Sexual deviations

See Paraphilias

Sexual dysfunction

The persistent or recurrent inability or lack of desire to perform sexually or engage in sexual activity.

Sexual dysfunction involves both somatic and psychic phenomena which contribute to an overall inability or lack of interest in performing sexually. In males, the condition is most associated with erectile dysfunction (ED), formerly referred to as male “impotence.” Studies estimate that 10-20 million American males have some degree of ED, which clinically presents as a persistent inability to attain or maintain penile erection sufficient for sexual intercourse.

Female sexual dysfunction falls into four main categories: (1) a low libido or aversion to sex; (2) difficulty in attaining sexual arousal; (3) inability to experience or attain orgasm; and (4) pain during sexual intercourse. Research in this area indicates that as many as 4 in 10 American women experience some form of sexual dysfunction.

Assessment

As recently as the mid-twentieth century, sexual dysfunction was considered a psychological condition or disorder. The Kinsey Reports and Masters and Johnson’s studies tended to isolate “performance anxiety” as the root of most sexual disorders. Later, in the 1970s, Helen Singer Kaplan impressed many colleagues and practitioners with her focus on enhancing sexual desire rather than sexual performance. Her biological approach to sexuality, i.e., equating sexual desire with physical appetite, was indeed helpful in sex therapy. Her approach was further justified by the fact that epidemiological studies during the 1980s showed a disproportionate incidence of treatment-resistant desire disorders in the sex-therapy clinical populations of the United States and Northern Europe. It is clear that the proliferation of erotic material available to the general public (pornographic publications, movies, sex toys, Internet sites, etc.) from the 1970s to the 1990s paralleled the therapeutic effort to enhance sexual desire rather than treat sexual performance.

However, by the 1990s, human sexuality was emerging as a complex bio-psychosocial phenomenon. Contemporary studies view the great majority of sexual dysfunction cases as having somatic or organic rather than psychologic etiologies, or at least as being “comorbid” in origin. This is particularly true in male disorders, where up to 80 percent of ED is the result of physical conditions which interfere with nerves and blood vessels. Most commonly, vascular disease is blamed for decreased blood flow to the penis. Once a physical condition affects the ability to maintain penile erection, psychological distress and performance anxiety sets in, complicating the problem. This leads to avoidance of sexual activity and the male may become socially withdrawn or depressed.

It is generally believed that for women, more so than for men, sexual drives and satisfactions are more complex and organized around the entire sexual relationship or sexual partner. Moreover, collateral factors such as birth control, abortion, fear of sexually-transmitted diseases, and feminism have greatly affected women’s general approach to sexual activity and sexual behavior. Key psychological causes associated with sexual dysfunction range from past sexual abuse, to unsatisfactory emotional relationships with sexual partners, to poor self-assessment regarding body image or appearance. Another factor to be considered is that half of all women over the age of 60 are without a partner (even though they have forestalled menopause with hormone replacement therapy), and the “use it or lose it” thinking about sexual activity has proven to have some medical basis. (Research suggests that long periods of sexual inactivity may result in loss of elasticity to the vagina in females, and muscle atrophy in the penis of males.) All of these factors may put pressure on both sexes to “perform” or engage in sexual activity more often, even if sexual intercourse results in physical pain. Thus, “remedicalization” of dysfunction from the psychological to the medical arena may not always address the coexisting psychosocial aspects of the condition. Adjunct psychological therapy may be warranted.

Treatment

The recent emphasis on physical rather than psychological etiology in addressing sexual dysfunction corre-
lates with the widespread success of prescription and non-prescription drug therapy for ED, such as that found in Viagra (sildenafil citrate), which effectively increases blood flow to the genitals. By 2000, doctors increasingly considered therapeutic doses of testosterone to both male and female patients, as testosterone is known to enhance sexual libido in both sexes.

For women, treatment of sexual dysfunction has been more varied because of the varying causes and presenting symptoms. During 1999, studies were commenced to test the efficacy of Viagra on females who complained of low sexual desire or inability to become sexually aroused. However, initial results published in May 2000 indicated that Viagra proved no more effective than a placebo in the female group. This finding may further support the belief that a synergy between the mind and body provides the best relief for female sexual dysfunction.

Notwithstanding, for both genders, several physical conditions greatly affect sexual functioning. These include diabetes, obesity, vascular disease, stress, fatigue, and untoward affects of medication. Menopausal and post-menopausal women may experience pain with sexual intercourse caused by decreased lubrication of mucous membranes and tissues. In all of the above, treatment of the underlying medical condition may render the sexual dysfunction as nonexistent or effectively relieved.

Some studies have shown that a decrease in dietary minerals, particularly zinc, may adversely affect libido. Such dietary deficits are related to pituitary hormone production of prolactin, which, at high levels, contributes to sexual dysfunction. It is therefore believed that some persons may be helped by increasing their dietary intake of red meats, dark meat poultry, seafood, leafy greens, and whole grains (all rich in zinc).

Finally, in treating sexual dysfunction, clients and couples are encouraged to refrain from thinking of sexual intercourse as the only or the ultimate goal of sexual activity. Therapists advise couples to frequently engage in non-coital sexual activity, including oral and manual stimulation, and to continue to provide such sexual pleasure even if the male loses his erection. Further, couples are encouraged to make sexual activity a priority and not an accidental happening when they retire at night. This is because testosterone levels are in fact lower in the evening hours, and both persons may be tired. Added to this is the fact that with age, it takes both sexes longer to become sexually stimulated. Partners should also try to incorporate sensual and affectional feelings into their activities, for obvious benefit.

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Further Reading


Sexuality

The full range of thoughts and actions that describe sexual motivation and behavior.

While sex is not necessary for an individual’s survival, without it a species would cease to exist. The determinants of sexual motivation and behavior include an individual’s physiology, learned behavior, the physical environment, and the social environment.

A person’s sex is determined at conception by whether one out of the 23 chromosomes in the father’s sperm is either X (female) or Y (male). All female eggs contain an X chromosome, so each fertilized egg, or embryo, has a genotype of either XX (female) or XY (male). Reproductive hormones produced by the gonads (male testes and female ovaries) determine the development of the reproductive organs and the fetal brain, especially the hypothalamus. All the human reproductive hormones are found in both sexes but in different amounts. The principal female hormones are estrogens and progesterone (of which the main ones are estradiol and progesterone); the primarily male hormones are androgens (mainly testosterone). In males, levels of testosterone remain fairly constant, regulated by a feedback loop to the brain and pituitary gland, which control hormone secretion. In females, hormone levels fluctuate within each menstrual cycle, rising at ovulation. Reproductive hormones have two types of effects on the body. Organizational effects, which occur primarily before birth, are irreversible and permanently govern an individual’s response to further hormone secretion. Activational effects govern behavior temporarily while hormone levels are elevated.

Human females are born with about 400,000 immature eggs. Each one is contained in a sac called a