

THE AMERICAN ACADEMY OF CLINICAL SEXOLOGISTS
AT MAIMONIDES UNIVERSITY

SEARCHING FOR A LOGIC IN SEXUALITY

CLINICAL SEXOLOGY AS A CONCEPT APPLIED TO THE BUILDING
OF LASTING RELATIONSHIPS

A DISSERTATION SUBMITTED TO THE FACULTY OF THE
AMERICAN ACADEMY OF CLINICAL SEXOLOGISTS AT
MAIMONIDES UNIVERSITY IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

BY
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BOCA RATON, FLORIDA

FEBRUARY 2005

DISSERTATION APPROVAL

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ACKNOWLEDGEMENTS

I am deeply grateful to those who have read this manuscript and whose comments have helped to improve it, specifically to the members of my Advisory Committee, William. A. Granzig, Ph.D., Sally Valentine, Ph.D. and Charlotte Willis, Ph.D.. Special recognition is given to Maj-Briht Bergström-Walan, Ph.D., M.D. for her share in the facilitation of my search. I also thank Godfrey D. Ripley, M.D., who reviewed the manuscript with specific attention to medical aspects.

I dedicate my work to the memory of Stefi Pedersen, Ph.D., who showed me the way, having herself made a brave and poignant journey from Nazi Germany to Norway and then to Sweden.

ABSTRACT

This study aims at shedding light on what constitutes healthy sexuality. For that purpose the study includes a review of the history of the sexual moral code and a review of sexual surveys, including those by Kinsey, Hite, Blumstein and Schwarz, as well as a general population study performed recently in Sweden. Masters and Johnson's research into the human sexual response has been included for an understanding of the physical side of sexual response. The modification by Kaplan of the brief therapy model introduced by Masters and Johnson is explored with a review of the effects of the nervous system in sexual dysfunctions. Sexual desire disorders are reviewed, as is Kaplan's approach to treatment by identifying both immediate and deeper causes. The developments by the object relations theorists of Freud's view of sexuality have been included to add an understanding of challenges faced in couple's relationships. Couples relationships are further explored, including gender differences, partner choice and effects of barriers and bias on communication. The co-morbidity of medical concerns with emotional and sexual problems is addressed with a review of recent research as well as in clinical observations.

ABBREVIATIONS

EC	=	European Commission
ED	=	Erectile Dysfunction
EU	=	European Union
FSD	=	Female Sexual Dysfunction
FSH	=	Follicle Stimulating Hormone
HIV	=	Human Immunodeficiency Virus
ISD	=	Inhibited Sexual Desire
JAMA	=	Journal of the American Medical Association
LH	=	Luteinizing Hormone
NIPH	=	National Institute of Public Health (Sweden)
SF	=	Sensate Focus Exercise
SSSS	=	Society for the Scientific Study of Sexuality
WHO	=	World Health Organization

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RATIONALE FOR INVESTIGATION: WHY THIS STUDY IS IMPORTANT FOR SEXOLOGY

In my practice as a clinical social worker I have frequently observed co-morbidity, such as presentations of emotional, sexual and relationship concerns together with medical problems. It has also become apparent that some clients' problems are refractory to the common approach of Brief Intervention both with emotional problems and with sexual concerns. I learnt at the annual meeting of the Society for the Scientific Study of Sexuality (SSSS) in November 2003 about the research by Whipple on the vagus nerve. She found that the vagus, the longest of the cranial nerves, associated with a multitude of bodily functions, can serve, in cases of spinal cord injury, as a by-pass for sexual stimulation to orgasm to be registered in the brain. This raised my curiosity about the connection between sexual response and medical conditions that involve the vagus, specifically digestive, substance abuse and weight and eating disorders. The focus of the study was triggered by this curiosity, with the resulting necessity to explore what in everyday life is hidden from open view.

As a visual image of this exploration, reference is made to an art piece by The Christos – creators of the present “wrapping of Central Park”, New York City, 2005. The referenced image is of a woman who is held back from moving ahead into the future by dragging the well wrapped “baggage” of her past on her journey. The artists – it is my understanding – challenge the viewer to see what is hidden by carefully covering it, thereby, awakening the observer's curiosity.

METHODOLOGY

The method used for this investigation has been guided by the principles outlined in *Qualitative Analysis for Social Scientists* (Strauss, 1987). The study is based on review of research, literature, professional books and journals as well as – information obtained in workshops and seminars. Observations from a clinical sample is presented to exemplify the presence of self reported medical conditions and co-morbidity with sexual or emotional problems. Also noted were the outcome of therapy and the presence of deeper more complex causes. It is to be noted that these observations are only presented as an illustration and have no claim to provide scientifically standardized or validated information.

PROLOG

The focus of this investigation is on healthy sexuality. What is it? Who sets the standards? How do we know about it? How did we arrive at what we know today? How can we use this knowledge to enhance not only sexual health but also physical well-being? Could this, in addition, build a healthier community and socio-political environment, which would appreciate the value of sexuality - not only for reproduction - but as a motivational force for healthy living? How can we find the balance of knowledge needed to create an environment in which children can mature into healthy adults, who can enjoy a full and rewarding sexual life? What are the obstacles for this vision? This author will attempt to answer these questions.

Many writers and researchers have tackled these questions, perhaps - most eloquently - poets and other creative artists. Through their imagination and persistence there is a wealth of information from which to draw. In reviewing a sample of what has been explored - and expressed in various forms - an intricate weave of life presents itself. It becomes apparent that there is a life force, which forges its way ahead regardless of obstacles - or is, perhaps, empowered by these same obstacles. Through relentless curiosity we now know more about the influences of power imbalance, culture (Masters and Johnson, 1988; Hutchinson, 1990), temperament, physiology (Masters and Johnson, 1964) - and the central role of the brain and nervous system - especially the Tenth Cranial - or vagus - nerve (Whipple, 2003). The gradual evolution of this knowledge shows how intuition and curiosity have developed far earlier than specific cognition and serve as a driving motivational force (Maslow, 1968). The underlying forces of emotion,

religion and philosophy – with their subtle or not so subtle - effects on man’s motivations and resultant actions deserve close attention. The author of this dissertation acknowledges the philosopher, Kierkegaard (1989) as her mentor in her quest for an understanding of human sexuality. In his writings on the concept of “irony” and the question of “either or,” the suggestion that truth can be found in irony and that the intellectual process can be furthered by “either or”, i.e. the value of thinking in opposites is particularly pertinent to the study of sexuality, which is guided by opposites: tension/release; excitatory/inhibitory impulses; libidinal/anti-libidinal urges; and both fantasy and anti-fantasy. The interface to be studied is that between personal, basic sexual thoughts and society’s heavy handed attempts to either stifle these or channel them into acceptable pathways.

It is a privilege and a humbling experience to explore these matters. Rich and comprehensive presentations of the present state of knowledge in the area of sexuality can be found, for example, in *On Sex and Human Loving* (Masters, Johnson and Kolodny, 1988) and *The Anatomy of Sex and Power* (Hutchinson, 1990).

CHAPTER 1

HISTORY: PHILOSOPHY AND THEOLOGY

To understand sexuality in the present, it is necessary to have an understanding of the history of the concepts, from which our knowledge has developed.

Naturally, the overriding theme in the evolution of the conceptualization of sexuality is procreation, creation of new life. As the sexual act, up till recent years, has been the only way that humankind has had for procreation; it is around this act that a plethora of thoughts have been created, savored - and consummated. These experiences have given rise to enchantment - and also disenchantment – and have been surrounded by secrecy and silence. A comprehensive and most revealing history of sexuality over the life span of modern man, encompassing power, politics, religion, sociology, biology and more, can be found in *History of Sexuality* (Foucault, 1990). In this, Foucault makes the following summation of his work: (Although somewhat lengthy – and verbose – this researcher considers it appropriate to give this quotation in its entirety):

Perhaps, one day people will wonder at this. They will not be able to understand how a civilization so intent on developing enormous instruments of production and destruction found the time and the infinite patience to inquire so anxiously concerning the actual state of sex; people will smile perhaps when they recall that here were men - meaning ourselves - who believed that therein resided a truth every bit as precious as the one they had already demanded from the earth, the stars, and the pure forms of their thought; people will be surprised at the eagerness with which we went about pretending to rouse from its slumber a sexuality which everything - our discourses, our customs, our institutions, our regulations, our knowledge - was busy producing in the light of day and broadcasting to noisy accompaniment, and the rule of silence regarding what was the nosiest of our preoccupations. In retrospect, this noise may appear to have been out of place, but how much stranger will seem our persistence in interpreting it as but the refusal to speak and the order to remain silent. People will wonder what could have made us so presumptuous; they will look for the reasons that might explain why we pride ourselves on being the first to grant sex the

importance we say is its due and how we came to congratulate ourselves for finally - in the twentieth century - having broken free of a long period of harsh repression, a protracted Christian asceticism, greedily and fastidiously adapted to the imperatives of bourgeois economy. And what we now perceive as the chronicle of a censorship and the difficult struggle to remove it will be seen rather as the centuries-long rise of a complex deployment for compelling sex to speak, for fastening our attention and concern upon sex, for getting us to believe in the sovereignty of its law when in fact we were moved by the power mechanisms of sexuality (Foucault, 1990, 158-159).

The Beginnings

The question of how it all started has fascinated mankind throughout history and, with expanding knowledge, new theories have been formulated. Of interest in the study of sexuality, the relationship between man and woman, and the continuation of life through childbirth, are thoughts uncovered recently, *Sex, Time and Power* (Schlain, 2003). Schlain has developed an intriguing idea of how, through evolution, man and woman started to live in a committed relationship based on the realization of death and the striving by man for immortality. In brief, in pre-historic time during the evolution of mankind, the human brain tripled in size, while the female pelvic girdle - through which this rapidly enlarging brain within its skull - had to pass at birth, did not keep pace. Functional constraints prevented the channel in the female's pelvis from enlarging sufficiently to accommodate easily the continually growing size of the fetus's brain, resulting in an increase in peri-natal mortality (Schlain, 2003, 5). Subsequently - over time - man came to recognize the value of having children, thereby assuring a continuation of himself, helping him to fight off his dread of death. For a man to know that he is the father of the child, he had to have a committed relationship to the mother of that child (Schlain, 331).

Perhaps this was the beginning of the “Sex Contract”. According to Hutchinson (1990, 332), this has been “the most solid, unshakable, unquestionable ordering principle of human existence” for “hundreds of thousands of years”. Foucault gives his interpretation of the sex contract in *The Use of Pleasure*. He emphasizes an ethical divide:

Women were generally subjected (excepting the liberty they could be granted by a status like that of courtesan) to extremely strict constraints, and yet this ethics was not addressed to women; it was not their duties or obligations that were recalled, justified, or spelled out. It was an ethics for men: an ethics thought, written, and taught by men, and addressed to men – to free men obviously. A male ethics consequently, in which women figured only as objects or, at most, as partners that one had best train, educate, and watch over when one had them under one’s power, but stay away from when they were under the power of someone else (father, husband, tutor). It was an elaboration of masculine conduct carried out from the viewpoint of men in order to give form to *their* behavior (Foucault, 1990, 22-23).

Biblical Time

The second class status of women, which has been so eagerly, bravely and persistently fought in past decades by women through the feminist movement, started in biblical times – and most likely even before. The Bible gives instructions on what is right and what is wrong for man, as well as what the relationship between man and woman should be. Family creation is codified in Genesis 2:21-24 with the following command: “Therefore a man shall leave his father and mother and be joined to his wife, and they shall become one flesh” (Holy Bible, 1990, 2). In Leviticus 18:6-16 instructions are given against incestuous relationships: “None of you shall approach anyone who is near of kin to him to uncover his nakedness ... the nakedness of your father or the

nakedness of your mother you shall not uncover” (Holy Bible, 1990, 110-111).

Homosexual acts were proscribed in the words in Leviticus 18:22: “You shall not lie with a male as with a woman” (Holy Bible, 1990, 111). The relative negotiable value of the two genders can be found in Leviticus 27:3-4: “If your valuation is of a male from twenty years old up to sixty years old, then your valuation shall be fifty shekels of silver, according to the shekel of the sanctuary. If it is a female then your valuation shall be thirty shekels ...” (Holy Bible, 1990, 121). Sex was recognized as a pleasurable force and was not considered evil or restricted to procreation - as described in the Song of Solomon (Holy bible, 1990, 647-652; Masters, Johnson, Kolodny, 1988, 12). The language in The Song is direct and evocative. It invites the imagination to create fantasy, arguably the most important incentive to sexual pleasure. Song of Solomon 5:4 reads:

My beloved put his hand
By the latch of the door,
And my heart yearned for him

and Song of Solomon 5:8:

I charge you, O daughters of
Jerusalem
If you find my beloved
That you tell him I am lovesick!

(Holy Bible, 1990, 650)

The above quotes are provided to enlighten the reader to the influence of history. It is to be noted that the Holy Bible has been translated through many languages until it has arrived in the New King James Version. The original words, in their original language, have been subject to euphemistic interpretations.

Philosophy and Theology

The philosopher Bertrand Russel, in *Marriage and morals*, (Russel, 1970) states that rules for marriage were established with the advent of Christianity. Rules for promoting chastity were recorded as follows: “It is good for a man not to touch a woman”; avoidance of fornication – “Let every man have his own wife, and let every woman have her own husband;” relationship between husband and wife – “Let the husband render unto the wife due benevolence: and likewise also the wife unto the husband;” power hierarchy – “The wife hath not power of her own body, but the husband: and likewise also the husband hath not power of his own body, but the wife;” fidelity, “Defraud ye not one the other, except it be with consent for a time, that ye may give yourselves to fasting and prayer; and come together again, that Satan tempt you not for your incontineny”; consent, “But I speak this by permission, and not of commandment”; “For I would that all men were even as I myself. But every man hath his proper gift of God, one after this manner, and another after that”; “I say therefore to the unmarried and widows. It is good for them if they abide even as I”; “but if they cannot contain, let them marry: for it is better to marry than to burn” (44-45).

Russel gives his interpretation of the view on marriage of the Catholic Church, as follows:

From St. Paul one gathers that marriage is to be regarded solely as a more or less legitimate outlet for lust. One would not gather from his words that he would have any objection to birth control: on the contrary, one would be led to suppose that he would regard as dangerous the periods of continence involved in pregnancy and child-birth. The Church has taken a different view. Marriage in the orthodox Christian doctrine has two purposes: one that recognized by St. Paul, the other, the procreation of children. The consequence has been to make sexual morality even more difficult than it was made by St. Paul. Not only is sexual

intercourse only legitimate within marriage, but even between husband and wife it becomes a sin unless it is hoped that it will lead to pregnancy. The desire for legitimate offspring is, in fact, according to the Catholic Church, the only motive which can justify sexual intercourse. But this motive always justifies it, no matter what cruelty may accompany it. If the wife hates sexual intercourse, if she is likely to die of another pregnancy, if the child is likely to be diseased or insane, if there is not enough money to prevent the utmost extreme of misery, that does not prevent the man from being justified in insisting on his conjugal rights, provided only that he hopes to beget a child (Russel, 1970, 52-53).

Subsequently, according to Russel, the Catholic Church established the doctrine that marriage is a sacrament, the inference being that marriage could not be dissolved. Although, under certain circumstances, a separation could be granted, the right to remarry could never be obtained. However the Church recognized that ordinary human nature could not be expected to live up to its expectations and became prepared to give absolution for fornication provided the sinner acknowledged his fault and did penance. This gave the clergy power, since they alone could pronounce absolution, and without it fornication would entail eternal damnation (Russel, 1970, 54-55).

Further, Russel tells us that with regards to the Lutheran views on marriage the Protestant Church abandoned both the praise of celibacy and the doctrine that marriage is a sacrament, which had been adopted by the Catholic Church. Divorce was tolerated in certain circumstances. However, the Protestant Church was even more rigid in its condemnation of fornication, and also abandoned the practice of confession and absolution (Russel, 1970, 55-56).

In contrast, Judaism - according to Rabbi Boteach - has never had a prudish or conservative sexual ethic. Judaism offers guidelines. The essence of Jewish thought is to move forward in an open fashion. Judaism does not condemn mankind for its enjoyment of love and sensual pleasure. It focuses on the enjoyment of sexual relations over and

above the biologic urge (Boteach, 1999, 10-11). From the Holy Bible Boteach identifies three categories of sex – anaesthetizing (i.e. releasing basic libidinal urges), procreative and relational. He endorses, virtually “giving the Seal of Kashrut” to, the relational, intimate sex, as the form that can “lead to something truly blessed” (Boteach, 2001).

Boteach represents very well the tradition of Maimonides, the twelfth century philosopher and teacher, also known as Rambam, Rabbi Moses. He was the first to write a systematic code of Jewish law, the *Mishneh Torah* and the *Guide to the Perplexed*, a philosophic statement of Judaism. The *Mishneh Torah* can be seen a guide for the individual in all areas of life. Maimonides is unique in that his teachings have been an influence in both the West and the East, as stated by a Soviet scholar at a UNESCO conference in Paris in 1985:

Maimonides is perhaps the only philosopher in the Middle Ages, perhaps even now, who symbolizes a confluence of four cultures: Greco-Roman, Arab, Jewish, and Western.

(Retrieved from: <http://www.usisrael.org/jsource/biograph/Maimonides.html>)

In ancient Greece, in the first millennium B.C., women were considered second-class citizens, if citizens at all. The Greek word for woman was *gyne*, meaning “bearer of children”. On the other hand male homosexuality, within certain limits, was not only tolerated but also accepted in every-day life. Whilst relationships between adult men and adolescent boys past the age of puberty were commonplace, homosexual acts between adult men were frowned upon and homosexual contacts between adult males and boys under the age of puberty were illegal (Tannahill, 1980, 94-95).

Christianity based its attitude on sexuality upon an intermingling of the ideas expressed in Greek and Jewish religions. There was a separation of *eros*, or “carnal love”, from *agape*, a “spiritual, nonphysical love.” Catholicism placed a high ideal on celibacy. The negative views of the Church were dramatically emphasized by St. Augustine, a religious leader in the fourth century A.D., in his *Confessions*; a recount of his own involvement with “filth and lewdness”. Sex was condemned in all forms, although marital procreative sex was seen as less evil than other types (Masters, Johnson and Kolodny, 1988, 12-13).

Islamic, Hindu and ancient Oriental sexual attitudes were considerably more positive. In China “sex was not something to be feared, nor was it regarded as sinful, but rather, it was an act of worship” and even a path toward immortality (Bullough, 1976, 275-310). A detailed sexmanual, Kama Sutra, was compiled in India at the same time as St. Augustine wrote his Confessions. Similar sex manuals in ancient China and Japan glorified sexual pleasure and variety (Masters, Johnson, Kolodny, 1988, 13).

Of interest is the initiative by Drs. Phyllis and Eberhard Kronhausen for the First International Exhibition of Erotic Art presented at Museum of Art in the university city of Lund, Sweden in 1968. The poster for the exhibition presents a piece of erotic art from India (Kronhausen P. and Kronhausen E., 1978, 9). The erotic art of India and China, from as early as 1200, took a prominent place in this exhibition, and has arguably served as inspiration for similar art forms in other countries from medieval to modern time. An exquisite example of erotic art in modern time can be found in the creative work of Betty Dodson (Rae Larson, 2003).

The Church assumed greater power in Europe in the twelfth and thirteenth centuries, theology supplanted common law and there was an oppressive “official” attitude toward sex except for procreation. There was marked hypocrisy between policies and practices (Taylor, 1954, 19). This era was characterized on the one hand by Romanticism, which was a non-carnal, agape-love and on the other by misogyny, an illicit carnal love with degradation of both women and sexuality. (Masters and Johnson, 1988, 13)

The Romantic era of courtly love was a time, during which women, especially high-ranking women in the privileged classes, became idealized in song, poetry and literature. Stendahl, although writing several centuries later, in the eighteenth century, has contributed his description of refinements in the art of loving. His ideal in romance was passion-love, in which all else in life is forgotten except the thought of one’s beloved, two humans merging each with the other to become as one. He describes expressions of love and sexuality such as glances – “Anything can be said by a glance and yet one can always repudiate a glance because it cannot be quoted word for word” (Stendahl, 1947, 81), and modesty – “modesty lends to love the help of the imagination, thus giving it life” (72).

The opposite of romanticism was the degrading and illicit side of sexual life. In marriage, the wife had no rights. In the Middle Ages immorality was widespread; “bishops lived in open sin with their own daughters, and archbishops promoted their male favorites....” (Cf. Lea, “History of the Inquisition in the Middle Ages,” Vol. I pp.9, 14; Russel, 1970, 63). There was a belief in the celibacy of clergy but it was not until the thirteenth century that attempts were made to enforce that belief. However, the clergy

continued to have illicit relations with women, though they could not give dignity or beauty to their relations as they themselves considered them immoral and impure (Russel, 1970, 63-64).

Russel quotes from the *History of European Morals* (W.E. H. Lecky, Vol. II, 350-351) an eloquent description of what could take place at that time:

It was not surprising that, having once broken their vows and begun to live what they deemed a life of habitual sin, the clergy should soon have sunk far below the level of laity. We may not lay much stress on such isolated instances of depravity as that of Pope John XXIII, who was condemned for incest, among many other crimes and for adultery; or the abbot-elect of St. Augustine, at Canterbury, who in 1171 was found, on investigation, to have seventeen illegitimate children in a single village; or an abbot of St. Pelayo, in Spain, who in 1130 was proved to have kept not less than seventy concubines; or Henry III, Bishop of Liège, who was deposed in 1274 for having sixty-five illegitimate children; but it is impossible to resist the evidence of a long chain of Councils and ecclesiastical writer, who conspire in depicting far greater evils than simple concubinage. It was observed, that when the priests actually took wives, the knowledge, that these connections were illegal was peculiarly fatal to their fidelity, and bigamy and extreme mobility of attachments were especially common among them. The writers of the middle ages are full of accounts of nunneries that were like brothels, of the vast multitude of infanticides within their walls, and of that inveterate prevalence of incest among the clergy, which rendered it necessary again and again to issue the most stringent enactments that priests should not be permitted to live with their mothers or sister. Unnatural love, which it had been one of the great services of Christianity almost to eradicate from the world, is more than once spoken of as lingering in the monasteries; and shortly before the Reformation, complaints became loud and frequent of the employment of the confessional for the purpose of debauchery” (Russel, 1970, 64-65).

It is noteworthy that Stendhal was among many whose writings were forbidden to Catholics by the Pope: Index Librorum Prohibitorum (Bayley, 2001, 361) published originally in 1559 by the Roman Office of the Inquisition. He was in good company on that List, which included the Hebrew Bible, the Muslim Koran and even the writings of King Henry VIII of England (Index Librorum Prohibitorum).

CHAPTER 2

PROSTITUTION, HOMOSEXUALITY AND DEVIANT SEXUAL EXPRESSION: THE BIRTH OF SEX RESEARCH

The changes in society from an agrarian to an industrial basis brought new patterns of sexual expression in the proliferation of prostitution. Prostitution was not a new phenomenon but became more prominent with the gathering in the big cities of both men and women with limited opportunity to make a living. Society was divided into social classes; those who were wealthy and had status - and those who depended on the benevolence of others for work and income. Toward the end of the eighteenth century with the increasing immigration from Europe to the new world prostitution became more wide spread especially in ports of entry. Gilfoyle describes this in *The City of Eros*, a comprehensive account of the rise and fall of promiscuity, prostitution and moneymaking whilst striving for “the good life” in New York City at the turn of the Century:

The major factor inducing young women to sell their bodies was the low wages for female labor. The “unjust arrangement of remuneration for services performed,” wrote the Sun in 1833, “increases the temptation to licentiousness.” As teenage women moved to the city in growing numbers after 1800, a large pool of cheap female wage labor appeared. Because sewing and other forms of outwork were seasonal, female employees constantly shifted from one shop to another in an industry plagued with massive underemployment (Gilfoyle, 1992, 59).

Furthermore, regarding the male;

Family life endured new pressures as New York industrialized and grew into a modern metropolis. Many young males found it more and more difficult to marry and raise a family. By the 1820s, city apprentices and journeymen were increasingly exploited by their employers as the old artisan system broke down and gave way to one of wage labor. Greater disparities between rich and poor were apparent by the Jacksonian era, and it became harder for unskilled laborers and journeymen workers to support a family. Some complained that only men with sufficient wealth in New York could afford to court, marry and maintain a family (Gilfoyle, 1992, 113).

This combination of social and political circumstances fashioned a new characteristic male behavior, which came to be portrayed as “the sporting male”, described as follows:

Above all, his popularity among large numbers of urban youths represented the emergence of a “sporting male” culture. Organized around various forms of gaming - horse racing, gambling, cockfighting, pugilism and other “blood” sports - sporting-male culture defended and promoted male sexual aggressiveness and promiscuity. Prostitution, sexual display and erotic entertainment brought excitement to a prosaic world. Respectable, reproductive heterosexuality, in contrast, was associated with femininity and female control. Self-indulgence, not self-sacrifice, meant freedom; unregulated sex was the categorical imperative for the sporting male (Gilfoyle, 1992, 99).

The growing city, the accumulation of capital in the city, the lucrative way of using real estate and the gathering of people from various backgrounds and cultures led to anonymity and the collective hunger for excitement and progression in society. Men and women from all walks of life were participating in all different capacities in this development (Gilfoyle, 1992).

The mores and conditions of the time has also been eloquently described by George Bernhard Shaw’s play “Mrs. Warren’s profession”, which describes the social implications of the limited choices to reach the status of the well-to-do class in England at that time (Shaw, 1990).

Bullough has made extensive study of the history of sexuality and sexology (1976; 1994) and describes the role of Jean Baptiste Parent Duchâtelet, as the pioneer in the study of prostitution. As a physician in early nineteenth Century Paris he documented his findings about the lives of prostitutes in that city. He initiated his study in an effort to go beyond traditional medicine and, in his words, bring the methods of science to the study of people. Duchâtelet gathered information about the 3,558 registered prostitutes in

Paris. He found that the average prostitute was in her late teens or early twenties. She was illiterate, poor, probably illegitimate or from a broken family, and likely to have regarded herself as a prostitute for a relatively brief period. She was also willing to leave prostitution if something better turned up, a finding that has more or less consistently appeared in research into prostitution in Western culture for more than 150 years (Bullough, 1994, 31-32).

William Sanger was one among American physicians in the nineteenth century, who was concerned with public health issues related to the increasing prostitution and promiscuity, specifically with regards to sexually transmitted diseases. He undertook a survey of 2,000 prostitutes and found that 50 percent came from families, in which a parent died early and most of the parents were alcoholics. Of interest were the parental occupational backgrounds. In Sanger's sample the majority belonged to families with middle-class or skilled artisan parents. About 6 percent had a father who enjoyed high status or wealth. Nearly three-quarters of the women appeared to have enjoyed at least a stable agrarian or artisan-class upbringing (Gilfoyle, 1992, 66).

Sanger, having observed the nature of these women, commented on the sympathy and kindness they displayed toward each other. They were helpful to one another, shared resources and created bonds that lasted beyond their prostitution (Gilfoyle, 1992, 68).

Beside prostitution, homosexuality and other forms of "deviant" sexual expression were the focus of the early study of sexuality. These were considered criminal acts and the individuals involved with such behavior found themselves in criminal court. The medical profession became increasingly concerned and there was an effort to medicalize these matters. As a consequence many physicians became involved

and sexuality – except for the purpose of procreation within marriage – became viewed as pathology. Perhaps the best known of these was, Richard von Krafft Ebbing, who although specifically interested in criminal cases involving “deviant” sexual behavior, was instrumental in bringing to the public attention the importance of sexuality. Sexuality for him was “the most important factor in social existence, the strongest incentive to the exertion of strength and acquisition of property, to the foundation of a home, and the awakening of altruistic feeling, first for a person, then for the off spring, and in a wider sense for all humanity” (Bullough, 1994, 40-41). Sigmund Freud, Magnus Hirschfeld and Havelock Ellis soon followed, making this a focus in their respective works on sexuality (Brechner 1969).

Havelock Ellis was among the first to focus attention on women’s sexuality. He wrote that women’s capacity for sexual enjoyment was comparable with that of men but differed in that the impulse was more passive, more complex and less spontaneous. The impulse grew in strength after sexual relationships had been established, the threshold of excess was less easily reached, the sexual sphere was larger and more diffuse, there was more periodicity, and there was greater variation among women and within a single woman. In addition to clitoral erection Ellis wrote about the importance of vagina and uterus. For men, on the contrary, the sexual excitement was wholly contained in a single event, penile erection. Ellis pointed out that it was the diffuse nature of women’s sexuality that made courtship necessary and essential (Bullough, 1994, 84-85).

Freud and the Sexual Instinct – an Explanation of “Mental Illness”

Freud emphasized that the sexual instinct in humans served the purpose of procreation. The pleasure and pleasurable gratification were natural aspects of child development. Sexuality was the key to much of Freud's thinking and he claimed that every neurosis had a specific sexual cause. According to Frank Sulloway sexuality became for Freud the indispensable organic foundation for the scientific explanation to mental illness. The main principles of psychoanalytic thought, as identified by Freud, include the following: dreams are the disguised fulfillment of the unconscious, mainly of infantile wishes; all human beings have an Oedipus complex in which they wish to kill the parent of the same sex and possess the parent of the opposite sex; children have sexual feelings; the division of the human mind into superego, ego and id; and the concept of the death instinct (Bullough, 1994, 87-88). Freud's major contributions to sex research were his concept of the unconscious and his emphasis on the importance of both biological and psychological factors. Freud made an understanding of sexuality a key to the understanding of human nature (Bullough, 1994, 91).

Contraception and the Prevention of Sexually Transmitted Disease

As the positive aspects of sexuality became more accepted, ways to fight venereal disease were developed (Bullough, 1994, 98-100). Contraceptive methods became more available and women became involved in sexuality research (Bullough, 1994, 105). Victoria Woodhull, a leader of the “free-love movement,” taught that sex was not only central to human existence but also essential to preserve one’s health and vital strength (Bullough, 1994, 101).

With the easing of the strict moral code, sexuality became a public concern and in 1905 Prince A. Morrow, an American dermatologist, established the Society for Sanitary and Moral Prophylaxis. Its mission was to educate the public about sex and sexually transmitted diseases (Bullough, 1994, 104). He saw the need to eliminate the false impression held by young men that sexual indulgence was essential to health and that chastity was incompatible with full vigor. Morrow attacked the double standard and asserted his belief that the male should be held as culpable as the prostitute he patronized (Bullough, 1994, 103).

CHAPTER 3

SURVEYS OF SEXUAL BEHAVIOR

Subsequent to acting as the chair person for a grand jury charged with determining whether white slavery rings existed in New York City, John D. Rockefeller Jr. acted on a recommendation to establish a commission to study the laws related to the methods of dealing with prostitution. As the recommendation was turned down Rockefeller decided to start his own commission in 1911. He established the Bureau of Social Hygiene. To lead the commission Katherine Bement Davis was chosen. She had been a warden of the new Reformatory for women at Bedford Hills in New York, many of whose inhabitants had been prostitutes. Bement had advanced ideas of how to treat the potentially reformable sex offender (Bullough, 1994, 113). In 1920 Bement agreed to co-ordinate a study of the sex life of women. It was recognized that in order to deal with prostitution and other sex-related problems, it would be necessary to have a comprehensive understanding of sexuality itself. Bement planned and executed a study of twenty-two hundred women using one questionnaire for those married and another for those unmarried. The areas of inquiry were contraceptives, frequency of intercourse, happiness of the married women in terms of both general factors and sex, backgrounds of the unmarried sample, autoerotic practices among both married and unmarried women, periodicity of sexual desire among both married and unmarried women and prevalence of lesbianism in both married and unmarried women (Bullough, 1994, 115). One of the findings was that 50 percent of all women in the study reported experiencing “intense emotional relations with women” – but not physical. 64.8 percent of the unmarried women reported masturbating at some time, compared to 40.1 percent of those married.

Only a small number of women reported intercourse before marriage. The majority of women used some form of contraceptive. 9.3 percent of the married women had at least one induced abortion. The women who were classified as highly erotic, more often had received sex instruction from a responsible resource. Women, who desired intercourse more frequently than they engaged in intercourse, were more likely to be unhappy. The average frequency of sexual intercourse was found to be once or twice per week (Bullough, 1994, 115-116).

This opened the readiness for sex research, which was now taken over by the National Research Council, who planned comprehensive research into sexual habits and attitudes. Other areas identified to require research were marriage, divorce, family planning and sex education in addition to physiological and psychological aspects of continence, aberrations and investigation into prostitution (Bullough, 1994, 117).

The Kinsey Report

Based on personal interviewing of thousands of men and women across the country from all segments of the population, Alfred C. Kinsey, assisted by Wardell Pomeroy and Clyde Martin, performed the most comprehensive study of sexuality up to that time. Their investigation included a vast array of behaviors, habits, attitudes and expressions of sexuality over the life span. Their results were published in two volumes, the first, *Sexual Behavior in the Human Male* in January of 1948 (Kinsey, Pomeroy and Martin, 1948), followed by *Sexual Behavior in the Human Female* in 1953 (Kinsey, Pomeroy and Martin, 1953). Although Kinsey and his colleagues attempted to describe

how people behave sexually without moral or medical value judgments their work was severely criticized on methodological and moral grounds. For instance Life magazine called it “an assault on the family and a basic unit of society, a negation of moral law, and a celebration of licentiousness.” Margaret Mead criticized Kinsey for dealing with sex “as an impersonal, meaningless act” (New York Times, March 31, 1948). A professor from Columbia University stated, “There should be a law against doing research dealing exclusively with sex” (New York Times, April 1, 1948). However there was also praise and recognition of the value of this kind of research. The second report on female sexuality was met with even fiercer criticism and attack of being offensive. Church leaders and educators called Kinsey’s findings amoral, antifamily and even tainted by communism (Masters, Johnson, Kolodny, 1988, 20-21).

The findings of Kinsey’s research included information such as extent of homosexuality, bi-sexuality, premarital sex, frequency of intercourse, incest etc. Information such as the fact that 40 percent of husbands reported that they had been unfaithful to their wives; and 62 percent of the women reported that they had tried masturbation, may have been found disturbing contributing to the critical reception by some of the reports.

Kinsey put emphasis on homosexuality and pointed out the moral implications of society’s effort to repress homosexuality. Kinsey considered homosexuality a matter of “partner choice” rather than inherent sexuality. Kinsey’s findings indicated that, among males, 6.3 percent of all orgasms came from homosexual contacts, 69.4 percent from heterosexual contacts and 24 percent from masturbation or nocturnal emissions and 0.3

percent from contacts with animals and other species. The numbers for homosexuality in women according to Kinsey's report parallels the numbers for male homosexuals except that the numbers are smaller (Brechner, 1969, 132-33).

Kinsey reported sexual behavior in young children. He pointed out, predicting findings of subsequent research, that these behaviors may be more frequent than stated, as adults based their reports on memory (Brechner, 1969, 136).

Preadolescent homosexual play was reported by 48 percent of males and 40 percent reported preadolescent heterosexual play. Among women 48 percent reported sexual play before adolescence, homosexual play being slightly more common than heterosexual play. The report further included findings of the frequency of child-adult sexual contacts. One in four women recalled sexual contacts before adolescence with males at least fifteen years of age and at least five years older than they were. These contacts were divided as follows: 52 percent were with strangers, 32 percent with friends and acquaintances, 9 percent with uncles, 4 percent with fathers and 3 percent with brothers (Brechner, 1969, 138).

It is understandable that this information was disturbing to the "innocent" community. Specifically upsetting was the information about sexual behaviors involving children. These findings, however, provided a challenge to figure out how to use the information for the benefit of society itself. Realization of the sexual involvement with children has paved the way for changing the ways courts handle allegations of sexual abuse of children today – an area in which further research and understanding is imperative. Developments have shown that society has responded to the challenge. Our

knowledge of sexual behaviors, preferences and needs continue to be enlightened through research in all areas of human activities. These surveys have played an important role in helping identify and take steps to overcome prejudice and stereotypical thinking about sexuality and gender roles. Kinsey's legacy continues at the Kinsey Institute at the University of Indiana, Bloomington, Indiana.

The Hite Report

If the Kinsey reports opened our eyes to the vast variety of sexual behaviors, the Hite report served to educate society-at-large about the unspoken needs of men and women and to reveal the prevalence of ignorance, specifically about the importance of recognizing women's sexuality. Particularly revealing were words from many women regarding their need for clitoral stimulation for orgasm and the relative unimportance of "vaginal orgasm". There had been a longstanding misconception of female sexuality, which originated in the theory established by Freud. He had written that there was a qualitative difference between clitoral and vaginal orgasm and that clitoral orgasm was a regression – only vaginal orgasm, in his perception, was an appropriate expression of mature sexuality. Needless to say, other researchers contradicted Freud's notion as uninformed. Havelock Ellis, among others, wrote that Freud's idea about female orgasm – exclusively vaginal – could only have been advanced by someone who lacked any direct knowledge of women's sexual response (Bullough, 1994, 84). What was even more detrimental to relationships between men and women was that, short of shared vaginal orgasm with the partner, the woman was accused of frigidity, a condition that has produced guilt and shame to both men and women. The first report, *The Hite Report: A*

Nationwide Study of Female Sexuality was published in 1976 (Hite, 1976) and was followed in 1981 by *The Hite Report on Male Sexuality* (Hite, 1981).

In her own analysis of her reports, Hite makes the following statement:

Is sex basically “intercourse” – or an individual vocabulary of activities? The Hite Report on Female Sexuality in 1976 argued for undefining sexuality - both the physical “acts” that we define as “sex” and the cultural atmosphere surrounding “sex.” Sex could become a vocabulary of activities, chosen to show how we want to express ourselves at a given time, with a specific feeling and meaning – an individual choice of activities, not always necessarily “foreplay” followed by “vaginal penetration” (why not call it “penile covering”?) and intercourse, ending with male orgasm. (Hite, 1993, 332)

The Report further served to give voice to men and women at a time when, for many, sexual matters remained both confusing and uncomfortable. The Report also gave opportunity to recognize the realm of options in sexuality, available both physically and emotionally. It served to highlight how much mankind is still governed by prejudice. It helped to create an atmosphere conducive to building better balance in relationships between men and women and served to enlighten and strengthen not only women but also men in this endeavor.

In the words of Hite herself:

While women in most academic disciplines and many feminist writers have done great work in critiquing “male” culture, women’s building of a new way of looking at things, reformulating their philosophy, can be said to be most importantly taking place now in the thoughts and actions of women everywhere – as seen in this study.

The interesting and important thing about this revolution is that it is not just being made by an isolated group of people; it is women and some men everywhere who are thinking these thoughts. For women these issues are pressing, since many women meet the “system” every day in the faces of men

they love: the exquisite pain and contradiction women experience receiving men's double messages lifts many beyond the daily to the highest plateaus of thought and reflection. Thus, as we have seen, it is in large part the behaviors of men they love which have led to the crystallization of the level of awareness women are now expressing – an awareness which cannot be removed from history of consciousness. (Hite, 1993, 407)

American Couples

A comprehensive study of American Couples was published in 1983 (Blumstein and Schwartz, 1983). The study focused on money, work and sex and included heterosexual married couples and co-habiting couples as well as gay and lesbian couples. The study analysis the choices available – whether to marry, divorce or remain single – and addresses how, apart from other societal issues, demographics may be a decisive factor in the choices made.

This topic is of renewed interest today with the increase in the divorce rate with, as a consequence, an increased number of children growing up in a single parent family. Not unrelated is the disturbing fact that a similarly increased number of children are growing up in poverty. According to the recent findings of the Welfare Reform Committee of the National Conference of State Legislatures (Jarchow, 2003) one-third of all births are to unmarried mothers. Other statistics show that over 50 percent of first marriages end in divorce; nearly 40 percent of all children do not live with their biologic father and, whilst only 6 percent of children in married-couple families were poor in 1999, 35 percent in single-mother families met the criteria for poverty. Forty-three percent of unmarried women have children by at least two men compared to 15 percent of married women. This report also indicated that the “benefits” of marriage include better physical and emotional health for all family members, who are less likely to

engage in drug and alcohol use. Children, who live with biologic parents, tend to have better cognitive and emotional development and school achievement than children living with a single parent. Children raised in single-parent homes are at greater risk of poverty, juvenile delinquency and teen pregnancy and are more likely to divorce as adults.

In the early eighties Blumstein and Schwartz (1983) noted the following with regards to marriage and childbearing. Whereas 28 percent of American women between the ages of twenty and twenty-four had not yet married in 1960, by 1981 the number of single women had increased to 52 percent. In 1970, among twenty-five to twenty-nine year old women, who had married, 16 percent were childless. In 1981, that number rose to 25 percent. The highest fertility rate was among women thirty to thirty four years old. The actual fertility replacement rate in 1981 was about 1.8, substantially below the required level of 2.1. The repercussions of later marriage could adversely affect the number of children a woman will bear over the course of her life. The later the marriage the later childbearing begins, and the smaller the family. On the positive side delaying marriage gives both men and women more opportunity for advanced education and training. Blumstein and Schwartz make reference to Paul Glick, a former demographer at the U.S. Bureau of Census, who put forward the concept of “marriage squeeze”. By this term he means that the number of individuals who want to marry is greater than can be accommodated. Women tend to marry men who are two to three years older than they, which would work out well if the size of the populations at each of these ages stayed approximately the same. The baby boom women, i.e. those born soon after World War II, found, in the nineteen-eighties, that it was “hard to find a good man to marry”, whether it was a first or second marriage, as the birth rate was lower during the war

years. In addition, men who remarry in their forties are more likely to choose a partner ten years younger than themselves. These are some of the examples of the influence of demographics on opportunities for marriage (Blumstein and Schwartz, 1983, 31-33).

Regarding divorce it was noted that the highest probability of divorce fell between the second and sixth years of marriage and between the first and fourth years in second marriages. However the rate remains high through out the entire life cycle. The greatest increase in the rate of divorce was found in those between the ages of twenty-five to twenty-nine. It had risen 65 percent in the ten years from 1968 to 1978. Those younger than twenty-five and those, who were between forty and sixty-five showed an increase in divorce rate of 50 percent. Even above the age of 65, the divorce rate rose by 35 percent. Furthermore, divorce rates for second marriages were even higher than for first marriages. In the nineteen-eighties the number of children involved in divorce rose by more than one million each year. The number of children below the age of eighteen in households headed by women increased from 8.7 million in 1970 to 9.4 million in 1976 and to 10 million in 1980. This represents one quarter of all American children! (Blumstein and Schwartz, 1983, 34)

The debate on what constitute a couple is continuing and has become intensified through the voice of both the women's movement and of gay rights groups, such as the National Gay Task Force. Heated debate continues this very day on the formalization of relationships between couples of the same sex.

Blumstein and Schwartz further studied the sexual habits and expectations of the participants. They enquired into how well these expectations were being met and, how

sex was being used to influence the partner and gain power even beyond areas of sex. Also studied were the ways in which sex fits into the life of the more than twelve thousand people represented in the study.

Quantity and Quality of Sex

Findings included the fact that those married had more sex, more regularly, than generally expected. Most couples had sex at least once per week and even after ten years of marriage 63 percent continued this frequency of sexual activity. Only a small percentage had sex once a month or less (Blumstein and Schwartz, 1983, 195)

However, a large percentage of cohabiters had more frequent sex than married couples and continued a higher frequency. There was a big difference when comparing heterosexual couples with gay and lesbian couples. Gay men had sex more often in the early part of their relationship than any other type of couple but after ten years, they had sex together far less frequently than married couples. The authors postulate that gay men are much less monogamous than other couples and although sex with their partner may decline, their interest in sex remains high. Also it was noted that gay men, although oriented to sexual expression, rely less on sexuality as a focus for their commitment to an ongoing relationship (195)

The least frequent sexual activity was found among lesbians, who appeared not to compensate through sex outside of the relationship. This trend continued at every stage of the relationship at every point in their lives. It was learnt, however, that lesbians prized non-genital physical contact such as cuddling, touching and hugging, more than

other couples. They also saw this activity as an end in itself. This leads the authors to consider the influence on female sexual expression on the influence and presence of a male, who is generally considered to have the stronger sexual appetite, perhaps as nature's way to assure the continuation of the species. (195-197)

The report indicates that the frequency of sex declined in all couples the longer they stayed together. Most appeared to accept this fact, attributing it to lack of time, lack of physical energy or having become accustomed to each other. In older couples declining health was considered to be a contributing factor (198).

However, it was established that both the quantity and the quality of sex seemed to be important to the wellbeing of the relationship for all types of couples. Couples with frequent sex described their sex life as good, while infrequent sex was associated with conflict. Married couples with infrequent sex tended to be dissatisfied with their relationship overall. The question then presents itself whether it is the unsatisfactory relationship that leads to less sex or whether problems in the sexual relationship affect other areas of their life together. The sexual relationship may be undermined by other problems such as arguments about housekeeping, income or work. It was suggested that frequent sex could serve as a bond in the marriage but also that the institution of marriage could serve to preserve a relationship even when sex is less frequent. With cohabitators the frequency of sex may be more important, as they do not have the security of the institution of marriage. It was the impression of the authors that with gay men and lesbians the relationship could be preserved even when sex is less (201).

Initiating and Refusing

Despite the equalizing of the relationship between the sexes it was found that with married couples, the husband initiated sex more frequently than the wife – with refusal being the prerogative of the wife (206). Cohabiting couples shared initiation equally. (208). The authors present an interesting observation with regards initiating in homosexual males. As men commonly are the initiators in all relationships, in a gay couple both may be initiators, which leads to frequent sex in the early stages. Frequency was found to decrease over time as the relationship continued. An explanation given was that one partner might start feeling pushed and react with refusal leading to a decline in the couple's sexual life. It is no surprise that they found that it was the more expressive partner who initiated sex in all couples. The more powerful partner tended to be more likely to refuse sex, whether it was the man or the woman who held this position. Some understanding of the degree of power and dependency in the relationship and how this is expressed through the sexual relationship can be gleaned from the balance of initiation and refusal in the couple (217-219).

With regards the quality of sex life and the equality of initiation it was no surprise to find that couples who initiate and refuse sex on an equal basis were more satisfied with their sex life. They also had more frequent sex. (222).

Sexual Acts

Another area of study was sexual acts. The acts chosen were those common in both heterosexual and homosexual relationships. It was found that kissing was not always a part of sex. Couples tended to use kissing less when they felt emotionally removed or dealing with conflicts outside of the sexual area. Heterosexual couples tended to kiss less than lesbian couples and gay males used kissing least of all the couples (Blumstein and Schwartz, 1983, 226).

Surprisingly, the authors found that intercourse is more essential in the sexual relationship of heterosexual women than it is for heterosexual men. It was found that when it came to contentment with sex life and satisfaction with the entire relationship, intercourse was just one aspect for men but a central ingredient in women's happiness. The authors suggest that this may be so, because the act of intercourse requires "equal participation of both partners", and women appreciate – perhaps more than men – the shared intimacy of intercourse (227)

The missionary position in intercourse was most common in heterosexual couples with traditional values and in relationships in which the woman had less power. In relationships in which the couple shared power equally there tended to be more openness to the woman taking the "male" position (228).

Other findings include; when heterosexual women are perceived as attractive, they had more varied sex lives; heterosexual men who received oral sex were happier with their sex lives and with their relationships in general; men who performed oral sex were also happier; oral sex was not necessary for heterosexual women's sexual satisfaction; the more often lesbians had oral sex, the happier they were with their sex life

and with their relationship. They found that whilst lesbians were happy with oral sex, it was not a common behavior for the majority. For homosexual men oral sex was important for their satisfaction. However, anal sex could be disruptive to the couple, as it may bring up connotations of power and control (Blumstein and Schwartz, 1983, 239-240)

Beauty, Competitiveness, and Possessiveness

The study showed that perceived beauty affected all couples in the way they interacted and how they dealt with the wider world.

Findings included the following: that marriage and commitment did not free couples from the fact that beauty is important and that lesbian couples were the only ones who did not let physical beauty – or lack thereof – affect their happiness. Furthermore, those heterosexual men and women, who were very attractive, resented it when their partner received more attention from others than they did. Conflict was noted when same-sex couples competed with each other for the attention of others. Men were less possessive than women, which the authors ascribe to men having more options. In order to have sex, women – more than men – needed to be in love. This made women more possessive, which escalated when one partner feared that the other might have a meaningful affair. This was so for all the couples studied, possessiveness bearing no relationship to commitment except, not surprisingly, in the case of wives (247-267).

In summary women are the keepers of fidelity while men are more likely to seek variety. However men who have female partners are commonly attuned to their partners'

needs and do not go outside of the marriage. Rather they design their sex life to meet their own needs within the relationship (Blumstein and Schwartz, 1983, 302). The authors believe that their findings indicate clear trends to male behavior whether straight or gay – and that the same applies to female behavior. Husbands and male cohabitators are more like gay men, and lesbians are more like heterosexual women. (303). When couples share equal responsibility for initiating and refusing sex, frequency and satisfaction tend to be higher. When the male is the initiator, he tends to take his responsibility seriously and this will result in more frequent sex – even more so if the woman allows herself to participate by being accessible or by offering encouragement. The level of sexual activity in the lesbian couple appears to be less frequent as they share the discomfort associated with the assertiveness required in initiation (303). On the contrary, the gay couple tends to share the sense of right to initiate and this may lead to competition. Being initiator validates male identity while being the one to accept or refuse may be resented. In the gay couple it is important to maintain reciprocity in chosen sexual activities and avoid the imagery of “servicing” or “controlling” (304).

There are men and women who take a different view of sex roles and are more open to share. However the old views linger. Also, when sex roles are reversed in the heterosexual couple, the relationship has a tendency to not work out so well. For the gay male the most important aspect is the negotiation around power and respect. Ridding themselves of the stigma attached to homosexuality is important in a society which still tends to condemn them (305).

In *Sex and Reason* Posner presents a discussion on the effects on behavior of rules governing marriage and divorce. Marriage, as the only legitimate channel for sexual

activity, has been “bequeathed” to mankind by the Catholic Church, regardless of their religious beliefs. It entails restrictions of freedom in the marital contract with the aim at creating a companionate relationship in the marriage (Posner, 1992). According to Posner the Church wanted people to marry young in order to reduce the opportunities for non-marital sexual activity – “but not too young because then marriage was unlikely to be companionate” (245). He outlines how sexual behavior and the initiative to make the relationship companionate are affected by the rules both of restricted marriage/divorce and unrestricted or readily available marriage/divorce (Posner 1992, 245-252). The findings in the research by Blumstein and Schwartz contribute to shed light on these complex societal issues.

Sex in Sweden

National Institute of Public Health, Sweden (NIPH, 2000) recently presented a survey of “Swedish Sexual Life”, a population based study with 2,810 participants. This was the second such survey in Sweden. The first was presented in 1967 as a government official report. The 2000 study was initiated upon encouragement from World Health Organization and prior to that by European Union through the European Commission, Concerted Action on Sexual Behavior and Risks of HIV (NIPH, 2000, 5).

This survey is a comprehensive study of behaviors, attitudes, health and more. Selected observations have been chosen by this writer for their specific interest related to her study.

Sexual Desire

The question was frequency of sexual desire among men and women and the choices of answer included: often, sometimes, rarely and never. It was found, not surprisingly that – regarding reported frequency of sexual desire – the proportion of both women and men who “often felt sexual desire” decreased with age. Roughly two-thirds of the men in the age group 18-24 as compared to one-third of women reported that they “often felt sexual desire”. There was a decrease of 10 percent up to the age of 50 in both groups followed by a drastic drop to 3 percent of women and 12 percent of men reporting feeling sexual desire “often” at the age of 66-74. In the overall sample (18-74) the proportion of respondents reporting experiencing sexual desire “often” was, in women, 22 percent and in men, 49 percent – in men roughly double the frequency of women. Of women in the age group 25 – 34 the answer of “sometimes” was given in 63 percent of cases and in 37 percent of men. In the age group 50 – 65 women gave the answer “sometime” in 69 percent of cases, while in men the answer “sometime” was chosen by 63 percent. The report indicates that three quarters of the respondents had steady partner relationships and that the women with such relationship reported a higher level of sexual desire than did those who were single (NIPH, 2000, 201).

First Experience of Sexual Intercourse and Gender

The report differentiates between those with “Early first intercourse” and those with “Late first intercourse”. “Early” and “Late” were not given a definition in the report. The findings were that in both men and women for both early and late first intercourse exactly one third gave their sex life a high rating. It is noted that among men

those with “late first intercourse” rated their sex life low 8 percent more often than those with “early first intercourse” (NIPH, 2000, 165).

“Good Sexuality”

The participants were given the opportunity to mark among eight alternatives the most important feature of good sexuality, including: Freedom, Companionship, Desire, Pleasure, Consideration, Excitement, Tenderness and Sharing. One fourth of both those with “Early” and those with “Late” first experience of first intercourse marked Sharing and Tenderness as most important. Among men with “Late” first experience Consideration was identified as most important while among those with “Early” first experience Desire and Pleasure was chosen as most important (NIPH, 2000, 164).

Total Number of Sexual Partners

It is noted that there was no difference between the sexes in the number of sexual partners in the 12 months preceding the study. However the average number of sexual partners in total was found to be twice as high among men as compared to women. Further it was found that the median number of sexual partners was considerably smaller than the average leading to a suggestion that there is a smaller group of men with a large number of sexual partners (Sex in Sweden, 2000, 135). It was noted that 10 percent of the most active men had had 53 percent of all sexual partners and 10 percent of women had had 41 percent of all sexual partners. This finding prompted a discussion of a re-evaluation of how to approach risk behavior and identified a need to obtain more understanding of the lifestyle in this “super active” group (NIPH, 2000, 72-73).

Health and “Sexual ability”

The report also addresses the connection between perceived health and sexual dysfunctions. The parameters “poor health” and “good health” were used. Medical problems included in “poor health” were back problems, asthma/chronic lung disease, high blood pressure, rheumatoid disease, diseases of stomach/intestinal canal or coronary arteries or pain, diabetes, emphysema and depression. It was found that among men, with “poor health”, 14 percent had low sexual desire compared to 2 percent of those who reported “good health”. Of the women, 12 percent with “good health” reported low sexual desire as compared to 29 percent in those reporting “poor health”. The same pattern was found for lubricative ability in women and retarded ejaculation in men. However there was no clear pattern for reduced orgasmic ability or in men premature ejaculation (NIPH, 2000, 220-221).

Although there are certain cultural differences between Sweden and The United States with regards sexuality these statistics are presented as an illustration of, among others, gender differences, which are most likely not unique to Sweden. It is also to be noted that Sweden may differ from some other countries in that the influence of religion has lost its prominence over recent generations.

CHAPTER 4

THE HUMAN SEXUAL RESPONSE: PHYSIOLOGY

Freud's sexual drive theory was accompanied by several other theories focusing on the natural sexual response, such as those of Havelock Ellis and Van de Velde. They were eager to share their discoveries, obtained through patient contacts as well as personal experiences. Havelock Ellis took 25 years to write *Studies in the Psychology of Sex*, from 1899 through 1928. Topics included: The Evolution of Modesty and The phenomena of Sexual Periodicity and Auto-Erotism. Further studies were: Analysis of the Sexual Impulse, Love and Pain, The Sexual Impulse in Women and Sexual Selection in Man. He could not rest with that but went on to address: Sexual Inversion, The Mechanism of Sexual Detumescence, The Doctrine of Erogenic Zones, and The Menstrual Curve of Sexual Impulse. Ellis dedicated a whole volume to *Sex in Relation to Society* (1910) addressing among other concerns, love, chastity, abstinence, marriage, procreation, mother-child relationships, sex education and venereal disease (Brechner, 1969, 36-37).

The findings presented in Ellis' *Studies* precede many of those subsequently described by Kinsey, Masters and Johnson, and other more recent researchers, including the following, which refers to Ellis as quoted by Brechner:

Sexual behavior and sexual responses often appear at a very early age – long before puberty – in both boys and girls. Masturbation is a common phenomenon at all ages in both males and females. Boys tend to reach a peak of sexual activity earlier than girls-while still in adolescence. Girls mature earlier physically; but their sexual activity often blossoms and flowers at a later age. Homosexuality and heterosexuality are not absolutes like black and white; they are present in varying degrees. The absence of sexual desire among women is a Victorian myth. Indeed, some women are more highly sexed than most men, and

take the active role in initiating sex relations. The orgasm is remarkably similar in men and women. (Brechner, 1969, 37-38).

Theodoor Hendrik Van de Velde (1873-1937) was another important influence on the development of modern concepts on the human sexual response. His book, *Ideal Marriage* (Van de Velde, 1963), became the prime source of information on sexual matters for “a whole generation of Europeans and Americans” according to Brechner (Brechner, 1969, 82). Van de Velde stated his need to share his findings as follows: “There is a need to this knowledge; there is too much suffering endured which might well be avoided, too much joy untasted which could enhance life’s worth...”. (Van de Velde, 1963, xxvi, Personal Introductory Statement). Van de Velde’s primary focus was on the responsibility of the male to initiate his female partner to eroticism and assure that this eroticism was kept fresh over the whole time frame of marriage. He was a true representative of his time in that he introduced variety to the sexual experience. However, this was only to be enjoyed as part of matrimony. Van de Velde defines as normal “that intercourse which takes place between two sexually mature individuals of opposite sexes; which excludes cruelty and the use of artificial means for producing voluptuous sensations; which aims directly or indirectly at the consummation of sexual satisfaction, and which, having achieved a certain degree of stimulation, concludes with the ejaculation – or emission – of the semen into the vagina, at the nearly simultaneous culmination of sensation – or orgasm – of both partners”. Van de Velde divided the sexual response in four phases: prelude, love-play, sexual union or communion (coitus) and after-play or epilogue (postlude) (Van de Velde, 1963, 145). He emphasizes the importance of paying close attention to the prelude, which might include “coquetry” and

“flirtation” but most important is the exchange of impressions and ideas on the subject of love. He describes, “the general organic” effect shown by rapid heart action, “the psychic stimuli produce an unmistakable physical symptom in both men and woman – at least in the erotically experienced woman”. He emphasizes the importance of the erotic kiss as an introduction to the love play among Westerners. He points out the cultural differences between Westerners and, among others, the Japanese, who would find the erotic kiss both indecent and obscene. The author gives a detailed description of the various kinds of kisses in poetic and flowery language (Van de Velde, 1963, 151-153). He points out the different kinds of pleasure that is achieved by being the giver - or the receiver, subsequently the basis for Masters and Johnson’s Sensate Focus Exercises, used to sensitize the lovers to their erotic sensations. Van de Velde describes how this stage is followed by mutual caresses leading to the third phase, sexual communion or coitus. Although according to Van de Velde cunnilingus and fellatio leading to orgasm was “pathological”, for the purpose of pre-coital arousal it was unobjectionable (Brechner, 1969, 92-93). In accordance with the time, the mutual simultaneous communion (orgasm) was the goal. However, Van de Velde takes pains to describe what may happen with an inexperienced female partner using graphic depiction, as, also, shown so poignantly in the motion picture *Kinsey* (Condon, 2004).

Van de Velde’s marriage manual included some misperceptions of his time including that of insufficient development of the clitoris, supposed to be due to “a certain degree of *arrested development or genital infantilism*,” although he pointed out that this was so common that “it should not be considered morbid” (Van Velde, 1963, 179).

The impact of the Masters and Johnson sexuality research (Masters and Johnson, 1964) in the nineteen fifties was revolutionary in the development of sex therapy. Their research project lasted twelve years and made use of volunteers. There were 694 participants. There was only one prerequisite for the volunteers; that they would be able to reach orgasm during both masturbation and coitus while under observation in the laboratory setting. The laboratory research program was kept separate (Masters and Johnson, 1964) from a clinical program which was started in 1959 and which is described in detail in *Human Sexual Inadequacy* (Masters and Johnson, 1970). Participants in the research program were predominantly white, but included eleven black couples. There were thirty-four married couples over the age of fifty, including some in their sixties and seventies. All walks of life were presented, “young and old, the fat and the thin, the tall and the short, the rich and the poor, blacks and whites, the single, the married, the divorced and the widowed, the circumcised and the uncircumcised, women who had never borne a child, women who had had one child, and women with two, three and four children” (Brechner, 1969, 298).

The following activities were observed with results recorded: (1) Masturbation with the hand or fingers, (2) Masturbation with a mechanical vibrator, (3) Sexual intercourse with the woman on her back, (4) Sexual intercourse with the man on his back, (5) “Artificial coition” with a transparent probe with optical qualities, and (6) Stimulation of the breasts alone, without genital contact. At a later time standard laboratory observation were used with women capable of reaching orgasm through fantasy alone, without direct contact stimulation. It was found that the sexual response cycles were identical with the cycles produced with more ordinary means. The most important

finding in this research was that the human sexual response is natural, consisting of a normal cycle of events in response to erotic stimulation. The physiological response can be compared to that of the normal digestive cycle as well as that of the cardiovascular rhythm. Four distinct cycles were identified: excitement, plateau, orgasm, and resolution (Brechner, 1969, 299).

For a review of the human sexual response Kaplan's description, based on Masters and Johnson's findings (Masters and Johnson, 1964), will be used in this enquiry. Kaplan explains that, before coitus can take place, the body needs to go through a process of adaptation, involving extensive chemical and physiological changes. They occur in both the male and the female, and are distinctly different – but complementary. Neurological, vascular, muscular and hormonal changes are elicited which affect the functioning of the entire body. Masters and Johnson (1964) identified four distinct stages: excitement, plateau, orgasm and resolution.

In the excitement stage there is an onset of erotic feelings and in the male, erection of the penis and in the female vaginal lubrication. There is also a sexual tension and generalized bodily reaction of vasocongestion and myotonia, breathing becomes heavier, heart rate and blood pressure increase etc. In addition to the erection of the penis the scrotum thickens and the scrotal sack flattens and thickens while the testes become elevated (Kaplan, 1974, 5-6).

In the female there is local genital and general vasocongestion of the skin and myotonia. There is a marked skin reaction in women and breasts begin to swell and nipples become erect. Vaginal lubrication is the distinguishing feature in the excitement stage, which occurs within 10 to 30 seconds of initiation of stimulation. In some women

the clitoris becomes erect; the uterus becomes enlarged due to vascular engorgement and it begins to rise from the pelvic floor. The vagina begins to enlarge and balloon to accommodate the penis (Kaplan, 1974, 6-7).

The plateau stage is a heightened arousal immediately preceding orgasm. The vasocongestion in the sex organs peaks in both sexes. The penis is tumesced, filled with blood to the limits of its capacity; erection is firm and shaft extended to maximum size. Testicles are engorged and increased in size by 50 percent. They are raised into close apposition to the perineum and a few drops of mucoid fluid appear, produced by Cowper's gland (Kaplan, 1974, 9).

In women there is also vasocongestion. There is a swelling and coloration of the labia minora, which has been named "sex skin". It ranges from bright red to burgundy and there is a formation of a thickened plate of congested tissue, which Masters and Johnson (1964) refer to as the "orgasmic platform." This is the area surrounding the entrance to and lower portion of the vagina. The uterus ascends from the pelvic floor and the outer third of the vagina balloons. Just prior to orgasm the clitoris rises and retracts in a flat position behind the symphysis pubis (Kaplan, 1974, 10-11).

During orgasm semen is ejected out of the erect penis in three to seven ejaculatory spurts at .8 second intervals. This is considered the most intensely pleasurable of the sexual sensations. Dual components of the male orgasm, as described by Masters and Johnson, are: (1) contractions of the internal organs, which signals the sensation of "ejaculatory inevitability;" (2) immediately followed thereafter by the rhythmic contractions of the perineal muscles. This constitutes the second component and is

experienced as the orgasm and is followed by a refractory period of a variable period (Kaplan, 1974, 11).

Masters and Johnson (1964) described the female orgasm as consisting of .8-second reflex rhythmic contractions of the circumvaginal and perineal muscles. This, they stated, occurs in all females and requires stimulation of the clitoris. They established that the female does not have the refractory period experienced in the male, and is capable of multiple orgasms (Kaplan, 1974, 11-12).

Resolution is the final phase of the sexual response cycle. Sex-specific physiological responses abate and the body returns to its basal state. Heart rate, blood pressure, respiration and skin vascularity return to a resting state. The testicles detumescence and return to their basal position. Some young men may ejaculate a second time without losing their erection. The penis detumescence in two stages, in the first stage the penis is reduced to half its fully erect size, as a result of the emptying of the corpora cavernosa. In the second stage the corpus spongiosum and glans, are emptied and diminished in size. It may be another half hour before this happens. In the older man this process may happen within minutes (Kaplan 1974, 12).

In the female the clitoris returns to its normal position five to ten seconds after orgasm. According to Masters and Johnson (1964) the vagina may take as long as ten to fifteen minutes to return to its relaxed and pale resting state, while there is a rapid detumescence of the orgasmic platform. The cervical os continues to “gape” for twenty to thirty minutes after orgasm. After that time the uterus descends into the pelvis. The “sex skin” of the labia minora loses its deep coloration ten to fifteen seconds after cessation of the orgasmic contraction (Kaplan, 1974, 12).

Kaplan, has built on the model created by Masters and Johnson to arrive at a deepened understanding of the sexual response as a basis for treatment of sexual dysfunction. She describes in *The New Sex Therapy* how the sexual response can be conceptualized as biphasic (Kaplan, 1974). She identifies two distinct and relatively independent components: A genital vascongestive reaction, which produces penile erection in the male and a vaginal lubrication and swelling in the female; and the reflex clonic muscular contractions, which constitute orgasm in both genders. Kaplan emphasizes that the two components involve different anatomical structures innervated by different components of both the central and the autonomic nervous systems. The parasympathetic division of the latter mediates erection, while ejaculation is primarily a sympathetic function. Vasocongestion and orgasm differ with respect to their vulnerability to the effects of physical trauma, drugs, and age. Different psychopathological mechanisms impact on erection and ejaculation as compared to the lubrication and orgasm in the female and result in distinct clinical syndromes, which in turn respond to different procedures. Semans (1956) – followed by Masters and Johnson (1964) and then by Kaplan (1974) – demonstrated, when they drew a distinction in the treatment of the erectile and the ejaculatory disorders, that they recognized the biphasic nature of the male sexual response. Kaplan points out that the dual nature of the female sexual response, i.e. lubrication-swelling and orgasm will need to be equally recognized (Kaplan, 1974, 13-14). Since that time there have been increased clinical studies in this area with developing treatment modalities. This broadens the horizon in the enhancement of women's health (Berman and Berman, 2004).

In a comparison between the two genders, Kaplan states that the sexual response in the two sexes is more similar than different. Although the vascongestive phase in men and women are analogous, they differ in vulnerability. Kaplan found that men's presentation with erectile dysfunction was more frequent than women's complaints of vaginal dryness (Kaplan, 1974, 33). No doubt this recognition helped to accelerate the development and success of pharmaceutical agents for erectile dysfunction such as Viagra, Levitra and Cialis.

Orgasm is also analogous in both genders (Kaplan, 1974, 32-33). However, the female orgasm seems more vulnerable to inhibition than does that of the male. According to Kaplan, while orgasmic dysfunction is prevalent in the female population, retarded ejaculation is relatively uncommon. With regards to libido, it is observed that the female sexual response seems more variable than that of the male and Kaplan's presumption that this is because the female is more susceptible to psychological and cultural influences, while sexual arousal in the male, especially when he is young, is governed primarily by physical factors and less vulnerable to psychic influences.

The Brain, Nervous System and Sex

In the study of sexual health it is interesting to learn what Kaplan (1974) has to say about the neurophysiologic aspects of motivation, pain and pleasure. Avoidance of pain and the seeking of pleasure govern human behavior. However, sexuality is unique among the drives in that it is dominated mainly by the pleasure principle. Kaplan states that studies have confirmed the clinical impressions that there is an intimate relationship between the cerebral centers that mediate sexual behavior and the pleasure centers of the

brain. She states that the tactile and proprioceptive impulses activated by sexual arousal and orgasm, project to the pleasure centers of the brain, thereby giving sexual activity its pleasurable quality. It has been demonstrated experimentally that some cerebral loci, which produce the sexual responses of erection and ejaculation, are closely associated with those which, upon electrical stimulation, produce pleasure. The author further documents that some women reported that the day after they had engaged in a particularly satisfying sexual encounter, they experienced profoundly pleasurable “flashbacks”, accompanied by intense erotic sensations and feelings of “euphoria and love”. (Kaplan, 1974, 43-44)

It has further been reported that orgasm is associated with electrical discharges in a specific region of the brain and is associated with intense pleasurable affect – feelings of love and affection – and with reduction of anger and irritability. (Kaplan, 1974, 44)

The author comments that the neural control of sexual functioning is organized in such a manner that all the levels of the brain intricately and reciprocally influence the sexual response. The genital organs and the cerebral sex centers send impulses to and receive impulses from virtually all the neural centers and circuits. Kaplan states:

... The sexual response is subject to influences from numerous sources: memories, experiences, emotions, thoughts and association. The influences can inhibit or enhance. Hence, the sexual reflexes can readily be impaired by multiple potential inhibitory influences such as fear or hatred; conversely, sexual responsiveness can potentially be increased by other psychic forces such as love and fantasy.

It is the aim of sexual therapy to allow couples to experience the natural unfolding of their sexual responses, free from the inhibitory influences, which can, because of the hierarchical construction of our nervous system, impinge on these from numerous sources. The aim of sex therapy should transcend the elimination of inhibition, however, and attempt to teach the partners to create a loving and tranquil ambience and to maximize the sensuous and psychic

stimulation, which potentially can enhance and amplify the pleasurable aspects of sexuality (Kaplan, 1976, 45).

The connection between pain and pleasure and the intricate involvement of the central nervous system is currently under examination by Whipple (Whipple, 2003). This will be further addressed in Chapter 8.

We owe thanks to Kaplan for her unrelenting work in bringing sex therapy to the next level following Masters and Johnson's landmark research (1964) and design of treatments for impotence and orgasmic disorders. Masters and Johnson (1970) based their treatment on the presumption that performance anxiety is the principal cause of sexual dysfunction and therefore emphasized the sensate focus (SF) exercises as a way to reduce anxiety, using this for all presentations of psychosexual dysfunctions (Masters and Johnson, 1970). It was the treatment failures with this method that brought Kaplan (1995) on the track of recognizing the existence of disorders of sexual desire. Patients presenting with these disorders, i.e. dysfunctional regulation of sexual motivation, often did not respond to sensate focus-centered therapy. These exercises were effective primarily with psychogenic erectile dysfunction and had limited success with patients with other sexual problems. Such patients came to be labeled "resistant" for the wrong reason (Kaplan, 1995, 2).

She further states that each form of sexual dysfunction is produced by impairment at differing points of the sexual response cycle and is manifest via differing pathogenic mechanisms. Each therefore requires its own individual therapeutic approach. The author gives, as an example, the theory that in most cases of premature ejaculation the immediate cause is not performance anxiety but the man's failure to register erotic genital sensations. Therefore the treatment needs to be a method, which forces the patient to pay

attention to the rising erotic sensations, i.e. behavioral exercises centering on interrupted penile stimulation. Another example is vaginismus, which is caused by the involuntary, reflex spasm of the muscles around the introitus. Based on this, the treatment is a behavioral program centering on gradual, progressive stretching and dilatation of the circum-vaginal muscles by the woman herself (Kaplan, 1995, 2-3).

To explain elements involved in sexual motivation, Kaplan (1995, 17) makes reference to Kupferman (1991, 751), who states: “all examples of physiological motivational control seem to involve dual effects – inhibitory and excitatory – which function together to adjust the system”. Translated to normal sexual functioning, this means that there is a balance between the “erotic motor”, which incites desire to have sex, and the “sexual brakes” which keep libidinous urges in check. If the normal control mechanisms go awry the person will experience dysfunctional increase or decrease in sexual desire, explained by Kaplan as follows:

In other words, I am suggesting that hyperactive and hypoactive sexual desire disorders are the result of malfunctions or dysfunctions of the sex-regulating mechanism that ordinarily modulates our sexual desires and adjusts these to the opportunities and hazards of the environment (Kaplan, 1995, 19).

Kaplan uses this paradigm to demonstrate the similarity of sexual desire disorders to eating disorders, as both can be conceptualized as the result of the failure of important regulatory systems. In hyper-sexuality, as in obesity/bulimia, it is the lack of control over the respective functions, which causes failure, while in hypoactive sexual desire and anorexia nervosa, the dysfunctional regulation is in excessive over-control (Kaplan, 1995, 19).

Kaplan (1995) presents a psychosomatic model for dual control elements in the sexual motivation of sexual inciters and sexual suppressors originating in the hypothalamic and limbic sex regulating centers. These create sexual desire or avoidance respectively. She divides sexual inciters and sexual suppressors into physiological or psychological. Kaplan identified as examples of physiologic sexual inciters: testosterone, “aphrodisiac drugs”, and physical/genital stimulation. For psychological inciters she quoted – attractive partner, erotic stimulation, fantasy, love, and courtship. Examples of physiologic sexual suppressors include: certain hormone disorders, drugs with sexual side effects and depression. Among the psychological inhibitors she quoted: unattractive partner, negative thoughts, anti-fantasies, negative emotions, stress and anger (Kaplan, 1995, 17).

Hormones and Sex

The effects of hormones on human behavior are becoming clearer through ongoing research. The effect of androgen on gender and sexual behavior has already been extensively researched. The reciprocal effect of hormones and behavior has also been established.

The function of androgen on the developing fetus has been researched by John Money and others and described by Kaplan in *The New Sex Therapy* (1974) as follows:

If androgen is present at critical times of differentiation, the external genitalia and parts of the central nervous system mediating postnatal sexual (and gender specific) behavior become masculinized; if androgen is not present, or if its action is successfully blocked, the external genitalia as well as postnatal sexual behavior will be female (Kaplan, 1974, 48).

Through animal research it has been established that sexual behavior is mediated by the hypothalamus. Gender specific behaviors identified in the female include: maternal instincts, submissiveness and receptivity to the male. In the male, behaviors include mounting, the absence of maternal behavior, and greater aggressiveness. The study of these phenomena in humans has been limited to opportunities offered by circumstances. Such an opportunity was offered when, in the 1950's, whilst attempting to save threatened pregnancies; women were given various progestational compounds. When it became known that these compounds were chemically similar to testosterone and could be presumed to have a virilizing effect, studies were undertaken of the female children of those women who had received this treatment. Not surprisingly it was found that these girls were acting like "tomboys". They liked competitive sports, they disliked doll play and disdained frilly clothes and were more concerned with their future careers than with having babies. They also tended to have higher IQs. In comparison, girls diagnosed with Turner's syndrome i.e. the congenital absence of ovaries, thereby lacking any prenatal hormonal influence of their own, except to the extent that maternal hormones influence their development, exhibit normal "little girl" behavior. They are less energetic and competitive than boys and enjoy doll play and maternal rehearsal behavior (Kaplan, 1974, 49).

Of interest is that the girls whose brains had been "androgenized" in utero were not homosexual – and their gender identity was unambiguously female. It has been hypothesized, however, that boys who have had low level of fetal androgens may be predisposed to exhibit female-like behavior postnatally and that in interaction with the environment, this could be an important determinant of the "primary forms" of male

homosexuality. A low androgen-estrogen ratio, while sufficient to produce masculinization of the body, may not be sufficient to masculinize the fetal brain and thereby, it is postulated, to have been a contributing factor to “primary” homosexuality. The gentle and timid behavior in the boy may result in negative family interactions specifically with a disappointed father dismayed by female behavior in his son. Studies have shown that maternal stress during pregnancy can have demasculinizing effect on male offspring (Kaplan, 1974, 46-50).

The study of the effects of androgens – not only on sexual behavior but also on non-sexual behavior – has been actively pursued. It has been found that men with low testosterone levels lose their sexual interest and ability to have erections. Testosterone is also a prerequisite for libido in women and it has been reported that testosterone increases female libido. The importance of androgens in women’s sexual desire has only recently been recognized. Women deprived of sources of androgens through surgery, may lose all sexual desire, cease to have erotic dreams and fantasies and are unable to be stimulated by previously effective stimulation. When given testosterone for medicinal purposes, these women have been found to become assertive and highly charged in sexual arousal. They may even develop desire for sex independently of their relationship to their partner. A contra-indication for use of testosterone in treating women is its tendency to cause masculinization. Testosterone, which affects the brain to enhance erotic desire and motivation, also has an effect on the functioning of the genital organs. It may also affect territorial and dominance behavior, energy, appetite, metabolism and aggressive behavior. One study found that criminal behavior in adolescents might be related to high testosterone levels. Low androgen level in contrast appear to be related to reduction in

anger, aggression and energy and increase in responsiveness and sensitivity to odors, pain and touch as well as enhancing care taking activities (Kaplan, 1974, 50-52).

What Baron-Cohen (2003) has identified as “the extreme male brain” is currently being researched and has been described in *The Essential Difference: Men, Women and the Truth about Autism*. This will be further addressed in Chapter 7, page 86.

While sexually attractive opportunities, stimulation and activity tend to be associated with an increase of the blood testosterone level in men, depression, defeat and humiliation, the loss of a relationship and excessive stress are associated with dramatically lowered testosterone levels. In women it is known that stress and emotional crises may be associated with disturbances in the menstrual cycle. Effects of stress on female hormones are less understood (Kaplan, 1974, 53-54).

There is reason to make a point of understanding where in the menstrual cycle a woman finds herself when attending couple’s sex therapy, specifically as to its effect on her emotional state. Contradiction is found on the effects of estrogen and progesterone levels on the level of sexual interest in women. Kaplan describes the menstrual cycle as follows with regards to estrogen and progesterone:

The two hormones secreted by ovarian tissue – estrogen and progesterone – behave as follows:

The estrogens peak at the time of ovulation, and also show a secondary rise during the luteal phase of the cycle. They fall sharply at and during menstruation. Progesterone, secreted by the corpus luteum, increases at the time of ovulation, and also diminishes during menstruation.

Concurrently, the two pituitary hormones, which regulate the cycle, behave as follows:

LH is sharply elevated for a day or two at the time of ovulation.

FSH is relatively constant, being reported as somewhat lower during the luteal phase. (Kaplan, 1974, 53-54)

Kaplan (1974) reports that there have been many investigations of the fluctuations of emotional, medical, psychiatric and behavioral problems during the menstrual cycle. Studies indicate that the maximum disturbance and the highest incidence of violence, illness and accidents occur during eight consecutive days – four premenstrual and four menstrual with another small peak in disturbance at ovulation. The highest incidence of disturbance occurs during the phase of the menstrual period when the estrogen level is low and a small mid-cycle peak at the time of mid-cycle estrogen dip. It is postulated that endocrine factors are important determinants. Perimenstrual tension does not occur during non-ovulatory cycles, when no progesterone is produced, no corpus luteum having been formed. Severe perimenstrual tension syndrome or dysphoria is often helped by ovulation suppressive medication, such as the type used for contraception. A commonality of the women who suffer perimenstrual dysphoria is the great increase in anger or aggression, which some women seem able to tolerate and integrate. Others, however, cannot; some become disorganized; they behave self-destructively or have rage; they become ill, depressed, withdraw and are more likely to have “accidents”. But it also is an opportunity for some to express their feelings in a creative art form. (Kaplan, 1974, 53-57)

Attachment, Bonding and Commitment

Crenshaw, in *The Alchemy of Lust and Love* (1996) provides a vivid picture of how hormones may play a decisive part in how couples relate and how their relationships either grow or fall apart. She stresses the importance for couples to have some

understanding of the fluctuations in their hormones, and the relationship of these to mood and behavior. (Crenshaw, 1996)

Whilst those variations related both to women's menstrual cycle and men's aging are well recognized, diurnal fluctuations are attracting increasing attention.

For the purpose of examining sexual health, this presentation will focus on the neuropeptide oxytocin. This has been described dramatically by Crenshaw (1996):

Touch alters the chemical composition of your body. When you caress someone, or they stroke your skin, when you hug or cuddle or hold hands, a chain reaction takes place that signals your brain. "This is good. Pleasurable. It soothes me. I want more." The more you touch, the more you want to touch. And the more you touch the same person, the stronger the bond between you grows. The more you want to be together. Touching is, in a very real sense, addictive (Crenshaw, 1996, 91).

The health benefits of touch are only starting to be appreciated, while the consequences of touch deprivation have been known for a long time. Spitz in the 1930's, during his study of orphans, discovered that babies failed to thrive and sometimes died for lack of touch, or became physically or mentally retarded. Older people may die or become senile faster if not touched. Without touch the individual may develop depression, stress, anxiety, aggression or crisis. (Crenshaw, 1996, 92)

Through animal research it is known that oxytocin increases sensitivity to touch and "encourages mating, grooming, and cuddling" in both sexes. It intensifies the female lordosis (sexual presenting) and affects the body's response to pheromones. Oxytocin also has a role in a woman's orgasm, possibly also in the orgasm of the male (97).

Oxytocin plays an important role, apart from that in coitus, in the birth process and breast-feeding as reported by Newton (1978; 1989), who studied oxytocin for over thirty years. Oxytocin causes uterine contractions in labor, facilitating the birth process.

The vaginal stretching in the course of vaginal delivery releases oxytocin, which is thought to produce pain-relieving, euphoric, endorphin-like effects, and is considered to act as a trigger for uterine contractions. Oxytocin also plays a part in the uterine contractions experienced in orgasm. An oxytocin-like substance has been used to induce labor. Stimulation of the nipples also releases oxytocin, creating the milk letdown reflex in the nursing mother, the euphoric effect contributing to the bond between mother and child. (Crenshaw, 1996, 98)

CHAPTER 5

BIO-PSYCHOSEXUAL DEVELOPMENT: PSYCHOLOGICAL RESPONSE

In this chapter an overview will be given of the basics of bio-psychosexual development. This will address the child's basic developmental needs and how they are met – or are not met. The maturational process prepares the individual for compatible relationships – or may establish barriers for successful social and sexual functioning. It is to be noted that in real life optimal conditions for such relationships are rare and may present themselves but occasionally, while daily experiences may remain uneventful and mundane.

It is the form of attachment to parents or primary caretakers, which is paramount in subsequent relationship building. Studies have shown that many infants develop attachments to parents based on feelings of anxiety and insecurity rather than on feelings of basic trust and a sense of security (Firestone and Catlett, 2001, 64-65).

With the advent of brief sextherapy, psychoanalysis is no longer accepted as the modality of choice for treating sexual dysfunction. However, recognition of Freud's ground-breaking findings, on the importance of sexuality in the infant's maturation to adulthood, is imperative. It is the basis for understanding both normal development and psychopathology, specifically for the understanding of resistance and transference. Kaplan recognizes that "the new sexual experiences and ways of relating which are entailed in the process of sex therapy often mobilize considerable anxiety and defenses" and that "the resolution of such resistances is the *sine qua non* of successful sex therapy" (Kaplan, 1974, 144).

Freud and the Sexual Drive Theory

Freud made an essential contribution to our understanding in that he focused attention on the importance of childhood sexuality at a time when this met with considerable objection. Today it is generally accepted that sexuality plays an important role in human development and in many dysfunctions. Freud postulated that the child goes through three stages of psychosexual development, i.e. oral (birth to 18 months), anal (18 months to four years) and genital or phallic (age four to six). In the oral stage the erotogenic zone is the mouth and pleasure comes from sucking. Sublimation or repression of oral eroticism was thought to result in character traits, such as generosity and dependency, and neurotic traits such as depression or “deviant” oral sexual practices. Disturbances during the anal stage of development were said to result in obsessive-compulsive, parsimonious and controlling, neurotic personality manifestations as well as other forms of sexual deviations. The successful resolution of the oedipal stage of development (phallic or genital) is the cornerstone of Freudian theory. The crucial feature of this phase is the child’s choice of opposite sex parent as the object of his/her erotic aims, causing frustration, guilt, anxiety and conflict in the child’s relationship with the parent of the same gender. Healthy resolution of this conflict depends on the child’s identification with the same sex parent together with repression and sublimation of incestuous wishes. According to Freudian theory, unresolved oedipal conflict constitutes the specific and sole cause for sexual pathology (Freud, 1938; Kaplan, 1974, 140).

Kaplan, in her critique of Freudian theory, points out that sexual dysfunction often occurs in persons who show no evidence of oedipal problems while in other cases, although oedipal problems do appear and contribute to the dysfunction, these can be

bypassed and the conflict resolved in brief therapy - without resolution of unconscious issues. Kaplan states: "When children are actually observed, it appears that the sex drive indeed makes an early appearance. However, it is the genitals not the mouth or anus, which seems to be endowed with sexual sensations and pleasure from birth on" (Kaplan, 1974, 144).

Object Relations and Self-psychology

Development of psychoanalytic theory has continued with the object relations and self-psychology theoreticians, some building on Freud's drive theory and others focusing on object relationships as the basis for the child's psychological development. Greenberg and Mitchell (1983) present an overview of this endeavor in *Object Relations in Psychoanalytic Theory* (Greenberg and Mitchell, 1983, vii-ix). This review will include the following theoreticians: Sullivan, Fromm, Klein, Fairbairn, Winnicott, Mahler, Kohut and Bowlby.

For Freud, the benchmark of successful development is the ability to establish consistent relationships with whole objects, which, according to the drive/structure model, are dependent on the integration of childhood sexual impulses into a single drive of genital sexuality. Freud stressed the polarity between active and passive sexual aims and claimed that the tension between these paves the way for the child's detachment from his early dependency, which leads to the surmounting of the oedipal ties and overcoming of incestuous fixations, thereby facilitating later independent functioning. Only by abandoning these fixations can the child find in the outside world appropriate sexual

objects (Freud, 1910b, 1912a, 1918a). The movement from passivity to activity - together with the movement from embeddedness with oedipal objects – provides the release from dependency into autonomy (Greenberg and Mitchell, 1983, 49).

According to Sullivan (1953) persons are motivated by “needs for satisfaction and needs for security”. Balancing between these are the determinants for emotional health versus constrictive pathology in day-to-day living. The satisfaction of the infant’s needs requires another person. The activity of the infant induces tenderness in the mother and an active response in order to relieve the infant’s needs. Sullivan called this the “tenderness theorem” to explain the manner in which the infant’s expression of needs induces the integration of an interaction with the mother leading to mutual satisfaction of that need (Sullivan, 1953, 39).

According to Greenburg & Mitchell (1983) Sullivan describes the child’s development as follows: the child (age one to four) seeks participation of adults as an “audience” for his play and efforts; the juvenile (four to eight) seeks competition, cooperation, and compromise with other juveniles. The preadolescent (eight to puberty) seeks an intimate, collaborative, and loving relationship with someone of the same sex, the “chum”, and the late adolescent (post puberty) seeks an intimate, collaborative, loving and sexual relationship with someone of the opposite sex. The failure to satisfy these needs results in loneliness. Fear, caused either by violent disturbances in perception or by threats to biological integrity - such as hunger or pain - may interfere with smooth development. The child may also pick up anxiety from those around him, a process Sullivan calls “empathic linkage” (Greenberg and Mitchell, 1983, 92-93).

Healthy development, according to Fromm, is predicated upon coming to terms with the loss of the “primary ties” of infancy as a necessary condition for developing the ability to establish intimacy with others based on differentiation and mutuality. For the neurotic, differentiation means being alone, and therefore recognition of the loss is avoided at all costs. Neurosis is the perpetuation of the illusion of embeddedness or merger with others. Fromm makes a distinction between progressive and regressive relatedness with others (Greenberg and Mitchell, 1983, 111).

Fromm is critical of Freud’s work, arguing that Freud took the content of the blatant hypocrisies of the Victorian era, which involved sexuality and aggression, and extrapolated a universal and unidimensional motivational theory out of them. Nevertheless, he was strongly influenced by Freud (Greenberg and Mitchell, 1983, 107).

According to Fromm, before birth the human organism is at one with nature, embedded within the maternal environment. Through birth he is expelled from paradisaical harmony into a world in which he is fundamentally alone. Therefore the individual needs to reestablish his attachment and involvement with others, which had been experienced in his mother’s body which had provided him with full-time nurturing care. The individual has to make a choice between two alternatives. One is a progressive, rational and individuated response, in which his separateness is acknowledged and accepted and relations with others proceed on the basis of intimate yet differentiated involvements. The other is a response, entailing denial of the reality of one’s separateness and of individual responsibility for fashioning one’s life, relying on illusion and fantasy to avoid the actuality of separateness in order to support “the pretense of blissful security” (Greenberg and Mitchell, 1983, 108).

Interpreting the underlying psychodynamics in relational terms, Fromm draws on Freud's description of character as follows: The oral personality becomes the receptive personality; the anal-sadistic becomes the exploitative personality; and the anal-retentive becomes the hoarding personality. For Fromm, the key issue is the mode of relatedness rather than the underlying component drive. For the oral personality, magical properties are attributed to something outside of the self, i.e. food, love, sex, ideas etc. The motivational core is the position vis-à-vis others in which magic is always on the outside, temporarily ingested but never owned and consolidated. What Freud attributed to biologically determined drive organization, Fromm ascribes to relational configurations, "an attitude toward the world in the language of the body" (Fromm 1941, 320; Greenberg and Mitchell, 1983, 110).

In her writings, Klein, a member of the British Object Relations School, caused controversy, in both the British and the international analytic community (Greenberg and Mitchell, 1983, 120). However she is now acknowledged for her many important theoretical and clinical innovations. She was a key figure in the shift in emphasis to the study of the earliest relationship between infant and mother; the discovery of early introjects and identification; appreciation of phantasy and her development of the concepts of internal objects with her definition of the internal object world. She has contributed greatly to the understanding of psychotic, neurotic, and normal mental functioning with her formulations concerning primitive persecutory anxieties, early defenses dominated by splitting - and with depressive anxiety and its repair (Greenberg and Mitchell, 1983, 145).

The conceptualization of the motivational system in Klein's theory developed through three phases. In the first phase, the pursuit of sexual pleasure and knowledge is the central focus. The attempt to master persecutory anxiety, gain reassurance against the dangers of destruction and retaliation becomes the central focus in the second phase. The transition from the drive/structure model to the relational/structure model, anxiety about the fate of the object, attempts to restore it; to make it whole again through love is the focus of the third phase (Greenberg and Mitchell, 1983, 126).

In Klein's own words

The attempts to save the love object, to repair and restore it, attempts which in the state of depression are coupled with despair, since the ego doubts its capacity to achieve this restoration, are determining factors for all sublimations and the whole of the ego-development (Klein, 1935, 290).

Fairbairn, also from the British School, suggests that the infant is oriented toward others from the beginning and for biological survival he is relation-seeking. For Fairbairn the erogenous zones provide modes for relatedness to others, providing pathways to the object. The mouth for the infant becomes a salient zone and the first object for the infant is the mother's breast for the purpose of emotional and biological survival and development. Fairbairn suggests that the libido chooses the zones of "least resistance" (Greenberg and Mitchell, 1983, 157). For healthy maturity, rich and intimate mutuality with another is a crucial aspect. This theorist sees this capacity for intimacy to be primary and sees the genitalia as a channel to this relationship. In Fairbairn's words "It is not the libidinal attitude which determines the object-relationship, but the object relationship which determines the libidinal attitude" (Fairbairn, 1941, 34; Greenberg and Mitchell, 1983, 157). When relationships with real objects are unsatisfying, the child

establishes internal objects, which act as substitutes. For Fairbairn, while psychology is the “study of the relationships of the individual to his objects,” psychopathology is the study of the relationships of the ego to its internalized objects (Fairbairn, 1943, 60).

Aggression according to this theorist is not a natural motivational factor but a reaction to the frustration of the primary aim towards a relationship (Greenberg and Mitchell, 1983, 159). Human emotional development in this theory is seen to traverse several stages. Maturation refers to differing modes of relations with others, not as maturation of bodily zones. Fairbairn identifies three broad phases: the earliest period of infantile dependence; a transitional phase; and a state of maturity, which he terms “mature dependence.” He views normal development as a gradual process through which an infantile, dependent manner of relations to others is replaced by a capacity for adult maturity. It is noteworthy that he formulated these ideas during the dark days of World War II. (Fairbairn, 1941, 34; Greenberg and Mitchell, 1983, 160).

The transitional phase entails a renunciation of compulsive attachments to objects based on primary identification and merger in favor of relationships based on differentiation and exchange. The child also has to renounce his intense attachments to his compensatory internal objects, which have served to provide security and continuity. This was missing in the reality of the relationship with his parents (Greenberg and Mitchell, 1983, 161).

According to Fairbairn the child has three different experiences of his mother and subsequently also of his father: gratifying mother; enticing mother; and depriving mother. When the relationship to the mother becomes unsatisfying it gets internalized into three internal objects: the ideal object (the gratifying aspects of the mother); the exciting object

(the promising and enticing aspects of the mother); and the rejecting object. The “exciting object” becomes the “libidinal ego” and the “rejecting object” becomes the “anti-libidinal object”. The remaining ego, “the central ego”, is available for relations in the real world. The anti-libidinal ego, which is identified with the aspects of the mother experienced as depriving and withholding, is the part of the ego that becomes the repository for all the hatred and destructiveness and comes from the frustrated libidinal longings. Much of the rage is directed towards the exciting object – the promises and enticements of the mother, and is the enemy of hope and may be the basis for negative transference in the psychoanalytic situation (Greenberg and Mitchell, 1983, 166).

According to Greenberg and Mitchell, for Mahler the central concept is the process of “separation-individuation”, later followed by the “psychological birth”. The essential struggles of childhood for Mahler are related to the gradual emergence from symbiotic fusion with the mother into independent selfhood. In her theory the child must continually reconcile his longing for independence, autonomous existence, with an equally powerful urge to surrender and reimmerse himself in the enveloping fusion from which he has come. The developmental process, as described by Mahler, has six phases. The first phase is (1) *the normal autistic phase*, which falls in the first several weeks; followed by (2) *the normal symbiotic phase* starting at three to four weeks, in which the infant shows increased sensitivity to external stimulation. The third phase is (3) *the differentiation sub phase* from four or five months until ten months, the first of the phases of separation-individuation, during which the infant appears for the first time to be more or less permanently alert when awake. The following phase is (4) *the practicing sub phase*, in which the child develops capacity to move some distance from mother, who

continues to be important for “emotional refueling”, resulting in a specific bond between the child and mother and a dramatic growth in the autonomous functions of the ego. In (5) *the rapprochement sub phase*, which lasts from about eighteen to twenty-four months the child starts the use of language for sharing new discoveries with the mother.

He experiences “rapprochement crises”, in which the child has to learn to cope with the conflict between need for help from outside and simultaneously, in the service of his consolidating separateness and individuation, needs to deny that it actually comes from another person. This leads to behaviors of intense neediness and clinging to the mother with equally intense negativity and, in Mahler’s words, “battling her”. Successful resolution of the rapprochement crisis is a central requirement for the avoidance of subsequent psychopathology. During the third year of life the child develops (6) *libidinal object constancy*. The major tasks to be accomplished are attaining of a sense of his individuality as well as a sense of the other – i.e. the mother - as an internal, positively cathected, projected presence (Greenberg and Mitchell, 1983, 274-278).

There is a neutralizing process, which comes about through the mother’s love and acceptance of the toddler and of his ambivalence. This enables the toddler to cathect his self-representation with neutralized energy (Greenberg and Mitchell, 1983, 291-292).

Another crucial phase of identity formation in Mahler’s theory is the resolution of bisexual identity. Three conditions are necessary for this to evolve successfully: adequate integration of pregenital phases; successful identification with the same sex parent; and the child’s ego must be able to organize memories, ideas and feelings about the self into a hierarchically stratified, firmly cathected organization of self-representations (Mahler, 1958a, 1958b). The parental reaction to the child’s gender and

sexuality is an important attribute in this development (Greenberg and Mitchell, 1983, 300-301).

The work of Kohut has specific importance to this examination, as he has focused specifically on the disorders of the self. Kohut identifies chronic failure of the parents to respond empathically and serve as empathic self-objects for the child, because of their own narcissistic disorders, as contributing to the child's drive-fixations, which may result in obsessions with food, anality, or oedipal sexuality. If the parents cannot respond empathically to the child's emerging self, the child's original search for self objects breaks down into sexual and aggressive concerns corresponding to the parents' pathological preoccupations. Kohut sees traumatic events and parental seduction as destructive because they reflect a chronic lack of empathy for the child in the parent (Kohut, 1977; Greenberg and Mitchell, 1983, 355-56).

For Winnicott the emergence of a healthy, creative self is contingent upon the environmental provisions of "good-enough-mothering". When the mother is able to anticipate the child's needs with precise timing on a consistent basis, the child becomes attuned to his own bodily functions and impulses. A failure of mother's attunement results in the development of a split between "a true self" and a "false self" and the child becomes compulsively attuned to the claims of others (Winnicott, 1958; Greenberg and Mitchell, 1983, 192-93).

Bowlby developed his theory of attachment outside the range of psychoanalysis and instead looked to biology and presented a "new type of instinct theory" (Bowlby 1969, 17). According to Bowlby "instinctive behavior" in man developed for survival. He was mostly focused on the behaviors constituting the child's "attachment" to the

mother. He saw attachment as mediated by five component instinctive responses: sucking, smiling, clinging, crying, and proximity maintaining behavior (Bowlby 1969, 180). Attachment behavior is part of an “archaic heritage” whose function is species survival. In contrast to other theorists Bowlby claims that the mother is important from the start and not only because she gratifies the child’s needs. Bowlby claimed that the young child reacts to the loss of the mother with true mourning. He claimed that all areas of classic theory needed reconsideration based on the concept of attachment. He wrote that all anxiety - phobic and otherwise- is related to separation from the mothering figure; dependency is understood in terms of anxious attachment; anger is a response to separation (1973); the core of all defenses is a deactivation of the need for attachment (1980). Bowlby stated that emotional struggles derive from attachment disturbances - “Whether a child or adult is in a state of security, anxiety, or distress is determined in large part by the accessibility and responsiveness of his principal attachment figure”. (1973, 23) Emotional health relies on the confidence that the attachment figure is available. Anticipation that attachment figures will be available builds up slowly throughout childhood, adolescence and is generally stable in later life. These expectations are reflective of actual experiences with parents (Greenberg and Mitchell, 1983, 184-87).

This presentation of object-relations theory has been included at some length to demonstrate how early experiences, when favorable, may resonate in couple’s attunement in their sexual relationship and contribute to mutuality and compatibility, and, when unfavorable, may result in lack of attunement.

CHAPTER 6

THE HUMAN SEXUAL RESPONSE: THE RELATIONSHIP PERSPECTIVE

Masters and Johnson (1964) uncovered the natural physiological sexual response to physical stimulation and created their clinical interventions based on this knowledge. They emphasized the notion of reducing immediate anxiety with the expectation that the natural sexual function of the body would “push” toward pleasurable sex (Charlton, Yalom, 1997, 47). Kaplan (1995) added to their model the concept of sexual desire proposing: “if there is no interest the rest of the cycle never happens” (Charlton, Yalom, 1997, 50). Primary focus in treatment, according to Masters and Johnson (1970), was reduction of performance anxiety and, according to Kaplan (1995), eliminating anti-fantasy and counter sexuality thoughts and attitudes.

“The Sexual Crucible”

Marital/sex therapist David Schnarch has developed an additional model presented in *Constructing the Sexual Crucible* (Schnarch, 1991). This model builds on previous sex therapy models as well as other psychological models and adds the dimension of relational elements of sexuality. It places the sexual relationship in a larger context of human relationships and personal history and focuses on the human capacity to assign complex meanings to the sexual encounter. Therapy in this model focuses on the process and meaning of the sexual experience. Passion and intimacy are seen as the “mainstays of meaningful sex” and seen as interrelated experiences. The essence of this model is the capacity to withstand anxiety. Allowing oneself to feel sexual passion and

to present one's sexual self, one's needs and desires together with the recognition of potential for rejection in the relationship, naturally cause anxiety. This requires of the partners the capacity to be both separate and related at the same time (Schnarch, 1991; Charlton, Yalom, 1997, 53).

This model focuses on the internal experiences of the sexual partners and incorporates exploration of areas traditionally addressed in psychoanalysis, psychodynamic therapy and marital therapy, integrating insights from medical, psychiatric, psychological and marital and family systems theories. Among the advantages of this model compared to prior models are: it allows for a more complete assessment of sexual function and dysfunction; it allows for sex therapy to be integrated with existing models of intrapsychic and dyadic processes; and it allows for interventions along physical, psychological and relational dimensions. This model also can assess the "psychological readiness" of the partners to engage in sexual exercises including sensate focus, which require intimate expression. Furthermore it encourages the clinician to think in multiple ways about a given disorder; it is a dyadic model and hence relieves the individuals from sole ownership of the sexual problem. It recognizes the disorder as intermittent and related to fluctuations in physical stimulation, the psychological processes of the receiver and changes in threshold for sexual stimulation (Charlton, Yalom, 1997, 54-55).

Nonsexual Marriage

McCarthy (1977) addresses the concept of “nonsexual marriage”. McCarthy reports that – adopting an arbitrary criterion of having sexual intercourse less than 10 times a year – 20 percent of married couples have a nonsexual relationship, which he identifies as a major mental health problem which poses a threat to marital satisfaction and viability. He identifies the prime functions of marital sexuality as shared pleasure, a way to deepen and reinforce intimacy, and a tension reducer to deal with the hassles of life and marriage. McCarthy suggests that – although not a prime factor – when sexuality functions well, it constitutes 15-20 percent of the positive integers of marriage. On the other hand when sexuality is dysfunctional or nonexistent it constitutes 50-70 percent of the negatives, draining the marriage of intimacy and good feelings. The cause of what McCarthy calls Inhibited Sexual Desire (ISD) is that the couple has become trapped in a cycle of anticipatory anxiety, failed performance and sexual avoidance and – unless addressed – this can become a chronic problem (231). McCarthy reports that one in three women and one in seven men reports ISD and – on occasion – half of all married couples may experience ISD or a desire discrepancy (232). McCarthy suggests that ISD needs to be treated as a couple’s rather than an individual issue and the prescription for change is personal responsibility for one’s sexuality, rebuilding intimacy, reintroducing non-demand pleasuring and adding erotic stimulation. McCarthy recommends cognitive-behavioral therapy together with sexual exercises. McCarthy stresses that while society idealizes romantic, spontaneous, intense non-verbal sexual passion – this is non-existent when ISD has become a chronic problem. The antidote is “intentional planned sexual

dates”, which will be introduced to the couple. The goal is to recognize the core concepts of sexual desire which are identified as (a) anticipation and freedom, (b) owning sexuality, (c) deserving sexual pleasure, (d) enjoying arousing, orgasmic sex, and (e) valuing intimate sexuality (235). McCarthy emphasizes that this entails more than “functional sex and orgasm”. The couple will need to learn to increase sexual comfort, pleasure and being an intimate team (236). Further it is important for the couple to accept that desire and satisfaction are more important than, not synonymous with, arousal and orgasm – quality is more important than quantity. When the couple break the cycle of nonsexual marriage this will result in pride and satisfaction. However the author cautions – as Kaplan also had identified – the importance of maintaining a regular rhythm for intimacy whatever its frequency (239). The following quote summarizes succinctly the challenges to the couple:

You are responsible for your sexuality. It is not the spouse’s job to make you desirous or turn you on. An important element is accepting your sexual history, including negative and traumatic experiences. Negative sexual experiences are an almost universal phenomena for both women and men. It is normal to have negative sexual experiences, whether as a child, adolescent or adult. In building a sexually satisfying marriage, it is important to accept traumatic experiences, share them with your spouse, and integrate them into your sexual self-esteem as a survivor. A non sexual marriage exacerbates the impact of past sexual trauma. Feeling controlled by guilt or shame cheats you from feeling accepted as a sexual person. The couple who are “partners in healing” feel pride and satisfaction. In an intimate marriage, your sexual feelings, preferences and desires count. You deserve to experience sexuality as a healthy marital resource (235- 236)

The Concept of Love

Levine (1995) suggests that sex therapists need to pay more attention to “love matters” and “not just desire, arousal and orgasm difficulties”. He recommends that therapists should attend to the diagnosis of – and therapy for – the fears, incapacities, and

skill deficiencies for love matters (190). Like McCarthy above he recognizes that sexual health in long-term relationships requires skills which the individual does not necessarily possess when entering a relationship. He states that “the best way to ensure sexual health is to remain vigilant to emotional health throughout life – beginning in childhood” (183). He also includes recognition that the homosexual couple face the same developmental challenges as the heterosexual couple, such as finding a life partner, learning how to enhance the partner’s comfort and maturation, learning when and when not to put the self second, developing a deepening love without personally creating chaos and despair, and privately neutralizing aggression toward the partner (187). Levine identifies how our past experience of “parental good-enough love” is a bridge to loving in the marital relationship and that the expectation to have deficiencies compensated and corrected in the marital relationship will interfere with marital and sexual adjustment. These ideas have also been developed by Firestone and Catlett (2001) as the “fantasy bond”.

It has been suggested that a way to overcome both physical and emotional barriers to the experience of a true connection with oneself and one’s partner – honoring the natural energy created in true sexual intimacy – has come from exploring the ancient Hindi tradition of Tantra (Richardson, 2003). The concept of tantric sex has become a guide to enhancing sexual fulfillment. Other influences such as Tao, Kabbala, Native American and even Christian mysticism have been described by Barratt (2002) who has conceptualized these as “esoteric sexuality”.

Juska (2003) describes the sexuality of the middle aged woman in an explicit personal documentation, which pulls the covers not only off the bed but also of the need to satisfy basic desire.

CHAPTER 7

MALE AND FEMALE: GENDER CONCERNS

From the earliest embryonic stage there are influences which may contribute to cast ambiguity on the gender of the individual. Embryological research, specifically that performed by John Money, MD of John Hopkins School of Medicine, have furthered our knowledge in this area. (Brechner, 1969, 198)

Physical Development

The basic gender is determined at fertilization and dependent on the presence or absence of the Y chromosome, in the XX or XY pair. Maleness depends of the presence of the Y chromosome. In its absence femaleness develops. At about the seventh week the XY pair effects the development of testicles, the XX pair produce ovaries. A variety of chromosomal abnormalities may effect the maleness or femaleness of the fetus and may result in gender ambiguity. During the second or third month of gestation the testes of the male fetus secrete substantial amounts of the male hormone androgens. It is the presence of androgens, which masculinize the rest of the fetal body. If androgens are not secreted in sufficient amount at the time, the fetus may develop as a girl (Brechner, 1969, 200-201).

There is a second flush of male hormones in the male at puberty – also in the female to a lesser degree - triggering the physical changes of adolescence. This is

another time when, if the system fails to work appropriately, the masculinization or feminization of both males and females may be affected (Brechner, 1969, 203).

Most individuals develop into either males or females and will be secure in their gender identity, developing a congruent gender role. However, there are exceptions.

Gender Ambiguity

Transsexuals experience themselves as trapped in the wrong body and have a persistent urge to have their sex changed to their “true” or “inner” gender (Brechner, 1969, 205). The cross dresser is basically a heterosexual, most often a man, who occasionally has an urge, to dress in female clothes. He may function in two different gender roles – in his basic identity as a heterosexual male and, when cross dressed as a female, attracted to a male or female (Larsson and Bergström-Walan, 1999, 147). In their article, “Multi-Sexuality, Crossdressing and the Multiplicity of Mind,” Larsson and Bergström-Walan, base their discussion on self-theory – manifestation of a second self or a “feminine self” in the cross dresser, and on the multiplicity of the mind, i.e. the experience of several selves (Larson and Bergström-Walan, 1999, 141). Homosexuals and bi-sexuals are those who are attracted to same sex partners or, in the case of bi-sexuals, partners of either gender. It is to be noted that most bisexuals tend to favor one gender while recognizing their attraction to the other (Handout from Compass, Inc., 2004). Apart from what is known about chromosomal and hormonal development, the etiology of these differences remains mainly unknown and under continuing research. It is important to recognize that, regardless of an individual’s orientation, the degree of masculinity and femininity, and any other personality characteristics and life style

choices, are distributed on a continuum in each individual in the same way as in any other individuals and are not specifically related to any specific orientation (Handout from Compass, Inc., 2004).

It is of interest to note that the United Kingdom has instituted The Gender Recognition Act 2004, which becomes Law April 2005. This will allow transsexuals to gain legal recognition of their acquired gender (Pershouse, 2004).

Gender Differences and Similarities

The debate on how to understand the basic differences and similarities in the way men and women behave, communicate and function intensified in the late twentieth century with the feminist and equal opportunity movements. Maccoby (1980) is one of those who studied development in young children. The areas reviewed included attachment behavior, gender awareness, effects of gender typing, choice of toys and activities in individual play. She reviewed cognitive and moral development and peer relationships. Maccoby and Jacklin (1974) made a study of 2000 books and articles on sex differences in children to ascertain how an earlier claim of differences and superior male skills in certain areas was justified. They concluded that there was no evidence that girls were more social than boys. They found that girls and boys are very similar in self-esteem throughout childhood and adolescence – but pick different areas in which they feel they have greatest self-confidence. Further more, their research demonstrated that both sexes perform equally well at simple, repetitive tasks – differences develop in adolescence when boys excel in mathematical abilities. Boys, they discovered, are not

more analytical than girls; girls' verbal abilities mature more rapidly than boys'; boys and girls are equally motivated to achieve but by different factors; girls are less aggressive than boys, a difference exhibited as early as age two, when social play begins. They also found that boys and girls are equally likely to be persuaded by others and to imitate the behavior of people around them; male and female infants respond alike to aspects of their environment that require hearing and sight (Masters, Johnson and Kolodny, 1988, 203-205).

An ongoing scrutiny of the Oedipus complex, as described by Freud, has led to the following observations of children before the age of the onset of the "phallic phase". Stoller (1968) has shown that by age 18 months both girls and boys have developed what he called a "core gender identity," largely a function of cognitive development, parental attitudes and gender labeling of the child. Other more recent studies (Kleeman, 1977; Kohlberg, 1996) have reported that boys, although strongly attached to their mothers, experienced themselves as boys; and that, girls, as early as one year of age, showed pleasure and pride in being girls (Jordan et al, 1999, 103).

The debate about what differences are basic and what are the results of cultural influences continues.

Extensive work has been done at the Stone Center, Wellesly College in Wellesly, Massachusetts, which claims to be the world's largest women's research center. Here, female researchers (Jordan et al, 1991) attempt to understand human development through the study of women, through the principals of female development. The authors have the ambition to move beyond developmental theory, which stresses separation at different stages of growth into closure of "identity" before adulthood. Instead, the

authors suggest a relational pathway as being primary and continuous in the lives of women (52). According to the authors, it has been established through research and clinical observation that most women have a greater ability for relatedness, emotional closeness, and emotional flexibility than do most men. The central organizing concept in women's relational experience is identified as capacity for empathy, first developed in the mother-daughter relationship, and the authors emphasizes the need for further study on the way empathy can be taught – and learnt – through the study of this relationship. The assumption is that the self is organized through practice in relationships, where the goal is the increasing development of mutually empathic relationships (Jordan et al 1991, 54).

The following is a quote from Gilder in *Men and Marriage* (1993) and chosen to demonstrate the different world of men – as conceptualized by Gilder based on a cross-cultural study by Ford and Beach – to that of women, as described in the Stone Center research.

Under most conditions, young men are subject to nearly unremitting sexual drives, involving their very identities as males. Unless they have an enduring relationship with a woman—a relationship that affords them sexual confidence—men will accept almost any convenient sexual offer. This drive arises early in their lives, and if it is not appeased by women it is slaked by masturbation and pornography. The existence of a semi-illegal, multibillion-dollar pornography market, almost entirely male-oriented, bespeaks the difference in sexual character between men and women. One can be sure that if women passionately wanted porn, it would be provided. Though sexual liberals have denied it so often as to thoroughly confuse each sex about the feelings of the other, the fact is that women lack the kind of importunate, undifferentiated lust that infects almost all men. (Gilder, 1993, 11)

This highlights the challenge men and women confront when negotiating their relationships. This is where the father's role in his son's life becomes

apparent and the mother's role in supporting the father is paramount. The goal is to develop a relationship with the son, in which he can learn what it means to be a man and to be introduced to the world of relationships under guidance and support (Elium, 1996, 21-25). The force at work is described by Elium as the powerful cycle of energy, fundamental to the make up of the man: a short buildup of tension followed by a quick, gratifying, and decisive release. He considers this cycle of energy as an atavistic remnant from the days of the hunter/gatherer (Elium, 1996, 17).

Gilder warns against women renouncing their role based on a more intelligent and controlled sexuality, which makes human communities possible. He points out that although women are physiologically capable of "greater orgasmic pleasure" than men – and therefore may seek intercourse, they are also more capable of abstaining from sex. In most societies it is the men who pay for sex with gifts or services to women. Single women's strengths can also be seen in their greater mental health as compared to that of single males. According to Gilder it is the woman who is superior in most sexual encounters. She is the one who sets the terms and conditions of the journey. She is the one to "impose the disciplines, make the choices and summon the male efforts to support it" (Gilder, 1993, 12).

Partner Choice

Love Maps

John Money first introduced the concept of “love maps” in the 1980’s (Money, 1983). Money states that “love maps” are not present at birth but develop and differentiate within the first few years of life. He describes the love map as a template, which develops through “special senses” and is an image of the idealized lover and his idealized romantic, erotic and sexualized relationship, first made up in dreams and fantasies and then maybe translated into action. The love map fantasy forms the basis for “sexuoerotic (*sic*) rehearsal play” in infancy and childhood and this is a prerequisite for healthy love map formation. For most individuals, when this plan is followed, the development is into a healthy heterosexual orientation (Money, 1993, xvi).

Money also explains how the concept of the love map can be used to understand sexual pathology. If rehearsal play does not take place because it is prevented or met with punishment or discipline, this may lead to pathology. The pathology, which is incurred in infancy, only manifests itself at puberty. Money identifies three different categories of pathology, i.e. “hypophilia (also referred to as sexual dysfunction), hyperphilia (erotomania), and paraphilia (legally known as perversion). He describes the process by which paraphilia develops as “a strategy for turning tragedy into triumph” as the paraphilia allows sexuoerotic (*sic*) arousal and genital performance and orgasm to take place, even if it is only when using fantasy of the special imagery of the paraphilia (Money, 1993, xvii).

Under normal circumstances rehearsal play starts during the first year of life when the infants discover the sensuousness of their genitalia. By the age of three or four

children may be seen in flirtatious rehearsal play with a parent or a child of the opposite sex. By the age of five, this may develop into girlfriend-boyfriend romance. At the age of eight the two partners may become pair bonded, which may be seen as rehearsal play but sometimes leads to a relationship through adolescence into adulthood (Money, 1993, 17).

According to Money boys and girls who experience opportunities to grow up with other children, both boys and girls of similar ages, with opportunity to rehearsal play, are more likely to be comfortable with themselves as male and female. When they reach adolescence they choose heterosexual relationships. In Money's language "they are well synchronized in the genitoerotic roles of male and female, reciprocally" (24-25).

Of interest is what Money has to say about the difference in response to varied stimulus. He suggests a hypothesis that the greater paraphilic vulnerability of the male may be based on his greater dependency on visual imagery for the arousal of erotic initiative as compared to females who experience predominantly tactual imagery. This can be observed in the greater interest among males of explicit erotic pictures, movies and videotapes while women are more interested in romantic tales of "yielding and being taken" (28-29).

Limerence

Limerence is a concept developed by Tennov (Tennov, 1979). Her study is based on interviews with college students and started when the students brought their stories about love relationships to her. Tennov found that there was a pattern in these stories and she identified the following characteristics of limerence as described by Morin (1995) in

The Erotic Mind: intrusive thinking about the limerent object; acute longing for reciprocation; dependency of mood of the limerent object; inability to act limerent to more than one person at a time; fear of rejection; intensification through adversity; an aching of the heart when uncertainty is strong; buoyancy (walking on air) when reciprocation seems evident; intensity of feelings that leaves other concerns in the background and a remarkable ability to emphasize what is admirable in the limerent object whilst avoiding the negatives (Tennov, 1979; Morin, 1995, 59).

Tennov's concept of limerence appears to have some similarity to Money's concept of love map (Money, 1993). One of the signs that indicate limerence is the sustained alertness and heightened awareness that is invested in the pursuit of the limerent object. She suggests that the limerent object is identified through body language and that the alertness may be triggered by the mixed messages the limerent object gives through his/ her body language (Tennov, 1979, 62). Also indicative is the subjectivity with which the limerent person interprets signals from the limerent object, i.e. basing interest solely on a glance from the person. (63) The limerent person indicates the feeling coming from the heart and the author suggests that this may explain the limerent's intrusive thoughts as a mutual feedback between the heart and the brain (64). Essential limerent strategies include: sending ambiguous messages; playing games; playacting and being coy.

The role of sex becomes confusing in limerence, in which awareness of physical attraction plays an important role (Tennov, 1979, 72-73). The author points out that the limerent fantasies are intrusive rather than voluntary (75). She states that limerence comes on at a certain stage of psychosexual development, around puberty or even earlier

– sometimes even when there is no limerent object available yet. The state of limerence may continue in some adults throughout life (106). Not surprisingly she found that while the limerents saw the state of limerence as something attractive and expressed a real need for this kind of connection, those who were non-limerent felt much more indifferent about such an experience. (107-108).

The sense of independence from the lover was found as an indicator for those who were non-limerent. Their affectional bonding emphasized compatibility of interests, mutual preferences in leisure activities, ability to work together and a degree of relative contentment – while the limerents reported continuous and unwanted intrusive thinking, intense need for exclusivity, reciprocal goals and speaking about ecstasy (Tennov, 1979, 130).

She also gives an interesting discussion of a relationship between a limerent person and a non-limerent person and the effects of this combination on their sexuality and length of relationship, indicating that, because of the condition of limerence, such a couple may hold on to the relationship longer because of the uncertainty and degree of hope which would permit the limerence in the other person to continue (Tennov, 1979, 135).

A broad spectrum of feelings is involved in the limerent relationship and depression and violence – as well as suicidal and homicidal ideation and, tragically, action – have been reported as part of this condition (Tennov 1979, 149).

Olfaction

Somewhat more esoteric is the findings of Insel and colleagues, as reported by Kaplan. Insel et al, in studying the release of oxytocin in monogamous mammals, in this case voles, on partner selection (Insel, 1992; Fakelman, 1993; Insel, Carter, & Shapiro, 1993). Their findings were that females are more likely to choose and attach themselves to a male who is secreting oxytocin than to one whose oxytocin release has been chemically blocked (Kaplan, 1995, 31).

Kaplan further discusses the role of olfaction in sexual functioning and partner choice and suggests that humans also secrete pheromones. She references Bieber (1974), who suggested that object choice is determined by the partner's odor. He also speculates that the oedipal phase attraction to the opposite sex may be related to the child's unconscious perception of his parent's sexual odors (Kaplan, 1974, 42).

Evidence has also been presented by Berliner (1993) (Kaplan 1995, 29) that the human nose may have the capacity to respond to a variety of odorless chemicals produced by the human skin. It has been reported that inhaling these pheromones has a tranquilizing and euphoric effect on mood, which Berliner suggests may play a part in human bonding. Kaplan further reports anecdotal evidence from her clinical practice indicating that patients have disclosed that their partner's aroma act as an attractant. This has lead Kaplan to speculate that smell may be an important element in human partner choice. Based on this premise Coco Chanel made her name world famous.

“The Sex Contract”

In the *Anatomy of Sex and Power*, Hutchinson (1990) writes about the changes in sexual relations in today’s society with a sense of hope and optimism. He sees the sexual revolution, the women’s movement and the antisex crusade as “preliminary tremors” indicating that a bigger change can be expected. He sees how sex is gradually being severed from its ancient contractual bond. He sees the possibility for men and women to relate in a new way with mutual respect, affection, and love. There is an opportunity to create a new order of society based on men and women as equals, sharers, partners and lovers. However he also recognizes the power of the old “sex contract” and the strong forces holding on to the age-old structure (Hutchinson, 1990, 331-332). See also Foucault’s statement about the ancient “sex contract” above on page 3.

Communication, Bias and Barriers

As a participant in a research project studying how friends talk to each other at different grade levels, Tannen was surprised to learn the differences that separated females from males at each grade level. Over the span of the grade levels there was a striking continuity and similarity with females on the one hand and with the males on the other (Tannen, 1990). The following are some of her observations: girls and women sit closer to each other and look at each other directly; boys and men sit at angles to each other and rarely look directly into each other’s face; girls and women “anchor” their gaze on each other’s faces, occasionally glancing away; boys and men “anchor” their gaze elsewhere in the room, occasionally glancing at each other. She found that

women and men tend to differ in physical alignment, and that in the verbal expression of personal problems, men tend to be more indirect (Tannen, 1990, 252).

When observers of different gender viewed tapes of activities of a group of boys and another group of girls, it was apparent that the reactions of the observers tended to be gender specific. The female observers felt warmly about the girls and were irritated by the boys while the male observers felt sympathetic to the energy of the boys and did not trust the girls' behavior. Again, not surprisingly, it appears that each identifies more benevolently with their own gender (Tannen, 1990, 254). It has also been documented that boys show greater physical activity and aggressiveness, tend to have parallel play and take opposite stances, while girls elaborate on one another's ideas in a mutually positive way. The girls kept connected to one another by calling out what they were doing and responding to one another's comments (Tannen, 1990, 256).

As mentioned above, according to Tannen, it has been observed that men do not look directly at the person they are talking to, while women do. Therefore when a man is asked to look at the speaker or his partner, he is asked to do something he is not comfortable with. For the man, looking directly at another man may seem aggressive or – at women, sexual. For women not looking at the other person may be seen as avoidance, while for men it is a way to create a friendly connection. This difference for the most part is not obvious to the participants and it is easy to see how misunderstandings take place. The author suggests that, with this knowledge, we might choose to recognize that males and females use different means for involvement (Tannen, 1990, 268-269).

In conversation with their group of same sex peers, girls are found to work hard to create community, connection and bonding. They talk about their concerns – while boys work hard to show their independence. Looking at the content of their interaction, however, it becomes clear that the girls' communication shows a lack of alignment, while there is symmetry in the communication among boys. Women frequently find that in trying to talk to their male partners honestly, it appears that they speak different languages. The author calls this phenomenon speaking “different genderlects” (Tannen, 1990, 278-279).

The asymmetrical alignment can be understood from the tendency to create masculinity and femininity in our behaviors to one another, believing that we are acting naturally. Tannen quotes Goffman who states that gender relations are patterned after parent-child relationships:

....men are to women as adults are to children, loving protectors who will hold open doors, offer the first portion of sweets, reach high shelves, and lift heavy loads (Tannen, 1990, 287).

So what does this mean to women? Goffman finds that, like children, women can easily be interrupted; their time and territory are expandable. There is a loss of rights with perhaps the tendency to be treated as a lesser person, while the protector is considered competent, capable and deserving of respect (Tannen, 1990, 287).

Tannen cites the finding of Blumstein and Schwartz in their study *American Couples* (1983) that things have different meaning to men and women. They give the example of money for men meaning power, while for women money equaled security. The authors noted that lesbians may use money to avoid being dependent while a gay male may feel more successful if his partner earns less than he does (Tannen, 1990, 292).

There is an expectation of boys to appear skillful and knowledgeable and this can become a burden for some. For the girl it is important not to appear better than the other and this may interfere with her achievement of status (Tannen, 1990, 293).

The author suggests that men and women could learn from one another; for women to learn from men to accept some conflict and difference without feeling it as a threat to intimacy; and for men to learn from women to accept interdependence without seeing it as a threat (Tannen, 1990, 294).

Autism and Other Emotional Disorders

A condition, which creates serious problems in communication between men and women, is the presence of a disorder such as autism or Asperger's Disease. In an article entitled "We need science to study our minds", Mark Henderson, *The Times* (London, UK, May 15, 2004) reports on the symposium, "Literature, Science and Human Nature" at the University of Surrey, England. He references a recent book by Simon Baron-Cohen, of Cambridge University, England. In *The Essential Difference: Men, Women and the Truth about Autism* (Baron-Cohen, 2003), the author theorizes that there are two distinctly different types of human mind with regards functioning; one appropriate to the building and understanding of systems, the other more suited to empathizing and communicating. The former, he states, is found more frequently in males, the latter in females. Understandably, this research was met with accusations of stereotyping and sexual bias and it is mentioned that the researcher delayed publication with this consideration in mind. Sufferers of autism and Asperger's are exceptionally poor at empathizing while many are even brilliant with technical skills and systems. The author

cites findings that these conditions are more common in infants who have been identified as having high prenatal inter-uterine testosterone levels. Furthermore, the author is quoted to have found that autism and Asperger's are thirteen times more common in males than females. He hypothesizes that this could be the result of "the extreme male brain". Research into the connections is in progress.

Firestone and Catlett in their work with couples relationships have identified the concept of "fantasy bond" (Firestone and Catlett, 2001), a pathological expression frequently leading to inability to communicate effectively and resulting in discord in the couple's relationship.

Needless to say the presence of any emotional disorder such as depression, anxiety and, specifically, experience of abuse and trauma may well manifest itself in miscommunication, defensiveness, anger and misunderstanding. Courtois (1988), Briere (1989), Lew (1990) and Salter (1995) have described extensively the effects of abuse and trauma on communication, capacity for intimacy and relationships as well as sexual functioning. Co-morbidity with other disorders, such as compulsivity, addictive behavior and eating disorders, is also recognized as prevalent in this group.

It is obvious that knowledge, acceptance and recognition of not only differences between expressions by men and women but also barriers to communication, such as depression and anxiety, will be of utmost importance for the effective relating between partners. This knowledge stretches beyond active listening and paraphrasing and the learning of communication skills. According to Gottman, learning listening skills, which is frequently used in couples' therapy, has proved to have little effect on outcomes. (Gottman, 2000).

CHAPTER 8

SEX THERAPY AND RECOGNITION OF BARRIERS: CO-MORBIDITY OF SEXUAL DYSFUNCTION WITH EMOTIONAL, PHYSICAL AND MARITAL PROBLEMS

One of the challenges in treating sexual disorders and providing sex therapy for couples is the co-morbidity of – on the one hand – emotional and physical disorders and – on the other – sexual dysfunction and marital discord. The challenge is to ascertain which disorder is primary and which is secondary.

Assessment and Treatment

In their structured, intensive treatment program, Masters and Johnson (1970) used a comprehensive sex history structured to develop a chronologic framework of life-cycle influences. This assessment also reflected sexually oriented attitudes and feelings, expectations and experiences, environmental changes and practices. Furthermore, history taking was expected to define the character, etiological background, symptom onset, severity and duration, and psychosocial effect of the presenting sexual dysfunction. Emphasis was put on the knowledge of the basic personalities of the marital partners, desirable changes, and personal resources. In addition their health, their motivation and expectations of therapy were assessed. In addition they emphasized the importance of knowing the sexual value system of the couple. (Masters and Johnson, 1970, 24-25).

The importance of differentiating between pathology, lack of sexual knowledge and unrealistic expectations in regard to sexual function was stressed (27). They warned against professional assumptions of existent psychopathology and also against

communicating prejudice to a patient already fearful of revealing unacceptable facets of his or her sexual character (28).

It is to be noted that Masters and Johnson followed a strict protocol using co-therapists, one of each gender, and the first session focused on a comprehensive history taking of all aspects of psycho-social-sexual functioning over the life cycle (32-33). This was followed by a second interview, now with the male therapist interviewing the women and vice versa (53). The couple was instructed to devote fourteen days to the treatment and put aside all other engagements. A comprehensive physical exam was performed on the third day followed by a round table discussion with the co-therapists and the couple (56-60). This discussion was used to summarize the information received and to start education of the couple on important knowledge needed to understand the sexual relationship as perceived by each partner. “Spectatoring” (mentally observing his/her sexual response, or lack of response, trying to will a sexual response, removing sexual functioning from its natural context) is a specific concept introduced early in treatment, as this was identified as one common reason for lack of full participation in the sexual act leading to “performance anxiety” and possible dysfunction (65). Masters and Johnson stressed the importance to the understanding of the human sexual response in recognizing the influence of, on the one hand, the biophysical and, on the other, the psychosocial system and seeing dysfunction as failure of one or both systems (66).

Following this comprehensive assessment the couple was instructed to start the sensate focus exercises, which were the basis for treatment. These consist of a gradual introduction to non demand touching, experience of being touched and touching one’s partner first in a solely sensual way with no demands other than the experience of

pleasure. Prohibition to touch eretical zones in the first part of the exercise is an important step to eliminate any sense of pressure. Under the authority and instruction of the co-therapists the couple graduates to erotic touch and coitus when ready (Masters and Johnson, 1970, 72-73).

Touch was chosen to provide the sensory experience appropriately available for married partners as a medium for physical exchange in reconstitution of natural responsivity to sexual stimuli (Masters and Johnson, 1970, 76).

Through the thorough intake criteria and referral process as well as in-depth interviewing, Masters and Johnson came to treat motivated couples, who were selected only when other psychopathology was ruled out. This may explain their very good outcomes with brief intensive treatment, which hence have been difficult for followers to replicate. However, this does not detract from the revolutionary change in sex therapy and also for therapy in general resulting from their behavioral approach.

While keeping the objective to make the treatment brief and problem focused, Kaplan, who had a background in psychiatry and psychoanalytically oriented therapy, proceeded to develop a different protocol for treatment. Kaplan stresses the importance of using the “sexual status examination” (Kaplan, 1995, 94) as a diagnostic tool for establishing the depth of sexual functioning in a couple. The purpose of the sexual status exam can be compared with that of the comprehensive medical exam. It provides a full mental picture of the couples’ current sexual experience, including genital functioning, sexual behaviors, mental processes, perceptions, emotional state and the interaction between the partners. Information to be obtained from the sexual status exam include: whether or not the patient’s libido is deficient; whether a diagnosis of sexual disorder is

warranted (DSM IV-R, 1994, 493-522); starting to identify the *immediate cause* of the patient's inadequate sex drive or the specifics of phobic avoidance of sex. The examiner wants to get a picture of the patient's anti-fantasies and countersexual behaviors – what scares or repels him or her about sex; how the partner fits into the picture; how the patient down-regulates his/her sexual desire; whether the patient noticed any changes in the spontaneous fluctuation of libido; and whether this is related to any specific event (Kaplan 1995, 98-99).

Other areas to assess include: whether the symptom is global or situational; generalized or partner specific; lifelong or acquired; organic or psychological. Is the loss of sexual desire related to another pathological condition, such as a urological or gynecological disease? Is it due to painful intercourse or secondary to a psychiatric condition? (Kaplan 1995, 98-105; DSM IV, 1994)

Co-Morbidity of Sexual Dysfunction and Mental Disorders

Depression

Kaplan (1976) states that loss of libido is one of the major signs of depression and may be a sign of mild or sub clinical depression. Depression is a common problem in patients who seek sex therapy. A mild reactive depression, caused by sexual inadequacy, would likely be responsive to sex therapy and disappear when sexual functioning is restored. Depression may also be the cause of low sexual interest in either gender and cause erectile dysfunction in men and orgasmic difficulties in women. In the same way as the depressed patient loses his appetite, suffers from constipation and sleep

disturbance, libido may be extinguished and the patient resistant to arousal, due to impairment of the physiological vasocongestive sexual response. Erection is especially vulnerable to depression and endocrine and psychological factors may also be implicated. Therefore the depression should be treated first before sex therapy is started as the libido may return spontaneously when depression has lifted. (Kaplan, 1976, 475) She stresses that in the treatment of a couple when depression is present it is important to assess both the patient and his/her partner for depression, as the treatment process may aggravate depression (Kaplan, 1976, 477).

Anxiety and Panic Disorder

Anxiety and panic disorder may be found in patients presenting with sexual aversion disorders (DSM IV, 1994, 499-500) and phobias. This condition often makes the patient susceptible to fears and phobias in many situations, including sexual activity. Other areas may be: fear of heights; enclosed places; open spaces; public speaking; flying, and socializing. Following medication, which may reduce the anxiety, sex therapy can proceed (Kaplan, 1974, 480; 1987; 1995).

Substance Abuse

Active abuse of substances may be a physical/biochemical cause, of decreased sexual desire. The behavior of the substance-abusing patient may also be too destructive and prevent success with sex therapy. Therefore substance abuse treatment should precede sex therapy (Kaplan, 1974, 107; DSM-IV, 1994, 519-522).

Personality Disorders

Personality disorders and other axis II diagnoses (DSM-IV, 1994, 629-673), such as obsessive-compulsive, narcissistic, or borderline personality disorder, may not preclude sex therapy but the prognosis may be poor and outcome uncertain (Kaplan, 1995, 107-108). Kaplan states that there is a complex relationship between the neurotic and personality disorders and sexual dysfunction, which is not yet understood. Highly neurotic patients are quite frequently found to enjoy good sex. Sexual problems may be enmeshed in a neurosis or be an expression of character disorder. Other times sexual problems can be independent of any neurotic or characteriological problems. It is important to recognize that unconscious, irrational fears do not invariably cause sexual dysfunction. The individual may defend him/herself against sexual abandonment for many other reasons, including: anticipation of failure; fear of rejection; disappointment with partner; being overprotective of partner; or having anger at him/herself or partner. Even if defenses against sexuality are based in the personality structure, this does not mean that there need be a change in structure for sexual dysfunction to be “cured” (Kaplan, 1974, 481-483).

Sex therapy with the neurotic or character disordered patient may be successful if focus is on the resolution of specific destructive behavior or helping the patient to protect his vulnerable sexual response against neurotic anxiety in sexual situations (Kaplan, 1974, 484).

Schizophrenia

The patient with a diagnosis of schizophrenia may suffer sexual dysfunction for the same reason as anyone else. However this patient is vulnerable in two specific ways: he is more vulnerable to the effects of emotional arousal; and the sexual symptoms and defenses against intimacy and against sexual abandonment may serve as protection against emergence of acute psychosis. Kaplan cautions however that this is not always the case and that sexual dysfunction can aggravate the schizophrenia and if so respond well to sex therapy. However, a thorough assessment is important, specifically with regard to the patient's vulnerability to psychosis. (Kaplan, 1974, 495).

Stress and Fatigue

If the loss of libido is caused by overwhelming and chronic stress and fatigue, the patient should be helped to reassess his life situation and to resolve the stressful situation (Kaplan, 1995, 108).

Sex Therapy or Marital Therapy

Sexual dysfunctions may appear along with marital discord. This has been described by Sager in *The New Sex Therapy* (Sager, 1974, 501-516). The marital discord could include lack of harmony, heated fights or violence, mates being distant and living parallel lives or never touching in intimacy (502). The most common complaints of couples seeking marital counseling are: lack of communication; constant arguments;

unfulfilled emotional needs; sexual dissatisfaction; financial disagreements; in-law trouble; infidelity; conflicts about children and domineering or suspicious spouse (Greene, 1970). Sager reports that 75 percent of those seeking marital counseling have a sexual problem. Of those seeking treatment for a sexual problem, 70 percent have had significant marital complaints (Sager, 1974, 502). If couples are able to meet a minimum level of co-operation, they may benefit from sex therapy. The requirements include: to be able to put aside their fights and hostility for a period of a few weeks so that negative components do not determine significant actions; accept one another as sexual partners and have a genuine desire to help one another and themselves. Furthermore one or the other spouse being prepared to put his or her gratification aside for several weeks in order to participate in maintaining a sexually non-demanding ambience (503).

Denial of Hostility

A contraindication to sex therapy is when one partner is not prepared to recognize his/her hostility. Denial of hostility and defenses against its awareness and overt expression are more destructive than overt expression of hostility. Manifestations of covert hostility include; sexual putdowns; lack of compassion for their mate; lack of willingness to give to the other and ignoring partner's expressed needs (Sager, 1974, 503).

Anxiety resulting from change or threat of change needs to be differentiated from other hostility, as this kind of anxiety is a normal part of treatment. Acts of sabotage based on a need to injure one's partner are very different from fear of change. Whilst in marital therapy the partners would be urged to explore their hostile feelings, negative

games, power struggles, competitiveness, and destructive acts toward each other, sex therapy requires a non-hostile environment. A wish for improvement is a requirement for either marital or sex therapy. Since sex therapy is focused on the sexual dysfunction and that alone, the couple must be able to control destructive hostile acts towards one another. Sexual performance is especially sensitive to hostile manifestations (Sager, 1974 , 503-504).

Differential Diagnosis

In determining if sex therapy is appropriate for a couple with marital difficulties couples can be divided into three general categories: (1) sexual dysfunction producing secondary discord within the marital relationship, in which case sex therapy usually is the treatment of choice; (2) marital discord impairing sexual functions – with positive feelings and the desire to improve the sexual functioning outweighing the negative aspects – in which case sex therapy is the choice; and (3) severe marital discord with basic hostility, which would prevent partners from cooperating in rapid treatment of sexual dysfunction, thereby excluding sex therapy (Sager, 1974, 505-506).

Systems Approach to Sextherapy

In his “Sexual Crucible” approach to sex therapy Schnarch (1991) introduces concepts such as “differentiation of self” in the relationship (Bowen, 1978; Kerr, 1988; Schnarch, 1991), “wanting to want” in the sexual relationship and having enough courage to risk being vulnerable and taking the next step to increased intimacy and passion.

Important for the couple's relationship is that each partner takes responsibility for expressing his/her personal needs and preferences and participates actively. In this approach sexual problems are addressed in an integrated manner with focus on the balance in the relationship rather than on the individual.

Fear of Intimacy

Fear of intimacy, a common cause of sexual and relationship problems, has been extensively researched by Firestone and Catlett (2001) and is presented in *Fear of Intimacy*. The authors stress the importance of helping the patient to identify negative and destructive internal messages, originating in the individual's early experiences. Early experiences may cause the individual to relate to his/her partner based on fantasy established in the past in response to disappointment and fear, preventing the individual from relating in healthy ways in the present. The authors have created a therapy approach, the objective of which is to come to terms with reality by dealing with the internal negative and restricting voices and messages and to help the patient trace the origin of such voices in their heads. The authors have identified their approach as "voice therapy". (Firestone and Catlett, 2001, 279-300)

Brief Sex Therapy Treatment

The human sexual response cycle is divided into three phases: desire, arousal, and orgasm (Kaplan, 1995). The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 1994) includes diagnoses for each of these stages in the female and in the male: Hypoactive Sexual Desire Disorder; Sexual Aversion Disorder; Female Sexual

Arousal Disorder; Male Erectile Disorder, Female Orgasmic Disorder; Male Orgasmic Disorder; Premature Ejaculation; Dyspareunia; and Vaginismus (496-515). In addition there are diagnoses for Sexual Dysfunction Due to General Medical Condition; Substance-Induced Sexual Dysfunction; Paraphilias; and Gender Identity Disorders (515-538).

According to Kaplan (1995, 109-110) the three basic phases are controlled by separate nerves and modulated by different neurotransmitters, involved with different parts of the genital anatomy. Therefore impairment can appear in one component and not the others. A patient with erectile dysfunction may feel normal sexual desire and ejaculate normally; women – although unable to achieve orgasm – may feel intense desire, lubricate normally and feel satisfied after sexual contact; a man – with an ejaculatory disorder – can have excellent erections and high sex drive; a patient with low desire may still have erections, lubricate and reach orgasm. However, normally the systems function in harmony and overlap in time into a single, pleasurable, harmonious, subjective experience. The sexual response cycle and the motivation work in synchrony in a “functional feedback loops” described by Kaplan as follows:

A high level of sexual desire or lust facilitates and maximizes the erection-lubrication and orgasm-ejaculation responses and sensations, while lowering the threshold for the genital reflexes. (Kaplan, 1995, 110)

It also works in the opposite way. When the desire for sex is low, the thresholds for erection and orgasm are raised.

The goal of the new sex therapy, as developed by Masters and Johnson (1970) and Kaplan (1974; 1995), is symptom relief or cure, through brief focused treatment of the immediate causes. Only in exceptional cases may treatment require attention to the

deeper causes. Brief sex therapy treatment is based on learning theory, in which the symptom is considered to be the disorder. The expectation is that the symptom can be extinct and mastery and improved self-esteem be experienced. Kaplan cautions, from her own clinical experience, that the patient's psychic functioning will be affected in one of three ways: in the majority of cases, there seems to be no permanent change in the patient's psychic status; in some profound positive change; and in rare instances a negative change. Following symptom relief and acceptance that sex can be enjoyable, patients may develop an attitude of "taking-it-for granted"(Kaplan 1974, 446).

Effects on Sexuality of Trauma

In recent years a whole new area of work with intimacy disorders has been developed growing out of emotional conditions which have proved themselves refractory to the brief sex therapy treatment developed by Masters and Johnson and discussed above. These are the trauma-based disorders – compulsive and addictive behaviors and eating disorders. Appropriately, Masters and Johnson have lent their name to a group researching – and creating new approaches to treatment and education for professionals and patients alike about recovery of healthy functioning – when addictions, compulsive and eating disorders prevent emotional health (Schwartz, 2002).

The relationship between the experience of trauma, both sexual and otherwise, and addiction is presently subject to intensive study helped by the rapid emergence of new knowledge from brain research.

Ken Roy, MD, (Roy, 2004) states that sexual trauma is prevalent in addiction and 30-60 percent of women in treatment for substance dependence are also victims of trauma. While the number of males is somewhat lower, the difference is not great. In this population there is a high instance of re-victimization, perpetration, sexual compulsivity and sexual anorexia. Roy identifies causes of addiction to include: genetics; environment, including dysfunctional family of origin; physical abuse; sexual and other trauma; and medical conditions, primarily pain. These disorders are manifested in the primitive instinctual survival part of the brain, the limbic area and the midbrain nuclei: “mesolimbic dopamine system, which governs emotions, survival, and reward and pleasure systems.”

Roy (2004) states that sexual trauma always effects life, love and relationships and that it is impossible not to respond to victimization and inappropriate sexual messages. For the person with addictive disease the response is frequently, either sexual compulsivity or sexual anorexia. Sexual addiction resembles substance addiction in that there is compulsion with loss of control which causes major life problems. Treatment for addiction requires the resolution of denial, dealing with relapse issues such as developmental issues of childhood and adolescence, relationships, love and sexual issues, medical conditions and pain as well as financial and career insecurities. The individual’s “core beliefs” are affected by trauma resulting in feelings of unworthiness, undeserving of love, confusion about needs and wants and inappropriate sexual messages.

Breaking New Ground

With sophisticated brain imaging the close relationship between sexual function and mental and physical problems and the behavioral manifestations of these problems is presently under research.

Investigators are now beginning to map neurobiology in the area of addiction – specifically craving – and learning why alcohol and other drug habits or compulsive behaviors are hard to give up. It has been found that addiction changes the brain in ways that sensitize individuals with addiction to specific cues – sights, sounds and smells. It appears that deeply entrenched neural patterns light up the brain’s memory, pleasure, and reward circuits moments before a sober alcoholic recognizes the familiar urge (Vastag, 2004).

Arguably, there are reasons to believe that this may pertain to other urges and reactions as well, such as those related to sexual addiction, experiences of early trauma as well as “secondary victimization” of a close partner to a traumatized individual. Research is in progress in this area. It has been suggested that the partners of childhood sexual abuse survivors can experience marked personal and relationship distress by virtue of their close proximity to the survivor (Brittain & Merriam, 1988). Partners of primary survivors may become “secondary victims” (Remer & Elliot, 1988b, 389) of the trauma experienced by their partner (Wiersma, 2003, 151).

Physicians have long known that physical pain and depression are intertwined. Chronic pain can cause depression, while depression can magnify pain. It is reported that 80% of patients with depression present with mainly physical symptoms (*Am J Psychiatry*, 1993, 734-731). A first-line therapy for fibromyalgia and other pain

syndromes is the tricyclic antidepressants (*Curr Opin Investig Drugs*, 2002; 3:454-458). Routine autonomic input is suppressed, when the body is functioning normally and serotonin and norepinephrine circuits are involved. The author makes a comparison to the digestive system and gives as an example the autonomic input from the stomach during digestion, which “prevents the brain from wasting energy on irrelevant details”. However, it has been found that in depressed people these routinely ignored sensations may reach the brain (Vastag, 2003, 2389-2390). The same author presents an interesting discussion of preliminary findings of how two areas of the brain may be implicated in the experience of social rejection. As participants felt excluded, “the anterior cingulate cortex became more active” and when the person felt less excluded “the right ventral prefrontal cortex displayed more activity”. The author sees this as possible evidence that the brain registers pain like alarm in response to rejection or exclusion, explained by the need for the young mammals to be near their caregivers to survive. (2390)

Whipple (2003) has studied extensively the connection between pain and pleasure as recorded in the brain. Her latest research involves brain imaging during orgasm in women with or without complete spinal cord injury. She references Kinsey’s studies in the fifties and Prakash’s studies in the sixties with findings that the whole body has a potential to be eroticized, including skeletal and muscular stimulation. This has led to a redefinition by Whipple to a focus on whole body connection. In an experiment with cervical stimulation it was found that a woman whose major spinal-cord pathways were interrupted by spinal cord injury could experience orgasm. It has been suggested that the vagus nerve, the tenth cranial nerve, serves as an alternative sensory pathway capable of carrying sensory cervical information to the brain. It was concluded that orgasm is

experienced in the brain and is not just a reflex. The finding was that the cortex is stimulated with orgasm in the same way as with pain. This has led to a hypothesis regarding the relationship between pleasure and pain and the question “Is pain barred by the orgasm”? There is an explosion of oxytocin into the blood stream during orgasm, inducing the uterus to contract. Whipple poses the question – can we cool down hot spots in the brain due to pain – could we learn to create pleasure over pain?

The above research was also presented at the European Federation of Sexology conference in Brighton, England, in May 2004. In an article (The Times, London, UK, May 15, 2004) “Sex on the brain” Suzi Godson reports on Whipple’s research. The reporter recognizes the benefits of being able to use updated imaging technology to expand our knowledge but cautions that there is a fine line between finding information and creating insecurity. The reporter sites earlier research and findings on the G-spot first proposed in 1950 by German gynecologist, Ernest Grafenberg and revitalized by Whipple and colleagues in 1981. The findings on the G-spot caused extensive excitement and raised expectations – only to be found questionable and no more than anecdotal according to research findings by Hines, professor of psychology at New York’s Pace University reported in *The American Journal of Obstetrics and Gynecology* in August 2001. The Times reporter further sites a statement by David Goldmeier, a leading expert in sexual medicine at St. Mary’s Hospital in London, who states that the mental stimulation needed for orgasm in most women is “words softly spoken” and that inability to orgasm is less of a problem for the women than for their partners, who interpret it as a negative reflection on their performance (The Times, London, UK, Saturday, May 15, 2004).

Whipple's research, however, and her findings evoke thoughts about the role of the vagus nerve in problems encountered in clinical practice. It has been observed by this writer (Helmer) that, individuals presenting with sexual and relationship problems commonly report anxiety and depression as well as physical symptoms, history of physical or sexual trauma, substance abuse, many of which may be associated with the activity of the vagus nerve.

The vagus nerve, so called after the Latin term for wandering, runs from the brain through the neck to supply not only the gastro-intestinal system but also, through its branches, the larynx, the chest cavity, heart and pelvis. In addition it carries a major part of the parasympathetic system. (retrieved from <http://www.usneurosurgery.com/glossary/v/vajs%20nerve.htm>, December 6, 2003) (Merck, 1999, 1460). An anecdotal reference to these connections can be found in an observation by a family physician with the patient's presentation of "a pain in my neck". Behind this statement was a significant sexual concern (Ripley, 1984).

The above research findings are presented to provide the reader with examples of the complexity of the mind, the body and the emotional system – and to help the individual imagine both tangible and intangible connections that influence the human functioning, in which sexual health may find its niche and yet knows no boundaries.

This presentation would be incomplete without mentioning the importance of recent advances in pharmaceutical interventions for sexual dysfunction such as Viagra, Cialis and Levitra for erectile dysfunction and the present status of medical evaluation and intervention (Shabsig, 2000, 6-9; Mulhall, 2000, 19-23; Sharlip, 2000, 10-13), which also includes the use of implants, injections and other treatments as a choice in erectile

dysfunction, which is refractory to other treatments (Melman, 2000, 28-34; Padma-Nathan, 2000, 14-18).

The importance of diagnosing and treating depression in patients with erectile dysfunction and to manage the adverse effects of antidepressant medication on sexual functioning is now being recognized in medical treatment (Seagraves, 2000, 24-27). A description of medical assessment of female sexual dysfunction and identification of changes with age as well as effects of medical conditions, such as cardiovascular disease, on sexual functioning in women as well as men can be found in *A Special Report: Educational Advances in Sexual Dysfunction* (Wessels, 2000). It is reported that while the overall prevalence of female sexual dysfunction is 43 percent in men the prevalence is 31 percent. Of interest is the indication that although the prevalence of lack of sexual desire and of lubrication disorders is high in women, the disorder is found to be less prevalent in married women.

CHAPTER 9

CLINICAL OBSERVATIONS

This writer has observed patients seeking counseling for relationship or marital problems. She has noted that, together with the presentation of anxiety, depression and sexual concerns, self-reported medical problems are common. These observations are presented as an illustration of trends in co-morbidity between sexual and emotional problems on the one hand and medical symptoms on the other. The information is of anecdotal nature and is not to be perceived as scientific data.

Common reasons for seeking counseling are anxiety and depression, observed in both woman and men. Sexual concerns are seen in both sexes - and commonly include anhedonia, low sexual desire and sex addiction. Furthermore, a history of physical or sexual abuse is frequently found in women and slightly less so in men.

This writer is specifically interested in ascertaining the prevalence of medical symptoms suggesting disturbances in which the vagus nerve could be implicated, such as digestive concerns – observed in nearly half of the women and in approximately one third of the men. A history of substance abuse was noted in approximately one fourth of both men and women; and weight problems (over- or under-) in one third of the women but less frequently in men.

It is in sexual abuse victims that these symptoms are most commonly found. Courtois (1988) lists the following physical symptoms in abuse victims: gastrointestinal disturbances and pain including gagging, nausea, eating disorders, ulcers, and stomach

cramps. Other common complaints are sleep disturbances, including insomnia, nightmares, night terrors; and anxiety, depression, migraine headaches; startle responses, dissociation, fears, lethargy, passivity; frozen watchfulness, self-soothing behavior, inability to concentrate and self-injury. Of importance also is the fact that these symptoms are commonly denied in the abuse victim, perhaps in order to keep the secret of abuse (Courtois, 1988, 97).

A small number of patients fail to complete treatment. Reasons for non-completion can be many. This writer presumes that these could include more complex psychopathology - such as abuse, family dysfunction or depression – and medical concerns. These patients require more extensive, multidisciplinary assessment and treatment.

CHAPTER 10

DISCUSSION, CONCLUSION AND RECOMMENDATIONS FOR FUTURE RESEARCH

Man is not unique in having the biologic imperative driven by the motor of sexuality. However, he is the only one studied who can take his complaint of sexual dysfunction to a listening ear. Whilst he spends his youth being prepared for work, play and productivity, very little – if any – time and resources are given by contemporary society in preparation for the sequential triad of marriage, sex and children. Money (1993) has given lucid guidelines for this process. Blumstein and Schwartz (1983) have highlighted in their couple's research some of the challenges which meet the young adult when he is ready to start adult life and prepare for a family, such as finding a suitable partner. The role of sex and sexual behavior in preserving society has been recognized from early days and handed down from generation to generation with a plethora of prohibitions. In spite of these, unexpected consequences have occurred. The HIV epidemic in the developing world serves as an alarming reminder of these. The secrecy surrounding sexual matters has gradually been cleared through sex research over the past century. Society is beginning to emerge from behind the veil of secrecy.

This study has brought awareness that it is in enhancing our understanding of the effects of proscriptions and parameters – negative in the case of the former, positive in the latter – that societal sexuality can be strengthened as a healthy force. This was bravely envisioned by Ellis, Kinsey, Masters and Johnson and Hite who brought knowledge about healthy sexuality out into the open. The task now is to bring this

knowledge to all societal institutions and functions so that any and all can be allowed access and opportunity to sexual health and well being.

This dissertation – or exploratory journey – would not be complete without reference to the creative world of drama, art and music. In Mozart’s opera *The Magic Flute* Papageno wins his Papagena only after a “trial by fire and water”, negotiating “the forces of darkness” with help from his mentor, Prince Tamino. This is where the journey begins.

Recommendation for Future Research

One of the basic questions posed by this writer (Helmer) was related to the co-morbidity between, on the one hand sexual and emotional problems, and, on the other, medical concerns, specifically those which could be seen as related to the various functions of the vagus nerve, which also are frequently found in abuse victims. Her review of the literature validates the complex interactions between bodily systems, which are emerging from current research. Her clinical observations also indicate the same trend. It appears that, whilst the majority of patients respond to brief treatment, the presence of deeper causes and more complex symptoms, may contribute to lack of completion. In order to establish the scientific basis for a possible synergy between multiple symptoms and specifically co-morbidity with medical concerns, further research, such as has been pioneered by Whipple, is indicated.

Who decides what healthy sexuality is? Based on the findings identified in this report it is proposed that sexual health – in the same way as general health – must be defined by the individual within parameters established by society.

EPILOG

I was only three years old when I first realized that I was different from my friends and family and that there was something I needed to find out. This is when my journey of self discovery started and it would take many years and many experiences to get to where I am today. The road traveled was by self observation, personal analysis and a study of the human condition. Most important, however, has been the learning from others in working as a clinical social worker. For the past twenty years I have worked with individuals, couples and families with emotional and behavioral problems including sexual concerns. In reviewing both my clinical experiences and my personal journey it became apparent how complex the journey to health is - and how illusive the concept of social and sexual wellbeing can be. This sparked my curiosity into the concept of sexual health and into a review of the role of sexuality in the lives of individuals as well as society. This enquiry serves as a summation of what has been important for my journey and the work has been inspiring and eye-opening beyond expectation.

The journey of the past couple of years has opened my eyes not only to the depth and wealth of the human experience but also enhanced my appreciation of the joys and perils of the world of relationships. I will use as an example a description from the biography of Hector Berlioz – perhaps the most romantic of the 19th Century composers – of young love and what is now termed limerence (Tennov, 1979). From grade school Berlioz had been fascinated by Shakespeare’s Romeo and Juliet as well as Hamlet. Berlioz came to idolize Juliet and Ophelia. As a young music student in Paris he saw the two plays for the first time spoken in Shakespeare’s own language. He fell violently in

love with the actress who, on successive nights, played the parts of both Juliet and Ophelia. He saw every performance and sent flowers and love verses to his beloved – but to no avail – she refused to see him. The following is a quote from the composer’s own program notes for his *Symphony fantastique*:

“Rejected by the woman he loves, in desperation a young musician of heightened sensitivity and feverish imagination poisons himself with opium, hoping to die. The dose, however, is too weak to bring death but plunges him into a deep sleep, accompanied by bizarre visions in which his sensations are transformed into a melody – a theme – that pursues him everywhere”.

(Cairns, 1969; Rose, 2001; Ripley, 2003)

THE END

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