drugs like Viagra, Cialis or LeVitra have the potential to overcome the specific psychiatric or physical problems inhibiting a satisfying, personal devoid of anger and hostility.

Treating Sexual Dysfunctions That Were Induced by Antipsychotic Medication

To treat physical and psychiatric conditions/sexual dysfunction secondary to alcohol or illicit drug use, prescribed medication is usually the first step in treatment. If possible, patients should avoid the use of drugs associated with sexual dysfunction, such as smoking, abstaining from alcohol and illicit drugs, maintaining normal blood sugar levels in diabetic patients, and treating hypertension (high blood pressure). A reduction in the dose of antipsychotic drugs responsible for side effects may also be recommended. As we described above, the impact of antipsychotic-induced sexual dysfunction negatively affects one's quality of life; and it may potentially cause the patient not to adhere to medication.

General Medical Conditions

Diabetes Mellitus

Diabetes mellitus (DM) is a state of hyperglycemia, where there is too much sugar in the blood because of inadequate insulin activity. This is also known as Type 1 diabetes and occurs in about 5%-10% of diabetic patients. Type 2 DM is related to increased insulin resistance when cells in our muscles, fat, and liver do not respond well to insulin. Treatment for Type 2 DM is often quite simple, involving oral hypoglycemic drugs and the implementation of a proper diet in comparison to routine insulin injections, which is a common approach in Type 1 diabetes.

In males, diabetes may produce a high prevalence of ED, especially when the illness has been present in their lives for a lengthy period. In some cases, ED or difficulties involving ejaculation may be a warning sign that of vascular or neurological damage, leading to the reveal of other illnesses that one may not have been aware of previously.

In women, a higher incidence of orgasmic dysfunction of diabetic women are noted. Comparing diabetic and non-diabetic women, research found that 35% of diabetic women had problems related to orgasmic difficulties in comparison to the 6% in general populations. Orgasmic dysfunction is usually diagnosed only if the woman has been sufficiently aroused but still cannot orgasm. Other studies found that diabetic women reported impaired vaginal lubrication, which may very well be associated with orgasmic difficulty. Out of 81 Type 1 diabetic women assessed, 47% were diagnosed with sexual dysfunction related to inhibited sexual excitement, low sexual desire, and dyspareunia, or painful sexual activity.

Upon examining all the studies discussed above and related to diabetes, two major themes appear: depression in women is contributes to their sexual problems and secondly, sexual dryness expressed by many women, may not necessarily relate to impaired sexual arousal. Diabetes, indeed, interferes with vaginal lubrication, but not necessarily with other aspects of the woman's sexual experience.

Cardiovascular Disease

Most cardiovascular diseases, which affect the heart and blood vessels, result from either the narrowing of arteries (IHD) or from raised blood pressure. It may result in angina (which is chest pain or discomfort which are the result of the heart muscle not getting enough oxygen-rich blood), and predispositions to Myocardial Infarction (MI), commonly referred to as a 'heart attack'. As far as the sexual effects of cardiovascular disease go, erectile dysfunction was found to be an early sign of arterial disease. It was found that up to 75% of people who suffered a heart attack stopped sexual activity as a consequence, while 80% of those with congestive heart failure report marked difficulties or even terminations of sex. Up to 75% of men with coronary heart disease experience some degree of erectile dysfunction, as cardiac medications may also contribute to this problem as well.

Hypertension

There is uncertainty as to the effects of high blood pressure on sexual function. A research project which studied 459 hypertensive men and women in France, indicated that 49% percent of men and 18% of women reported sexual problems. It appears that hypertension may not negatively affect erectile function, although it is possible that as time goes by, it may contribute to peripheral artery disease. In such cases, it could then impair sexual functioning by affecting the blood vessels feeding blood to the penis.

Neurology

A General Review

The neural perception and connection of sexual function involves the interconnection of the brain, spinal cord, and genital pathways, as there are many points of potential interruption. Take for example pelvic surgery, which may be performed in order to alleviate a problem with the prostate, bladder, or the bowel. It can, potentially, damage nerves affecting sexual function even if the genitalia are not part of the surgery itself. Spinal cord injuries (SCI) can affect sexual functioning depending on the location of the damage along the spinal cord. Erections and vaginal lubrication which could be induced mentally through the thought of sexually arousing material may become lost if the injury is complete and above the T10 neurological level. This refers to damage of the nerves that control the muscles of the lower abdomen. If, on the other hand, the sacral cord (located in the lower lumbar area of the body and is responsible for bladder contractions), is damaged, there is loss of genital touch that affects arousal potential. Men with SCI in particular have stark changes to the erections, ejaculations and semen quality they procure, as all these attributes become poorer and less stable. Interestingly, 45% of men and 50% of women report orgasmic ability after CSI regardless of the level or nature of injury.

Patients with brain injuries report having lower energy and interest in initiating sex, difficulties with arousal (including erection for men or lubrication in women), and difficulties reaching orgasm. Both genders reported experiencing difficulties with body position, movement, and sensation, influencing feelings of attractiveness.

Sexual dysfunction is common in Parkinson's disease (PD) in both sexes. It was found that 75% of women with PD report difficulties with arousal and orgasm, and 50% experience low sexual interest. Seventy percent of men with PD experience erectile dysfunction – with 40% of them having premature ejaculations and another 40% have delayed orgasm.

Multiple Sclerosis (MS) can affect cognitive, motor and sensory dysfunction depending on the area of the brain or spinal cord involved. Up to 70% of men and women experience some form of sexual dysfunction associated with MS. These may include libido problems, the inability to experience orgasm, and the general condition of the body which may affect the patient's ability to engage in intercourse.

Epilepsy

It may be unbelievable in this day and age, but masturbation has, in the past, been described as causing epilepsy. Dr. Kinsey and his research group, noted the similarity between orgasm and an epileptic seizure. Epilepsy may affect sexuality in three main ways:

1. *Sexual manifestations of epileptic seizures* – epileptic seizures may involve a range of sexual sensations, erection, orgasm, and ejaculation, and are most likely associated with temporal lobe lesions. This is located in the temporal lower lobe of the cortex, sitting close to ear level within the skull. It is largely responsible for creating and preserving both conscious and long-term memory.
2. *Sexual activity may produce a seizure*, and although it is not common, it does occur.

3. *In-between seizure sexuality* – people afflicted with epilepsy report a number of sexual problems, including lack of sexual fantasies, no sexual interest, or inability to achieve orgasm. Occasionally, hypersexuality (or excessive preoccupation with sexual fantasies, urges or behaviors that is difficult to control) is reported. It is common for episodic seizures to be mostly confined to increased masturbation. Difficulty in responding to sexual stimulation for women and erectile dysfunctions for men were also reported.

Multiple Sclerosis (MS)

Multiple Sclerosis (MS) is caused by demyelination of nerve fibers in the brain. It is an inflammatory autoimmune illness of the central nervous system which represents the most common cause of neurological disability among young adults. MS can develop in people between the ages of 12 to 60 and is as twice as common in women than in men. Its cause is unknown, and has a tendency to 'come and go'. While it can be severe and debilitating, others may have mild or transient forms of the disease without even being aware that they have it! And while the physical and cognitive impairments associated with MS are often addressed by the medical establishment, that is not the case regarding the sexual dysfunctions (SD) related to this illness.

Sexual dysfunction in MS can be divided into three distinct categories: primary, secondary, and tertiary SD. Primary SD is defined as dysfunction which is directly related to MS-related neurological changes that are closely associated with such responses like erectile dysfunction or inadequate vaginal lubrication. Secondary SD refers to physical changes that may significantly impact sexual functioning, such as fatigue or spasticity. Tertiary SD are the psychological, emotional, social, and cultural aspects of MS, which often include low self-esteem, negative body image, depression, or anxiety. Needless to say, these factors all commonly contribute to the negative affect of one's sexual functioning. The fear of sexual rejection due to their illness is a significant tertiary factor that contributes to sexual dysfunction. And within the MS population, women experience higher rates of sexual dysfunction (43%) than men (31%) do.

Patients with MS also suffer from neurological relapses and residual symptoms related to development of new lesions. Although medical interventions for MS have revolutionized the treatment and medications that can help MS sufferers, the management of MS patients' specific symptoms, including sensory deficits, muscle weakness, tremor, bladder dysfunction, fatigue, and cognitive impairment, are still not resolved. Sexual dysfunction (SD), particularly in that suffered by males with MS, is another frequent and disabling characteristic of the illness that severely affects patients' interpersonal relationships. Up to 50% of females and 75% of males with MS experience SD. MS is frequently associated with neuropsychiatric symptoms and patients, consequently, report decreased quality of life. They may face difficulties communicating, hugging, engaging in intercourse, and maintaining urinary and bowel continence during sexual activity. Consequently, they may consider their sexual dysfunction as a devastating consequence of their MS. The secondary SD may include fatigue, bladder dysfunction, and cognitive symptoms. MS drugs add to the problem, since they have adverse effects and are frequently responsible for secondary SD. The tertiary SD is caused by the

psychological, social, cultural, and educational issues of having a permanent disabling disease that affects sexual functioning.

Of people with MS, both genders experience SD in higher rates than the general population or even those with other chronic illnesses. Sexual dysfunctions befall on women afflicted with MS at a higher frequency than in males. They thus engage in sexual activity at a lower rate than males do. Symptoms of MS may undermine self-confidence and consequently, one's sexual potential as well, which later ushers in fears of rejection, and decreased sexual confidence.

It is not just those afflicted with MS that suffer from SD but their partners as well. MS patients often show increased dependence on others, including partners, family members, and friends, which can obviously impact the nature of intimate and non-intimate relationships. The literature indicates that MS sufferers reduce their social contacts and have a shrinking circle of friends. Moreover, fears of sexual rejection and feelings of inadequacy are prevalent among females with MS might limit sexual advances, and thus, sexual involvement. Some women with MS reported, in a study relating to relational issues of people with MS, that they engaged in sexual activity with their husbands to comply with their perceived gender roles and to meet their husband's sexual needs. Others who feared of losing their husbands if they were unable to satisfy their sexual needs, engaged in sexual activity without wanting or enjoying it. The majority of women reported avoiding intimate relationships due to physical discomfort and feeling like they were a burden on their partners. That resulted in feelings of unworthiness, unattractiveness, and declines in self-identity.

Sexuality may also be influenced by other MS-related symptoms such as cognitive impairment, lower urinary tract dysfunctions, and urinary incontinence which can impact their emotional health and engagement in physical and sexual recreation. Depression is a major complaint of people with MS and deserves a brief review. Individuals with MS most frequently complain of depression, with an estimated lifetime risk of approximately 50%, compared to 10–15% in the general population. Depression contributes to decreased libido, and the psychotropic medications that may be consumed in order to lower or eliminate that depression adds to its list of sexual side effects.

Prevalence of Sexual Dysfunctions among People with MS

Studies on the prevalence of sexual problems in MS have showed that 40%–80% of women and 50%–90% of men have had sexual complaints. ED has been empirically considered the most frequent SD reported by MS afflicted men, where 50%-70% of MS male patients complain of ED. Fifty percent complain of ejaculatory dysfunction including premature, retarded, or retrograde ejaculations, which are often associated with anorgasmia (the inability to orgasm) that is experienced by 37% of these patients. Secondary and tertiary SD prevalence is definitely harder to estimate. Secondary symptoms which are known to impair sexual activity included muscle weakness (reported by 58% of patients), spasticity (24%), contractures (12%), and incontinence (5%). Up to 75% of MS patients who suffer from spasticity can experience adductor spasms during intercourse, which often result in fatigue, and pain. That may discourage them from engaging in sexual activity, especially when discomfort and pain may be the 'price' they pay afterwards. Bladder symptoms which originate in the nerves connected to the bladder include urinary frequency, urgency, incontinence, retention which is experienced by about 98% of MS male patients with ED. Up to 65% of patients complain of cognitive

dysfunction has been known to be an early symptom of MS. Additionally, many treatments currently used to combat symptoms, such as antispastics, anticonvulsants and antidepressants may have the potential to cause urinary disturbances, ED, decreased libido, and precipitating secondary SD. Regarding tertiary SD, it was shown that mood disorders, particularly depression which 24% to 54% of patients suffer from, contributes to SD.

Depression and MS

More than 50% of people with MS have major depressive episodes – with some of these being related to the location of lesions in the brain. Depending on the location of the lesion, it was reported alterations in sensation and perception may consequently make sexual intercourse become painful and sensationless. The sources of this depression are so multifaceted that they can be difficult to manage. Consequently, it was pointed out that the treatment of depression in MS patients should include psychotherapy and as well as medications, which may be used concurrently. For both the MS patient and his or her partner, managing depression can enhance intimacy and allow closer relationships.

Parkinson's Disease (PD)

Recent findings by Dr. Braak have shown that Parkinson's disease (PD) is a multi-system disorder that severely damages predisposed cell types in circumscribed regions of the human nervous system. Parkinson's is a progressive and degenerative disease of the central nervous system, which occurs commonly at or after middle age, found in 1 per 1000 in the general population, and 1 per 200 in the elderly. This pathological process commonly begins at two sites and progresses at a predictable sequence.

As the disease progresses, components of the autonomic, limbic, and somatomotor systems become progressively affected. Sexual dysfunction is one of the more disabling aspects of PD. However, it remains scarcely researched as its physical, psychological, neurobiological, and pharmacological features often merge and are not easily distinguishable.

Sexual Dysfunction in Parkinson's Disease (PD)

Both genders experience problems related to PD. Sexual problems in women included difficulty with sexual arousal (reported by up to 87% of women), 75% in reaching an orgasm, and 47% with low sexual desire. In men, researchers found that 68% reported having ED, 41% having premature ejaculation, 39% suffering from retarded ejaculation (which involves as extended period of sexual stimulation for the man to reach sexual climax and ejaculate), and 65% complained of a general sexual dissatisfaction. PD may affect sexual performance through its muscle rigidity and slowness of movement. This may impair sexual activity and genital responses as well as orgasm and ejaculation. And on top of it all, psychological reactions to the disease may seriously impair the sexual relationship.

Several epidemiological studies have found that the most important factor in the development of sexual dysfunction is aging. This finding makes a lot of intuitive sense since most conditions associated with sexual dysfunction are often seen in aging patients. These may include hyperlipidemias (genetic disorders which result in a high level of lipids that circulate in the blood stream) and their vascular complications, diabetes with its characteristic neurovascular dysfunctions, hormonal dysfunction, and surgical procedures in the pelvic area, resulting in functional sexual restriction in both genders. Moreover, hypertension or high blood pressure increases with age and is a risk factor for sexual dysfunction in men. Some medications prescribed for hypertension and which may hardly have any effects on a young man's erection, may drastically reduce the quality of an erection in an older man. Depressive symptoms and its treatment can negatively influence the patients' sexual functioning and satisfaction. Sexual dysfunction, one of the most demoralizing and disabling features of PD, reduces both desire and function and, consequently, the frequency of sexual activity.

Dr. Basson, who conducted research on the sexuality of those afflicted with PD, found that decreased sexual desires, erectile dysfunctions, vaginismus, difficulty in reaching orgasm and internalizing tremor during arousal, had a significant negative effect on the patients and their sex lives. Most partners of people with PD, who were prevalently women, cited sexuality-related problems as those that had the biggest impact on their lives. These partners often expressed sexual dissatisfaction and consequently, had a significantly lower sexual desire. Various studies confirmed that up to 80% of patients with pelvic organ dysfunction experienced erectile dysfunction which was found to be nearly twice as frequent as that found in those not afflicted with PD. These patients experienced erectile dysfunction and a loss of ejaculation control in male patients, with much lower self-esteem in female patients. Up to 70% of young PD women complained of reduced libido compared to 40% of males with PD. Research indicated that 88% of *women* afflicted with PD reported difficulties with arousal, 75% with reaching an orgasm, almost 50% with low sexual desire, and 40% with sexual dissatisfaction (38%). Sixty-eight percent of *men* reported erectile dysfunction, 65% with sexual dissatisfaction, and 40% with premature ejaculation and reaching orgasm. However, it is interesting that despite their reduced ability to get sexually aroused and experience orgasm, both genders are interested in sex, with their sexual fantasies still remaining intact.

PD, Sexuality and Intimate Relationships

Dr. Buhmann and his research team, carried out a study, in 2017 that examined the impact of Parkinson's disease (PD) on couples, their relationship and sexuality. They concluded that Parkinson's disease has a profound and widespread negative impact on patients' sexuality and sexual relationship. While various behaviors and sexual functions are negatively affected by PD, gender-specific effects can be seen in men. For instance, men who experience dysfunctional orgasms have a fear of sexual malfunction and consequently tend to avoid sex. They also tend to withdraw from their relationship upon the diagnosis of PD. Alternatively, PD also had some positive effects in that it strengthened non-sexual aspects of relationships in both genders. As the couple's relationship was of long duration, and they were thus older, it had a positive influence on relational stability. This shows that sexual life is influenced by many factors, including personality, cultural background, relationship, and general health.

In PD, the prevalence of sexual dysfunction is higher in ill patients, than in those not ill of the same age. A change of desire, and not being satisfied with their sexual life is encountered in both genders of people with this condition. Sexual dysfunction, such as erectile dysfunction and impaired ejaculation in male PD patients might cause them to fear that they may not be fulfilling their partner's sexual expectations. Interesting gender differences were noted, in that while women experienced less dysfunction since their PD diagnosis, men reported significantly more impairment after PD diagnosis. It was suggested that sexual alienation from the healthy male partner may be the reason for higher rates of female masturbation and orgasms during sexual activities outside of sexual intercourse. Healthy male partners of women with MS, have also expressed more sexual dissatisfaction which may be related to their lowered attraction to their female mates due to physical symptoms of PD. As people age, thoughts about divorce occur less frequently, indicating an increased stability of the relationship. It was noted that as the duration of the disease increased, the frequency of tenderness with a partner increased. Thus, it appears that non-sexual aspects of relationships seem to get more important with age.

Parkinson's and Paraphilia (Sexual Aversion)

It is certain that the risk of aberrant sexual behaviour, such as hypersexuality and other forms of obsessive sexual deviation, is probably underestimated in PD patients being treated with high doses of L-Dopa or dopaminergic agonists. These medications work by imitating the actions of dopamine when levels are low and thus improve motor functioning and body movement. Research pointed out that in severe PD, not only physiological changes caused by the disease occur, but psychological factors such as personality, coping style, external stressors, reduced self-esteem and comorbid psychiatric symptoms such as anxiety and depression, have important repercussions that may intensify sexual dysfunction.

Effects of Surgery and Pharmacotherapy on Sexual Functioning of People with PD

Several studies have reported varying increases of up to 50% in sexual desire associated with dopamine treatment. Eight percent of PD patients who were treated with L-Dopa were able to resume their sexual activity, and that may have been the result of the effects of the drug on motor function. In approximately 1% of patients, L-Dopa treatment led to hypersexuality manifesting itself as a hypo-maniacal aspect, which is characterized by revved up sexual behavior, way above a normal level. Similarly, when prescribed a dopamine agonist aimed at treating dopamine deficiency, 3% of patients displayed compulsive sexual behaviour. Together with an involuntary erection within 30 minutes of administration in a patient without sexual dysfunction, the erection lasted 10-15 minutes – causing the patient physical and psychological discomfort. In depressed men with PD Viagra, 85% reported that it helped improve erection, and 75% revealing an improvement in depressive symptoms.

The Effect of Spinal Cord Injury (SCI) on Sexuality and Intimacy

In general, debilitating illnesses or injuries complicate intimate relations and sexual encounters. Disabled persons may view themselves as being less desirable sexually, and may not be able to engage in sexual activity or do so to a limited degree. Potential partners may view those with disabilities as incapable of sex or as the patient being asexual. Research suggests that relationships that begin *after* a spinal cord injury are more stable than relationships that began prior to the injury, as then the partner knows how limited the injured person is. In more stable marriages, partners were found to be more sexually active, content, and independent than persons married before the injury. Researchers believed that couples who were married after the injury probably discussed and worked out the mechanics of their relationship by taking into consideration of their partner's injury. In comparison, it was believed that those who faced injury after they started their relationships as healthy people found the transition to be too challenging and distressing.

Who are the ones attracted to people with injuries? Dr. DeLoach and Dr. Greer developed, in 1981, four categories to describe those attracted to the injured: (a) *the walking wounded*, including those who were deeply hurt by previous relationships and consequently look for someone that they believe will not hurt them; (b) *the would-be dictators* – the insecure among us who view individuals with a disability as an easy audience to dominate; (c) *the unsolicited missionaries* – people who seek to rescue individuals with disabilities; and (d) *the gallant gesturers* – ones who believe that they "save" the disabled person by marrying him or her. It is noted that while it cannot be ruled out that some able-bodied partners might have inappropriate and complex reasons for becoming intimately involved with individuals with a disability, their numbers are admittedly quite small.

Men with SCI reported that interest in sexual activities remained high for them, and rather than focusing on themselves during sex and on orgasming, they focused on pleasing their partners. As the loss in sensation begins to increase, men were found to be less interested in sexual excitement. Lower sperm counts and decreased sperm motility were also found in these samples as well.

Men who suffer spinal cord injuries and are actively involved in their respective communities find that the physical changes resulting from their traumas are often complemented with neuropathic pain, sexual dysfunction, incontinence of bowel and bladder movements and a lack of self-confidence. The medical system has viewed spinal cord trauma mostly in terms of its physical aspects. However, we are here to note that neurological dysfunction has major adverse effects on the psychological and social dimension of the person. Commonly, spinal cord trauma may be caused by a fall from construction sites, trees and road traffic accidents.

Sexual Stigmatization

The social stigma and lack of public education regarding the sexual needs of people with a spinal cord injury are well recognized. Unfortunately, many healthcare professions and even caregivers are not aware that disabled people struggle with sexual anxieties and frequently meet them with disregard or even dismissal. The sexuality of people with spinal cord injuries has

commonly been stigmatized due to a lack of recognition which devalues the sexual lives of these people as central aspects of their overall health. A 2010 study explored the attitudes and perceptions of sexuality towards service providers, people with visible disabilities, and people with invisible disabilities. The researchers found that disabled individuals were commonly viewed as asexual.

Moreover, societal stigma may negatively influence a person's self-confidence and reduce their motivations to find a partner. It was also noted that men in particular held significant changes in their sexual functioning following a spinal cord injury. A project conducted in Greece found that SCI patients identified several barriers to a satisfying sexual life, including inappropriate personal assistance, social disapproval, and a lack of accessibility to others.

Spinal Cord Injury as a Barrier to Sexual Satisfaction

There has been a scarcity of information on what emotional aspects of sexuality are involved in people with spinal cord injuries. Most men who sustained spinal cord injuries apparently experience ejaculatory dysfunction, but also yearn for satisfying sexual relationships. These sexual desires were linked to increased rates of depression when sexual prowess was not experienced, as cultural norms would dictate.

We need to remember that all aspects of the person, such as age, gender, comorbid medical conditions, and the degree of satisfaction that the person has with his sexual partner, must be considered if we are to understand his situation, wishes and desires; sexually or otherwise. A study examining the experience of sexuality for men with spinal cord injuries yielded the following themes: diminished independence and perceptions of masculinity following injury, the loss of and need for intimate contact, and an inability to display intimate physical contact. It was found that religion and certain forms of coping could either help or hinder sexuality post injury, depending on individual's perspective. It was noted that although ejaculation and orgasm can occur without erection and ejaculation, injured men who still held sensation in their genitals experienced more enjoyment in their sexual experiences than those who did not. Interestingly, it was found that a possible formation of new areas related to sexual arousal may occur as a result of multiple factors including neuroplasticity and psychological adaptation.

A 2007 study which aimed to estimate sexual activity and sexual satisfaction in men with traumatic spinal cord lesion in Helsinki involved interviewing 92 men who came for a clinical visit. Results indicated that 86% of the men experienced sexual desire and 68% had been sexually active in the last 12 months. The authors noted that although (clinical) treatments for ejaculatory dysfunction were effective, we must also be mindful of the psychological and emotional consequences of spinal cord injury on sexuality.

What about the Injured Men's Partner?

Limited studies to date have addressed the partner or spousal's sexual satisfaction of injured men. A survey of 482 male veterans with a spinal cord injury asked about their intimate relationships and about their partners' sexual satisfaction. It appears that those men who were married or who had sexual partners with knowledge of non-intercourse expressions increased

their partners' sexual satisfaction. The researchers highlighted the notion that sexual satisfaction behaviour and enjoyment is not just a product of physiological parameters but is also strongly associated with quality of the relationship and the attending partner's sexual satisfaction. Another study found that while spinal cord injury impaired sexual functioning, sexual satisfaction is apparently less dependent on physical factors like erectile dysfunction, genital sensation, or the men's ability to orgasm. In fact, it is more affected by the couple's sexual desire and relationship quality. When the partner of the spinal cord injured person is affected, a major psychosocial and existential crisis may be caused to the patient as well as their partners.

SCI Cross-Culturally

Across cultures, it was shown that the loss of physical sensations which previously accompanied sexual encounters could cause sexual difficulty – while some men believed that the injury made them better lovers. Since they have lost sensations in their penises, they switched their focus from fulfilling their own needs to those of their partners, pleasing and using sexual aids to enhance partner's satisfaction. Women with SCI reported being concerned with their sexual attractiveness, and one participant in a Swedish study said simply and bluntly "I feel ashamed of my body." Some differences between SCI of men and women are noted. When injury occurs later in life, sexual self-esteem for women decreases as she loses sexual interest due to the injury and its ramifications. However, it was found that younger, injured women face a greater likelihood or engaging in sexual relationships, even after suffering the injury. On the other hand, women who are younger than 18 years old at the time of injury were less likely to be sexually active. The important thing to remember is that people with SCI remain as sexual beings and can lead sexually satisfying lives. However, the loss of genital sensation and the inability to experience orgasm will affect their sexual activity and experiences.

The Impact of Dementia on Intimacy and Sexuality

Mild memory impairment (MMI) or and mild cognitive impairment (MCI) are considered to be transitional stages between normal aging and early stages of Alzheimer's disease (AD). MMI is present in those who exhibit a memory decline relative to their former level of functioning but who do not currently meet criteria for a clinical diagnosis of dementia. MMI, which may affect their decisions about caregiving later on, has significant implications for the emotional well-being of partners in a romantic dyad. However, the field of early dementia and sexual intimacy has hardly been researched.

Based on the meager research which is available, we know that MCI and AD present a considerable psychological burden on those who care for MCI and AD patients as well as on the patients themselves. In AD, there is a higher incidence of erectile problems for patients, concerns about changing sexual behavior as a result of disease progression, inappropriate sexual behavior, and the patient's ongoing need for touch. The authors concluded that while AD patients and their partners will have sexual needs and feelings, the disease is likely to limit

what they could do. Couples afflicted by AD experience overwhelming losses within many areas of relationships including communication, closeness, intellectual stimulation, and assistance with decision-making. Such couples have difficulties with sexual experiences, which may be the result of having trouble remembering appropriate actions, trouble with sequencing, and the physical limitations which the patients may experience. Spouses caring for people with mild memory loss generally experience a less severe negative impact on these relational areas than couples who are struggling with more severe dementia.

Research has also indicated that as patients progress down the path of the disease, changes may include reduced verbal expression and personality changes involving apathy, increased egocentricity, or impaired emotional control. People with MCI have also been shown to consistently experience depression and anxiety. The presence of such problems may result in communication barriers which would likely not enhance their relationships or get them closer to one another, particularly through the loss of relationship rituals. It is suggested that changing relationship rituals as soon as possible after a diagnosis of memory impairment could help facilitate a stronger sense of marital cohesion – especially as memory problems progress. Further, it was found that spouses of both, patients with MMI or MCI, have experienced significant spousal caregiver burden and psychiatric morbidity. It is therefore important that caregivers be afforded therapeutic interventions prior to the development of psychiatric problems in their partners.

Illicit substance abuse – the use of street drugs may cause impulsivity or heightened libido in people – resulting in a greater number of sexual partners and with it, an increase of acquiring a Sexually Transmitted Disease (STD). The majority of men using stimulants, such as amphetamines, reported increased sexual excitement, intensified orgasm, and longer durations of intercourse when under the influence of such substances. Thus, contributing to their repeated use of these drugs.

Alcohol – in women, alcohol impairs sexual response by interfering with her sex hormones causing irregular menstruation, infertility, early menopause, a lack of sexual interest, and painful intercourse. Alcoholic men have problems with ED, delayed ejaculation, and engaged in less frequent intercourse as they aged.

To conclude, this chapter clearly illustrates the devastating impact that ill health may have on sexuality, mood, and consequently, intimate relationships.

*

A man was seeing his doctor. The doctor said, “I have good news and bad news.” “What’s the bad news?” “Your wife has syphilis.” “Jeez! What could possibly be good news.”

“She didn’t get it from you.”

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A college professor reminds her class of the next day’s final exam saying, “I won’t tolerate any excuses for you not being there tomorrow. I might consider a nuclear attack or a serious personal injury or illness, or a death in your immediate family, but that’s it, no other excuses whatsoever.”

A guy sitting at the back asks, “What would you say if tomorrow I said I was suffering from complete and utter sexual exhaustion?”

The teacher smiles sympathetically at the student, and says, “Well, I guess you’d have to write the exam with your other hand.”

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Chapter 9

The ‘Bad’: When Things Don’t Go the Way They Should

> One of the people who came to ask for help was a male in his mid-40s who complained of sexual difficulties. When I suggested that we look into his life, including his relationships and medical history, he spoke about his great difficulty to achieve and maintain an erection – a newfound problem that never affected his sex life in the past. As we dug into his life story, it became clear that his marriage had dried up, as he and his wife did not see eye to eye anymore and was living their own separate lives. Despite this, they remained sexually active together and did not face any challenges in that department. Sometime later, the man had found a new woman and became romantically and sexually involved with each other. In this new relationship, he was unable to maintain an erection for more than a minute, and was often unable to resume or complete intercourse with his new love. He was flabbergasted, since he truly loved the woman with whom he had an affair. As we engaged in some psychotherapy, it was revealed that his new partner wanted to get married and have a child with him. He was not, yet, ready to divorce his wife. Upon reflection, his penis protected him from an unwanted pregnancy and commitment to that woman, while he couldn’t bring himself to tell her that openly. He was, of course, completely unaware of it at the time.

How Common Are Sexual Problems?

Sexual disorders involve problematic sexual behaviors that range from hypoactive sexuality, which is a persistent and recurrent loss of desire in sexual activity, thoughts and sexual stimulation, to compulsions or even hyperactive sexuality which involves a continuous desire to engage in sexual behavior. The prevalence of sexual disorders in the general population is still unclear, with some estimates suggesting that about 20% of the entire population having hypoactive sexual disorders while a staggering 30% of the female population has some sort of orgasm disturbance. It was found that 36% of women feared sex, 32% having experienced a diminished sexual interest, and 36% reporting less than desirable rates of sexual pleasure. Generally, it was suggested by researchers that some form of sexual dysfunction afflicts up to 35% of females in the general population.

Examining the genders separately, it appears that 26% of men in the community reported persistently avoiding sexual activities, while 26% suffered from sexual arousal disorders, and another 12% struggling with a range of orgasmic disorders from premature ejaculation to delayed ejaculation. These findings support other research which suggests that roughly 16% of men suffer from a hypoactive sexual desire disorder – a relatively high number overall.

However, it appears that women suffer more from certain forms of sexual dysfunction than men, as up to 34% of women were found to have a type of sexual pain disorder. This conclusion is echoed by a survey of 1,749 women and 1,410 men who were interviewed regarding their sexuality. The authors found that 43% of women and 31% of men, from that sample, reported

experiencing some degree of sexual dysfunction. Clearly, the rates of sexual dysfunction in the general population are alarmingly high, while the prevalence of hypersexual behavior is significantly lower.

These findings may be contributed to the experiences that significantly impact our sexual arousal beyond a physiological perspective. Healthy and satisfying sexual activity has been repeatedly shown to be important for our overall health. Individuals who suffer from dysfunctional sex were found to experience a diminished quality of life according to an American study conducted by Dr. Biddle and colleagues in 2009. They found that a whopping 70% of women who were dissatisfied with their level of sexual desire also experienced personal and relational consequences, such as having a negative self-perception, a lack of confidence, and a feeling of being less connected to their sexual partner. In turn, it is apparent that sexual satisfaction and psychological health are closely related and may even directly influence each other in certain relational contexts.

In contrast, recent estimates found that 6%–8% of Americans were self-proclaimed "sex addicts." A large online survey of 9,265 participants found that 17% of people reported having sexual compulsions when asked about their sexual habits. In general, research has found that hypersexuality occurs more often among males than females with ratios of three to one. Sexual compulsivity was also found to be significantly higher in men than that found in women, as other studies have found that men have commonly identified themselves to researchers as being four times more sexually addicted than women. Within this research, various definitions of hypersexuality were included in the study, as compulsive masturbation, dependence on pornography, and protracted promiscuity were all notable themes of this condition. Overall, it appears that sexual dysfunction disorders such as performance, orgasm, or pain dysfunctions are more prevalent in females, whereas hypersexuality is far more common in males.

What Are Sexual Disorders?

In 2010, a committee of eight members across five countries sought to define, classify and examine the epidemiology of sexual dysfunctions through an analysis of the distribution, patterns and determinants of healthy and unhealthy sexual conditions in various populations. The description of the sexual disorders that will be described, below, do not generally separate organic from psychogenic (meaning, originating from the mind or in mental/emotional conflict) caused dysfunctions.

Sexual interest/desire dysfunctions – which is applicable to both men and women, indicates a diminished, or even absent feeling of sexual desires, thoughts and/or fantasies. In women, sexual arousal disorders are comprised of three subtypes, namely *genital sexual arousal dysfunctions* which indicates an impaired or lack of genital sexual arousal expressed through minimal vaginal lubrication and reduced sexual sensation from direct genital stimulation; *subjective sexual arousal dysfunction* which is the absence of sexual excitement and sexual pleasure from any type of sexual stimulation and *combined genital and subjective arousal dysfunction* which indicates markedly diminished sexual arousal and pleasure from *any* type of sexual stimulation expressed by impaired, or even absent, vulvar swelling or lubrication.

In men, *erectile dysfunctions* (ED) are the main disorder that negatively impacts sexual arousal. ED is a recurring inability of obtaining or keeping an erection that allows for sexual

activity to successfully occur. *Persistent genital arousal dysfunction* involves spontaneous, intrusive, and unwanted genital arousal without the person being sexually interested. In such cases, individuals may suffer from a consistent arousal which persists for hours or even days after one or more orgasms. The timing of these orgasms become incredibly important in the context of sex, as ejaculation between men and women exhibit distinct differences. Premature ejaculation from men nearly always occurs prior to or within about 1 minute of vaginal penetration. As the male may face challenges in delaying ejaculation once vaginal ejaculation is attempted, the consequences of distress, frustration, or embarrassment can lead to the avoidance of sexual intimacy.

In contrast, anejaculation is the absence of ejaculation at the time of orgasm. It is different from *orgasmic dysfunction*, which involves the inability to achieve orgasm or experiencing a marked delay of orgasm during any kind of sexual stimulation. This condition may occur comorbidly with ejaculatory dysfunction in men. *Delayed ejaculation* is the unwanted delay of ejaculation during sexual activity. *Dyspareunia* is the recurrent pain felt during sexual activity. In women, it happens upon entry into the vagina or during penile/vaginal intercourse. This may also be attributed to *vaginismus*, which is the forceful closure of the vaginal opening that prevents any sexual intercourse, insertion of feminine products or gynecological check-ups possible without pain. This condition often incites fear in its victims.

Incidence of Sexual Dysfunctions

As one of the world’s most researched sexual disorder, five population-based studies across the United States, Brazil, Netherlands and Finland found that 26 to 28 cases per 1,000 of individuals suffer from ED. Similar trends were shown across all populations, as incidences grew with age. Notably, incidences of ED from Finland and from Brazil were shown to be higher overall, 39 and 66 cases/1,000, respectively.

Prevalence

Based on studies that were conducted in the U.S., Europe, Canada, Iran, Morocco, and Puerto Rico, there is a variation in the prevalence rate reported for sexual dysfunction. This may partly be due to the range in severity of the dysfunction across the population. Epidemiological data indicates that about 40%–45% of adult women and 20%–30% of adult men experience at least one sexual dysfunction.

In women, low levels of sexual interest vary between 17% to 55% with higher rates noted in approximately 10% of women up to the age of 49. By 50-65 years, the rate doubles to 22% and then doubles again to 47% in those aged 66-74. Arousal and lubrication problems are experienced by 8%-15% of women, though some studies base the range at 21%–28% in sexually active women. The prevalence of orgasmic dysfunctions, however, were found to vary by country. In the United States, Australia, Canada, and Sweden, the prevalence is about 16%–25% in 18–74-year-old women. Incredibly, two studies from Nordic countries reported that in women aged 18 to 74 years old, more than 80% of sexually active women reported experiencing some degree of orgasmic dysfunction; meaning, most women experience some difficulty reaching an orgasm. In Australia, the prevalence of dyspareunia is particularly low (1%), while

in seven other reports from around the world, it can reach up to 24%. Dysfunctions in sexual desire also seem to be much less prevalent in men than it is for women. On average, individuals ranging from early teens to 60 years of age experience stable sexual interest. This decreases significantly overtime from 61 years onwards. In contrast, reports from Australia, Argentina, Southeast Asia, Korea, and Italy indicated that the prevalence of dysfunctional sexual interest captured about 25% of women aged 16 to 59. Ejaculatory dysfunction ranged from 8% – 30% for men of all age groups, with two exceptions from a U.S. study (55% in 50–59-year-old men) and UK study (a very low prevalence of 4% in 18–77-year-olds surveyed in London). Recent reports also show that in Asia and Latin America, the rates of premature ejaculation are higher and get up to 25%, though in China the rate is lower at 18%. Orgasmic problems, however, were found to be within the range of affecting 12%–19% of participants.

The prevalence of genital pain in men during sexual intercourse has only been rarely studied. On average, 3% to 6% of men reported suffering from such pain, with alternative rates ranging from 1% to 2% in other studies and even higher rates in older populations. As we mentioned above, erectile dysfunction (ED) is probably the most popular studied sexual dysfunction to date. In Australia this was found to affect about 21% for men aged 40–80 years. Another study showed an increasing, but still low rate of 13% to 19% with additional potential to reach up to 25% for individuals ages 40–49 and 50–59 years. Marked increases in ED starting at age 60 were noted another report. And as can be expected, were only shown to rise following each passing decade. In fact, about 50% to 75% of men in their 70s and 80s were shown to face ED challenges. This showcases the stark contrasts shown between different trends of ED across varying ages, as less than 10% of individuals under the age of 40 report facing these challenges.

Risk Factors for Sexual Dysfunctions

Sexual dysfunctions, for both genders, are associated with common risk factors including complications to their health status through the presence of diabetes, genitourinary disease, or cardiovascular disease. Other risk factors may include psychological or psychiatric disorders. For example, certain medications, hormonal factors and smoking have been shown to contribute to ED across men. In *women*, however, large scale studies from the United States, Brazil, and Australia did not find a significant relationship between diabetes, desire, arousal, or orgasm. Instead, researchers believed that hypertension, high blood pressure, or the use of hypertensive drugs were more associated with dysfunctions in orgasm and lubrication, as well as lowered sexual interest. Stress urinary incontinence, or a leakage of urine during moments of physical activity, was shown to be closely associated with dyspareunia and vaginismus.

Other studies found that hysterectomies had a negative effect on women's sexuality, while psychiatric disorders were more closely associated with orgasmic dysfunction and dyspareunia. Anxiety and depression, as well as emotional or sexual abuse, are associated with sexual dysfunction. Some research indicated that being a single woman or married in a troubled marriage seemed to be associated with dysfunctions of sexual interest, vaginal lubrication, orgasm, and dyspareunia. Men with overall poorer health were found to suffer from lower sexual interest or desire, early ejaculation, and ED as well. In turn, increased risks of ED were found to be related with cancer, stroke, diabetes, and hypertension. A decreased risk was associated with loneliness, moderate alcohol consumption, and non-smoking.

In General, What Causes Sexual Dysfunctions?

The causes of sexual dysfunctions can be categorized into biological, psychological, and social factors.

Biological – biological factors which are known to impair sexual function or cause pain during sex include the natural aging process, the presence of chronic illnesses, physical disabilities, medications and street drugs. In aging, varying levels of hormonal changes may cause a decrease of sexual desire and functioning. Chronic illnesses which are often seen in geriatric populations such as cardiovascular and nervous diseases, diabetes, and multiple sclerosis may significantly affect sexual functioning and satisfaction. Certain cancers have also been linked to some sexual problems, though frequently it is the cancer treatment itself that poses the most threats one's sexuality than the actual disease. For instance, cancers of the breast, penis, and testicles, which require surgical treatment, tend to change the body in very noticeable ways and often create body image issues that hamper sexual desire and activity. Likewise, ejaculatory difficulties are often noted following surgery for prostate cancer. Other issues like untreated sexually transmitted infections (STIs) such as chlamydia and gonorrhea can turn into pelvic inflammatory diseases in women; a condition that can lead to painful intercourse and impair ability to reach orgasm. Drugs and medication can add to these experienced difficulties as well. Medication, alcohol and tobacco have negative sexual side effects, as antidepressants (namely SSRIs) in particular tend to delay orgasm in men and women. It is noted that continuous use of cocaine, opiates, and other such drugs can inhibit sexual arousal and response overtime.

Psychological – these causes of sexual dysfunctions may include distraction, learned experiences of unhealthy sexual behaviors and practices, negative beliefs about sexuality and difficulties, poor body image, influences of personality and specific attachment styles as well as mental illness. Dr. Masters and Ms. Johnson described what they termed "spectatoring" as watching one's own sexual performance and evaluating it while being engaged in sexual activity. That, they asserted is highly disturbing to healthy and fulfilling sexual activity.

Learning experiences from our past can significantly affect our sexual functioning. For instance, those who were taught that sex is a shameful or sinful activity, such as the purity discourse in women, may end up thinking about these unpleasant thoughts during the act and therefore, reduce their sexual responses and pleasures. Traumatized people, like those who have been raped or have experienced childhood sexual abuse, may experience post-traumatic stress and feel an aversion to sex – thus, refusing to engage in it. Our beliefs about sexual dysfunctions are linked to our experiences with sexual problems. So, for instance, research has found that among women, greater beliefs in one's sexual difficulties are related to decreasing their own sexual functioning. Poor body image may also discourage the person from having sex, so that he does not expose her or his body. If the person lacks familiarity with their own genital anatomy, this may lead to complications related to orgasms – as known across many women. Personality and attachment styles may also affect our degree of comfort with intimacy, as well as the way we approach sexual interactions as they have been linked to various sexual problems. Finally, mental illness may also be linked to sexual dysfunctions in a variety of ways. For example, affective and mood disorders are commonly associated with low libido as in the case of major depression, or with hypersexuality, as in the case of bipolar disorder, especially when people are in manic phases.

Social – social variables may also be correlated with lowered sexual satisfaction, as in the case of those who have been socialized with poor education revolving sex and sexual practices. Relational problems such as anger or unresolved conflict often reduce desire for sexual activity with one's partner, thus, increasing potential problems emerging within the relationship. As we can imagine, the way in which our partners view sex can affect their arousal, enjoyment, and orgasm. This is most prominently seen amongst individuals with strong religious or cultural ties. Certain prohibitions which may discourage or even prevent the experience of pleasure from sex are evident in various beliefs. For example, East Asian cultures tend to have more conservative attitudes toward sex than European cultures. Coincidentally, East Asian people were also found to have lower sexual desire and functioning.

Taking a Closer Look at Causes of Sexual Dysfunctions

Sexual difficulties may occur at varying levels, but are present in most of our lives; at least occasionally. Some individuals may experience only one sexual difficulty, while others may be the acquaintance of several. The following review will describe the various causes of sexual difficulties in men and women.

Generally, the various causes of sexual problems that have been outlined above can include internal psychological processes, interpersonal/relational, cultural/psychosocial organic factors (meaning changes in a bodily organ) and the quality of the erotic contact that the person is exposed to. It's important to remember that causes are multi-dimensional and thus, require a more complex investigation to understand the root of its sexual difficulty.

Intrapsychic Factors

Psychological factors that cause later sexual difficulties may begin to develop in early childhood. It is understood that many of these influences are drawn from a child's interactions with their family members. Minute gestures such as the way a child's diaper is changed, the way a caregiver soothed a child, and whether they did so with love or repulsion may have a long-term effect on the child's feelings about their own body. The way the child's parents relate to one another may also teach the child about intimacy, and whether it is safe or potentially damaging. While parents may not openly teach their children about sexuality, the way they conduct themselves at home, talk about sexual acts and closeness, and comment about books that deal with the topic have significant influence on how their children view and feel about sex. Should caregivers, who are usually the parents, transmit discomfort with sexuality, it will ultimately affect the child in negative ways. And if physical or sexual abuse are present; it may further intensify those feelings.

During adolescent and adulthood years, low self-esteem, fears of inadequacy and fears of pregnancy and/or of sexually transmitted diseases (STDs) can interfere with sexual pleasure, and even eliminate it.

Interpersonal and Relational Factors

While internal psychological factors may create sexual problems in some people, relational difficulties may be the one to "blame" for these situations. Challenges with not being able to openly discuss about problematic issues, conflict resolution strategies, anger, or even, the inability to be assertive with one's partner and express what we really need may significantly affect the couple's sexual relationship. For a couple who experiences relational conflict, the bedroom may become the stage for acting out their hostilities and the hurt that they have suffered from their partner. Further, the inability to resolve relational difficulties effectively may give rise to power struggles and withdrawal, which once again, may play out in bed and be expressed as shying away from sexual activity. Affairs, jealousy, and distrust are also contributors to sexual problems. It was found that following infidelity, the betrayed partner may fear being so disappointed and hurt again that he or she may block the partner's attempt to become, again, emotionally and physically open as if no betrayal took place.

Cultural Psychosocial Factors

There are various cultural means of teaching children about sexuality. Sex education may be delivered via religious teachings, school sex education, and through familial beliefs. *Religious teachings* promote certain values and sexual behaviors that are aligned with the religious beliefs. Family-based teachings involve implied but not clearly stated messages involving the topic.

For instance, the child may or may not hear about sexuality at home. Nudity may be hidden or outright forbidden, and if there are explicit lessons, they focus on teaching children what *not* to do without any positive messages about how to express their sexuality. Most of the sexual dysfunctions that women suffer from are related to negative messages that they received from their parents, like believing that 'sex is dirty' and 'is sinful'.

School-based sex education – Schools offer sex education which is based on the region in which the school is situated. The population that lives in that region, including their degree of religiosity and political zeitgeist gives precedence to the ways sexuality is understood in these places. The consequences of these teachings, however, fails to capture the complexities of adult sexuality which are often missed by students raised in areas of the world with less comprehensive understandings of sex and sex education.

Organic Factors Causing Sexual Problems

Anything that affects the body, positively or negatively, may influence our sexuality. Amongst those that may damage our sexuality are disease, disability, drugs, vascular, neurological or endocrine irregularities. For example, cardiovascular disease (i.e., heart problems), along with the various medications that used to treat it, can significantly reduce one's sexual arousal and response. More precisely, whatever restricts blood flow to the heart can also do the same to the genitals and diminish sexual functioning. For men, erectile dysfunctions may be a sign of

cardiovascular issues – and in women, low arousal and lubrication may be indicative of heart disease.

Central Nervous System Neurological Disorders

The central nervous system (CNS) controls most functions of the body and mind. It consists of two parts: the brain and the spinal cord. Disorders, diseases, or injury may cause damage to the central nervous system, such as multiple sclerosis or spinal cord injuries. These conditions can severely limit the person's ability to engage in sexual activity and enjoy it. Diabetes, which starts as an endocrine disorder (i.e., a disorder related to the insufficient release or use of insulin) may affect one's sexuality by inhibiting the central nervous system. This may reduce blood flow to the genitals and thus, directly affect sexual functioning and satisfaction. This is commonly seen in men who are diabetic, as a complaint of this condition includes erectile dysfunction.

Sexual Difficulties Caused by Drugs

Since the publication of Dr. Masters and Ms. Johnson's seminal research in 1970, debate regarding the cause of sexual dysfunctions from a physiological or psychological lens has been raised. Even 50 years later, it is still unclear as to what is mainly responsible for sexual difficulties. Drugs, as defined here, include over the counter medications, prescription drugs, and recreational or street substances. Among those with the most negative and significant effect on sexuality are medications that are prescribed to treat cardiovascular diseases, arthritis, high cholesterol, as well as psychiatric drugs – especially those prescribed to treat depression and anxiety. It is known, for instance, that Prozac (a common drug used to treat depression and panic attacks) inhibits arousal. Other substances like Paxil (an antidepressant) makes orgasm difficult to reach, and Effexor (a treatment used for managing depression and low energy) lowers desire significantly. Recreational drugs like alcohol and narcotics may depress the central nervous system to lower sexual desire. Other substances like cocaine and methamphetamines, on the other hand, act as stimulants and may cause disinhibition or aphrodisiac properties which enhance desire.

Sexual Problems May Be Caused by Sex Which Is Not Satisfying

Most people, apparently, are reluctant to share what their sexual pleasures, fantasies and desires are. If sex is to be arousing, satisfying, and exciting, then couples need to have an openness towards sharing what turns each other on.

Sexual Dysfunctions in Men and Women

Sexual dysfunctions can be categorized into those that are experienced by men, women, by both genders. For example, *both genders* may experience a lack of sexual desire and anorgasmia, or the inability to achieve orgasm.

Males – Men may experience a variety of sexual dysfunctions, including: premature ejaculation (the inability to control the timing of ejaculation), retrograde ejaculation (ejaculating into the bladder rather than expelling semen), erectile dysfunction (the inability to achieve or maintain an erection suitable for intercourse), delayed ejaculation (the absent or delayed action of ejaculating despite adequate sexual stimulation), and anejaculation (the inability to ejaculate).

Females – Women may face sexual pain, such as dyspareunia, vaginismus (an inability to relax the vaginal muscles during intercourse) or even inadequate vaginal lubrication, likely due to a lack of sexual desire or excitement.

Sexual Desire Disorders

Hypoactive Sexual Desire Disorder (HSDD) is characterized by a low desire to have sex, in addition to sexual aversion, which is included in this group of disorders, as having a very negative or fearful response to sexual interaction. This reaction is most often found in those who were sexually traumatized.

Commonly, women and men tend to blur the distinction between desire and arousal. Sexual difficulties including the prevention of sexual arousal may be caused by a multitude of causes. Amongst these causes, a lack of attraction to a sexual partner, having been sexually assaulted in the past, having ongoing fatigue and stress (typically seen in married couples with kids), and a fear of pregnancy, all contribute to challenges related to sexual arousal. This may be further affected by cultural values which may not permit open expressions of sexual desire. Thus, making partners feel 'trapped' in not being able to express what they need or want.

Another problem that some couples face includes discrepancy in sexual desire. Couples may seek sex therapy if there is a disbalance of sexual libido within the partnership. This can be seen in the case of a low desire partner grappling to keep their relationship with a high arousal 'sex addict'. While they may not individually, have a problem, it is clear that their relationship does. Some of the reasons underlying their differing sexual appetites may include exhaustion due to life's responsibilities, a lack of familial or community support in addressing life's demands, and raising a family which may drain one's energy and sex drive. For instance, during breastfeeding, women complained of vaginal dryness and pain experienced during intercourse. That is not considered a dysfunction, but rather a normal occurrence during breast feeding. If the couple is not aware of its inevitability, marital disharmony may follow including blaming, suspicion, and anger. If the couple insists on having intercourse despite the vaginal dryness, pain may then be associated with sexual relations and thus, reduce further desire in the future. If a woman feels aroused but does not lubricate (which is expected to occur if the woman is aroused), factors like breastfeeding or post-menopause must be known and heeded by the couple. The consumption of antihistamines or decongestants that the woman may take to treat

allergies, may cause dryness across the entire body beyond just the weepy eyes and runny nose, but also her vaginal mucus as well.

Erectile Dysfunction

Erectile dysfunction (ED) is considered one of the most common and distressing male sexual complaint. About 50% of males aged 60 and over suffer from it, and the percentage goes up as they age. ED is not just experiencing difficulties in attaining an erection, but also that they have difficulty maintaining it. There are two categories of ED. *Generalized* ED may occur across situations and is generally a condition where the man cannot get and maintain an erection, while *situational* is one that occurs only under some conditions, like when with one's partner but not while masturbating. The causes of ED are rooted in a disturbed flow of blood into the penis. Organic causes of ED include cardiovascular disease which restricts blood flow to the heart but to the penis as well, diabetes, and the side effects of psychotropic or anti-hypertensive drugs. Additionally, conflicts with one's sexual or intimate partner, communication problems, as well as a history of sexual abuse may all cause, or contribute, to ED. The role of performance anxiety, as first described by Dr. Masters and Ms. Johnson, is known to effectively block an erection from occurring due to the immense pressure to perform.

Orgasmic Disorders

Premature ejaculation – is the most common disorder of males. Dr. Masters and Ms. Johnson defined it as a man's inability to maintain an erection long enough to bring his partner to orgasm without ejaculating too fast, which will practically bring the sexual intercourse to an end. It is a problematic definition which rests on the assumption that every male wishes to have sex vaginally. A more recent definition of premature ejaculation sees a man suffering from this dysfunction if he ejaculates within 60 seconds of penetration, about 75% of the time. Causes for premature ejaculation and the inability to control one's degree of sexual excitement may include anxiety, genetic factors, or penile hypersensitivity.

Delayed ejaculation (DE) – also known as ejaculatory incompetence or retarded ejaculation, is the most under-reported male sexual dysfunction. It is commonly believed that men who are able to withhold from ejaculating are more favored, and are rarely seen as a problem. Research has demonstrated that men who have difficulty ejaculating with a partner, can usually ejaculate while masturbating. Among the causes for DE is the use of psychotropic drugs which are prescribed to treat psychological disorders and mental illness, especially antidepressants and anti-psychotics. We know that the cause of DE is organic if the man has never been able to reach an orgasm. Some researchers have suggested that a man who can ejaculate only while masturbating may have developed a unique masturbatory style which cannot be replicated with his sexual partner.

Female orgasmic disorder – often called anorgasmia, is defined as persistent inability to reach orgasm. If it is a lifelong inability, it is termed as primary, while if it has recently developed, it is referred to as secondary. Primary anorgasmia is often seen to originate from the woman's lack of knowledge of her body and sexual response. An additional cause of

anorgasmia can be traced to the neglect of the clitoris by the woman, who is unaware of its crucial role in producing pleasure, which is actually its only function. Anorgasmia may also be caused by medications such as anti-psychotics which disrupt orgasms in both genders, as well as interpersonal difficulties that the woman experiences in her intimate relationship.

Sexual Dysfunctions Which Are Painful

Dyspareunia – is pain related to sexual activity, but is present even without it. It may strike both men and women. Such pain may be felt during erection or following ejaculation and may be related to diseases such as cancer of the prostate or the testes, and Pyronine's disease, where the penis is curved when erect, thus, eliciting pain in the man.

Penetration disorder – involves pain and a significant muscular component occurring during vaginal penetration. It combines both dyspareunia and vaginismus. It may stem from genital pelvic problems and issues involving ovulation. Commonly, pain is reported to emerge from one side of the pelvis, or upon penetration, which may signify endometriosis – a painful disorder in which tissue similar to the tissue that normally lines the inside of the uterus (called the endometrium) grows outside of it. Pain of the vulva, which includes the opening of the vagina, the labia majora or outer lips, the labia minora or inner lips, and the clitoris, may be the result of various dermatological causes like herpes, blisters, or genital warts. Perineal pain, which is pain from the space between the vaginal opening and the anus, may be caused by STIs or by irritation from vaginal infections. Vaginal pain may be the result of vaginal dryness, persistent thrusting of the penis or a dildo, pelvic inflammatory disease, or ovarian cancer. The muscular component of pain in intercourse, which was previously referred to as vaginismus, is an involuntary spasm at the entry into the vagina, which makes penetration difficult or impossible. The causes for it are varied, and may include a history of pain during intercourse, faulty sexual education which demonized sexual experiences with the vagina and or a fear of pregnancy. Examined from a functional perspective, vaginismus may well be an adaptive response to the woman's reluctance to engage in intercourse, and consequently, needs to be a reluctance that must be addressed. It is as if the woman's musculature in the vagina is saying 'no!'.

Female Sexual Dysfunctions

Previously, we addressed painful dysfunctions of both males and females. This section will focus on dysfunctions that affect woman only. Female sexual dysfunction is reported by 25% to a whopping 91% of people worldwide. Since it is a complex issue, a variety of medical, psychological, biological, social, and interpersonal factors have been shown to affect female sexual functioning. Impairment of sexual functioning results in sexual dysfunction. And sexual dysfunction has been known to negatively affect a partnership's quality of life, and may even create economic, psychological, interpersonal, and intrapersonal difficulties. Let's, first, examine how the woman reacts to sexual stimulation, as that will aid our understanding of any sexual dysfunctions that she may be suffering from.

Models of Female Sexual Response Cycle

There are various models of sexual response cycle. Dr. Basson and her sex research team, developed a model in 2010 which represented the stages of desire excitement, orgasm, and resolution during sexuality and the influence of the brain throughout this process. Contrary to other theories, this model magnifies the central role that emotional intimacy, physical satisfaction, and emotional fulfillment play during sexual activity. It should be mentioned, however, that since not all women respond similarly to sexual stimuli, their sexual response does not necessarily start from desire and end in resolution. Sexual arousal is the subjective experience of becoming sexually aroused by mental and physical stimuli, and largely involves the brain. That kind of sexual arousal is not the same as genital sexual arousal, which is the physical engorgement of genital organs and vaginal lubrication. In general, women are more aware of their feelings of sexual desire and are more inclined to get involved with sexual activity due to primary psychological triggers.

Some women can become sexually aroused and even reach orgasm just by having sexual thoughts and fantasies. Stimuli involving sights, certain smells, words, intimate or erotic conversation, moans and orgasmic cries have been reported to be highly arousing for some women. Research has found that partaking in an intimate relationship and experiencing feelings of love, emotional intimacy and attachment to the sexual partner may initiate, and maintain, sexual satisfaction and pleasure.

Sexual Dysfunctions Defined

Sexual dysfunction is experienced by women of all ages across the world. These dysfunctions are often varied and include sexual desire, arousal, and pain disorder as well as orgasmic dysfunction. In addition, female sexual dysfunction also includes: a lack or loss of sexual desire, enjoyment, a strong dislike of sexual activity referred to as sexual aversion, a failure of genital response whether through orgasmic dysfunction or an inability to reach orgasm, an excessive sexual drive, or other sexual dysfunctions not caused by organic disorder or disease. Sexual disorders can emerge from the beginning of a woman's sexual life, or may be acquired along the way or during situational contexts.

Dr. Khajehei and colleagues detail in their 2015 article regarding female sexual dysfunctions with the following:

- *"Hyperactive sexual desire disorder (sexual compulsion)* – high levels of sexual fantasies, thoughts and interest that interfere with normal life, work and relationships.
- *Hypoactive sexual desire disorder* – an unusual decline or lack of sexual desire, thoughts and fantasies; lack of desire or motivation for sexual activity or to involve in any sexual relationships; no incentive to become sexually aroused; no response to sexual stimuli.
- *Sexual aversion disorder* – distaste towards a sexual relationship with a partner, with an avoidance of sex with a partner and fear of being touched in the genital area by others.

- *Sexual arousal disorder* – lack of sexual pleasure; not becoming sexually aroused by either genital or non-genital stimuli.
- *Genital sexual arousal disorder* – lack of lubrication and vulvar swelling during sexual activity.
- *Orgasmic dysfunction* – difficulty to reach orgasm; lack of orgasm during sexual activity.
- *Sexual pain disorders* – vaginismus, repeated or long-lasting unintentional contractions of vaginal muscles in the lower third of vaginal canal.
- *Dyspareunia* – strong and permanent genital pain during penile-vaginal penetration.”

The multifactorial nature of women’s sexual dysfunctions emphasizes several cultural, biological, psychological, medical, and surgical conditions that should be taken into consideration when investigated by a health professional. Among the many contributors of sexual dysfunctions, we know of: genetics, mental health status, symptoms of depression and anxiety, the quality of relationships that the woman is part of, menopause, hormonal imbalances, hysterectomies, ovariectomies (i.e., the surgical removal of one or both ovaries), sexual abuse, negative sexual attitudes, negative body image, drug and alcohol abuse, childbirth and its outcomes, the number of childbirths and the fears of pregnancy or sexually transmitted diseases as having an influence to these issues.

Sexual Function/Response

The type of sexual activity that women engage in, like penile-genital intercourse, masturbation, or anal sex may affect their sexual functioning. Research indicated that penile-vaginal intercourse may provide higher levels of sexual satisfaction, increase one’s quality of life, and significantly contribute to relationship satisfaction while contributing to lower rates of depression among women. Moreover, these women experienced more frequent orgasms and in general, enjoyed a more satisfying relationship. Sexual activity with a partner may also increase one’s well-being and lower levels of stress.

Historically, masturbation was thought of as a harmful activity that could damage both the mind and the body. Some still believe so to this day – at least, in some societies. In some places, the prohibition against masturbation is so strong that young girls are forced to undergo female genital mutilation, where their clitoris is partially or completely removed so that they will not be able to engage in premarital sexual activity or self-pleasuring. However, as is well established now, masturbation causes no harm to individuals and in fact, contributes to the release of sexual, physical, and emotional tension. However, there are some reports that suggest that masturbation is associated with less sexual satisfaction and less orgasms during penile-vaginal intercourse which may lead to women’s sexual dysfunction. Couples who masturbated, were found to be less satisfied with their relationships. It was suggested that women who masturbated were not satisfied from their partnered sexual activity as a result of cultural and religious beliefs which deem women as passive, and disconnected from sexual pleasure. Research has also shown that women’s sexual dysfunction and medical conditions were related, while there seems to be no association between level of income and sexual practice.

Medical Conditions and Sexual Function and Dysfunction

Lower urinary tract symptoms are associated with various sexual problems such as hypoactive sexual desire disorder, sexual arousal disorder, orgasmic problems, dyspareunia, and noncoital genital pain. In particular, women's sexual dysfunction has been associated with urinary incontinence or the involuntary leakage of urine. This may include urine leakage particularly during intercourse and orgasm, urination problems, and pain in their bladder. Medical problems involving the genitals such as endometriosis, may contribute to sexual dysfunction in women. Those suffering from genitourinary cancer (i.e., cancers of the urinary tract or genitals) experience a variety of negative emotional changes and physical trauma that is often induced by various treatment procedures, be it surgery, chemotherapy or radiation. Similarly, breast cancer may contribute to similar dysfunctions as well, with reports of experiencing lower quality sex lives, difficulties with lubrication, pain during intercourse and orgasmic disorders. Other diseases such as diabetes, coronary artery diseases, heart diseases, rheumatoid arthritis, multiple sclerosis, thyroid problems, arthritis, and inflammatory or irritable bowel disease may also exacerbate sexual dysfunction. Neurological conditions and spinal cord injuries (SCI) may also be associated with hypoactive sexual desire disorder, less frequent masturbation, and less ability to achieve vaginal lubrication and orgasm.

Some Comments about the Treatment of Female Sexual Dysfunction

As mentioned earlier regarding the multifactorial nature of women's sexual dysfunction, the best way to treat women's sexual dysfunction is through a multidisciplinary approach. It is therefore noted that a woman who suffers from sexual dysfunction needs to, first, visit a physician, and possibly a urogynecologist and psychosexual therapist. Non-pharmacological treatments and psychosexual therapy may be considered as the first line of intervention – particularly when no physical causes can be identified.

Education on problem solving and communication, as well as couple's sex therapy, may promote better couple communication and thus, improve their sexual relations which may positively affect their sexual functioning and satisfaction. And as stress, fatigue and exhaustion are commonly involved in such matters, another helpful strategy may be to introduce the woman to stress management courses, yoga or meditation. It was demonstrated that Kegel exercises which relax and tighten the muscles that control urine flow as well as pelvic floor lifts that focus on the functional control of the pelvic muscles may help the woman suffering from dyspareunia, vaginismus, and pelvic pain to cope with the symptoms. Medications prescribed to the woman should also be reviewed during treatment, as we know that certain substances (like antidepressants) have been linked to women's sexual problems. A lack of vaginal lubrication can also exacerbate sexual difficulties, and so topical water-soluble lubricants and vaginal moisturizers should be recommended to reduce vaginal dryness and dyspareunia. Surgery may be considered as a last resort if medication, psychotherapy and other interventions have not reduced these symptoms.

Sexual desire is said to be the most elusive of passions. While it can be easily ignited during a new relationship, it can, unfortunately, be easily extinguished. A simple scent, image or a

fantasy may help it maintain its intense, lively, and life-affirming feeling – leaving the experience of *desire* as a notable complaint in sexual dysfunctions.

Active and satisfying sex lives testify to the emotional and physical health of the person. Desires which evaporate often leave the relationship to falter as a result. Toys and devices designed for piquing sexual arousal are definitely not at a shortage, such as pro-erection drugs, arousal creams, vibrators, and massage oils. However, should one be disinterested in sexual activity, he or she are made to feel deficient, dissatisfied or dysfunctional. Sexual desire is a subjective feeling which is triggered by both internal and external cues, which may or may not bring about sexual activity. It may originate from a fantasy, an awareness of genital arousal or from the environment through seductive language, provocative touches or erotic images. Rates of prevalence of desire disorders range from as low as 8% to a high of 55%.

Women have often been painted as the ones that lack a strong resilient sex drive, as men are always believed to be interested in sex. The truth is, not all women are lust-less creatures without lively libidos, and not all men are bursting with testosterone-infused sexual motivation, as observed by Dr. Leiblum. It is reported that the number of men who are disinterested in sex is similar to the number of women who exhibit low sexual interest. On a similar note, gradual and significant declines in sexual desire are shown in both genders between the ages of 40 to 70 years old. Although, studies have indicated a decline in sexual interests amongst young males. It must be understood as well that women with low sexual desires can still partake in sexual relationships and men with low libido can use other ways to satisfy an insistent sexual partner. Age and sexual desire have been shown to have a negative relationship, as younger people have higher sexual desires. Similar studies have shown, however, that with age, people become less distressed about their lowered desire.

Causes of Sexual Desire Disorders in Women

Among the causes of sexual disinterest are the following:

- *Biological factors* – such as hormonal imbalances or insufficiencies, medications and their side effects, or chronic illnesses.
- *Developmental factors* – lack of sexual education, emotional, physical or verbal deprivation, sexual trauma, or coercion.
- *Psychological factors* – depression, anxiety, personality or psychiatric disorders.
- *Interpersonal factors* – relational problems, losses, or a partner's sexual incompetence or dysfunction.
- *Cultural factors* – religious or cultural standards concerning proper sexual behavior.
- *Contextual factors* – factors such as privacy, safety, and comfort with one's surroundings. Not every environment or situation feels safe and private for sexual activity.

Taking a different view, we can look at desire disorders from other angles:

- *Predisposing factors making one inclined to be disinterested in sex* – here we may find factors like temperament, shyness, impulsivity, or various personality traits which do not go along with intimate close relationships.
- *Developmental factors mirroring the path the person grew up on* – such as certain problematic attachment experiences or exposure to physical or sexual violence in childhood.
- *Precipitating, or causal factors* – may include divorce, infidelity, menopausal changes, or substance abuse.
- *Maintaining factors which cause the disinterest to last* – ongoing stress, fatigue, relational conflict, or significant body image concerns.

The Impact of Life and Relationship on Female Sexual Functioning

Most women hope that their sexual functioning will remain consistent, satisfactory, and pleasant throughout their life span. Certain normal events, such as pregnancy, children, and aging play a role in sexual functioning and dysfunction. Crossing these events without significant problems will be the course for most women. However, some will develop sexual problems that require intervention. Let's review three of those events: pregnancy, parenthood, and aging.

Pregnancy – pregnancy is an expected result of sexual activity. Some who do not or cannot get pregnant, will experience it as a significant impediment to satisfying sex. In turn, one of the more common sexual problems during pregnancy is not a diagnostic entity at all, but rather, involves a male's reaction to the fact that his partner is carrying a child. Male partners of pregnant woman are commonly concerned that intercourse may harm the developing fetus in some way. This concern can easily be alleviated by explaining to the couple that the fetus is well protected and will not be harmed by sexual activity. It should also be noted that women's sexual functioning and desire decline steadily during pregnancy until its lowest point in the third trimester. However, morning sickness and fatigue during the first trimester may cause a decline in their sexual desire and rebound into the second and third. This is a normal occurrence and is clearly not a dysfunction.

Given that sex appears less desirable when we are tired, some women will, expectedly, experience reduced sexual activity for this reason. Decreased sexual desire may be the result of hormonal changes that can be expressed through breast tenderness and anxiety that can dampen one's desire and arousal. As her abdomen increases in size and other physical effects of pregnancy are felt, the couple may then face the issue of discomfort during intercourse. Thus, a woman's desire may consequently diminish. What may assist the couple during this period is experimentation with alternate positions for intercourse, as well as other forms of sexual stimulation. However, research provided evidence that libido, clitoral sensitivity, and orgasm are all reduced during pregnancy. Women are afraid that intercourse during pregnancy will cause abnormal bleeding, damage the fetus, vaginal or urinary infections or even result in vaginal pain. However, research has shown that these events actually are quite rare. Most women are advised, by their physicians, to refrain from intercourse for six weeks postpartum to allow for vaginal healing. This recess from sexual activity also takes into account the very real fatigue that women and most of their spouses' experience while caring for the newborn. It

appears that just giving birth and waiting for the customary six weeks may not be enough. Problems with sexual functioning can even be experienced after three months postpartum. It may be expressed through the loss of sexual desire, a lack of vaginal lubrication, pain experienced during intercourse, difficulty with orgasm, a vagina that no longer “fits” the penis due to delivery, bleeding, or irritation after sex. However, six months following childbirth, most women note significant improvement in these symptoms.

Parenthood – As those of us who have parented children know, raising children has its challenges and rewards. Many parents look forward to nurturing the new life that they have created and guiding them towards becoming a productive person. And while raising kids takes a lot of time and effort, women, usually, do not expect that it will affect their sexual desire and activity. New parents commonly experience a dissatisfaction in their sex lives related to the challenges of having less time, energy, and opportunity for sexual activity with their partner. Among the demands of parenting include financial pressures and the tasks involved with raising children. For some parents, they often find themselves “sandwiched” between their children and aging parents that require attention of their own.

For newer parents, the birth of a child can interrupt the rhythm that the couple has previously established. As a consequence, the couple must readjust their expectations of what is reasonable, sexually. It is not uncommon that one partner becomes the main caretaker of the newborn, leaving other feeling neglected and sexually undesirable. Couples can resolve this issue through mutually defining their problems and setting aside time for intimacy that is comfortable for both partners. Changes in sexual patterns which previously worked well for the couple during their early relationship may now be limited due to their fatigue and scheduling constraints – thus, further reducing their sexual involvement and satisfaction. The woman may need more time to climax, while the husband may be exhausted and fall asleep beside her. In such cases, it is no wonder that the woman’s desire for sexual activity wanes.

Insistent pain during sexual activity can also occur. Take for example the episiotomies which are being performed routinely on women during delivery. They may not heal properly, and thus, cause pain during sexual activity. Some women will develop pain related to vulvodynia or other related medical problems that will, undoubtedly, influence the trajectory of the couple’s sexual interactions.

Financial pressures also play a huge factor in lowering sexual desire. In some cases, one partner works longer hours to compensate for the lost income in their family due to their spouse being home to care for their child. Consequently, both are mostly exhausted when it comes time for frolicking. Remarkably, not much research exists on the impact of parenthood on sexual function and satisfaction, though we can intuitively tell that it lowers sexual desire and the frequency of sexual activities. And indeed, research from 2003 also confirmed these beliefs as parenthood has been shown lower marital satisfaction. In relation to that, it may be noted that men’s greater desire for sex often produces frustration in light of the demands that childbearing and child-rearing place on sexual availability. Clearly, the woman who is at home is much less available for sex than the man whose work location is outside of the home.

On the other hand, it appears that women’s dissatisfaction with their marriage declines as their children grow older. A study involving 2,081 women aged 33-43 years indicated that those who had more than one child had fewer orgasm problems compared to women who had not given birth to a child. They also found that childless women experience greater pain-related problems and had less sexual satisfaction than women with children, suggesting that children may have a positive impact on the couple’s sexual relations.

However, problems involving sexual desire is the most frequently reported issue for both men and women experiencing challenges with intimacy. The second most common problem for women is orgasmic difficulties. This is similar for men, as premature ejaculation is the second most reported problem for this population. Research suggested that stress arising from issues that couples face played a significant role in sexual dysfunctions in the women. A way of handling that situation is by attempting to schedule these intimate moments – although some people may prefer a more spontaneous love making. This isn't to suggest that sex becomes scheduled like a carpool, but that couples should plan the "when and how" of their sexual activity to ensure that it happens and, hopefully, increase their satisfaction.

Aging – Aging may make intercourse difficult. Add to that the discomfort that thrusting may cause at later years, and it may not surprise us if the elderly may become sexually inactive. women who enjoy regular reproductive health care may be aware and prepared for the inevitable changes that menopause and later life can bring to sexual functioning. Those changes in bodily functions and processes will affect sexuality so that it is different than it was in their younger years. These include physiological changes such as the thinning of the vaginal epithelium (which is the inner lining of the vagina), reduced vaginal lubrication as well as pelvic blood flow which can lead to discomfort or even painful intercourse. Muscles become weaker, joints become less flexible, and changes in the nervous system can make some activities, including sexual ones, less satisfying or even uncomfortable. All these hurdles are a normal part of aging, but they still require adaptations in order to ensure a pleasurable intimate and sexual outcome.

Research on older women's sexual activity and adjustment showed that older women who "use it" don't lose it! Twenty-three percent of those 80 years or older report being always or almost always aroused while 28% of women who were aroused reported lubrication concurrently with arousal. Twenty-eight percent of that sample also reported always or almost always reaching orgasm as well. These women who 'used it' reported low discomfort with intercourse, or none at all. Obviously, not all women are similarly blessed. For others, modifications to their sexual activity may be necessary and may include assistance from psychological and/or sexological counseling that involves both them and their partners. It is frequently reported by those who experience discomfort that give up intercourse if the pain or discomfort is too disturbing and uncomfortable. Sensate focus, as developed by Dr. Masters and Ms. Johnson, was found to increase physical intimacy without necessarily engaging in intercourse. This is suggested to be the most suitable for these couples.

Overall, sexual desire and physical intimacy do not have to involve intercourse. There are now available lubricants, vaginal moisturizers, and hormonal therapies which could assist in making the woman feel more comfortable during sexual activity. Others may simply benefit from communication skills training, which could help improve how a woman discusses sexual interactions with her partner, and thus, get his cooperation. Our culture has influenced women to adopt the belief that aging and sexual activity are diametrically opposed, or alternatively, that sexual activity and satisfaction are invariant throughout the life span. That, naturally, needs to be corrected, and resolved to fit our modern-day functioning.

Females' Orgasmic Disorders

Although women now, compared to the mid-20th century, believe and even expect to experience pleasurable and satisfying orgasms, orgasmic complaints are still a significant issue for many women. Historically, concerns involving how to achieve the 'right' kind of orgasm (i.e., vaginal or clitoral) is still debated. As such, it is well known that uncertainties about the basic mechanisms of female sexual responses are still unknown as emphasized by Dr. Freud. And despite the pharmacological advances proliferating the market today, there is currently no medication that has been created specifically for enhancing female orgasms.

Over the centuries, women's orgasm meant different things and ranged from good or bad for the woman, her partner and their marriage. Currently, we value a woman's orgasm as a healthy occurrence which may contribute to the intimate relationship and enhance her sexuality. A brief historic overview of a Western approach to women's orgasm will show that in the late 17th to early 18th century, Western Europe believed women needed to feel the pleasure of orgasm for conception. By the 1830s, beliefs changed to that of the orgasm for pleasure as unnecessary for conception. In the latter half of the 19th century, therapeutic and social control of sexual activity was of great importance, while the 20th century marked the focus on inhibited or lost sexual behaviors and feelings. Dr. Sigmund Freud helped bring the issue of the orgasm to the attention of the scientific community and the public, despite creating mistaken distinction between both types.

Dr. Havelock Ellis, the English physician, writer, progressive intellectual and social reformer who studied human sexuality saw women's sexuality as more extensive than that of men; given their vagina, clitoris, and womb. However, he saw women as naturally passive and therefore required courtship and stimulation by a man to get them to respond sexually. Based on his extensive research on human sexuality, Dr. Kinsey provided a different conceptualization of women's sexuality and orgasms. Following his research, the orgasm became the key variable in examining one's sexuality. Masters and Johnson's data regarding sexual responses pointed out that women's orgasms were more similar than dissimilar to male orgasms and were the result of the same neurophysiological processes elicited by the woman. That encouraged women's perception that they had the "right to orgasm." It is now acceptable for women to voice their dissatisfaction with the sexuality they experience, and for their local healthcare communities to support them. This is something that a mere 100 years ago, in Victorian England, Europe, or the USA would have never promoted.

Orgasms are usually a result of both subjective experiences and physiological changes in the vagina. Interestingly, some women report experiencing orgasms without accompanying muscular contractions, however, that does not affect their enjoyment of it. Masters and Johnson demonstrated that the entire body was involved in the orgasmic experience, including rhythmic contractions of the uterus, and the rectal sphincter. Moreover, these changes were also accompanied by facial grimaces, generalized muscle myotonia, in which the relaxation of a muscle is impaired, and contractions of the abdominal and gluteal muscles located in the buttocks. Masters and Johnson further noted that the stimulation of the clitoris is central and even more important to the orgasmic response than stimulating the vagina.

In a major study involving 1,749 U.S. women of various ethnicities, socioeconomic levels, education, and ages, it was found that 24% of participants complained of orgasmic difficulties – making it the second most commonly identified problem for women. In the UK, a study on a

random sample of British women found that 16% complained of infrequent orgasms. A clinic-based sample of women aged 18 to 73 who sought help for sexual dysfunctions found that 29% complained of orgasmic problems, 11% experienced frequent intercourse pain, and up to 38% reported anxiety and inhibition during sex.

Anorgasmia, referring to the difficulty of reaching orgasm after ample sexual stimulation, is distinguished into primary and secondary stages. A woman who never experienced orgasm is said to have the primary anorgasmia, while secondary anorgasmia refers to the infrequent experience of orgasms. Orgasmic problems do not necessarily cause sexual distress or relational problems, but may leave the woman wanting more out of their sexual endeavors.

Causes of Anorgasmia

The clitoris and the vagina are the anatomical areas important for orgasm. The most sensitive to touch are the labia, the introitus of the vagina (which leads to the vaginal canal), and the clitoris. These parts are richly innervated and have vasocongestive, or blood pooling capacity. It may possibly surprise you to learn that the *vagina* itself is relatively insensitive to touch, though strong deep pressure, as in intercourse, may add sensory stimuli. The pubococcygeal (PC) muscle, which is the hammock-like muscle found in both sexes, stretches from the pubic bone to the coccyx (tail bone) to form the floor of the pelvic cavity that supports the pelvic organs located at 4 and 8 o'clock positions inside the vagina (if you can imagine looking at the vaginal canal as if it was a clock). It is capable of generating pleasurable sensations when stimulated by pressure and by stroking. A few centimeters from the opening of the vagina on the front vaginal wall is a one-centimeter point, termed the Grafenberg or "G" spot, which can result in a pleasant, fluid expulsion upon stimulation during orgasm.

The *brain* is, obviously, another major source of sexual arousal, as it was reported that people can experience orgasm with no direct genital stimulation, but by just thinking or imagining. For instance, paraplegics report that orgasms which occur following the stimulation of certain areas in the brain, or achieved by fantasy alone can be experienced by women who had clitoral and labial removal or vaginal reconstruction.

Neurophysiological Factors in Orgasm

Little is known about the anatomical nerve structure that is required for female sexual responses, as there are various assumptions and theoretical formulations on how orgasm is achieved. Dr. Masters and Johnson found that sexual stimulation results in the pooling of blood in the pelvis, vaginal lubrication, vaginal lengthening and contraction, the increase of labial size, elevation of the uterus, and clitoral retraction under its hood.

Psychosocial Factors

We are not aware of much research that has explored the effects of religion, education, age, social class, and other sociocultural factors on sexuality and sexual dysfunctions. Research

found that anorgasmic women tended to be younger, unmarried, and had less education than women who can reach orgasm. Risk factors for orgasmic complaints, include infrequent sex, not thinking about sexual activity and having been sexually harassed in the past. Arousal disorders may be preceded by the woman having had a sexually transmitted disease, urinary tract issues, emotional problems, stress, or is in poorer general health than the majority without religious affiliation.

As far as psychological factors, it was found that low sexual desire was associated with depression, previous sexual abuse, and orgasmic problems. Some women who experienced orgasmic problems were abandoned, in their history, by an important male figure, commonly the father. Relationship factors, as we can intuitively predict, are related to sexual responses, as those who are treated well by their partner tend to be more orgasmic than women who are not treated well by their partner.

Not Interested in Sex: Female Hypoactive Sexual Disorder (HSDD)

Hypoactive sexual desire disorder (HSDD) is the most common form of female sexual dysfunction, where the woman suffers from a markedly low sexual arousal, or a complete disinterest in sex. In the United States, it is estimated that one in ten, or seven million adult women suffer from it, with similar rates throughout the world. Dr. Basson, who wrote extensively about female sexuality proposed that, unlike men's sexual response, women's sexual responses were much less spontaneous and much more responsive like what Havelock Ellis said many decades ago. Sexual intimacy, past sexual experiences, relationships (whether positive or negative), and sexual satisfaction (or lack thereof from oneself) heavily influence a woman's ability to experience sexual desire.

The Characteristics and Prevalence of HSDD

Up to 40% of all women suffer from sexual dysfunction, as we mentioned earlier. Those dysfunctions range from low desire or interest in sex, to orgasmic difficulties. In Europe, rates of desire, arousal, pleasure, or orgasm issues range from 18% to 36%, and as high as 70% in Asia. Research found that 7% percent of European adult women, and 16% of Australian women suffer from low sexual desire. In the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), female HSDD and female sexual arousal disorder (FSAD) have been combined to create female sexual interest/arousal disorder (FSIAD), which includes the following symptoms: significantly reduced, or completely lacking sexual interest or arousal, a lack of erotic thoughts or fantasies, and a lack of excitation or pleasure during sexual activity. HSDD is defined as being a chronic state that is disruptive to a woman's life and sense of self.

Vulvodynia is a vulvovaginal pain, which includes rawness, stretching and throbbing pain. Burning or itching of the vagina or vulva inflicts up to 8% of reproductive-aged women from the general population. It is often described as a burning pain which can be set off by vaginal penetration, gynecologic examinations, or even the insertion of a tampon. It was formerly referred to as dyspareunia and vaginismus; two separate conditions. As can be predicted, increased sexual distress are associated with vulvodynia.

Vulvodynia and Its Effect on Intimate Relations

Losing a partner is a frequent fear commonly reported by women with vulvodynia. Since vulvodynia pain occurs mainly during partnered sexual activities and has effects on both participants, partners of such women may experience sexual dysfunction (which may include their unconscious responses to the woman's pain and fear of sex) and lower levels of overall sexual satisfaction. A study involving women who filled a daily diary showed that women's sexual function was lower on days when she was courted by her partner. It was hypothesized, by the researchers, that the spouses apparently reinforced the notion that expressions of the woman's pain result in increased sexual dysfunction. Further research about partners dealing with vulvodynia indicated that emotional intimacy is a central dyadic process within romantic relationships. As such, negative associations of psychological adjustment were linked to chronic pain and illness, as high psychological adjustment was found to be related with decreased chronic pain. Intimacy gives rise to a fulfilling sex life and is thus addressed in sex and couple therapy as an important component of a healthy relationship and sexuality. It is a dynamic process that largely involves a disclosure of one's empathic responses to their partner. With women who suffer pain during intercourse, the couple in therapy is challenged to steer the focus away from intercourse and to develop a more flexible repertoire of sexual activity, which may not include penile-vaginal connection. This process, could of course, be possible if the woman is ready to disclose and that her partner will respond empathically. Disclosure may facilitate adjustment to the pain that the woman experiences for their spouses, especially since many partners of women with vulvodynia reported, in research, poorer sexual communication. Empathic responses commonly give rise to feelings of validation, which have been associated with increased sexual satisfaction.

In a 2016 study by Dr. Bois and colleagues, 50 women and their spouses were investigated to explore their ability to produce empathic responses and disclosures with relation to sexual satisfaction and distress in women with vulvodynia. Results confirmed that disclosure about the impact of vulvodynia on the woman's part and empathic responses from her partner appear to increase sexual satisfaction and lessen sexual distress in both, the man and the woman.

Dr. Leiblum described in her 2007 book *Persistent genital arousal disorder (PGAD)* as "…an unusual, perplexing, and troubling condition that has only been recently recognized, described, and diagnosed. It refers to a condition of unsolicited genital arousal that perseveres for hours or days despite the absence of sexual desire or sexual stimulation." That condition involves the woman being constantly aroused and experience self-induced or aided orgasms multiple times a day. While these orgasms provide but a temporary relief, shortly thereafter the woman is aroused again – feeling distressed and unfulfilled. Prevalence rates are still unknown for this disorder. PGAD is quite unique, especially when we remember that most female sexual complaints are about a *deficiency or lack* of sexual response (i.e., lack of sexual desire, too few genital sensations, inability to experience orgasms, or too little sexual pleasure). PGAD, in contrast, represents a condition with a '*too much'* response that is unremitting. The women who suffer from PGAD may be young or old, heterosexual or gay, married or single, premenopausal, perimenopausal, or post-menopausal. Regardless, they all complain of a persistent feeling of vaginal vasocongestion (i.e., the filling with blood), and other physical signs of sexual arousal when they actually may not be interested in sexual activity. The condition is so distressing that it was described by a 71-year-old woman who Dr. Leiblum interviewed as "It's just a horror; it bothers me more than breast cancer because it never stops, it never lets up, and it ruins

everything, including riding in a car, seeing friends, or simply sitting still. It colors your whole life." In addition to the distressing condition itself, women who suffer from it are also distressed about the reactions that they may get from loved ones and from their physicians when they open up and talk about the situation and their constant sexual arousal.

Dr. Leiblum described five descriptive features of PGAD, which include:

- Physiological responses that relate to sexual arousal in women, like genital and breast vasocongestion and sensitivity, and extended menstruation.
- Orgasmic experiences that last for hours and result in arousal and a wish for more orgasms continuously.
- Physiological arousal is experienced regardless of the woman's interest in sex.
- The persistent sexual arousal may be triggered by seemingly nonsexual stimuli or just by itself.
- The physiological arousal which the woman experiences is uninvited, intrusive, and unwanted. That is particularly so for orgasms that may occur spontaneously and without warning.

It is important to distinguish between persistent genital arousal and hypersexuality. Hypersexuality, contrary to what was described above regarding PGAD, involves strong, insistent, and frequent feelings of sexual desire. That may result in insistent or intrusive sexual fantasies, masturbation, or sexual behaviors. Usually, those sexual experiences are perceived as pleasurable, though the woman may experience guilt or recrimination. Unlike in PGAD, hypersexuality involves excessive feelings of sexual desire with or without persistent genital arousal, which is quite the opposite of PGAD. Additionally, once having experienced an orgasm, hypersexual women feel satisfied.

What Triggers PGAD?

Most women cannot be certain of what caused their PGAD, but some hypotheses regarding the causes include the initiation or termination of some type of medication such as SSRIs, hormone replacement therapies, certain surgical procedures such as caesarean sections, or even cycling (which may place insistent pressure on the genitals). Previous sexual abuse was also seen as a cause of PGAD. Women opined that regardless of what the initial cause of their condition was, their symptoms seemed to wax and wane as per their psychological stress or heightened anxiety.

As such, PGAD appears to be similar to vulvodynia. Both are medical conditions with diverse causes and symptoms. Women, in both conditions, find it difficult to discuss with their physicians their condition, and when they do so, they may face a dismissive attitude. While some instances of vulvodynia may have been caused by chronic vaginal infections, trauma, or irritation, the majority of cases appear to be with no known origin. No agreed-upon efficacious treatment was developed for either condition.

PGAD in women, and priapism in men have some similarities. Priapism (a prolonged erection) is a pathological condition that is unrelated to sexual stimulation. In men, priapism seems to follow a blunt or penetrating perineal trauma. There is another form of priapism termed 'stuttering and recurrent', where in the man experiences permanent erectile dysfunction.

Stuttering priapism is typically associated with sickle cell disease and may occur in men who experience recurrent prolonged erections with no known cause.

The Disturbing Effects of Childhood Sexual Abuse

Dr. Hall wrote in 2007 about the effects of childhood sexual abuse on sexual dysfunction. He asserted that “The prevalence of unwanted sexual contact with children and young adolescents by adults is staggering, and it often goes underreported and undisclosed. In almost all cases, it involves the abuse of power, and the perpetrator is often someone known and familiar frequently a friend of the family or even a family member. There appears to be little variation across ethnic or cultural groups, although girls are more likely to experience sexual abuse than boys, to endure it for longer periods of time, and to be abused by a family member.” Numerous behaviors constitute sexual abuse, which is understood as any behavior that exploits the child for the sexual gratification of the adult abusing him or her. That may involve physical force, a threat of force, intimidation, bribery, drugs, or other forms of abuse of power. Larger prevalence rates are shown amongst women under 18, as 33% are believed to experience some degree of sexual abuse. For boys, the rates are much lower – impacting 5%-10% of boys of the same age. Contact abuse, as the one reported, can vary from rubbing to fondling, to forced vaginal, oral or anal penetration. The abuse could be repeated and occur over the years or be a one-time occurrence, which is naturally less traumatic. And although there is not much cross-cultural research available, it appears that African American girls are significantly more assaulted than their white counterparts, who report higher percentages of rape. Girls, it was found, are usually abused by a family member, while it is a stranger who will end up abusing a boy. Some kids are traumatized by such abuse, while others, surprisingly, are not. Let’s take a closer look at how CSA affects boys and girls.

CSA and Its Effect on Sexual Functioning

The Effect on Women

It was found that when they are grown up, women who have been sexually abused are more sexually dissatisfied than women who were not. The most prevalent problems that these women experience are disorders of desire, arousal, and orgasm, while dyspareunia and vaginismus are less frequently reported. Women who were abused in childhood also complain about flashbacks of their abuse when engaging in sexual activity with their partner. They experience dissociation during sex and feel distressed, shameful and guilty about their sexual responses, compulsions, panic, aversions, and sometimes complete sexual avoidance. Such women have been found to engage in risky behaviors, including committing sexual assaults as adults. Studies have shown that more frequent histories of sexual abuse during childhood are related to higher rates of unwanted, unprotected, and risky sexual activity that women get involved in. Other projects have supported this finding, as histories of emotional and physical abuse can lead to greater risky behaviors in midlife (i.e., our 50s and 60s). Women were found to still be affected by their sexual abuse histories despite the years that have passed since that experience. These

relationships tended to be shorter than non-abused women, and women were reported being less impressed with their partner's characteristics. Those who were both, physically and sexually abused, suffered the greatest negative impact on their sexuality, including viewing their bodies as less attractive. They reported experiencing greater rates of fear, anger, or disgust during their sexual arousal than non-abused women. But while most women who were sexually abused as children experience sexual and relational dysfunctions to some degree, not all of them will.

The Effect on Men

Men who have been sexually abused in childhood also suffer from emotional, behavioral, and sexual consequences. Their sexual problems include compulsive sexual behavior that invokes a desire to copulate incessantly, exhibiting sexually aggressive behavior which does not apply in most romantic situations, having multiple sexual partners, and experiencing erectile problems, premature ejaculation, fetishism, and sadomasochism. These men commit compulsive sexual behaviors which may include frequent masturbation (up to four or five times daily) and sexual activity with other men that usually takes place in pornographic stores or washrooms. These men may feel that they have no control over these behaviors, and may report frequently suffering from urogenital complaints that may necessitate surgeries. Compared to adolescents who were not sexually abused, adolescent males with histories of abuse as children experience a higher rate of sexual acting out and sexual identity confusion with higher rates of HIV infection. These abused males hold the belief that they would ultimately be used, manipulated, or abused in intimate relationships, just as they were in childhood. From this, they experience difficulty in establishing trust and stability in a romantic relationship. These men may show poor boundaries and sexually provocative behavior with others, as well as homophobia, and confusions regarding their gender identity.

A study which explored the effects of sexual abuse on 1,032 university undergraduates found that women who were sexually abused as children engaged more frequently, than non-abused females, in intercourse and masturbation. It appears that the violation of trust by a man they once knew and trusted is inherent in girls' abuse, but not in boys who may have been abused by a stranger. In general, men are less likely than women to see themselves being victimized by sexual abuse, especially if the perpetrator is a female. In a study of 50 gay and bisexual men, it was found that males who did not view their experiences as negative or abusive were similar in their adult adjustment to men who have never been abused. It appears that men and women in clinical populations, meaning those who sought mental health assistance, are much more profoundly affected by childhood sexual abuse than men in the general population.

A Look at CSA and Sexual Dysfunctions

Women are more likely to suffer from sexual dysfunction due to CSA than men. Research did not find any significant differences between survivors of CSA and nonvictims, which may suggest that CSA may not precede male sexual dysfunction. Although, researchers have found a very strong association between sexual dysfunctions and CSA in females. Rather, significant correlations were found between sexual dysfunction in men and "adverse" family environments

that left the child emotionally neglected. A study which made very poignant observations suggested that 75% to 94% of women with a sexual dysfunction were mostly victims of CSA. It appears that CSA which included penetration was responsible for most of the sexual dysfunction that was found in that population. Additionally, women who experienced sexual dysfunction were found to lack sexual education and were unaware of basic knowledge in this area.

Among men, there appears to be a significant correlation between CSA and sexually compulsive behavior. Homosexuals revealed that 20% underwent CSA, primarily by non-family members. The men who were sexually abused in childhood behaved in aggressive and hostile ways, much more than their female counterparts. They were more likely to have been subjected to sexual penetration and physical force than women on average. A meta-analysis which statistically examined the results of 166 studies regarding CSA in boys found that men who were victims of CSA were much more likely to engage in frequent, high-risk sexual behavior such as prostitution and unprotected sex with greater numbers of sexual partners compared to men in the general population. Those individuals recalled that their first sexual experiences occurred prior to them reaching the age of seven with a significantly older person.

Both genders who suffered CSA have engaged in sexually compulsive behavior. When sex addicts were investigated, it was found that 39% of males and 63% of females were survivors of CSA. In general, women are far less likely to suffer from hypersexual behavior, but if they do, it is closely related to having been sexually abused in childhood. To summarize, CSA appears to be highly correlated to hypersexual behavior in both men and women, though men are more likely to act in such a manner.

Another meta-analysis of 45 studies investigating the effects of CSA indicated that sexualized behavior was the most common symptom of CSA survivors. That behavior may include everything from sexualized play with dolls, to inserting objects into one's sexual orifices (vagina or anus) and public masturbation or generally seductive behavior. Interestingly, CSA has also been associated with sexual withdrawal. It is clear that CSA has tremendous influence on both externalizing responses and internalizing responses that result in victims demonstrating sexually enhanced or inhibited behaviors.

Men's Sexual Problems

Sexually Dysfunctional Men and Their Approach to Sex

Sexual experiences commonly evoke strong emotional reactions. Therefore, men's positive and negative emotional reactions to sexual situations would be important in their development and maintenance of sexual functioning and relational satisfaction. Psycho-affective responses to sexual situations constitutes one of the most notable and reliable psychological differences between men with and without sexual dysfunction. Men who suffer with sexual dysfunctions experience a negative effect to erotic stimuli, such as porn during sex with their partners, more than men without these challenges. They often report experiencing substantial distress and negativity, whereas others show little or none. In 2012, a group of researchers set out to explore that issue and studied a sample of 53 men who suffered from erectile dysfunction; three who experienced premature ejaculation, and ten who had both erectile dysfunction and premature

ejaculation. Unsurprisingly, they found that the severity of the dysfunction was related to the apprehension/distress felt by the man. Such men are likely to feel both frustration and low self-efficacy during sex with their partner, which would clearly affect their overall assessment of the sexual experience. As we may expect, young men were likely to experience greater apprehension and distress about their dysfunction than older men. Younger men are expected to perform well sexually which may relentlessly pressure them and negative affect not only the quality but also the quantity of their sexual experiences. That situation was much less pronounced in older men who naturally ‘slow down’ sexually. In the same study, participants also demonstrated that higher values placed onto one’s sexuality had more negative and less positive sexual experiences with his partner when rated.

As such, it is important that therapeutic strategies should be implemented to reduce the challenges related to sexual dysfunctions, regardless of the problem. This may draw the attention to issues that affect the emotional experiences, communication styles or even health issues that are associated with sexual activity. Without aid, these sustained negative emotions surrounding sex are likely to lead to sexual avoidance and a further loss of intimacy, which may ultimately erode the quality of the sexual relationship.

Diminished Ejaculatory Problems

Diminished ejaculation disorders are a subset of male orgasmic disorders including altered ejaculation and/or orgasm, reduced semen volume, retrograde (directed backwards) ejaculation, decreased force and sensation of ejaculation, and altered ejaculatory latency (the time it takes for a man to achieve ejaculation after vaginal penetration is achieved).

Ejaculatory latency time spans from premature to delayed to anejaculation, which is the inability to ejaculate. Various causes for ejaculatory latency dysfunction include illness or medical conditions, psychological, and genetic factors. The International Society for Sexual Medicine (ISSM) described premature ejaculation (PE)) as ejaculation which may occur prior to or within about one minute of vaginal penetration. This includes the men’s inability to delay ejaculation on all or nearly all vaginal penetrations. The ISSM noted that distress, frustrations and/or avoidances of sexual intimacy may be the consequence of this condition. Evidence from research projects suggests that more than 80% of men with lifelong PE tend to ejaculate less than a minute after intravaginal entrance, with the rest being able to ejaculate under 2 minutes after entering the vagina. The prevalence of PE can vary based on cultural norms and practice, but also on whether it is based on clinical diagnosis or self-report, which may not be accurate. The International Global Study of Sexual Attitudes and Behaviors (GSSAB) reported a 30% prevalence of PE across all age groups, and the Premature Ejaculation Prevalence and Attitude Survey found that 23% among men 18–70 years old experience PE.

However, delayed ejaculation and anejaculation are often poorly understood due to a scarcity of research addressing these disorders. While PE is quite common, delayed ejaculation is relatively rare with a prevalence rate of less than 3% of the population. The causes of delayed ejaculation are often unknown, although various iatrogenic causes including nervous system disorders such as multiple sclerosis, diabetes mellitus, or spinal cord injuries significantly contribute to this disorder, similarly to drugs that contribute to delayed ejaculation. Most instances of delayed ejaculation are of unknown origin, and it is simply not possible to discern

whether the cause is due to genetic and developmental factors as opposed to pathological disease processes. Aging, just like it affects various functions, plays a central role in regulating one's ejaculatory latency. The aging process brings a decrease in penile sensitivity and likely contributes to delayed ejaculatory latency. Additionally, changes in the sensitivity of the ejaculatory reflex pathway may increase the time it takes for a man to achieve ejaculation.

Hypoactive Sexual Desire in Men

The absence or decrease of frequency in which a person experiences desire for sexual activity is referred to as low sexual desire. Sexual desire can be seen in behaviors such as attempts to initiate sexual activity, masturbation, erotic fantasies, and spontaneous genital sensations of arousal. Hypoactive sexual desire precipitates distress, especially when it occurs on many occasions most of the time. Although, research has indicated that up to 16% of 'normal' couples are composed of men who lack interest in sex. The National Health and Social Life Survey (NHSLS reported that 14%–17% of men aged 18–44 years have low sexual desire. Apparently, it was found that married men were less likely to experience low desire, and ethnicity was not associated with sexual desire at all. Another study called The National Survey of Sexual Attitudes and Lifestyles (NATSAL) explored the sexual behaviors of 11,161 British men and women 16-44 years old. Results from this project were astonishing since they revealed that the most common complaint in this cohort was a "lack of interest in sex." And indeed, another large Australian study found that 16% of men between the ages of 18 to 59 reported this same complaint. Across Australian men, the most prominent symptom of sexual dysfunctions was premature ejaculation; closely followed by low sexual interest. These results were supported by a large-scale Swedish study which reported similar results regarding HSDD. It found that men aged 66 to 74 years reported decreased interest in sex at similar rates as women, and those men with low sexual desire had also suffered from premature ejaculation (26%), complained of low or lack of partner's lubrication (39%), and a partner who experienced orgasmic difficulties (24%). Similarly, an American survey of 742 men aged 40-80 years found that 3% of men complained of lowered or absent sexual interest with an additional 5% of participants noting an 'occasional' lack of sexual interest from time to time.

Physiology of Hypoactive Sexual Desire

The physiology of sexual desire is complex and involves several biochemical as well as psychological factors. While we do not know much about the biological basis of sexual desire, findings suggest that these feelings seem to be the result of thoughts and fantasies, in combination with neurophysiological (bodily) arousal and emotional states. While sexual desire commonly precedes arousal, much more is known about the body's arousal which is actually in anticipation of sexual activity than sexual desire. Arousal leads to increased blood flow to the erectile tissue in the penis; together with increased heart rate and muscle tone. Testosterone appears to be necessary for male sexual drive, although it is unclear about the relationships between testosterone and sexual desire.

Many psychiatric diagnoses, medical conditions, and medications have a significant negative impact on sexual function resulting in decreased sexual desire. Take for instance major depression disorder (MDD). It is evident that 40% of males who complain of decreased sexual desire often have MDD. Consequently, an evaluation of hypoactive sexual desire must include a focus on mood disorders. Studies have found a strong association between anxiety, major depression, somatization disorders, and hypoactive sexual desire in both genders. Consequently, emotional distress and prescribed medications can also negatively impact libido. Hypothyroidism, which occurs when the thyroid produces lower thyroid hormones than necessary and aging have been associated with decreased sexual desire in men of all ages. In fact, a Swedish study of 500 men aged 51 years found that low levels of free testosterone were associated with low sexual interest. The Global Study of Sexual Attitudes and Behaviors also reported several risk factors for low sexual desire in men that includes poor overall health, vascular disease which affects the blood vessels, depression, divorce, and financial problems. However, contrasting findings in a large 2007 study reported some more optimistic news. While sexual activity does decline with age, a significant percentage of men and women do remain sexually active well into their ninth decade of life.

Treatment of Hypoactive Disorder in Men

In general, people who are depressed need to be assisted to deal with their mood. Couples who experience relational problems can be helped with couples' therapy. Individuals with underlying medical conditions should be treated or referred to appropriate medical specialists that can help with their issue. Similarly, patients with abnormal (thyroid) TSH levels should be referred to an appropriate specialist to determine necessary treatment and follow-up. In such cases, it was observed that the greatest challenge with treatment involves those with no underlying cause for low libido. There are currently no medications for low sexual desire, with current treatment options being limited to psychotherapy and off-label pharmacotherapy. Research indicated that cognitive behavioral therapy (CBT) is an effective approach in treating low sexual desire in women, but it is unclear whether it is effective with men.

Rapid, or Premature Ejaculation (PE)

Premature ejaculation does not preclude sexual activity or orgasmic release (at least not for the man), and it was thus assumed that it would not pose a major distress to couples' sexual activity. However, it was shown to be one of the most frequent complaints of men and their partners. Over the years, treatment approaches for this problem ranged from psychotherapy and/or behavioral treatment prior to the mid-1990s, to prescription medications which could help to increase ejaculatory latency. In 2007, sex researcher Dr. Althof commented a cautionary tale regarding medications and their potential for assisting men who face sexual dysfunctions. He observed that "…one of the lessons from the 'Viagra revolution' for the treatment of erectile

dysfunction was that no matter how efficacious and safe the medical intervention, by itself, medications could not, in many men and couples, surmount the psychosocial obstacles that maintained the dysfunction and interfered with sexual life." We should remember that although many are attracted to the 'quick fix' of medications, they are, often a band aid solution, rather than a real one.

What Is Premature Ejaculation (PE)?

Various definitions were offered by the American Psychiatric Association, the World Health Organization, and the American Urological Association with some common features mentioned by all of them. Three of those features include ejaculatory latency, involuntary control, and the presence of marked distress or interpersonal disturbance. The DSM-IV-TR's, which is the latest psychiatric "bible" of disorders specified that PE is recurrent ejaculation that occurs with minimal sexual stimulation prior to or shortly after penetration. It was also noted that the disturbance causes distress and interpersonal difficulties which could negatively affect the couple's union. When a man is experiencing PE, it needs to be clarified whether it has been a primary (lifelong) or secondary (acquired) problem and whether it occurs consistently ("generalized") or only at specific times or situations. It was highlighted that it is important to ascertain whether it may be due to psychological or biological factors. Men with secondary PE tended to be older with decreased libidos due to age and mostly experienced erectile dysfunctions, decreased erotic arousal, and decreased penile sensitivity. In contrast, those suffering from primary PE reported increased anxiety and emotional disturbance.

'Generalized' refers to those who experience PE with all partners, while the specific type of PE may be completed during the sexual act in a well-timed manner, while in others, be lacking. It is well accepted that psychological factors are involved in the specific type. It is known, clinically, that a man may have PE when he copulates with his wife but may not with his lover. In other cases, he may 'perform' well usually, but experiences PE following an argument with his wife. As we could see, definitions of PE are abounded; but are vague and, at times, overlap.

How Common Is PE?

Recent international studies suggest that PE prevalence rate is around 20%-30%. However, the nature of this self-reported data may not provide an accurate estimate as its true prevalence. For some individuals, simply being dissatisfied with their ejaculation or sexual performance may be marked as PE, but clinically, wouldn't be accurate. In turn, it was suggested by sex researchers that the true number of those suffering from PE is significantly smaller, and the 'proof' is shown by the scarce number of patients present for treatment than would be expected with a true prevalence of around 30%. It has always been accepted that premature ejaculation is a dysfunction mainly experienced by the young, though that belief was challenged by two studies which confirmed that the prevalence of rapid ejaculation was constant across age groups ranging from 18 to 70.

The Causes of Premature Ejaculation

Masters and Johnson established the understanding that rapid ejaculation was a psychological or learned condition. However, more recent investigations have pointed to physiological causes leading theorists to propose that organic factors significantly contribute to this condition, although, the biological etiology of PE is not yet well understood. At present, what we do know points to causes which may include the role of serotonin receptors, an individual's genetic predisposition, and increased penile sensitivity. One interesting study indicated that rapid ejaculators take substantially longer to ejaculate with masturbation in comparison to intercourse (1.5 vs. 4.5 minutes) which may indicate that vaginal intercourse may be less sensitive to their personal stimulation needs, which are being met optimally during masturbation.

Psychological Theories about What Causes PE

The various psychological theories that attempt to explain why men develop PE are typically not based on evidence-based studies, and through the thoughtful syntheses by clinicians from various schools of thought. As such, we may need to take them with a grain of salt, so to speak. In 1927, German psychoanalyst Dr. Karl Abraham studied the role of infant sexuality in character development and mental illness overtime. He speculated that PE was the result of the man's unconscious hostile feelings toward women, and together with the child's pleasure, would lose control of his urine. In adulthood, that childhood loss of control was believed to represent the individual 'giving up control' over ejaculation.

Another psychoanalytic, or Freudian, explanation suggests that the excessive narcissism which characterizes us during infancy results in the infant placing exaggerated importance on his penis. That explanation tries to understand the selfishness observed in some rapid ejaculators who care less about their partner's dissatisfaction due to their rapid orgasmic response. Although, most men are negatively affected by their inability to delay ejaculation as well. Another explanation that was offered conceived of PE as a psychosomatic disorder that expresses the man's conflicts. That explanation is not dissimilar to explanations of headaches, backaches, and stomach pains.

Masters and Johnson approached PE from a behavioral perspective and suggested that the man's early learned experiences centered around initial sexual experiences which were hurried, nervous, and insecure like when they first made love in the backseat of a car. Men, thus, became conditioned to ejaculate rapidly, as it was adaptable in those past situations. Dr. Helen Singer Kaplan, a noted sex researcher and clinician, published her book on PE in 1989 and observed that this condition may be a result of a lack of sensory awareness. In her view, those suffering from PE failed to develop sufficient feedback regarding their level of sexual arousal, and thus, go from a low to very high level of arousal without their awareness. From this, the individual experiences an orgasm and ejaculation which is too fast for them and clearly for their partner. *Performance anxiety*, or the anxiety a man may develop about his performance in bed through the constant evaluation of how he is doing during sex, does not, usually, cause the initial episode of rapid ejaculation, but is important in maintaining it. Once performance anxiety sets in, it becomes the sole issue that the man is focusing on further preventing him from exerting voluntary control over sexual arousal and ejaculation.

The Effect That PE Has on the Man and on His Partner

Clearly, premature ejaculation impacts both the man and his partner, as well as their relationship. In a study of 28 men aged 25-70 with self-reported PE, it was found that 68% of them reported a decrease in sexual self-confidence. Moreover, half of the single men avoided establishing new relationships, while those who were already in a relationship were quite distressed about not being able to satisfy their partner. Further concerns about whether their partner may seek sexual fulfillment outside of their union were also noted as well. Similar to what we know about men in general, they do not hurry to consult a physician about their PE due to embarrassment. One study found that a whopping 67% of men with ejaculatory problems did not consult a physician, and another large percentage of them (up to 50%) did not even realize that treatment could help them. Instead, they were found to be preoccupied with thoughts about controlling their orgasm, anxiously anticipating failure, and questioning their ability to keep an erection. In another study investigating their relationships, PE sufferers scored lower on the emotional, social, sexual, recreational aspects of intimacy than sexually functional men. Partners of those with PE are obviously affected by their condition and by their lover's reaction to it. Research further found that partners reported lower sexual satisfaction, since the man's rapid ejaculation also results in an abrupt end to the couple's intimacy − leaving them unfulfilled. And while some women may be angry that the man may not be doing enough to 'fix' the problem, men, on the other hand, do not believe that their partner truly realizes the degree of frustration and humiliation which they face. Thus, causing considerable relational tensions to emerge.

Delayed Ejaculation

Delayed ejaculation (DE) is one of the most challenging male sexual disorders to exist. When a man cannot ejaculate with a partner or when he masturbates, he ends up feeling frustrated and baffled, anxious, and sexually incompetent. Although supposedly, while the partner should be happy with a man who continues to copulate for a long time, in reality, it results in a person who feels distressed, deprived, and unsure of whether they are doing the right thing, sexually, for their partner. Compared to all other male sexual dysfunctions, DE has received the least attention. Therefore, we do not understand how and why it occurs.

Male orgasmic disorder or DE has been compared to female orgasmic disorder. Although ejaculation and orgasm usually occur simultaneously, they are two separate phenomena. It is therefore referred to as 'delayed ejaculation', which contrasts with rapid ejaculation and may or may not be related to the man's orgasmic capabilities. In general, DE is an involuntary inhibition of the male orgasmic reflex, and in some ways, is like female orgasmic dysfunction. DE can be 'primary' (lifelong), or it can be acquired ('secondary'). It may occur in every sexual encounter, or only occasionally. Some men with secondary disorder can achieve orgasm through masturbation, while others cannot.

The most prevalent DE is coital anorgasmia, where intercourse does not end in orgasm, though orgasm can be experienced through masturbation or even through partner's oral stimulation. Generally, men who suffer from DE can attain an erection and their sexual desire is typically not impaired. Dr. Kaplan classified ejaculatory delays according to its severity. It

ranges from mild (in which the man can achieve intravaginal orgasm sometimes), to moderate (where the man can ejaculate but not via vaginal intercourse), severe (when orgasm can only be achieved when masturbating alone), and most severe (meaning, the man has never been able to achieve orgasm). A common sexual myth is that a man with DE can’t pleasure his partner completely which is untrue, since a man who cannot orgasm may continue intercourse way beyond the pleasurable point. However, this may result in displeasure since the man is desperately trying to achieve orgasm and is less available to please his partner. Once their erection declines, or they cannot see that they can reach an orgasm, men will usually stop sexual interaction as it becomes ‘hard work’ rather than pleasurable intimacy. And since vaginal lubrication lessens or disappears as the intercourse time increases, thrusting intravaginally may become unpleasant or even painful for the woman on their end. Women, on their part, usually reproach themselves for not being able to help the man orgasm. The woman may end up feeling unneeded or rejected. Both partners may simply lose their motivation to engage in sexual activity. As a result, some men may experience secondary erectile dysfunction, loss of desire, or even feelings of disgust.

It also appears that DE is not as rare as is generally assumed. Research found that while only 8% of men complain of an inability to achieve orgasm, the prevalence ranged between 1-10%. A study of 250 men found that 2% complained of severe DE while 6% had a mild form of this condition. Age seems to be related to a reduced ejaculation as in general, advancements come with a greater prevalence of sexual disorders.

Causes of DE

Several psychological theories have attempted to explain the etiology of DE. Mostly, they are derived from clinical experience, meaning, there is not a lot of research to backup these claims although they may be useful in helping us understand this disorder.

Blocked perception of the inner world – Mostly, men are said to have blocked their perception of their inner world, their thoughts, and the way they feel. This, and the tendency of these men to experience anxiety, shame, and concern being vulnerable, may explain why they would prefer to treat sexual problems with medications rather than with psychotherapy or sex therapy. Two sex researchers, Dr. Hartmann and Dr. Waldinger, wrote in 2007 that “…many men believe that their sexual response can (and should) be automatic, which is a defense against their own vulnerabilities and needs. The individual basic conditions for a satisfying sexuality are blurred and their history reveals only rudimentary sexual competence at best” (p. 251). The causes for it may be varied and could be the result of the male’s upbringing which may have highlighted toughening up and battling against physical and mental weakness.

Absence of an erotic world – Aside from the pressure to perform and the fear of failure, the loss of an erotic world is a significant problem of male sexuality. It is extremely useful differentiate everyday reality from erotic reality, as that may help treat the dysfunctional man. Sexual excitation changes our consciousness, and we, thus, perceive the world differently than in everyday life. Most people are aware of it and typically adjust to the difference. However, these two worlds may mix, such as when boring tasks may become clouded with erotic thoughts. In contrast, some men protect the separation of these two worlds so zealously that they will not let that ‘mixing’ to occur. From a clinical standpoint, it was hypothesized that those with DE have difficulties differentiating between these two worlds. They refrain from

entering the erotic world since moving from one reality to another is experienced by them as unnecessary and exhausting. Their inner erotic world has become impoverished, and they can no longer create sexual excitement, have no sexual spark or excited anticipation. And so, many men who suffer from DE have not learned to make requests for their most arousing type of erotic stimulation. Thus, sex becomes mechanical and loses its function of giving and receiving pleasure-oriented touching.

Dr. Kaplan, the same sex researcher and clinician that we mentioned previously, compared the causes of DE with constipation, where reflexes which are normally under voluntary control can be inhibited by psychological conflicts. The qualities of the psychological conflicts, a-la-Dr. Kaplan, are non-specific, which makes it almost impossible to identify a specific etiology that will allow a clear differentiation of DE from other sexual disorders like erectile dysfunction. Kaplan believed that the DE sufferer unconsciously holds back their anxieties derived from the sexual act or orgasm by increasing his efforts to control such conditions – leading to the impairment of his ejaculatory mechanism. Some clinicians suggested that DE may be related to a fear of unwanted pregnancy, traumatic sexual experiences, or sexually transmitted diseases, though similar reasons were enumerated regarding erectile dysfunction. Additionally, deficient sexual stimulation, not sharing with one's partner what one likes sexually, and the fear of getting caught in the middle of intercourse may also contribute to DE. The psychological conflicts, mostly unconscious, were suggested as contributors to the problem:

Incest fears – where every sexual intercourse and orgasm are imagined by the man, consciously or unconsciously to be an incestuous act accompanied by taboo, and the fear of punishment.

Castration fears which Sigmond Freud wrote about – are related to incest fears. This involves fears of the penis becoming injured or damaged inside the vagina, but is actually attributed to self-loss, of letting go and of not being in control.

Fears of hurting the woman – the penis is perceived as a dangerous weapon and sexual intercourse and ejaculation are experienced by the man as very threatening and harmful to the woman.

Fear of loss of control – that was mentioned earlier. The letting go which is associated with orgasming is the source of strong fears. This may be related to the person's childhood where he was not allowed to show emotions.

Hostility and anger – men with DE are assumed to exhibit marked feelings of hostility and even rage against women. These feelings can be traced to unresolved psychosexual conflicts stemming from the person's early years where the man may mask themselves through gentle and caring behavior towards women.

Fear of sperm loss – some men believe this to be true. Especially in certain cultural (i.e., Islamic, Asian, or African cultures), and social (i.e., sports coaches) spaces, the belief that every ejaculation depletes a man of his vitality is understood to weaken them greatly. Thus, some men are informed that ejaculation must be avoided.

Paraphilic impulses – or the experience of intense sexual arousal to atypical objects, can be involved in every sexual dysfunction. That is particularly important in those with DE. They may reach erection with paraphilic fantasies, but then become threatened if they realize that they need that fantasy to get sexually aroused; thus, avoiding orgasm. Some researchers observed that, quite simply, frequent masturbation or utilizing peculiar masturbatory techniques may be among the most frequent causes of DE.

Men's Sexual Dysfunction and Health

Sexual health is commonly defined as a state of physical, emotional, mental, and social well-being related to sexuality, which requires a positive and respectful approach to sexuality and sexual relationship. In particular, physical and sexual health are closely and positively associated. For instance, there is a close association between erectile dysfunction and high blood pressure, high triglycerides, diabetes, and obesity. Additionally, men with erectile dysfunction usually have other medical conditions as well. They have been shown to have a two to three times higher chance of suffering from cardiovascular issues compared to men without erectile dysfunction. Thus, ED may become an important alarm marker for cardiovascular disease and stroke.

The Olmsted Country Study which was published in 2009 showed that community dwelling men with erectile dysfunction was associated with an 80% higher risk of subsequent coronary artery disease, especially among younger aged men. Another large-scale study investigating 25,650 men revealed that those with preexisting erectile dysfunction had a 75% increased risk of peripheral vascular disease or blood circulation disorder that causes the blood vessels outside of the heart and brain to narrow, block, or spasm. Often, ED appears about 1-5 years prior to symptomatic cardiovascular diseases. This is particularly so for men over 50 years of age, and those with existing cardiovascular risk factors.

Testosterone deficiency and premature ejaculation are two other conditions which negatively affects men's sexual health. Testosterone deficiency is a clinical and biochemical syndrome that is frequently associated with age and various medical conditions. Clinically, testosterone deficiency diminishes muscle strength, is related to visceral obesity, and alterations in mood. It commonly manifests itself as low sexual desire, erectile dysfunction, and delayed ejaculations. Low testosterone levels have also been shown to predict type 2 diabetes, while on the other hand, obesity and type 2 diabetes predict subsequent testosterone deficiency.

Premature ejaculation was later found to be related to the dysregulation of serotonin, and usually occurs with medical conditions like prostatitis, chronic pelvic pain syndrome, and thyroid disease.

How Is Sexual Dysfunction Related to Psychological Health?

Psychological health does not usually go with sexual dysfunctions. For instance, sexually dysfunctional men are often depressed. In fact, hypogonadism, or the diminished functional activity of the testes, is also associated with depression. With this in mind, research has shown that lower levels of testosterone are also associated with depression – especially in older samples. Therefore, men's sexual health across all age groups is, indeed, intimately related to men's physical and mental health.

Sexuality of the Aging Man

Life expectancy has significantly increased in the 21st century, and people are living healthier, longer lives. Global aging represents a triumph of medical, social, and economic advances over

disease, but do not come without its challenges. Population aging affects economic growth, trade, migration, disease patterns and prevalence, and fundamental assumptions about growing older. The needs of older people will become increasingly more pressing as the number of older people increase. And as we've discussed before, male sexual health is often complex and is affected significantly, based on one's endocrine functioning, general health status, sexual desire, frequency and quantity of sexual activities, and satisfaction with their overall sex life. All these domains are influenced by the fitness of both partners and their health. In fact, negative emotional states have been found to be associated with male sexual health. Feeling puzzled, disgraced, weakened, and frightened are known to negatively affect the couple's relationship and sexuality. Hence, male sexual dysfunction is quite the variable, complex, and challenging condition which is touched by organic, endocrinal, relational, and intrapsychic determinants.

Sexual health can also be considered a mirror of general health, and, in turn, general health becomes a prerequisite for sexual heath. We know that as people get older, they usually are affected by multiple organic or physiological diseases which can interfere with sexual functioning. For instance, they may suffer from cardiovascular (CV) and metabolic diseases including coronary artery disease, myocardial infarction, hypertension, and diabetes mellitus, which could significantly contribute to age-related sexual dysfunction. Based on combined data from two cross-sectional surveys of the aging population in America, Dr. Lindau and Dr. Gavrilova founded the concept of one's "sexually active life expectancy," which they defined as the average number of years remaining spent as sexually active. Men were found to have a longer, more sexually active life expectancy than women. However, they lose more years of their sexually active life due to their deteriorating health. Accordingly, the life expectancy of men is about 6 years lower than that of women.

Women are more resilient than men in many areas including their health, and are more likely to mobilize their strengths and consequently end up living longer. Western beliefs about masculinity and manhood also play a huge role in shaping the behavioral patterns of men in ways that have negative consequences for their health. The male tendency to suppress emotions and pain may also be reflected in their tendency to avoid these issues – thus, leading them to neglect their health. In this context, it is funny how men with sexual dysfunction can be therefore paradoxically considered "lucky," since the sexual problem might offer them the opportunity to be screened, and thus, potentially diagnosed with other comorbid conditions which are needed to be treated.

In aging, there are physiological modifications to the genital structures, including a decrease in penile sensitivity which was mentioned earlier, and consequently the achievement and maintenance of having an erection. For the aging male, this process becomes more dependent on direct physical stimulation and less dependent on visual, psychological, or non-genital excitation. So, while a young man may achieve a full erection in seconds, an older man may require several minutes to attain a similar response; and that is normal for aging men! However, despite these age-related changes, studies indicate that elderly men continue to be sexually active throughout their lives. Masters and Johnson did not find any upper age limit to men's ability to sexually function and enjoy it. Although, research has indicated that sexual functioning frequency declines with age. Dr. Helgason and colleagues studied Swedish men aged 50–80 years and found that the frequency of desire, erections, orgasm and intercourse all decreased as a function of age, as can be expected. Similarly, a nationwide study in France found that 66% of men aged 70–79 reported being sexually active, with a fraction of them

(18%) having had one or more sexual intercourses per week. Mirroring results have been reported in Australian and European populations. For example, an American study confirmed that age declines in the areas of sexual intercourse, erection, sexual desire, masturbation, satisfaction with sex, and difficulty with orgasm.

Difficulties in Getting and Maintaining Erection in Older Age

Challenges with ED have been known to cause stress and relationship problems that eventually affect the man's self-confidence; raising questions about his masculinity. While sexual functioning declines with aging, it should be remembered that normal erections are not an absolute prerequisite to remain sexually active. A study involving 1,688 sexually active men (aged 50–78 years old) indicated that 17%–28% of them had abnormal erections – confirming that normal erections are not an absolute prerequisite for sexual activity in the elderly. In line with that assertion, research has also indicated that more than 40% of men declared they often utilized other ways of getting sexual gratification that do not require a good erection, including forgoing intercourse, manually arousing themselves and/or their partner, the use of adult toys, or watching pornography together.

ED is considered a multi-dimensional disorder, deriving from a general deviation of all the components involved with erectile responses. This includes the body (organic domain), the couple (relational domain), and the mind (intra-psychic domain). And while ED may be caused by any of the three components, eventually it will negatively affect the other two as well. Relational factors significantly affect the manner of development of ED in older patients, while the reverse is true for intrapsychic, or internal psychological processes.

Prevalence of ED in Older Age

Various large-scale studies substantiated the global prevalence of ED and its close association to aging. The Massachusetts Male Aging Study for example, is a well-known project which investigated the effects of aging on male sexual health. Results showed a combined prevalence of minimal, moderate, and complete impotence of no less than 52% of the participants. A research project of eight European centers investigating ED (i.e., the European Male Aging Study (EMAS) in men aged 40-79 with a mean age of 60 years old found that 30% of the entire EMAS sample reported ED, with numbers increasing as men aged, and peaking in men 70 years and older (64%).

As such, the rapid expansion of the aging population coupled with the increase of life expectancy in the majority of the world contributes to the increased number of aging men with ED. It was estimated that by 2025, 9.5% of the worldwide population will be men older than 65 years of age. Thus, the incidence of sexual dysfunctions will increase as well. Not only will the prevalence be affected, but also the severity of ED itself – partially due to related illnesses and other problems that people face with age such as hypertension, vascular disease, chronic kidney disease, and depression. ED in the aging male is of a multifactorial origin and therefore needs a holistic assessment. Consequently, the initial evaluation of ED should include a complete medical, psychosocial, and sexual history.

Sexual Desire and Aging

Sexual desire, which at times may be referred to as lust, sexual appetite, and libido, is the main motivator of all sexual acts. It is more correlated with personal attitudes toward sexuality than with biological factors and diseases. In 1977, Dr. Kaplan was the first to develop and address the concept of hypoactive sexual desire disorder (HSDD), which is a persistent or recurrent deficiency or absence of sexual fantasies or desire for sexual activity. When only one member of the couple experiences HSDD, it can generate conflict resulting in a reduced quality of life.

It was also found that the negative effect of age on desire is more related to overall health problems than to aging itself. In fact, an Australian study involving nearly 6,000 men aged 40 found that 37% of this sample reported a decrease in sexual interest, with a rate that reached almost 60% for those aged 70. Similar figures have come from the United States. It was speculated that a reduction in sexual desire represents an adaptive, evolutionist strategy to prolong survival in aging males as they may be able to spare energy through these means.

Orgasmic and Ejaculatory Dysfunction in the Elderly

Orgasmic and ejaculatory dysfunctions are relatively common disorders of aging males and include conditions ranging from premature ejaculation (PE) to delayed ejaculation (DE) and anejaculation. Other ejaculatory dysfunctions include reduced orgasmic pleasure. In comparison to other sexual symptoms, PE is often believed to be a non-medical issue, and as such, it is difficult to estimate its prevalence. The best estimate of its prevalence ranges from 30% to 40% and decreases as the man ages.

Delayed ejaculation is the least understood male sexual dysfunction and occurs when a man with mild DE is able to engage in intercourse, but only within limited conditions. As the condition's severity increases, partnered intercourse becomes impossible as the man can reach orgasm only when he masturbates alone. Similar to PE, the prevalence of DE is difficult to determine, since normative data is lacking. In most studies, DE is reported as a relatively rare condition, not exceeding 3% of the population. Most of the available studies suggest that the prevalence of DE increases with aging. A very large survey conducted in 29 countries worldwide with more than 13,000 community-dwelling men aged 40–80 years showed that DE is positively correlated with age. And not unlike what has been observed for other male sexual dysfunctions, *concern* about their orgasmic function is much lower in older males than in their younger counterparts.

Studies indicate that testosterone production falls progressively with age and that, naturally, contributes to sexual dysfunctions. However, it is yet unclear if that decline is due to aging alone or with conflicting lifestyle, or psychological, organic, or relational changes; many of which may occur as the person gains in years. In that vein, Dr. Corona and his research team observed that "…healthcare professionals should not over-sexualize the ageing process, nor over-medicalize declining sexual function and interest…Educating elderly patients is an important task and this might be obtained by healthcare providers through verbal suggestion, expectation, meaning, conditioning, teaching, reward and reduction of anxiety and behaviors and attitudes" (p. 595).

Erectile Dysfunction (ED) of the Elderly

Before the 20th century, elderly sexuality was not an issue since humans did not live beyond the reproductive years. It was generally assumed that as people age, they lose their sexual desire and prowess which consequently caused these sexual dysfunctions to be generally ignored. However, as our global life expectancy continues to improve, we are finding that both genders want to be sexually active for many years.

Declines in sexual activity is typically attributed to both general health problems as well as specific sexual dysfunctions. In a large US study, researchers found that the proportion of males aged 57-64 who were still sexually active was 84%, while only 39% of those aged 75-85 were still sexually functioning. The advent of Viagra, a safe oral therapy for the treatment of ED, has brought attention to this dysfunction and may have contributed to increased attendance at medical clinics requesting a prescription. Unfortunately, about a third of ED patients do not respond well to medications such as this, and consequently, contribute to the demand for surgical options to rise.

What Should the Physician Do When an Older Person Complains of Sexual Dysfunction?

The goal of history-taking should be to not only understand the specific erectile condition, but to also explore any possible underlying and reversible or treatable disorders. A thorough medical assessment is mandatory particularly in older men who may be at a high risk for cardiovascular disease. These patients should undergo cardiovascular assessment before the continuation of sexual activity and before initiating therapy for ED to check whether sexual activity is advised for them. There are various and numerous underlying conditions which need to be ruled out as possible causes of ED for treatment. These may include depression, diabetes, hypogonadism (diminished functional activity of the testes), and medication/surgically induced causes of ED. A thorough review of medications which they consume are essential, since some of them may significantly interfere with their sexual functioning.

Sexual History

Sexual histories must be understood to identify and clarify plausible causes of ED. This may include information about the current sexual relationship(s), the emotional and the physical status of the patient and the partner, and the reasons behind the couple's intentions to seek therapy or consultation. For instance, the physician may need to know whether the patient has nocturnal erections, and whether erections appear during masturbation, as they can give clues about the etiology of ED. It is necessary to determine whether ED is the primary sexual problem or whether other aspects of the sexual response cycle (desire, ejaculation, orgasm) are involved. And as we mentioned before, problems with arousal, ejaculation, and difficulty reaching orgasm may be signs of underlying illnesses and disorders which the attending physician needs to be aware of and may consequently offer treatment for. Another important issue which needs to be explored is the impact of ED and other sexual dysfunctions on the general well-being and

sexual satisfaction of both the patient and the partner. If such is the case, couples therapy may be offered as a potential solution.

Physical Examination

Physical examinations are an essential part of assessing ED and is particularly helpful in finding signs of underlying or additional medical conditions. Such a physical should include a general screening examination, including cardiovascular, neurologic, and metabolic health status. Similarly, one's blood pressure and heart rate should be measured. In fact, an examination of the genitals can also provide important information about the patient's health. Genital and perineal sensation needs to be explored as a way of assessing possible neurological issues which may contribute to the dysfunction. Laboratory investigations may identify treatable conditions or previously undetected medical illnesses that may contribute directly to ED.

Treatment Approaches

Counseling

Counseling may assist in setting treatment goals, reviewing findings of the initial evaluation, and when needed, provide educational sessions about the anatomy and physiology of sexual functioning. This can provide clients with an appropriate understanding of the specific medical or physiological pathology related to ED and assist the healthcare professional in improving the patient's sexual understanding, comfort, and expression.

Medical Treatment

Although oral pharmacological treatments such as Viagra for ED do not 'cure' the condition, they can nevertheless be relied upon to improve erectile functioning in patients without medical illnesses or underlying disorders such as diabetes. The elderly patient needs to be made aware of that a fully rigid erection is not expected to occur with the use of oral pharmacotherapy, due to aging and related conditions. The patient and his partner should be further educated about the possible pharmacological and nonpharmacological treatment options. If penile-vaginal sexual intercourse is not a viable option, the couple needs to be educated about additional ways to please one another. Mental health is directly associated with one's satisfaction with sex. And consequently, if men with ED can learn to be satisfied with other forms of intimacy, their mental health could be preserved.

Obesity, a sedentary lifestyle, and cigarette smoking are the most common lifestyle factors that cause or contribute to elderly ED. Without a limitation of these habits, one may face great challenges in overcoming elderly ED. Therefore, patients should be educated about the beneficial effects of weight loss, increasing exercise, and quitting smoking for erectile functioning. Multiple medications can cause even or contribute to preexisting ED as the patient needs to be familiarized with what they are, and thus, be able to explore substitutes. It should

be noted that aside from medications, the patient should be informed that recreational drugs such as alcohol, cocaine, marijuana, amphetamines, and opiates have also been linked to ED if that is something they engage in.

Vacuum Constriction Devices

This is a manually operated device that creates negative pressure around the penis, resulting in the passive engorgement of the erectile tissues. Those who do not respond adequately to medical therapy may be advised to utilize such a device. And although 90% of patients reported high efficacy, its use might be perceived as disturbing the sexual activity and spontaneity.

Surgical Treatment

Surgical treatment which may be radical and/or invasive may be recommended to patients who have found no luck with prescribed medications. Revascularization, meaning, the restructuring of the penile blood vessels, and reconstructive procedures are mainly reserved for the treatment of ED in young patients with specific conditions. More commonly, however, a penile prosthesis is implanted in these individuals. There are three types of penile prosthesis: two or three-piece inflatable devices, semirigid devices, and soft silicone devices. Findings suggest that both patient and partner satisfaction is apparently very high with satisfaction rates reaching 90%–98% for the three-piece inflatable devices. Although, auto-inflation, which can occur and erectile length loss are some of the bothersome side effects of implants.

Sexual Dysfunctions and Self-Efficacy

The concept of self-efficacy is essential in understanding general psychological health, including healthy sexual responses. The self-efficacy construct refers to our perceived ability to act effectively at a situation we face and relates to the control that we believe we have over the situation. People's beliefs about their self-efficacy determine how they feel, think, motivate themselves, and behave. As such, it plays an important role in what people choose to do or to refrain from. To clarify, people commonly choose goals that they believe that they can reach, and so their thoughts and emotional reactions to a situation are closely affected by their self-efficacy. Self-efficacy also affects people's expectancies. Those with high self-efficacy prepare for situations utilizing positive performance strategies and visualizing success even when they must cope and overcome serious problems and obstacles, whereas those with low self-efficacy dwell on the negatives of the situation and envision failure.

How Are Self-Efficacy and Sexual Response Connected?

The concept of self-efficacy is intertwined with premature ejaculation (PE). Men may commonly say or think to themselves that they 'lack control over ejaculation,' 'feel unable to

postpone ejaculation,' or 'ejaculate before I wish to' – which all infer a condition in which the individual lacks an ability to control the delay of their ejaculatory response. It is suggested that with other sexual dysfunctions like inhibited orgasm, erectile failure, and low sexual desire, self-efficacy plays a central role. No matter the problem, the person commonly seeks the assistance of a health professional or some other remedy to help overcome the problem.

Research which was conducted on self-efficacy and sexual dysfunctions demonstrated that self-efficacy scores are significantly different between sexually functional and dysfunctional men; findings that were even predictive of their severity of the dysfunction. Dr. Rowland and colleagues suggested that due to its ability to predict cognitive, affective, motivational, and behavioral responses, self-efficacy could play a more important role in constructing and assessing treatments for sexual problems. And when treatment is evaluated as to its efficacy, it may be deemed successful when the person treated believes he or she is equipped with the tools and strategies necessary to achieve their desired goal.

Sexual Health of Men and Women

Dr. Lehmiller, who wrote extensively about human sexuality, stated that sexual health is "…a state of physical, emotional, mental and social well-being in relation 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" (p. 747).

What Affects Our Sexual Health?

Our sexual health is affected not only by physical, emotional, or relational factors, but also by various 'environmental factors' which need to be understood and modified in order to enhance sexual well-being. Sexual health is not easy to define, and is often dependant on the sexual lifestyle and culture in which the person lives. There is a paucity of research regarding the following environmental factors that will be briefly described:

Obesity – Presently in the USA, over one third of the population is obese. People with a body mass index (BMI) between 25 and 30 kg/m^2 are defined as overweight, while those with a BMI greater than 30 kg/m^2 are obese. With regards to sexual functioning, obesity has shown less then promising results. A study examined 45 obese women and compared them with 30 healthy controls. The study found a negative correlation between BMI and orgasm as well as between weight and sexual satisfaction existed – meaning that the higher the BMI, the less orgasms and satisfaction was had by the women. The diagnosed rates of female sexual dysfunction, however, were not different between obese and non-obese women. As far as men are concerned, testosterone levels in obese men are lower compared to men with a lower BMI. Concurrently, it is well established that obesity contributes to hypertension, insulin resistance and diabetes, elevated triglycerides, and low levels of high-density lipoprotein, which has a negative impact on erectile function.

Diet – Due to complex cultural and financial considerations, the world population is shifting their consumption towards a "western" diet which is laced with refined grains, sugars, and red meats. At the same time, this diet is often low on what we would consider healthy foods, such as fresh fruits and vegetables. Since then, science has established that a healthy diet contributes to both physical, sexual and mental health – making increased sexual dysfunction less surprising, given our recent eating patterns.

Depression, which is experienced significantly more in obese people, is a well-known risk factor for sexual dysfunction. Men who are obese, diabetic, or suffer from cardiovascular disease are more commonly diagnosed with erectile dysfunction. As such, a study involving 145 obese men found a significant improvement in erectile functioning for those enrolled in a weight loss program employing diet and exercise. Regarding male fertility, a lower intake of fruits and vegetables and higher intake of meat was found to be associated with infertility.

Exercise – While exercise is generally considered a healthy endeavor, in excess it can impair fertility in women. A study of 187 infertile women and 419 women who gave birth found that vigorous physical activity or exercise that lasted more than 60 minutes per day could increase a women's risk for infertility associated with abnormal ovulation. It was found that female athletes show significantly more irregularities with their menstrual cycle as compared to sedentary women. Additionally, it was found that underweight women took an average of 29 months to achieve a pregnancy, as compared to the 6.8 months for women of normal weight. This, however, was not the case for men. For example, The Massachusetts Male Aging Study followed 593 men for eight years and found that those who exercised regularly showed a 30% decreased risk of developing ED. Even for obese men, regular exercise was found to make a difference. Specifically, it increased serum testosterone levels and improved erectile function. In general, regular aerobic exercise of moderate intensity is likely beneficial for the maintenance of fertility and sexual function.

Smoking – The smoking rate in the United States remains almost at 20% despite the fact that tobacco use in the Western world has decreased significantly over the past several decades. Research found that tobacco use was associated with many health conditions including lung cancer, heart disease, and, more recently, infertility. Heavy smokers experience worse fertility than lighter smokers. Male smokers in particular were found to have a 40% higher rate of ED than non-smokers. This number was found to vary according to the number of cigarettes they smoked. Former smokers were found to have significantly less ED than active smokers, which suggests that smoking cessation is sexually beneficial.

Alcohol – Alcohol is well known to cause malformation in the embryo if consumed by the woman during pregnancy. Both moderate (<100 g per week) and heavy (>100 g per week) alcohol consumptions have also been associated with female infertility. It appears that ovulatory dysfunction may result in infertility among women with histories of heavy alcohol intake. As far as women's sexual functioning, high blood alcohol levels are associated with decreased genital responsiveness. And while we know that moderate amounts of alcohol can increase libido in men, large quantities are likely to cause ED.

Illicit drugs – Marijuana and cocaine use have been associated with increased rates of infertility in women. A study done on 150 infertile women found that marijuana use increased the risk of infertility by about 70%, especially if it preceded pregnancy. Cocaine use was also found to be associated with increased infertility rates. It is generally thought that chronic use of most illicit drugs leads to decreased sexual responses, but with increased risky sexual

behavior, as well as an increased risk of STIs and unwanted pregnancies in women. Research demonstrated that the use of narcotics in men has deleterious effects on testosterone levels and erectile functioning. Marijuana users do not often report ED, while cocaine use impairs sperm concentration, motility, and morphology. Heroin as well has also been shown to negatively affect semen parameters.

The built environment – There is limited literature on this topic, but the built environment does have an effect on sexual health. In the 'built environment' we refer to, we understand this as the physical structures that people live in and around in their neighboring environment. Research into the effect of the built environment has found that adolescent residents from neighborhoods with limited access to healthcare resources and open spaces show higher rates of sexually transmitted infections (STIs), engage increasingly in unprotected sexual activities, and end up with higher rates of unintended pregnancies. Additionally, women in these areas are at increased risk for sexual assault.

Helping Couples Deal with Sexual Problems

Sexual dysfunction can significantly affect both partners in a relationship as well as their union, since a couple's sexuality encompasses reciprocal exchange of positive and negative feedback. One partner's libido and climax positively influences the other's sexual desire, and vice versa. For instance, when their partner suffers from ED, women report that their own sexual desire, arousal, orgasm, and satisfaction consequently decline. We, therefore, aim for achieving optimal dyadic sexual functioning which will ultimately enhance the couple's bond with one another.

The Effects of Infertility

Infertility is generally defined as the inability to conceive after one year of unprotected sex. It affects up to 15% of couples. Satisfying and productive sexual function and childbearing are considered important aspects of most partnerships which can deeply impact one's quality of life. The inability to conceive may make partners wonder about their femininity or masculinity, as well as the meaning of their relationship. In addition to their own sorrow for not being able to conceive, couples with fertility difficulties confront many challenges including societal and parental pressures for propagation, psychological conflicts, and potential financial burdens if they opt for assisted reproductive technologies. Such stressors can result in a decreased quality of life, marital disharmony, and sexual dysfunction.

The sex lives of those couples who seek medical assistance are often transformed from being carried out in the intimacy of their bedroom to the control of the healthcare establishment. Sex is altered and becomes methodical, predictable, and unexciting for those couples struggling with infertility. Infertility is also considered to be so stressful that it has been compared to that of cancer, AIDS, and other devastating illnesses as well as the loss of a loved one.

Infertile couples face numerous sexual problems such as a lack of desire, pleasure, or spontaneity to sexual dysfunction. Infertile women are known to suffer from sexual dysfunctions more than men, as both genders are known to be depressed, and feel quite

unhappy, partly due to their inability to conceive or to have sex spontaneously and lovingly. The invasiveness of medical treatments for infertility may include a wide range of medications, hormonal treatments or the stress created by a “demand” for an offspring – thus, resulting in the loss of libido.

The Psychosocial Implication for Infertile Men

Having a diagnosis of infertility is a psychological and relationship stressor that is highly associated with sexual dysfunction. Some research indicated that infertile men experience less distress than women do. Male partners of infertile couples report significantly less desire, and perceive their relationships as being more stressful with greater challenges in sexual functioning when compared to fertile couples. Men in these partnerships typically face greater difficulties in controlling their ejaculation and report less satisfaction with their sexual performance in general. It was found that men in infertile relationships have a higher than usual incidence of ED and depressive symptoms. They complain of low self-esteem, experience high anxiety and various somatic symptoms. It has been established that during infertility, many men develop performance anxiety, sexual avoidance, or even an aversion to sex – especially if sex is geared specifically for procreation.

The Psychosocial Implications for Women Unable to Become Pregnant

The evaluation and treatment of infertility may result in timed intercourses that naturally interfere with the spontaneity of a couple’s intimacy. These situations have been shown to affect females more than males. Research showed that even after two- or three-years following infertility treatment, up to 59% of women participants experienced negative consequences from those treatments in their sexual relationship. Additionally, hormonal therapy may cause the woman to experience weight gain, breast tenderness, and mood imbalances which would, naturally, have a negative effect on the couple’s sexual health. In short, sexual dysfunction is high in all infertile women and severe marital strains associated with these partnerships can leave those feeling sexually inhibited, experience anorgasmia, and even have a reduced interest in sex altogether.

Treating Sexual Dysfunctions in Couples

Even couples that never encounter major or disrupting sexual problems may experience episodes where their sexual desire is low. That may be the result of emotional distress, physical strains of infertility or from a specific treatment. This episodic and diminished sexual desire can be easily resolved. However, consistent and extensive diminished sexual desire in infertile men and women is usually more problematic and multifactorial in nature.

Infertile couples are commonly reluctant to discuss sexual dysfunction due to their concern that it may interfere or interrupt medical treatment to hamper their attempt to conceive. Overall, the management of sexual dysfunction is best provided by a combination approach, which

successfully integrates both physical and psychosocial factors. Integrating sex therapy and sexual pharmaceuticals is commonly the best treatment approach for sexual dysfunction. As in some couples, therapy may be the key form of treatment for partners that blame themselves or each other for their infertility or medical diagnosis. This may often result in anger that interferes with sexual desire and functioning, which must be explored and resolved. Numerous partner-related psychosexual issues may also adversely affect their outcome. And so, if the sexual problems seem to be rooted in more fundamental relationship problems, it should be considered whether marital issues must take precedence over further infertility treatment.

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> Elon Musk and Bill Gates have decided to partner in a joint venture to invent medication to overcome erectile dysfunction. They have decided to name the new drug 'Elongates'.

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Chapter 10

The 'Ugly': Unlawful Sexual Behaviors

> The jail where I served as a psychologist for almost three decades, 'housed' various criminals that were from the 'garden variety' type (those who stole, were a public nuisance, etc.) to those who killed or committed sexual abuse. Two cases stayed with me after all those many years. The first one was of a sexual sadist who, while having sex with his wife, used to beat and choke her as a way of becoming aroused until one day she fainted and almost died. He had to call for an ambulance, and for a long time, had maintained that he did not know how his wife sustained all the blue and red marks on her body and around her neck. The second case was of a man in his late twenties, who upon being interviewed by me as he entered this particular jail, relayed that he was sentenced to jail due to his behavior with a minor. Apparently, while skating at a local rink, he noticed a nine-year old who left her father and went to the washroom. He followed her, went into her cubicle, and locked the door. There, he assaulted her and intended to rape her. Someone, thankfully, came in and prevented him from doing so, but unfortunately the damage was already done and she was severely traumatised. My son was the same age, at the time. As a result, this case shook me up, as it prevented the professional distancing that I could utilize in other cases to be used so that I could do my job as a psychologist.

Paraphilias

People are commonly afraid of sex offenders, and that fear generally elicits a push for punitive policies aimed at harsh punishments, incarceration, and playing down the option of treatment, even though it can significantly contribute to public safety. Cultural differences may account for less punitive public responses, or even harsher punishments. For example, a British study indicated that therapeutic interventions for sex offenders were more prevalent in European countries than in England and Wales. However, even the Europeans are shifting towards a more punitive approach since sexual offences have become a more serious problem in Europe. It was observed that prosecutors take the position that sex offenders are the worst offenders, as they are prone to reoffend, and therefore should be kept in jail indefinitely. As inaccurate as these views may be, they significantly affect public reaction towards sex offenders.

Historical Perspective

Addressing sexual paraphilias, it begets looking at how society has addressed this issue over the years. All societies through history have imposed boundaries or limits on the types of sexual behaviors regarded as acceptable, although changes in sexual beliefs may occur over time. It was observed that in, both, biblical Israel as well as ancient Greece there was a clash between religious and secular approaches; of which the religious were more associated with the moral

condemnation of sexual deviance while greater liberalism was displayed by the secular point of view. There are various factors that may indicate whether behaviors are to be regarded as sexually deviant. Amongst them are the degree of consent by the participants, the age of those involved, the nature of the sexual act and whether any distress or harm may occur. It was only in the nineteenth century that sexual deviance started to be regarded as a medical phenomenon, following the publication of *Psychopathia Sexualis* by Kraft-Ebbing. Dr. Emile Kraepelin, the famed German psychiatrist, further brought this topic to the academic attention when he wrote about a man with pedophilic tendencies. In the 20th century, treatment approaches leaned mainly towards psychoanalysis, relying on Freud's early theory of sexuality which remains as the basis of the psychoanalytic understanding of sexual deviance.

As our understanding of this topic began to strengthen, and more research and theories were developed, sexual deviance was perceived as a combination of biological and developmental factors. Presently, we differentiate between sexual lifestyle practices such as homosexuality or cross dressing which are both legal, and deviant sexuality which is unlawful and socially unacceptable, like pedophilia, which is punishable under the law. At present, the main view of paraphilias is that they are a form of impulse control disorders, or alternatively, are on the obsessional compulsive spectrum. Paraphilias may be associated with elevated risks for self-harm and others as there, indeed, are effective treatment modalities available.

What Is Legal and What Is Not

According to the *Diagnostic and Statistical Manual Disorder Fifth Edition* (DSM-5), or to the *International Classification of Mental Diseases* (ICD-10th), paraphilias are defined as sexual disorders which are characterized by recurrent, intense, and sexually arousing fantasies, urges or behaviors that generally involve various objects and actions. It may include non-human objects, causing pain or humiliation to oneself or one's partner, and sexually engaging with children or other nonconsenting persons. These instances may cause clinically significant distress or impairment in social or other important areas of functioning.

According to the aforementioned sources, eight specific disorders of this type include exhibitionism, fetishism, frotteurism, pedophilia, sexual masochism, sexual sadism, voyeurism and transvestic fetishism. The term itself comes from the Greek word 'philia', meaning love, and 'para' which means beside. People with what was termed as an exclusive form of paraphilia may not be sexually aroused by anything other than their paraphiliac imagery or behavior, though a person with a non-exclusive form may be aroused by other sexual fantasies, stimuli, and behaviors. Although, it is not uncommon to find that their paraphilias interfere with their overall sexual preferences. Most paraphilias tend to be chronic, lasting for many years if not a lifetime. Naturally, these desires and fantasies are not illegal *if kept internally*, but may lead to legal offences if acted upon. Below, we will define each of the major paraphilias as mentioned:

Exhibitionism: The person experiences recurrent, intense, sexually arousing fantasies regarding the act of exposing his (as it is mostly his and not her) genitals to an unsuspecting stranger. The onset usually occurs before the age of 18 and it tends to wane after age 40.

Frotteurism: Involves recurrent and intense fantasies and behaviors which are concerned with touching or rubbing against a nonconsenting person. Sometimes it can be seen on buses or trains, particularly if there are many people standing closely together. It seems to start in

adolescence and continues until approximately age 25, after which it declines in frequency, but may not completely diminish.

Voyeurism – Refers to the term denoting fantasies and sexual urges to observe a naked, unsuspecting person, or one disrobing and engaging in sexual activity. The onset is commonly before the age of 15. The voyeur will peek into windows of undressing women, use binoculars to 'spy' on them, and engage in various socially uncondoned behaviors to get his wish of seeing a woman disrobing or fornicating.

Fetishism – The person has strong urges and is sexually aroused using nonliving objects, like female underwear or shoes. It concerns mostly males and is usually only seen during adolescence. In my clinical practice, I met some fetishists who were sexually turned on by *used* women's underwear, and would thus steal them from clothes lines.

Sadomasochism – Becoming sexually aroused from giving or receiving physical or emotional humiliation to their partners or selves. This often splits into two categories: *Sexual masochism* involves sexual arousal from being humiliated, beaten, bound, or otherwise made to suffer. *Sexual sadism* involves acts in which the psychological or physical suffering of a victim is sexually arousing and exciting to the one that causes it. Sadism, at its most severe, may be further associated with rape which is seen to mainly represent an act of aggression.

Pedophilia – Sexual attraction to children 12 years or younger which may result in acting out those sexual urges. Pedophiles are considered those who are at least 16 years of age and are at least five years older than their victim. In at least 90% of cases, pedophiles are males. As pedophiles age and their sexual urges subside, recidivism rates decrease. Pedophiles may be sexually attracted to males, to females, or both. *Hebephilia, a subcategory of pedophilia,* is the sexual interest of males or females who are prepubescent or are adolescents, meaning older than 12 years. *Infantophilia,* on the other end of the spectrum, is used to describe individuals interested in children younger than five years. When acting on their urges, pedophiles may limit their activity to undressing the child and just looking, exposing themselves to the child and masturbating or touching and fondling of the child, including fellatio or cunnilingus by penetrating the child's vagina, mouth, or anus with their fingers, foreign objects, or penis and may use varying degrees of force to do so. It should be noted that child molestation is not necessarily synonymous with pedophilia, which needs to involve the adult's desire to imagine or engage sexually with a child, while child molestation may be committed by adults who are not pedophiles.

Sex Offenders

As we mentioned, not all paraphilias lead to criminal behavior, but those that do can range from mild to catastrophic. The diagnosis depends on the history of victimization and the number of victims, their age, and the degree of victimization, such as whether penetration was or was not involved.

The DSM-5 now distinguishes between paraphilias and paraphilic disorders, in an attempt to destigmatize non-normative sexual interests and behaviors from those that are, indeed, pathological in nature.

Deviant Sexual Interest

Deviant sexual interests, similar to paraphilic acts, are defined as an enduring sexual attraction to sexual acts that are illegal, such as rape, sex with children or acts which are highly unusual such as fetishism. Deviant sexual fantasies are those that contain acts of inflicting harm upon another person mostly in illegal fashion. When asked about the kind of fantasies they have, non-incarcerated individuals reported general sexual interests and fantasies to a larger degree than deviant sexual fantasies. Specifically, 94% of males in the general population report experiencing general sexual fantasies, while fewer than 2% of men report experiencing deviant sexual fantasies which may include raping or beating a woman, being raped by a woman, seducing a woman who pretended to resist, and other fantasies including bestiality, sadism, and transvestism.

Prevalence rates of deviant sexual interest among individuals who sexually offend varies based on the age and type of offender involved. Research found that 25% of sexual offenders, including child molesters and rapists, report deviant sexual fantasies. Deviant sexual interest is consistently identified as one of the best predictors of sexual reoffending amongst those individuals who sexually offend, though their general reoffending rate is low. It has been established that general sexual interest declines with age in men and that is for various reasons, including work related stress, relationship related stress, masturbation, pornography use, and a lack of attraction to one's partner. A study of sex, romance, and sexuality in older adults found that over 50% of adult males in their fifties experienced daily sexual fantasies, which dropped to 42% in their sixties, and to as low as 27% when they got older. While previous research found that sexual interest and sexual fantasies wane in older adulthood among the general population, no current research is available to shed light on why sexual interests and sexual fantasizing is reduced in older individuals who sexually offend.

Origins of Deviant Sexual Arousal

Dr. Worling conducted a thorough review of deviant sexual arousals which garnered a number of theoretical positions about the origins of these issues. Early theorists were heavily influenced by psychoanalytical concepts and viewed deviant sexual behavior as due to unresolved libidinal conflict and subsequent "fixations" throughout psychosexual development. This was hallmarked by Sigmund Freud who believed that fixations throughout the psychosexual stages resulted in diminished or unhealthy development. Not much research is available to validate this theoretical approach.

Other theorists suggested that the sexual attraction of prepubescent children may be the result of brain anomalies. In their review of the relevant research, a well-known sexual paraphilias researcher, Dr. Blanchard, explored pedophilic tendencies and asserted that variations in hormonal and brain functioning could be responsible for sexual arousal to prepubescent children.

Other theorists suggest that challenges in attachment may be linked to this phenomenon, as disruptions to the caregiver-child relationship may increase the risk of developing deviant sexual interests and behaviors. Early attachment to parental figures provides the child with a working model of his or her relationships with others. Disrupted attachments can, thus, influence various factors that are necessary for healthy sexual relationships such as

interpersonal intimacy, the ability to manage one's emotions, self-esteem, and empathy. Looking at deviant sexual arousal from a learning theory perspective, it was proposed that an accidental pairing of random stimuli with orgasm experienced by the pubescent boy could be responsible for subsequent deviant sexual interests. It was suggested that if the person continues to masturbate to fantasies related to the initial deviant sexual experience, it helps to further reinforce deviant sexual arousal patterns. Other researchers saw sexual victimization as responsible for such deviant sexual arousal.

Sociocultural influences may also have a significant impact on the development of deviant sexual arousal, especially in adolescents. For instance, feminist theorists pointed out that attitudes supportive of sexual violence against women are condoned in many cultures, and consequently, men in those cultures may develop rape-supportive attitudes and act on them. In Western culture, prepubescent girls are often sexualized and some have argued that this approach could potentially influence the development of deviant sexual fantasies and interests for some adolescents. In turn, it is worth noting what Dr. Worling concluded after his comprehensive review of these theoretical viewpoints. He asserted that "It is possible that there are different pathways to the development of deviant sexual arousal patterns among adolescents. Genetic influences, brain injuries, or prenatal hormonal anomalies may predispose some adolescents to develop sexual arousal to prepubescent children and/or sexual violence, whereas respondent and operant conditioning mechanisms may be responsible in other instances" (p. 39).

Factors Maintaining Sexual Offending

Researchers, Dr. Ward and Dr. Beech, proposed that deviant thoughts and fantasies, as well as deviant arousal, are dynamic risk factors which likely precipitate sexual offending. They suggested that deviant sexual fantasies and/or sexual interests heightened sexual arousal and resulted in sexual offending behavior. This can be shown in trends related to male testosterone production and sexual offending. Overtime, testosterone production in men begins to decline as early as their 40s. That is known to cause a decrease in their sexual arousal which subsequently lowers their proclivity to commit sexual deviant behavior. This, in accordance with other biological factors like cardiovascular disease, arthritis, diabetes, high blood pressure and reproductive organ cancers, further reduce sexual arousal and sexual offending behaviours.

However, issues related to attachment and empathy were found to be significant indicators of inappropriate sexual dispositions. According to the famed Canadian sex researcher, Dr. Marshall, the quality of our early childhood attachments is essential to the development of healthy sexual beliefs and attitudes in later adulthood. As research has shown time and time again, a secure parent-child relationship during childhood is the basis of developing healthy, loving relationships in adulthood. They added that adult loneliness is the result of disruptive parent-child relationships in childhood. Children who have strong attachment bonds with their parents were found to display warmth toward others, have fewer emotional problems, handle stress well, and be well regarded by those around them. On the other hand, children with disrupted or poor-quality relationships with their parents had markedly negative effects on relationships as adults. These children were found to become anxious or avoidant adults that experienced repeated social and intimate difficulties. However, Dr. Marshall observed that poor

relationships with one's parents did not necessarily doom the growing person to a life of loneliness or alienation. Positive experiences with others such as teachers, or caregivers, can offset the negative effects of such relationships. In Dr. Marshall's theoretical approach to sexual offending, vulnerability is a central feature in motivating males to offend sexually. People, mainly males, do not sexually offend unless they observe an opportunity to do so.

How Does Disruptive Attachment Influence Children?

Let's look at what Dr. Marshall believes occurs during adolescence. During that period, the youngster undergoes radical hormonal changes that, naturally, influences his behavior to become more aggressive and progressive with his sexual needs. A youngster who had poor attachment in childhood will be ill equipped to develop healthy attachments with their peers, potentially resulting in frustration and anger which can leave the boy looking for whatever may provide him with some relief and calmness.

People experience loneliness and vulnerability not only in adolescence but during adulthood as well. Loneliness in adulthood may arise from poor quality childhood attachments, which relates to the child being unable to form effective relationships to satisfy his yearning for intimacy. An adult who had rejecting parents will develop an anxious or avoidant relationship style, which basically comes to protect the individual from an expected rejection. These people will be unable to achieve satisfactory levels of intimacy and will experience loneliness which may result in aggression. Lonely adults tend to score higher on measures of hostility and aggression than those who have good, intimate relationships. It is quite clear, then, that poor parent-child relationships do not prepare the adult with the necessary skills to have appropriately intimate, satisfying, and effective relationships. As a result, they either avoid relationships or enter superficial ones characterized by the approach and avoidance of the other person. Such relationships which are obviously are not conducive to developing true intimacy, enhance their experience of loneliness.

When abusers fall into this category, the result often leaves them seeing others as objects to simply serve their sexual needs. As a result, sexual offending may follow. In one study, 86% of adult rapists reported having few or no friends due to great difficulties in relating to their classmates in as early as elementary school. They all perceived their parents as having neglected them, and other research has shown that violence was commonly present in these family households. Their fathers were typically drunkards and physically abused their children – leaving them not feeling loved, accepted, or protected.

Cognitive Distortions

Child sexual offenders and abusers are known to utilize cognitive distortions such as warped attitudes, thoughts or beliefs in order to help them justify their offences against children. Examples of offense-supportive beliefs adopted by this population are: that children are sexually autonomous beings who yearn for sexual contact; that only forceful sexual behavior is harmful to children (therefore, non-forceful sexual behavior is ok); that they are attractive and interested to learn about sexuality and that the adult could teach them by example to meet the child's perceived sexual needs.

Additionally, the offender believes that he is entitled to obtain sexual gratification. In these circumstances, adult victims pose a greater threat to restricting the offender from satisfying their sexual needs. Thus, child or underage victims may be chosen to reduce the likelihood of this occurring. Offenders against women also tend to endorse the following distortions: that women are dangerous and are also sexual objects who were created for their gratification. It was suggested that these distorted ways of thinking serve as frameworks which the offenders believe are the victims' desires and wishes. Such offenders interpret their victims' behavior as inviting, thus strengthening cognitive distortions about their victims.

The Various Sex Offender Types

Research has addressed the shared characteristics of sexual offenders. For one, neurological differences were found amongst these populations as magnetic resonance imaging (MRI) abnormalities were found in 60% of violent sexual offenders and in 22% of less violent sexual offenders. Additionally, dysfunctions with the prefrontal and cerebral cortex (which covers the front part of the frontal lobe) were found among sexual offenders.

Psychiatric characteristics of sexual offenders have also been described by several investigators. It was discovered that 93% of sexual offenders in treatment programs suffered a mental disorder which was mostly depression and/or psychosis. The high prevalence of alcohol/drug abuse is also common among sexual offenders. This is often coupled with increased rates of loneliness and personal distress with decreased empathy and emotional attachment. In addition to these attributes, other known characteristics of sexual offenders include emotional defensiveness, negative self-perception, and narcissistic self-focus. Most sex offenders are young, in their twenties, and single. White ethnic identities were observed three times more in sexual offenders than Latino ethnic identities. And lastly, a history of physical or sexual childhood victimization was a common characteristic of sexual offenders.

Drs. Young, Justice, and Erdberg were interested to find whether rape offenders differed from molesting offenders. Their sample included 246 participants who were receiving psychiatric treatment while in prison. Twenty-four percent of them had been convicted of a sexual offense. Among sexual offenders, 25% had been convicted of molesting and 75% had been convicted of rape. Consistent with previous research they found, rape offenders were more likely to have been convicted of high violence offenses other than sexual offenses, and in addition, were likely to have a history of murder. The intellectual functioning of molesting offenders were predominantly within normal range while rape offenders on average were scored lower. Rape offenders were typically found to be in the impaired range of their neuropsychological testing, indicating neurological challenges across a range of their cortical functioning. Particular dysfunctions were found in areas responsible for attention and learning related to working memory, flexible thinking, and self-control. Molest offenders did not show such impairments.

Psychological evaluations between the two samples found that rape offenders experienced distorted thinking and lower psychological attachment to others. Molesting offenders were found to be predominantly more logical with their thought processes, experienced a greater need for emotional attachment, and had greater feelings of emotional alienation.

Research showed that sexual offending was often an aggressive act. Studies examining sex offenders found that 51% of rape offenders had a history of juvenile offenses that were of such severity and/or frequency that they were incarcerated in facilities designated for young offenders. Thirteen percent of rape offenders had both juvenile and adult sexual offenses with 44% of rape offenders having been convicted of murder. This was further supported by research which examined the criminal histories of 572 adult male sexual offenders and found similar results. Researchers found that rape offenders had versatile offense histories, including substantial nonsexual and sexual offenses.

Molest offenders, on the other hand, tended to have offense histories related mainly to molestation, without other types of offenses. Thus, it was proposed that rape was deemed as an aggressive behavior which has sexual manifestations, whereas molestation may be a sexual behavior which brought about immature psychological development combined with feelings of alienation. According to this proposition, rape may mainly be associated with early learning related to child victimization, which motivated the child to commit antisocial acts, and created a limited need for the child to want psychological attachments. Furthermore, rape offenders experience difficulties with managing their emotions, impulse control, reasoning, and planning. In contrast, molesters are mainly characterized as exhibiting psychological immaturity and high feelings of inadequacy. Rapists do not have specific identifiable characteristics. They vary tremendously in occupation, education, marital status, and previous criminal record.

As such, it must be clarified that rape is a serious, traumatic event that often leaves its effects to persist for many years. Raped women continue to report fear, anxiety, self-esteem problems, sexual disorders and feelings of self-blame which is linked to poor long-term psychological outcomes for victims. Additionally, women often report damages to their physical health, with cuts, bruises, vaginal or rectal pain and bleeding as a result. Spouses or partners of rape victims also “pay a price” for their trauma when their relationship with the victim suffers, deteriorates, and may end.

‘Date rape’ is one that is committed while the victim is involved in a date or even a steady relationship. It mostly occurs on college campuses. Date rapes often involve slipping the drug, Rhoypnol, into a drink which leaves the woman feeling drowsy and sleepy. This vulnerable state allows the victim to be taken advantage of in their drug-induced slumber and be raped in the process. Additionally, the drug also causes the woman to experience complete amnesia as to what had happened – leaving no memory of the rape to exist.

Up to 13% of married women had been raped by their husbands, termed ‘marital rape’. This trauma is equally as severe to those who have been raped by a stranger. Research has shown a connection between marital violence and marital rape. Causes of marital rape span from feelings of anger, power, a need to dominate, sadism, or a desire for sex when the wife is unwilling to engage in it.

Intimate Relationships of Sex Offenders

Research found that the population of sex offenders (SOs), especially released rapists and child molesters, often struggle to maintain their intimate relationships through and after their time in prison. This is in contrast to single sex offenders which often refrain from dating due to their shame and insecurity, and are thus faced with various problems when attempting to maintain a

stable relationship over time. In 1989, Dr. Marshall, described sex offenders in his therapeutic work as "…rush(ing) into live-in relationships with women without giving much thought to their actual compatibility with their partner" (p. 497). He observed that having sex offenders with insecure parental attachment styles might lead to low self-confidence and empathy deficits, which then impede the offender in "…fully shar(ing) the emotional issues relevant to their partners" (p. 497).

Many sex offenders display an insecure attachment style which may hamper their expression of intimacy towards a potential partner. These empathy and intimacy deficits combined with the 'rushed-into' style of sex offenders' relationships could result in frustrated and dissatisfied couples. A study comparing 92 heterosexual incest offenders with a control group of noncriminal men, found that offenders almost doubled the number of married partners than control group participants. The incest offenders had undergone significantly more marital disharmony which included mistrustfulness, a lack of mutual friends and time spent together with their partner, and emotional instability in comparison with the controls. Another project which explored the relationships of sexually dysfunctional sex offenders and satisfied couples who had all been in the relationship before the sex offense occurred found that the sex offender couples had the highest levels of distress, conflict, and were not happy with their marriages. They often struggled with conflict resolution mainly due to their chaotic interactive patterns which made their interactions complicated, unpredictable, and stormy, accompanied by high levels of mutual aggression and withdrawal.

Another study on sex offenders' relationship focused on four groups of offenders: child molesters, rapists, violent nonsexual offenders, and nonviolent nonsexual offenders. It was found that the two sex-offending groups (rapists and child molesters) differed and scored lower on most factors (i.e., self-disclosure, expression of affection, sexual satisfaction, mutual empathy, and conflict resolution in intimate relationships) than did the nonviolent, nonsexual control group, but only rarely from the violent nonsexual group. The child molester, rapist, and violent groups scored significantly lower than the nonsexual, nonviolent sample. That could be explained by the child molesters' largely preoccupied attachment style. To conclude, research seems to have highlighted multiple deficits in sex offenders and their partners, including malfunctioning conflict management, empathy deficits, intimacy deficits, and a low level of affection expression.

Additionally, research from 2014 by Drs. Iffland, Berner, and Briken found that women romantically involved with sex offenders demonstrated high levels of relationship anxiety and vigilantly scrutinized their relationships to detect signs of rejection, as well as being unsure of how worthy they were of being loved. The sex offenders' intimate partners might tend to rationalize the sex offense and see it as concomitant with their belief that they do not deserve better. These researchers also found some interesting personality profiles in the sex offenders' partners; for example, sex-offenders in their sample were less neurotic, or irrational when compared with a nonclinical population. The combination of the offenders' *low* level of neuroticism with their partners' *high* level of neuroticism possibly serves as a stabilizing factor in the relationship since the men were able to balance out their partners' emotion. The sex offenders in their study also expressed very low interest in passionate sexuality and rejected sexually aggressive behavior in relationships. It is suggested that the female partners of these sex offenders might experience sexual aggression on the part of their partners, and thus, see it as a welcome sign that they have changed, improved, and are no longer dangerous. This attitude on the part of the female partners might have a stabilizing effect on the relationships. It is

interesting to note that both the sex offenders and their partners were satisfied with their sexuality in these relationships.

Public View of Sex Offenders

The term *sex offender* generally incites negative attitudes and stereotypes, and indeed in jails, sex offenders are usually at the bottom of the social ladder. The public holds such myths that sex offenders cannot be cured; that they are all the same and thus pose equal risk to society as their sexual assaults can encourage them to commit nonsexual crimes like robbery or violence. The reporting of sexual offense-related behaviors is habitually negative and often sensationalist which therefore contributes to the reinforcement of public feelings of repulsion and hostility towards them. Upon their release from jail, sex offenders face disintegrative shaming and further ostracization from the public. Even among professionals, we can see that sexual offenders face harsher and more restrictive treatment options as far as the public is concerned. A study which performed a meta-analysis of 80 treatment versus non-treatment groups (involving over 22,000 offenders from the USA, UK, Canada, and various German-speaking nations), concluded that treatment does have a positive impact on sexual recidivism. This research found hormonal medication and Cognitive Behavior Therapy (CBT) as being the most promising treatment types. Moreover, the best results were related to the voluntary participation of sex offenders in the treatment programs. A 2011 study by Drs. Rogers, Hirst, and Davies set out to investigate how the public views sex offenders, the treatment that they receive, and chances of rehabilitating them. This compared the attitudes of male and female forensic professionals towards sex offenders and found that males held fewer negative attitudes towards sex offenders than females. Similarly, these gender differences in attitudes towards this group may not be confined to just the general public. These trends can be interpreted that as sexual offenders are predominantly male, men are more likely to identify with and less likely to blame offenders for their criminal activity than are women.

Does the age of the victim make a difference in the way sexual offenders are viewed? Research found that a male CSA (child sexual abuser) perpetrator was blamed more by members of the public when his victim was depicted to be a 10-year-old child compared to when he offended a 15-year-old. As we know from media reports, prison officers, and other non-sex offenders, view child sex offenders to be more immoral than those who sexually assault adult women. Interestingly, men's attitudes towards sex offenders were dependent on a victim's age while women's attitudes were not. This may be attributed to people, especially women, deeming the sexual assault of (younger) children more abhorrent than almost any other type of crime.

How Does the Public View Rehabilitation?

Sex offender treatment has been repeatedly found to be effective in reducing recidivism among sex offenders. Whilst higher risk offenders may not wish to complete treatment programs, those who do successfully complete those offered treatment options pose less risk of reoffending. Overall evidence suggests that if not to cure, sex offender treatment programs have at least

some positive impacts on reducing recidivism or reoffending rates. Public attitudes toward these programs found that most of the public believed in the help that the programs may offer, with most believing that treatment offered in prison (71% of the sample) or in the community (65%) is effective in reducing recidivism. Although, in addition to receiving therapeutic help, the public also wants sex offenders to be punished, via incarceration.

Stigmatization of Sex Offenders

Sex offenders are stigmatized by society at large, by professionals, and in the jails where they serve time for their offences. Corrections scholars have noted that more sex offenders have been incarcerated in Canadian and American prisons since the early 1990s. In fact, more recent American statistics indicate that sex offenders (SO) make up 15% of the jail population.

The status of the ex-offender has been described as one of the most stigmatizing statuses in Western societies. However, what is even more stigmatizing is the status of SO that views the offender as one who victimized women or children. Beyond being criminals, SOs were perceived, by lay people, as monsters deserving no respect, tolerance, nor acceptance in society. That stigmatizing label inflicted on persons convicted of sexual offences is magnified by SO registries and community notifications about released sex offenders.

Stigma

A stigma signifies severe censure or condemnation that is attached to an individual with a characteristic that is considered a negative one. In consequence of this “branding,” these individuals are viewed negatively as inferior, dangerous, or less than human. A stigmatized person is devalued socially. This process of being labelled publicly influences an individual socially, and consequently limits the rehabilitative potential of incarcerates during and post release from prison.

Inside Correctional Institutions: The Effect of the Stigma

Professionals and other prisoners in the prison environment largely have very negative attitudes toward SOs. It appears that correctional officers, psychologists, and other inmates, as well as police officers, have even more negative attitudes toward SOs than probation officers, and other prisoners. Correctional officers held the most negative views of SOs. And although one study found that police officers had the worst views of SOs, paraprofessionals and professionals felt that their practices were most affected by such stigmas, and thus tried to stay away from seeing SO clients. It may be surprising to us, but rapists (themselves despised by other inmates) are slightly higher in status than pedophiles and those who victimize children. Sex offenders are, commonly, outcasts among inmates and may suffer violence directed at them while in jail. As such, they are perceived to be legitimate targets for robberies, victimization, and harassment. Given the vulnerable status of SOs in prison, some SOs try to pass themselves off as robbers, thieves, and those convicted on violent charges to appear more ‘solid’ and get more approval

from other inmates. Sex offenders often became vulnerable in the jail system once their charges became known to other prisoners, and experience ongoing threats of victimization. Aside from this, sex offenders are also often penalized within these environments. They are excluded from prisoner groups and culture and, consequently, lack social support, relief, and friendship, thus intensifying their loneliness and social isolation. That stigma and loneliness act as a barrier to SOs acquiring or freely seeking needed treatments during their incarceration.

In 2013, a study published by Drs. Ricciardelli and Moir sought to explore the prison life of sex offenders in Canada. They interviewed 56 Canadian men on parole after they had served federal prison terms. They were aged between 19 and 58 years, with a mean age of 37. They were mindful of the hierarchy that exists among incarcerated men where different crimes were more positively or negatively stigmatized, and thus, dictated where the men stood on this hierarchy. "Solid" charges, such as imprisonment for armed robberies, drug trafficking, murder, and organized crime, earned the men a higher status than those whose victims were either women or children, including charges of rape, sexual interference and child pornography. These men occupied the lowest rungs of the social ladder in jail. They were often demonized, disrespected, condemned, and viewed as "evil," and the stigma of sexual charges takes precedence over any seemingly positive qualities that they may have. For instance, should a prisoner live on a range for a while (months or years) before his sex-related offences are exposed, he will be treated as any 'regular' inmate. But once his charges are exposed, he must immediately leave the range, which is the area where the inmates live, or he will be victimized – often by the people who only minutes earlier were his acquaintances or even friends. Consequently, even if a 'regular' inmate befriended a sex offender, it is likely that the other inmate whom he befriended will ignore him for fear of acquiring "courtesy stigma" which affects one's social status within the prison system due to their connection with the stigmatized individual. The stigma erodes and destroys any social resources the SO may try to create and utilize, and thus the stigma is reinforced, and its effects deepen.

Violence is present in most correctional institutions, and SOs are more threatened and vulnerable than 'solid' inmates. Beyond existing as the dregs of prison society, they are usually taunted and physically harmed by other inmates with their canteen or personal goods stolen. These factors further contributed to their social withdrawal, isolation, and loneliness in prison. Drs. Ricciardelli and Moir concluded that "…the stigma surrounding SOs has multiple effects: (1) it creates a virtual social identity that erases all positive characteristics of the SO's actual social identity; (2) it prevents other prisoners from associating with the SO due to a courtesy stigma; and (3) it is reinforced by a systemic stigma rooted in PC or the prisons that are known to house SOs. This stigma is evident in the position of SOs in the prisoner prison hierarchy" (p. 376).

Offenders of Child Sexual Exploitation Materials (CSEM)

While in the early 2000s, Child Sexual Exploitation Materials (CSEM) offenders were a relatively unknown group of offenders, their number has increased steadily in the past decade. CSEM offenders are now much more known to police, community supervision officers, and treatment providers who deliver sexual offender programs. The downloading and possession of CSEM is a frequently identified form of child sexual abuse.

What Motivates CSEM Offenders?

Theoretical models which aim to understand CSEM sexual offensive views see it as an interaction between motivational and facilitative factors. Motivational factors include problems in the sexual domain like a high sex drive, sexual preoccupation, and atypical sexual interest such as pedophilia and antisocial tendencies (which cause the person to disregard societal norms and the safety of others while being unable to experience remorse and impulsivity). It was suggested that problems in the sexual domain provide a motivation for sexual offence, and antisocial tendencies are needed in order to move the motivational state into a behavior. It was also found that a higher sex drive and use of sexual fantasies involving children were associated with CSEM offending behavior, whereas antisociality was a predictor of behaving inappropriately against children; more so than CSEM offending which did not necessarily require antisocial tendencies.

Internet Access

CSEM-exclusive offenders tend to have greater access to the Internet, relative to mixed offenders and SOC. That highlights the point that criminal behavior requires motivated offenders, available victims, and a lack of supervision. The Internet is largely unregulated and thus provides both conditions (i.e., victim opportunity and a lack of supervision) for motivated individuals to view CSEM. Although, CSEM-exclusive offenders often have little or no access to children, much less than that of mixed offenders and contact sexual offenders. It can thus be concluded that access to children is a key factor that is considered in police case prioritization.

The Thoughts and Beliefs Experienced by CSEMs

Offense-supportive cognitions are typically defined as attitudes or beliefs that support sexual offending against children. Evidence indicates that attitudes tolerant of sexual offending predict future sexual coercive behaviors. CSEM offenders exhibit distinct cognitive distortions which enhance their belief that their behaviors are acceptable and non-harmful. In fact, Drs. Bartels and Merdian analyzed, in 2016, the existing CSEM research and proposed five implicit theories:

- “Unhappy world” (believing the world is a dejected place and that individuals are uninterested/rejecting)
- “Children as sexual objects” (the belief that children are objects that can be used to meet one’s sexual needs)
- “Nature of harm (CSEM variant)” (believing that CSEM use is not harmful and/or that the behavior in CSEM is not harmful)
- “Self as uncontrollable” (believing that one’s character/behavior is stable, unchangeable, and uncontrollable); and

- "Self as collector" (belief that one's self-concept and social status is dependent upon the possession of certain objects) (in Babchishin, Merdian, Bartels, & Perkins, 2018, p. 132).

Sexual Arousal and Use of CSEM

Sexual arousal is thought to play an important and facilitative role in CSEM offending, but we lack research in this area. Sexual arousal, just like thirst or anger, is a visceral, or from the gut, state that can negatively affect self-control and decision-making. In other words, sexual arousal focuses one's attention on sex-related stimuli and boosts one's willingness to engage in sexual behavior. This can cause people to ignore considerations that would normally prevent them from engaging in an activity that satisfies the visceral state and seek immediate gratification regardless of the consequences. Some CSEM offenders have progressed from viewing legal pornography to viewing CSEM, which is illegal. This escalatory process is powered by the visceral effects of sexual arousal. This process involves a person who becomes sexually aroused by viewing legal material, and thus, may be more willing (or less able to control the urge) to click on risky "pop-ups" or search for more deviant material. Such material may include young children or more violent videos. Without realizing the consequences of their actions, Child Sexual Exploitation Material offenders have also reported a sense of losing control when using CSEM, and were found to utilize maladaptive coping strategies for avoidance and distraction.

However, not all CSEM offenders are alike. There are those CSEM whose use is driven by a desire to engage in sexual contact with children (referred to as contact-driven) and those whose CSEM engagement remains manifested in the online context with little intention to get engaged with children (referred to as fantasy-driven). Some CSEM offenders may engage in sexual fantasies about children but realize that it is morally unacceptable and will not act on it. These individuals would be expected to fall within the fantasy-driven distinction of CSEM offenders. A key motivator for contact driven offenders is having an opportunity for direct sexual contact with a potential victim. They may also show some degree of stability in criminal behaviors, such as having past criminal records, unreported intimate partner violence, and a lack of insight into the harmfulness of their actions, which may be an indication of antisocial lifestyle.

Treatment Approaches That May Help CSEM Offenders

Child Sexual Exploitation Materials offenders present risk profiles and treatment needs that are different from contact sexual offenders. Unfortunately, there is relatively little literature on treatment programs tailored to CSEM offenders. The available literature indicates that programs following the Risk, Need, and Responsivity (RNR) principles are the most effective at reducing reoffending. Those treatment programs provide help to the highest risk offenders (Risk) to target criminogenic needs (Need), and are delivered in a manner suited to the offender's culture and their ability to learn and absorb (Responsivity).

As such, Dr. Gillespie and colleagues examined, in 2016, the effectiveness of a community-based treatment program for CSEM offenders called "Inform Plus Treatment" which

acknowledged CSEM offenders. The "Inform Plus" content was delivered in 10 group sessions, and included:

1. Offense analysis
2. The role of sexual fantasy in sexual offending
3. Addictions and compulsions
4. Disclosure, social skills, and relationships
5. Criminal justice information
6. Victim empathy; and
7. Lifestyle change and future planning (p. 138).

Examining change following treatment completion among 92 CSEM offenders, the program described above was found to improve affective and interpersonal functioning with reductions in distorted attitudes in this sample.

In turn, sexual offense treatments are believed to contribute to reductions in recidivism for some individuals. But what are the principles upon which effective treatment rests? Interestingly, certain program features such as a therapeutic group climate, a sense of responsibility and hope that the group instills group cohesiveness have been associated with positive therapeutic change in clients participating in sexual offense treatment. This is not surprising since these are the corner stones of psychotherapy in general. Some therapist's characteristics may also have influence on the client's participation and engagement in the treatment program. Among them are the therapist's ability to demonstrate genuineness and warmth, model appropriate self-disclosure by talking about him or herself in a therapeutically appropriate manner, and reward prosocial behaviors (behaviors which are not antisocial and are condoned by society). Establishing and maintaining therapeutic alliances are critical features of effective sexual offense treatment programs, regardless of treatment modality. Clients' characteristics, such as psychopathy, denial/minimization, intellectual or learning difficulties, and offense type, are associated with high rates of treatment attrition, or refusal, to engage in treatment to begin with.

Intervention Approaches

After formulating an understanding of the nature and purpose of a problem behavior, clinicians need to develop intervention techniques for managing and reducing the impact of these factors. This requires an understanding of the client's possible difficulties and problem behaviors whilst also recognizing the context and environment in which those behaviors and problems occur. This is because offenders are likely influenced by these environments which harbor such behaviors and may become detrimental if they return to it upon their release from jail. Goals and interventions developed to address each type of need will vary with the intended function/effect of that problem behavior. At times, client depression may interfere with their attendance or engagement in treatment, which of course needs to be addressed. Overall, when developing intervention techniques, we need to consider, aside from all the above, also the clients' abilities, strengths, and weaknesses, and the style and characteristics of the clinicians offering that treatment.

The general public is particularly alarmed and concerned about sexual crimes, and media coverage of it is often emotionally laden. However, most sexual offenses are not so serious that they justify lifetime sentences, especially since there are also increased attempts to prevent reoffending through correctional treatment. Germany took that approach quite seriously and introduced reform of the penal law in 1998 to introduce mandatory treatment for sexual offenders who received a prison sentence of more than two years. As such, a review of various treatment approaches observed that treatment methods which demonstrate consistent and significantly positive impacts were ones that helped change the way offenders thought and later justified their unacceptable and unlawful behaviors.

Treatment of Paraphilias

Early treatment of paraphilias can be traced back to the late nineteenth century. Initially, treatment approaches focused on surgical castration, which was first used in Switzerland in 1892 for a patient with hypersexuality. Castration was known throughout history with early origins beginning in Greek mythology, and even auto-castration in the early days of Christianity as a punishment for sex crimes. It was also routinely used to produce eunuchs in Eastern harems, and to produce operatic sopranos in Italian boys, prior to the 18th century. While in the U.S., sexual castration was used in the beginning of the 20th century, as well as in certain European countries such as Germany, Switzerland, Denmark, Norway, and the Netherlands.

The effects of the surgical castration resulted in a significant reduction of sex offence recidivism.

Since the 1970s, surgical castration in Europe has been discontinued except in Germany, while in the UK it was never embraced. In post war West Germany, there was some use of neurosurgery, which like castration, is irreversible. And by the 1940s, several attempts were developed to try and treat sex offenders by medical methods like using estrogens, but was ultimately replaced by anti-libido oral medication to reduce testosterone levels which minimized offenders' interest in sexual activity. This was largely due to the feminizing effects of estrogen in these treatments. And unlike surgical castration, the effects of antilibido medication are reversible when discontinued. There are also injections that can reduce one's testosterone to very low levels and thus contribute to very low levels of recidivism.

Some evidence has also suggested that the use of selective serotonin reuptake inhibitors (SSRIs) can reduce male libido, as almost any psychotropic medication seems to do, and thus reduce interest in sexual activity. While medication may be the treatment of choice with sex offenders, it must be accompanied, according to recent research, by psychotherapy or cognitive behavioral therapy. An optimum formula for the treatment of paraphilias may well be a combination of cognitive behavioral therapy and antilibido medication administered in a dynamic psychotherapeutic framework.

Group Therapy

A 2017 paper by Drs. Jennings and Deming described an exhaustive review of various treatment programs for sex offenders, and concluded that after Freudian psychotherapy, oral medications, and injections, there has been a surge of interest and empirical research in sex

offender–specific group therapy and therapeutic factors. Their review included 48 studies and 55 clinical/practice articles that addressed group intervention with sex offenders. The researchers highlighted three clear conclusions of what was important in applying group therapy intervention for sexual offenders: the therapist's qualities of warmth, empathy, encouragement and guidance; the quality of group cohesion, or togetherness; and the encouragement of non-confrontational approaches in group therapy. It was found that sex offenders often preferred group over individual therapy.

Treatment Effectiveness

While there are treatments aimed to help sex offenders, the overall effectiveness of treatment remains unclear. Against a slew of studies that show promising results are those that are skeptical. A 2017 meta-analysis conducted by Dr. Soldino and Dr. Carbonell-Vayá indicated that amongst the three types of recidivism by sex offenders (the sexual, the violent, and the general), recidivism rates of treated sex offenders were lower than those observed in the treatment of non-sexual offenders. The high rates of general recidivism observed (49.31%) might be due to the importance of the combination of the antisocial characteristics of these individuals with sexual deviation as precursors to sexual offending. Consequently, it was suggested by the authors that if we want to reduce recidivism of sexual offenders, we should work on reducing antisocial characteristics in addition to sexual deviations in sex offenders. The effectiveness of psychological treatment in reducing recidivism in sex offenders has been evaluated and debated over the last four decades without a clear answer.

To conclude, a meta-analysis examining rates of recidivism in treated sex offenders found a reduction of recidivism in this population. It was demonstrated that there are successful interventions for adolescent and adult sex offenders. These findings offer support for existing strategies that strengthen advocates' request for their continuation and expansion. Specifically, they noted that the treatment of adolescent sex offenders is preferable and more successful than those offered to adult sex offenders. Apparently, the American Medical Association (AMA) is opposed to physicians participating in surgical castration or engaging in medical practices that serve to punish rather than treat sex offenders. There are also concerns about whether the treatments violate offenders' human rights. In addition, the most recent data that is available suggests that community-based treatments compared to institutional treatments have a larger effect in reducing recidivism.

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> A typical macho man married a typical good-looking lady, and after the wedding, he laid down the following rules. "I'll be home when I want, if I want, what time I want, and I don't expect any hassle from you. I expect a great dinner to be on the table, unless I tell you that I won't be home for dinner. I'll go hunting, fishing, boozing, and card playing when I want with my old buddies, and don't you give me a hard time about it. Those are my rules. Any comments?" His new bride said, "No, that's fine with me. Just understand that there will be sex here at seven o'clock every night, whether you're here or not."

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Chapter 11

Sexual Variations: It's Different, But Not Always 'Bad'

> Jim, 34 years old, walked into my office clearly looking troubled by something that I had not known at the time. I thought to myself: he is working at his father-in-law's company, getting a good salary, and is married to the woman that he loves. So, I wondered, what is the problem?! However, looking at how tense Jim appeared, it was clear that the issue deeply bothered and disturbed him. Apparently, last week, while looking for something in their bedroom, his wife discovered three used pieces of underwear which did not belong to her in his drawer. She confronted Jim that evening, and learned of his fetish that she was completely unaware of until that moment. Jim, in addition to their sexual activities, used to also masturbate and could orgasm only if he rubbed his penis with the used underwear of a woman. To get those articles, he would steal them from cloth lines. During one instance, a woman spotted him and left him waiting to see whether the police would come knocking on his door. We had to address his anxiety and stress, the marital situation which involved an angry and shocked wife, and prepare for a possible legal case (which, it turned out, never came). Jim was in therapy for over a year, and between his wife's support and my guidance, he was able to express his fetish appropriately and without breaking the law.

The term paraphilia comes from the Greek 'para' meaning besides, and 'philia' meaning friendship. It is used to describe a sexual arousal to objects, situations, or non-consenting individuals, which are commonly not part of the usual sexual interests. It was estimated that there are, at least, 547 different paraphilias; most of which are apparently rare. Eight paraphilias usually come to clinical attention and are also mentioned in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) which include: Pedophilia, Transvestic Fetishism, Exhibitionism, Fetishism, Voyeurism, Sexual Masochism, Sexual Sadism, and Frotteurism. Although some paraphilias are legally defined as sexual offenses (take for example, Exhibitionism, Frotteurism, Pedophilia, Voyeurism, or Rape, which is referred to as Paraphilic Coercive Disorder), others may have some aspects of the paraphilic activity that *may be* illegal, dependent upon issues of consent, such as Sexual Masochism or Sexual Sadism.

The word paraphilia is often translated as "beyond typical love" or "abnormal love." However, defining what 'typical' or 'normal' love is, becomes complicated since sexual normalcy is culturally relative. For instance, in the Western world, it is now the consensus of the medical and psychological communities that homosexuality is but a normal variation in sexual behavior. It is seen to occur on a range spanning from heterosexuality to asexuality, with many variations in between. Since culture has such an important part in defining sexual normalcy, other locations like some parts of Africa and the Middle East, see certain types of love as irregular or even sinful. For example, homosexuality continues to be seen not only as an illness but as a "crime against nature" which may involve severe, even deadly, punishments. The age of sexual consent could also illustrate how sexuality is culturally related. Sexual consent in some countries is as low as 12, but in others, as high as 21. Consequently, the same sexual act may be viewed as legal and acceptable in one place, or illegal and punishable in

another. When discussing this topic, it is useful to distinguish between having a paraphilia and having a paraphilic disorder. A paraphilia is merely an unusual sexual interest that is relatively harmless and may not require any treatment. A paraphilic disorder, however, includes persistent patterns of behavior which are distressing to the individual and may perhaps disturb him (it's usually 'him') from establishing a satisfying sexual or romantic relationship. This may lead to more serious acts, as it could involve the victimization of others. Non-normative sexual interests are only considered pathological if acting on them causes some harm to others.

A clear distinction between paraphilias and paraphilic disorders is necessary since individuals may have unusual sexual desires that are consensual, harmless and are not harmful to others; thus, making it legal if they are consensual.

It is theorized that certain hormones, such as testosterone, and serotonin (a neurotransmitter which is a chemical messenger that carries, boosts, and balances signals between neurons in the brain), are associated with paraphilic interests. Research has found that medications that alter the balance of these chemicals in the body can effectively reduce paraphilic desires. Learning theory, which postulates that we learn as we grow or are conditioned to behave and to feel excited by certain events, has been seen as a possible explanation to the development of several paraphilias through conditioning, which may explain the wide use of behavioral therapy in treating paraphilic disorders. Psychologists also believe that when people's characteristics and personality are not conducive to establishing functional relationships, they may resort to paraphilic preferences. Additionally, poor interpersonal skills are also known to be linked to developing paraphilias. Thus, it seems that the more problems people have with interacting with others, the more likely they are to have unusual sexual interests. Sexual arousal has also been found to contribute to the development of paraphilias, as arousal was shown to override 'disgust' impulses usually experienced by the majority of the population. That is, during intense arousal, some things that we may normally find unpleasant or disgusting do not seem quite as offensive and, instead, may be perceived as pleasurable. A novel study by Dr. Borg and Dr. Jong, two sexuality researchers, illustrates this phenomenon. In this study, heterosexual women were randomly assigned to watch either (1) a sexually arousing film, (2) an emotionally, but not sexually arousing film (like a film depicting people skydiving and rock climbing), or (3) a neutral and non-arousing video. Following the viewing of the videos, the women were asked to perform a task that most people would find quite disgusting. They had to put their hand in a bowl full of what appeared to be used condoms. The researchers found that those who were sexually aroused after watching the movie were most willing to attempt the disgusting task and felt the least disgusted by it. Two other researchers conducted a study with heterosexual men who were asked to rate how sexually attractive they found 20 different stimuli to be. They were shown women's shoes, a woman urinating, and having sex with an animal. Participants rated each stimulus twice: once while unaroused, and a second time while masturbating. Just like the previous study results, sexual arousal reduced disgust, and a whopping 19 out of the 20 stimuli in the masturbation condition were found more desirable by the aroused men than by the non-aroused ones! These findings could illustrate how some people are able to incorporate what would be considered disgusting things into their sex lives. If, indeed, high levels of arousal change our judgment as to what is and is not disgusting for us, it may enable us to try things we might normally stay away from, and thus develop all kinds of unusual interests.

Research clearly pointed out that overwhelmingly, paraphilias are more common among men than they are among women. We still do not know the reason for that gender difference, but hypothesize that it may have something to do with women's supposedly greater erotic

plasticity. If, indeed, men's sexuality is more "fixed" than women's, that could clarify men becoming oriented on a specific sexual interest and be less open to changing that fixation. Paraphilias are characterized by a clearly deviant manner of sexual gratification, which commonly may include arousing thoughts, fantasies, urges, or the suffering of others such as children or non-consenting individuals. In that situation, the person is sexually aroused in response to this deviant activity. Such thoughts, feelings, and behaviors usually cause a significant amount of distress or even impairment in the functioning for the individual. Paraphilias commonly begin during adolescence, regardless of ethnicity or socioeconomic status. It was estimated that approximately 58% of sex offenders had paraphilias.

Clarifying Paraphilic Terminology

Let's start with defining the terminology related to paraphilias since they are multiple. 'Sexual deviance' was the term which was used to describe behaviors that went against the norms of society, including early judgements placed upon common behaviors such as masturbation, premarital sex, or oral sex. Since the term 'deviance' acquired negative connotations, it was changed by '*perversions*' meaning a 'wrong' behavior, which was then stigmatized. In 1924, the term '*paraphilias*' was coined, instead of perversion. There are, apparently, up to 250 different paraphilias, including necrophilia (sexual interest in dead bodies), zoophilia (interest in sex with animals), klismaphilia (love of enemas) along with various 'isms', like fetishism, sadism, masochism, and what the entertainer Bill Cosby is said to suffer from which was termed Somnophilia, or getting sexually aroused by sex with a sleeping woman. In 1948 the term '*variations*' instead of paraphilias was introduced. In a 1980 study on sexual variations such as fetishism, sadomasochism, and transvestism, they minimized the emphasis on pathology and abnormality and indicated that those types of sexual behaviors were not necessarily problematic for the individuals involved in them.

How Prevalent Are the Various Paraphilias?

As we indicated earlier, paraphilic behavior is found more often in men of all ethnic and socioeconomic groups, and among all sexual orientations and identities. Dr. Joyal and Dr. Carpentier researched a sample of 1,040 men and women aged 18-64 years old from the general population in 2017 to further explore this topic. They found that overall, more men than women had experienced a paraphilic behavior at least once in their lifetime and were more interested than women to actually engage in a paraphilic behavior. Their findings indicated that men, more than women, experience and desire voyeurism and frotteurism, whereas women showed significantly higher rates of masochistic experiences and desires. Let's look at some specific paraphilias.

Zoophilia – is sometimes referred to as 'bestiality,' and involves deriving sexual pleasure from animals. True zoophilia is not diagnosed after a single sexual encounter with an animal, but is seen as only when the individual prefers animals as sexual contact regardless of what other sexual outlets are available. While Dr. Kinsey and his research group reported that about 8% of the men and 4% of the women they surveyed had experienced at least one sexual contact

with animals, it was noted that the frequency was much higher among those reared on farms. Of that group, up to 17% of men had such contact, though these activities accounted for less than 1% of their total sexual activity. A 1980 study found that 5% of men had fantasized about having sex with an animal, though the researchers did not indicate how many men actually realized that fantasy. Zoophilia may start during adolescence when a male may penetrate an animal or have his genitals licked by one. Females are more likely to have contact with a household pet, such as having penetration, having the animal lick their genitals, or masturbating the animal.

Sleeping with the Dog …

The following real-life story illustrates that not everyone who engages in a behavior which is not practiced by most, is necessarily a pervert, or in this case, is even attracted to sexual activity with animals. I interviewed a woman, let's call her Jane, who was in her late seventies, relatively healthy, and was 'full of life'. She was involved in a long-term relationship that may have lacked sexual intimacy, touch, and closeness in her later years. The woman told me that some years earlier, she went overseas to visit her friend who was a widow and lived alone with her dog. Jane advised that she usually slept naked and so she did when she retired to her bedroom in her friend's home. In the middle of the night, she felt the friend's dog crawling underneath the cover snuggling up to her. However, rather than staying beside her, the dog approached her vagina and started to lick it, as if it were trained to do so. The woman enjoyed the experience tremendously, and thus pretended to sleep while the dog helped her reach orgasm "better than a man could do." She never repeated that experience.

Contrary to earlier beliefs, and in line with what is described as a paraphilia rather than a paraphilic disorder, those involved in sexual acts with animals, usually, do not prefer it over sex with a human, but do so in addition to their regular sexual activities, just like it was the case with Jane. One study found that half of those who had a paraphilia were in a committed relationship with a human partner. Another study of 114 who identified themselves as having zoophilia examined their sexual interest in animals. Results, quite unexpectedly, indicated that more than nine out of every ten Zoophiles were concerned with the welfare of the animals, and perceived sex with the animals to be an extension of their love for them. Understandably, sadism towards the animals was expressed by these men in less than 1% of the cases. Three study participants made the following comments: "My relationship with animals is a loving one in which sex is an extension of that as it is with humans, and I do not have sex with a horse unless it consents. Although I do get an erection when interacting sexually with a stallion, my first priority is always the animal's pleasure, erection, and personal affection to me." "Humans use sex to manipulate and control…Animals do not judge you. They just love and enjoy the pleasures of sex without all the politics." Dogs (63%) and horses (29%) were the most favorite animals for zoophiles, followed by sheep, cats, cows, and chickens. The researchers suggested that sexual activity with animals is so enticing to these people since it is usually immediate, easy, and intense, thus reinforcing the behavior.

Frotteurism

Frotteurism involves recurrent, intense, sexually arousing fantasies, sexual urges or behaviors involving touching and rubbing against a non-consenting person. That behavior commonly occurs in crowded public places like buses or trains. About 10% of those with a paraphilia have engaged in that behavior, which commonly started in early adulthood.

Research from 2017 indicated that approximately 32% of males and 21% of women reported experiencing frotteurism at least once in their lifetime. Men who engage in frotteurism rub their clothed penis against a woman's buttocks, pubic groin, thighs or may rub his hands also on her breasts; clearly a serious sexual and unlawful imposition on an unwilling woman. It was found that frotteuristic disorder often occurs with other paraphilias, especially exhibitionism disorder and voyeuristic disorder. Victims of frotteurism are usually females, and sexual contact commonly occurs from the rear. In Japan, it was found that up to 70% of high school females reported having been groped. While in North America, approximately 30% of the general population (mainly men) have committed acts that would qualify as frotteuristic, which in some cases, may progress to more serious and dangerous offences such as rape.

Hypersexuality

Hyper, overactive, or frantic sexual activity includes nymphomania and satyriasis which both involve extraordinarily high levels of sexual activity and sex drive in women and men respectively. In extreme conditions, it can consume the person's entire being and cause an endless search for sexual activity. It should be noted that it is difficult to define what an abnormally high sexual drive or behavior is. Consequently, some prefer the term hypersexuality rather than the labels described above to refer to an excessive and insatiable sex drive in either gender. Such a disorder often leads to compulsive sexual behavior which is never truly satisfying and may seriously impair other areas in the person's life. At its extreme form, the person desires more and more sex to the point where it overshadows all other concerns, interests and daily activities. The hypersexualized person is commonly not satisfied by sexual activities, and may be facing difficulties reaching orgasm – thus, resulting in a cycle of disappointment and frustration. In a study on hypersexualized people, they were found to achieve about eight orgasms per week, spending approximately one to two hours a day in unconventional sexual activity that usually started around the young age of 19. The most common behaviors referenced above include: compulsive masturbation (which 67% of the sample engaged in), long-lasting promiscuity (56%), and significant dependence on pornography (41%). The most common paraphilias among this group were exhibitionism (35% of those with a paraphilia), voyeurism (27%), and pedophilia (25%).

However, the definition and description of hypersexuality which was provided above does not apply to women. This is because women with anorgasmia may simply yearn for an orgasm and engage in high frequencies of sex in their attempt to relieve their sexual tension. This experience may also be conflated with women's ability to experience multiple orgasms during a sexual session, which would confuse the count of orgasms reached per week as a way of defining hypersexualism.

Asexuality

There are two extreme ends to the extent of human sexual expression. Those who are hypersexualized and desire frequent sex, and those with hyposexuality who may not even be interested in sex at all. Most people are somewhat on that range between hyper and hypo sexuality, and the next section will focus on those who are not interested in sex. For example, catholic priests are traditionally celibate, although for the past two decades, we are becoming aware of their desire for touch and sexuality, whether by committing sexual acts with adults, or with children. That indicates that while they may not have sex, they may indeed desire it, and thus are not actually asexual.

'Jay' is a self-identified asexual who defined it as "someone who does not experience sexual attraction. Unlike celibacy which people *choose*, asexuality is an intrinsic part of who we are." Accordingly, asexuals may, indeed, experience attraction to others, though they are not *sexually* attracted to them. In one research, male respondents were asked various questions about attraction to others or lack thereof. The researchers found that 1% of males and females indicated that they were asexual. Results from another study, in Australia, found that 0.2% of men and 0.6% of women described their sexuality as asexuality out of a sample of 9,729 men and 9,578 women aged 16-59. Those who described themselves as asexual were more likely to be female, religious, have short stature, attained a low education level, were from a low socioeconomic status, and complained of poor health. Consequently, the researcher suggested that based on these results, asexuality is influenced by both biological and psychosocial causes. In 2007, sex researchers Dr. Prause and Dr. Graham recruited 41 self-identified asexuals and compared them to 732 university students. The asexuals from that study reported significantly lower desires for a sexual partner, lower responses to sexual stimuli, and lower inclinations to engage in sex. Based on these results, the authors concluded, that low or non-existent sexual desire is a primary characteristic of asexuality. It should be noted that research on asexuality is still in its infancy, and there is much to learn and explore in this area.

Lately, the distinction between sexual and asexual persons comes more to the general, and academic, attention. The public sees asexuality simply as someone who does not experience sexual attraction. Studies indicated that 2% of New Zealanders may be asexual, and up to 3% of Finnish people are. Masturbation, which asexuals may engage in, raised doubt about the true nature of asexuality. There is conflicting evidence as to the frequency of masturbation among asexual individuals. Studies provide evidence that masturbation occurs as frequently with asexual people as it does with sexual ones. One study, for instance, indicated that 80% of asexual men and 73% of asexual women had engaged in masturbation, and these frequencies were similar to that reported in a British national probability sample of sexual individuals. In another sample, asexual women were also found to be significantly less likely to masturbate than sexual women and asexual men. The motivation for masturbation among asexual individuals is still not entirely clear. It was hypothesized that masturbation among asexual individuals might arise for non-sexual reasons. And when asexual individuals were queried, the most commonly cited motivations for masturbation were to seek pleasurable sensations or physical release of sexual tension, though they also wanted to engage in bodily exploration, get to sleep, or to reduce boredom or loneliness. Asexual participants were significantly more likely, than sexual people, to report never having had a sexual fantasy, with 40% of asexual

participants in one study having never experienced it. This is in stark contrast to the 8% of sexual participants in that same research who lacked experiencing sexual fantasies as well.

However, it is interesting to note that a substantial proportion of asexual individuals in the study carried out by Dr. Yule and his research team in 2014 reported engaging in sexual fantasies (65% of asexual women and 80% of asexual men), and a large number (51% of asexual women and 75% of asexual men) engaged in both sexual fantasy and masturbation, despite reporting a lack of sexual attraction. The researchers suggested that since sexual fantasies are thought to be an indicator of an individual's true sexual interest, this raises questions about the meaning of these sexual fantasies for the construct of asexuality, which we see as one who lacks sexual interest.

Fetishism

> "Some men love women. Some men love other men, some love dogs and horses, and occasionally you find one who loves his raincoat" (Schulman, in Hyde & DeLamater, 2011, p. 340).

The word '*fetish*' is a Portuguese one signifying a love token, or an erotic icon. The fetishistic quality is on a continuum where a person may need to look or touch the subject of his fetishism to an extreme point were that subject becomes the focus of his sexuality and may alienate him from his sexual partner. Usually, the fetish may involve a clothing item or other items closely associated with the body. Two subcategories of fetishes were identified: media fetish and form fetish. Media fetish is a source of great arousal due to its material, such as leather. In contrast, form fetish refers to the arousal experienced when identifying the form of an object like a shoe, lingerie, or nylon stockings.

Fetishism is mostly a male's variant behavior and is found rarely in women. There are three main categories of fetishism: partialism (which includes the arousal of thinking or seeing one specific part of the body), an inanimate extension of the body such as underwear or other articles of clothing, or a specific source of tactile stimulation such as rubber. Fetishism mainly focuses on non-living objects. The most common fetishistic targets are female underwear, feet, and shoes. The early days of fetishism usually begins at puberty or even earlier. And when the fetish target is unavailable, the man may experience sexual dysfunction. Most fetishists are comfortable with their fetish and pose no harms to others, thus, never seeking treatment. However, others who experience depression, shame, and guilt for their fetishes may seek professional help. And unless the fetishist enjoys stealing, for instance, the authorities will not be called.

The Underlying Causes of Fetishism

It is unclear why people become fetishists. *Learning theory* (which we mentioned earlier) for instance, suggests that conditioning to a fetishized object through instances of sexual arousal followed by orgasm seals the fate of fetishistic interest. Cognitive psychology, which deals mainly with the ways we think, suggested that fetishists have a serious distortion in the way

they perceive the world and think about it, whereby they perceive non-sexual stimulus as erotic, and they are then driven to sexual behavior.

Partialism

This is the closest category to normal behavior where a specific body part may be sexually erotic, though it may override the person's interest in the other person. The famed sex researcher Dr. Von Kraft-Ebbing provided a rich account of fetishes in the 19th century in his 1965 novel and highlighted the difference in societal ties of what were considered fetishes then and now. Von Kraft-Ebbing described hands as being a subject of fetishism, possibly as a reaction to the prohibition of masturbation during that time, which is not at all seen today. In his work, he also described foot fetish as well – which is quite common currently. Sexual attraction to female amputees, for example, were also seen in the 19th century and in the present as well.

Inanimate Extension of the Body

Here we refer to clothing articles such as panties, boots, and shoes, which are perhaps the most common type of fetishes known. Women's clothing often overlaps with transvestism, while diapers may be linked to babies. Fetishes that are also focused on the specific texture of an object are also incredibly common. This includes clothing made of rubber, leather, or shiny black plastic. Interestingly, in the 19th century, furs, velvets, and silks were the preferred textures. As with other aspects of sexuality, the internet has contributed the world of fetishism by providing a wide assortment of fetish stimuli, as well as groups and clubs which the fetishists may belong to. A relatively recent development is the website called Wikifeet, which is dedicated to the admiration of women's feet for individuals to congregate and exchange their thoughts.

Sadomasochism

A sexual *masochist* is one who is sexually aroused by fantasies, or actual behaviors, where they are beaten, humiliated, bound, or even tortured. This variation is named after author Leopold von Sacher-Masoch who engaged in this behavior and wrote novels expressing his fantasies. *Sexual masochism* involves sexual arousal from being humiliated, beaten, slapped, bound, or made to suffer in some physical or emotional manner. Sometimes, these fantasies may be part of masturbation or intercourse. Masochistic practices may include needle insertion, slapping, applying electrical current to the body, or even self-asphyxiation, which is known to not infrequently result in death. Such practices experienced with a willing partner rarely come to official attention or result in criminal charges, making it difficult to identify the demographic characteristics associated with this paraphilia. Masochists are usually well educated and well-adjusted socially, and rarely seek professional help. Interestingly, research revealed that about

one third of masochists also engage in sadistic behavior, in which case both sadomasochistic partners may derive sexual pleasure from either receiving or inflicting pain.

Some characteristics of masochists include:

- *Self-identification* – Masochists describe themselves as such, but also as 'submissive', 'masochistic dominator', 'predominant' while some described themselves as a 'switch' – meaning that they can assume either the role of the dominant or submissive in their sexual practices.
- *Accessories used* – Numerous accessories and instruments may be used by practitioners of BDSM (Bondage, Discipline, Sadism, Masochism). The whip, the martinet, the paddle, or the English cane which may cause extreme pain are often used in BDSM enactments. Sensory deprivation or constraint are achieved by using ropes, chains, handcuffs, ball gag, blindfolds, or hoods; all of which are available (at least in the Western world) in sex stores. Objects of penetration which may also be used in BDSM include butt plugs, dildos, or strap-ons which is mostly used by women on another woman or man. It is known that many masochists opt for anal penetration by those instruments or penises, while oral or vaginal penetration may be sought by women. Spanking and slapping occur routinely in those practices. Urophilia, or "Golden Showers"' (urinating on someone) are also very commonly practiced.
- *Language* – plays an important role in SM (Sado-Masochism). Words help define what can be done at what intensity, the ground rules, and the way of signaling that the 'game' has gone too far when a "safe word" is used.
- *Fantasies* – some fantasies are related to books or movies that people read, or to experiences which they had growing up. Such experiences may include corporal punishments which were administered to them by an adult or restricting their genitals to the point of both pain and arousal.

Research found that masochistic practices result in providing stability for its practitioners. These practices may resolve sexual disorders by releasing the person from the need to perform sexually. Psychological conflicts with the partner that a person may be struggling with may be resolved that when it allows for contact, but not one that is too intimate or "sexual" when feared some circumstances. Consequently, masochistic fantasies or behaviors may serve as a way to lower anxiety levels in those people. It appears to be a way of playing and replaying a previous traumatic scene, or to help empty it of its humiliating aspect, by bringing about erotic gratification. Pain is, usually, unwelcomed by humans, but feeling pain in the SM scene, can help 'wake up' people whose feelings are numbed by previous traumas, as when they feel pain and pleasure, they come alive. Consequently, pain is never the final end goal of SM activities, but a way to fulfill people's needs and fantasies. Pain seeking may be a result of earlier sexual abuse, possibly recreating the abuse they underwent but this time with the woman (as it is usually women who suffer these tragic circumstances) being able to control when and how much they are abused. Men who have been sexually abused describe these experiences as including surprise, intimidation, an abuse of power, and sexual coercion. They re-enact them in SM scenarios, with, as women do, increased control on what is done to them. Most of those masochists grew up in dysfunctional families and were exposed to violence or psychological abuse. Masochistic practices allow them to relieve their childhood abuse and do so as active

participants by controlling what is done to them, and this time, not confusing love with pain in light of being beaten by parents who are supposed to love and protect their children.

Sadism is named after the author Marquis de Sade who practiced the behavior and wrote books about it. Sadistic individuals derive sexual arousal from inflicting physical or psychological pain on another person. Mostly, males have that paraphilia. Sadistic fantasies or behaviors may involve dominance of oneself over the victim – like forcing the victim to crawl or keeping the victim in a cage, restraining the other person, whipping, blindfolding, strangulating, torturing, and even mutilation. If sadism is associated with an antisocial personality, the person may get into sadistic acts that lead to serious injuries or death.

Sadism may be of two distinct kinds: one which accompanies sexual violence, and is considered a criminal and unacceptable behavior, and the other which is a part of a ritualized sadomasochistic pattern of sexual interaction between two consenting adults who derive pleasure from their variant BDSM interaction. A key element in BDSM is the setting of very clear rules as to what is allowed, and how the receiving partner may indicate that they wish to stop. And although there may be preferences for playing the dominant or submissive role by one of the partners, it is commonly shared by both partners – one who receives and later gives pain.

Fetishism and sadomasochism tend to occur together in the general population, and interest in bondage is not unusual amongst fetishists. In searching for the causes of those variant behaviors, the fact that they are connected may suggest that the same causes may have been at play for both variations. Causes may thus, stem from difficulties that the individual may have with relating to others and especially to sexual partners. Clearly, we need more definitive answers in regards to the validity of these explanations.

Transvestism

This variation refers to dressing as a member of the opposite gender, which was termed cross-dressing. Some gay men – drag queens – dress up as women, while drag kings are lesbians dressed in men’s clothing. Transvestism is almost exclusively a male sexual variation. It is a harmless, victimless sexual variation, particularly when it is done in private. However, if it becomes the only way a person can be sexually aroused, it obviously requires attention and treatment, as it may affect the person sexual enjoyment and relationships.

Troilism, or triolism – are sexual encounters involving three people (also known as a ménage à trois). It may involve three people actively engaging in sex, or a spouse watching her spouse having sex with another person, which is practiced mainly by voyeurs. While troilism is a staple of erotic video and stories, it has not been thoroughly researched.

Saliromania – is the desire, mostly expressed by men, to soil a woman or of an image of a woman such as a painting with his ejaculate. The man becomes sexually excited and may ejaculate during the act. Related to it are *coprophilia and urophilia*, both related to excretion of feces or urine on the other person.

Sexomania, or sleep sex – is a rare disorder which is both automatic and unintentional. It tends to occur during nonrapid eye movement sleep and was found to be related to an abnormal transition between sleep and wake states and is characterized by reduced control of the cortex, (the ultimate control and information-processing center in the brain) leading to uninhibited

behavior. The result is persistent sexual arousal like erections, lubrication and ejaculation during the episode. The range of reported sexual behaviors during these instances include sounds like moaning as well as fondling, masturbation, cunnilingus, sexual intercourse with or without orgasm, and even sexual assault. Eighty-percent of these cases involve men. Partners may experience physical injuries as well. Various negative psychosocial aftereffects, including guilt, shame, embarrassment, alarm, and low self-esteem were reported by those involved. Sexomania, as can be expected, commonly cause relational problems. Causes or contributing features include things that can disrupt normal sleep cycles, including sleep apnea, sleep deprivation, stress, alcohol use or abuse, and some medications.

Asphyxiophilia

This paraphilia is a desire to induce sexual arousal by creating an oxygen deficiency to enhance sexual arousal. Strangulation by a rope, holding a pillow against one’s face, or pulling a plastic bag over one’s face, are some of the methods used to restrict oxygen. Needless to say, this is a potentially very dangerous practice that can lead to death, and indeed, does so in close to 1,000 people per year in the U.S. When examined, it is easy to determine one’s cause of death as a result of a paraphilia. Victims are commonly naked, cross-dressed, and have their genitals exposed with evidence of sexual activity at the time of death, and with pornography laying close by. A small minority of such cases involve women. Interestingly, it is unclear whether asphyxiation can actually enhance orgasm.

Paraphilias which are less common include Klismaphilia (sexual arousal of receiving or administering enemas), Necrophilia (sexual arousal followed by sexual contact with a corpse), Telephone Scatalogia (making indecent phone calls), and Zoophilia or bestiality.

Telephone Scatologia – is the making of obscene phone calls to unsuspecting people. It is considered a paraphilia since the behavior is compulsive and usually associated with fantasies that involve causing distress to the person. Those who make those phone calls get sexually aroused – especially when the victim reacts in shock or is horrified. These obscene phone calls are usually made randomly. The overwhelming majority of callers are males who find great delight in making their victims feel annoyed, frightened, anxious, upset, or angry. They, themselves, often suffer from feelings of inadequacy and insecurity, which may explain their need to remain anonymous, rather than engaging in a real relationship with a partner.

Necrophilia

Having sexual activity with a corpse is referred to as *necrophilia*, which is (thankfully) an extremely deviant behavior. The corpse with which the person may attempt sexual activity with may be mutilated at the termination of the intercourse. Most necrophiliacs are not caught since the corpses do not object or report the violation which was delivered upon them. And while we may find descriptions of necrophilia in literature and horror stories, it is most likely said to be committed largely by those who work with corpses in mortuaries and morgues who have become desensitized to dead bodies. But to clarify, the vast majority of those handling corpses do not have any sexual interest in them. Research which explored necrophilia indicated that the

most common motive for necrophilia was the possession of a partner who neither resisted nor rejected them. Clearly, many people with necrophilia are severely mentally disturbed.

The Main Paraphilias

Pedophilia

To briefly reiterate our previous description, “Pedophilia is defined as an individual having recurrent and intense sexually arousing fantasies, sexual urges, or behaviors, involving sexual activity with children 13 years old or younger. The individual should be at least 16 years, and be at least five years older than their victim/s. Although individuals are typically male, the condition has been observed in females…Pedophilic interest would appear to stable across the individual’s lifespan…and typically first appears in adolescence” (as defined by Dr. Beech and Dr. Harkins).

It should be clarified that pedophilic disorder is different from “child sexual abuse,” “child molestation,” and “incest,” although all denote sex with minors, which is a criminal action. Though for the pedophile, having sex with children may be the only way to get sexually aroused, though some people with pedophilic disorder are sexually attracted to both children and adults. Pedophilic behaviors rarely involve sexual intercourse. Instead, the pedophile will sexually touch the child and may ask the child to touch their genitals as well. The person may masturbate in the presence of the child with occasional oral or anal stimulation being involved.

Simply put, pedophilia involves repeated and intense fantasies and urges to have sex with a child, whether that is expressed behaviorally or not. Pedophiles tend to be repeat offenders, but incest does not necessarily involve pedophilia. Research found that child molesters are usually uncomfortable with adults of the opposite sex, that they may have suffered some brain damage during their childhood, and/or have a strong mental association between children and sex.

It should be noted that individuals who sexually abuse children come from three groups: those who are pedophilic (attracted only to prepubescent children); those who are attracted to pubescent children (hebephiles), those who are aroused by both teenagers and adults; and those who are aroused primarily by adults, but who sexually abuse children for reasons to do with power, control, or sense of entitlement to sex. This is most common amongst incestuous offenders.

Child Sexual Abuse

Child sexual abuse (CSA) is steadily gaining coverage from the public and academic spheres as we are becoming more aware of the greater prevalence and negative impact it has on its victims. Following CSA, the grownup child may display behaviors ranging from withdrawal and dysfunction on one end of the spectrum to hypersexuality and compulsion on the other. Various factors have been examined to understand the different outcomes of behavior displayed by victims of CSA. Only two distinct factors show a strong correlation between the variable response of sexual inhibition vs. sexual hyperactivity to CSA. This is largely related to the

victim's gender and the age when victimization began. Boys who were sexually abused are more likely to display aggression, sexualized behavior, compulsive behaviors, and become hypersexual in their adulthood. Girls commonly react to CSA by developing depression, displaying anxiety related symptoms, and suffering from sexual dysfunctions in their later life. It appears that the victim's age at the time of the abuse can significantly impact their sexual behavior at adulthood. For instance, the younger the child is at victimization, the more likely he or she is to respond to the abuse with sexualized external behavior. Victims younger than six years old are particularly prone to exhibiting inappropriate and aggressive sexualized behavior. In contrast, children over the age of 12 at victimization are more likely to react with internalizing behavior and become inhibited and fearful of sex altogether.

Is Child Sexual Abuse Common?

According to a recent study, rates of child abuse have ranged from 10% to 62%. A survey incorporating data from 15,831 individuals indicated that 22% of both males and females self-reported a history of CSA. Females were found to be two to four times more likely to be victimized than males. An American study of 1,528 college students found that six percent of females and two percent of males reported "unwanted sexual contact" in their childhood.

The Sexual Disorders That Follow CSA

In 2021, Dr. Aaron defined sexual disorders as "…all problem sexual behaviors on the continuum from dysfunction and hypoactive sexuality to compulsions and hyperactive sexual behavior." It is estimated that 20% of men in the general population are hypoactive when reporting their avoidance of sexual activities, while 26% reported experiencing sexual arousal disorders such as erectile dysfunction with 12% of this sample reporting a range of orgasm disorders spanning from premature to delayed ejaculation.

In contrast, 30% of women reported as having some orgasmic disturbance, with 32% reporting diminished sexual interest, and 36% having experienced less than desirable sexual pleasure thus far. Similarly, up to 33% of women reported experiencing sexual pain with a greater prevalence of sexual dysfunctions than men. A 1998 estimate by the National Council on Sexual Addiction and Compulsivity, now known as the Society for the Advancement of Sexual Health (SASH), indicated that 6%–8% of Americans are "sex addicts." In a more recent study from 2000, by Dr. Cooper and his team, 9,265 respondents were surveyed about their online sexual usage and found that 17% of them scored positively for sexual compulsivity. Hypersexuality was found to occur much more often in men as 80% of sexual addicts identified as male.

The Relationship of Sexual Disorders to CSA

In addition to sexual abuse, a negative family background significantly contributed to sexual dysfunction in both genders who grew up in such homes. The association between sexual abuse

and sexual dysfunctions was weak in men, but very strong in women. Apparently, the greatest variable of CSA that could predict subsequent sexual dysfunction was whether penetration had occurred.

Among men, there appears to be a significant correlation between CSA and sexually compulsive behavior. Men who were subjected to forceful sexual abuse showed riskier sexual behavior in adulthood, including having more partners and higher rates of STDs. In a study of 14 men who self-identified as sexually addicted, 13 of them experienced CSA. Further, nine of the men described their behavior as like their own sexual abuse. And so, men who experienced forcefulness or rape in their past reported their own similar behaviors in adulthood akin to that – mainly through aggressive or coercive sex.

It was suggested that the nature of the abuse and the way that the child's environment responded to these events may affect the severity of the symptoms described above. For instance, a lack of support from caretakers, particularly from the mother, is a major cause of negative outcomes. When the mother believes the child's complaint of sexual abuse, and responds in a protective, nurturing way, she is said to be showing support and care of the child. This is incredibly important when we recognize the impact of trauma on child victims of sexual abuse. In fact, traumatic symptoms were closely related to the relationship between the child and their perpetrator. The closer the perpetrator was to the victim (thus, there was no way for the child to expect abuse), the more serious the effects of their trauma. Other factors involving the force, frequency, duration, and severity of the abuse also largely contributed to the severity of the child's victims. In particular, this also encompasses whether the victim was physically and forcefully restrained during the act(s) and if penetration had occurred.

Another important factor that affects the severity of symptoms is the age of abuse. It was found that when sexual abuse occurs to preschool children, it resulted in 35% of them exhibiting inappropriate sexualized behavior. Only 6% of school age children (aged 6 – 12 years old) were found to demonstrate these behaviors, and none of the adolescents in the sample showed such actions. Therefore, the younger the child victim is, the more likely he or she is to react to abuse through externalizing inappropriate sexualized behavior. In contrast, almost half of adolescents with histories of CSA reacted to their sexual abuse by withdrawing from others or struggling with depression, anxiety, and somatic complaints.

The gender of the child victim also plays a significant role in subsequent sexual behavior. Women tend to internalize the trauma of the CSA with greater reports of anxiety, while men externalize and experience greater addictive and antisocial behavior.

Exhibitionism

"Flashing," or exhibitionism complements Voyeurism. It involves a person who derives sexual pleasure from exposing his genitals to strangers on the street or in a park, and the more shocked and frightened they are, the more sexually aroused he becomes. Exhibitionists are usually men. And while women do expose themselves, in night clubs for instance, it is commonly seen as attractive, while males who expose themselves are considered offensive and frightening. Exhibitionistic behavior usually starts before the boy reaches age 12, and the childhood of such a child is typically characterized by inconsistent discipline, a lack of affection, and little training in appropriate social behaviors.

The exhibitionist often has recurrent, intense, and sexually arousing fantasies or behaviors about exposing his genitals to others with the intent to shock or frighten them. He may masturbate at the scene, or privately later. Some exhibitionists suffer from courtship disorder, meaning that they have great difficulty in approaching or interacting with others whom he may be romantically or sexually interested in. Exhibitionism usually occurs in the mid-teens with many coming from families where physical or emotional abuse were practiced, and did not experience healthy physical and sexual boundaries.

Exhibitionists usually report lower life satisfaction and struggle with substance and alcohol addiction more than the general population. They often spend much time setting up and then engaging in exhibitionist behaviors, leaving little if any time or energy to engage in intimate relationships. And though it is considered to mainly be a male disorder, women are known to engage in it as well.

Voyeurism

Voyeurists derive sexual excitement and satisfaction by observing non-consenting individuals naked, undressing or engaged in sexual activity. Masturbation can occur while engaged in the activity or later. To some extent, many people are voyeurs, as can be seen by the slowing of cars to look at an accident, the desire to read sizzling details of celebrities' lives, or enjoying pictures of naked or partly naked bodies. Voyeurism usually develops by the age of 15 and afflicts mainly males. And while it is a non-contact disorder which seemingly demonstrates harmless behavior, voyeurism can have quite an impact on its victims who are typically horrified, humiliated, and extremely fearful when they discover that they have been watched during an intimate activity.

Voyeurism is sometimes referred to as 'peeping tom' but has many variations in its name. In particular, Scoptophillia describes the condition of being sexually aroused when observing sexual genitals and acts as seen through pornography. In general, this involves the person deriving sexual pleasure from observing nude people. This condition becomes paraphilic when the fantasies, urges, or behaviors cause marked distress and interpersonal difficulty, such as scouting neighborhoods in search of undressing people, mainly women.

Can Treatment Help Paraphilic Disorders?

Several approaches have been tried in an attempt to treat paraphilias, including behavioral techniques, cognitive-behavioral therapy, chemical castration, and the use of selective serotonin re-uptake inhibitors (SSRIs). They will be described briefly.

Behavioral techniques – utilize learning principles to change deviant sexual interests and replace them with more appropriate ones. Here, we see the use of a variety of reconditioning techniques including electric aversion therapy, aversion smell (olfactory) therapy and covert sensitization. This particular type of aversion therapy helps reduce unwanted behaviors by repeated, imagined associations with an unpleasant consequence and masturbatory reconditioning where masturbation is reconnected with a more acceptable stimulus. These

modalities are often supplemented by social skills training, assertiveness training, and/or sexual education.

Electric aversion therapy is used to reorient those with deviant sexual interest. This technique involves an uncomfortable shock to the leg or the arm of the offending person while he thinks about the deviant topics or fantasizes about them. Presently, it is used infrequently, mainly due to ethical concerns. *Olfactory aversion therapy* involves pairing a deviant fantasy with an offensive olfactory experience, such as the smell of rotting eggs. The aim is to associate the two events, so that the deviant imagery becomes less arousing. There is some evidence that olfactory aversion can, indeed, reduce deviant sexual arousal. *Covert sensitization* is a technique which involves the pairing of an imagined target with an unpleasant outcome, such as imagining that the offender discovered unsightly sores on the body of his victim. It is a rarely utilized approach. Instead, it has been used in conjunction with olfactory aversions to minimize deviant fantasies. *Masturbatory reconditioning* is used to change one's sexual preferences. The client is instructed to masturbate to a deviant theme until the point of orgasm inevitability where the man feels that orgasm is about to happen, at which point the client switches to a non-deviant fantasy, so that orgasm is associated with the non-deviant fantasy. *Cognitive-behavior therapy* (*CBT*) is the most common method of treating sex offenders, as it aims to change the pro-offending thoughts, which are cognitive distortions, that influences their emotions and behaviors. The sex offenders are made aware of the connection between their thinking and offence, and the negative implications it has for their victims.

A variation of CBT includes modeling and skills training which involve relapse prevention strategies that help the offender to identify particular thoughts, moods, and situations that may lead to his reoffence. The aim of this approach is to empower the offender to develop appropriate self-management skills to prevent relapse. It is an evidence-based methodology that has been largely supported to legitimize its efficacy when compared with other treatment approaches.

Chemical and physical castration – Antiandrogenic drugs are sometimes prescribed to help reduce deviant sexual behaviours and thoughts. Depo-Provera, which is a hormone-suppressing drug that lowers testosterone levels, is thought to minimize sexually deviant behaviors by decreasing a man's sex drive. Other forms of physical procedures involve castration, which undoubtedly reduces sexual interest (libido) and performance, thus, reducing or even eliminating sexual behaviors, such as pedophilia. The physical castration of sexual offenders was implemented in Europe during the first half of the 20th century. And although it features a morally dubious approach to this issue, it was found to reduce recidivism rates to 5% when compared with expected rates of 50% or more in uncastrated sex offenders. Research ultimately suggests that hormonal (antiandrogenic drugs) and surgical castration are much more effective in reducing recidivism than psychological approaches alone.

Selective serotonin reuptake inhibitors (SSRIs) – SSRIs may also play a role in reducing deviant arousal or fantasies. Studies have shown that its impact has resulted in decreases of the level of reported deviant sexual fantasies experienced by offenders and decreases in unconventional/abnormal sexual behaviors obsessions and compulsions as well.

Incest

Incest, or sexual contact between blood relatives, can also occur between non-blood relatives such as a stepfather and stepdaughter. It may be unbeknownst to the general public, but the majority of child sexual abuse cases are perpetrated within the family, including sibling incest. The effects of such sexual abuse on the child can be serious and long lasting. Children who were sexually abused may struggle with depression, anxiety, eating disorders, health problems, alcohol and drug dependency in their adulthood. This may also affect their views of sexuality in a negative manner, and lead to a complete avoidance of any sexual activity altogether – often resulting in difficulties with forming safe and stable romantic relations. The risk for these difficulties is greater if intercourse was involved, if it occurred repeatedly over many years, and if it was committed by a father or a stepfather. A brother-sister sexual engagement, however, may be less damaging to the child if both parties were children during the time of the abuse.

Victims of Sexual Offences

Sexual victimization leaves various psychological and physical effects on its victims. Physical injuries may include non-genital injuries, vaginal and/or anal lacerations, bleeding and pain. Post-assault medical investigations may add to the trauma caused to the child due to injury detection procedures, forensic medical examinations, or treatment for sexually transmitted infections and pregnancy. As such, the psychological trauma of this abuse may lead to increased risks of developing post-traumatic stress disorder (PTSD), depression, substance abuse, and panic attacks. Depression following sexual victimization is five times more common in women that have been abused when compared to the non-abused population. Early signs of child sexual abuse involve children exhibiting fears, nightmares, cruelty towards others, anxiety, acute stress disorders, delinquency, poor self-esteem, and sexually inappropriate behaviors that may displayed as early as in kindergarten or elementary school.

Sexual Addiction

Sexual addicts are those who engage in sex in a compulsive manner, often with multiple partners whom they may not even know. The sexual histories of these people include frequent sexual activity and an intense desire or craving for sexual engagement that often leads to experiencing impairments in their work, family, and social functioning within their daily lives. In one study, sexual addiction and alcoholism were compared to reveal that each episode of sexually addictive behavior proceeds through a four-step cycle that intensifies each time it is repeated: Firstly, *preoccupation* is where the person is intensely preoccupied with the sexual act to which he or she is addicted. Then come the *rituals* which are enacted and preclude the addictive act. The third step involves *compulsive sexual behaviors* which the person commits since they feel that they cannot control their urge to commit it. And lastly comes *despair*. Rather than feeling good after the sexual act is completed, the addict falls into a feeling of hopelessness and despair. Research aiming to understand the roots of sexual addiction included interviews with men who identified as gay or bisexual and had at least two male partners in the last 90

days. When asked about the causes of their behavior they identified depression, low self-esteem, a need for validation and affection, and stress release that caused them to become addicted to sex. Other studies report that from 30% to 78% of people with sexual compulsivity have been sexually abused.

Sexual addictions are estimated to range from 3%-17% of the general population. In the USA, it may be translated to 17-37 million people with 50% of them being women. Since these percentages are so significant, the reasons and causes of these addictions need to be reviewed and studied for clarity. In one study, four main areas were examined as causes of sexual addictions which included factors such as trauma, attachment, shame, and cultural contributions. In general, research shows that sexually addicted people, especially women, were often subjects of childhood trauma.

Cybersexual Addiction: The Role of the Internet

The advent of the internet has enabled the engagement of a wide variety of potential online sexual behaviors. People can engage in different behaviors that may take on addictive qualities, including, but not restricted to internet sex. The five components of sexual addiction are, firstly, *tolerance* (i.e., a need to increase the amount and intensity of sexual behavior continuously and markedly in order to achieve the desired effect); and secondly, *withdrawal* (i.e., the experience of characteristic withdrawal symptoms upon the discontinuation of sexual behavior). Additionally, when withdrawal is attempted, similar sexual behavior is exhibited to relieve or avoid withdrawal symptoms. Thirdly, the sexual behavior is engaged in for a long period of time, and at high intensity. Fourth, the individual experiences a persistence to cut down or control their sexual behavior – similarly to how addicts act in general. And lastly, the addict sacrifices important social, occupational, or recreational activities because of their sexual addiction.

The Reasons for Using the Internet for Sex

Scientific interest in human sexual behaviour began with Dr. Alfred Kinsey's famous studies. Kinsey revealed activities that traditionally belonged in a married couple's bedroom. They were, thus, destigmatized by his research and subjected to a scientific perspective, as well as became fodder for day-to-day discussions by the public. Similarly, as the internet began to enter homes and daily modern life, there was a surge of studies investigating how human sexual behaviour is enacted on the internet. Sex on the internet is particularly viable because of the inherent qualities involved with its 'Triple A' engine: Access, Affordability and Anonymity. The online world includes explicit sexual material that is immediately accessible from anywhere, as long as there is an internet connection in place.

Sexual compulsions and (sub)clinical conditions, such as mood and anxiety disorders as well as impulsivity was found to be related. Psychosocial risk factors to this occurrence include stress and interpersonal problems. And in combination with the convenience of the internet, these vulnerabilities may initiate online sexual compulsivity. Cybersex is said to become a sexual outlet and potential form of sexual gratification that further serves as a positive

reinforcer. Additionally, by engaging in cybersex, the user can escape from everyday troubles and forget their problems for the time they spend online.

An article by Dr. Orzack and Dr. Ross published in 2000 described two case studies of sexually addicted patients which were admitted to a treatment program. Both patients engaged, excessively, in sexual chat websites, wrote and read sexually related e-mails, had contact with prostitutes, and looked at on and offline pornography. Generally, the characteristics of cybersex abusers involved heavy internet users who are generally married and are often well-educated professionals. Many experienced sexual abusers were found to be depressed, while females were generally younger than males (30 vs. 38 years). Males, on the other hand, were more likely to become substance dependent and addicted to real-life sex.

A 2006 study which collected data from 1,835 adults regarding internet usage, relationships, and sexuality, indicated that spending three to ten hours a week on the internet significantly increased the likelihood of becoming an online sexually addict. Additionally, a 2010 study which explored the relations between sexual compulsivity, seeking a sexual partner, drug and alcohol use, and sexual behaviors was conducted on a sample of 309 men averaging 29 years of age. The study revealed several significant differences between those who were engaged in sexually compulsive behaviors (SCs) and those who are not sexually compulsive (NSCs). The results indicated that the SCs were significantly more likely to be married, employed full-time, and in a sexual relationship with more than one person. Moreover, they were more likely than NSCs to have unprotected sex with other men.

Overall, the internet has been described as a heaven for erotic minorities who have specialized tastes and a right to satisfy them. As such, our online cyberspace shows that sex is not between our legs but between our ears. Similarly, to homosexuals and bisexuals, women find the internet as a liberating space which can enable an almost infinite exploration of sexuality without latent taboos imposed by societal and cultural environments.

A Therapist's Perspective on Sexual Addiction

Sexually addicted people have been reported to engage in frequent sexual encounters, riskier sexual behaviors, compulsive masturbation, frequent use of pornography, and experience obsessive sexual thoughts. They report experiencing shame, a lack of control, a separation of intimacy from sexual activity, and thus may wish to keep it in secrecy. It should be noted that the frequency and scope of sexual addiction tends to increase with time and may extend to exploitation or illegal behavior. Sexual addictions reportedly result in distress, a reduced quality of life, and poor physical and psychological health.

Two therapists, Dr. Brewer and Dr. Tidy, researched other therapists who also treated sexual addicts back in 2017. Their observations represented three themes which govern sexual addicts: (1) distress; (2) risk; and (3) treatment.

Distress – sexual activity was viewed as an attempt by these addicts to regulate their emotions through their maladaptive nature of sexual behavior. This is not unsurprising, as sexual behavior has been shown to reduce feelings of pain, fear or anger. Consequently, treatment programs directed at this population must include interventions which support the development of adaptive coping mechanisms, including the strengthening of one's social networks.

Risk – the risks of engaging in sexually compulsive behaviours have been at an all-time high with the development of dating sites and sexual mobile apps. These situations often involved sexual addicts meeting in high crime areas with strangers from the internet. As such, clients often put themselves at substantial risk of physical harm. The sexually addicted were also found to known to commonly practice unsafe sex, making themselves vulnerable to contracting sexually transmitted infections and unplanned pregnancy which may in turn lead to greater shame, depression, and substance use. Therapists across the board reported that clients presented with co-addictions which often included addictions to alcohol, gambling, and illegal substances.

Treatment – therapists were found to show low levels of concerns and awareness shown across healthcare professionals and counsellors. Consequently, treatment was rarely ever offered, if at all. Clearly, specific training in working with the sexually addicted is greatly relevant. Treatment rests on empathy to their plight using a wide range of techniques such as cognitive behavioral therapy, trauma work, psychodynamic therapy, and psychoeducation that is necessary for progress.

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If I was addicted to masturbation, and then became addicted to sex, would it be safe to say that my addiction got out of hand?

*

A doctor is telling three women what they are addicted to. He says to the first one, “You are addicted to money; you named your daughter Penny” He says to the second one “You are addicted to food; you named you daughter Candy.” Then the third one whispers to her son “Come on Dick, let’s go.”

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Chapter 12

The Ins and Outs of Sex Therapy

Brenda and Abe, in their mid 40s, came into my office one afternoon looking sad, dejected, and anxious. When I asked them to tell me about themselves, they looked at one another, not knowing who should begin. Finally, Abe started. He was a shift supervisor of the cleaning crew at a large local hospital, having been there for 15 years, liking his job, and doing it very well. Brenda was a high school teacher whose specialty was in physics and algebra, and had been at that particular school for the past five years. The couple had three kids together and their marriage seemed solid as they did not argue, agreed on almost all issues, and had never wanted to seek romantic partners outside of the marriage. The problem that caused them to seek my help, however, was Abe's erectile dysfunctions during their attempts at intercourse. The problem existed for the past year and had bothered both of them although it was never addressed through discussions, or other attempts to resolve the situation.

We started to talk about their marriage, feelings, likes and dislikes, and in addition, I wanted to ascertain that nothing was medically wrong with Abe. His health, I was told, was very good. He felt strong and energized, and from my questions, it was found that he was capable of early morning erections, and those that also occur during masturbation. That meant, to me, that his sexual 'plumbing' is fine, and there must've been other reasons for his ED. Apparently, Abe came from what he described as a "broken home" where his parents fought incessantly until they divorced. He vowed that he will not repeat the pattern, and so he never argued with Brenda, though at times he felt misunderstood, ignored, and belittled. He expressed his frustrations and anger in the bedroom without being consciously aware of it. His ED had actually punished Brenda and prevented her from enjoying sex for what she has done to Abe out of the bedroom, of which he was unable to deal with openly. We engaged in four-months of marital therapy which helped the couple communicate openly, making the ED unnecessary, and was ultimately resolved.

Great Lovers

We are approaching the topic of sex therapy. But in order to appreciate why it may be needed, let's look at what the professional literature says about great lovers; those who do not need the help of sex therapy. Dr. Kleinplatz, a relational sex therapist and researcher, sought, in 2009, to understand what made sex 'great' with her research team. Altogether, they interviewed 67 participants who were in relationships for at least 25 years and identified their sex as being fantastic. On average, participants were 66 years old and described to the researchers why they saw their sex as great. Dr. Kleinplatz distilled their responses to several succinct points:

- Optimal sex requires that the participants be completely immersed and focused on the experience.
- Sexual partners need to have a sense of connection and lose oneself with their partner.

- Deep mutual respect, caring, genuine acceptance and admiration enhance deep erotic intimacy.
- Interpersonal risk-taking through exploration was viewed as fun. Sex was seen as an adventure; an exploration which allows humor and laughter in the experience.
- During sex, participants feel free to be themselves, uninhibited, and totally free to express their wishes.
- Great sex requires 'letting go', being vulnerable, reveling in the sensation, and completely surrendering to one's partner.
- Great sexual experiences were often characterized by a sense of peace, bliss, and a feeling of utter timelessness, growth enhancing and healing.

As Dr. Kleinplatz noted, great lovers are not born but become that way. It seems that in youth, having satisfying sex may seem wonderful, but as people mature their sexual relations can grow with their given time, experiences, and commitments to making sex the best and most exciting experience they can. Interestingly, these people indicated that if they were able to unlearn whatever they learned about sex in their youth, it would have helped them to achieve great sex. That may include overcoming shame they may have felt towards their body, diminishing any types of performance anxieties if they had any, and developing new and personalized visions of sexuality that replaced their old ones. Other factors like having increased comfort with who they are was precipitated by self-knowledge which came with maturity, allowing them to better handle their fears, expectations, and other thoughts or perceptions that could stay in their way. To achieve that state, they needed to develop courage, boldness, creativity, openness and the freedom to take chances regardless of the mistakes they may have made along the way.

Not only were personal changes and growth responsible for optimal sex, but also an ever-deepening relationship with increased sexual interest in oneself and one's partner was shown to have influence as well. 'Great sex' is said to occur most frequently in relationships characterized by trust, consideration, respect, and most especially, open and empathic communication. Partners also reported that they were quite insistent on getting whatever they desired sexually. The expectation now is not related to the quantity of sexual experiences, but the quality of the framed sexual connection. Good sex does not simply happen but must be invited into one's life. Good sex can be had if there is significant and considerable planning, prioritizing, intentionality, and devotion to it, as needed. It is not a fly-by-night occurrence, but a deliberate act of building anticipation which involves as many senses as it can. Time is freed for as long as they desire to engage in sex. And lastly, the couple needs to decide which kind of environment they desire – private and quiet, or a less private place such as a hotel room to create their sexual encounter. Great sex, as we said, does not happen spontaneously.

Both familiarity as well as exploration are advantageous. While the media and public may highlight novel sexual positions or adult toys, those who discovered great sex emphasized the opportunity for self-exploration; revealing one another anew in ever-deep ways. And secondly, while it is true that novelty may have its place, familiarity should not be overlooked. Participants indicated that they needed a balance between discovery and trust. Trust to dive in and to try what they like even if by doing it they make mistakes.

Research suggested that even aging, chronic illness, or disability should not pose obstacles to optimal sexuality. Interestingly, most people do not experience great sex until their midlife.

And while the aged may be riddled with poor health and physical impairments, their subjective perceptions were of people who can have good and enjoyable sex. Dr. Kleinplatz was, clearly, unprepared for those results and shared that "…it is heartening to discover that personal and relationship development over the course of a lifetime can help open the door to optimal sexuality…(she) was struck by the contrast between the physical impediments of sexual functioning that most of us – including many sex therapists – would see on encountering such individuals and the fact that their ill health did not interfere with their capacity with optimal sexuality" (Kleinplatz, 2010; p. 64).

It appears that a full physical sexual functioning is not sufficient for wonderful sex. As mentioned above, it requires more. Much more. Disappointing sex lives can, indeed, be changed and improved. It may take time, effort, and experience, but it can be improved. President Clinton, declaring that he "did not have sex with that woman" missed that point. Sex is not just intercourse, but includes also touching, smelling, caressing, and pleasuring. It may or may not end in orgasm. And it is important that people who engage in sex should do so when they desire it, and not just as a duty or an attempt to please a partner. High-quality sex must include trust, sharing, exploring one's own and another's desires, as well as be an active form listening to not only what is said but also what is not said. Sometimes sex may be disappointing. But rather than being discouraged, I urge you to not deny it and find out why it was so and with your partner to improve it.

Just like poor eating habits, one's poor management of their sexual activities may result in subsequent health problems. When we engage in sex for the wrong reasons like in inappropriate circumstances that that do not enhance our relationships, it may result in mental health problems as well. Sex therapists evaluate various sexual issues in people who seek psychotherapy. Among them are sexual relationships which may face crises, confuse sexual responses related to one's uncertainty of their identity of orientation, have intrusive or disturbing thoughts or images of past sexual experiences or abuse, and even sexual performance issues. Mental health problems may revolve around trauma, anxiety, lowered self-esteem, and depression. It was observed that mental health problems and sexual behaviors are often related, and we have recently become aware of how such traumatic issues may cause anguish in the affected parties.

There is a complex interplay between sexual behavior and mental health, with various aspects of sexual history and sexual behavior potentially affecting one's mental well-being. Such mental health problems may stem from relational concerns, the sexual aspects of the relationship or be related to intra-personal sexual conflicts which one of the partners may deal with. It is kind of obvious that when a relationship creates difficulties or heartache for one or both partners, sexual behavior can be negatively influenced, and often is. While issues such as anxiety or depression may significantly affect sexual behavior, dysfunctional sexual behavior may be associated with lowered self-esteem, depression, or even trauma. Thankfully, good and satisfying sexual behaviors that are in line with our psychological needs can promote good mental health. Successful relationships seem to contribute to a sense of identity, belonging, being valued, and feeling validated. When things go awry, such as through a lack of internal order or harmony this may result in a poor fit between one's subjective needs and capacities. And if a sexual relationship fails to meet the basic and important needs for love, intimacy, and belonging, we may develop a loss of self-esteem, anxiety, or depression that can lead to many difficult emotions (i.e., anger, grief, fear, shame, guilt, self-hate, feelings of inadequacy, distrust, confusion, and loneliness). Research has shown time and time again that the experience of belonging through secure attachments are closely related with good mental health. Thus,

emphasizing that when these ingredients are present, they tend to promote good mental health as well as relational and sexual satisfaction.

Long term relationships, which provide the partners with a feeling of belonging and attachment, can lead to better physical and psychological health, especially for men. Such relationships seem to enhance their partners' resiliency, as they tend to function better and have fewer psychological difficulties, including lower incidences of loneliness and depression. When these relational 'ingredients' are missing, sadness, depression, jealousy, and loneliness are experienced by the partners. Relationship dissolution, as well as infidelity may bring about mental health problems. Such losses are associated with grief, pain, disorientation, and emptiness, along with rage, poor sleep and concentration, depression, and may even give rise to suicidal ideation.

Alternatively, experiences like child sexual abuse have been linked to poor mental health, depression, substance abuse, anxiety, aggression, and self-destructive behavior. Unsurprisingly, women who suffered sexual abuse showed sexual disturbance or dysfunction in addition to the inevitable depression. A meta-analysis which examined a variety of other studies indicated that among the long-term effects of child sexual abuse, we can find post-traumatic stress disorder (PTSD), depression, suicide, and sexual promiscuity as typical factors which are detrimental to sexual relationships. It should be noted that sexual abuse is not limited to children and can also be seen in some adult relationships with similar destructive results.

People who are conflicted regarding their sexual identity or orientation have also been known to encounter mental health problems. Homosexuals, for instance, are at greater risk of depression, engaging in substance abuse, and experiencing anxiety disorders. Bisexual and lesbian women reported generally poorer metal health when compared to heterosexual women. They were also found to suffer greater rates of depression, anxiety, anger, and suicidal ideation and attempts. Apparently, the cause for these negative consequences is the internal conflict which stems from viewing one's own homosexuality negatively, and not simply due to a connection between homosexuality orientation and major depression.

Casual sex, cybersex, internet pornography, and other forms of sex outside of established sexual relationships may also negatively affect the person involved. Issues such as the loss of effective interpersonal boundaries, the disconnection between sex and belonging (two concepts that are and should go together), the rewards of enacting on impulsive sexual urges, and an addiction to pornography are all known to compromise mental health.

But how does poor mental health actually affect our sexuality when compared to the effect of problematic sexuality on our mental health? Mental health problems seem to affect sexual performance problems, as well as the relationship itself. Since mental health problems often involve depression (although not necessarily so), its impact largely lowers sexual arousal and drive − hence, negatively impacting the relationship. However, depression sometimes brings about increased sexual activity in an attempt to combat depression. In general, mild depression may be associated with increased sexual activity and risk taking when the loss of libido is typically only associated with severe depression.

For other disorders, research has indicated that high and continuous anxiety experienced by men is linked with premature ejaculation, while in women it is associated with desire, arousal, and orgasm difficulties. Other conditions including obsessive compulsive disorder (OCD), panic disorder, and PTSD are all associated with sexual performance problems as well. So, the effect of mental health or lack thereof on our sexuality is clear and may serve as one more reminder for us to attend to our feelings and thoughts, lest they negatively affect our

relationships and sexuality. As such, let's begin to redirect our attention towards the treatment effects of psychotherapy in this field as most people may not be closely aware of what it is, and how it can help those with sexual problems.

The Goals of Psychotherapy

Psychotherapy aims to make sense of the client's experience; to help them understand their complex interactions, motives, and emotions. People usually go for psychotherapy when they are in psychic pain, and so it may aim at helping the person reduce or at least cope better with their pain and manage their situations more adaptively. In general, therapy attempts (but success cannot be guaranteed) to promote the client's mental health. We need to remember that the significant role of the psychologist or mental health professional in interpretation of the client's experiences is geared to influence their perceptions and understanding of themselves and of their experiences. And when warranted, to also shape their values in a positive and socially acceptable direction.

But while there is agreement that some behaviors – such as the sexual abuse of children or adults – are unacceptable, such rules are not as clear regarding other sexual behaviors. For instance, at what age is one ready to engage in sexual behavior? Should casual sex be discouraged? Is accessing internet pornography helpful? And considering all that: when should the psychotherapist challenge their client?

Sex therapy is not an exact science and there are various gray areas which do not have clear cut answers. For instance, it is difficult to define a dysfunction clearly or determine what behaviors are acceptable. In turn, this leaves making clear links between sexual behaviors and mental health especially challenging. Dr. Schneider, a prolific writer and research on sexual matter opined regarding what sexual activity is all about and wrote that "…if it is true that sexual activity has no meaning apart from the sating of biological drives and the provision of mutual pleasure and perhaps for reproduction and it was not yet decided upon…and that sexual activity has no enduring consequence for either party (unless someone happens to fall pregnant), and that moral values are relative to prevailing sentiments, an appropriate psychological goal might simply be to promote the conditions for a 'satisfying' sexual experience free of internal sexual conflict. It may follow that personal fulfillment and sexual release may validly be seen as the primary functions of sexual activity and the measure of good mental health" (p. 155). In other words, we are still struggling to define and attach meaning to sexual activity. However, since that is not a view that psychology, or our Western society promotes, it is incumbent upon psychologists to assist clients who may be exploring their sexuality and help them manage it effectively or resolve it. Promoting intrapsychic harmony is associated with positive self-image, and therefore therapists should enhance such harmony and encourage respect between the client and his partner.

When Facing a Sexual Problem: What Do We Expect from Therapists?

Everyone has sexual feelings, thoughts, and experiences. That is part of being human. And sometimes, that part gets intertwined with sexual problems which end up motivating people to

seek therapy. Most people are shy and embarrassed to reveal their sexual problems, and while they often dread talking about it, they actually long for those very questions. Therapists in general do not, often, make those inquiries, saying to themselves such things like 'I am not used to talking about sex. My discomfort and awkwardness will be obvious', or 'I do not know how to respond to what I hear if I ask such questions', 'I may offend or embarrass my client', or 'I am too embarrassed to consult with my colleagues'.

Should a therapist ask, for instance, about a client's sexual experiences? Since many clients have a problem discussing their sexual concerns, the therapist must assume responsibility for raising the issue, and as a client or patient you need to expect the therapist to do so. The emphasis of our culture on youth and beauty may interfere with therapists' readiness to ask the elderly about sexual matters, since they are commonly seen as asexual. As we know, timing is important, so a person who is grieving a loss of a loved one should not be asked about sexual matters. But once the time is right, it is important to inquire about those matters.

Dr. Risen, a sex therapist and clinician, outlined in a 2010 book the best way to achieve the goal of addressing sexual issues. First and foremost, the clinician must use the proper vocabulary; one that the client can understand. It is often difficult to correctly pronounce words such as penis, vagina, masturbation, erectile problems, lack of sexual desire, or clitoris, but the therapist should not shy away from discussing such topics. And so, the clinician needs to open a discussion about sexuality, and then let the client tell his story, as he sees fit. Such stories have a pattern of flow, characters, and meanings.

One more note to the therapist: be flexible and ask open ended questions that encourage clients to open up and discuss their issues using their own language at their own speed. During couple's therapy, there are three main issues which clinicians need to be aware and sensitive of: one is that most couples do not discuss sex; two and related to the previous point, each partner may provide his or her own unique point of view which may differ and even contradict; and three, there may be sexual thoughts, fantasies, desires, and secrets that the couple did not share with each other and they may have difficulties sharing these ideas with their therapist, in front of their partner. Consequently, and as I have always done in my own practice, it is wise to start with a joint session but then see each partner separately, at least once and often twice. Each partner's desire, arousal, and orgasm patterns impact one's partner in a positive or negative manner. Equilibrium is continually sought after and may account for the different outcomes from one partner to another and even from different sexual encounters with the same partner.

Managing Boundaries between Client and Therapist

During the normal course of the therapist's work, he or she is likely to meet colleagues, students, or clients with whom the therapist may feel closeness and care for. This is a normal occurrence and happens in any human interaction. The client, who shares his or her life story is, thus, vulnerable. That vulnerability may give rise to strong feelings that the therapist may experience. Handling those feelings is one of the greatest challenges to being a health care professional. Dr. Plaut, in 2010, discussed therapy for clients who have sexual problems and observed that "…if those feelings are unrecognized, denied, or mishandled, we risk crossing appropriate provider-client boundaries. Boundary crossing may range from social contact

outside the practice setting, to excessive personal disclosure, to sexual activity with a client" (p. 21). Boundaries are important, and as a potential client in therapy, you need to be aware of them and not allow them to be crossed. While the onus is on therapist to keep boundaries intact, you need to watch for any violations and alert the therapist to such occurrences. Dr. Plaut reviewed the causes which may be responsible to boundary violation, and which stem from the kind of therapy that is being sought:

- *The nature and basis of the therapist's obligation to clients* – professionals are given significant power by their clients. Our relationships are based on trust and support, in which the clients have faith in their therapist's knowledge, skills, and ethical behavior. A professional relationship, as Dr. Plaut pointed out, demands a degree of separateness and objectivity that is critical to clinical relationships. You, the client, may even attempt to cross a boundary, but it is clearly the responsibility of the therapist not to let it happen.
- *Sex therapy includes some risk factors for, both, the client and therapist.* Personal characteristics that either the client or therapist have may make them more vulnerable to cross boundaries, and thus, put the professional relationship at risk. Such vulnerabilities which may heighten the risk of boundary violations and may include inadequate social support systems, a history of physical, psychological, or sexual abuse, or the absence of genuine care in their relationships outside of the therapeutic room. If any, or several, of those conditions exist, the client may reach out to the professional in an attempt to secure the care and love that he is lacking. Clearly, a sexualized behavior on the part of the therapist is unacceptable, and will most certainly be damaging to the client.
- *The process of client-provider boundaries.* Intimacy between a client and therapist exists on a continuum. Amongst the problematic issues that therapists must be cognizant about are the dual relationships that need to be avoided as much as possible. This may include personal and inappropriate disclosures to clients that may also involve any exchange of gifts, unless they are token ones.
- *Why are boundaries* so important? Psychotherapy or sex therapy are intimate, non-sexual exchanges that may lead to close and emotionally tied bonds. Both the client and therapist may, naturally, be pulled closer to one another, and thus cross boundaries. Events which may seem isolated at first within the context of the relationship can surpass isolated boundaries that may be seen as naïve or unintentional, but may later be cause for greater concern.

Reversing Sexual Side Effects of Medications

It was suggested that due to the shame of discussing their sexual difficulties, patients may become medication noncompliant, if those medications result in sexual dysfunction. Research has documented that in Great Britain, Spain and the USA (all are Western countries), only one third of those patients will openly discuss their sexual difficulties without the therapist or physician inquiring about it.

Drug-induced sexual dysfunction. If sexual dysfunctions are caused by medications that were prescribed to a client, it must be based on a carefully taken sexual history which should be a part of every comprehensive initial evaluation. As sexual problems begin within days or weeks after consuming the medication, it should be relatively easy to understand the effects of these medications on a healthy patient's sexuality. Those difficulties may include a decrease in libido or sexual fantasies, ejaculatory problems, erectile dysfunction, or orgasmic difficulties which may occur during masturbation or sex with a partner.

A complicated situation may arise if the disease for which the medication was prescribed may also cause sexual dysfunction, like diabetes. Sexual dysfunctions are known to be associated with such psychiatric conditions such as depression, anxiety, anorexia, borderline personality disorder, and schizophrenia. Other physical illnesses which are also associated with sexual problems include hypertension, cardiovascular diseases, multiple sclerosis, epilepsy, and kidney failure. Evaluating these conditions become complicated if the patient's sexual functioning was less-than-normal prior to the use of the prescribed drug.

Psychiatric drugs are also known to cause sexual problems as well. As a rule of thumb, most drug-induced sexual difficulties occur at the initiation of drug therapy or following increases in dosage. A closer look at various drug groups reveals that *antidepressant drugs*, especially SSRIs, are associated with orgasm or ejaculatory delay, some erectile difficulties, and decreased libido. This is often more pronounced in men than in women. Tricyclic antidepressants, which are different from SSRIs, may cause ejaculatory delays, and in some, inhibit orgasm. *Tranquilizers*, such as Xanax, Valium, Ativan, or Librium, which aim to calm the person interfere with ejaculation and orgasm. *Antipsychotic drugs* have been shown to cause decreased libido and erectile dysfunction in men and anorgasmia in women. Various antipsychotic drugs have been linked to priapism in men and women, with a prolonged, painful erection that can result in damaged corporal cavernosa tissues, the spongy tissue in the penis which facilitate erection in men, or painful clitoral priapism in women. *Nonpsychotic drugs*, such as those prescribed for high blood pressure, may result in erectile problems in men (yet it is still unknown how they affect women). *Chemotherapy and radiation* (which are often used to treat cancer), are associated with problems in libido, erection, and lubrication. In fact, an increased frequency of sexual dysfunctions has been found in cancer survivors. For example, women with breast cancer suffer from menopause and severe dyspareunia or genital pain due to the fragility of the inner lining of the vagina and decreased capacity to lubricate when sexually aroused.

Drug abuse has also been implicated in causing sexual dysfunctions, including (ironically) aphrodisiacs, which aim to increase sexual arousal or pleasure. Alcohol and tobacco, which are legal and are often seen as 'social lubricants' may, if consumed chronically, result in sexual problems. Alcohol may inhibit testosterone production and lead to feminization in men, while in women it may result in hypoactive sexual desire disorder. On the other hand, smoking interferes with erections due to the potential development of atherosclerosis which inhibits blood flow into the penis, and thus hampers erection. Cannabis and Illicit substances such as cocaine may initially increase sexual desire and arousal (which may, at times, result in priapism). However, chronic consumption of cocaine has been associated with impotence and orgasmic difficulties. This is similar to other substances like amphetamines or cannabis, which have similar effects following chronic use.

What Changed: Evolutions and Revolutions in Sex Therapy

Western society has long placed a great premium on male sexual prowess. And while the meanings and narratives surrounding male potency has evolved over time, it has always been hailed as important. Therefore, what has also followed is a pressure placed onto men to maintain performance in their sexual lives. Yet, when performance fails, it may be seen as painful and humiliating. Consequently, Western history is marked by a repeated and unrelenting demand for effective cures allocated for men's sexual problems and dysfunctions. At present, medications are the leading treatment approach for male sexual dysfunction, such as Viagra. But apparently, this chemical approach has not been new. In the past, physicians, academics, and even charlatans have been known to offer purportedly revolutionary cures, such as rhinoceros' horn, Spanish flies, mandrake root, and a host of other 'herbological' methods to safeguard men's sexual performance. It is interesting to take a tour, in a time capsule, of cultures and eras of bygone years to see what 'solutions' were offered to man's sexual difficulties.

The History of Treating Sexual Dysfunctions

From the Ancients to the Middle Ages

Impotence in ancient times was considered an illness, and thus had to be cured. To this day, we still hold that binary approach which results in us looking at sexual functioning in terms of health and pathology; normalcy and abnormality. Ancient societies conceptualized sexual dysfunctions, and their causes, in physical and biological terms – believing that erectile dysfunctions were the result of physical exhaustion, illness, and old age. Ancient cultures were influenced, to a large degree, by spiritual and mystical explanations for cures treating sexual dysfunctions. For the most part, ancient civilizations attributed dysfunctions to biological and natural causes, disregarding the psychological and social factors which significantly influence these conditions. These, naturally, affected the ancient cultures' treatment practices. The most widely known of ancient societies were the ancient Greek and Roman cultures who treated sexual dysfunctions with herbs, and documented these treatment methods quite well in their scriptures. European healers often used magic and herbology to treat sexual dysfunctions. In general, medieval societies did not acknowledge psychology as a significant dimension of men's sexual problems, favoring physical and metaphysical explanations and cures.

The Precursors of Sexual Medicine

Although ineffective sexual treatments continue to be used and aggressively marketed online even today, the history of these processes invoked a significant shift which transpired through the 17th and 18th centuries. This paved the way for scientific and medical models that now govern the legitimate sexual treatments of our time. And in those centuries marked a gradual shift from metaphysics and religion towards medical scientism, which led to the development of our contemporary biopsychosocial model; which considers biological, psychological, and social factors as causing dysfunction.

Recent History

The period between the 1880s and 1930s has been described as the first definitive era in the history of sexology. However, the era between the mid-19th and mid-20th centuries revealed the emergence of psychological explanations and psychotherapeutic cures for sexual dysfunctions – which, at times, neglected physiological theories and treatments. This marked the 20th century's idea of sex therapy as being primarily psychological in orientation; underemphasizing the biological aspects of treatment. In turn, as the 20th century progressed, psychologists gained influence in the field which increasingly became multidisciplinary.

Masters and Johnson: Biopsychosocial Sex Therapy Pioneers

Between the 1950s through the 1970s, there was a shift from psychodynamic techniques to cognitive behavioral treatment approaches, and the biopsychosocial model which we largely use today. Its first explicit articulation in the sex therapy field was pioneered by Masters and Johnson in 1970 who were often known as the "Masters of sex," after whom was the TV series of five years ago named. They asserted that proper sexual functioning requires an effective coordination between the biophysical and the psychosocial dimensions of sexual responses. And in failing to do so will ultimately affect both perspectives.

Biopsychosocial Sex Therapy and Biomedicine

Throughout the 1980s and 1990s, we saw an increase in the utilization of physiological methods by health practitioners to treat sexual dysfunctions. This included methods such as vasodilator injection therapies (i.e., medications that opened/dilated blood vessels), hormone replacement therapy, vacuum pumps and penile implant surgeries to treat erectile dysfunctions, as well as the use of selective serotonergic reuptake inhibitors (antidepressants) to treat premature ejaculation. The advent of Viagra (sildenafil), in 1998 from the United States, and other such drugs like Cialias and Levitra in 2004 further entrenched this biomedical orientation. And as the medical approach began to take hold in the 21st century, fostered an understanding of pharmacotherapy as the treatment of choice. And so, whereas the ancient Greeks and Romans prescribed "an inciting herb or beverage" to reduce sexual dysfunctions, contemporary physicians prescribe Viagra instead.

Dr. Berry, who wrote about the history of sexual treatment in 2013, stated that "…despite their revolutionary qualities, sexuopharmaceuticals, (medications designed to improve or maintain sexual function) are not a self-sufficient cure for men's sexual dysfunctions…First, pharmaceutical interventions believe the true complexity of sexual dysfunctions. As is widely accepted, the biomedical approach to sexual dysfunctions simply disregards the psychological and interpersonal dimensions of sexual behavior...Simply put, drug therapies are not a panacea, and the biomedical model embodied by the Viagra revolution poses a serious threat to comprehensive biopsychosocial treatment," which are essential since humans and their dysfunctions are complex (p. 33).

What Happens When Love and Sex Clash?

Whether there is an association between relational and sexual problems is what unfolds as therapy progresses. It is noted that not all couples with sexual problems have a deep-rooted relational difficulty. Bad sex may also happen to happy couples. Sexual problems may, or may not be, related to underlying anger or a lack of fulfillment. It should be noted that a minority of couples still have great sex despite being in conflicted, unhealthy relationships. In that, good sex also happens to unhappy couples. So, we cannot automatically think that sexual problems signal relationship conflict. Therefore, how does bad, or even a lack of sex, happen to 'good' couples? It is known that long term relationships may drift toward sexual stagnation. Moreover, it was found that sexual dysfunction is associated with relational conflict. Consequently, it is interesting to examine how couples lose their sexual connection and whether it can be revitalized in these pairings.

In 2008, Dr. Meana and Dr. Sims conducted a study of 20 married women who experienced distressing decreases in sexual desire. The women were asked to explain what has occurred and their responses were categorized into three major themes:

- *The relationship became institutionalized* – the women claimed that when the relationships became formalized, their desire decreased. Sex was now seen as an obligation rather than an exciting adventure. By being so accessible, it left little room for a desire to build into a crescendo. As cited by the researchers, "…Marriage (they said) came with budgets, mortgages, juggling work and kids' schedules, and much anxiety about future security. Little room was left for the carefree, present-focused abandon that they associated with exciting sex."
- *Overfamiliarity* – the gradual loss of individuality in both wives and husbands that married life encourages was seen as responsible for the dissipation of romance. Thus, turning sex into a mechanical, orgasm-centred exercise.
- *Desexualizing roles* – with the roles that these women occupied in their daily activities, such as being mothers, housewives, and working women, it was difficult to adopt their sexual roles outside these identities. They simply stopped seeing themselves as sexual beings.

It was theorized that passion may not be a result of any specific level of intimacy, but rather a function of *changes* in intimacy. One's passion may reach its peak during periods when intimacy 'jumped' from one level to a higher one, like when a new relationship with a stranger quickly becomes into a friend or lover. However, as that level of intimacy stabilizes, passion subsides until the next leap occurs. We could, consequently, say that passion is energized by discovery and not by familiarity. Consequently, during sex therapy, there needs to be an emphasis on maximizing intimacy in an attempt to reenergize passion. In that context, I would like to quote Dr. Meana, who in 2010, poignantly wrote that "…Many couples function as if their relationship is background music that can only be turned up after all the more urgent tasks have been addressed (which of course never seem to happen). This is not so. A sexual connection is quite fragile and does not generally survive delays as well as do house renovations or that golf game." Sexual dysfunctions, should they occur, are experienced more detrimentally by unhappy couples than by couples who are doing relationally well.

Psychological and Relational Factors in Sexual Functioning

In 2010, Dr. McCabe and colleagues succinctly summarized what can promote sexual function or dysfunction. Take a listen. "…The ways in which love and affection are expressed in one's family of origin, the traumatic sexual experiences one has growing up, the religious, cultural, and societal messages about sex, and the ever-increasing impact of the media on one's beliefs and behavior clearly play a role in promoting sexual health or dysfunction" (p. 327).

The Predisposing, Precipitating, and Maintaining Factors of Sexual Dysfunctions

Factors which *predispose, or make the person inclined,* to increased prevalence of sexual dysfunction includes, both, constitutional meaning such as congenital illness or anatomic deformities, and prior life experiences. As, for example, problematic attachments, neglectful parents or sexual and/or physical abuse. *Precipitating*, or causal factors, differ from person to person impair sexual desire or performance and trigger sexual problems. For instance, repeated humiliation from one's spouse for experiencing erectile problems may cause one man to lose his erection, while it does not affect another man. Similarly, in response to the discovery of a partner's infidelity, one woman may lose sexual desire, while another may become more driven and sexually active.

Although, not every problematic or distressing event results in a long-term dysfunction. However, conflictual separation or divorce, unsatisfying sexual experiences, mutilating surgeries, or other disabling events, may damage one's self-confidence and result in sexual dysfunction. For a problem or dysfunction to persist, it requires factors which will maintain it. *Maintaining* factors include relational conflict, performance anxiety (which either partner may have but is usually the domain of men), guilt, inadequate sexual stimulation, psychiatric disorders which interfere with emotional closeness or sexual performance, a fear of intimacy, anger/resentment towards a partner, or even poor communication may prolong and exacerbate problems, regardless of what caused them in the first place. *Contextual factors*, which may 'help' in maintaining a sexual difficulty encompass the present-day stresses and demands that impinge on the individual or couple. That may include, among other issues, serious financial struggles, unemployment, and the burdens of caretaking for a sick parent, child, or partner.

How Does Anxiety Affect Sexual Dysfunction?

Anxiety was identified by psychodynamic approaches as a significant cause of sexual disorders, and consequently became the foundation for the causal factors of sex therapy established by Dr. Masters, Ms. Johnson and Dr. Helen Singer Kaplan in the 1970s. Recent studies found that sexually dysfunctional individuals exhibit heightened levels of anxiety, confirming the central role of anxiety in the maintenance of sexual disorders. Anxiety, which may be a stable personality factor, might be a condition that plagues the person in their daily life or may just be confined to the sexual sphere. There are various studies that pointed to the close relation of erectile dysfunctions (ED) and anxiety. Laboratory evidence has indicated that anxiety, does not facilitate or hamper sexual arousal in functional people. It was suggested that a difference

in selective attention distinguishes functional from dysfunctional sexual responding. Meaning, that what sex therapists commonly consider as performance anxiety, a fear of inadequacy, or spectatoring are seen as forms of cognitive activities that distract dysfunctional individuals from appropriately processing stimuli in a sexual context. For women, the relationship between anxiety and sexual performance is mixed, with the possibility that it is more a negative than a facilitative factor. It is important to differentiate between general anxiety, sexual anxiety, and performance anxiety. Anxiety could be sexually disruptive if there is a chronic history of anxiety which seems to impair sexual functioning. All in all, recent literature suggests that the role played by anxiety in the development of sexual dysfunctions may not be as pivotal as was proposed in the 1970s.

Depression and Its Effect on Sexual Function

It is believed that both mood and sexual disorders are highly prevalent and are believed to occur together with shared common causalities. It is generally accepted that the relationship between depressive mood and sexual dysfunctions are bidirectional, and are not at all helped by the complicating effects of antidepressant medication. And while the exact direction of causality is difficult to ascertain, research supports the functional significance of mood disorders in causing and maintaining sexual dysfunction. Consequently, assessing for depression and the role of antidepressant medication as it pertains to sexual difficulties becomes incredibly important during the initial evaluation of those with sexual dysfunctions.

Interpersonal Factors of Sexual Function and Dysfunction

Sexual problems may sometimes cause and be the result of dysfunctional or unsatisfactory relationships. Often, it is difficult to determine which came first; a non-intimate and non-loving relationship, or problems related to sexual desire and/or performance in one or both partners. Based on related research on the topic, we know that there is a significant relationship between sexual and relationship functioning. It appears that the chance for better long-term outcomes is increased when relationship issues and sexual problems are treated and resolved.

When we deal with interpersonal factors, we may want to explore the role of love and intimacy in sexuality. Cultures vary greatly in the degree with which they perceive the importance of love in marriage. In the Western hemisphere, emotional intimacy and feelings of love are fundamental to sexual satisfaction and pleasure. And indeed, love seems to be a vital ingredient that is needed to foster and maintain strong and satisfying interpersonal and sexual intimacy. Therefore, it is logical to assume that the treatment of sexual problems must address the quality of care and love between partners, particularly over long-term relationships.

Psychological Treatment of Female Sexual Dysfunction

Sexual complaints of women range from a lack of or diminished sexual desire to pain during both genital and non-genital sexual activities. Many women also report sexual dissatisfactions

that do not involve actual physical impairments, but rather, such complaints related to a lack of pleasure, enjoyment, satisfaction, and passion. Interestingly, as pointed out by Dr. McCabe, it is these behaviors that lead to successful treatment in women. As such, women commonly perceive genital arousal without pleasure as an unsatisfactory compromise. Let's explore some other complaints that women have with this topic.

The most prevalent female sexual complaint is Hypoactive Sexual Desire Disorder (HSDD) which is described as having a low libido or sexual desire that is associated with a lack of interest in sex. About 30% to 35% of women complain of it. In fact, a 2001 study by Dr. Trudel and colleagues compared CBT geared to address desire disorders to a control group which were not treated with CBT and found astonishing results. Only 26% of the low-desire women continued to report this problem at the end of treatment, pointing to the significant improvement that CBT may bring to one's sexual and marital life, sexual satisfaction, perception of sexual arousal, sexual self-esteem, and the reduction of internalizing symptoms like depression or anxiety.

Sexual Arousal Disorders

Lately, increased attention has focused on reexamining female arousal disorders. It has been proposed that female arousal disorders are comprised of four subtypes: *genital sexual arousal disorder* (where the woman experiences spontaneous genital arousal), *subjective sexual arousal disorder* (where a genital response to sexual stimulation occurs without mental awareness of sexual pleasure), combined *genital and subjective arousal disorder*, and a more recently conceptualized condition called *persistent genital arousal disorder* – which is characterized by persistent genital vasocongestion (i.e., the swelling of bodily tissues caused by increased vascular blood flow and localized increases in blood pressure). This may occur without the women consciously desiring sex, leading to dissatisfaction in feeling unrelieved and distress.

Orgasmic Disorders

No single factor has been shown to be strongly related to orgasmic responses and dysfunction in women. Research has indicated that women with orgasm difficulties tend to experience feelings of guilt, are not sexually assertive, and hold negative attitudes toward sexual activity which includes intercourse or masturbation. They tend to be less aware of the physiological signs of arousal and orgasm, and they often fear the loss of control which experiencing orgasm requires.

Similar to other sexual dysfunctions, female orgasmic disorder can be divided into lifelong and acquired subtypes; each requiring a different treatment approach. Lifelong and generalized orgasmic problems respond well to masturbation training which was started in the 1970s in New York. It focused on self-stimulation as a way of becoming aware of the type of stimulation needed to increase the woman's sexual arousal. In various studies involving a total of 600 women who experienced orgasmic dysfunction, it was found that those who have the most successful results were those prescribed with directed masturbation. In contrast, other treatments like systematic desensitization, which is a behavioral therapy based on the principle

of classical conditioning and directed masturbation with sensate focus (which Masters and Johnson originated) were less effective when done alone. This process works by refocusing the participants on their own sensory perceptions and sensuality instead of goal-oriented behavior focused on the genitals and penetrative sex. As some women with acquired and situational female orgasmic disorder become less satisfied with their overall relationships, treatments which address the couple's issues along with sex therapy is effective for the resolution of these problems. Although, it should also be noted that acquired orgasmic dysfunction may also be the result of medication side effects, especially antidepressants. Generally, most treatment programs for acquired female orgasm problems include a combination of sex education, sexual skills training, couple's therapy, masturbatory training, and sensate focus exercises.

Treatment Approaches for Anorgasmia

Treatment for the most common complaints related to female sexual dysfunctions are organized, below, according to the school of thought on which they are based.

Psychoanalytic (or Freudian) theory views sexual dysfunction as a symptom that expresses a pathological process in personality development. That may be the result of castration fantasies and unconscious fears about sexuality which the individual may harbor. The ability to experience orgasm is seen as an indication of ability to relate to others. Object relations theory, which is related to the psychoanalytic approach, addressed the ability to relate to others and saw the relationship with the mother as pertinent to adult heterosexual functioning. According to this theoretical orientation, mother-child relationships reflect the infant's attempt to fulfill their mother's emotional needs similar to that of their sexual partner in adulthood. As such, clear boundaries with an internal sense of separateness are needed in order for one to be able to tolerate intimacy. If those clear boundaries cannot be established, conflict with closeness may result in anger, inability to trust, hostility, and inhibited orgasm. Several ego defenses may be related to orgasmic dysfunction such as denial or projective identification which results in one unconsciously projecting their feelings on a significant other and thereby addressing unacceptable impulses that may interfere with orgasmic responses. As we can gather, psychoanalytic approaches wish to explore the underlying conflict which may have caused the problem, but does not aim to fix it.

Cognitive behavioral approaches (like *CBT*) are based on theories of learning and cognitive processing to explain the origins and maintenance of orgasmic problems. Anxiety, which may have been associated with sexual arousal, interferes with relaxation and makes orgasmic response unachievable. Cognitive behavioral approaches aim to promote cognitive change, reduce anxiety, increase orgasmic frequency, and enhance the connection between positive emotions and sexual behavior. According to this approach, treating women requires privately enacted behavioral exercises, the "debriefing" of the results, and new exercises which are assigned to meet the client's needs. Women who suffer from primary anorgasmia are often prescribed Directed Masturbation (DM), wherein the woman is taught to kinesthetically explore her body and then masturbate. It's quite effective with a success rate of between 80% to 90%. Another behavioral technique called the coital alignment sees the woman in a supine position (i.e., on her back) with the man lying up and across from her so that there is enhanced clitoral contact, which increases her ability to orgasm. Kegel exercises, which were developed to

instruct women on how to contract the PC muscle, may contribute to enhanced arousal and facilitate a woman's awareness and comfort with her own genitals, thus, leading her to orgasm.

Systems theory approaches has been primarily developed with marital and family therapies. However, several of its concepts may be applied to sexuality. According to this approach, each person is a system that lives within a system (i.e., the family) which lives yet within a larger, macro system like society. The systems approach sees the couple as more than the sum of the two people and includes the relationships between the couple in that 'calculation'. This helps to view the couple as one that can be helped together, rather than adopting a 'one against the other' approach. It teaches them to build a non-judgmental working alliance. Additionally, the couple is taught how to change and adapt, maintain stability, and understand that a change in one element of the relationship influences the other elements.

Pharmacotherapy. Despite the success of Viagra (Sildenafil citrate), there is no counterpart medication for women. No studies exist, to date, about medications for women with orgasmic dysfunction that is not caused by another medication.

Sexual education and bibliotherapy have produced positive results for the amelioration of orgasmic disorders. Sexual education has been found to reduce sexual anxiety and increase orgasmic frequency. It appears that reading may be an adequate intervention for a motivated woman.

Male Sexual Dysfunctions

Hypoactive Sexual Desire Disorder (HSDD)

There is no research that has focused solely on the psychological treatment of men with HSDDs despite this dysfunction being more common in men than in women. Both pharmacological and psychological treatments have been utilized thus far, but no research to date has yet to indicate whether they are effective.

Erectile Dysfunction (ED)

Men with either lifelong or acquired ED have been shown to achieve significant gains following participation in sex therapy. Sex therapy assists those with acquired ED more than those men with lifelong ED. Dr. Masters and Dr. Johnson reported initial failure rates of 41% for lifelong (primary) and 26% for acquired (secondary) ED. According to this research, gains achieved in therapy persisted two to five years following treatment. Dr. Mohr and Dr. Bentler reviewed in 1990 a variety of treatment programs for men with ED and observed that "…The component parts of these treatments typically include behavioral, cognitive, systemic and interpersonal communication interventions. Averaging across studies, it appears that approximately two-thirds of the men suffering from erectile failure will be satisfied with their improvement at follow-up(s) ranging from six months to six years." In short, men with ED can be helped.

What does the sex therapy of ED consist of? It employs systematic desensitization, sensate focus, psychodynamic interventions (which help to resolve underlying internal conflicts or shame), behavioral assignments, sex education, communications and sexual skills training, as

well as masturbation exercises that encourage healthy erectile outcomes for the man. Like most sexual dysfunctions, ED affects not only men, but their partner(s) as well. It negatively impacts the man's psychological well-being and may be associated with behavioral changes such as an avoidance of intimacy which may harm the couple's relationship. As such, roughly 75% of treated couples reported a recurrence of or continuing difficulty with this type of sexual problem.

Medical and Psychological Treatment Approaches for ED

ED is associated with a variety of medical and psychological risk factors which may result in not only in negative, but at times, devastating effects on a man's self-esteem. Apparently, ED may be an early marker for cardiovascular conditions and other diseases like heart problems related to diabetes. The availability of safe and effective oral therapies, such as Viagra, has resulted in a dramatic increase of men who seek treatment.

Some interesting facts about ED:

- While ED may occasionally manifest in men during their 40s and 50s, it increases markedly in men over 60 years of age.
- In their youth, men are very bothered by ED. As they age, they seem to be less bothered by it. As expected, treatment is sought mainly by younger men.
- Prevalence of ED is highly correlated with known risk factors and other illnesses. Hypertension, hypercholesterolemia (high cholesterol), diabetes mellitus, and metabolic syndrome (which is a group of health problems that include too much fat around the waist, elevated blood pressure, high triglycerides, elevated blood sugar, and low HDL cholesterol) have all been shown to be associated with ED. Depression has also been positively correlated with ED.
- Lifestyle factors, such as smoking, obesity, and lack of exercise are significant predictors of ED.

The Viagra Revolution

Since 1998, as the sale of Viagra, Cialis and Levitra skyrocketed, it marked a major change in the treatment of ED. More men were ready to come forward and seek treatment for ED, and treatment was now offered mostly by primary care physicians with invasive procedures, which were used in the past, quickly declining in popularity. Instead, new guidelines suggest that a brief sexual and medical history be collected, physical examination and standard laboratory test be done to rule out such diseases as diabetes or hypogonadism for oral medication to be prescribed. And although the use of Viagra is safe and widespread, there are some medical risks that need to be taken into account before its use in treatment. For instance, those who may use nitrates should not use Viagra or the other meds for ED.

Of the three erectile medications that were mentioned, results have shown their effectiveness to be quite high as they can restore erections in about 75% of men. But while these drugs may facilitate better erections, they cannot address other issues related to relational problems may be responsible for such failed erections. One study found that 58% of men with erectile problems had discussed with a health professional about their concerns, but fewer than half of them received a prescription for Viagra or other medications. Of this sample, only 16% of them continued to use the drug when queried by the researchers – citing fears of side effects, concerns voiced by their partner, and a general distrust of medications as having contributed to the discontinuation of the prescribed medications. Couples who have experienced chronic sexual or marital conflict, lack of desire, or significant psychiatric illness in either partner, may benefit from erectile medication much less.

As such, authors and clinicians recommended a combination of medical and psychological interventions to deal with ED, particularly when low desire, sexual initiation difficulties, or the presence of other sexual dysfunctions in either partner may make progress difficult. Marital therapy could be useful in addressing ED, with or without medication. However, it is much less used presently, due to the ease of getting prescriptions for Viagra. Overall, it is highly recommended that an integrated model for the treatment of ED be utilized, regardless of whether it is caused by organic or psychogenic factors.

Psychological Factors in ED

Psychological causes of ED have been divided into immediate and remote factors. Within the immediate factors, we can find performance anxiety, a fear of failure, a lack of adequate stimulation, and relational conflicts in this category. Performance anxiety, in particular, is known to be a major psychological hindrance to erections. This may lead to the man adopting the ‘spectator role’, as Masters and Johnson termed it, where the man is focused mainly on his performance during the sexual act, rather than on erotic stimulation. And among the remote or early developmental causes of arousal disorders such as ED, we can find childhood sexual trauma, sexual identity or orientation issues, unresolved partner or parental attachment, and religious or cultural taboos has having significant impacts on sexual disorders as well.

Cognitive components must also be considered when treating ED. Specifically, male attitudes to sexuality. Men with ED are known to experience shame and guilt with their ED and prefer to think of it as organic rather than psychological in source. And when anxiety is present in men during sexual arousal, it is almost always enhanced by cognitive factors.

Along with the individual causes of ED, we can also find couple and relational issues such as communication difficulties, a lack of intimacy or trust, power conflicts or a loss of sexual attraction as adding to the initial causes of ED. Sexual stimulation may also be a problem as men age, due to stronger, more intensive physical and mental stimulation being needed for satisfactory erections to occur. Since older men respond less to provocative imagery with age, direct sexual stimulation to the penis rather than an emphasis of erotic imagery or fantasy during sexual acts is required. Unfortunately, the female partners of aging men are, usually, unaware of these changed needs and may erroneously believe that the man’s lack of arousal is due to sexual disinterest or that he does not find her attractive anymore.

How Is ED Treated?

Traditional sex therapy approaches have emphasized four major areas of intervention:

- Anxiety reduction to make the man more relaxed so that he does not get involved with spectating
- Cognitive-behavioral intervention
- Appropriate sexual stimulation
- Improving couple communication

As was mentioned earlier, men may resist psychological treatment and prefer medical approaches. However, it must be understood that the combination of medical and psychological treatments may be most effective for these conditions. Additional strategies that may be utilized are the use of self-hypnosis and fantasy training for overcoming psychogenic, or 'mind produced', ED. These techniques are not widely used.

Sexual stimulation techniques – couples who lack alternatives to penile-vaginal intercourse exert increased pressure on the man to 'produce' an erection. This increases his fear of failure which may result in reduced desire overtime as the man does not want to get into situations that may produce future failures. A vicious cycle may develop where a loss of sexual or affectionate interaction is associated with increased performance demands and interpersonal distress. As such, the woman has a critical role in helping treat the ED, depending on her attitudes toward coital sexual stimulation. If the man can be reassured that his partner finds their lovemaking satisfactory and that her enjoyment and orgasms do not depend on his ability to get an erection, his performance anxiety will be markedly reduced, and significantly increase his chances of getting a satisfactory erection.

Interpersonal and systemic interventions – As was earlier alluded to, couple issues play a role (and sometimes, even a major one) in many cases of ED. Relational difficulties may be a primary cause of ED and exacerbate or maintain the man's inability to achieve or maintain an erection. There is a lack of agreement, however, between therapists as to the most effective approach of marital treatment when helping couples experiencing ED. As such, more research is needed in this area.

In turn, numerous treatment approaches have been suggested for single males suffering from ED. These include changing one's sexual attitudes, assertiveness training (so that the man may clearly and openly express himself), masturbation exercises, and help in developing his social skills, which may assist him in finding a partner. In the past, sexual surrogate therapy has been used in treating males with ED. Issues of possible medical risks and legal status greatly limit the use of surrogates in present therapy for ED, although it is still available. From what I know, it is effective for these problems.

Relapse prevention – the high rate of dropout and relapse of men treated for ED is a major problem. To facilitate the maintenance of treatment gains, the use of relapse prevention training is recommended. That may include strategies such as scheduling occasional nondemanding sessions focused solely on pleasure, the rehearsal of coping with unsatisfactory or negative sexual experiences, a focus on affectional or sexual behaviors which are not focused or related to intercourse, and the scheduling of periodic therapy during follow up sessions. This approach

was shown to encourage treatment maintenance and helped resolve sexual conflicts if they arise following the initial treatment.

Medical treatment approaches – prior to the advent of medication such as Viagra, a range of medical and surgical options were available. Today they are rarely used.

- Intracavernosal injection therapy, or an injection into the base of the penis – was, in the past, the most widely used medical therapy for males with erectile dysfunction. Injection therapy proved to be effective in most ED cases, with a 70%-80% success rate. It is not recommended for men with hypersensitivity to the drug used, or have a high risk of priapism. Side effects may include prolonged erections or priapism, penile pain, and fibrosis, resulting scar tissue, which may follow chronic use. These contribute to its discontinuation overtime.
- Vacuum constriction device (VCD) therapy – the use of VCD has been in use for a long time and is a non-invasive method of treatment approved in the U.S. by the FDA. In this treatment, the device applies negative pressure to the flaccid penis, thus drawing venous blood into the penis which is retained by an elastic constriction band placed at the base of the penis. Efficacy rates are 60%-80%, although side effects like penile pain, numbness, bruising and delayed ejaculation may occur and contribute to its high patient discontinuation as well.
- Surgical treatment – this includes the surgical implantation of a semi rigid or inflatable penile prosthesis, which these days is performed only in rare cases. And although the implants may cause inconvenience, they were associated with high rates of patient satisfaction.

Therapy needs to address, or at least be aware, of other sexual dysfunctions of either partner that remain unresolved despite utilizing therapy to treat ED. This should include couple relational problems that have persisted and may have caused or resulted in the development of ED in the first place.

Rapid (or Premature) Ejaculation

Rapid ejaculation is defined as one that occurs within about one minute of vaginal penetration, or an inability to control one's ejaculation which often results in distress or the avoidance of sexual intimacy. Since Masters and Johnson have highlighted the problem and described their treatment strategies, a variety of additional individual, conjoint, and group therapy approaches were developed. Masters and Johnson treated 432 men who suffered from PE and achieved a 97.8% success rate immediately after treatment and 97.3% at the 5-year follow-up. More recent studies which compared the efficacy of a new functional-sexological treatment for premature ejaculation (where men learn how to control their arousal without having to interrupt sexual activity) with behavioral treatments (which utilizes stop-start techniques involving the ceasing of sexual stimulation just prior to ejaculation and its renewal after it's diminished) found similar results.

Treatment of Premature Ejaculation

There are several possibilities to address PE: individual therapy for one or both partners, conjoint or couple treatment, pharmacotherapy alone, or combined pharmacological and psychological treatment. Let's examine each of these approaches.

Psychotherapy – psychotherapy alone should be offered for men and couples whom the precipitating and maintaining factors are psychological or psychosocial, rather than physiological. That may include a patient's performance anxiety or depression, a partner's ability or inability to cope with the man's sexual dysfunction, a development of a sexual dysfunction (like anorgasmia), an unsatisfying relationship, or a partners' unrealistic expectations from therapy. For single men, the default choice is individual therapy. And while individual therapy may initially be of aid to these men, it may not be highly effective long-term due to its solitary treatment form. For those men who are in a relationship, individual therapy is the treatment of choice if it is clear that their condition results from intrapsychic, internal and psychological reasons rather than interpersonal causes. This may include issues such as having fears of penetrating a dark, warm, and wet vagina or hostility that they may harbor towards women. When the relationship is deemed too chaotic to be able to work with both partners, individual therapy is also the preferred approach.

Present day psychotherapy for rapid ejaculation is a combination of psychodynamic, systems, behavioral, and cognitive approaches utilized within short term therapy. It aims to help the man lessen their performance anxiety, learn how to control or delay ejaculation, resolve interpersonal issues that may have caused or maintained their dysfunction, and increase the couple's communication. The exceptionally high outcomes (around 98% of men reached ejaculatory control) reported by Masters and Johnson, could not be replicated by others as other researchers have reported 80% success rate. All researchers reported problems of relapse, with up to 75% of couples that experienced a return of the problem to the same or lesser degree than prior to treatment.

Pharmacotherapy alone is recommended when the man has severe lifelong premature ejaculation and is in a satisfying relationship. With these factors in mind, there is a relatively good chance that treatment could help. If prescribed medication, it is noted that ED may be helped but will not be 'cured' as the condition will return as soon as the man stops taking the medication. Ejaculatory control is observed within the first week and improves thereafter. Some of the side effects of the medication includes fatigue, nausea, gastrointestinal upset, and excessive sweating – which may be quite bothersome and cause the man to stop taking the medication.

Treatment of DE (Delayed Ejaculation)

DE is seen as an involuntary and unconscious inhibition. The ultimate goal is of its treatment is to 'inhibit the inhibition'. Guided stimulation techniques aim at distracting the man from excessive control and increasing the stimulation which may hasten orgasm during partnered sex. In treatment, the client undergoes desensitization aimed at intravaginal ejaculation using tactile genital play and fantasy in order to distract the man from his fears of failure. The couple is instructed to perform specific sexual tasks aimed at desensitizing the partner gradually. The

man is given permission to be ‘selfish’ and to ‘use’ his partner to fulfill his needs. Overall, if dyadic conflicts exist, such needs require further exploration in order to be resolved.

Reframing Attitude Change

Should it be found that cognitions disturb the man from reaching an orgasm, reframing approaches can be used to resolve this problem. This technique acknowledges a lack of desire for coitus and arousal during intercourse with a partner by attending to attitude changes which may reduce these factors. Attitude and distorted belief changes are a central component of this approach. It sees the man as more motivated to pleasure his partner than himself, and when he becomes quickly erect, he does not ask for further stimulation. Thus, his low to moderate arousal level is maintained − blocking the erotic flow toward higher levels of arousal and orgasm. As such, it is recommended that the woman help the man achieve orgasm for himself, and not as a way of satisfying her.

Integrated Treatment for Sexual Dysfunction

The term ‘integrated’ is used here to denote the combination of psychological and medical interventions for sexual dysfunction. Too often, medical treatments only address a narrow proportion of sexual dysfunction while failing to treat larger biopsychosocial issues. And while their efficacy generally yields good results (50%–90% efficacy) for individuals, approximately 60% of individuals fail to continue treatment. That may indicate that psychological and interpersonal issues which they patient may have, have not been addressed. Such factors may include patient’s performance anxiety, a partner’s poor mental or physical health, partner disinterest and the poor quality of the overall relationship and/or contextual variables such as current life stresses with money or children.

Issues in Defining Women’s Sexual Dysfunctions

Dr. Pereira and colleagues observed that 40% to 45% of adult women suffer from some form of sexual dysfunction. The literature has indicated that up to 64% of women complain of desire problems, 35% of orgasmic difficulties, 31% of arousal problems, and 26% of pain during sexual activity. Desire has been recognized as the most important phase of the three phases of sexual responses according to Dr. Pereira, including desire, arousal, and orgasm. Orgasmic disorders could be primary (i.e., never experienced orgasm) or secondary (i.e., could achieve orgasm by self-stimulation but not through coitus). Anxiety is seen to have a major role in sexual dysfunctions, and accordingly, sex therapy is aimed at reducing anxiety related to sexual situations and improve sexual skills and repertoire. Additionally, it addresses the following ‘ingredients’ of healthy sexuality including communication and listening skills, emotional expression and reflection, and conflict resolution.

As such, the focus of present sex therapy seems to in achieving ‘the big O’, meaning orgasm. Since anxiety was given an important role in etiology of sexual dysfunction, CBT has

been utilized in treatment strategies. Adding to these changes, behavioral strategies could improve one's quality of their sex life.

Sexual Dysfunction and Dysfunctional Sexuality

Sex therapists are confronted not only with sexual dysfunctions, which may be characterized as a disruption in the sexual response cycle, but also with dysfunctional sexuality, which is sexuality that causes, rather than joy and pleasure, turmoil and unhappiness in a woman's life. Some examples of dysfunctional sexuality may include sexual abuse, serious sexual harassment, sexual addiction, and sexual diseases including (since the 1980s) AIDS. An example may involve sexual addiction where one's life revolves around sex, but not due to increased sexual desire. This is often seen as an attempt to dispel painful feelings and to enhance a fantasy of an enlarged self-esteem that quickly evaporates. Similarly, sexual abuse, which may be destructive to the woman's body, may not be so recognized by her, and as she attempts to please her partner, she may attempt to accept and adjust to it.

So, what can a clinician do to improve his clinical understanding of the situation?

- Firstly, the clinician needs to understand what area of sexuality is of concern to the client.
- Before any treatment is attempted, the clinician must look for marked distress and interpersonal difficulties.
- The dysfunctions that the client complains about, such as being unable to orgasm, experiencing pain during sex and having absent desire needs to be evaluated objectively.
- The relationship of dysfunction to distress needs to be explored. The connection of the dysfunction to the couple's stressful relationship, if such exists, needs to be illuminated.

  People and relationships are complex. Complexity needs to be expected. If it was an easy case, a girlfriend or self-help book would have been employed as a strategy of improving the situation. The problems that get into the sex therapist's treatment room are often complex, difficult and need skilled intervention.

Addressing Sexual Trauma

While sexual abuse and trauma have existed since the beginning of time, they were viewed as shameful and were often kept secretive by clinicians and the public. We now know that there are those (albeit, a small percentage) who suffered sexual abuse in their childhood and can go on living full lives not allowing it to define them. However, generally speaking, childhood sexual trauma is often associated with severe adult psychopathology, as well as sexual dysfunction. Let's understand what sexual trauma entails.

In 2010, Dr. McCarthy and Dr. Breetz wrote about sexual trauma and its view of negative sexual experiences on a continuum. According to them, these negative sexual experiences, which can occur during childhood, adolescence, young adulthood, or adulthood may include

sexual humiliation, sexual harassment, sexual rejection, unwanted pregnancy, sexually transmitted infections, stigmas about sexual dysfunction, or even by hurtful labels from a partner as a ‘sexual loser’. Additionally, the ways in which the trauma was dealt with in real time will determine how the person copes with it. Ultimately, clear differences in how a person views these experiences as shameful or whether they believe that these experiences control his or her sexual journey in life has significant impacts on their development overtime.

Although, the *prevalence* of sexual trauma is unclear, since many do not report the incidences that could give rise to such trauma. The estimate of child (i.e., younger than 12 years of age) sexual abuse is one in three girls and one in seven boys, which are shocking numbers. Incest was found to have the most enduring impact due to the violation of trust and bonds that are supposed to exist between the child and his or her abuser. Importantly, and across all ages, rape by someone that the child knows is far more common than by a stranger, which happens to 15%-70% of adolescent and adult women.

Treatment

It was observed that clients tended to minimize the occurrence, extent, and impact of a sexual trauma that they may have endured. However, once those issues are raised, the client needs to be encouraged to describe how the abuse had impacted them psychologically, sexually, socially, and relationally. Specifically, the psychological impacts that it may have had on them, such as anxiety, depression, alcohol or drug abuse, disordered eating, and sexual dysfunction needs to be explored and addressed. It was discovered that rape accompanied by violence or the threat of violence was the most damaging form of sexual trauma and abuse. It is known, as I have also heard it from clients who were sexually abused, that when violence and sex occur together, it overwhelms the victim and his or her coping strategies. In turn, the closer the victim is to the abuser (i.e., father, brother, cousin, minister or counselor) the greater the impact of the abuse due to the betrayal of trust which is involved. Ongoing abuse, especially if it is unexpected, has more of an impact than an isolated incidence. Boy victims tend to deny their abuse since, culturally, we are taught that it mostly happens to girls. Sex therapy to the couple can be helpful in reducing anxiety and restoring a sense of pleasure and control during sexual interactions. Although, progress is seldom linear. However, a positive sign that the person is no longer controlled by the trauma, is if she experiences desire, arousal, orgasm, and pleasure from the sexual activity.

Painful Sex

Research indicates that between 8% to 21% of American women suffer from painful sex. Moreover, an epidemiological study indicated that only 60% of women who suffer from painful sex seek treatment, while the rest (40%) remain undiagnosed and therefore untreated. Up to about 25 years ago, a woman who complained of painful sex was, almost automatically, offered sex or relational therapy accompanied with vaginal dilation. In contrast, modern approaches to these issues choose to explore the characteristics, frequency, and situations of where the pain occurs and what needs to be explored before designing specific treatment plans. As such, these

factors need to be examined first, and questions about sexual pain and its characteristics need to be asked routinely by the medical or mental health treatment provider.

For instance, it was shown that the only difference between women suffering from dyspareunia and vaginismus is the avoidance of penetration by the sufferers of vaginismus. Since these two sexual issues may be caused by a variety of factors including physical pathology, endometriosis, retroverted uterus, developmental events such as vaginal birth delivery and/or menopause clearly distinguishes what the dysfunction is and its origins. But regardless of the initial cause, pain during sexual activity diminishes one's overall quality of life, and tends to affect the women, her partner, and her mood significantly. We need to remember that these woman "…will question their worth as women, wonder what is wrong with them psychologically and sexually, and doubt their love and attraction for their partner," as Dr. Bergeron and colleagues noted in 2010.

The women's perception of their sexual dysfunction and its origins have also been shown to affect their levels of pain during sexual activity. For instance, women who attribute their dyspareunia to psychosocial factors report higher levels of pain, more sexual dysfunction, as well as more psychological and marital distress than those who attribute their pain to physical factors; regardless of what the true causes of their conditions were. Additionally, the fear of pain and the consequent hypervigilance of it, are positively correlated with pain intensity and sexual impairment.

What Can Treatment Offer?

Generally, current therapeutic options for painful sex or genital pain include medical, cognitive, behavioral, physical therapy and surgical interventions. Unfortunately, most approaches are employed one at a time rather than in combination, aiming to alleviate but one aspect of the complex array of symptoms that characterize painful sex. *Medical interventions* are recommended as the treatment of choice during the first stage of dyspareunia, and may include topical application of various kinds of corticosteroid or estrogen creams, or topical lidocaine (a local anesthetic) applied nightly.

Behavioral interventions include sex therapy, pelvic floor physical therapy, and cognitive-behavioral pain management, which teaches the woman to control pain intensity with her thinking. Studies reported success with a combination of behavioral pain management and sex therapy in helping relieve the pain of dyspareunia. Apparently, CBT was found to significantly reduce pain. Biofeedback and pelvic floor rehabilitation were found to be effective in treating vestibulodynia – which causes chronic pain and discomfort. Vestibulectomy, a minor surgical procedure to remove the painful tissue has been consistently reported as having achieved the best therapeutic outcome, with success rates from 43% to 100%, with average rates surpassing 65%-70% most of the time.

Existential therapeutic approaches have also been applied to sex therapy since it offers a significantly different perspective. But while it may be, somewhat, hard to precisely define existential therapy since there are many different branches which emphasize different elements, it mainly sees people as constructing meaning of their existence and who actively try to make sense of their world.

Clients of existential therapists are encouraged to explore the assumptions on which their world views are based and examine whether those views and assumptions became rigid and

fixed or can be changed. This leaves the client to consider alternative ways which may be more beneficial, rational, and helpful – remaining as a refreshing way of thinking even for those who do not struggle with sexual dysfunctions. Clients are particularly encouraged to acknowledge our inevitable death and our freedom to make choices in life. Thus, understanding that we are essentially alone, despite our connection with others, and the fact that life has no meaning, aside from the one we create for it.

Dr. Kelinplatz and her existential-experiential approach to sex therapy explored the lived experiences of clients with sexual dysfunctions. A brief description of a case which was described by Dr. Kelinplatz, and quoted by Dr. Barker in 2011 is as follows: “Ms. Smith was terrified of vaginal penetration. Ms. Smith had a background where sex-talk was taboo and had an ‘awful’ relationship with a man who pressured her to let him penetrate her, before she embarked on a much more positive relationship with her now-fiancé. Rather than attempting the standard desensitization treatment, Dr. Kleinplatz encouraged Ms. Smith to describe her lived experience of being orally assaulted by her previous partner. This resulted in her confronting her feelings of powerlessness in many relationships and exploring feelings of anger and ways in which she could take control. Over six sessions, her feelings of shame around her body disappeared and she reported a new-found sense of freedom. In follow-up sessions, she reported that her ‘vaginismus’ had “disappeared.”

Existential therapy sees sex as a handy existential barometer, and explorations of it within the context of the client’s whole lived experience. It can be very revealing about what they regard as meaningful, and how they relate to others and to themselves. Take for example an orgasm that can be experienced in a variety of ways, including as a mechanical release a relief of stress, a display of intimacy, the height of physical pleasure, a spiritual experience, a giving of power to another, or a form of creative self-expression. Consequently, as Dr. Kleinplatz warns, is that therapists should not focus on dysfunctional penises or vaginas, but on the meanings that the client attributes to the situation.

Mindfulness-Based Sex Therapy

There is emerging evidence that mindfulness-based interventions for improving women’s sexual functioning are helpful and effective. A lack of sexual motivation affects up to 40% of women aged 16–44, and is the most common reason prompting women to seek sex therapy. Up to 12% of women are distressed because of that. They may complain of a lack of desire for sex, having no sexual thoughts or fantasies, a lacking of sexual pleasure, and an experiencing an impaired physical sexual arousal response. To date, treatment focused approaches have mainly focused on prescribing topical testosterone, though psychological treatment has also been a major treatment method for women with sexual desire difficulties. This is because cognitive distractions during sexual activity is common in women, which has significant negative impacts on their sexual satisfaction and desire. Research has also indicated that CBT is effective for women with low sexual desire, but also has its limitations due to the often-noted distractibility, anxiety proneness, judgmental intrusions, and inattention which those women report. Consequently, other skill-based approaches may be necessary for women who do not benefit from cognitive challenging, as CBT will provide. As such, mindfulness-based cognitive therapy has been gaining traction in many domains of physical and psychological health. Mindfulness meditation has a 3500-year history and for nearly the past four decades, has made its way into

Western medicine. Mindfulness is, basically, the present-moment, non-judgmental awareness with curiosity, openness, and acceptance. It has been found to increase the ability to experience thoughts merely as mental events. Several studies indicate that mindfulness has been effective for the treatment of sexual dysfunction in women. For some, it was suggested that mindfulness may reduce the tendency those women have of spectatoring during their intimate activities. And while it is still not entirely clear how mindfulness helps to improve women's sexual functioning, but its results prove to be promising nonetheless.

Sexual Addiction and Child Sexual Abuse

While socially, ethically, and morally reprehensible, childhood sexual abuse (CSA) happens more often than we would like to believe. The sexual responses to CSA range from withdrawal and dysfunction on one end of the spectrum to hypersexuality and compulsion on the other. Although, these reactions to CSA are not characteristic of all those who were subjected to it.

Research found that factors such as the quality of one's home life and the responsiveness of their adult caretakers can reduce the harmful and negative effects of CSA. Additional factors such as whether the child knew the abuser, the extent and duration of the abuse, whether force was employed and at what extent, and negative messages and shaming activities by people within the child's environment were all contributed to exacerbating the trauma suffered by the child.

The gender of the victim and the age at the onset of victimization are significantly associated with the dysfunction that the woman will express, be it sexual inhibition or sexual hyperactivity. More specifically, boys are more likely to externalize their behavior through such expressions as aggression, sexualized behavior, and compulsive behaviors, while girls tend to internalize their behavior through depressive and anxiety. Men are much more prone towards sexually compulsive behavior whereas women (more than men) are likely to suffer from some form of sexual dysfunction. Additionally, the younger the child victims are the more at risk they become of responding to the abuse with sexualized external behavior. Younger children below the age of six will externalize the sexual abuse via through inappropriate and aggressive sexualized behavior, while children aged 12 and above will internalize and become inhibited and fearful of sex.

In turn, epidemiological studies have found a broad range of occurrences for CSA. For example, CSA ranges from 3% to 29% in the general population. However, if clinical populations are added into the calculation, it was estimated that CSA has been experienced anywhere from 10% to 62% of children. A recent survey of 15,831 individuals indicated that 22% of both males and females reported a history of CSA. However, in general, studies indicate that females are 2-4 times more likely to be victimized than males.

Treatment Option for Sexually Abused People

Treatment for adults who were sexually abused in childhood have been described as unusually long. Increased trust and self-esteem with decreased sexual problems was reported by sexually abused women who participated in year-long group therapy. Individual therapy for people with

of CSA are still relatively new, and little research to date are available regarding their effectiveness.

Sex therapy is best suited to address sexual concerns of those molested as children, given its focus on alleviating sexual anxiety and emphasis on building good communication and relearning ways of being sexual. What is of prime importance in treatment is the motivation for success, relationship satisfaction, and compliance with homework assignments. It is quite challenging to develop trusting therapeutic relationships with people who were abused, since their abuse involved a violation of trust and power, not unlike those which exist between them and the therapist. They may, consequently, display sexually provocative or even aggressive behaviors, for that is the manner they know in dealing with such situations. It makes clinical sense to first resolve the trauma of their abuse before proceeding to sex therapy, although there is not much research supporting that approach. Partners who are involved with the therapeutic process may experience vicarious and non-direct traumatization hearing what their partner went through. But it is still recommended for them to be included in sex therapy as well.

As was previously mentioned, sex therapy needs to be paced according to the client's needs and tolerance. The presenting sexual complaint needs to be defined as a couple's issue, even though people who have been sexually abused tend to take the blame for the sexual problem that the couple is dealing with. It is important that healthy and realistic goals be established. Sex therapy, or the sensual exercises prescribed, may precipitate anxiety, panic, dissociation, or flashbacks. Inner self-talk can help the client remain in the present and minimize the occurrence of dissociation throughout treatment.

Sexual Dysfunctions: Efficacy of Psychological Interventions

Around 46% of the general population report sexual dysfunctions. Sexual dysfunction is associated with impaired sexual and marital satisfaction as well as reduced quality of life. The following nine sexual disorders have been categorized into four subgroups, including: sexual desire disorders like Hypoactive Sexual Desire Disorder, Sexual Aversion Disorder; sexual arousal disorders including Male Erectile Disorder, Female Sexual Arousal Disorder; orgasm disorders which include Female Orgasmic Disorder, Male Orgasmic Disorder, Premature Ejaculation; and pain disorders which are Dyspareunia, Vaginismus. The prevalence of these sexual disorders varies. In women, for instance, hypoactive sexual desire disorders are most common (16%), while orgasmic disorders (4%) and dyspareunia (3%) are less frequent. Twenty-six percent of men suffer from hypoactive sexual desire disorders, while premature ejaculation and erectile dysfunction are appreciably lower (5% each). And since psychological factors are important in the development and maintenance of sexual dysfunction, psychological interventions have been recommended as the treatment of choice for treating sexual disorders.

Psychological interventions have two main advantages. One is that they do not have negative physical side effects like pharmacological treatments may have, and they aim to re-establish sexual functioning by increasing sexual satisfaction beyond the reduction of target symptoms. Various psychological interventions have been employed over the years in order to help those suffering of sexual dysfunctions. Treatment that was developed by Dr. Masters and Ms. Johnson originally included therapists and both partners within its process. Their approach included psychoeducational information regarding the sexual response cycle, the assignment

of behavioral exercises which they termed ‘sensate focus’ activities, and daily treatment packages which were provided in their institute over a course of 2-3 weeks. Since then, other programs have been developed, but mostly has its roots based on Dr. Masters and Dr. Johnson’s approach. In contrast to the specialized sex therapy approach, four more general intervention strategies have been proposed for the treatment of patients with sexual dysfunctions:

- Cognitive restructuring/emotional regulation, which relates to reorganizing our thinking, and gaining better control of our emotions.
- Stimulus control/desensitization, which is basically diminishing of a behavior which is triggered by the presence or absence of some stimulus.
- Behavioral activation, which helps us understand how behaviors influence emotions.
- Relationship skills building.

Other treatment options for sexual dysfunctions are marital or couple therapy, psychodynamic therapy, and cognitive therapy. Dr. Frühauf and colleagues carried out a meta-analysis in 2013 which found that psychological interventions were effective in improving both symptom severity and sexual satisfaction in patients with female orgasmic disorder and female hypoactive sexual desire disorder. Although, no clear evidence was found for sexual dysfunctions such as erectile dysfunction, premature ejaculation, vaginismus, and mixed sexual dysfunctions. Only a few studies dealt with vaginismus and dyspareunia in the results. Male hypoactive sexual desire disorder, sexual aversion disorder, female sexual arousal disorder, male dyspareunia, and male orgasmic disorder were never investigated. As such, this group of researchers concluded that psychological interventions are, indeed, effective treatment options for particular types of sexual dysfunction.

When Sexual Appetite Differs: Can We Do Anything about It?

Research indicated that about half of all married couples experience inhibited sexual desire or desire discrepancy at some time in their marriage. Apparently, inhibited sexual desire causes more stress in a marriage and long-term relationships than any other sexual function problem. An issue that many couples are unaware of is that their sexual desire levels may vary. It is known that in most long-term relationships, sexual passion subsides, but not always at the same rate for each partner which may impact the relationship. In a 2014 study of 1,054 married couples, husbands reported larger discrepancies between their desire and frequency of sexual contact with their spouse in comparison to their wives. However, another study which explored the sexual desires of 229 couples indicated that women may actually desire to have sex more often than their husbands or partners think. Sex therapists think that differences arise because, for example, one or both partners may be fatigued, ill, under the influence of alcohol or other drugs, consumed with the tasks of daily living or experiencing power imbalances or anger.

The enhancement of sexual relationships may also include some of the following: (1) Enjoying whatever sex you have rather than desiring more and being concerned by not having it. (2) Not trying to change your partner’s libido. People have different levels of sexual desire. Just accept it. (3) Attempting to negotiate a mutually agreeable compromise between your high and your partner’s low sexual desire. (4) Scheduling sex dates, which will help make sure that

sexual activity will take place. Scheduling has an advantage of eliminating sexual uncertainty for couples facing major desire differences. (5) Cultivating nonsexual affection to lower sexual expectations. As fluctuations and differences in sexual desire are normal for most couples, putting sole attention to "fixing" any discrepancy problems may not be the wisest choice. In fact, it was suggested that these discrepancies should be viewed as normal and be expected, since no two people want sex and intimacy in the same frequency or intensity all the time.

Although, since there is no norm for sexual desire, defining low desire is quite tricky. And even when one defines it, it is often based on the assumption that there is an optimal level of sexual desire. Research has indicated that lower sexual desire develops when we reach adulthood in relation to psychological distress, and that may be related or caused by, for example, depression, stressful life events, or interpersonal difficulties. The loss of desire, whether ongoing or situational, can negatively affect a relationship. A Finnish study clearly indicated that sexual desire declines for most people over time. It involved 2,650 adults and found that sexual desire was negatively associated with age and the length of the relationship, meaning that the older people got, and the longer their relationship, the more their sexual desire declined. A study of 741 women of 48 years on average found that sexual desire was lower among older, postmenopausal women. This also included those in long-term relationships and those whose partner experienced a sexual dysfunction – indicating that a sexual difficulty experienced by one partner is most often related to sexual difficulties in the other partner. Sexual desire and orgasm disorders were found to frequently accompany sexual avoidance and create stress in sexual relationships. If there are no physiological or substance use reasons for poor vaginal lubrication, it is often diagnosed as psychosomatic. However, the lack of vaginal lubrication may be misleading, since some women report vaginal dryness but are actually sexually excited, while others who experience vaginal lubrication and even clitoral engorgement, are not psychologically aroused. Consequently, many sex therapists believe that sexual arousal is much more of a psychological process in women than in men.

Male hypoactive (or low) sexual desire disorder may be associated with erectile and/or ejaculatory difficulties. A man with this disorder may not initiate sexual activity with his partner, nor will he be particularly responsive to sexual advances. These declines may be related to aging, failing mental or physical health, alcohol use, relational problems, or early life sexual trauma. Interestingly, while our culture and medical professionals advocate for healthy living and daily physical exercise, it was recently found that strenuous exercise is associated with lower sexual desire!

Enhancing Your Sex Life

What are the prerequisite conditions for good sex? Essentially, we need to be in a relaxed and comfortable situation which will enhance our desire to experience exciting sex. These conditions may vary between individuals and may include, among other 'ingredients', feeling intimate and emotionally close with one's partner, being physically and mentally alert, and embracing one's own sexual desire and eroticism. As such, we must also be comfortable with communicating these things to our partner(s) as well.

Sexual enhancement programs often assign homework to their participants. Those include:

- *Mirror examination* – use a full-length mirror to examine your nude body, without criticism, which is often difficult for most.
- *Body exploration* – after a relaxing shower or bath, engage in slow and mindful body exploration – becoming aware of the thoughts, feelings, and sensations that come up.
- *Masturbate* – while in the past masturbation was frowned upon, we now realize that it is normal, natural and contributes to our sexual health. Masturbation can start without oils, and then introduce oils without orgasm for several sessions. Simply let yourself orgasm. That way you can learn what your body likes, even if you do not orgasm.
- *Acquaint yourself with sexual aids (toys)* – sexual aids, also known as adult toys, can enhance sexual and erotic responsiveness. These toys include such aids like vibrators, dildos, G-spot stimulators, artificial vaginas and mouths, clitoral stimulators, vibrating nipple clips, explicit videos, oils, lubricants, and lotions, as well as shower massages and erotic films. They truly enhance and enrich sexual activity and pleasure.

Intensifying Erotic Pleasure

Many may believe that sexual desire is just there or happens automatically when the couple is together. However, as the relationship becomes settled and especially when they get older, their desire may need awakening. Desire can be enhanced since everyone's sexual desire is responsive and depends on the context one is in. For that to happen, the couple needs to share their life with one another, talk openly about their sexual preferences and likes, and teach each other how to be a better lover. That includes communicating wishes and sexual dislikes, being aware and perceptive of your partner's wants, trying sexual variations that both partners agree on and focusing not only on yours and your partner's genitals but also on your lips and hearts. A recent project involving 38,747 participants identified sexual attitudes and behaviors of cohabitating and married men and women who had been together at least three years. In their study, one in three couples indicated that their passion was greater now than it was in the past, with two thirds reporting that their present sex lives were as passionate as they were in the past and that sexual satisfaction was higher among those who had sex most frequently. This reportedly led to having more consistent orgasms, and incorporating a large variety of sexual acts in their intimate experiences through healthy sexual communication. As we can see, there is much to learn from that research.

The Movement from Sex Therapy to Sexuality Counseling

Sexuality counseling is a relatively new treatment approach. Various shifts in the treatment approaches to sexual problems have occurred since Dr. Masters and Dr. Johnson's ground-breaking book on human sexual dysfunction about 50 years ago. With the incredible expansion of the internet and the ease of surfing and getting to unlimited sources of information, pictures, movies, and professional publications, individuals are free to explore their sexualities and to obtain information and interactions related to sexual expression. However, this has also

significantly contributed to higher rates of compulsive cybersex. Since then, the term 'sexual addiction' has been coined and the increased use of internet-based pornography became more prevalent in fueling sexual variances and predatory sexual activities.

Medicalization of Sexual Problems

Unfortunately, the field of sex therapy − not unlike the approach utilized by psychiatry at large − has been dominated by a trend toward greater medicalization and an increasing emphasis upon pharmacological intervention, especially in recent years. Commercials for Viagra, Levitra, and Cialis provides ample evidence of direct marketing to men's' sexual rehabilitation services. These commercials normalize older people's continual interest in sex, which is a blessing. Especially in the U.S., insurance companies are more likely to reimburse for interventions provided by urologists and gynecologists than from sex therapists, and thus, most treatment of sexual dysfunctions tends to be medicalized.

What Do Men Want?

Men prefer a "quick fix," and by that, they want to avoid the demands of intimacy and true relational therapy. Consequently, men may be utilizing desensitizing gels in an attempt to delay ejaculation, rubber bands, and rings to prolong erection and intercourse, and various herbal and over-the-counter remedies to recover their potency, all of which focus on the hydraulics or mechanical aspects of sex. Since male sexuality is, evolutionarily speaking, fundamentally related to competition and conquest, it is easy to understand the allure of Viagra and other similar medications. Utilizing the "little blue pill" makes experiencing vulnerability, communication with one's partner, empathy or collaborating intimately with the other, not necessary. While Viagra can usually fix the functioning of the penis, it does not fix the functioning of the relationship – thus, leaving the problem to persist.

And Women, What Do They Need?

Women do not want a "little pink pill" to fix their sexual concerns. Instead, they seek answers to relational issues, and awareness of cultural values which guide their treatment for sexual dysfunctions, referred to as the 'new vision' of female sexuality.

Sexuality Counseling

Based on recent calls to address sexual dysfunctions in its totality, and not as a mechanical or hydraulic issue, we may refer to Dr. Annon's model of treating sexual problems, with his PLISSIT approach as a new method to sexuality counseling. That model pays special attention to stages of change in sexuality counseling:

P – Permission to talk about sexuality and sexual issues, and empowerment to make choices about sexual changes.

LI – Limited information; sex education; exploration and clarification of gender and sexual myths and stereotypes;

SS – Specific Suggestions; interventions which may include medical, psychological, and relational factors unique to the case.

IT – Intensive Therapy which may be required; ongoing engagement of the couple in systematic individual and conjoint services focusing on relationship dynamics, psychological concerns, and complex presenting problems.

We now need to examine who could provide the various services in the PLISSITT model. Counselors from marriage and family or mental health counseling training programs may be equipped by the education and clinical training to provide Permission and Limited Information. Specific Suggestions and Intensive Therapy is the domain of clinicians whose license and specialized training prepares them to offer sex therapy. In some cases, couples, or one of the partners, may require in-depth therapy in order to free their present sexual relations from the pain and shame of the past, and that should, naturally, be offered.

Towards Optimal Sexual Health

The encouraging thing about sexuality counseling is that it can be used not only to remove roadblocks linked to specific sexual disorders, but to also strengthen intimacy in committed relationships. It can assist the couple to move away from blame, shame, and guilt toward their goals in sexuality counseling. Play, loving play, and sexual play can be introduced to couples or reestablished between partners. Treatment may include instruction on expressing desires and encourage the couple to explore sexual fantasies and preferences. Additional important goals that sexuality counseling may encourage couples to engage in, are:

- Appreciating one's own body.
- Realize that sexual activity may or may not include reproduction or genital sexual experience.
- Exploring one's own sexual orientation and respecting the sexual orientation of others.
- Learning how to express love and intimacy in appropriate ways.
- Developing meaningful relationships.
- Avoiding exploitative relationships.
- Exhibiting skills that enhance personal relationships.
- Knowing the difference between life enhancing sexual behaviors and those that are harmful to self-and/or others. Expressing one's sexuality in ways congruent with one's values. (See Southern and Cade's 2011 article for a more detailed description of the above points).

This list of sexuality counseling strategies is an antithesis of the medicalized approach; reemphasizing the centrality of relational and sociocultural factors in sexual satisfaction.

The Evolution and Future of Sex Therapy

Sex therapy still remains as alive and well – being fueled by public demand and interest in the information and services that are offered by it, and by pharmacological agents that promise a longer and more fulfilling sex life. Sex therapy appears well ensconced in the clinical landscape.

While many strategies that are utilized in sex therapy are the very same ones that Masters and Johnson initiated and developed, times have certainly changed, and a new generation of researchers and clinicians view sexual dysfunctions in novel ways and developed innovative approaches to treat problems with arousal, desire, pain, and inability to orgasm. Dr. Paterson, Dr. Handy, and Dr. Brotto from the University of British Columbia in Canada developed, in 2017, an approach which directs a group of women to tune into erotic sensations and then introduce them into sexual encounters in their own bedroom. Research demonstrated the efficacy of that approach as having significant, positive implications for the field. Another study from 2018, utilized that very approach on men with erectile dysfunction, and is now under review regarding its efficacy on reducing premature ejaculation in this sample as well.

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Two women had been having a friendly lunch when the subject turned to sex. "You know, John and I have been having some sexual problems," Linda told her friend. "That's amazing!" Mary replied, "So have Tom and I. We're thinking of going to a sex therapist," said Linda. "Oh, we could never do that! We'd be too embarrassed!" responded Mary. "But after you go, will you please tell me how it went?"

Several weeks passed, and the two friends met for lunch again. "So how did the sex therapy work out, Linda?" Mary asked. "Things couldn't be better!" Linda exclaimed. "We began with a physical exam, and afterward the doctor said he was certain he could help us. He told us to stop at the grocery store on the way home and buy a bunch of grapes and a dozen donuts. He told us to sit on the floor nude, and toss the grapes and donuts at each other. Every grape that went into my vagina, John had to get it out with his tongue. Every donut that I ringed his penis with, I had to eat. Our sex life is wonderful, in fact it's better than it's ever been!"

With that endorsement Mary talked her husband into an appointment with the same sex therapist. After the physical exams were completed, the doctor called Mary and Tom into his office. "I'm afraid there is nothing I can do for you," he said. "But doctor," Mary complained, "You did such good for Linda and John, surely you must have a suggestion for us! Please, please, can't you give us some help? Any help at all?" "Well, OK," the doctor answered. "On your way home, I want you to stop at the grocery store and buy a sack of apples and a box of Cheerios."

*

A famous sex therapist was on the radio taking questions when a caller asked, 'Doctor, why do men always want to marry a virgin?' To which the doctor responded, 'To avoid criticism.'

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Chapter 13

Sexuality and Relationships

Sexuality and relationships go hand in hand. Yes, they can exist separately, but they are not as yummy, empowering, rich, and nurturing when they do not co-occur. In addition to my private practice, I teach at a local university and usually my classes are populated by students in their mid-20s. One of them, we will call her Samantha (or Sam) was talking about her relationship with her boyfriend, who made good money and liked to go out with her, but was encountering sexual problems at the time. We would not get too personal discussing it in class, but Sam made it clear that she was lonely in that relationship and did not enjoy their sex as she was unsure whether sure she loved him anymore. She was prepared to settle for any of the relational and sexual crumbs that she got; fearing that otherwise, she would be alone and lonely. Later that day, she asked to speak with me privately in my university office, and as she opened up, it became clear that for her, sex and relationships go together. Her boyfriend was quite good mechanically and even though she did reach orgasms, most of the time, she was often left feeling hollow and empty. Love, commitment, and emotional closeness were not there – and without them, sex is just an activity that couples do. Aside from providing that physical relief, it did little to get them closer together. I recommended for her to seek couple's therapy with her partner. Months later, I saw her in the hallway on my way to a class. The couple realized that they were better off separated, and Sam was attending her own individual therapy so she would be ready for when the 'right' guy shows up.

Sex and Belonging

Sexuality is often related to the behaviors and physical characteristics that each partner possesses. However, it also includes the sexual acts, the intentionality, and the behaviors leading to it as well. Here, we find the ingredients of this topic including physiological arousal, which is accompanied by various activated hormones that create physical tension and prime the person for sexual release, and the desire for experiencing sexual pleasure which results from either one's own or their partner's actions. Sexuality is naturally related to entering another person's personal space with the intent of stimulating sexual interest and perhaps establishing a subjective connection with that person. Thus, ultimately resulting in copulation and bonding.

Humans are extensively motivated to belong. They have a strong desire to form and maintain enduring interpersonal attachments; an essential part of being human. In 2014, I wrote that "…there is a basic human need to belong, to be part of an intimate and caring relationship with a partner who is close, and deeply concerned about us, so that we are driven to establish close contact with others, and participate in intimate relationships" (p. 155). Research has confirmed that belonging has many positive effects on our physical, mental, emotional, and spiritual health. Given that the need to belong and be attached is so central to humans, it makes

sense that it constitutes as a primary function of a sexual relationship, which concretizes the couple's closeness, intimacy, belonging, and sharing of a personal space.

How can sex associate with belonging? Well, when I share my body with another person, we share not only our physical selves but also our inner selves whilst discovering and enjoying the inner self of another person. In sexual activity, the physical and interpersonal boundaries that we are so aware of and protective over, are moved aside when two bodies become shared territories. This mutual connection requires interpersonal sensitivity, trust, mutual commitment to the other's well-being, and love and intimacy in order for it to exist and be satisfactory and fulfilling.

The Need for Intimacy and Belonging

This need to belong is associated with the desire for oneness or unity, for closeness, and for affiliation. That naturally connects sexual activity with our relationships. Those with a secure attachment history would be motivated to enter sexual relationships to replicate their early attachment experiences. *Intimacy*, however, is not just belonging but also involves the sharing of the body in a sensual encounter as well as the sharing of the body and inner self in a sexual encounter. Intimacy involves disclosing one's feelings to the other person, being acknowledged and validated in a true sense, allowing oneself to become vulnerable, and feeling safe in doing so. Intimacy also requires that one be able to truly listen, to be transparent, and to be able to articulate their thoughts and feelings.

The Need for Love

The need for love is related to the need to *express love* for the other person, and it is also about the need to *feel loved* by another. Generally, both aspects exist in the same sexual relationship where love is a factor. Love is a critical factor in romantic relationships and includes such constructs as 'being in love' and 'falling in love'. Falling in love involves the wish to express love (often to an extreme), and during that process the person is ready to forfeit such things as their money, career, and even one's future for the sake of the loved one. At the same time, there is an overwhelming desire to feel loved and cared for. The desire to express love stems from valuing a person so much that one is ready to give oneself to that person, whether practically or emotionally, by pleasing them and promoting their well-being, while looking for their love to be recognized and appreciated.

Our ability to offer love and nurture another is self-rewarding. As a result, we feel needed, empowered, and valued. In an interesting 2019 publication written by Dr. Schneider it was suggested that giving without an external reward or even suffering for the love object may increase one's feelings of love, since such personal investment in that person increases their value to the giver. Thus, the 'giver' persists with the hope of getting it back at some point. There is also the need to feel loved by a significant other, which includes being accepted, valued, wanted, and desired without expectation or demand, so that the one offering the love freely invests in the relationship. Being loved results in us feeling special. It increases our

self-esteem, promotes emotional security, and provides a sense of “having a place” in someone’s life. The absence of feeling accepted can result in relational and sexual performance anxiety, where the person continually feels the need to prove their value, and fears being rejected if he does not. It was suggested that there are both erotic and non-erotic aspects in the need to be loved. The erotic aspect involves the need to be accepted, valued, and desired *as a sexual being.* The non-erotic aspect is the need to sexually please another person to *be loved* by that person. Paradoxically, that need can lead to manipulative behavior.

Choosing a Sexual and Intimate Partner

Sexual Relations

Sexual relationships are as much about relationships as they are about sexuality. Sexual and romantic relationship involves mate selection and then pairing, with the romantic aspect of the relationship involving needs for intimacy, belonging, and love.

Familiarity has to do with knowing someone well. Attraction to the familiar is about being attracted to what we know, like someone we may share a history or attributes with. All of these factors make it easier to know and understand another person. In turn, research has repeatedly supported the notion that similarities attract. People are drawn to others of the same religion, race, age, socioeconomic class, educational level, intelligence, height, and even physical attractiveness. It was even found that spouses with similar personalities experience more closeness, friendliness, marital satisfaction, and less marital conflict.

Although, our relationships with our parents have a profound effect on our later interpersonal relationships. It significantly impacts our attachment style, intimacy skills, and our capacity for love and nurturance for another person. The parent is the first person with whom the infant connects with, and consequently, a mental model is created that the infant learns from. This informs the individual of what is expected from a relationship, and what a close relationship and an intimate partner will be like. A person whose infant relationship with their parent was a close and satisfying one will tend to recreate a loving parent-figure in an intimate adult relationship. However, it should be noted that obviously not everyone desires to recreate a parent-figure relationship, since not all those relationships are positive and nurturing. In cases where those early experiences are negative and traumatic, we may seek a partner with very different qualities that do not remind us of the parent who may have caused us grief.

Another form of seeking a partner may not relate to the partner’s personality but to his or her *role* in the relationship. For instance, one may need and thus, seek a partner who will allow a degree of dependency in order to satisfy a childhood need. We may opt for a partner who is nurturing and strong, and goes along with our need to be in the child role, which may be comforting to us. Others may not desire to be nurtured, but instead, want to nurture their partner in the way they were nurtured. These are but some highlights of how childhood experiences of parental love and intimacy can color a person’s intentions and expressions in adult sexual relationships.

Establishing Intimate Relationships

Practical Concerns Which May Be Present

Practical concerns and issues can play a role in choosing a mate. For instance, one primary drive for establishing a relationship may be to find economical security. It can be seen when one partner sees the marriage as a way to leave an oppressive or economically deprived culture, or securing a promising (financially, at least) future. However, that same hope could be experienced sexually by one who feels trapped in a domestic situation and for whom an extramarital sexual relationship offers the promise of freedom. On the other hand, the practical securities of a relationship may prompt a person to remain in that relationship and even continue to keep his or her partner satisfied, even when sexual interest or desire has faded and the sense of belonging weakened. Another practical concern in choosing a mate is proximity, and one may be drawn to someone who lives close by. The closer people live to one another, the greater the odds that they will meet, and an attraction will develop between them. Other practicalities include previous relationship or marital history (and what we learned from them), the presence of children from a previous relationship, the capacity to have and want children, health issues, and the physical and relational availability of the person. One more practical consideration is worth mentioning, and that is the attainability of the potential partner. If the potential object of sexual interest or desire is perceived to be unattainable, we may quickly lose interest and our sexual desire will be inhibited. However, for some people, unattainability may only enhance their desire and resolve to capture that person's interest and make them their partner.

Sexual Desire Inhibition

Interestingly, desire, unlike sexual activity, does not focus on the other but is self-focused with its motive as being for our own pleasure. Desire does not even require the presence of another person, or their participation, as it can arise from reading or viewing erotic material, masturbation, or viewing a desirable person from afar.

Sexual desire is also not only affected by what attracts us, but also by what inhibits or repels us. The themes that can inhibit sexual desire or arousal include such things as negative emotions which may result in self-protective or avoidant behaviors. Among these emotions are anxiety, fear, disgust, anger, hurt, guilt, shame, disappointment, and inadequacy. To illustrate, fear or anxiety might stem from a person's expectation of being criticized or rejected, while a betrayal of trust may arouse anger. Sadness may be felt following separation or failure and lead to withdrawal. Such behaviors, regardless of their initial source, lead to disconnection in the relationship. Those with insecure or avoidant attachment histories are prone to inhibitory themes. This may prevent the establishment of a sexual relationship if shown when a relationship already exists. Thus, leading to the fracturing of a present relationship. Interestingly, inhibitory themes can coexist with themes of attraction and sexual desire, but such a complex situation will result in internal tension and ambivalence. In general, inhibitory drives can lower desire for a sexual relationship. The themes that create the inhibitory motives include, among others, social inadequacy, a fear of entrapment, the instinct toward social withdrawal, the need for self-protection, and a general disgust towards sex.

Social Inadequacy

Social inadequacy is fueled by lack of social skills and social confidence, which can lead to a fear of intimate relationships. Feeling socially inadequate is, usually, associated with poor communication skills, discomfort in social situations, difficulty feeling or showing empathy, and having low emotional intelligence. This can be further described as the ability to understand, use, and manage your own emotions in positive ways to relieve stress, communicate effectively and empathize with others. Social inadequacy affects not only the capacity to initiate relationships, but also the desire to do so which creates a challenge for the person experiencing the feelings of inadequacy. Such a situation can contribute to a fear of intimacy, which requires good communication skills, emotional awareness of the other, and self-confidence to persist. Thus, the person may have a history of social isolation, emotional immaturity, and of being the 'odd one out' socially. These fears revolving around rejection by those around them, are outnumbered by the fear of being unable to relate to others; and consequently, leaving them uncertain about their ability to enter a relationship with someone of the opposite sex.

Fear of Entrapment

A fear of entrapment is associated with the fear of losing one's freedom to disempowerment, control, and being unable to meet relational expectations. Since sexual behavior may be a part of an ongoing relationship, it makes sense to assume that this fear will preclude engagement in sexual activity. A potential relationship may be viewed by the one who feels socially inadequate as including expectations or even demands that may be too difficult to fulfill, or that may disagree with personal interests or even become a threat to personal liberties. Such concerns may be related to a fear of losing one's identity, of sharing one's possessions, or even a general distrust of the other person and their future behaviors. It is also possible that the person already has a satisfying lifestyle and could be concerned about compromising or being suffocated by the demands of a partner who may be needy. Additionally, the person may be a perfectionist and fear of making the wrong decision by getting 'stuck' in a less-than-perfect relationship; a fear often shared by people who saw their parental relationship deteriorate and end in divorce (which is not uncommon in, both, men and women). All in all, the fear of entrapment may prevent one from entering into an intimate relationship with another.

The Instinct to Withdraw

This instinct to withdraw relates to both emotional and social withdrawal − predisposing one to emotional disconnection. A person who fears being rejected can, and thus, emotionally withdraw from the other to protect themselves from harm. It relates to additional fears such as the fear of 'being discovered' as less of a person than one presents socially, resulting in poor self-esteem. Specifically, some people have the fear that if they allow others to get to know them well, the others will discover their flaws, weaknesses, and failings which will consequently lead them to experiencing disappointment and rejection towards them. The

instinct to withdraw can also occur due to psychiatric and addiction problems, or when the person desperately wants to hide their flaws and insecurities. Without self-acceptance, we cannot be accepted by others or invited to become close to them. Additionally, guilt that results from infidelity may activate the instinct to withdraw.

The Need for Self-Protection

The drive towards self-protection has two aspects: emotional and physical. The physical aspect has to do with health reasons, such as a woman who wants to avoid pregnancy or avoid acquiring a disease that could be transmitted through sexual contact. The emotional aspect of this need is associated with protection from being humiliated, dishonored, disrespected, or belittled. The need for self-protection can not only be expressed via withdrawal, but also through vigilance, controlling behaviors, or limiting one's investment in the relationship. Such a person has little confidence in the relationship, and there is an expectation that the other person will prove to be unreliable, unsafe, and may even display treacherous behavior, which would then justify the need for self-protection. Self-doubt, lowered self-esteem, and emotional pain typically results from past infidelity and subsequent distrust permeates future relationships.

Early childhood experiences of abandonment, relational instability, or sexual abuse can result in the self-protective rejection of another person. These early experiences are related to both anxious and avoidant attachment patterns, which interfere with later adult attachments to a partner, lower sexual satisfaction, and increase sexual problems. All of this can result in the person being reluctant to enter long-term commitments in sexual relationships. And when you meet such a person, his/her behavior can be reflected in the person's aloofness, distrust, ambivalence about intimacy, and also a preference to pursue sex for nonromantic reasons.

Disgust about the Potential Partner

Disgust is considered the most reliable and dangerous threat to romantic or sexual passion. It may be triggered by some repellent information that one becomes aware of or by some physical stimulus, or fragrance. The person feeling the disgust may hold high moral standards or have religious or behavioral expectations, which may lead to them developing a list of "shoulds" that the other person may fail to meet and ultimately result in their rejection. Disgust will quickly erode sexual attraction or desire, since repulsion will result in the person wanting to distance himself from the "contaminated" person.

Disgusted by Sex

Some are not disgusted by a person, but by the act of sex itself. It may be related to the feeling of being 'contaminated' due to the exchange of body fluids, or what the sexual activity represents. In this light, the relationship is seen by that person as one that will negatively affect them. To illustrate, the person may connect the sexual act with dominating another person and

the expression of lust with accompanying uncomfortable feelings or a loss of self-control. If sex is perceived as contamination, it may also contribute to the person's wish to avoid sex in lieu of 'remaining pure'. For one who idolizes his mother, and then all women, he may not want to contaminate them by engaging with them in sex, and so sex may be sacrificed.

The Importance of Sexuality

In 2016, Dr. Levin clarified the importance of sex in his book. He believed that sex has the ability to: please, stabilize the relationship, emotionally and physically satisfy the relationship, improve one's understanding of their body and soul, and improve one's understanding of love to another. Sex can also enhance life through reproduction if that is what the couple chooses to do. In fact, he viewed all sexual behavior – whether solitary or partnered, normal or dysfunctional, morally acceptable or socially disapproved of – as basically resting on four general sources: biology, psychology, interpersonal relationships, and culture. This principle reminds us that neither understanding, treatment, sexual behavior nor dysfunction are straightforward or unidimensional as we have described in the chapter on sexual dysfunctions. Thus, we do not need to find solutions unless we take into consideration most, if not all, of the four dimensions.

It is well-known that adult sexual relationships have the potential to stabilize, enrich and provide satisfaction for individuals in their interpersonal relationships. Adults are known to want and be nurtured by psychological intimacy and partnered sexual behavior. Of course, it is true that partnered sexual behavior can exist without psychological intimacy and vice versa, but when they are successfully integrated, there is a greater degree of mutual nurturance that results in the maximization of one's sexual capacities. This leads to the engagement of sexual activity in these partnerships which help to create a new degree of psychological intimacy.

What Does It Take to Create Relational Intimacy?

Conversation is known to be a major ingredient of an intimate relationship. A conversation involves one person speaking at a time, while the other listens. The speaker is expected to share their inner psychological processes, trust the safety of the relationship, and have sufficient linguistic skills to express (in words) thoughts, feelings, perceptions, and history. The listener, on their part, needs to provide undivided attention to the speaker; to not criticize what is being said, and must accurately reflect on what was said in a manner that will indicate to the speaker that they have been understood. Intimacy, we note, will not occur (despite the couple's talking) if these several ingredients are not present. Psychological intimacy within a sexual relationship possesses a special power to repeatedly ease the way to sexual behavior. The bonding between speaker and listener in an intimate relationship is strengthened by an open, honest, and heart-to-heart conversation which leads to pleasant thoughts. The listener gains a deeper understanding of the speaker and experiences pleasure in being of value to the speaker, so that the speaker is encouraged to share their internal feelings and thoughts. Moments like this make loneliness fade away and reaffirms the person's bond to the speaker by enhancing their optimism and encouragement to share again. It was found that psychological intimacy can be

a powerful, erotic stimulus and can serve as the most powerful aphrodisiac for couples in romantic relationships.

Shared intense experiences, on the other hand, do not necessarily require much conversation, but can create psychological intimacy and bring the couple closer.

Sexual behavior is, largely, a shared and nonverbal experience that has behavioral and emotional components. It has the potential to significantly contribute to intimacy. Just think about it. Seeing your partner's naked body can be a powerful experience in the process of knowing and getting closer to that person. Along time, you learn of the partner's interest in specific sexual behaviors. Each person witnesses the other in arousal, and takes part in facilitating, listening to, and watching the partner's orgasm. These intensely private and subjective experiences create the sense of knowing one's partner in ways that others do not, thus enhancing their unique intimacy. In this way, sex creates a profound degree of connection, which enhances the couple's intimacy promoting love and bonding.

Learning about the partner's sexuality over time, as the couple engages in sexual behavior, promotes the discovery of their partners' range of sexual comfort. They come to know and identify their own and their partner's variations in desire, arousal, and orgasm. Over months or years, sexual activity allows them to gain a rich understanding of the sensual capacities of the other and how best to relate to them. Part of the reason that intimacy is so important in the couple's life is that what one partner experiences will heavily depend on the interplay between their own and their partner's component characteristics.

Intimacy and Sexuality

Satisfying romantic relationships are important for the quality of life and health of both partners, as it helps to buffer daily stress and enhance overall well-being. Intimacy is said to trigger sexual desire and may be seen as a reward resulting from the experience of sexual arousal and – in particular – of orgasm. In his 1986 essay on love, Dr. Sternberg defined intimacy as the experience of having strong feelings of closeness, connectedness, and bonding. One project which involved daily journaling from both male and female partners reported that intimacy was, indeed, associated with higher chances that sexual activity with their partner will occur.

In addition, experimental research in 2016 by Dr. Birnbaum and her team found that when one partner exhibited higher emotional responsiveness, sexual desire and intimacy increased as well. This effect was found to be stronger in women than in men. Women's sexual desire is more likely to emerge once they feel emotionally intimate with their partner, while for men, intimacy and sexual desire are not so closely connected as their sexual desire is more biologically driven. In longer romantic relationships, proactive sexual desire occurs more in men than in women. As such, a 1999 article by Drs. Baumeister and Bratslavsky even suggested that ongoing intimacy is not sufficient enough for inducing passion and sexual desire; instead, only abrupt rises in intimacy would allow sexual desire to arise. Therefore, they suggested that passionate love cannot persist during stable levels of emotional intimacy, and only increments or increases in intimacy will heighten one's desire level. In turn, this suggests that the emergence of sexual desire in women would thus depend on larger increments of intimacy than in men.

Support for this proposition was found in a longitudinal study which explored how 67 heterosexual couples in long-term relationships acted regarding intimacy levels and sexuality. Drs. Rubin and Campbell found that couples were more likely to report having sex on a particular day if they experienced an increase in intimacy from the previous day. This is especially important to note as research from a national US sample of married couples found that the incidence and frequency of sexual activity was found to decline over the life course, as we have previously mentioned. Causes for this decline were attributed to biological aging, diminished health, and habituation to sex − which is commonly found in long-term relationships. In turn, women in those relationships were reported to have a lower sexual desire. To summarize, intimacy appears to act as a precursor of sexual desire that, ultimately, increases the odds for partnered sexual activity to occur for both women and men.

What Contributes to Sexual Satisfaction?

Sexuality is a central feature of a marital relationship. Unsurprisingly, there is a close association between the satisfaction with one's relationship and its sexual activity. In fact, research has found that sexual satisfaction is linked to stability in these unions. For example, married couples are generally sexually satisfied, and indeed research has indicated that 88% of married adults were either "extremely" or "very" physically pleased in their relationship, while 85% were emotionally satisfied.

Marital satisfaction is an important indicator of sexual satisfaction. When high quality marital relationships are present, greater sexual satisfaction was reported. Indeed, a rewarding marital relationship can lead to a satisfying sexual relationship. However, the reverse can also be said as lower-quality marital relationship is associated with lower sexual satisfaction. Although, to be fair, the relationship between sexual satisfaction and marital satisfaction is likely bidirectional and affect each other simultaneously.

Frequency of sex is mostly correlated with sexual satisfaction. The more satisfied the couple is, the more they will tend to have sex. As such, the frequency of sex a couple has is positively related to both physical pleasure and emotional satisfaction.

Keeping Passion Alive

People have historically asked the age-old question: Can we keep passion alive? And if so, how do we do it? Keeping sexual activity fresh and lively as relationships progress and habituate is obviously important, but the couple may find it challenging to be continuously creative. What's even more elusive is maintaining the passion over time, which only a few people are known to manage in long-term relationships. Let's review what is known about strategies of increasing passion.

While we are aware that there are many sexual and affectionate behaviors couples incorporate into their sex lives, its importance to intensifying passion and sexual satisfaction has not been documented. For instance, in cultures where kissing is a part of the romantic-sexual repertoire, it becomes an important part of arousal and closeness before, during, and after sex acts. Both men and women report higher sexual satisfaction when they report more

frequent kissing, cuddling, touching, and caressing with their partner. *The extent of foreplay* and length of sexual encounters also matter for sexual satisfaction. What is perhaps most important to women is that foreplay increases the likelihood of orgasm, but it also serves a greater purpose as well. In my experience as a sex and couple's therapist, I routinely inquire about foreplay; asking how long it is, and whether each caters to the other. That, in my opinion, is a reliable indicator of the couple's passion, closeness, and sexual interest in each other. *Extending the duration of sexual activity* by engaging in different intercourse positions is likely a common practice. That may include trying different sex positions and other activities which the partners like. Research found that women desired more activities that demonstrate love and intimacy, such as talking lovingly, and being softly attended to, while men focused on desiring increased partner initiative, rough play, and (for some) dirty talk.

However, specific types of sexual activity have been identified in the literature. For example, the prevalence of anal intercourse has been widely studied as it becomes more socially agreeable to practice − though, the relationship between anal sex and sexual satisfaction is largely unexamined by researchers. Sex therapists, unlike researchers, have indicated, for example, that people seem to experience more pleasure from anal stimulation and not necessarily from anal intercourse. Other activities including the frequency of vaginal intercourse, oral sex, and orgasm have been established as contributors to sexual satisfaction, and couples who have sex more often report greater satisfaction with their sex life. Intimate relationship experts suggested that decline of the frequency of sexual activity is due, at least partly, to the dimming of passion after the exciting early days of falling in love.

As such, sexual satisfaction and the frequency of sex a couple experiences both decline but sexual satisfaction may decline much slower. One possible intervening variable is whether orgasm is consistently a part of sexual activity. People who orgasm more frequently report greater sexual satisfaction, regardless of the frequency of their sex. Despite changes in sexual frequency, certain specific sexual behaviors are likely to affect both sexual satisfaction and orgasm frequency. Among them is oral sex, including both fellatio and cunnilingus, which are practiced by the majority of people in the Western world. When people are open about their sexual desires and fantasies, they report being more satisfied with their sex lives.

With his team, Dr. Fredrick examined a large data set of 38,747 participants aged (on average) 40 years of men and women who responded to questions about their sex lives online in 2016. Most of the participants (83% women; 83% men) were satisfied with their sex life during their first six months together. Satisfaction with their sex life later on in the relationship was reported by 55% women and 43% men, and the rest (18% women; 16% men) as feeling neutral or dissatisfied (27% women; 41% men). The researchers examined behaviors and attitudes of heterosexual men and women who are sexually satisfied and compared it to those who are sexually dissatisfied. Clearly, most participants felt that their sexual satisfaction and passion declined over time. However, Fredrick stated that their data indicated that "…if properly nurtured, passion can last for decades. Nearly two-thirds of sexually satisfied respondents reported that their sex lives were as passionate as in early days together; beyond that global statement, over one-third of sexually satisfied men and women selected 'passionate' as the single best word (out of six) to describe their most recent sexual encounter…One in three women, but also more than one in four men, said they feel more emotional closeness during sex now than at the start of their relationship. To name just a few items, hugging, cuddling, after play, and saying 'I love you,' can be part of sex and as deserving of study as climaxing."

In their study, men indicated that they saw the frequency of receiving oral sex as highly important to their sexual satisfaction, while it was less important for women.

Sexual Activity and Well-Being

Research has repeatedly confirmed that social relationships are a basic human need since they are crucial for positive health and well-being. While social support is explored as part of well-being and close relationships, the importance of nonverbal interactions, such as sex or touch, are often neglected. Sexual activity, which mostly happens in romantic relationships, is a nonverbal interaction which is often experienced as a highly intimate experience which is, and as we saw, very important. A robust positive association has been found between sexual frequency and well-being. In a large and nationally representative US sample, sexual frequency was positively correlated with greater general happiness. General well-being emerges from the accumulation of daily, mostly positive, events and emotions. Interactions and intimate exchanges with a romantic partner are essential in determining the couple's emotions. Although, research focused on sex therapy has not largely explored how sex is associated with affective states. And for those that did have found a link of positive affect and sex. In experimental settings, sexual arousal has been associated with more positive and less negative affect in men and women.

The Effects of Affectionate Experiences

Since people have a fundamental need to belong, they strive to experience satisfying emotions in their bonds with those they care about or love. One of the ways to achieve that is by experiencing affection which Dr. Floyed defined as "…a feeling of fondness and intense positive regard" for another person or perceived from another person in 2018 (p. 4). Both verbal and nonverbal behaviors can convey affectionate feelings. Touch, and especially affectionate types, are a main non-verbal message which is seen to be promoted by sex and occurs frequently in romantic relationships. In turn, it is also clear that affection and in particular, affectionate touching, enhances well-being. Research has indicated that people experiencing more affection are at lower risk for depression and anxiety. Greater levels of touch in romantic relationships have led to higher reports of better psychological well-being over time. This is also extended to physical well-being as well. It was found that affectionate interactions are associated with daily changes in cortisol levels, which are characteristic of a healthier stress response. Affection is rewarding to not only the receivers, but also to those who give it and fosters their well-being as well.

In 2017, Dr. Debrot and colleagues conducted a study which found that sexual experiences on one day predicted the feeling of subsequent positive feelings the next morning. This may indicate that feelings of positivity are not only experienced during sex but lasts afterwards. They also found that by engaging in sex, people not only seek an intimate connection but experience more affection both during and long after sex. Hence, sex seems not only beneficial because of its physiological or hedonic effects, but because it promotes a stronger and more positive connection with their partner.

The few studies that can be found on sexuality and intimate relationship quality suggest that greater sexual satisfaction has a stronger effect on relational satisfaction. As we should emphasize, it is not the frequency of sexual activity that creates strong relationships but rather, its quality. Two questions seem to spring from those findings:

1) *Does better sex lead to better relationships?*
   Several studies found that better sexual functioning results in better relationship quality over time. It has been discovered that men who date tend to break up the relationship if they are sexually dissatisfied. When communication about sex (i.e., its frequency and when and where to have it, for instance) is better, couples experience the same sexual satisfaction over time. In sum, research indicates that better sex can improve relationship satisfaction, or at least slow down any decline that may occur.
2) *Does a better relationship lead to better sex?*
   The answer to this question is a qualified yes. Studies showed that husbands and wives who reported more open and empathic communication had greater overall sexual satisfaction. In the end, sexual satisfaction in higher quality relationships may improve, or at least not deteriorate, as a result of the relationship.

Relational Intimacy and Sex

Sex can mean different things to different people as it can be experienced differently within and across different social groups. Still, research indicates that a 'healthy sex life' and the mutuality of sexual desire are key cornerstones of successful relationships. Through research, scientists have found that heterosexual men tend to face discrepancies in their desires for others, while heterosexual women tend to diffuse emotionally uptight sexual scenarios through humor. Men were found to respond differently, as they often saw the experience of sexual dysfunction as personally offensive.

Sex in different types of relationships have also shown unique trends in its association with sexual frequency. Parenthood, for example, is often linked with decline in sexual frequency over time. It was observed that women are culturally expected to complete emotional labor to sustain intimate relationships and manage sexual dissonance in these unions. The concept of "relationship work" is also particularly helpful in understanding the demands and rewards of an intimate relationship as it examines what is done, the time and energy required to complete tasks, and the means, tools, and conditions under which labor takes place. That is particularly important if we subscribe to the understanding that good relationships require work. Sustaining positive, lifelong unions requires the couple to continually work on themselves, their relationships and their sex lives.

Overtime, one's openness towards their partner can increase and facilitate mutually rewarding sexual intimacy. This was explored by Dr. Gabb, who in 2019, succinctly summarized what is needed for a good long-lasting relationship. I will introduce it in his words. "Couples' sexual repertoires range from hot sex, kink, vanilla intimacy, perfunctory and functional sex, sensuality and fond affection – to cite but a few shades of the erotic rainbow. What makes sex successful – in relationship terms – is that it works for each individual and the couple, something that builds upon intimate knowledge accumulated over the partnership

duration. For some couples, uneasy compromises can be reached; for others mutually satisfying sexual novelty…Crucially, then, the capacity to work through sex issues is not personal: it requires individuals to wrestle with the cultural norms associated with hetero-masculinity. Couples' recourse to humorous sexual solutions is a highly effective form of relationship work when the sources of issues are diminished female desire or bodily changes experienced by women or gay men" (p. 13).

The link between couple intimacy and overall relationship satisfaction is well established in current literature. Feelings of intimacy are associated with high levels of relationship satisfaction, and a lack of intimacy is commonly associated with lack of a sense of security. That is usually the reason that couples seek therapy. Research has consistently found that good communication is the cornerstone of health couple relationships as it can facilitate or otherwise inhibit intimacy in close relations. For example, once the couple discusses their vulnerabilities and mutually enhance each other's self-disclosure, they are more likely to feel intimate with each other. Conversely, intimacy will not be developed if open and accepting communication are missing in the relationship.

Discrepancies in partners' perceptions of emotional and sexual aspects of intimacy, when present, can affect their relationship satisfaction. A study found that sexual satisfaction significantly influenced emotional intimacy for both husbands and wives, while the influence of emotional intimacy on sexual satisfaction was negligible. Spouses who perceived their partners as communicating positively were more likely to feel satisfied with their relationships, which is consistent with the well-acknowledged association between communication and relationship satisfaction.

The Interplay of Attachment Style and Sexuality

The Effect of Childhood Attachment on Adult Sexuality

While sexuality is an integral part of romantic relationships, it can also be a source of relational disharmony and separation. Approximately 50% of marriages and romantic unions in the United States end in dissolution, increasing the risk for emotional suffering and psychological ill health. It is therefore important to understand what influences marital and sexual relationships, in addition to the factors mentioned above.

Attachment theory seems to be particularly suited to explain relationships and sexuality. This theory, in brief, sees early interactions between the infant and their parents as instilling expectations and beliefs which shape cognitions and behaviors with romantic partners in adulthood. In a 2012 article by Drs. Stefanou and McCabe, the researchers focused on two independent dimensions that explain individual differences in adult attachment: attachment-related anxiety which is related to one's concern and fear of being rejected, and attachment-related avoidance, which motivates the person who feels discomfort with closeness and dependence to seek distance from others. Anxious attachment is characterized by high anxiety and low avoidance, while avoidant attachment has the opposite direction of the two dimensions.

During adulthood, when attachment figures are seen as available and responsive, the person feels secure and forms close bonds with others. However, if attachment figures are unavailable or unresponsive, some strategies are activated to cope with the sense of insecurity, including

distancing which is self-protecting. When attachment figures are inconsistently available, then the person will display anxious clinging or aggression to obtain attention and care.

Attachment and Sexual Behavior

Attachment and sexuality are two instinctual systems that are central to human behavior. They have a reciprocal relationship since the manner in which sexual interactions are experienced is influenced largely by one's attachment style. Smooth and proper functioning of the sexual system depends on the coordination of both partners' sexual behaviors, while sexual dysfunctions reflect the use of hyperactivating and deactivating strategies. Sexual hyperactivation involves encouraging one's partner to have sex, since it is presented as having significant value within the relationship, as well as indicating that refusal will be perceived as rejection by one's partner. Sexual deactivation, on the other hand, inhibits one's sexual desire, distancing from one's intimate partner, and inhibiting one's sexual arousal and orgasmic joy.

Referencing Drs. Stefanou and McCabe once more, the researchers also reviewed a total of 15 studies that related, in some way, sexual functioning to attachment in 2012. Summarizing their findings, they noted that both anxious and avoidant attachment were found to be consistently associated with less satisfying sexual experiences in married, dating, and homosexual partnerships. Previous research has indicated that avoidantly attached individuals readily end their relationships as soon as they become dissatisfied; possibly as a way to prevent themselves from being rejected by a dissatisfied partner.

More specifically, studies on female sexuality indicated that both anxious and avoidant attachment are associated with lower sexual arousal, lubrication difficulties, anorgasmia, and dyspareunia. Insecurely attached males had more erectile problems compared with securely attached males. For, both, males and females who are avoidantly attached, lower intercourse frequency was reported. Consequently, males employ hyperactivating and deactivating strategies that significantly and negatively impact sexual functioning within intimate relationships.

Research that has examined the relationship between love and attachment style has found that anxiously attached individuals equated sex with romantic love and that they have sex to reduce insecurity and foster intimacy. It reminds me of a phrase I once read in that regard. It said: "We all want love, and if we cannot get it, we settle for sex." Quite accurate. Anxiously attached individuals assess the quality of their relationship by their sexual experiences, and so, gratifying sexual experiences were seen as a confirmation of being loved and valued, which temporarily reduced fears of rejection. Disappointing sexual experiences were interpreted as signs of partner disapproval, which evoked fears of abandonment.

Does Sex Contribute to the Attachment and Maintenance of Relationships?

Sexual activities are regulated by an inborn sexual behavioral system; a species-universal nervous system. That system exists for genetic reproduction. However, impregnation is not enough. The newborn spends a long period of vulnerability in infancy, and therefore, the parents hang around long enough to care for their offspring. Throughout history, evolution has always encouraged physical proximity and intimate contact, which further contributes to the

formation and maintenance of attachment bonds. Sexual behavior plays a major role not only in attracting potential parents to each other but also in fostering the development of an emotional bond between them. Interestingly, research proved that the vaginal angle in women has shifted over evolutionary time in order to make penetration easier. Opined by researchers, the human tendency to sleep together after sex also enhances intimacy and attachment. This is largely attributed to the increase in serum oxytocin levels in both men and women during sexual intercourse which is known to promote closeness and attachment.

We can also examine the opposite direction: from attachment to the sexual process. Since the attachment system is the earliest developing social-behavioral system, it is very influential on the way the individual views life. These mental models affect relationship expectations and guide interpersonal interactions throughout one's lifetime. In line with their pursuit of establishing intimate, and satisfying long-term relationships, securely attached individuals prefer their committed romantic relationships to include sexual activity, which contributes to mutually intimate and gratifying sexual interactions that further enhances their sexual satisfaction. The anxiously attached tend to rely heavily on sex, which allows them to get closer to their partner and to interpret sex as answering their strong needs for security and love. And so, they may engage in sex to achieve emotional intimacy, approval, and to be cared for by their partner. Attachment-avoidant individuals are known to feel uncomfortable with the closeness inherently involved in sexual interactions and therefore tend to detach sexuality from situations that offer psychological intimacy. This may result in an avoidance of sexual behaviors via engaging in sexual fantasies that feature interpersonally distant and alienated relationships between the object of their fantasies and themselves. They may also rely on masturbation rather than partnered sex, and engaging in one-night stands, or sex with casual partners. When engaging in sexual activity with their romantic partners, these avoidant individuals experience relatively strong feelings of estrangement and alienation and display low levels of physical affection.

Distress Regulation, Attachment, and Sex

It has been observed that relationship threats may also enhance sexual motivation. At the same time, the presence of relationship threats may give rise to negative thoughts and feelings about one's partner, thereby interfering with sexual desire. Research regarding relational threats found that responses to those threats are moderated by attachment insecurities. Results of a study that explored the response of people to relationally threatening situations, like infidelity vs. non-relational threats like failing an exam, indicated that relationship threats strengthened pro relationship motives, suggesting that people use sex to both maintain their self-esteem and to repair the threatened relationship. Dr. Birnbaum and colleagues asked couples in 2010 to discuss and resolve either a major or a minor problem in their relationship and then to report their sexual motivation. Results indicated that major relational conflicts had a negative effect on the sexual motivation of more anxiously attached people and a beneficial effect on the sexual motivation of less anxiously attached individuals. Overall, these findings suggest that securely attached individuals tend to usually utilize more constructive conflict-resolution strategies, which may increase emotional closeness and sexual motivation. In contrast, the use of destructive conflict-resolution strategies which anxiously attached people use, may weaken sexual desire and interfere with intimacy.

Divorce rates are incredibly high in Western countries, which is understandably significantly influenced by a couple's quality and satisfaction of their sexual relationship. Sexual satisfaction is closely related to how well we can self-disclose and talk about our sexual preferences or dislikes. As such, dysfunctional communication was found to be associated with attachment theory. Since insecurely attached individuals tend to have pessimistic expectations regarding their partner's responsiveness during times of need, there is no use, as far as they are concerned, to openly express any sexual issues or needs to their partner, which ultimately affects their sexual relations in negative ways.

Sexual Motivation of Couples

Since sexual activity occurs mostly in established intimate relationships, sexual partners play an important and central role in enhancing each other's sexual fulfillment. Thus, it stands to reason that people whose partner is highly motivated to meet their sexual needs would be especially satisfied. It is only natural to expect that romantic partners will inevitably encounter times in which their sexual interests differ, or that they will sometimes disagree on whether to have sex at all or on the specific sexual activities in which they want, or do not want to engage. It is therefore interesting to examine whether being motivated to meet a partner's sexual needs ultimately benefits a relationship, which is what sexual researchers, Drs. Muise and Impett, set out to do in 2015.

Communal strength refers to the extent to which partners feel responsible for meeting their partner's needs without expecting them to immediately reciprocate. What the individual gets from their giving behavior are increased feelings of gratitude from their partner, and increased satisfaction when knowing that their romantic partner is fulfilled. People who are high in sexual communal strength experienced higher sexual desire for their partner throughout their relationship. As such, research has repeatedly demonstrated that sexual activity can significantly affect marital satisfaction. Those who adjust to their partner's sexual needs, regarding, for instance, the frequency or type of sexual activity they'd like to engage in, report greater satisfaction in their intimate relationship. It was suggested that when people perceive that their partner is aware and supportive of their needs it enhances intimate relationships and the satisfaction from it. Dr. Muise and Dr. Impett found that people feel more committed and satisfied with their relationships when they have partners who are motivated to meet their sexual needs. It makes quite a lot of intuitive sense.

Treating Relational and Sexual Dysfunctions

In his writing from 2013, Dr. Kozlowski combined the fields of relationship, mindfulness, and mindful mating to identify the connection between mindfulness and relationship satisfaction. Mindfulness has been shown to enhance openness in one's mental and emotional processes. When an individual can remain open and in touch with their thoughts, feelings, and experiences, there is an easier acceptance of circumstances which foster a sense of understanding, empathy, and compassion. Due to its interpersonal benefits, couples can better understand and relate to

one another in adaptive ways, resolve problems, and better manage challenging situations – which, in turn, promotes relationship satisfaction.

Another study on mindfulness and sexuality explored three groups: (a) individuals who participated in yoga and meditation; (b) individuals who played sports; and (c) a control group of people who did not participate in sports, yoga, or meditation. It was found that participants involved in sports activities were less sexually distressed than those involved in meditation. Individuals who engaged in mindfulness activities experienced improvements in their sexuality and were less reactive in their relationships. They gained a new understanding about the nature of connection between people, including a deeper experience of intimacy and independence within relationships.

Furthermore, mindfulness and the "good-enough sex" model (GES) was developed by researchers Drs. McCarthy and Wald in 2013. The GES model requires consistent practice, feedback, and refinement. Utilizing this model involves an attempt to create a respectful, accepting, and warm sexual experiences instead of overpromised set-ups for failure. The authors explained that mindfulness practices and the GES model can be used to promote healthy sexual identity. The GES model creatively encourages pleasure and satisfaction while discouraging the idea of perfect erections. Dr. McCarthy and Dr. Wald added that mindfulness and the GES model complement one another by breaking traditional models and providing a space where two individuals are equally responsible for their sexual experience, while enhancing a more positive outlook on sexuality and sexual pleasure.

Another pair of sex researchers named Drs. Mize and Iantaffi also explored in 2013 the connection between mindfulness and sex. In particular, they examined whether mindfulness could improve women's sexual health. They wondered whether a body-oriented approach focused on bodily sensations, with meditation, would induce improvement in women's sexual health. Results indicated that 10 out of 12 participants experienced overall positive benefits after attending therapy sessions. Additionally, mindfulness and this therapeutic approach seemed to increase compassion and kindness toward oneself. Participants reported increased patience and were more in tune with their bodies.

In contrast, the consumption of pornography has shown to have costs in sexual relationships, tending to have a negative effect on sexual satisfaction. Pornography is primarily a solitary activity, and when it is not done as a couple, it can be a cause or an effect of problematic relations between spouses. Married women often view their husband's consumption of pornography as a sexual pursuit outside of the relationship – almost as a form of infidelity. Discovering that their partner views pornography may cause women to feel mistrustful, experience loss, devastation, and anger. It was found that pornography use may also reduce one's own satisfaction with the conjugal relationship, as what one may see and desire in pornographic movies, is often not related to real relationships, and may consequently lead men to criticize their own performance, that of their sexual partner, or their physical appearance.

That being said, premarital sex and cohabitation with a spouse seems to contribute to more realistic expectations concerning their sex life than those found in couples without shared premarital sexual experience. Additionally, premarital sex or cohabitation may indicate, and filter out, couples that are incompatible, leaving the satisfied couples to marry. This indicates that couples whose actual experience matches expectations, are likely to maintain their relationship. But what about premarital cohabitation with others than one's marital partner?

In interpersonal relationships, previous romantic unions provide expectations regarding the costs and rewards for subsequent unions. This often involves the judgement of one's present relationship to their past experiences. If a person's current sexual rewards and costs compare poorly to those from a previous union, it may result in lower sexual satisfaction in their current intimate relationship. As a result, there is a positive association between premarital cohabitation and sexual infidelity during marriage. If, on the other hand, a spouse's previous experience with premarital cohabitation produces anxiety or embarrassment, it can be considered a costly exchange, thereby reducing sexual satisfaction.

Sexual Satisfaction and Relationship Happiness in Midlife and Older Couples

It appears that research aiming to understand the place of sexuality in human lives rarely studies intact couples in ongoing relationships. Consequently, there is limited research evidence examining sexual relationships throughout the lifetime regarding the independent contributions of coupled partners to one another's sex and relationship outcomes. Long-lasting relationships seem to depend on life quality, health, and satisfaction from the relationship. Sexuality appears to play an essential function in relationship durability and satisfaction.

In 2011, Dr. Heiman and her research associates sought to explore sexuality and relationships among middle-aged and older individuals in marriages of 1-51 years in duration. Their sample included 1009 couples, or 2,018 people. They conducted the study in Brazil, Germany, Japan, Spain, and the United States, recruiting men 40-70 years of age and their female partners. They wanted to assess the importance of the relationship, their sexual behavior, and the role that sexuality played in men's and women's health and life satisfaction for those in committed relationships. A large majority of their participants reported being happy with their relationship. As with prior studies, relationship and sexual satisfaction were significantly correlated. Women experienced greater sexual satisfaction than men, although greater relationship happiness was reported by men. Findings indicated that physical intimacy variables such as kissing/cuddling, partner touch/caressing and, to a lesser extent, the importance of a partner's orgasm, predicted relationship happiness for men and in some respect for women as well. For both men and women, sexual frequency was related to sexual satisfaction but not to relationship happiness, and that may indicate that sexual activity can be independent (at least to some degree) from relationship satisfaction. It was suggested that the level of sexual functioning had a pronounced and central effect on sexual satisfaction for both genders.

However, men were found to report greater lifetime sexual partners than women. Increased numbers of sexual partners were shown to predict less sexual satisfaction. Specifically, men's relationship happiness increased linearly with each category of length in the relationship, while women's did not. Women experienced less relationship happiness in the first 15 years of their relationship, with greater levels starting at 20–50 years together. During the 20–40 years of a relationship, women's relationship happiness was significantly lower than men's.

When the Relationship 'Squeaks': As Lack of Intimacy, Loneliness, and Sexual Infidelity Raise Their Ugly Head

People are social animals who are programmed to want an intimate, lasting, caring relationship with a partner who is close and deeply cares about them. Yearning to fulfill that need, we aim to develop intimate relationships. Partners in an intimate relationship possess extensive personal, confidential, and private *knowledge* about each other, and that may include their histories, preferences, and desires that they would not be so ready to reveal to other people. Establishing and maintaining close, intimate relationships with a loved one is a central motivation for humans. Marriage, which is considered as the most intimate form of adult bonding, serves as a primary source of affection, love, and support to answer our innate yearning for connection and belonging. Moreover, long-term, committed and intimate relationships are essential to physical and emotional well-being.

Loneliness is a natural human experience that shows no cultural boundaries and has been well documented for the past five decades. It is the subjective experience of one's perception of insufficient or limited social interaction, or as a discrepancy between relationships one has and the ones that the individual would like to have. As social animals, we need human connections to fulfill our need for belonging. Not having those connections results in social isolation, which creates pain and distress.

Love and Loneliness

Love and loneliness are typically not supposed to go together, but in many ways, they do. We experience loneliness when we feel unneeded, unwanted, emotionally disconnected, and not important to others. And when we are in a loving relationship where we expect to be cared for, and for our lover to share their experiences with us, we can also experience loneliness as well.

Love, as well as romantic relationships, can be harmed by the process of time, but also due to such occurrences as hurt feelings, jealousy, lying, and betrayal. We want to be loved by our intimate partners and we hope that our relational value – the degree to which our partner considers our intimate relationship as valuable, important, and close – is as high as we perceive it to be. If our value is lower than we would like it to be perceived by our partner, we experience pain, anger, hurt, and loneliness. When belongingness is threatened and when feelings of alienation intensify, people may either work hard to regain their partner's regard or start looking elsewhere. *Betrayals,* which are most closely related to loneliness and may stem from it, are probably the most hurtful of relationship spoilers. Common examples of betrayal include lying and sexual/ emotional infidelity, which violates the norms of loyalty expected in such intimate relationships. It was found that betrayal, of some form, occurred in half of all intimate relationships, and is therefore seen as a common occurrence in close relationships. Betrayal, infidelity, and divorce commonly occur as a result of couple's dissatisfaction and disappointments.

Infidelity

Exclusivity, including sexual exclusivity, is the socially accepted norm in intimate relationships such as marriage. Betraying this exclusivity – often referred to as adultery, cheating, or unfaithfulness – can have a major negative impact on the relationship, or bring it to dissolution. In a study examining the attitudes towards adultery, it was found that approximately 97% of the general public agrees that engaging in extramarital affairs is wrong, and 94% to 99% of people expect monogamy in their own intimate relationships. The prevalence of infidelity in relationships was estimated to occur between 20%–25% of the time. Research indicated that at least 20% of married men and at least 10% of married women committed adultery. When researchers included in their calculations not only marriages but "marriage-like" relationships, the prevalence rate soared to between 30% and 40%. Research established three variables to predict the occurrence of infidelity: individual characteristics, circumstances, and relational factors. It was reported that increased sex drives often led people to seek extradyadic affairs. It was also found that the same number of men and women were also found to be adulterous. But what makes a person to decide upon acting on their drive for extramarital affairs? Some of the reasons included one of the parties feeling like the relationship no longer benefits them based on their perception of what they put into it. We do know that the quality of marital satisfaction and the quality and frequency of sexual intercourse are negatively correlated with the occurrence of infidelity, meaning that a good marital relationship which enhances sexual satisfaction will, most often, not result in infidelity.

As such, infidelity is often followed by loneliness, depression, and compromised self-esteem. Its association with increased anxiety and depression often gives rise to suicidal ideation when revealed. A partner's infidelity is among the top reasons for divorces and for developing depressive symptoms. And as a result of having their self-concept and their belief of romance and intimacy broken, those who have experienced unfaithful partners often feel shame, anger, sadness, self-blame, and harsh or negative self-views of themself. Events like infidelity often results in psychological distress due to the rejection and exclusion felt from losing your social role as a partner. It is not uncommon that when infidelity is revealed, feelings of isolation and deprivation from existing social supports, such as friends and family, are experienced as well.

Following the discovery and disclosure of infidelity, the adulterers, or those who were responsible, often are distressed, depressed, anxious, and lonely. It is common for the adulterer, not only the victim, to be ostracized and deprived of their social resources due to the nature of their transgression.

Revealing the infidelity of a loved one disrupts a person's identity and self-worth, which then leads to a perception of the self as unattractive and uninteresting. Sexuality is thus expected to be practiced within the marital union. But when its boundaries are blurred, the union may not only suffer but ultimately, dissolve.

*

> Dentist warns his patient, "This might be a bit painful."
> Patient: "That's OK, I'll handle it."
> The dentist sighs, "For a while now, I've been having an affair with your wife."

*

I asked my wife to let me know next time she has an orgasm.
She said she doesn't like to bother me when I'm at work.

*

Arguing with your partner is like trying to read the "Terms of Use" on the internet.
Eventually, you just give up and say, "I Agree."

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Epilogue

In this book, we have covered a great deal about human sexuality, its functions, dysfunctions, paraphilias, relationships, and treatment approaches. In essence, you could say that we have covered the good, the bad, and the ugly of human sexuality. Sexuality was once a hidden, controversial topic. But now, as we usher into the 21st century, discussions related to sexuality and related research has become more prominent and recognized into mainstream views. Today, we can view more explicit sex scenes in media that is readily available to the public such as TV shows, movies, and pornography. Our views regarding abnormal sexual behaviours become heavily influenced by the stigmatizing language used by our society; by the popular culture that we are exposed to, and by the media. Moreover, behaviours that previously seen as taboo have also become more normalized in our society. For example, some people enjoy displaying their body on the beach which is, at its core, exhibitionistic. Others may have a fetish where they enjoy sleeping in their lover's clothes. Typically, there is no concern when these behaviours occur, especially if they occur between two consenting adults. It is these unique sexual behaviours which are interesting, enticing, and may be unknown to some.

We have explored in great detail a compilation of topics that have not been as covered by other sexuality books. In doing so, I hope that we were able to provide you with another angle and point of view regarding controversial sexual topics. In essence, the topic of human sexuality is an area where research will continue to expand as there is yet a lot of work to be done and knowledge to be gained. For example, the exploration of sexuality and sexual dysfunctions in combination with different genders and sexuality preferences is still yet to be known. Regardless, we have brought together a variety of current existing literature on a wide array of topics meant to provide you with another perspective of these fewer common topics. Therefore, I hope that you will not read this book once and toss it aside, but refer to it when questions, concerns, and issues relating to sexuality arise. I hope that it will enlighten you and assist in understanding those situations that you may be called to deal with.

One more thought – the general public, and especially youth (like millennials), are more conservative regarding sexuality, than their parents were. So, in line with furthering research and clinical practice in the area of human sexuality, it is important to educate the public, enrich their understanding, and make sense of a topic which is now being discussed openly, non-defensibly, and in a manner that enhances our social and emotional development.

We will end with several stories that highlight the issues that we covered.

*

Billy Crystal once claimed that women need a reason to have sex, while men just need a place to do it.

*

Steve Martin advised women not to have sex with men, for then they will need to also kiss them, and then even talk to them.

*

"Doctor" said the man, "Can you, please, lower my sex drive?" "Are you sure that you want that?" wondered the doctor. "Well… yes, lower it by three feet. It is all in my head only…"

*

Two sperm, Johnny and Gerry, are swimming fast on their way to meet the ovum. "Is there still a long way to go?" asks Gerry. "I am afraid so," said Johnny, "We just passed the vocal cords."

Index

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20th century, ix, 3, 4, 18, 22, 40, 84, 147, 207, 227, 238, 252, 270, 286
21st century, x, 10, 16, 17, 19, 26, 80, 94, 102, 115, 223, 286, 335

A

Acquired Immune Deficiency Syndrome (AIDS), 9, 10, 146, 169, 232, 299
adolescent and young adult patients (AYA), 165
aging, 68, 70, 73, 162, 166, 181, 185, 193, 204, 205, 206, 216, 217, 223, 224, 225, 226, 228, 231, 278, 294, 306, 321
Alzheimer's disease (AD), 185
American Psychological Association (APA), 19, 136, 139, 148, 155, 156
analgesic effect, 42, 89
andrology, 159
anorgasmia, 71, 174, 179, 197, 198, 208, 220, 233, 259, 284, 291, 297, 326
anxiety, 45, 51, 64, 71, 79, 86, 90, 98, 104, 118, 125, 151, 158, 159, 163, 164, 166, 168, 171, 172, 173, 175, 178, 182, 186, 192, 196, 198, 201, 203, 204, 208, 211, 217, 218, 219, 221, 226, 233, 244, 245, 255, 263, 267, 268, 271, 272, 279, 280, 284, 287, 288, 290, 291, 292, 294, 295, 297, 298, 299, 300, 302, 303, 304, 315, 316, 323, 325, 330, 332
Argentina, 5, 192
arousal, 31, 32, 36, 37, 38, 43, 44, 47, 48, 51, 52, 55, 57, 61, 64, 72, 73, 80, 97, 99, 105, 133, 134, 140, 143, 144, 149, 152, 154, 155, 156, 158, 171, 172, 173, 175, 177, 181, 190, 191, 192, 194, 196, 197, 200, 201, 203, 204, 206, 209, 210, 211, 212, 216, 218,219, 227, 232, 235, 241, 250, 256, 261, 263, 265, 270, 280, 282, 284, 290, 292, 294, 296, 298, 300, 304, 310, 313, 316, 320, 321
asexual, 26, 65, 138, 139, 156, 183, 184, 260, 261, 274, 275, 282
asphyxiophilia, 265
attachment, 53, 73, 77, 78, 79, 95, 96, 97, 103, 104, 109, 113, 114, 120, 193, 200, 204, 240, 241, 242, 243, 245, 272, 280, 294, 314, 315, 316, 318, 325, 326, 327, 328, 333, 334
autoeroticism, 63

B

behavioral techniques, 269
belong/belonging, vii, x, 6, 12, 89, 90, 92, 103, 113, 118, 129, 145, 255, 262, 279, 280, 311, 313, 314, 315, 316, 323, 331, 334
biological factors, 139, 141, 193, 218, 226, 241
biopsychosocial treatment, 286
birth control methods, 15, 22
bisexual, 24, 26, 57, 82, 83, 128, 137, 138, 140, 141, 144, 146, 147, 149, 150, 151, 213, 271, 280
breast cancer, 71, 160, 161, 164, 165, 202, 210, 284
Buddhism, 4, 8

C

cancer, 39, 134, 157, 159, 160, 161, 162, 163, 164, 165, 166, 168, 170, 187, 192, 193, 199, 202, 231, 232, 284
cardiovascular disease, 176, 192, 195, 196, 198, 223, 227, 231, 241, 284
casual sex, 46, 49, 60, 62, 84, 85, 101, 281
Catholic Church, 5
Centers for Disease Control and Prevention (CDC), 24
child sexual abuse (CSA), xi, 193, 212, 213, 214, 234, 246, 248, 266, 267, 268, 271, 274, 280, 303, 304, 311
Child Sexual Exploitation Materials (CSEM), 248, 249, 250, 251
children, ix, 2, 7, 12, 15, 26, 29, 59, 63, 65, 68, 76, 77, 82, 83, 86, 94, 100, 109, 119, 129, 132, 148, 151, 156, 157, 161, 194, 195, 204, 205, 212, 213, 238, 239, 240, 241, 242, 246, 247, 248, 249, 250, 257, 260, 264, 266, 267, 268, 271, 280, 281, 298, 303, 304, 316
Chile, 5
China, 4, 6, 8, 10, 13, 14, 15, 16, 58, 99, 100, 105, 192
Christianity, 2, 58, 252
clitoris, 9, 13, 27, 31, 32, 33, 34, 36, 38, 41, 42, 43, 44, 45, 46, 54, 56, 154, 163, 199, 201, 207, 208, 282
cognitive distortions, 242, 243, 249, 270
cognitive social learning theory, 62, 63

cognitive-behavior therapy (CBT), 217, 246, 270, 290, 291, 299, 301, 302
commercialized sex, 18
commitment, 18, 28, 36, 49, 50, 53, 55, 62, 73, 84, 85, 89, 90, 92, 96, 97, 98, 101, 102, 104, 109, 113, 120, 131, 143, 189, 313, 314
communication, x, 45, 46, 55, 56, 75, 82, 83, 89, 103, 106, 107, 108, 112, 118, 119, 120, 121, 123, 124, 125, 126, 127, 128, 129, 130, 132, 133, 134, 136, 169, 170, 186, 198, 202, 206, 210, 215, 278, 288, 292, 294, 295, 297, 298, 307, 308, 317, 324, 325, 328, 333
complex marriage, 21
congenital disability, 169
coronary heart disease (CHD), 112, 116, 117, 118, 176
correctional institutions, 247, 248
covert sensitization, 269
cultural, ix, 4, 8, 9, 10, 12, 19, 23, 26, 27, 37, 57, 58, 59, 60, 63, 80, 94, 99, 100, 101, 111, 125, 128, 129, 139, 142, 143, 148, 149, 151, 152, 153, 156, 164, 174, 178, 179, 181, 184, 194, 195, 197, 201, 203, 212, 215, 222, 231, 237, 272, 273, 288, 294, 308, 325, 331
cultural influences, 12
culture(s), vii, ix, x, 1, 2, 4, 5, 6, 7, 9, 10, 12, 13, 14, 16, 18, 22, 23, 26, 29, 55, 57, 58, 59, 60, 63, 66, 68, 69, 85, 86, 89, 93, 99, 100, 101, 105, 111, 115, 124, 134, 139, 142, 143, 147, 149, 150, 151, 152, 185, 194, 206, 222, 230, 241, 248, 250, 255, 282, 285, 289, 306, 316, 319, 321, 335

D

delayed ejaculation (DE), 186, 189, 197, 198, 215, 220, 221, 222, 223, 226, 267, 274, 296, 297
depression, 37, 71, 84, 86, 90, 98, 110, 115, 116, 117, 118, 133, 151, 158, 159, 160, 163, 164, 166, 168, 171, 172, 174, 175, 176, 178, 179, 180, 182, 184, 186, 192, 193, 196, 201, 203, 209, 217, 223, 225, 227, 231, 243, 251, 261, 267, 268, 271, 272, 274, 279, 280, 284, 289, 290, 293, 297, 300, 306, 323, 332
deviant sexual interest, 240, 269, 270
diabetes mellitus (DM), 71, 175, 215, 224, 291, 293
disgust, 3, 129, 173, 213, 221, 256, 274, 316, 318
divorce, 2, 5, 6, 14, 22, 23, 89, 94, 106, 111, 115, 116, 117, 118, 123, 182, 189, 204, 217, 288, 317, 328, 331
Dr. William Masters and Virginia Johnson, 21

E

eating disorders, 151, 173, 174, 175, 271
elderly, 69, 160, 180, 206, 224, 225, 226, 227, 228, 282, 345
electric aversion therapy, 269
emotion, 51, 59, 78, 93, 99, 134, 136, 138, 245
emotional experience, 37, 215
emotional support, 73, 103, 109, 116
enjoyment, 36, 37, 56, 65, 68, 86, 158, 168, 184, 185, 194, 200, 207, 264, 290, 295
epilepsy, 177, 178, 187, 284
erectile dysfunctions (ED), 37, 54, 87, 136, 156, 158, 159, 160, 170, 171, 172, 173, 176, 178, 179, 180, 181, 186, 187, 190, 191, 192, 195, 198, 218, 223, 225, 227, 228, 229, 231, 232, 233, 234, 235, 277, 285, 286, 288, 292, 293, 294, 295, 296, 297, 311, 334
excitement, 9, 36, 37, 38, 39, 50, 70, 75, 76, 112, 176, 183, 186, 190, 197, 198, 200, 222, 269
exhibitionism, 238, 255, 259, 268, 269
extramarital sex, 5, 6, 9, 24, 62, 74, 101, 316

F

facial features, 74, 75, 150
fantasy(ies), 16, 23, 47, 48, 52, 54, 59, 61, 63, 64, 65, 66, 67, 72, 75, 76, 77, 78, 79, 80, 87, 99, 106, 107, 108, 124, 129, 138, 178, 181, 190, 196, 200, 203, 208, 209, 211, 216, 222, 226, 238, 239, 240, 241, 249, 250, 251, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 269, 270, 275, 282, 284, 291, 294, 295, 297, 299, 302, 309, 322, 327
fear of entrapment, 316, 317
female genitals/female genitalia, 7, 31, 32, 34, 141
fetishism, 213, 238, 239, 240, 255, 257, 261, 262, 264
frotteurism, 238, 255, 257, 259

G

gay, ix, 24, 26, 57, 67, 80, 83, 128, 137, 139, 140, 141, 142, 146, 147, 148, 149, 150, 152, 210, 213, 264, 271, 325
gender, 5, 9, 17, 22, 23, 34, 37, 43, 44, 46, 49, 53, 58, 60, 61, 62, 63, 64, 72, 99, 101, 106, 111, 124, 126, 127, 128, 129, 139, 140, 142, 143, 145, 146, 151, 152, 154, 171, 179, 181, 182, 184, 213, 246, 254, 256, 259, 264, 267, 268, 303, 309
gender differences, 43, 49, 53, 61, 62, 63, 64, 111, 127, 171, 182, 246
gender nonconforming, 151
good communication, 55, 108, 304, 317, 325

G-spot, 33, 40, 42, 66, 307
gynecological surgery(ies), 162

H

health, ix, 17, 18, 19, 23, 24, 26, 29, 56, 58, 63, 65, 66, 70, 71, 87, 90, 92, 98, 100, 102, 103, 105, 107, 112, 115, 116, 134, 135, 148, 151, 152, 156, 158, 159, 160, 169, 170, 172, 179, 181, 184, 186, 190, 192, 201, 203, 206, 209, 215, 216, 217, 218, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 244, 260, 267, 271, 273, 277, 279, 280, 281, 282, 285, 286, 288, 293, 294, 298, 303, 306, 307, 309, 313, 316, 318, 320, 321, 323, 325, 329, 330, 333
Hebrew Bible, 1, 2
Hebrew scriptures, 1, 2
heterosexual, 24, 49, 50, 57, 68, 74, 82, 83, 125, 128, 129, 130, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 149, 150, 151, 152, 153, 154, 155, 156, 210, 234, 245, 256, 280, 291, 321, 322, 324, 333
Hinduism, 3, 4
homosexual, 5, 6, 8, 9, 17, 24, 57, 61, 82, 83, 106, 137, 138, 140, 141, 142, 143, 144, 145, 146, 147, 148, 150, 151, 152, 153, 154, 155, 156, 326
homosexuality, 5, 6, 7, 8, 9, 10, 14, 17, 21, 128, 139, 140, 141, 142, 143, 145, 146, 147, 150, 151, 152, 153, 155, 156, 238, 255, 280
hooking up, 84, 85, 128
hormones, 35, 47, 48, 93, 116, 141, 154, 171, 186, 217, 256, 313
HPV-OSCC, 166, 167, 168
human papillomavirus (HPV), 166, 167, 168
hypersexuality, 178, 182, 190, 193, 211, 235, 252, 259, 266, 267, 303
hypertension, 71, 112, 117, 158, 175, 176, 181, 192, 224, 225, 230, 284, 293
hypoactive sexual desire, 72, 189, 197, 202, 216, 217, 226, 284, 290, 292, 304, 305, 311
hypoactive sexual desire disorder (HSDD), 72, 189, 197, 202, 209, 216, 226, 284, 290, 292, 304, 305

I

infertility, 23, 166, 186, 231, 232, 233, 234
infidelity, 60, 76, 83, 106, 107, 114, 115, 195, 204, 280, 288, 318, 327, 329, 330, 331, 332
instinct to withdraw, 317
internet, x, 16, 17, 18, 19, 24, 80, 81, 82, 83, 85, 86, 87, 90, 105, 106, 107, 115, 120, 128, 249, 262, 272, 273, 274, 280, 281, 307, 333
intervention, 154, 165, 166, 202, 204, 218, 251, 253, 292, 295, 299, 305, 308, 333
intimacy, vii, ix, x, 1, 13, 17, 22, 37, 50, 52, 53, 55, 57, 59, 69, 73, 75, 77, 78, 79, 83, 84, 89, 92, 93, 96, 97, 101, 102, 103, 104, 105, 106, 107, 110, 112, 113, 114, 117, 118, 119, 121, 123, 124, 131, 133, 134, 147, 158, 164, 165, 169, 173, 174, 180, 183, 185, 191, 193, 194, 200, 205, 206, 209, 210, 215, 220, 221, 228, 232, 233, 234, 241, 242, 245, 254, 258, 273, 278, 279, 283, 287, 288, 289, 291, 293, 294, 296, 302, 306, 308, 309, 314, 315, 317, 318, 319, 320, 321, 322, 324, 325, 326, 327, 329, 330, 331, 332, 333, 334
Islam, 3

J

Japan, 5, 6, 15, 16, 18, 111, 259, 330
Johnson, Virginia, 21, 23
Judaism, 1, 2, 58

K

Kaplan, Dr. Helen Singer, 37, 39, 219, 220, 222, 226, 235, 288
Kinsey report, The, 14, 16, 23, 47
Kinsey, Dr. Alfred, ix, x, 13, 14, 22, 24, 39, 42, 43, 44, 45, 46, 47, 60, 146, 156, 177, 187, 207, 257, 272
kissing, 7, 27, 66, 67, 73, 78, 84, 105, 116, 119, 120, 131, 167, 321, 330

L

Latin America, 5, 14, 15, 16, 192
lesbian, ix, 24, 57, 67, 128, 137, 139, 140, 141, 143, 146, 147, 148, 149, 150, 280
lesbian, gay, or bisexual (LGB), 139, 140, 148
loneliness, 84, 90, 94, 111, 112, 113, 114, 118, 130, 192, 241, 242, 243, 248, 254, 260, 279, 280, 319, 331, 332, 334
love, vii, x, xi, 2, 4, 16, 21, 22, 33, 50, 53, 59, 64, 68, 73, 78, 85, 87, 89, 91, 92, 93, 95, 96, 97, 98, 99, 100, 102, 103, 104, 107, 108, 110, 111, 112, 113, 114, 115, 118, 119, 120, 121, 128, 130, 131, 132, 136, 142, 147, 169, 189, 194, 200, 206, 219, 238, 255, 257, 258, 261, 264, 279, 283, 287, 288, 289, 301, 309, 311, 313, 314, 315, 319, 320, 322, 323, 326, 327, 331, 333, 334

M

marital sex, 5, 9, 18
marital success, 108, 109, 110, 126
marriage, ix, 1, 3, 5, 7, 9, 10, 12, 17, 21, 23, 28, 46, 55, 58, 59, 60, 73, 76, 84, 85, 89, 92, 93, 94, 95, 96, 98, 100, 101, 102, 108, 109, 110, 111, 112, 115, 116, 117, 123, 128, 136, 143, 147, 154, 157, 189, 192, 205, 207, 277, 287, 289, 305, 309, 316, 330, 331, 332
Masters and Johnson, 22, 23, 24, 32, 37, 38, 39, 41, 42, 45, 47, 48, 207, 208, 219, 224, 286, 291, 294, 296, 297, 310
Masters, Dr. William, 21, 23
masturbation, ix, x, 6, 9, 13, 14, 16, 21, 24, 27, 31, 36, 39, 46, 60, 61, 63, 65, 66, 67, 70, 72, 76, 77, 78, 82, 83, 102, 135, 147, 159, 170, 174, 177, 178, 182, 190, 201, 202, 211, 213, 214, 216, 219, 220, 222, 225, 227, 240, 256, 257, 259, 260, 261, 262, 265, 269,273, 274, 275, 277, 282, 284, 290, 291, 293, 295, 307, 316, 327
mating, 11, 12, 48, 49, 54, 62, 74, 75, 101, 155, 328, 333
mating strategies, 12, 74, 101
media, 8, 16, 17, 18, 26, 61, 62, 80, 81, 86, 87, 107, 128, 129, 150, 246, 252, 261, 278, 288, 335
medical conditions, vii, 37, 71, 157, 158, 159, 175, 184, 201, 202, 211, 215, 217, 223, 228
medical illnesses, 157, 228
medical treatment, 157, 228, 233, 298
mental health, 56, 71, 86, 115, 116, 147, 148, 151, 153, 155, 166, 170, 201, 213, 223, 228, 231, 234, 279, 280, 281, 301, 309, 311
Middle Ages, 148, 285
mild cognitive impairment (MCI), 185, 186
mild memory impairment (MMI), 185, 186
multiple sclerosis (MS), ix, x, 37, 165, 177, 178, 179, 180, 182, 187, 193, 196, 198, 202, 206, 215, 284, 288, 302, 305
myth(s), 54, 68, 69, 221

N

National Association for Research and Treatment of Homosexuality (NARTH), 154
National Center for Health Statistics (NCHS), 23
National Survey of Family Growth (NSFG), 23
National Survey of Sexual Health and Behavior (NSSHB), 24
nature of love, 96
necrophilia, 257, 265
neurology, 177
non-heterosexuals, 147, 153, 155
Non-Orthodox Jews, 58
Non-Relationship Sexual Pleasure, 14

O

obesity, 170, 223, 228, 230, 293
Oneidans, The, 21
oral HPV infections, 167
oral sex, 7, 8, 23, 26, 27, 29, 57, 66, 67, 70, 73, 105, 107, 166, 167, 168, 257, 322, 323, 333
orgasm, 7, 8, 13, 14, 27, 28, 31, 32, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 50, 52, 56, 60, 61, 65, 66, 67, 68, 70, 72, 73, 74, 76, 77, 86, 105, 107, 114, 125, 133, 140, 154, 158, 160, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 184, 185, 186, 189, 190, 191, 192, 193, 194, 196, 197, 198, 200, 201, 202, 204, 205, 206, 207, 208, 209, 211, 212, 215, 219, 220, 221, 222, 224, 226, 227, 230, 232, 234, 241, 255, 258, 259, 261, 265, 267, 270, 279, 280, 282, 284, 287, 290, 291, 297, 298, 299, 300, 302, 304, 306, 307, 310, 320, 322, 330, 333
oropharyngeal squamous cell carcinomas (OSCC), 166, 167, 168
Orthodox Jews, 58

P

pansexuality, 139
paraphilia (sexual aversion), 172, 174, 182, 197, 200, 234, 238, 255, 258, 259, 262, 264, 265, 274, 304, 305
paraphilias, xi, 237, 238, 239, 240, 252, 255, 256, 257, 259, 265, 266, 269, 335
paraphilic disorders, 239, 256, 269
Parkinson’s disease (PD), 177, 180, 181, 182
partialism, 261, 262
passion, 97, 98, 102, 103, 104, 105, 107, 109, 287, 290, 305, 307, 318, 320, 321, 322, 333, 334
pedophilia, x, 138, 238, 239, 249, 255, 259, 266, 270
persistent genital arousal disorder (PGAD), 210, 211, 290
plateau, 38, 41
PLISSIT, 308
pornography, 3, 4, 5, 6, 16, 23, 47, 60, 61, 62, 66, 68, 80, 81, 82, 86, 190, 225, 240, 248, 250, 259, 265, 269, 273, 280, 281, 308, 329, 335
post-traumatic stress disorder (PTSD), 173, 271, 280
premarital sex, 5, 9, 27, 62, 85, 201, 257, 329
premature ejaculation (PE), 72, 159, 171, 172, 173, 177, 180, 181, 189, 192, 197, 198, 206, 213, 214, 215, 216, 217, 218, 219, 220, 223, 226, 229, 280, 286, 296, 297, 304, 305, 310

prostate cancer, 66, 160, 164, 165, 170, 193
prostitution, 2, 3, 5, 6, 8, 14, 18, 21, 25, 82, 137, 154, 214
provoked vestibulodynia (PVD), 133, 134
psychological comfort, 55
psychological disorders, 170, 198
psychological factors, ix, 161, 182, 195, 209, 216, 218, 294, 304

R

rape, x, 5, 6, 10, 23, 27, 51, 74, 173, 212, 237, 239, 240, 241, 243, 244, 248, 254, 255, 259, 268, 300
refractory period, 36, 39, 43, 47, 70
relational intimacy, ix, 319, 324
religion, vii, 1, 2, 3, 18, 55, 57, 58, 59, 109, 143, 149, 156, 184, 208, 285, 315
reproduction, 5, 11, 12, 13, 21, 35, 40, 41, 45, 48, 62, 77, 171, 281, 309, 319, 326
resolution, 39, 103, 106, 195, 200, 245, 291, 298, 327
response, 2, 3, 5, 6, 8, 10, 18, 36, 37, 38, 39, 40, 41, 42, 47, 48, 51, 52, 53, 54, 55, 56, 61, 71, 87, 89, 92, 126, 143, 144, 147, 149, 156, 171, 172, 186, 193, 195, 197, 198, 199, 200, 201, 207, 209, 210, 219, 221, 224, 227, 229, 230, 257, 266, 288, 290, 291, 299, 302, 305, 323, 327
risk, need, and responsivity (RNR), 250
Roman Catholics, 58
romantic attitudes, 111
Russia, 5, 9, 10, 15, 16

S

sadomasochism (SM), 213, 239, 257, 262, 263, 264
satisfaction, x, 26, 28, 37, 43, 50, 53, 54, 55, 58, 62, 68, 70, 73, 74, 89, 96, 103, 105, 107, 108, 109, 110, 111, 115, 116, 117, 118, 120, 123, 124, 125, 126, 130, 131, 133, 134, 135, 136, 154, 159, 160, 164, 165, 166, 172, 173, 175, 181, 184, 185, 190, 193, 194, 196, 200, 201, 202, 205, 206, 209, 210, 214, 220, 224, 225, 228, 229, 230, 232, 233, 234, 245, 269, 280, 289, 290, 296, 302, 304, 305, 307, 309, 315, 318, 319, 321, 322, 324, 325, 327, 328, 329, 330, 332, 333, 334
schizophrenia, 171, 174, 175, 284
selective serotonin re-uptake inhibitors (SSRIs), 172, 193, 211, 252, 269, 270, 284
self-protection, 316, 318
sex drive, 60, 61, 69, 149, 154, 161, 197, 203, 249, 259, 270, 332, 336
sex offenders (SOs), 19, 41, 44, 51, 55, 106, 128, 145, 153, 157, 160, 193, 224, 237, 239, 243, 244, 245, 246, 247, 248, 252, 253, 254, 255, 257, 270, 280, 287, 299, 310, 335
sex research, x, 13, 21, 22, 23, 24, 25, 26, 27, 29, 36, 42, 49, 52, 55, 68, 135, 136, 137, 138, 155, 156, 165, 172, 187, 200, 217, 218, 219, 221, 222, 234, 235, 241, 260, 262, 274, 329, 333
sex response cycle, 38
sex surveys, 24
sex therapy, vii, 1, 23, 53, 60, 64, 157, 165, 197, 202, 221, 234, 235, 277, 283, 285, 286, 287, 288, 291, 292, 295, 298, 299, 301, 302, 304, 305, 307, 308, 309, 310, 311, 323
sexting, ix, 85, 86
sextortion, 85
sexual addiction, 234, 267, 271, 272, 273, 274, 275, 299, 303, 308
sexual arousal, 33, 36, 37, 38, 39, 43, 44, 47, 48, 50, 51, 52, 64, 65, 72, 73, 80, 137, 140, 143, 144, 156, 163, 171, 176, 180, 184, 189, 190, 193, 195, 197, 200, 201, 202, 203, 208, 209, 210, 211, 213, 219, 222, 239, 240, 241, 250, 254, 255, 256, 261, 262, 264, 265, 267, 270, 274, 280, 284, 288, 290, 291, 294, 302, 304, 305, 306, 320, 323, 326
sexual attitudes, 15, 17, 62, 80, 85, 149, 157, 201, 215, 216, 217, 295, 307
sexual attractiveness, 63, 160, 185
sexual behaviors, vii, xi, 1, 4, 5, 6, 8, 10, 17, 21, 24, 29, 46, 55, 62, 63, 65, 66, 67, 78, 79, 80, 85, 107, 124, 127, 131, 132, 133, 139, 140, 147, 155, 166, 167, 168, 173, 174, 189, 193, 195, 207, 211, 213, 216, 237, 257, 265, 267, 270, 271, 272, 273, 279, 281, 295, 309, 320, 322, 326, 327
sexual desire, x, xi, 21, 25, 28, 36, 37, 38, 46, 48, 49, 50, 51, 52, 53, 54, 57, 59, 61, 64, 67, 68, 69, 70, 71, 72, 75, 96, 107, 115, 124, 129, 131, 133, 134, 139, 140, 147, 149, 158, 160, 171, 172, 174, 176, 180, 181, 182, 184, 185, 190, 192, 193, 194, 196, 197, 200, 202, 203, 204, 205, 206, 209, 210, 211, 216, 217, 220, 223, 224, 225, 226, 227, 230, 232, 233, 234, 256, 260, 282, 284, 287, 288, 289, 290, 299, 302, 304, 305, 306, 307, 311, 316, 320, 321, 322, 324, 326, 327, 328
sexual differences, 11
sexual disorders, 189, 190, 220, 221, 222, 238, 244, 263, 267, 288, 289, 294, 304, 309
sexual dysfunction (SD), x, xi, 25, 28, 40, 64, 70, 71, 72, 75, 125, 134, 138, 158, 159, 160, 163, 171, 172, 173, 175, 176, 177, 178, 179, 180, 181, 182, 183, 187, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 206, 208, 209, 210, 212, 213, 214, 215, 216, 217, 220, 222, 223, 224, 225, 226, 227, 229, 230, 231, 232, 233, 234, 235, 261, 267, 283, 284, 285, 286, 287, 288, 289,

290, 291, 292, 293, 294, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 310, 311, 319, 324, 326, 328, 333, 335
sexual fluidity, 149
sexual intercourse/intercourse, 2, 3, 6, 7, 8, 9, 13, 14, 17, 23, 24, 27, 31, 33, 36, 39, 41, 44, 45, 46, 49, 50, 56, 57, 58, 59, 61, 64, 66, 67, 70, 73, 77, 78, 84, 102, 107, 110, 123, 128, 130, 133, 147, 154, 159, 160, 162, 164, 168, 172, 173, 174, 177, 178, 179, 180, 182, 184, 186, 189, 191, 192, 193, 197, 198, 199, 201, 202, 204, 206, 208, 210, 213, 219, 220, 222, 224, 225, 226, 228, 262, 265, 266, 271, 277, 279, 290, 295, 298, 308, 322, 326, 327, 332
sexual orientation, vii, 23, 24, 57, 61, 76, 83, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 257, 309
sexual rehabilitation, 165, 308
sexual reproduction, 11, 17
sexual selection, 11, 74
sexual technique, 7, 8
sexual trauma, 27, 29, 174, 203, 294, 299, 300, 306, 311
sexual violence, 4, 5, 10, 27, 59, 204, 241, 264
sexuality counseling, 307, 308, 309
sexually transmitted diseases (STD), ix, 9, 83, 174, 175, 186, 194, 201, 222, 268
sexually transmitted infection (STI), 25, 166, 168, 187, 193, 199, 232, 271, 274, 300
social inadequacy, 316, 317
social norms, 22, 84, 145
social stigma, 183
social structural theory, 62, 63
social support network, 90, 169
society, ix, 1, 6, 7, 12, 13, 19, 21, 57, 61, 63, 66, 68, 70, 90, 99, 100, 106, 120, 128, 136, 147, 153, 187, 215, 237, 246, 247, 248, 251, 257, 267, 281, 285, 292, 311, 335
South Korea, 15
spinal cord injury (SCI), 177, 183, 184, 185, 202
stigma, 25, 29, 90, 139, 145, 147, 148, 155, 156, 184, 247, 248
stimuli, 18, 36, 37, 38, 40, 42, 47, 48, 51, 52, 138, 144, 155, 200, 201, 208, 211, 214, 238, 241, 250, 256, 260, 262, 289
surgical treatment, 163, 193, 229

T

therapist, 31, 60, 125, 165, 202, 251, 253, 273, 274, 277, 282, 283, 299, 304, 310, 322
touch/touching, 26, 31, 32, 33, 34, 38, 48, 56, 58, 66, 93, 103, 105, 119, 120, 131, 133, 164, 177, 185, 208, 222, 238, 239, 258, 259, 260, 261, 266, 279, 322, 323, 328, 330
transvestism, 145, 240, 257, 262, 264

U

United States of America (USA), 11, 13, 14, 15, 16, 18, 69, 72, 74, 101, 167, 168, 171, 207, 230, 246, 272, 283
Uruguay, 5

V

vagina, ix, 16, 23, 32, 33, 34, 38, 39, 40, 41, 42, 43, 44, 45, 48, 70, 145, 162, 163, 166, 191, 199, 205, 206, 207, 208, 209, 214, 215, 222, 239, 258, 282, 284, 297, 310
venereal diseases (VD), 5, 6, 17
Viagra, 1, 83, 158, 172, 173, 175, 182, 187, 217, 227, 228, 285, 286, 292, 293, 294, 296, 308
virginity, 5, 15, 27, 29
voyeurism, 238, 239, 255, 257, 259, 268, 269
vulvodynia, 162, 205, 209, 210, 211, 234

W

well-being, xi, 26, 53, 59, 70, 83, 89, 92, 93, 98, 102, 104, 112, 115, 116, 118, 126, 131, 132, 133, 136, 151, 160, 161, 185, 201, 223, 227, 230, 279, 293, 314, 320, 323, 331, 333
Western culture, 25, 40, 48, 58, 59, 101, 102, 111, 128, 146, 241
wisdom, 345

Z

Zoophiles, 258
Zoophilia, 257, 265

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Ami Rokach is a clinical psychologist, who teaches at York University in Toronto, and is also the Editor-in-Chief of the *Journal of Psychology: Interdisciplinary and Applied*. While teaching the younger generation, and working with the elderly, he became aware of how much transfer of wisdom between those at the beginning and at the end of life is essential, and this project was born.

Human sexuality touches all of us, pun intended. We all either enjoy it, struggle with it, or may have been its victims. Humanity has dealt with this central issue for decades, and we still continue to learn as science and research are progressing and developing. When discussing sexuality, we mean human sexual functioning, the physiology of sex, the hormones involved and how they affect us, and the cultural norms related to it.

However, when sex is not functional it is a problem that can affect us in significant ways. This book will describe and explore its causes and the reasons that those dysfunctions are maintained, and what treatment methods have been proven successful.

Amongst its other contributions, this book will place sexuality where it belongs: within the context of relationships, and will demonstrate how it is related to intimacy and may enhance it, how it may be negatively influenced by destructive relationships, and how dysfunctions or paraphilias may influence the intimate union.

This book covers issues, angles, and points of view which are not commonly covered in sex books for the general public, replete with recent and updated information.

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