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Sexual Dysfunctions—The 3 R’s: Reflect, Recite, and Review
- Reflect
- Recite
- Review
Which of the following statements are the truth, and which are fiction? Look for the Truth-or-Fiction icons on the pages that follow to find the answers.

1. Sexual dysfunctions are rare.  T  F
2. Only men can reach orgasm too early.  T  F
3. The most common cause of painful intercourse in women is vaginal infection.  T  F
4. Sex therapy teaches a man with erectile disorder how to “will” an erection.  T  F
5. A doctor made a somewhat unusual presentation to a medical convention by dropping his pants to reveal an erection.  T  F
6. Many sex therapists recommend masturbation as the treatment for women who have never been able to reach orgasm.  T  F
7. A man can prevent ejaculation by squeezing his penis when he feels that he is about to ejaculate.  T  F
Derek, 39, and his wife Pam, 37, had not attempted sexual intercourse for five years. Sexual relations had been limited to fondling, caressing, and occasional oral–genital contact. They had given up attempting intercourse because of Derek’s difficulty in attaining and sustaining erections. But recently they had begun trying again. Some nights Derek would have an erection enabling him to penetrate, only to find that he quickly lost the erection. Many nights he was unable to perform at all. Each failure was another blow to his self-esteem. Pam worried that he could not perform because he was no longer attracted to her.

Terry, 24, has decided she is built differently from friends and women she reads about. They all reach orgasm, it seems, at the drop of a hat. But she has never managed “one of those things.” Her husband David, also 24, is considerate, but Terry knows that he, too, is frustrated and feels guilty with every ejaculation. Why should he enjoy sex if Terry cannot? Terry and David anticipate sex with

Derek and Terry have sexual dysfunctions. Sexual dysfunctions are persistent or recurrent problems in becoming sexually aroused or reaching orgasm. Many of us have sexual problems from time to time. Men occasionally have difficulty obtaining an erection or ejaculate more quickly than they would like. Women occasionally have difficulty lubricating or reaching orgasm. But sexual dysfunctions, per se, are persistent and cause significant distress.

People with sexual dysfunctions may avoid sexual opportunities for fear of failure. They may anticipate that sex will result in frustration or pain rather than pleasure and gratification. Because our culture emphasizes sexual competence, people with sexual dysfunctions may feel inadequate or incompetent, feelings that diminish their self-esteem (Fishman & Mamo, 2001). They may also experience guilt, shame, frustration, depression, and anxiety.

Many people with sexual dysfunctions find it difficult to talk about them, even with spouses or helping professionals. A woman who cannot reach orgasm with her husband may not want to “make a fuss.” A man may find it difficult to admit erectile problems to his physician during a physical exam. Many physicians are also uncomfortable talking about sex and may never ask about it.

We do not have precise figures on the occurrence of sexual dysfunctions. The most accurate information may be based on the National Health and Social Life Survey (Laumann et al., 1994) (see Table 15.1). The NHSLS group asked respondents whether there had been a period of several months during the past year when they were disinterested in sex, could not reach orgasm, reached orgasm too rapidly, had pain during sex, did not enjoy sex, were anxious about their sexual performance, had trouble obtaining or maintaining an erection (for men) or had trouble lubricating (for

CRITICAL THINKING

When does a sexual problem become a sexual dysfunction? Where do you draw the line? How can concern about a sexual problem develop into a dysfunction?

Sexual dysfunctions are persistent or recurrent difficulties in becoming sexually aroused or reaching orgasm.
**Table 15.1**

<table>
<thead>
<tr>
<th>Sexual Dysfunctions Reported within the Past Year, According to the NHSLS</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain during sex</td>
<td>3.0%</td>
<td>14.4%</td>
</tr>
<tr>
<td>Sex not pleasurable</td>
<td>8.1</td>
<td>21.2</td>
</tr>
<tr>
<td>Unable to reach orgasm</td>
<td>8.3</td>
<td>24.1</td>
</tr>
<tr>
<td>Lack of interest in sex</td>
<td>15.8</td>
<td>33.4</td>
</tr>
<tr>
<td>Anxiety about performance*</td>
<td>17.0</td>
<td>11.5</td>
</tr>
<tr>
<td>Reaching climax too early</td>
<td>28.5</td>
<td>10.3</td>
</tr>
<tr>
<td>Unable to keep an erection**</td>
<td>10.4</td>
<td>–</td>
</tr>
<tr>
<td>Having trouble lubricating</td>
<td>–</td>
<td>18.8</td>
</tr>
</tbody>
</table>

*Anxiety about performance is not itself a sexual dysfunction. However, it figures prominently in many sexual dysfunctions.

**Incidence increases with age, and the NHSLS figures may be an underestimate.


Women more often reported painful sex, lack of pleasure, inability to reach orgasm, and lack of desire. Men were more likely to report reaching orgasm too soon and anxiety about their performance.

**Truth or Fiction Revisited:** It is not true that sexual dysfunctions are rare. A national telephone survey found that perhaps one woman in four is seriously distressed about her sexuality or her sexual relationship (Bancroft, 2003). However, the NHSLS estimated that 43% of women had a sexual dysfunction (Laumann et al., 1994). Moreover, Rosen and Laumann (2003) argue that the telephone survey was inferior in methodology to the face-to-face interviews of the NHSLS.

**Types of Sexual Dysfunctions**

The most widely used system of classification of sexual dysfunctions is based on the American Psychiatric Association’s (2000) *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. The DSM proposes four categories of sexual dysfunctions:

1. **Sexual desire disorders.** These involve lack of interest in sex or aversion to sexual contact.

2. **Sexual arousal disorders.** Sexual arousal is mainly characterized by erection in the male and vaginal lubrication and swelling of the external genitalia in the female. In men, sexual arousal disorders involve difficulty in obtaining or sustaining erections sufficient to engage in sexual intercourse. In women, they typically involve insufficient lubrication.

3. **Orgasmic disorders.** Men or women may have difficulty reaching orgasm or reaching orgasm more quickly than they would like. Women are more likely to encounter difficulties reaching orgasm. Men are more likely to reach orgasm too quickly (have premature ejaculation).

**Sexual desire disorders**  Sexual dysfunctions in which people have persistent or recurrent lack of sexual desire or aversion to sexual contact.

**Sexual arousal disorders**  Sexual dysfunctions in which people persistently or recurrently fail to become adequately sexually aroused to engage in or sustain sexual intercourse.

**Orgasmic disorders**  Sexual dysfunctions in which people persistently or recurrently have difficulty reaching orgasm or reach orgasm more rapidly than they would like, despite attaining a level of sexual stimulation of sufficient intensity to normally result in orgasm.
4. **Sexual pain disorders.** Both men and women may suffer from **dyspareunia** (painful intercourse). Women may experience **vaginismus**, or involuntary contraction of muscles that surround the vaginal barrel, preventing penetration by the penis or making it painful.

Sexual dysfunctions are classified as lifelong or acquired. (Acquired dysfunctions follow a period of normal functioning.) Dysfunctions are also classified as generalized or situational. **Generalized dysfunctions** occur in all situations. **Situational dysfunctions** affect sexual functioning only in some situations, as during intercourse but not masturbation, or with one partner but not another. If a man has never been able to obtain an erection during sexual relations with a partner but can do so during masturbation, his dysfunction is lifelong and situational.

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**Real Students, Real Questions**

**Q** What does prude mean? Is this considered a sexual dysfunction?

**A** The word *prude* has the same origin as the word *proud*, and it refers to being highly or evenly excessively proper or modest in one's own speech, behavior, and dress. In other words, prudes prefer not to curse, engage in behaviors such as serious kissing in public, or dress seductively. They also typically disapprove of such displays by others. What they do privately in a committed relationship might be quite different. In fact, they might enjoy sex a great deal, so there is no necessary connection between public prudery and sexual functioning or dysfunctioning. The origins of prudery are uncertain. Being reared strictly may have something to do with it, although many young people rebel, especially in open societies. And there might just be a genetic component.

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**Sexual Desire Disorders**

Sexual desire disorders involve lack of sexual desire or aversion to genital sexual activity. People with little or no sexual interest or desire are said to have **hypoactive sexual desire disorder**. They often report an absence of sexual fantasies. Lack of desire is more common among women than men, with an estimated prevalence across cultures of 25 to 53% (Heiman, 2008). The incidence of low sexual desire in a nationally representative sample of some 2,000 women surveyed by Suzanne West and her colleagues (2008) was 26.7% for premenopausal women and 52.4% for postmenopausal women. Yet another survey put the rate at 39% (Shifren, 2008). Nevertheless, the belief that men are always eager for sex is a myth (Hackett, 2008).

Lack of sexual desire does not imply that a person is unable to achieve erection, lubricate adequately, or reach orgasm. Some people with low sexual desire can become sexually aroused and reach orgasm when stimulated adequately. Many enjoy sexual activity, even if they are unlikely to initiate it. Many appreciate the affection and closeness of physical intimacy, but have no interest in genital stimulation (Hackett, 2008).

Hypoactive sexual desire is one of the most commonly diagnosed sexual dysfunctions, yet there is no clear consensus among clinicians and researchers concern-
Types of Sexual Dysfunctions

Real Students, Real Questions

Q: I do not feel sexual during times when I have a lot of schoolwork. Is that normal?

A: If “a lot of schoolwork” translates into stress, it is absolutely normal. Some people turn to sex as a way of trying to escape feelings of stress, but it is just as normal—and perhaps more common—for stress to have a dampening effect on sexual desire.

SEXUAL AVersion DISORDER People with low sexual desire may have little or no interest in sex, but they are not repelled by genital contact. Some people, however, find sex disgusting or aversive and avoid genital contact.

A history of erectile problems can cause sexual aversion in men (Bancroft et al., 2005b, 2005c). Men with such histories may be anxious in sexual situations because they trigger feelings of failure and shame. Their partners may also develop an aversion to sexual contact because of their own frustration. A history of sexual trauma, such as rape or childhood sexual abuse or incest, often figures prominently in cases of sexual aversion, especially in women (Firestone et al., 2006b; Najman et al., 2005).

Sexual Arousal Disorders

When we are sexually stimulated, our bodies normally respond with vasocongestion, which produces erection in the male and vaginal lubrication in the female. People with sexual arousal disorders fail to achieve or sustain the lubrication or erection necessary to enable sexual activity (Rowland & Incrocci, 2008). Or they lack the feelings of sexual pleasure or excitement that normally accompany sexual arousal.

Problems of sexual arousal have sometimes been labeled impotence in the male and frigidity in the female. But these terms are pejorative, so many professionals prefer to use less threatening, more descriptive labels.

MALE ERECTILE DISORDER Sexual arousal disorder in the male is called male erectile disorder or erectile dysfunction. It is characterized by persistent
The Emotional Toll of Erectile Dysfunction. Male erectile disorder or erectile dysfunction is characterized by persistent difficulty in achieving or maintaining an erection sufficient to allow the completion of sexual activity. As many as 30 million men in the United States experience some degree of erectile dysfunction, and the incidence increases with age. Occasional erectile problems are common and may be caused by fatigue, alcohol, or anxiety about a new partner. However, fear of recurrence can create a vicious cycle, in which anxiety leads to failure, and failure heightens anxiety.

difficulty in achieving or maintaining an erection sufficient to allow the completion of sexual activity. In most cases the failure is limited to sexual activity with partners, or with some partners and not others. It can therefore be classified as situational. In some cases the dysfunction is found during any sexual activity, including masturbation. In these instances, it is considered generalized dysfunction. Some men with erectile disorder are unable to attain an erection with their partners (Aubin et al., 2009). Others can achieve erection but not sustain it (or recover it) long enough for penetration and ejaculation (Bancroft et al., 2005b).

As many as 30 million men in the United States experience some degree of erectile dysfunction (Goldstein, 1998). The incidence of erectile disorder increases with age, although there is great disagreement at to how many men are affected. The NHSLS reported that difficulty keeping an erection increases from about 6% in the 18- to 24-year-old age group to about 20% in the 55- to 59-year-old age group. Another study reported that about 3% of men in their 50s had difficulty obtaining or maintaining erections, and that this figure increased to about 35% for men in their 70s (Blanker et al., 2001). But urologist Irwin Goldstein (1998) found that nearly half the men aged 40 to 70 in a Massachusetts survey reported problems in obtaining and maintaining erections—at least now and then. We cannot account for these discrepancies between studies. We can only suggest that the incidence of erectile disorder may be more frequent than is commonly believed. Drugs used to treat the disorder sell quite briskly, although it is not known how many men with erectile disorder use them.

Erectile disorder usually develops after a period of normal functioning. Many men engage in years of successful coitus before the problem begins. Occasional problems in achieving or maintaining erection are quite common. Fatigue, alcohol, anxiety over impressing a new partner, and other factors may account for a transient episode. Even an isolated occurrence can lead to a persistent problem if the man fears recurrence, however. The more anxious and concerned the man becomes about his sexual ability, the more likely he is to suffer performance anxiety. This anxiety can
contribute to repeated failure, and a vicious cycle of anxiety and failure may develop (Bancroft et al., 2005c).

A man with erectile problems may try to “will” an erection, which can compound the problem. Each failure may further demoralize and defeat him. He may ruminate about his sexual inadequacy, setting the stage for yet more anxiety. His partner may try to comfort and support him by saying things like “It can happen to anyone,” “Don’t worry about it,” or “It will get better in time.” But attempts at reassurance may be to no avail. As one client put it,

> I always felt inferior, like I was on probation, having to prove myself. I felt like I was up against the wall. You can’t imagine how embarrassing this (erectile failure) was. It’s like you walk out in front of an audience that you think is a nudist convention and it turns out to be a tuxedo convention.

—The Authors’ Files

The vicious cycle of anxiety and erectile failure may be interrupted if the man recognizes that occasional problems are normal and does not overreact. The emphasis in our culture on men’s sexual prowess may spur them to view occasional failures as catastrophes rather than transient disappointments, however. Viewing occasional problems as an inconvenience, rather than a tragedy, may help avert development of persistent erectile problems.

**FEMALE SEXUAL AROUSAL DISORDER** Women may encounter persistent difficulties becoming sexually excited or sufficiently lubricated in response to sexual stimulation. In some cases these difficulties are lifelong. In others they develop after a period of normal functioning. In some cases difficulties are pervasive and occur during both masturbation and sex with a partner. More often they occur in certain situations. For example, they occur with some partners and not with others, or during intercourse but not during oral sex or masturbation (Goldstein et al., 2006).

Female sexual arousal disorder often accompanies other sexual disorders such as hypoactive sexual desire disorder and orgasmic disorders. Despite problems in becoming sexually aroused, women with sexual arousal disorders can often engage in coitus. Vaginal dryness may produce discomfort, however.

Female sexual arousal disorder, like its male counterpart, may have physical causes. A thorough evaluation by a medical specialist is recommended. Any neurological, vascular, or hormonal problem that interferes with the lubrication or swelling response of the vagina to sexual stimulation may contribute to female sexual arousal disorder. For example, diabetes mellitus may damage the nerves and blood vessels servicing the clitoral region. Reduced estrogen production can result in vaginal dryness.

Another interesting line of research suggests that the skin of some women with sexual arousal problems is not as sensitive to touch as the skin of women who do not have such problems (Frohlich & Meston, 2005). In such cases, the woman might seek to increase sexual stimulation—psychological as well as physical.

Female sexual arousal disorder more commonly has psychological causes, however. In some cases, women harbor deep-seated anger and resentment toward their partners (Moore & Heiman, 2006). They therefore find it difficult to turn off these feelings when they go to bed. In other cases, sexual trauma is implicated. Survivors of sexual abuse often find it difficult to respond sexually to their partners. Childhood sexual abuse is especially prevalent in cases of female sexual arousal disorder (Najman et al., 2005; van der Made et al., 2008; van Lankveld, 2008). Feelings of helplessness, anger, or guilt, or even flashbacks of the abuse, may surface when the
woman begins sexual activity, dampening her ability to become aroused. Other psychosocial causes include anxiety or guilt about sex and ineffective stimulation by the partner (Goldstein et al., 2006).

**Real Students, Real Questions**

**Q** I was molested as a child, and the thought of sex does not interest me. What can I do about this?

**A** We will offer you some generalizations, but we will also admit, right at the beginning, that we do not know enough about your situation and suggest that you might want to talk it over with a helping professional. Having said that, you might begin by allowing a good relationship to develop with a decent, caring person. If you are comfortable in the relationship, and are engaging in some cuddling and so on, you might find some interest in sex developing. Even if such a relationship seems unavailable to you, it would not hurt to discuss the situation with a professional.

**Orgasmic Disorders**

Orgasmic disorders include (1) female orgasmic disorder, (2) male orgasmic disorder, and (3) premature or rapid ejaculation. In female or male orgasmic disorder, the woman or man is persistently delayed in reaching orgasm or does not reach orgasm at all, despite achieving sexual stimulation of sufficient intensity to normally result in orgasm. The problem is more common among women than men. In some cases a person can reach orgasm without difficulty while engaging in sexual relations with one partner, but not with another.

**FEMALE ORGASMIC DISORDER** Women with female orgasmic disorder are unable to reach orgasm or have difficulty reaching orgasm following what would usually be an adequate amount of sexual stimulation. Women who have never achieved orgasm through any means are sometimes labeled anorgasmic or preorgasmic.

A woman who reaches orgasm through masturbation or oral sex may not necessarily reach orgasm during coitus with her partner. Penile thrusting during coitus may not provide sufficient clitoral stimulation to facilitate orgasm. An orgasmic disorder may be diagnosed, however, if orgasm during coitus was impaired by factors such as sexual guilt or performance anxiety. Women who try to force an orgasm may also find themselves unable to do so. They may assume a spectator role and observe rather than fully participate in their sexual encounters. “Spectatoring” may further decrease the likelihood of orgasm.

**MALE ORGASMIC DISORDER** Male orgasmic disorder has also been termed delayed ejaculation, retarded ejaculation, and ejaculatory incompetence. The problem may be lifelong or acquired, generalized or situational. There are very few cases of men who have never ejaculated. In most cases the disorder is limited to coitus.
The man may be capable of ejaculating during masturbation or oral sex, but find it difficult, if not impossible— despite high levels of sexual excitement—to ejaculate during intercourse. One might think that female partners could possibly enjoy such a dysfunction because it would enable a man to last longer. But the experience can be frustrating for both partners (Richardson et al., 2006). Male orgasmic disorder is relatively infrequent in the general population and in clinical practice, where it is among the least frequently diagnosed disorders.

Male orgasmic disorder may be caused by physical problems such as multiple sclerosis or neurological damage that interferes with neural control of ejaculation. It may also be a side effect of certain drugs. Various psychological factors may also play a role, including performance anxiety, sexual guilt, and hostility toward the partner. Emotional factors such as fears of pregnancy and anger toward one’s partner can also play a role.

As with other sexual dysfunctions, men with orgasmic disorder and their partners may “try harder.” But trying harder may worsen rather than help sexual problems. Sexual relations become a job to get done, a chore rather than an opportunity for pleasure and gratification.

**PREMATURE OR RAPID EJACULATION** A second type of male orgasmic disorder, premature or rapid ejaculation, is the most common male sexual dysfunction (Porst et al., 2008; see Table 15.1 on page 463). Men with premature (rapid) ejaculation ejaculate too rapidly to permit their partners or themselves to fully enjoy sexual relations. The degree of prematurity or rapidity varies. Some men ejaculate during foreplay, even at the sight of their partner disrobing. But most ejaculate either just prior to or immediately upon penetration, or following a few coital thrusts (Byers & Grenier, 2003). The point is that his partner—and he—would rather wait a while. In determining what is too rapid, some scholars argue that the focus should be on whether the couple is satisfied with the duration of coitus rather than on a specific time period (Byers & Grenier, 2003).

Helen Singer Kaplan (1974) suggested that the label “premature” should be applied to cases in which men persistently or recurrently lack voluntary control over their ejaculations. This may sound like a contradiction in terms since ejaculation is a reflex, and reflexes need not involve thought or conscious control. Kaplan meant, however, that a man may control ejaculation by regulating the amount of sexual stimulation he experiences so that it remains low enough not to trigger the ejaculation reflex until the partners are ready.

### Real Students, Real Questions

**Q** Do women find a man ejaculating disgusting? Is that a dysfunction?

**A** Some women find ejaculation disgusting. Others are turned on by it. Still others have no particular feelings about it. The reasons for these variations are unclear. Finding ejaculating disgusting is not in itself a sexual dysfunction. If it gives rise to a sexual aversion, it might be.

**Premature (rapid) ejaculation** A sexual dysfunction in which ejaculation occurs with minimal sexual stimulation and before the partners desire it.
RAPID FEMALE ORGASM: CAN WOMEN REACH ORGASM TOO QUICKLY?
The female counterpart to premature ejaculation, rapid orgasm, is so rarely recognized as a problem that it is generally ignored by clinicians and is not classified as a sexual dysfunction in the DSM system. Truth or Fiction Revisited: Still, some women experience orgasm rapidly and show little interest in continuing sexual activity so that their partners can achieve gratification. Many women who reach orgasm rapidly are open to continued sexual stimulation and capable of experiencing successive orgasms, however.

Sexual Pain Disorders
For most of us, coitus is a source of pleasure. For some of us, however, coitus gives rise to pain and discomfort.

DYSPAREUNIA One sexual pain disorder, dyspareunia, or painful coitus, afflicts both men and women. Dyspareunia is a common sexual dysfunction and a common complaint of women seeking gynecological services.

Pain is usually a sign that something is physically wrong (Brauer et al., 2009). Dyspareunia may result from physical causes, emotional factors, or an interaction of the two (Goldstein et al., 2006). But it should be noted that it is widely disputed whether dyspareunia should be listed in the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association, because its inclusion suggests that it is a mental disorder (Binik, 2005; Spitzer, 2005).

Truth or Fiction Revisited: The most common cause of painful intercourse—or dyspareunia—in women is not vaginal infection. It is lack of adequate lubrication. In such a case, additional foreplay or artificial lubrication may help. The normal changes of aging may play a role among perimenopausal and postmenopausal women (Brauer at al., 2009). Vaginal infections or sexually transmitted infections (STIs) may also produce painful sex. Allergic reactions to spermicides, even the latex material in condoms, can give rise to painful sex. Pain during deep thrusting may indicate endometriosis, pelvic inflammatory disease (PID), or structural disorders of the reproductive organs.

Psychological factors such as unresolved guilt or anxiety about sex or the lingering effects of sexual trauma may also be involved. These factors may inhibit lubrication and cause involuntary contractions of the vaginal musculature, making penetration painful or uncomfortable.

Painful intercourse is less common in men and is generally associated with genital infections that cause burning or painful ejaculation. Smegma under the penile foreskin of uncircumcised men may also irritate the penile glans during sexual contact.

VAGINISMUS Another sexual pain disorder, vaginismus, involves involuntary contraction of the pelvic muscles that surround the outer third of the vaginal barrel. Vaginismus occurs reflexively during attempts at vaginal penetration, making entry by the penis painful or impossible. The muscle contractions are accompanied by fear of penetration. Some women with vaginismus are unable to tolerate penetration by any object, including a finger, tampon, or a physician’s speculum. The prevalence of vaginismus is unknown.

The woman with vaginismus usually is not aware that she is contracting her vaginal muscles. In some cases, husbands of women with vaginismus develop erectile disorder after repeated failures at penetration.
Vaginismus is considered to be caused by psychological fear of penetration rather than physical injury or defect (Brauer et al., 2009; ter Kuile et al., 2009). Women with vaginismus often have histories of sexual trauma, rape, or botched abortions that resulted in vaginal injuries. They may desire sexual relations. They may be capable of becoming sexually aroused and achieving orgasm. However, fear of penetration triggers an involuntary spasm of the vaginal musculature at the point of penile insertion. Vaginismus can also be a cause or an effect of dyspareunia. Women who experience painful coitus may develop a fear of penetration. Fear then leads to the development of involuntary vaginal contractions. Vaginismus and dyspareunia may also give rise to, or result from, erectile disorder in men. Feelings of failure and anxiety can overwhelm both partners.

**VULVODYNIA**

The pain has lasted for months. You’re so uncomfortable you can hardly sit. Having sex is unthinkable. Nothing alleviates the pain, burning and irritation, at least not for long. (Mayo Clinic, 2006)

This is the Mayo Clinic’s (2006) description of **vulvodynia**. Vulvodynia is a gynecological condition characterized by vulval pain, particularly chronic burning sensations, irritation, and soreness (Lotery et al., 2004; Masheb et al., 2004). Although vulvodynia and related conditions, such as vestibulitis, can give rise to painful intercourse, they are not in themselves considered sexual dysfunctions (Kaler, 2005). Their causes are unknown, although a history of local infections, damage to local nerves, and allergies are among the suspects. Cold compresses, local anesthetics, and topical creams with estrogen or cortisone may provide relief (Mayo Clinic, 2006). Consult your gynecologist about other possible treatments.

Table 15.2 shows differences in the incidences of current sexual dysfunctions and other problems between European Americans and African Americans, according to

<table>
<thead>
<tr>
<th></th>
<th>European American Men</th>
<th>African American Men</th>
<th>European American Women</th>
<th>African American Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain during sex</td>
<td>3.0%</td>
<td>3.3%</td>
<td>14.7%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Sex not pleasurable</td>
<td>7.0</td>
<td>15.2</td>
<td>19.7</td>
<td>30.0</td>
</tr>
<tr>
<td>Unable to reach orgasm</td>
<td>7.4</td>
<td>9.9</td>
<td>23.2</td>
<td>29.2</td>
</tr>
<tr>
<td>Lack of interest in sex</td>
<td>14.7</td>
<td>20.0</td>
<td>30.9</td>
<td>44.5</td>
</tr>
<tr>
<td>Anxiety about performance</td>
<td>16.8</td>
<td>23.7</td>
<td>10.5</td>
<td>14.5</td>
</tr>
<tr>
<td>Reaching climax too early</td>
<td>27.7</td>
<td>33.8</td>
<td>7.5</td>
<td>20.4</td>
</tr>
<tr>
<td>Unable to keep an erection</td>
<td>9.9</td>
<td>14.5</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Having trouble lubricating</td>
<td>–</td>
<td>–</td>
<td>20.7</td>
<td>13.0</td>
</tr>
</tbody>
</table>

the NHSLS (Laumann et al., 1994). African American men report a higher incidence than European American men of sexual dysfunctions. African American women report a higher incidence of most sexual dysfunctions, with the exceptions of painful sex and trouble lubricating.

**Origins of Sexual Dysfunctions: A Biopsychosocial Approach**

*We human beings are complex*, with complex bodies as well as complex mental processes. We are also reared in families within cultural settings. For these reasons, we need to consider possible biological, psychological, and social factors in sexual dysfunctions (Brown & Haaser, 2005). For example, biological and psychosocial factors—hormonal deficiencies, depression, dissatisfaction with one’s relationship, and so on—contribute to lack of desire. Moreover, these factors can interact in a number of ways. Researchers refer to such an approach as a biopsychosocial model.

**Biological Causes**

Among the medical conditions that diminish sexual desire are testosterone deficiencies, thyroid overactivity or underactivity, and temporal lobe epilepsy. Sexual desire is stoked by testosterone, which is produced by men in the testes and both men and women in the adrenal glands (Heiman, 2008). Women may experience less sexual desire when their adrenal glands are surgically removed. Low sexual interest, along with erectile difficulties, are also common among men with hypogonadism, which is treated with testosterone (Lue, 2000).

The reduction in testosterone levels that occurs in middle and later life may in part explain a gradual decline in sexual desire among men (Hackett, 2008). But women’s sexual desire may also decline with age, because of physical and psychological changes, as we will see (Heiman, 2008). Some medications, especially those used to control anxiety or hypertension, may also reduce desire. Changing medications or doses may return the person’s previous level of desire.

Fatigue may lead to erectile disorder and orgasmic disorder in men, and to inadequate lubrication and orgasmic disorder in women. But these will be isolated incidents unless the person attaches too much meaning to them and becomes concerned about future performances. Painful sex, however, often reflects underlying infections. Medical conditions that affect sexual response include heart disease (Lane & Thayer, 2008), diabetes mellitus, multiple sclerosis, spinal cord injuries, complications from surgery (such as removal of the prostate in men), hormonal problems, and the use of some medicines, such as those used to treat hypertension and psychiatric disorders (Byerly et al., 2006; Olfson et al., 2005; Wooten, 2008).

**HIV and Sexual Dysfunctions** There is little doubt that HIV/AIDS is associated with sexual dysfunction in both men and women. Men with HIV are also more likely to have hypogonadism and erectile dysfunction, which are apparently worsened by antiretroviral therapy (Crum et al., 2005). Antiretroviral therapy is known to increase levels of estrogen in men (Lamba et al., 2004). A study of 78 seropositive gay males found a host of sexual dysfunctions ranging from loss of interest in sex to delayed ejaculation and erectile disorder (Cove & Petrak, 2004). Be-
cause the men were more capable of obtaining and maintaining erections without condoms than with condoms, many of them used condoms inconsistently.

HIV seropositive women, too, show various sexual dysfunctions, from lack of interest to sexual arousal disorders to orgasmic dysfunction (Florence et al., 2004). Researchers attribute the dysfunctions to psychological factors—anxiety, irritability, and depression—and to the effects of HIV.

**SSRIs AND SEXUAL RESPONSE** People and physicians need to be very, very aware of the sexual side effects of some drugs used to treat depression. So-called selective serotonin reuptake inhibitors—SSRIs for short—are widely prescribed not only for depression but also for panic disorder, obsessive-compulsive disorder, anorexia nervosa, and other ills. Most physicians are aware that these drugs have “some” sexual side effects in “some” patients. However, the fact of the matter is that they almost completely impair sexual arousal in many patients, especially older patients (Heiman, 2008). Moreover, even when the patients discontinue the drugs, sexual functioning does not necessarily bounce back (Bolton et al., 2006; Csoka & Shipko, 2006).

Some drugs that are helpful with depression may not impair sexual functioning—at least in the short run. Wellbutrin, at least when used temporarily, can improve sexual functioning and is sometimes prescribed along with an SSRI to help prevent sexual side effects. Ask your physician.

Researchers find that health problems can contribute to all kinds of sexual dysfunctions in men, but mostly to sexual pain in women (Barsky et al., 2006; Binik, 2005; Schultz et al., 2005). Even when biological factors are involved in sexual dysfunctions, psychological factors such as anger and depression can prolong or worsen them (Laurent & Simons, 2009).

Biological causes of erectile disorder affect the flow of blood to and through the penis—a problem that becomes more common as men age—or damage to nerves involved in erection (Goldstein, 1998). Erectile problems can arise when clogged or narrow arteries leading to the penis deprive the penis of oxygen (Thompson et al., 2005). For example, erectile disorder is common among men with diabetes mellitus, a disease that can damage blood vessels and nerves. Eric Rimm (2000) of the Harvard School of Public Health studied 2,000 men and found that erectile dysfunction was connected with a large waist, physical inactivity, and drinking too much alcohol (or not having any alcohol!). The common condition among these men may be high cholesterol levels. Cholesterol can impede the flow of blood to the penis just as it impedes the flow of blood to the heart. Another study connects erectile dysfunction with heart disease and hypertension (Johannes et al., 2000). Exercise, weight loss, and eating fewer animal fats help to lower cholesterol levels.

Similarly, aging can affect the sexual response of women. Perimenopausal and postmenopausal women usually produce less vaginal lubrication than younger women and the vaginal walls become thin—changes that can render sex painful (Dennerstein & Goldstein, 2005). These physical changes, along with negative stereotypes of older women and men, can create performance anxiety and fumbling performances, and discourage both partners from attempting sexual activity (McCabe,
In such cases, artificial lubrication can help supplement the woman’s own production, and estrogen replacement may halt or reverse some of the sexual changes of aging (Goldstein & Alexander, 2005). But partners also need to have realistic expectations and consider enjoyable sexual activities they can engage in without discomfort or high demands (McCarthy & Fucito, 2005; Mohan & Bhugra, 2005).

Middle-aged and older men might try weight control and regular exercise. The findings of the Massachusetts Male Aging Study suggest that men who exercise regularly seem to ward off erectile dysfunction (Derby, 2000). Men who burn 200 calories or more a day in physical activity, an amount that be achieved by briskly walking for two miles, cut their risk of erectile dysfunction by about half. Exercise seems to prevent clogging of arteries, keeping them clear for the flow of blood into the penis.

Nerve damage resulting from prostate surgery may impair erectile response. Former senator and presidential candidate Bob Dole encountered erectile problems following removal of his prostate gland. Erectile disorder may also result from multiple sclerosis (MS), a disease in which nerve cells lose the protective coatings that facilitate transmission of neural messages. MS has also been implicated in male orgasmic disorder.

The bacteria that cause syphilis, a sexually transmitted infection, can invade the spinal cord and affect the cells that control erections, resulting in erectile dysfunction. Chronic kidney disease, hypertension, cancer, emphysema, and heart disease can all impair erectile response, as can endocrine disorders that impair testosterone production (Ralph & McNicholas, 2000).

Women also develop vascular or nervous disorders that impair genital blood flow, reducing lubrication and sexual excitement, rendering intercourse painful, and reducing their ability to reach orgasm. As with men, these problems become more likely as women age.

People with sexual dysfunctions are generally advised to undergo a physical examination to determine whether their problems are biologically based. Men with erectile disorder may be evaluated in a sleep center to determine whether they attain erections while asleep. The technique is termed nocturnal penile tumescence (NPT). Healthy men usually have erections during rapid-eye-movement (REM) sleep, which occurs every 90 to 100 minutes. Men with biologically based erectile disorder often do not have nocturnal erections.

Prescription drugs and illicit drugs account for many cases of erectile disorder. Antidepressant medication and antipsychotic drugs may impair erectile functioning and cause orgasmic disorders (Olfsen et al., 2005; Taylor et al., 2005). Tranquilizers such as Valium and Xanax may cause orgasmic disorder in either men or women. Some drugs used to treat high blood pressure can impair erectile response. Switching to other blood pressure drugs or adjusting doses may help. Other drugs that can lead to erectile disorder include adrenergic blockers, diuretics, cholesterol-lowering drugs (statins), anti-convulsants, anti-Parkinson drugs, and dyspepsia and ulcer-healing drugs (Do et al., 2009).

Central nervous system depressants such as alcohol, heroin, and methadone can reduce sexual desire and impair sexual arousal (Brown et al., 2005). Narcotics also depress testosterone production, thereby reducing sexual desire and leading to erectile failure. Marijuana use has been associated with reduced sexual desire and performance (Wilson et al., 2000).

Regular use of cocaine can cause erectile disorder or male orgasmic disorder and reduce sexual desire in both women and men (Rawson et al., 2002). Some people report increased sexual pleasure from initial use of cocaine, but repeated use can lead
to dependency on the drug for sexual arousal. Long-term use may compromise the ability to experience sexual pleasure.

Despite the fact that alcohol can impair sexual arousal on a given occasion, Laumann and his colleagues (1999) found no general relationship between alcohol consumption and sexual dysfunctions. However, problems can arise when people misattribute the sexually dampening effects of depressants such as alcohol to causes within themselves. In other words, if you are unable to perform sexually when you have had a few drinks and do not know that alcohol can depress your performance, you may believe that something is wrong with you. This belief can create anxiety at your next sexual opportunity, and that anxiety can prevent normal functioning. A second failure may set off a vicious cycle in which self-doubts prompt anxiety, and anxiety results in repeated failure and more anxiety.

**Psychosocial Causes**

Abrupt changes in sexual desire are more often explained by psychological and interpersonal factors such as depression, stress, and problems in the relationship (Aubin et al., 2009; Moore & Heiman, 2006). Anxiety is the most commonly reported factor. It may dampen sexual desire, including performance anxiety (anxiety over being evaluated negatively), anxiety involving fears of pleasure or loss of control, and deeper sources of anxiety relating to fears of injury (Janssen & Bancroft, 2006). Depression is also a common cause of lack of desire (Laurent & Simons, 2009). A history of sexual assault has also been linked to low sexual desire (McCarthy et al., 2006).

Psychosocial factors connected with sexual dysfunctions include cultural influences, economic problems, psychosexual trauma, a gay sexual orientation, dissatisfaction with one’s relationship, lack of sexual skills, irrational beliefs, and performance anxiety (Bancroft et al., 2005b; McCabe, 2005).

**Cultural Influences**

Children reared in sexually repressive cultural or home environments may learn to respond to sex with feelings of anxiety and shame, rather than anticipation and pleasure (Nobre & Pinto-Gouveia, 2006). People whose parents instilled in them a sense of guilt over touching their genitals may find it difficult to accept their sex organs as sources of pleasure (McCarthy et al., 2006).

In most cultures, sexual pleasure has traditionally been a male preserve. Young women may be reared to believe that sex is a duty to be performed for their husbands, not a source of personal pleasure. Although the traditional double standard has diminished in developed countries (Fugl-Meyer et al., 2006), some girls are still exposed to repressive attitudes. Women are more likely than men to be taught to suppress sexual desires (Nobre & Pinto-Gouveia, 2006). Self-control and vigilance—not sexual awareness and acceptance—become identified as feminine virtues. Women reared with such attitudes may not learn about their sexual potentials or express their erotic desires to their partners.

Many women who are exposed to negative attitudes about sex during childhood and adolescence find it difficult to suddenly view sex as a source of pleasure and satisfaction as adults. A lifetime of learning to turn themselves off sexually may impair sexual arousal and enjoyment when an acceptable opportunity arises (Fishman & Mamo, 2001).

**Psychosexual Trauma**

Women and men who were sexually victimized in childhood are more likely to experience difficulty in becoming sexually aroused (Matthews et al., 2006; McCarthy et al., 2006; Mosher et al., 2005). Some learning
theorists speak of conditioned anxiety in explaining sexual dysfunctions. Sexual stimuli come to elicit anxiety when they have been paired with traumatic experiences, such as rape, incest, or sexual molestation. Unresolved anger, misplaced guilt, and feelings of disgust also make it difficult for victims of sexual trauma to respond sexually, even years later and with loving partners.

**SEXUAL ORIENTATION** Some gay males and lesbians test their sexual orientation by developing heterosexual relationships, even by entering “Brokeback marriages” in which they rear children with partners of the other sex. Others may wish to maintain the appearance of heterosexuality to avoid the social stigma attached to a gay male or lesbian sexual orientation. In such cases, problems with heterosexual partners can signify lack of heteroerotic interest (McCarthy et al., 2006).

**INEFFECTIVE SEXUAL TECHNIQUES** In some relationships, couples fall into a narrow sexual routine because one partner controls the timing and sequence of sexual techniques. A woman who remains unknowledgeable about the erotic importance of her clitoris may be unlikely to seek direct clitoral stimulation. A man who responds to one erectile failure by trying to force an erection may be unintentionally setting himself up for repeated failure. The couple who fail to communicate their sexual preferences or to experiment with new techniques may find themselves losing interest. Brevity of foreplay and coitus may contribute to female orgasmic disorder.

**EMOTIONAL FACTORS** Orgasm involves a sudden loss of voluntary control. Fear of losing control or “letting go” may block sexual arousal. Other emotional factors, especially depression, are often implicated in sexual dysfunctions (Laurent & Simons, 2009). Depression can contribute to lack of sexual desire. Stress can also interfere with sexual interest and response.

**PROBLEMS IN THE RELATIONSHIP** Problems in the relationship are not easily left at the bedroom door (Aubin et al., 2009; Moore & Heiman, 2006). Heterosexual and homosexual couples alike usually find that sex is no better than other facets of their relationship (Matthews et al., 2006). Partners who have general trouble communicating may also be unable to communicate their sexual desires. Couples who harbor resentments may make sex their combat arena. They may fail to become aroused by their partners or “withhold” orgasm to make their partners feel guilty or inadequate (Firestone et al., 2006b).

The following case highlights how sexual dysfunctions can develop against the backdrop of a troubled relationship:

After living together for six months, Paul and Petula are contemplating marriage. But a problem has brought them to a sex therapy clinic. As Petula puts it, “For the last two months he hasn’t been able to keep his erection after he enters me.” Paul is 26, a lawyer; Petula, 24, is a buyer for a large department store. They both grew up in middle-class, suburban families, were introduced through mutual friends and began having intercourse, without difficulty, a few months into their relationship. At Petula’s urging, Paul moved into her apartment, although he wasn’t sure he was ready for such a step. A week later he began to have difficulty maintaining his erection during intercourse, although he felt strong desires for his partner. When his erection waned, he would try again, but would lose his desire and be unable to achieve another erection. After a few times like this, Petula would become so angry that she began striking Paul in the chest and screaming at...
him. Paul, who at 200 pounds weighed more than twice as much as Petula, would just walk away, which angered Petula even more.

It became clear that sex was not the only trouble spot in their relationship. Petula complained that he preferred to be with his friends and go to baseball games than to spend time with her. When they were together at home, he would become absorbed in watching sports events on television, and showed no interest in activities she enjoyed—attending the theater, visiting museums, etc. Since there was no evidence that the sexual difficulty was due to either organic problems or depression, a diagnosis of male erectile disorder was given. Neither Paul nor Petula was willing to discuss their nonsexual problems with a therapist. While the sexual problem was treated successfully with a form of sex therapy modeled after techniques developed by Masters and Johnson [see discussion later in the chapter] and the couple later married, Paul’s ambivalence continued well into their marriage, and there were future recurrences of sexual problems as well. (Adapted from Spitzer et al., 1989, pp. 149–150)

**LACK OF SEXUAL SKILLS** Sexual competency involves sexual knowledge and skills that are acquired through learning. We generally learn what makes us and others feel good through trial and error and by talking and reading about sex. Some people may not develop sexual competency because of a lack of opportunity to acquire knowledge and experience—even within a committed relationship. People with sexual dysfunctions may have been reared in families in which discussions of sexuality were off limits and early sexual experimentation was harshly punished.

**IRRATIONAL BELIEFS** Irrational beliefs and attitudes may contribute to sexual dysfunctions. We cannot expect our partners to read our minds. We cannot assume that if they truly cared for us, they would know what we need, or want. Communication is one of the keys to sexual satisfaction.

**PERFORMANCE ANXIETY** Anxiety—especially performance anxiety—plays an important role in sexual dysfunctions (Bancroft et al., 2005b; McCabe, 2005).
Performance anxiety occurs when a person becomes overly concerned with how well he or she performs a certain act or task. Performance anxiety may place a dysfunctional individual in a spectator rather than a performer role. Rather than focusing on erotic sensations and allowing reflexes like erection, lubrication, and orgasm to occur naturally, he or she focuses on self-doubts and thinks, “Will I be able to do it this time? Will this be another failure?”

In men, performance anxiety can inhibit erection while also triggering a premature ejaculation (Hellstrom et al., 2006; Janssen & Bancroft, 2006). Erection, mediated by the parasympathetic nervous system, can be blocked by activation of the sympathetic nervous system in the form of anxiety. Since ejaculation, like anxiety, is mediated by the sympathetic nervous system, arousal of this system in the form of anxiety can increase the level of stimulation and thereby heighten the potential for premature ejaculation.

In women, performance anxiety can reduce vaginal lubrication and contribute to orgasmic disorder (Goldstein et al., 2006). Women with performance anxieties may try to force an orgasm, only to find that the harder they try, the more elusive it becomes.

### Treatment of Sexual Dysfunctions

When Kinsey conducted his surveys in the 1930s and 1940s, there was no effective treatment for sexual dysfunctions. At the time, the predominant model of therapy for sexual dysfunctions was long-term psychoanalysis. Psychoanalysts believed that the sexual problem would abate only if the presumed unconscious conflicts that lay at the root of the problem were resolved through long-term therapy. Evidence of the effectiveness of psychoanalysis in treating sexual dysfunctions is still lacking, however.

Since that time cognitive and behavioral models of short-term treatment, collectively called sex therapy, have emerged. Sex therapy aims to modify dysfunctional cognitions (beliefs and attitudes) and behavior as directly as possible. Sex therapists also recognize the roles of childhood conflicts and the quality of the partners’ relationship. Therefore, they draw from various forms of therapy, as needed (Adams, 2006; Hertlein & Weeks, 2008).

Although the particular approaches vary, sex therapies aim to:

2. Enhance sexual knowledge.
3. Teach sexual skills.
4. Improve sexual communication.
5. Reduce performance anxiety.

Sex therapy usually involves both partners, although individual therapy is preferred in some cases. Therapists find that granting people “permission” to sexually experiment or discuss negative attitudes about sex helps many people overcome sexual problems without the need for more intensive therapy.

Today, biological treatments have also been emerging for various sexual dysfunctions. Most public attention has been focused on Viagra, a drug that is helpful in most...
cases of erectile dysfunction. But competitors to Viagra and biological treatments for premature ejaculation, female orgasmic dysfunction, and lack of sexual desire are also emerging. Moreover, there are research findings to the effect that psychotherapy combined with Viagra or other medicines can be more effective than the medicine alone (Aubin et al., 2009).

In this section we explore psychological and behavioral approaches to the treatment of sexual dysfunctions. Let us begin with the pioneering work of Masters and Johnson.

The Masters and Johnson Approach

Masters and Johnson pioneered the use of direct cognitive-behavioral approaches to treating sexual dysfunctions (Masters & Johnson, 1970). A female–male therapy team focuses on the couple as the unit of treatment during a two-week residential program. Masters and Johnson consider the couple, not the individual, dysfunctional. A couple may describe the husband’s erectile disorder as the problem, but this problem is likely to have led to problems in the couple by the time they seek therapy. Similarly, a man whose wife has an orgasmic disorder is likely to be anxious about his ability to provide effective sexual stimulation.
The dual-therapist team permits each partner to discuss problems with someone of his or her own sex. It reduces the chance of therapist bias in favor of the female or male partner. It allows each partner to hear concerns expressed by another member of the other gender. Anxieties and resentments are aired, but the focus of treatment is behavioral change. Couples perform daily sexual homework assignments, such as **sensate focus exercises**, in the privacy of their own rooms.

Sensate focus sessions are carried out in the nude. Partners take turns giving and receiving stimulation in nongenital areas of the body. Without touching the breasts or genitals, the giver massages or fondles the receiving partner in order to provide pleasure under relaxing and nondemanding conditions. Since genital activity is restricted, there is no pressure to “perform.” The giving partner is freed to engage in trial-and-error learning about the receiving partner’s preferences. The receiving partner is also freed to enjoy the experience without feeling rushed to reciprocate or obliged to perform by becoming sexually aroused. The receiving partner’s only responsibility is to direct the giving partner as needed. In addition to these general sensate focus exercises, Masters and Johnson used specific assignments designed to help couples overcome particular sexual dysfunctions.

Masters and Johnson were pioneers in the development of sex therapy. Yet many sex therapists have departed from the Masters and Johnson format. For example, many do not treat clients in an intensive residential program. Many question the necessity of female–male therapist teams. Researchers find that one therapist is about as effective as two, regardless of her or his sex. Nor does it seem to matter whether sessions are conducted within a short period of time, as in the Masters and Johnson approach, or spaced over time.

### Integration of Sex Therapy and Psychotherapy

Sex therapy, as noted, has cognitive components—for example, addressing self-defeating attitudes and expectations, and sex education. Because sexual activity is so often embedded in relationships, many therapists (e.g., Coyle, 2006; McCarthy et al., 2004, 2006) use psychotherapy and couple therapy to help couples learn how to share the power in relationships, how to improve sexual communication, and how to negotiate differences. The combination of sex therapy and couple therapy appears to be a powerful tool for enhancing relationships as well as sex lives.

Helen Singer Kaplan (1974) combined sex therapy with psychoanalytic methods. She saw sexual dysfunctions as having **immediate causes** and **remote causes** (conflicts that date to childhood). As a sex therapist, Kaplan focused on improving the couple’s sexual communication, eliminating performance anxiety, and fostering sexual skills and knowledge. As a psychoanalyst, she used insight-oriented therapy when it appeared that remote causes impaired response to sex therapy. By so doing, she aimed to bring to awareness unconscious conflicts that might have stifled the person’s sexual desire or response.

Let us now consider some of the specific techniques that sex therapists have introduced in treating several of the major types of sexual dysfunction.

### Sexual Desire Disorders

Some therapists help kindle the sexual appetites of people with hypoactive sexual desire by prescribing self-stimulation exercises combined with erotic fantasies (Leiblum & Rosen, 2000; McCarthy et al., 2006). Sex therapists may also assist dysfunctional couples by prescribing sensate focus exercises, enhancing communica-
How Do You Find a Qualified Sex Therapist?

How would you find a qualified sex therapist if you had a sexual dysfunction? You might find advertisements for “sex therapists” in the Yellow Pages. But beware. Most states do not restrict usage of the term sex therapist to recognized professionals. In these states, anyone who wants to use the label may do so, including quacks and prostitutes.

Thus, it is essential to determine that a sex therapist is a member of a recognized profession (such as psychology, social work, medicine, or marriage and family counseling) with training and supervision in sex therapy. Professionals are usually licensed or certified by their states. All states require licensing of psychologists and physicians, but some states do not license social workers or couples therapists. If you have questions about the license laws in your state, contact your state’s professional licensing board. The ethical standards of these professions prohibit practitioners from claiming expertise in sex therapy without suitable training.

If you are uncertain as to how to locate a qualified sex therapist in your area, you may obtain names of local practitioners from various sources, such as your university or college psychology department, health department, or counseling center; a local medical or psychological association; a family physician; or your instructor. You may also seek services from a sex therapy clinic affiliated with a local medical center or medical school in your area, many of which charge for services on a sliding scale, depending on your income level. You may also contact the American Association of Sex Educators, Counselors, and Therapists (AA-SECT), a professional organization that certifies sex therapists. They can provide you with the names of certified sex therapists in your area. They are located at 11 Dupont Circle, N.W., Washington, DC.

Ethical professionals are not annoyed or embarrassed if you ask them (1) what their profession is, (2) where they earned their advanced degree, (3) whether they are licensed or certified by the state, (4) their fees, (5) their plans for treatment, and (6) the nature of their training in human sexuality and sex therapy. If the therapist hemms and haws, asks why you are asking such questions, or fails to provide a direct answer, beware.

Professionals are also restricted by the ethical principles of their professions from engaging in unethical practices, such as sexual relations with their clients. Clients may be vulnerable because the nature of therapy creates an unequal power relationship between the therapist and the client.
lessen anxiety about sexual contact. Fears may also need to be overcome through cognitive-behavioral exercises in which the client learns to manage the stimuli that evoke fears of sexual contact:

Bridget, 26, and Bryan, 30, were married for four years but had never consummated their relationship because Bridget would panic whenever Bryan attempted coitus with her. While she enjoyed foreplay and was capable of achieving orgasm with clitoral stimulation, her fears of sexual contact were triggered by Bryan’s attempts at vaginal penetration. The therapist employed a program of gradual exposure to the feared stimuli to allow Bridget the opportunity to overcome her fears in small, graduated steps. First she was instructed to view her genitals in a mirror when she was alone—this in order to violate her long-standing prohibition against looking at and enjoying her body. While this exercise initially made her feel anxious, with repeated exposure she became comfortable performing it and then progressed to touching her genitals directly. When she became comfortable with this step, and reported experiencing pleasurable erotic sensations, she was instructed to insert a finger into the vagina. She encountered intense anxiety at this step and required daily practice for two weeks before she could tolerate inserting her finger into her vagina without discomfort. Her husband was then brought into the treatment process. The couple was instructed to have Bridget insert her own finger in her vagina while Bryan watched. When she was comfortable with this exercise, she then guided his finger into her vagina. Later he placed one and then two fingers into her vagina, while she controlled the depth, speed and duration of penetration. When she felt ready, they proceeded to attempt penile penetration in the female superior position, which allowed her to maintain control over penetration. Over time, Bridget became more comfortable with penetration to the point that the couple developed a normal sexual relationship.

(Adapted from Kaplan, 1987, pp. 102–103)

Sexual Arousal Disorders

Sex therapists treat both male and female sexual arousal disorders.

**ERECTILE DISORDER** Male sexual arousal disorder is also known as *erectile disorder*. Men with erectile disorder may ask their therapists to “teach” them or “show” them how to obtain an erection. Some of our clients have asked us to tell them what fantasies they should entertain to obtain an erection, or how they should touch their partners or be touched. Erection is a reflex, however, not a skill. A man need not learn how to have an erection any more than he need learn how to breathe.

In sex therapy, women who have trouble becoming lubricated and men with erectile problems learn that they don’t need to “do” anything to become sexually aroused. As long as their problems are psychologically and not organically based, they need only receive sexual stimulation under relaxed circumstances, so that anxiety does not inhibit natural reflexes.

**Truth or Fiction Revisited:** It is not true that sex therapy teaches a man with erectile disorder how to “will” an erection. Men with erectile disorder are actually taught that it is not possible to “will” an erection. One can only set the stage for erection (or vaginal lubrication) to occur and then allow it to happen reflexively.

In order to reduce performance anxiety, the partners engage in non-demanding sexual contacts—contacts that do not demand lubrication or erection. They may start with non-genital sensate focus exercises in the style of Masters and Johnson. After a
Treatment of Sexual Dysfunctions

A Behavioral Approach to Treatment of Erectile Disorder. In one part of a program designed to overcome erectile disorder, a man’s partner repeatedly “teases” him to erection and allows the erection to subside. Thus the partner avoids creating performance anxiety that could lead to loss of erection. Through repeated regaining of erection, the man loses the fear that loss of erection means it will not return.

A couple of sessions, sensate focus extends to the genitals. The position shown in Figure 15.1 allows the woman easy access to her partner’s genitals. She repeatedly “teases” him to erection and allows the erection to subside. Thus she avoids creating performance anxiety that could lead to loss of erection. By repeatedly regaining his erection, the man loses the fear that loss of erection means it will not return. He learns also to focus on erotic sensations for their own sake. He experiences no demand to perform, as the couple is instructed to refrain from coitus.

When the dysfunctional partner can reliably achieve sexual excitement (denoted by erection in the male and lubrication in the female), the couple does not immediately attempt coitus, since this might rekindle performance anxiety. Rather, the couple engages in a series of nondemanding, pleasurable sexual activities, eventually culminating in coitus.

In the Masters and Johnson approach, the couple begin coitus after about 10 days of treatment. The woman teases the man to erection while she is sitting above him, straddling his thighs. When he is erect, she inserts the penis—to avoid fumbling attempts at entry—and moves slowly back and forth in a nondemanding way. Neither attempts to reach orgasm. If erection is lost, teasing and coitus are repeated. Once the couple become confident that erection can be retained—or reinstated if lost—they may increase coital thrusting gradually to reach orgasm.

BIOLOGICAL APPROACHES TO TREATMENT OF ERECTILE DISORDER

It takes women authors to write articles about Viagra with titles such as:

- “The Rise of Viagra” (Plante, 2006)—our runaway favorite
- “The New Virility” (Marshall, 2006)
- “Sex for Life?” (Potts et al., 2006)

Of course, none of them can top the performance of an urologist at a medical convention some years ago. He sounded the opening shot in the biological war against erectile disorder through a somewhat unusual presentation. Truth or Fiction Revisited: He dropped his pants to reveal an erection. He was demonstrating the effects of a chemical compound called alprostadil. The erection was not the result of sexual stimulation or sexual fantasies, but of an injection of alprostadil directly into his penis. Alprostadil is a vasodilator; it relaxes the muscles surrounding the
arteries in the penis, allowing more blood to flow in, increasing vasocongestion and causing erection. The speaker was giving a “live” demonstration of a biological method of treating erectile disorder.

Biological or biomedical approaches are helpful in treating erectile disorder, especially when organic factors are involved. Treatments include surgery, medication, and vacuum pumps (see Table 15.3).

**Real Students, Real Questions**

**Q** I know that Viagra helps put more blood into the penis—but how does it do that? How does it actually work?

**A** The answer is chemical and it applies to Levitra and Cialis as well as Viagra. The end point is to allow the arteries in the penis to dilate and fill up with blood to produce an erection. Chemically, what has to happen for arteries to dilate is that the brain sends a signal along a nerve fiber ending in a nonadrenergic–noncholinergic (NANC) cell in an artery; the NANC cell produces nitric oxide and injects it into the bloodstream and nearby cells. The nitric oxide causes a chemical called cyclic guanosine monophosphate (cGMP) to be produced, which relaxes the muscles that line an artery, increasing the flow of blood. However, a chemical called phosphodiesterase (PDE) deactivates cGMP. The specific type of PDE found in the penis is called PDE5.

Viagra, Levitra, and Cialis are all PDE5 inhibitors. That is, they work by deactivating PDE5. Step by step:

1. A man takes Viagra, Levitra, or Cialis.
2. The chemical in the pill circulates throughout his bloodstream.
3. The chemical attaches to PDE5 in his penis and deactivates most of it.
4. When he is sexually aroused, his brain sends the usual message to the cells in his penis, resulting in the output of nitric oxide.
5. In turn, the nitric oxide produces cGMP.
6. Because most PDE5 has been deactivated, cGMP builds up, allowing the arteries in the penis to dilate and produce a fuller erection.

Note: Although Viagra and its chemical cousins are marketed as PDE5 inhibitors, their effects are somewhat broader, which is why they sometimes produce migraines.

**SURGERY** There are two main types of surgery: vascular surgery and the installation of penile implants. Vascular surgery can help in cases in which the blood vessels that supply the penis are blocked, or in which structural defects in the penis restrict blood flow. Arterial bypass surgery reroutes vessels around the blockage.

A penile implant may be used when other treatments fail. Implants are either malleable (semi-rigid) or inflatable (see Figure 15.2). The semi-rigid implant is made of rods that remain in a permanent semi-rigid position. It is rigid enough for intercourse but permits the penis to hang reasonably close to the body at other times. The inflatable type requires that cylinders be implanted in the penis. A fluid reservoir is placed near the bladder, and a tiny pump is inserted in the scrotum. To attain erection, the
### Table 15.3

#### Biological Treatments of Erectile Problems

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vascular surgery</td>
<td>Helps when blood vessels that supply the penis are blocked.</td>
</tr>
<tr>
<td>Penile implants</td>
<td>May be used when other treatments fail because of biological problems.</td>
</tr>
<tr>
<td>Medication</td>
<td></td>
</tr>
<tr>
<td>Hormone therapy</td>
<td>Helps men (and women) with abnormally low levels of male sex hormones.</td>
</tr>
<tr>
<td>Injections</td>
<td>Muscle relaxants such as alprostadil and phentolamine are injected into the corpus cavernosum of the penis, relaxing the muscles that surround the arteries in the penis, allowing the vessels to dilate and blood to flow more freely.</td>
</tr>
<tr>
<td>Suppository</td>
<td>Alprostadil is inserted into the tip of the penis in gel form.</td>
</tr>
<tr>
<td>Oral medication</td>
<td>Oral forms of several compounds—sildenafil (Viagra), vardenafil (Levitra), and tadalfil (Cialis)—relax the muscles that surround the small blood vessels in the penis, allowing them to dilate so that blood can flow into them more freely. Apomorphine increases brain levels of the neurotransmitter dopamine. Called “Uprima,” the drug is in clinical trials. Bremelanotide apparently acts directly on the central nervous system and, as the book goes to press, is also in clinical trials.</td>
</tr>
<tr>
<td>Vacuum Pump</td>
<td>A vacuum constriction device creates a vacuum when it is held over the penis. The vacuum induces erection by increasing the flow of blood into the penis. Rubber bands around the base of the penis maintain the erection.</td>
</tr>
</tbody>
</table>

A man squeezes the pump, releasing fluid into the cylinders. When the erection is no longer needed, a release valve returns the fluid to the reservoir, deflating the penis. The inflatable implant more closely duplicates the normal processes of tumescence and detumescence. Some adverse side effects of penile implants have been reported, including destruction of erectile tissue, impairing the man’s ability to have normal erections. Penile implants do not affect sex drive, sexual sensations, or ejaculation.

Implant surgery is irreversible. Therefore, the National Institutes of Health recommend that penile implants be used only when less invasive techniques, such as sex therapy and medication, are unsuccessful.

**MEDICATION** There are several ways in which medication can be used to help men with erectile problems. For example, hormone (testosterone) treatments help restore the sex drive and erectile ability in many men with abnormally low levels of testosterone (Lue, 2000; Rakic et al., 1997). Hormone therapy does not appear to help men with normal hormone levels.

The muscle relaxants alprostadil (brand names Caverject and Edex) and phentolamine (Invicorp) can be injected into the corpus cavernosum of the penis. These chemicals relax the muscles that surround the small blood vessels in the penis. The vessels dilate and allow blood to flow in more freely. Alprostadil erections last for an hour or more and occur whether or not there is sexual stimulation. A physician teaches the man how to inject himself. If phentolamine is used along with the protein VIP, erection occurs only when sexual stimulation is applied.

Penile injections may have side effects, including pain from the injection itself and prolonged, painful erections (*priapism*) (Ralph & McNicholas, 2000). Many men find the idea of penile injections distasteful (the “wince factor”) and refuse them.
Alprostadil is also available as a suppository in gel form (brand name MUSE). It is then inserted into the tip of the penis by an applicator. The suppository helps men get around the “wince factor” that many experience with injections. “Putting a needle in your penis is not everybody’s idea of foreplay,” notes Dr. John Seely (Kolata, 2000b).

Other medications are taken orally. For example, the oral form of sildenafil is sold as Viagra, and the oral form of vardenafil is sold as Levitra. The oral form of tadalafil (Cialis) lasts up to 36 hours. Users in France dubbed it “the weekend pill.” There is ample evidence that these oral medications are effective with most men (e.g., W. A. Fisher et al., 2005; Hatzichristou et al., 2000, 2005).

The drug apomorphine (Uprima) heightens brain levels of dopamine, a neurotransmitter which is involved in erection. Uprima is available in the United Kingdom and without prescription online, but it is advisable to consult your physician before using it. Researchers became aware of the potential benefits of dopamine-enhancing drugs through research with Parkinson’s disease. Parkinson’s is apparently caused by the loss of dopamine-producing cells, and is connected with loss of motor coordination and erectile dysfunction. L-dopa and other drugs that are used to treat Parkinson’s raise dopamine levels and frequently have the “side effect” of erection (Thomas & Coughtrie, 2003).

VACUUM PUMPS  Sounding like something from the “What will they think of next?” category, a vacuum constriction device (VCD) helps men achieve erections through vacuum pressure. The device (brand name ErecAid) consists of a cylinder that is connected to a hand-operated vacuum pump. It creates a vacuum when it is held over the limp penis. The vacuum induces erection by increasing the flow of blood into the penis. Rubber bands around the base of the penis can maintain the erection for as long as 30 minutes.

The device has been used successfully by men with both organically and psychologically based erectile failure. However, side effects such as pain and black-and-blue marks are common. The rubber bands prevent normal ejaculation, so semen remains trapped in the urethra until the bands are released. The quality of the erections produced by the device is also considered inferior to spontaneous erections.

WHERE DO WE GO FROM HERE?  It would appear that oral medications (pills) will be the most popular biological treatment of erectile problems. They are helpful with most men and avoid the “wince factor.” Viagra and Levitra have side effects, though, such as migraine headaches, flushing, and some others. The migraines are not surprising since they are related to increased blood flow, and these drugs are not precise enough to direct blood only to the genitals. Soon after Viagra was approved by the FDA, there were scattered reports of men with cardiovascular problems experiencing heart attacks. A carefully conducted study of the effects of Viagra on 14 older men with at least one severely constricted coronary artery suggests that Viagra by itself is not the problem (Herrmann et al., 2000). In this study, reported in the prestigious New England Journal of Medicine, Viagra was not shown to have adverse effects on the blood supply to the heart. As a matter of fact, Viagra, which dilates blood vessels, is now being considered by some for use as a heart medicine.

FEMALE SEXUAL AROUSAL DISORDER  Psychological treatments for female sexual arousal disorder parallel those for orgasmic disorder and are discussed in the following pages. They involve sex education (labeling the parts, discussing their functions, and explaining how to arouse them), searching out and coping with
possible cognitive interference (such as negative sexual attitudes), creating non-demand situations in which sexual arousal may occur, and—when appropriate—working on problems in the relationship.

Yet many cases of female sexual arousal disorder reflect impaired blood flow to the genitals, just as in erectile disorder. Female sexual arousal involves vaginal lubrication, which permits sexual intercourse without a great deal of pain-causing friction. Lubrication is made possible by vasocongestion—the flow of blood into the genitals. Lack of lubrication can reflect the physical effects of aging, menopause, and surgically induced menopause, as through surgery.
Sometimes all that is necessary to deal with lack of lubrication is an artificial lubricant such as K-Y Jelly. But lessened blood flow to the genitals can also sap sexual pleasure and, as a consequence, lessen a woman’s desire for sex.

The development of treatments for women has lagged behind the development of treatments for men. Ironically, the treatments that are emerging are highly similar to those that help men with erectile disorder.

For example, drugs identical or similar to those used for men are being investigated for use with women (Leland, 2000). Many trials have been undertaken with Viagra for women (Nurnberg et al., 2008). Researchers are also developing alprostadil (the vasodilator) for use with women, largely in the form of creams that are inserted into the vagina to enhance the flow of blood and hence lubrication.

There is a perfect parallel in the area of lack of sexual desire for women who are low in sexual desire because of low levels of “male” sex hormones. As an aside, we might ask whether we should stop referring to estrogen as a female sex hormone and testosterone as a male sex hormone since they are both produced by both women and men—although in different quantities—and are both intricately involved with women’s and men’s health, sexual functioning, and other behavior. In any event, testosterone skin patches can be used by women who lack sexual desire because they lack adequate quantities of testosterone.

There is even a device—Eros—that is a parallel to the vacuum pump that is used by some men with erectile disorder. It is a clitoral device that is available by prescription. The clitoris swells during sexual arousal because of vasocongestion, and vasocongestion increases clitoral sexual sensations, thus moving somewhat in step with sexual interest and lubrication. The device creates gentle suction over the clitoris, increasing vasocongestion and sexual sensations (see Figure 15.3).

**Orgasmic Disorders**

Because orgasmic disorders among men are relatively rare, our response will focus mainly on women. Women who have never experienced orgasm often harbor negative sexual attitudes that cause anxiety and inhibit sexual response. Treatment in such cases may first address these attitudes.

Masters and Johnson use a couples-oriented approach in treating anorgasmic women. They begin with sensate focus exercises. Then, during genital massage and later, during coitus, the woman guides her partner in the caresses and movements that she finds sexually exciting. Taking charge helps free the woman from the traditional role of the passive, subordinate female.

Masters and Johnson recommend a training position (see Figure 15.4) that gives the man access to his partner’s breasts and genitals. She can guide his hands to show him the types of stimulation she enjoys. The genital play is *nondemanding*. The goals are to learn to provide and enjoy effective sexual stimulation, not to reach orgasm. The clitoris is not stimulated early, since doing so may produce a high level of stimulation, even hurt, before the woman is prepared.

After a number of occasions of genital play, the couple undertake coitus in the female-superior position (see Figure 15.5). This position allows the woman freedom of movement and control over her genital sensations. The couple engage in several sessions of deliberately slow thrusting to sensitize the woman to sensations produced by the penis and to break the common counterproductive pattern of desperate, rapid thrusting.

Orgasm cannot be willed or forced. When a woman receives effective stimulation, feels free to focus on erotic sensations, and feels that nothing is being demanded...
of her, she will generally reach orgasm. Once the woman is able to attain orgasm in the female-superior position, the couple may extend their sexual repertoire to other positions.

Masters and Johnson prefer working with the couple in cases of anorgasmia, but other sex therapists prefer to work with the woman individually through masturbation. **Truth or Fiction Revisited:** Many sex therapists do recommend masturbation as a treatment for women who have never been able to reach orgasm (Leiblum & Rosen, 2000). Masturbation allows people to get in touch with their sexual responses at their own pace. The sexual pleasure they experience helps counter lingering sexual anxieties. Although there is some variation among therapists, the following elements are commonly found in directed masturbation programs:

1. **Education.** The woman and her partner (if she has one) are educated about female sexuality.
2. **Self-exploration.** Self-exploration is encouraged as a way of increasing the woman’s sense of body awareness. She may hold a mirror between her legs to locate her sexual anatomic features.

3. **Self-massage.** The woman creates a private, relaxing setting for self-massage. She begins to explore the sensitivity of her body to touch, discovering and repeating the caresses she finds pleasurable. Nonalcohol-based oils and lotions may be used to enhance the sensuous quality of the massage and to provide lubrication for the external genitalia. To prevent performance anxiety, the woman does not attempt to reach orgasm during the first few occasions.

4. **Giving oneself permission.** The woman may be advised to challenge lingering guilt and anxiety about sex. For example, she might repeat to herself, “This is my body. I have a right to learn about my body and receive pleasure from it.”

5. **Use of fantasy.** Arousal is heightened through the use of sexual images, fantasies, and fantasy aids, such as erotic written or visual materials.

6. **Use of a vibrator.** A vibrator may provide more intense stimulation.

7. **Involvement of the partner.** Once the woman is capable of regularly achieving orgasm through masturbation, the focus may shift to her sexual relationship with her partner. Nondemanding sensate focus exercises may be followed by nondemanding coitus. The female-superior position is often used so that the woman can control the depth, angle, and rate of thrusting. She thus ensures that she receives the kinds of stimulation she needs to reach orgasm.

Our focus has been on sexual techniques, but it is worth noting that a combination of approaches that focus on sexual techniques and underlying interpersonal problems may be more effective than focusing on sexual techniques alone—at least for couples whose relationships are troubled (Firestone et al., 2006).

**MALE ORGASMIC DISORDER** Treatment of male orgasmic disorder generally focuses on increasing sexual stimulation and reducing performance anxiety (Leiblum & Rosen, 2000). Masters and Johnson instruct the couple to practice sensate focus exercises for several days, during which the man makes no attempt to ejaculate. The couple are then instructed to bring the man to orgasm in any way they can, usually manually. Once the man can ejaculate in his partner’s presence, she brings him to the point at which he is about to ejaculate. Then, in the female-superior position, she inserts the penis and thrusts vigorously to bring him to orgasm.

**PREMATURE EJACULATION** In the Masters and Johnson approach, sensate focus exercises are followed by practice in the training position shown in Figure 15.1 (refer to page 483). The woman teases her partner to erection and uses the **squeeze technique** when he indicates that he is about to ejaculate. She squeezes the tip of the penis, which temporarily prevents ejaculation. This process is repeated three or four times in a 15- to 20-minute session before the man purposely ejaculates.

**Truth or Fiction Revisited:** It is true that a man can be prevented from ejaculating by squeezing his penis when he feels that he is about to ejaculate. In using the squeeze technique, the partner holds the penis between the thumb and first two fingers of the same hand. The thumb presses against the frenulum. The fingers straddle the coronal ridge on the other side of the penis. Squeezing the thumb and forefingers together fairly hard for about 20 seconds (or until the man’s urge to ejac-
"The Pinking of Viagra Culture"

Before you decide to line up the authors before a firing squad, we would like to point out that the title of this “A Closer Look” is a quotation from author Heather Hartley (2006).

Her point, and that of numerous other researchers, is that Viagra and similar drugs are not just for men. Advances are being made in biomechanical methods and drugs for treating women with sexual dysfunctions (Nurnberg et al., 2008). As women age, they, like men, also experience a reduced flow of blood to the genital region (Thachil & Bhugra, 2006). The clitoris becomes less engorged during sexual arousal and may be connected with feelings of lessened sexual arousal overall. Postmenopausal women experience vaginal dryness because of drop-off in estrogen (Dennerstein & Goldstein, 2005). Large numbers of middle-aged and older women say that they have lost interest in sex or have difficulty becoming aroused. Table 15.4 on page 492 is an overview of methods in use or under development.

Many methods that have been helpful with men also hold promise for women. For example, drugs that enhance the flow of blood into the genital region, like Viagra, may enhance the sexual experiences of women as well as men. Many women report greater vaginal lubrication and stronger orgasms after using Viagra (e.g., Berman et al., 2001; Nurnberg et al., 2008).

Also consider a typical study of the effects of androgen replacement therapy with older women (Munarriz et al., 2002). The women reported a significant increase in sexual desire, vaginal lubrication, and orgasm, along with normalization in blood values of androgens, including testosterone. However, there were side effects related to the effects of male sex hormones. For example, 11% of the women showed increased facial hair and 5% developed acne.

Although the “medicalization” of sex therapy continues, medical treatments are unlikely to enhance the quality of a relationship. If people have serious problems with their partners, popping a pill is unlikely to erase them.

Urate passes) prevents ejaculation. The erect penis can withstand fairly strong pressure without discomfort, but erection may be partially lost.

After two or three days of these sessions, Masters and Johnson have the couple begin coitus in the female-superior position because it creates less pressure to ejaculate. The woman inserts the penis. At first she contains it without thrusting, allowing the man to get used to intravaginal sensations. If he signals that he is about to ejaculate, she lifts off and squeezes the penis. After some repetitions, she begins slowly to move backward and forward, lifting off and squeezing as needed. The man learns gradually to tolerate higher levels of sexual stimulation without ejaculating.

The “stop–start” method for treating premature ejaculation was introduced formally by urologist James Semans (1956). However, many men with premature ejaculation have thought to use stopping and starting on their own (Porst et al., 2007). Semans’s approach can be applied to manual stimulation or coitus. For example, the man’s partner can manually stimulate him until he is about to ejaculate. He then signals her to suspend sexual stimulation and allows his arousal to subside before stimulation is resumed. This process enables the man to recognize the cues that precede his point of ejaculatory inevitability, or “point of no return,” and to tolerate longer periods of sexual stimulation. When the stop–start technique is applied to coitus, the couple begin with simple vaginal containment with no pelvic thrusting, preferably in the female-superior position. The man withdraws if he feels he is about to ejaculate. As the man’s sense of control increases, thrusting can begin, along with variations in coital positions. The couple again stop when the man signals that he is approaching ejaculatory inevitability.
Some drugs that are usually used to treat psychological problems have been helpful in treating premature ejaculation (Bancroft et al., 2005b, 2005c). Clomipramine, which is used to treat people with obsessive-compulsive disorder or schizophrenia, can impair erectile response at high doses. But in a study with 15 couples, low doses helped men engage in coitus five times longer than usual without ejaculating (Althof, 1994). So-called anti-depressant drugs have also been helpful in treatment of premature ejaculation (Waldinger et al., 2001, 2002; Meston & Frohlich, 2000).

Why do drugs used to treat psychological problems help with premature ejaculation? The psychological problems are frequently connected with imbalances in body chemistry, such as neurotransmitters—the chemical messengers of the brain. Neurotransmitters are also involved in other bodily functions, including ejaculation. “Anti-depressant” drugs all work by increasing the action of the neurotransmitter serotonin. Serotonin, in turn, may inhibit the ejaculatory reflex (Meston & Frohlich, 2000; Shipko, 2000). But note the cautions about using SSRIs expressed earlier in the chapter! It remains to be seen whether medications continue to show positive effects and compare their effectiveness with psychological sex therapy techniques.

### Table 15.4
Various Biological Treatments in Use or under Investigation to Help Women with Sexual Dysfunctions

<table>
<thead>
<tr>
<th>Method</th>
<th>How Used</th>
<th>Effect</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alprostadil</td>
<td>Gel, cream</td>
<td>May improve blood flow to the clitoris, enhancing arousal</td>
<td>Studies under way</td>
</tr>
<tr>
<td>DHEA</td>
<td>Pill</td>
<td>May boost libido by increasing testosterone levels</td>
<td>Available by prescription; available as a dietary supplement, although experts caution against unsupervised use; studies under way</td>
</tr>
<tr>
<td>Eros (Figure 15.3)</td>
<td>Hand-held device that applies gentle suction to the clitoris</td>
<td>Promotes blood flow to the clitoris, enhancing arousal</td>
<td>Available by prescription</td>
</tr>
<tr>
<td>Estrogen</td>
<td>Pill, patch, gel, cream</td>
<td>Counts vaginal dryness</td>
<td>Available by prescription</td>
</tr>
<tr>
<td>PDE5 inhibitors</td>
<td>Pill</td>
<td>May improve blood flow to the clitoris, enhancing arousal</td>
<td>Viagra and Levitra available by prescription; studies under way for treating women’s sexual problems</td>
</tr>
<tr>
<td>Testosterone</td>
<td>Pill, patch, gel, cream</td>
<td>May boost libido</td>
<td>Available by prescription; studies under way for treating women’s sexual problems</td>
</tr>
<tr>
<td>VasoFem, Alista, FemProx</td>
<td>Viagra-like drugs</td>
<td>May improve blood flow to the clitoris, enhancing arousal</td>
<td>Studies under way for treating women’s sexual problems</td>
</tr>
<tr>
<td>Yohimbine with nitric oxide</td>
<td>Pill</td>
<td>May improve blood flow to the clitoris enhancing arousal</td>
<td>Studies under way</td>
</tr>
</tbody>
</table>

**BIOLOGICAL TREATMENT OF PREMATURE EJACULATION** Some drugs that are usually used to treat psychological problems have been helpful in treating premature ejaculation (Bancroft et al., 2005b, 2005c). Clomipramine, which is used to treat people with obsessive-compulsive disorder or schizophrenia, can impair erectile response at high doses. But in a study with 15 couples, low doses helped men engage in coitus five times longer than usual without ejaculating (Althof, 1994). So-called anti-depressant drugs have also been helpful in treatment of premature ejaculation (Waldinger et al., 2001, 2002; Meston & Frohlich, 2000).

Why do drugs used to treat psychological problems help with premature ejaculation? The psychological problems are frequently connected with imbalances in body chemistry, such as neurotransmitters—the chemical messengers of the brain. Neurotransmitters are also involved in other bodily functions, including ejaculation. “Anti-depressant” drugs all work by increasing the action of the neurotransmitter serotonin. Serotonin, in turn, may inhibit the ejaculatory reflex (Meston & Frohlich, 2000; Shipko, 2000). But note the cautions about using SSRIs expressed earlier in the chapter! It remains to be seen whether medications continue to show positive effects and compare their effectiveness with psychological sex therapy techniques.
Sexual Pain Disorders

There are two major sexual pain disorders: dyspareunia and vaginismus.

DYSPAREUNIA  Dyspareunia, or painful intercourse, generally calls for medical intervention to ascertain and treat any underlying physical problems, such as urinary tract genital infections, that might give rise to pain (Brauer et al., 2009; Goldstein & Alexander, 2005). When dyspareunia is caused by vaginismus, treatment of vaginismus through a cognitive-behavioral approach, described below, may reduce pain.

VAGINISMUS  Vaginismus is generally treated by “exposure”—that is, by insertion of fingers or vaginal dilators of increasing size under circumstances in which the woman remains relaxed. In one study, for example, women with vaginismus performed vaginal penetration exercises in the company of a female therapist (ter Kuile et al., 2009). When the woman is able to tolerate dilators (or fingers) equivalent in thickness to the penis, the couple may try coitus, but the woman should control insertion. Circumstances should remain relaxed and nondemanding. The idea is to avoid resensitizing her to fears of penetration. Since vaginismus often occurs among women with a history of sexual trauma, such as rape or incest, treatment for the psychological effects of these experiences may also be in order (Crowley et al., 2006).
Sexual Dysfunctions

The 3 R’s: Reflect, Recite, and Review

Your text uses the PQ4R method. Congratulations on completing the first R—reading the chapter. The remaining 3 R’s—reflect, recite, and review—will help you understand and recall the material in the chapter, as well as test your mastery.

Reflect

► CRITICAL THINKING: There is no consensus among clinicians and researchers concerning the definition of low sexual desire. How much sexual interest or desire would seem to be normal to you? Why?

• Are there any sexual attitudes common to people of your demographic background that can give rise to sexual problems or dysfunctions? What are the attitudes? Do you share these attitudes? Explain.

• If you had a sexual dysfunction, do you think that you would be willing to participate in sex therapy? Explain. (And do you think women or men are likely to be more willing to have sex therapy? Why?)

• Are there any sex therapy methods that seem “over the top” to you? Explain.

Recite

1. What kinds of sexual dysfunctions are there?

• Sexual dysfunctions are persistent or recurrent difficulties in becoming sexually aroused or reaching orgasm. Men are more likely to have rapid orgasm, and women are more likely to have lack of desire, difficulty reaching orgasm, and painful sex. In sexual desire disorders, the person experiences a lack of sexual desire or an aversion to genital sexual contact. In men, sexual arousal disorders involve recurrent difficulty in achieving or sustaining erections. In women, they typically involve failure to become sufficiently lubricated. Orgasmic disorders involve difficulty reaching orgasm or reaching orgasm too soon. Sexual pain disorders include dyspareunia, or painful sex, and vaginismus, in which involuntary contraction of vaginal muscles make penetration painful.

2. What are the causes of sexual dysfunctions?

• Fatigue may lead to erectile disorder in men and to orgasmic disorder and dyspareunia in women. Dyspareunia may reflect vaginal infections and STIs. Biological factors are likely involved in most cases of erectile disorder. Medications for various health problems may impair sexual functioning. Aging can also impair sexual functioning. Psychosocial factors connected with sexual dysfunctions include cultural influences (e.g., sexually repressive environments), psychosexual trauma, problems in the relationship, lack of sexual skills, irrational beliefs, and performance anxiety. Some people lack opportunity to acquire sexual knowledge and experience. Excessive needs for approval and perfection can contribute to sexual problems. Performance anxiety may place dysfunctional people in a spectator rather than performer role.

3. How are sexual dysfunctions treated?

• Sex therapy modifies dysfunctional behavior by changing self-defeating beliefs and attitudes, fostering sexual skills and knowledge, enhancing sexual communication, and using exercises that enhance sexual stimulation while reducing performance anxiety. Masters and Johnson employed an in-residence program that focused on the couple as the unit of treatment. Sensate focus exercises were used to enable the partners to give each other pleasure in a non-demanding situation. Other therapists combine sex therapy with couple therapy or, in the case of Helen Singer Kaplan, psychoanalytic therapy. Some sex therapists kindle the sexual appetites of people lacking desire through self-stimulation exercises combined with erotic fantasies. Androgens heighten the sex drive in people with androgen deficiencies. Noninvasive biological treatments facilitate blood flow to the genitals or affect levels of neurotransmitters. Masters and Johnson used a couples approach in treating anorgasmic women. Other therapists
prefer directed masturbation to enable women to learn about their own bodies at their own pace and free them of the need to rely on partners. Dyspareunia may be treated by tackling health problems, ensuring that the woman is adequately lubricated, or, among older women, using estrogen replacement. Vaginismus is generally treated with a series of dilators.

### Review

#### REVIEW

1. According to the NHSLS, the most common male sexual dysfunction is
   (a) male orgasmic disorder.
   (b) erectile disorder.
   (c) premature ejaculation.
   (d) performance anxiety.
2. Which of the following is most likely to have biological causes?
   (a) Dyspareunia
   (b) Vaginismus
   (c) Female orgasmic disorder
   (d) Performance anxiety
3. According to the NHSLS, the most common female sexual dysfunction is
   (a) dyspareunia.
   (b) lack of interest in sex.
   (c) reaching climax too early.
   (d) having trouble lubricating.
4. _____ is most likely to be connected with a history of sexual trauma.
   (a) Dyspareunia
   (b) Rapid ejaculation
   (c) Performance anxiety
   (d) Vaginismus
5. Alprostadil is used in the treatment of
   (a) premature ejaculation.
   (b) male erectile disorder.
   (c) female orgasmic disorder.
   (d) hypoactive sexual desire.
6. According to the text, a low level of ____ can lessen sexual desire.
   (a) testosterone
   (b) sildenafil
   (c) Depo-Provera
   (d) alprostadil
7. All of the following are sex therapy methods, with the exception of
   (a) penile implants.
   (b) improving sexual communication.
   (c) reducing performance anxiety.
   (d) sensate focus exercises.
8. ____ is sometimes treated with a series of rings of plastic dilators.
   (a) Dyspareunia
   (b) Female sexual arousal disorder
   (c) Vaginismus
   (d) Erectile disorder
9. Cialis is used to treat
   (a) erectile disorder.
   (b) female sexual arousal disorder.
   (c) dyspareunia.
   (d) premature ejaculation.
10. Sex therapists are most likely to recommend masturbation as a treatment for
    (a) premature ejaculation.
    (b) female orgasmic disorder.
    (c) vaginismus.
    (d) retarded ejaculation.

ANSWERS: 1. c; 2. a; 3. b; 4. d; 5. b; 6. a; 7. a; 8. c; 9. a; 10. b