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Abstract

The purpose of this study is to examine what is known about human sexual desire, historically, physically, and psychologically. In studying the evolution of sexual desire the research explains how behavior and attitudes develop. Medical knowledge advanced in the nineteenth century, and a new field, psychiatry, attempted to interpret our growing understanding of human sexuality. Psychology, in defining human sexual desire identifies where there is function, there is dysfunction, and developed methods to treat sexual desire disorders. Treatment of sexual desire disorders is systemic in that it encompasses the physical, mental, and relational. One observation is that a male dominated scientific world greatly ignored female sexuality. Today, the disparity of treatment between males and females is decreasing, and our knowledge of sexuality for both males and females is becoming one and the same.

The Etiology of Sexual Desire

The purpose of this study is to examine four aspects of the etiology of desire. Historically it examines how desire and sexuality has been defined and its place, be it viewed negatively or positively, in earlier cultures. Biologically and chemically, the study examines the physiology of desire in males and females and how it ultimately contributes to sexual performance. The psychology of desire is discussed, considering cultural perceptions and how they influence the expressions of desire and sexuality. Finally, for the psychotherapist with a focus on sexology, how sexual dysfunction and sexual desire disorders affect the individual and the couple is addressed.

Humankind has experienced, and attempted to define, sexual desire throughout recorded history. However, the study of sexual desire is challenging in that “there are no obvious physical changes that accompany this early stage of the sexual cycle, and therefore no way to objectively quantify the experience of sexual desire” (Retrieved from: Utxas.edu, 2000). Further, much of what we know about sexual desire comes from subjective data collected from individuals and couples. Contemporary theory addresses sexual desire, or excitement, as the beginning stage of sexual performance (Kaplan, 1995; Masters and Johnson, 1986). Biochemically, desire might be equated with the fuel that stokes the furnace—each necessary and dependent on the other for proper function. Other researchers have broken it down further, as in limerence. Tennov (1979) describes limerence as an incomplete, or unrequited, form of desire and an involuntary state of being whose end is difficult to achieve.

Some early contemporary observers and scientists brought human sexuality out of a religious focus as well as inexact, sometimes patently incorrect early science, where it

had been for centuries, and began to study human sexuality-desire, love and lust as functions of being male or female without moral judgment or recrimination.

Merriam-Webster's Collegiate Dictionary v. 2.5 (2000) defines desire as "a wish or hope for" and by this definition, desire can be viewed as an end unto itself. Noah Webster, creator of Webster's dictionary only referred to "love" in religious terms never addressing sexual desire at all (Ackerman, 1994). The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) only defines desire as a dysfunctional quality, citing Hypoactive Sexual Desire Disorder (1994, p. 496) and Sexual Aversion Disorder (1994, p. 499), but anyone who has ever experienced sexual desire knows that much more is included in the etiology of sexual desire. In this body of work, the etiology of desire will be examined from various medical, psychological and cultural viewpoints.

Much is written about hyper sexuality in males (Kaplan, 1995; Kinsey, Pomeroy and Martin, 1948; Masters, Johnson, and Kolodny, 1986) or satyriasis (Kinsey, Pomeroy and Martin, 1948; Costler and Willey, 1940), and there are vast bodies of literature on sexual dysfunction, but considerably less is written about desire as a normal and healthy part of female and male sexual energy. Sexual attraction or desire involves both psychological and physiological cues.

Chapter 1: History

Often the understanding of desire is an extrapolation from sex and love. Some of the earliest written languages reference *lubhyati*, a Sanskrit word for “he desires”, later translated to mean, “love,” and the Egyptians earliest description for love is translated into “a long desire” (Ackerman, 1994). In today’s language, Tomkiw uses John Gray’s definition of desire as more “wanting what we don’t have and love is wanting what we have” (Tomkiw, 1999, p. 104).

Historically desire is bisected into the expression of desire, and the repression of desire. In ancient societies, such as Egypt in which females were principal to the society, and deities often included female image as goddess, sexual desire in females was revered. While matriarchal societies celebrated the sexual desire of females, later patriarchal religions have attempted to repress the existence of female sexual desire (Walker, 1983).

The Ryrie Study Bible (1978) in Genesis (3:5-7) reads, “For God knows that in the day you eat from it your eyes will be opened, and you will be like God, knowing good and evil...she took from its fruit and ate; and she gave also to her husband with her, and he ate. Then the eyes of both of them were opened, and they knew they were naked; and they sewed fig leaves together and made themselves loin coverings, they then felt shame and tried to hide from God” (1978, p. 11). Davis (1998) reports that naked together man and woman became one flesh yet they knew no shame until they ate fruit from the forbidden tree, and “then they knew shame and tried to hide from God” (1998, p. 51). The King James Version of the bible reads that as a punishment for Adam and Eve’s knowledge “...of good and evil, thou shalt not eat of it: for in the day thou eatest thereof,

thou shall surely die” (Authorized King James Version, 1991). Thus, Judeo-Christian shame was born.

Yet while sexuality seems to be celebrated in the Old Testament, it is between husband and wife as throughout the Song of Solomon, and most specifically in Solomon to his Bride, (Ryrie, 1987: 4:1-15). This is one of the romantic and erotic poems about love and desire. The New Testament no longer celebrated sexuality openly, and instead love is something that is ideally reserved for God—desires of the mind and body are discouraged, and sometimes condemned. Sex in the New Testament becomes non-erotic and full of denial (Ackerman, 1994).

For Paulists, guilt and shame reached a pinnacle in the New Testament when Paul advises that it is good for a man not to touch a woman, but “he concedes marriage as a last resort for those who can not be celibate” (Ackerman, 1994, p. 48). Due to Paul, “for many centuries the church insisted that marital sex should be as barren of sensual pleasure as possible, and that orgasms in women were unseemly or even devilish” (Walker 1983, p. 913).

While earlier cultures were attempting to deal with, and potentially suppress desire through biblical writings, the Chinese were writing medical books about how to express desire. Chu, in *The Yin/Yang Butterfly* notes that the theme of ancient Chinese sexology states “Sexuality is a natural human urge which, if satisfied regularly in moderation, and enjoyed with pleasure, not only will give people greater sexual potency but will make them live healthier and longer” (1993, p. 79).

Ancient Egyptian’s relied on metaphor in love poems free from guilt, self-abasement or the curious combination of love/hate that we see today (Ackerman, 1994).

“...As in Egypt, where women chose and wooed their lovers at will. Egyptians described carnal knowledge as knowing a woman perfectly, and regarded it as joy” (Walker, 1983, p. 912). Ackerman (1994) relates that in Egyptian writings there are also references to fetishism, masochism, and other fringe element. Also included were concerns with birth control, describing a *pessary*, vaginal suppository of crocodile and elephant dung.

Hindus discuss having sex with any woman as having a union with the goddess herself. “To have carnal intercourse with the goddess Parvati is a virtue which destroys all sin” (Walker, 1983, p. 912). Indulging in sexual desire for the Hindu can remove sin contrary to the Judeo-Christian belief that sexual desire is sinful.

Symbols of desire have been recorded throughout history and mythology. Ancients reified gods and goddesses some of whose existence was to define or represent love and desire. In Greek mythology, Olympian deities predated mankind, and Aphrodite was the Olympian goddess dedicated to love and beauty (Seton-Williams, 1993).

“Plato’s call for sublimating one’s desires blended neatly with Christianity” (Ackerman 1994, p. 49). So it seems the foundation for suppression of desire for another person is as old as the written word, as the church taught love was only for God.

There is a long tradition of what appears to be a suppression of male’s sexual desire for females. In ancient Greece, wives were expected to retreat to women’s quarters if their husband brought home a male visitor (Ackerman, 1994). In modern mid-eastern cultures females are often required to be clothed completely from head to toe, including covering the face—viewing the world veiled through gauze.

Ackerman (1994) says that *youth*, in ancient Greece, was the siren. Female teenagers were unavailable, so male’s desire turned to young males available to view

naked in the Gymnasia. She reports the foreskin of the young males was tied, protecting the penis.

Ancient Rome tolerated oral sex between homosexual males or females, or it was enjoyed by heterosexual men at the hands of courtesans, but it was considered degrading for a man to pleasure a woman with his mouth, because females were considered a moral inferior. Such an act would put the man in a subservient position (Ackerman, 1994).

Supporting the dominance of males, even in homosexual affairs it was only acceptable to “pitch rather than catch” (Ackerman 1994, p. 39). Phallic worship was evident throughout Roman culture in art, signifying power and domination, as well as sex.

A great change in the Middle Ages was a shift from unilateral love to mutual love, an avant-garde and dangerous idea according to the church (Ackerman, 1994). During the Crusades, holy wars during the eleventh through thirteenth centuries, Troubadours began writing songs of love and yearning, the earliest recorded being by William IX, Duke of Aquitaine, in whose work Tennyson's (1979) limerence is demonstrated centuries before it was defined.

In the Middle Ages, courtly love took the form of a human chess game, the players acting out a love and desire tableau, from which love decisions between two people might be made (Ackerman, 1994). The term, courtly love was coined by Gaston Paris who referred to the *Amour Courtois* of twelfth century France. This illustrates the need for mankind to express desire in some acceptable societal context. Later, Medieval Europe warned against any male or female who was “enticing and seductive” as they may be demons (Spencer, 1995).

Even during the Medieval period, when males and females were burned at the stake—deemed to be witches for practicing homosexual sex, one Italian philosopher, Marsilio Ficaino observed about love and sex that:

The reproductive drive of the soul, being without cognition, makes no distinction between the sexes', and is 'naturally aroused for copulation whenever we judge any body to be beautiful'. For this reason, 'it often happens that those who associate with males, in order to satisfy the demands of the genital part, copulate with them.' There can be no doubt, he observes, that some men 'naturally love males'. (Spencer, 1995, p.134).

“During the seventeenth and eighteenth centuries, manuals of love and marriage were published, the most popular of these the Aristotle series” (Haller and Haller, 1974, p. 92), that have a heavy emphasis on pleasure for males and females, and saw sex as a healthy passion governed by natural laws. The clitoris was recognized as an integral part of a woman’s pleasure, and clitoral stimulation was believed to be necessary for conception. By the first half of the nineteenth century, love manuals became less explicit but still treated females as equal partners in desire and lovemaking. Pre-Victorian advice was to keep boys occupied in useful work, discouraging sexual notions or feeling from entering his head (Haller and Haller, 1974).

Proper Victorian society did everything it could to dissuade desire, including numerous books written such as H.N. Guersney, M.D. author of *Plain Talks on Avoided Subjects* (1882). “Young women should have no sexual propensity, or amorous feelings reinforced by the feelings of Acton whose book, *Functions and Disorders of the*

Reproductive Organs, expressedly limited the emotions of the modest woman to the love of home and domestic duties” (Haller and Haller, 1974, p. 109).

With the birth of the Victorian Era, modern society was further plunged into suppression of desire. Following the death of Prince Albert, Queen Victoria set a standard that the marriage should be honored even in widowhood (Tweedie, 1979/2000). It seems that this standard attempted to repress human sexual desire. The moral standards of the era placed the responsibility on females to instill morals and encourage spirituality requiring perfection in high moral standards. Although *proper Victorian ladies* were not to have sexual feelings or desires, even bicycle riding became suspect. The Academy of Medicine of Paris had one discussion, which caused American doctors to begin discourse on the morals of women cyclists and the occurrence of *bicycle face*. “...The wheel would beget or foster the habit of masturbation and one physician observed a case of an overwrought emaciated girl of fifteen whose saddle was arranged so that the front pommel rode upward at an angle of thirty-five degrees, who stooped noticeably forward in riding and whose actions...strongly suggested...the indulgence of masturbation” (Haller and Haller, 1974, pp. 184-185).

A Victorian wife’s role as a sex partner was to lie still, act helpless, and be unaroused, *without desire*, while her husband performed his bestial act. Further, a man, however, was not a man unless he “has woken up in an anonymous bed beside a face he’ll never see again, and he has never left a brothel at dawn feeling like jumping off a bridge into the river out of sheer physical disgust with life” (Ackerman 1994, p. 89).

Male’s desire and lust were tolerated, sometimes venerated, while concurrently females were never to deviate from their expected role. According to Chu (1993):

Early Western sexologists did not believe that women enjoyed sex. Sir William Aston, a prominent English Victorian physician and the author of several books on sexology, wrote: “The majority of women are not very much troubled with sexual feelings of any kind...A modest woman seldom desires any sexual gratification.” Aston called the attribution of sexual feeling to a woman a “vile aspersion.” Even the German psychiatrist Richard von Krafft-Ebing, considered the founder of modern sexology, says in his *Psychopathia Sexualis* (1886) that the sexual desire of a normal woman was small; if it were not, “the whole world would become a brothel” (p. 165).

In her book *The Technology of Orgasm*, an entertaining but serious history of the vibrator, Rachel P. Maines argues that women sought relief from hysteria by going to the doctor’s office and being massaged to orgasm, or as it was known in clinical terms, hysterical paroxysm. As a direct response to doctors wanting to help with this procedure, a British physician in the 1880’s invented a suitable instrument: the vibrator (Berman and Berman, 2001).

Satyriasis a fifteenth century word (Merriam-Webster, 2000), and nymphomania from the eighteenth century (Merriam-Webster, 2000) are terms still used by nineteenth and early twentieth century scientists studying human sexuality, including Kinsey’s writing as late as 1940. These terms describing hypersexuality in males and females have their origin in ancient mythology. Satyriasis is described by Costler and Willey (1940) in the legend of Hercules when he had to “...render pregnant in a single night the fifty daughters of Thespius” (1940, p. 486). Messalina, possessed by the demon of the flesh—and therefore suffering from nymphomania, according to Roman mythology and under

the assumed name of Lycia, went nightly to brothels where she "...gave herself up to laborers and the scum of the town...and after a night of amorous orgies, her lust would not be satisfied" (1940, p. 488).

The philosopher Nietzsche identified sexual desire as separate from a desire to procreate in both men and women:

If sexual instinct were synonymous with procreative urge, the former would disappear as soon as its aim, fecundation, were reached. But we know that on the contrary sexual desire is not extinguished, and is sometimes even increased, in a pregnant woman. This contradiction is so patent that a well-known sexologist has expressed it rather crudely: 'How can you lump love and procreation together, when the question that bothers humanity is how to have intercourse without pregnancy resulting (Costler and Willy, 1940, p. 160)

The late 1800's and early 1900's were pivotal times in the study of sexuality and desire. Physicians began to view sexuality from a more clinical perspective rather than the previous Victorian and Judeo-Christian doctrines of sexual repression. Among the great leaders in this movement was Magnus Hirschfeld, known as the "Einstein of Sex." In 1897 Hirschfeld founded the Scientific Humanitarian Committee in Germany to oppose the oppression of men and women he called sexual intermediates, thus was born the first modern gay rights organization. Among his other seminal achievements in the field of sexology, Hirschfeld started the Journal for Sexology in 1908, co-founded the Medical Society for Sexology and Eugenics, opened the Institute for Sexology in 1918, and organized the first international sexological congress in 1921. Along with Havelock Ellis and Auguste Forel in 1928, Hirschfeld cofounded a world league for sexual reform.

Another observer of human sexuality, Havelock Ellis, wrote in 1933 about *psychic-therapeutics* (1942). This process consists of the patient confessing to the physician their sexual impulses, which can bring a catharsis; this process is not unlike the Roman Catholic process of confession and absolution. In psychotherapeutics the physician takes an active part in removing an abnormal condition, and while this may not suffice to render the sexual impulse normal it certainly renders it less injurious, and at the same time restores the whole psychic life to some degree of harmonious equilibrium” (Ellis, 1942, pp. 6-7). This process Ellis attributes to Freud’s method of psychoanalysis.

Thurschwell’s work *Sigmund Freud* (2000) discusses the Freudian century and how Sigmund Freud’s theories on human sexuality reigned during the early part of the century. Freud believed religions had suppressed sexual desire and that Judaism and Christianity, through guilt, had repressed individual instinctual urges; so not only did culture and religion suppress the sexual, but also all that is instinct. Freud saw individual desires at odds with regulations, institutions, and laws of society. In part, his work was an attempt to define desires without recrimination. Costler and Willy, in 1937 wrote:

There can be no sexual love without desire; but, on the other hand, until the flux of desire has radiated through the organisms into its psychical components or at least into its social and effective elements, there is not any sexual love. Desire, that is specific sexual impulse, is undoubtedly the essential and primary element of this synthesis (1940: 5-6).

In the 1940’s Alfred Kinsey, a professor of zoology, published two of the most extensive writings on human sexuality, *Sexuality in the Human Male* (Kinsey, Pomeroy and Martin, 1948), and *Sexuality in the Human Female* (Kinsey, Pomeroy and Martin,

1953). Kinsey's writings are a major contribution to human sexuality, focusing on the physiology and biology of human sexual functioning, and he is deserving of mention when discussing the history of sexuality and desire.

According to Masters and Johnson (1966) without adequate support from basic physiology, much of psychological theory would remain theory and much of sociologic concept would remain concept. While their work remains in the physiology of human sexual behavior they recognized that not one area social, psychological, or physiological could unwrap the secrets of desire.

While Kelley and Byrne (1986) discuss more of an evolution of sexual freedom from post WWI through the Seventies, Ackerman (1994) sees birth control, the mass media, a growing respect for women, and a greater separation between religious and secular worlds and contributing to a sexual revolution.

Historically, desire has been celebrated or denied according to the cultural perceptions of that era. Frequently cultures have created systems that suppress rather than celebrate sexual desire. Most often this suppression of desire has been directed at women in order to control them in patriarchal societies. "But it was hard for men to see themselves as perfect when they conspicuously lacked the ability to bring forth new members of the race. Thus their endless quest for superiority nearly always required some travesty of motherhood" (Walker, 1983, p. 109). Regardless of the time, there is at least a tacit acceptance of male's desire and sexuality, but not so for females. Even for the Victorians, who professed the unseemliness of the sexual desire of males for females, there was an inequity. Twentieth century medicine and science recognize both males and females as sexual beings, capable of desire.

Chapter 2: Physiology of Desire

Physiology takes the study of desire out of the bedroom and into the laboratory. In order for sexual desire to manifest, there must be a stimulus/response system at work. The stimuli can come from a physical or psychological source, and in either case a chemical reaction will be triggered that will initiate and enhance desire.

Masters and Johnson (1986) identified the sexual response cycle as being a four-part cycle including excitement, plateau, orgasm, and resolution, preceded by sexual arousal, which they describe as “a state of activation of a complex system of reflexes involving the sex organs and the nervous system” (p. 56). Years later, noted sex therapist and physician Helen Singer Kaplan introduced the concept of the desire phase of this cycle for both men and women (Berman and Berman, 2001). Ackerman (1994) describes emotions, personality and desire all having their origins in flesh and chemicals. Reinisch and Beasley (1991) in *The Kinsey Institute New Report on Sex* say:

A type of sexual appetite (similar to being hungry for food) must exist or be created for arousal to take place. This arousal includes thinking about sex; encountering the smells, sights or touches that a person interprets as sexual; or receiving or giving a signal that sex is desired. (p. 80)

Reinisch and Beasley (1991) describe the onset of arousal as the nervous system sending messages to the brain which in turn lead to vasocongestion in the male and the female identified by engorgement of sexual organs in both sexes. It appears that a concert or orchestra of chemicals are responsible for these changes such as testosterone, androgen, oxytocin are all discovered to be responsible in aiding the arousal process

following the onset or initiation of desire. In order for an initiation of desire there must first be an object (person, place or thing), creating physical, sexual or emotional stimulus.

For sexologists, there must be an adequate understanding of the physical structure of the human body, specifically how sexual anatomy contributes to desire and sexual functioning. Kelley and Byrne (1986) are responsible for the following descriptions of female and male sexual anatomy.

Women's sexual organs can be divided into internal and external parts. The external female sex organs, collectively known as the vulva, include the mons pubis, labia majora and minora, vaginal introitus, hymen, and clitoris.

The mons pubis is a cushion of fat that lies over the pubic bone, and post puberty this area is covered by pubic hair, which can extend to the navel. The skin is sensitive to sensations of touch and capable of being indirectly sexually aroused when caressed, causing stimulation to the clitoral area.

The labia majora, or outer lips of the vulva are a fold of tissue surrounding the vaginal and urethral openings; varying in shape, color, and hairiness. The variations of the structure of the labia majora are not significantly related to a woman's sexual pleasure as the labia majora is not particularly sensitive to touch. The smaller, inner lips of the vulva, labia minora are somewhat more sensitive and during intercourse the labia minora secrete lubricating oil that keeps the skin flexible. The labia minora meet at the front of the vulva forming a fold of skin known as the clitoral hood that covers most of the clitoris during sexual excitement, protecting the clitoris from over stimulation during intercourse.

The clitoris, typically about one inch long, is a shaft containing spongy cylinders or corpora cavernosa that fill with blood during sexual excitement causing clitoral

erection, and the glans clitoris enlarges becoming increasingly sensitive to touch. The clitoral glans has the same density of nerve endings as the glans penis in males and has more dense nerve endings than any other surface of the female body. The clitoris has no reproductive function but is a crucial component of sexual arousal for the female.

The entrance to the vagina, the vaginal introitus, is found between the inner lips. It is a recessed area known as the vestibule that contains the clitoris and the urethral opening. The introitus contains two glands whose secretions contribute only minorly to sexual excitement. Usually for young, sexually inexperienced females, the vaginal introitus is covered by tissue known as the hymen, of which there are a number of types, shapes, sizes, and elasticity. "The absence of a hymen does not necessarily indicate that sexual intercourse has occurred, nor do female virgins typically bleed at first intercourse..." (Kelley and Byrne, 1986, p. 32).

The introitus contains many nerve endings and contributes to sexual excitement for the female. The pubococcygeus muscle (PC muscle) surrounds the introitus and is also sensitive to sexual excitement. Penile penetration and pressure on the PC muscle brings about lubrication and widening of the introitus. Another sexually sensitive area (in males as well as females) is the perineum that for females is between the vaginal introitus and the anus, and for males is between the scrotum and the anus. In females, it is the perineum which is often cut surgically during childbirth to allow a larger passage as the baby is born.

Internal female sex organs include the vagina, uterus, oviducts, and ovaries. The vagina is tubular, usually four to six inches long and is located between the urinary bladder and the rectum. Until penetrated (during intercourse by insertion of an object

such as the penis, or during menstruation the insertion of a tampon) the vagina is described as a potential space. When sexually aroused, fluid percolates through the vaginal walls producing lubrication. The walls of the vagina are muscular and unfold and stretch during sexual arousal. The role of the vagina and orgasm has been debated over time. Freud referred to vaginal stimulation as a more mature form of stimulation than clitoral stimulation. Masters and Johnson in 1966 ruled out the vagina as a site for sexual pleasure, but more recently the vagina has been found to contain several areas of sensitivity. Today it is widely accepted that the vagina contains a urethral sponge, possibly the Grafenberg spot (G-spot) and a perineal sponge, both sensitive to sexual arousal.

The ovaries have two functions, the first is to produce eggs, and the other is to secrete hormones, estrogen and progesterone. The uterus (or womb), located behind the vagina is an internal cavity in which a fetus is housed during pregnancy. Its lower opening, the cervix, connects the uterus to the vagina. The uterus is connected to the ovaries by oviducts found to the left and right of the top of the uterus. The mammary glands, or breasts, are not sexual organs, but can play a role in sexual arousal.

Males' external sexual organs are comprised of the penis and scrotum. The penis consists of a penile shaft that extends from the body to an enlarged tip known as the glans penis. The glans contains numerous nerve endings making it extremely responsive to touch. Encircling the glans is the corona, a raised ridge separating the glans from the shaft of the penis; also sensitive to stimulation. Males are born with a foreskin, a retractable layer of skin covering the glans, often removed by circumcision. On the underside of the penis is the frenulum that connects the glans with the foreskin. The

urethral opening, the meatus, is the opening at the tip of the glans through which urine and semen are expelled from the body.

The shaft of the penis contains three cylinders containing spongy tissue. This tissue fills with blood to enlarge the penis, producing an erection. Two of the cylinders, the corpora cavernosa lie on each side of the penis. The third cylinder, the corpus spongiosum containing the urethra, which is the passageway for urine and semen, runs along the underside of the shaft.

The scrotum, a saclike fold of loose skin underneath the penis contains two testes, or testicles in pouches on either side. A ridge called the raphe separates the pouches. Beneath the skin of the scrotum is a layer of muscle, the dartos muscle, which contracts during sexual stimulation. The dartos muscle also contracts and relaxes in temperature change maintaining a constant temperature important to sperm production causing the scrotum and testicles to rise up and contract.

The testicles have two major functions, firstly, the production of the hormone testosterone (affecting sexual development and interest) is produced in the Leydig cells. Secondly, sperm cells are produced within the testicles. Each testicle contains approximately 250 separate compartments with several coiled seminiferous tubules, each about one to three feet long.

Sperm production begins at puberty and usually continues throughout the male's entire life. After sperm are produced, the epididymis, a network of tubes coiled against the back of each testicle, store sperm before they are transported into the body. Approximately 200 million sperm are produced each day. Sperm are transported from the epididymis to the seminal vesicles and prostate gland through one of the vas deferens.

The vas deferens runs through the spermatic cord from which is suspended the testicle and it is the route through which sperm are transported. Sperm are suspended in semen, or seminal fluid, about thirty percent of which is produced by the prostate gland.

The prostate gland is located in front of the rectum. The fluid it produces is water, bicarbonate substance that neutralizes the acid environments of the urethra and the vagina, and a substance that acts as an antibiotic, which helps to prevent urinary tract infections in males. To keep acidic urine out of semen, the prostatic sphincters block off the bladder, another set of sphincters open permitting semen to enter the urethra.

The remaining fluid in a male's ejaculate comes from the seminal vesicles. The fluid contains fructose to nourish sperm, helping them to become highly mobile. At ejaculation, the bulbourethral (Cowper's) glands add lubrication to the urethra by secreting a mucous substance. The bulbourethral glands, resembling half-inch beads lie at each side of the base of the penis.

Sexually excited males and females experience vasocongestion—the blood engorgement of genital organs, thus becoming erect, lubricated, and swollen as the parasympathetic nervous systems response to erotic stimulation; as well as myotonia, or tension of voluntary muscles throughout the body but especially in the legs, buttocks, and arms.

Erotically stimulated males usually have an erect penis. This erection starts as a reflex originating in the lower spine, sometimes nipple erection, and sex flush—a rash on the face, neck, back, chest, or other parts of the body. Erotically stimulated females experience vaginal lubrication, sex flush, nipple erection, and sometime increase in breast size. Due to vasocongestion the clitoris and labia darken and swell, and the clitoral hood

begins to draw over the glans. Internally the vagina widens, the vagina's length increases as the uterus elevates- known as the tenting effect. The uterus enlarges and contracts. The swelling of the labia minora decreases the vaginal opening by thirty percent or more allowing the vagina to grip the penis.

The medical community has attempted to identify the various stages involved in sexual interaction, now more commonly known as the Sexual Response Cycle.

Initially, noted physician Havelock Ellis (1942) reported a two-stage cycle: tumescence and detumescence. Then, in the 1960s William Masters and Virginia Johnson identified a four stage cycle: excitement, plateau, orgasm, and resolution (Kelley and Byrne, 1986).

In the first phase of Masters and Johnson's Sexual Response Cycle, *excitement*, there are noted changes in heart rate, blood pressure and muscular tension. In males the testes begin moving closer to the body; the scrotal skin thickens; and the penis becomes erect. In females, the labia minora, the vagina, and the nipples increase in size; the clitoris becomes erect; and the vagina lubrication occurs.

In the second phase, *plateau*, excitement becomes enhanced. The penis becomes fully erect and the testes move even closer to the body. The clitoris retracts under the clitoral hood; the inner two-thirds of the vagina expand; and the outer third engorges with blood. The longer this phase is extended, the more intense the orgasmic response.

In the third phase, *orgasm*, both males and females experience intense pelvic contractions at less than one-second intervals. At this point involuntary muscle spasms occur throughout the body. In males, orgasm has two stages, the emission stage (build up of semen at base of penis) and the expulsion stage (semen is expelled from the urethra).

In females, the pelvic muscles and the uterus contract, usually between three and fifteen times. In males, there is a characteristic of inevitable orgasm, where the physical process cannot be stopped. In females, however, even a minor disruption or change of clitoral stroking can interrupt the orgasmic response, causing a loss of orgasm.

The final stage, *resolution*, is when the body returns to its pre-excitement state. In males, a refractory period is evident, during which they cannot have another orgasm. The length of the refractory period can be influenced by variables such as age. Females, however, are capable of moving through the resolution phase and returning to the plateau and orgasm phase repeatedly.

The brain, specifically the limbic system, controls physical manifestations of desire and arousal. Some of the structures of the limbic system, which contribute to sexual arousal and desire, are the amygdala and hippocampus, the thalamus and hypothalamus, the cingulate gyrus, and the brainstem. “The limbic system is the old or paleocortex, governing emotion or the functions and behavior of humans that are shared by lower species” (Tweedie, 2000, p. 126). Of the structures of the limbic system, friendship, love, affection, and the expression of mood are controlled by the amygdala, while the thalamus is associated with changes in emotional activity.

“The hypothalamus plays a major role in controlling the production of sex hormones and the regulation of fertility and menstrual cycles through its interaction with the pituitary gland...a gland that secretes hormones that influence the activity of other hormone glands, such as sex glands” (Retrieved from: www.Baubosworld.com, 1995).

“The hypothalamus produces a substance called *gonadotropin releasing hormone*

(GnRH) that controls the secretion of two hormones made in the pituitary gland that act on the gonads (ovaries and testes)” (Masters, Johnson, and Kolodny, 1986, p. 79).

The hypothalamus secretes a releasing factor into the blood signaling the secretion of a gonadotrophic hormone, which in turn stimulates the male testes to produce sperm and testosterone, and in the female it stimulates the ovary to produce eggs and secrete progesterone and estrogen. Cessation of the hormone production is produced in a feedback loop, which triggers the pituitaries release of hormones (Cardoso, 1997). The hypothalamus in a male is two to three times larger than in the female, the size difference is in response to higher levels of testosterone during the third and fourth months of pregnancy (Retrieved from: www.psych.athabascau.ca/, 2002). Of the remaining parts, the thalamus is associated with changes in emotional reactivity; the cingulate gyrus with sight, smell, and pleasant memories of previous emotions; and the brainstem, a primitive structure active and vital for survival is responsible for emotional reactions (reflexes) (Retrieved from: www.epub.org.br/, 2002).

Orgiastic response happens in two other areas of the brain, the septal region, and the ventral tegmental area located in the brainstem. Inside the septal region there are four centers for orgasm for females and one for males (information from: www.epub.org.br/, 2002).

Chapter 3: Chemicals Involved in Sexual Desire

Most hormones fall into one of three major classes: protein, steroid, or peptide. Estrogen and androgen, sex related hormones, are steroid hormones beginning as dehydroepiandrosterone (DHEA). DHEA, produced in the adrenal glands is the most common hormone in our bodies. It is present in larger amount in healthy individuals. DHEA is a precursor for the manufacture of many other hormones, such as estrogen, testosterone, progesterone, cortisone, and others. DHEA figures more significantly in female sexual desire than in male.

A Sloan Kettering study in 1950 traced the relationship of women's sexual desire and DHEA finding its production to be in the adrenal glands (Crenshaw, 1996). For males DHEA has less effect on sexual desire due to a male's abundance of testosterone, yet sufficient DHEA is necessary for testosterone production (Crenshaw, 1996). It has been used to treat hyposexuality in women (Crenshaw, 1996).

Dopamine

According to Crenshaw (1996) oxytocin, DHEA, and other factors bring people together, but it is dopamine and endorphin response, which are responsible for romantic attachments (Crenshaw, 1996; Tomikew, 1999). Dopamine is rewarding in that it produces a sense of well-being and pleasure, and without it sex would be "just a bodily function" (Tomikew, 1999, p. 35). Current studies support the theory that dopamine is thought to play a key role in rewarding dependence as well as pleasure; these dependencies could include alcohol, drugs, and relationships (Crenshaw, 1996; Hamer, 1994; Tomikew, 1999).

Masters, Johnson and Kolodny (1986) mention Dr. Michael Leibowitz's work *The Chemistry of Love*, and his observation of dopamine and serotonin as neurotransmitters responding to visual cues and sexual arousal as a plausible explanation of desire and the autonomic nervous system. Illustrating how the science of sexual desire is yet a relatively new field.

Research today recognizes the important role that dopamine plays in sexual desire. We now know that the release of dopamine signals the brain that a potential reward, in this case a love interest, is nearby and helps focus the attention on that person (Davidson, 2002). Dopamine, enhanced by testosterone drives “libido up and makes you *want the pleasure of sex, urgently...*” (Crenshaw, 1996, p. 134). Dopamine can cause or aggravate premature ejaculation (Crenshaw, 1996).

Estrogen

In utero, estrogen is produced in response to the two x-chromosomes that women have. This is responsible for shaping the embryo into a female image. Estrogen, in females, after birth remains relatively dormant until puberty, at which time it “builds breasts, cramps, blood, and mood swings” (Crenshaw, 1996, p. 168). “Men have relatively little estrogen. It is converted from DHEA and testosterone in the prostate and produced in small amounts by fat cells” (Crenshaw, 1996, p. 168). Excessive estrogen in males could cause them to grow pudgy breasts, and become hippy, their skin and hair patterns can change, and they become impotent (Crenshaw, 1996).

“Most female mammals including humans are more sexually receptive....when estrogen is highest. However, in cases where the ovaries have been surgically removed, which dramatically lowers levels of estrogen, human female sexual activity and interest

do not diminish significantly. Thus, researchers have concluded that estrogen does not affect sexual behavior directly” (Morris, 1996, p. 69). Crenshaw (1996) states while estrogen is not directly related to sexual behavior, when combined with oxytocin it does influence a woman’s desire to be vaginally penetrated, that “estrogen governs receptive sex: the desire to be penetrated and taken...” (1996, p. 172). “With estrogen and oxytocin working together, the lordotic response is at its most intense” (Crenshaw, 1996, p.173).

Estrogen is produced in the ovaries in women and the testes in men. Estrogen is important in maintaining the condition of the vagina and lubrication (Crenshaw, 1996; Masters, Johnson, and Kolodny, 1986). Estrogen influences or attracts some males by creating sexual scents, “making a woman more attractive to a man” (Crenshaw, 1996, p. 167).

Norepinephrine

As part of the fight-or-flight response norepinephrine gets your blood racing and primes you for action. It works in conjunction with PEA, dopamine and serotonin to create the initial attraction for another person, place, or thing (Ahmed, 2002).

Oxytocin

“Oxytocin is a peptide secreted by the posterior lobe of the pituitary gland” (Crenshaw, 1996, p. 97). “It plays an important role in romantic love, as a hormone that encourages cuddling between lovers and increases pleasure during lovemaking” (Ackerman, 1994, p. 163; Davidson, 2002). It is one of the few chemicals known to change during orgasm in males and females, to levels three to five time higher than pre orgasm and ejaculation. Although it figures more significantly in female’s orgasm than in

male's, it increases sensitivity to touch in both genders (Ackerman, 1994; Crenshaw, 1996). "Both males and females release oxytocin at the moment of sexual orgasm, suggesting that it might be involved in the strengthening of the bond between couples" (Davidson, 2002). Oxytocin in males increases penile sensitivity, amount of ejaculate, and sperm count (Tomkew, 1999).

"Unlike other hormones, oxytocin arousal can be generated by physical and emotional cues" (Ackerman, 1994, p. 163). In males the sight of something he perceives as sexually attractive will generate an immediate rise in his, DHEA, PEA, and consequently oxytocin level (Ackerman, 1994; Crenshaw, 1996; Davidson, 2002; Tomikew, 1999). As arousal builds more oxytocin is produced, causing the nerves in the genitals to fire spontaneously, causing or bringing on orgasm (Ackerman, 1994). For adults, a lover's smell, voice, or touch can create production of oxytocin (Ackerman, 1994). Oxytocin has a synergistic relationship with estrogen, potentiating the production of estrogen, which in turn triggers the vagina to lubricate prior to and during sexual arousal (Crenshaw, 1996).

Phenylethylamine (PEA)

PEA is a natural amphetamine that floods the brain when romance ensues, furthering sexual excitement and stimulation (Crenshaw 1996; Tomikaw 1999; www.psych.athabascau.ca/,2002). PEA levels are higher in females, especially near ovulation, which could contribute to a woman's desire to mate and procreate (Crenshaw, 1996). Ackerman (1994) also says that PEA speeds up the flow of information between nerve cells. PEA functions in males and females; it creates excitement in the body, a sense of confidence, and a readiness to try something new (Ackerman, 1994).

In males, PEA is released in the bloodstream when he visually perceives something as sexually exciting by increasing heart rate and releasing other hormones and chemicals making him believe he is in love or at least in lust (Crenshaw 1996). “PEA is a potent antidepressant—that’s why people in love feel like they’re on top of the world” (Tomikew, 1999, p. 33). Ackerman (1994) also cites Liebowitz and Klein’s studies that found people would pursue relationships to gain a sense of well being. “Researchers estimate the decay rate of the neurotransmitter as between eighteen months and five years, which may explain why many relationships end in that time period” (Davidson, 2002). However, evidence suggests that a second biochemical reaction can start which facilitates couples ability to bond and form long-term attachments (Retrieved from: www.canby.com/buzz/Addicted_to_love). Giving MAO-inhibitors, antidepressants, to a person depressed following the breakup of a relationship suppressed the body’s production of an enzyme that was reducing the effects of the body’s natural production and release of PEA.

Progesterone

Produced by the ovaries and adrenal glands, progesterone is primarily an androgen (male hormone) (Crenshaw, 1996). Because it counteracts testosterone and estrogen, it could leave a woman less sexually desirous (Crenshaw, 1996). Progesterone mutes testosterone in adolescent females, decreasing active sex drive. For some females, it increases passive receptivity, decreases genital sensation and perception of touch, decreases transmission and perception of pheromonal cues, or decreases uterine contractibility (Crenshaw, 1996). While its effects concerning desire are contrary to desire, it is important in pregnancy, breastfeeding, and nurturing of a child.

Serotonin

Serotonin is a phenolic amine neurotransmitter that is a vasoconstrictor (Merriem-Webster, 2000). Serotonin modulates testosterone levels and sexual aggression, contributing to hypo- or hypersexuality (Crenshaw, 1996). It is more abundant and influential in females, although increased serotonin decreases sex drive in males and females, which is why, *Prozac*, a serotonin selective reuptake inhibitor (SSRI) does the same (Tomikew, 1999).

Testosterone

“The male sex hormone testosterone is a small and simple molecule that directs sexual differentiation [in the forming embryo]” (Hamer and Copeland, 1994, p. 156). In utero, Testes Determining Factor (TDF) located on the Y-chromosome is responsible for activating two switches within a period of two days. One switch turns off the female pathway and the other turns on the male pathway (Hamer and Copeland, 1994) permitting the former to remain female and the latter to become male. The Leydig cells convert cholesterol to pregnenolone and this converts to testosterone. Testosterone production and regulation are by the hormone (Luteinizing Hormone- Releasing Hormone) LHRH, which keeps it at its optimum level (Crenshaw, 1996).

As the body synthesizes testosterone three major areas are affected, the internal genitalia, external genitalia, and the brain. There are three major surges of testosterone in a male's lifetime, the first is during sexual differentiation of the embryo, the second is immediately prior to and for about two month after birth, and the third is after a period of dormancy having lasted from about two months old until the beginning of puberty

signified by the male's growth of facial hair, deepening voice, and enlarged penis (Crenshaw, 1996; Hamer and Copeland, 1994).

Once a male reaches puberty, the normal range of total testosterone in a man's blood varies between 250 and 1,200 ng/dl (Crenshaw, 1996). Unattached or free testosterone is the hormone capable of contributing to sexual desire. An erection is somewhat dependent on testosterone, testosterone is more necessary for desire than function; it increases desire while decreasing tactile sensitivity of the penis. Free testosterone comprises approximately five percent of total testosterone (Crenshaw, 1996).

Females have about ten percent of a male's level of testosterone and is produced in the ovaries and adrenal glands (Masters, Johnson, and Kolodny, 1986). Testosterone, not estrogen causes "heightened erotic sensitivity of the clitoris, breasts, and nipples" (Crenshaw, 1996, p. 124). It maintains fullness of genital tissue, and accounts for romantic interest.

In both males and females, testosterone causes the desire to seek out sexual experiences, and the focus on the genitals. Above average levels of testosterone can cause aggressiveness, irritability, isolation, and a desire for solitary masturbation for males and females (Crenshaw, 1996).

Vasopressin

"Vasopressin is a peptide much like oxytocin...and [is] secreted from the same general area of the brain—the posterior pituitary. It seems to synchronize with DHEA in the brain and magnify the effects of DHEA in our bloodstream. In most respects it balances or opposes oxytocin's influence" (Crenshaw, 1996, p. 102). Basically a male chemical, it depends on testosterone for its sexual effects.

Research has shown us that sexual desire is a complex and sophisticated process. Researchers such as Kinsey, and Masters and Johnson have taught us much about the functioning of sexual organs and human sexual response. Current scientific investigation is teaching us more about the numerous chemicals involved in a combination that affect our sexual desire and performance. In consort with the physical and chemical, there is a psychological component to human sexual desire.

Chapter 4: Psychology of Desire

The psychology of sexual desire in humans is just as important an ingredient as the physiology. Hock (2002) relates:

Many people might logically place the study of sexual behavior into the disciplines of biology or physiology, and it is true that these sciences certainly connect to the topic in various ways and are the central focus of sexual behavior of animals. However, for humans, sex is a distinctly psychological event. Think about it: Sexual attraction, sexual desire, and sexual functioning are all largely dependent upon psychology....most people engage in sexual behavior for many reasons other than reproduction. Those reasons are usually psychological. Also humans, are the only species on earth to suffer from sexual problems such as inhibited sexual desire, anorgasmia, erectile dysfunction, premature ejaculation, inhibited orgasm, vaginismus, and so on. These problems usually have psychological causes. (p. 154)

Throughout history, various psychological theories have been formulated that influence the understanding of sexual desire. Over time, these theories have evolved and have been amended in response to a deeper understanding of how the human mind and body function. From Freud and his psychodynamic theory to the Post Modernist theorists, human sexuality has been explored from the most basic instincts to a more sophisticated understanding of how we process thoughts and feelings both individually and in relationship to another.

One of the most noted theories on love, lust and desire, is Tennov's concept of limerence. The word limerence is used to describe the state of falling in love or being

romantically in love. There are several components to this theory. The initial stage is intrusive thinking about the limerent object (sexual desires are included). Next is an acute longing for reciprocation from the limerent object followed by a “feeling of walking on air” when reciprocation seems evident. Then, a general feeling of intensity occurs that leaves other life issues in the background. Finally, one emphasizes the other’s positive attributes and minimizes the negative. Tennov includes sexual attraction as an important component in limerence. Although people observed in a limerent stage of a relationship may seem irrational, it is an important stage in the beginning of a relationship, as it will influence the quality and tone of their relationship for as long as it lasts, which may be a lifetime (McWhirter and Mattison, 1984).

Noted sex therapist and physician Helen Singer Kaplan added a desire phase to Masters and Johnson (1986) sexual response cycle. This is the first introduction of a psychological component to the pre-existing physiological model of the response cycle. Kaplan proposes that there must be a preexisting sexual desire in order for desire to occur. As lack of sexual desire is the most common sexual complaint in women, with thirty-three percent of women and seventeen percent of men reporting sexual disinterest, this psychological component is an important aspect of sexuality (Phillips, 2000).

Kelley and Byrne (1986) discuss three steps for sexual attraction to occur. “First, there is the *aesthetic response* based on physical attractiveness... Second, after this initial positive impression, there is likely to be an *approach response* [in which] we try to get physically close to the attractive individual. Third, if two people are mutually attracted, the next step is a *genital response*...” (p. 265).

Sexual desire in human beings is influenced by a number of external and internal, psychological and physiological factors. According to Cauthery and Stanway (1986):

Despite the fact that sexual behavior in humans is controlled and driven by one of the most primitive parts of our brain, at the same time it is strongly influenced and modulated by learned experience, as well as by the social, ethnic and cultural environment; making it an unique blend of the physiological and the psychological spheres. In addition, what is considered “normal” and “abnormal” in human sexual behavior is highly variable across culture and times; and, as such, it has changed considerably in the Western societies in the last, permissive decades. (p.119)

The role of the brain as a sexual organ cannot be underestimated. It receives and transmits sexual signals that influence sexual desire. In normal circumstances, sexual response in the brain can be triggered by sight, smell, sound, taste, and thought/fantasy (Reichman, 1998). There is a distinct difference in how males and females are triggered by and respond to external stimuli. Greene (2001) states that “the male is traditionally vulnerable to the visual...for women the weakness is language and words...” (p. 23). In contrast, Morris (1996) makes the point that “Women are likely to become sexually aroused through direct stimulation such as touch, whereas males can become sexually aroused through a visual image” (p. 420).

The DSM-IV (1994) cites the lack of sexual fantasies as one criteria contributing to Hypoactive Sexual Desire Disorder, suggesting that fantasy plays an important role in a person’s sexual desire. However, there appears to be very little empirical information regarding the role of sexual fantasy in functional sexual desire. Shame, guilt, inhibition

and repression are factors relating to the difficulty to collecting such data. Kronhausen and Kronhausen (1969) state that fantasies “serve as mental aphrodisiacs and psychological stimulants, underlying “normal” sexual behavior...they serve as safety valves for bottled-up sex feelings, strivings, and wishes...” (p. xii).

There appear to be significant gender-specific differences regarding sexual fantasy. Males have roughly twice as many sexual fantasies as females (Buss, 1994, p. 82-3). George and Caine report that eighty-four percent of females say they’ve had fantasies during sex (1998). Male’s fantasies often include strangers, multiple or anonymous partners. Their fantasies tend to focus on body parts without emotional context. In contrast, female’s sexual fantasies often contain familiar partners, focusing on someone with whom they are already romantically and sexually involved. Emotions and personality are crucial for women. Female’s fantasies often emphasize tenderness and romance, paying more attention to the way their partners respond to them rather than the visual image of the partner (Buss, 1994). “The less often they make love and the less content she is with her marriage and with her husband’s performance as a lover the more likely is a wife to fantasize” (Cauthery and Stanway, 1986:66).

Fantasy has a tremendous ability to affect an individual’s sexual psyche. “But can fantasy alone (e.g., just the power of the brain) trigger orgasm without any input from below? Masters and Johnson reported it could, as did Alfred C. Kinsey of the famed Kinsey Institute” (Reichman, 1998, p. 16). According to John Money in *The Science of Sex*, “in early adolescence, some boys report non-masturbatory ejaculation in response to erotic fantasy, with or without input from pictures, narratives, or other perceptual stimulation. The prevalence of the corresponding phenomenon in adolescent girls is

uncertain” (Retrieved from: www.heretical.com/sexsci-m/hypersex.html, 2002).

However, it is not uncommon for some women to orgasm from fantasy alone (The Boston Women’s Health Book Collective, 1998). Further, various external stimuli including sight, smell, and hearing can evoke a physical response in men identified as the psychogenic erection, which occurs absent of any physical stimulation. “A man’s brain perceives these sensations and then transmits nerve impulses to relay station in the spinal cord...(Spark, 2000, p. 72).

Reichman (1998) illustrates how sexual attitudes are shaped by family and culture: “libido is a product of our psychological, social, and physical development. It is where our bodies meet up with our culture, our instincts—and what our parents and teachers taught us” (p. 9). Cauthery and Stanway (1986) point to societal influences as contributing to some of the challenges females face in developing healthy sexual attitudes:

Our culture, and the way we bring up young girls must take a good deal of the blame for disorders of desire and response in women. Unconsciously, negative feelings towards sex still persist, and do untold harm. Virtually every woman is influenced by them to some extent, although they may well not be apparent to their conscious mind. The most severely affected women are those with desire and/or orgasm difficulties. (p. 119)

Self-image is also a contributor to healthy sexual expression. A woman may learn, for example, that if her looks don’t conform to the ideal—if she is fat or old or has a disability, then she has no right to be sexual (The Boston Women’s Health Book Collective, 1998). “In a Kinsey study women reported that a sense of well being was

most important in determining sexual happiness. Orgasm and other sexual physical response ranked fourth as important to sexual happiness”

(Retrieved from:

www.newshe.com/fsff2000/Relationship_and_General_Well_Being.shtml).

External and internal influences also affect the sexual perception and performance of males. If a man struggles with depression, anxiety, fear, or guilt, he is likely to have difficulty performing sexually, i.e. maintaining an erection (Cauthery and Stanway, 1986).

Along with a healthy sense of self, effective communication is important to functional sexual desire for the person in a relationship with another. Timothy Perper, PhD., biologist, co-editor of *The Complete Directory of Sexology*, notes that sexuality is a language—one of the many languages humans communicate with. Among the signals we send are cues about our sexual state of mind, arousal, desire, and interest (George and Caine, 1998). “An open mind and direct communication are the keys to developing and enhancing a healthy sex life between partners” (George and Caine, p. 40). Milsten and Slowinski (1999) suggest deficits in communication could be learned in the family.

Expressing emotions in their child home may have been discouraged or limited to angry outbursts. Such a background can leave a man with skill deficits when it comes to feeling and expressing emotions (of course, women can also have had poor role models at home...) p. 273.

Above all, individuals need to have an internal perception of safety in order to express healthy sexual desire. According to Bader (2002), “People get aroused if and

only if they feel safe enough to do so. When something jeopardizes our safety, sexual desire is inhibited” (p. 282).

Sexual desire is influenced by various factors throughout the lifecycle.

Physiological and emotional changes shape the way humans develop and age. An individual’s sexual desire may vary from others in his/her age group. There are notable differences concerning sexual desire in males and females throughout the life cycles.

George and Caine (1998) describe these various physiological and psychological changes:

In their twenties, if not in their late teens, males are at their sexual peak, while females reach their sexual peak in their thirties. For males in their thirties, this is a time of less sexual desire since career and societal stressors may be increasing.

As males enter their forties sexual desire continues to decline, in part, as a result of lowering testosterone levels. Lifestyle and diet may also be contributing factors in a declining sex drive. In females, the forties represent the perimenopause period, as estrogen levels begin to fluctuate. A female’s testosterone level may also be declining, blunting her sexual desire.

As the decade of the fifties approaches, a male’s desire for sex continues to decline, steadily but not dramatically. Males may notice slower, less intense sexual responses; orgasms may be less intense and refractory periods may increase. During this lifecycle females may experience a renewed interest in sex, as they no longer need worry about an unwanted pregnancy. However, during this time females may also experience menopause. Along with declining estrogen levels, females may experience a thinning of

the vaginal walls, causing dryness and making sexual intercourse painful. Hormone replacement therapy may elevate these symptoms.

In their sixties, males may become better lovers because the experience of lovemaking itself, rather than the orgasm, becomes the focus of their lovemaking. Females continue to orgasm, however orgasms may be less intense and females may have fewer multiple orgasms. At this time in the life cycle, since a male takes longer to reach orgasm, a male's and female's sexual response times are more in sync than ever.

According to SIECUS in *Sexuality and Man* (1970), sexuality in the older years exists in one form or another in all individuals who have been studied. "This does not mean that it necessarily expresses itself the ability of intercourse, for some it expresses itself only in the need for continued closeness, affection, and intimacy, in a continued intellectual interest in eroticism, or in the need for some romance in life" (p. 99).

Chapter 5: Desire Disorders

Desire disorders are perhaps one of the most challenging aspects facing us in biology and psychology treatment. While there are volumes of literature available about sexual performance disorders, considerably less addresses desire disorders. Further, Eisnitz (1999) relates that desire problems are vastly underreported, since people do not feel as entitled to seek treatment for a desire problem as they do for a sexual dysfunction. The DSM-IV cites only two sexual desire disorders, “Hypoactive Sexual Desire Disorder” (1994, p. 496) and “Sexual Aversion Disorder” (1994, p. 499). Kaplan (1995) in *The Sexual Desire Disorders: Dysfunctional Regulation of Sexual Motivation* creates a third category of sexual desire disorder, Hyperactive Sexual Desire characterized by the deregulation or lack of control over sexual motivation. Although not listed in the DSM-IV it may be diagnosed under sexual disorder not otherwise specified.

Hypoactive Sexual Desire Disorder

According to the DSM-IV (1994), Hypoactive Sexual Desire Disorder is described as a deficiency or absence of sexual fantasies and desire for sexual activity; causes marked interpersonal difficulty; is not accounted for by another Axis I disorder. The DSM-IV (1994) characterizes the diagnostic features of Hypoactive Sexual Desire Disorder as follows:

May be global and encompass all forms of sexual expression or may be situational and limited to one partner or to a specific sexual activity (e.g., intercourse but not masturbation)...There is little motivation to seek stimuli and diminished frustration when deprived of the opportunity for sexual expression.

The individual usually does not initiate sexual activity or may only engage in it reluctantly when it is initiated by the partner...because of a lack of normative age- or gender- related data on frequency or degree of sexual desire, the diagnosis must rely on clinical judgment based on the individual's characteristics, the interpersonal determinants, the life context, and the cultural setting. (p. 497)

Important to note is that “although some individuals with low sexual desire are perfectly capable of becoming sexually aroused and having orgasms” (Retrieved from: Utxas.edu, 2000).

Associated features of Hypoactive Sexual Desire Disorder include medical factors (medical conditions, surgery, medications), physiological factors (hormone related), emotional factors (depression, anxiety, stress), relationship factors (conflicts, anger, lack of trust), or sexual arousal disorder (newshe.com:2002 and DSM-IV). Kaplan relates, “Our observations confirmed the findings of others, that patients with sexual desire disorders tend to have more serious underlying emotional and marital problems” (1995, p. 5).

Sexual Aversion Disorder

According to the DSM-IV (1994), Sexual Aversion Disorder is described as the aversion to and the active avoidance of genital sexual contact with a partner. The disturbance must cause a marked distress or interpersonal difficulty, and is not caused by another Axis I disorder. The DSM-IV (1994) characterizes the diagnostic features of Sexual Aversion Disorder as follows:

The individual reports anxiety, fear, or disgust when confronted by a sexual opportunity with a partner. The aversion to genital contact may be focused on a

particular aspect of sexual experience (e.g. genital secretions, vaginal penetration). Some individuals experience generalized revulsion to all sexual stimuli, including kissing and touching. The intensity of the individual's reaction, when exposed to the aversive stimulus may range from moderate anxiety to lack of pleasure to extreme psychological distress. (p. 499)

The DSM-IV (1994) describes several subtypes of these disorders, indicating onset (Lifelong vs. Acquired), context (Generalized versus Situational) and etiological factors (Due to Psychological Factors, due to Combined Factors).

Associated features of Sexual Aversion Disorder include psychologically or emotionally based problems that can result from physical or sexual abuse, childhood trauma, etc. (Retrieved from: www.newshe.com: 2002). Additional associated features include anxiety, panic attacks, nausea, dizziness and breathing difficulties. A person with this disorder may avoid sexual situations in many different ways, for example, neglecting personal appearance, using substances, over-involvement in work or social activities (DSM-IV: 1994).

Hyperactive Sexual Desire

Kaplan (1995) in *The Sexual Desire Disorders: Dysfunctional Regulation of Sexual Motivation* creates a third category of sexual desire disorder, Hyperactive Sexual Desire Disorder characterized by the deregulation or lack of control over sexual motivation. Although not listed in the DSM-IV, it is diagnosed under sexual disorder not otherwise specified.

According to Kaplan (1995), individuals diagnosed with Hyperactive Sexual Desire Disorder have sex frequently, often having several orgasms each day. "They are

typically preoccupied with sexual feelings and/or thoughts to the extent that this interferes with their functioning at work, and/or creates problems in their relationships (Kaplan, 1995, p. 58). Additional characteristics include compulsive sexual behavior, inadequate control of sexual impulses and intense, and spontaneous sexual desire.

Kaplan (1995) offers a continuum identifying six levels of sexual desire with characteristics of each level, including Hyperactive, High-Normal, Low-Normal, Mild Hypoactive, Severe Hyperactive, and Sexual Aversion Disorder (Appendix A). Assalin and Ravart (1993) state that hypersexuality has been conceptualized as a form of compulsive behavior that represents the individual's attempt to gain relief of depression and anxiety (Kaplan, 1995).

The addiction notion has been widely publicized and the Sexaholics Anonymous movement has gained considerable following (Kaplan 1995). Another nationwide movement gaining nationwide attention is Sex and Love Addicts Anonymous (SLA).

In contrast Kaplan (1995) states:

On the other hand, anyone who has worked with these patients must be impressed with the compulsive quality of their sexual behavior. In support of the obsessive-compulsive view, there have been some reports of the efficacy of SSRIs, medications that are often effective for OCD, for this condition. (p. 63)

These two attempts at dealing with hypersexuality illustrate the different perspectives regarding this behavioral disorder.

Chapter 6: Physiological Causes/Contributing Factors of Sexual Desire Disorders

Some general medical conditions that may contribute to sexual desire disorders include: coronary heart disease (restricts blood flow), high blood pressure (damages blood vessels), high cholesterol (plaque restricts blood flow), smoking (restricts blood flow), bicycle riding (nerve damage in genital area), diabetes (neuropathy), and spinal cord injury (Berman and Berman, 2001).

In females, specific medical conditions that may lead to sexual desire disorder include: pelvic surgery or injury (hysterectomy, uterine embolization, childbirth trauma, pelvic fractures), which may affect blood flow and nerve sensation to the general area. Additionally, problems related to the production of estrogen and testosterone can also affect desire, including: menopause, endocrine disorders (disorders of the pituitary gland, adrenal glands, thyroid gland), postpartum hormone deficiencies and diabetes. Further, females may experience other physical problems contributing to sexual dysfunction, thus perhaps to sexual desire, including: endometriosis and fibroids, vaginal and urinary tract infections, interstitial cystitis, pelvic floor disorders (Berman and Berman, 2001). Other related physical conditions include: dyspareunia (painful intercourse), vaginismus (vaginal spasms), and vulvodynia (burning sensation in vulva and/or vagina). “The entire sexual response cycle can be affected with consequent inhibitions of desire, arousal, orgasm, and satisfaction (Milsten and Slowinski, 1999, pp. 246-247).”

In males, specific physiological and/or medical conditions that may affect sexual desire include: penile abnormalities (Peyronie’s Disease), anything that produces pain (a torn foreskin, short fraenum), severe shortage of testosterone (underdeveloped testes), surgery (lumbar sympathectomy, renal transplants, pelvic surgery, prostatectomy).

Chapter 7: Pharmacological Causes/Contributing Factors of Low Sexual Desire

There are numerous pharmacological contributing factors that affect low sexual desire, including chemotherapy drugs, anticonvulsants, antidepressants, antihypertensive agents, anti-ulcer drugs, birth control pills, neuroleptics and sedatives (Retrieved from: www.newshe.com, 2002).

Psychological Causes/Contributing Factors of Sexual Desire Disorders

Some of the major psychological conditions that may be involved in desire disorders are: anger, depression, anxiety, stress reactions, post-traumatic stress, and relationship difficulties. Additionally, sexual or emotional abuse, body image and drug and alcohol may also affect sexual desire.

Based on a client's religious, familial and cultural background, he or she may be seeking permission or reassurance from the therapist in regards to his or her sexual activities or lifestyle. For example in the case of an individual with a history of childhood sexual abuse, sexuality may be affected with shame and anxiety (Berman and Berman, 2001).

Chapter 7: Physiological Treatment of Low Sexual Desire

As with the treatment of any physiological or psychological disorder, effective evaluation and diagnosis are of the utmost importance. The importance of a comprehensive assessment tool is vital in gathering history, onset, context and etiological factors of the disorder being treated. Treatment may include physiological, psychological or more likely a combination of both. For the diagnosis of sexual desire disorders, Helen Singer Kaplan (1995) offers clinicians a comprehensive questionnaire (Appendix B).

After gathering the complete history of a client (Appendix C), the clinician should identify a history of general medical conditions (as stated above), surgeries and traumas. If there is any evidence or report of any physiological abnormality past or present, the client should be referred to either their primary care physician, or the appropriate gynecologist, urologist, endocrinologist, neurologist, or other appropriate specialist.

Some of the treatments options for physiological conditions that may affect sexual desire include hormone therapy, pharmacological therapy, and therapeutic devices. Susan Rako, in *The Hormone of Desire*, (Berman and Berman, 2001) relates that a level of testosterone between 20-50ng/dl is a normal range to support a female's healthy sexual desire. During menopause or in the case of a hysterectomy, the hormone levels in females may decline, necessitating medical supervision. Regarding hormone therapy in females, according to a 1998 article by Lynda Charters in *Urology Times*, "Hormone therapy combining testosterone and estrogen was more effective in maintaining sexual desire than estrogen alone or placebo in women who had undergone hysterectomy and removal of both ovaries..." (Retrieved from: www.findarticles/article.jhtml?term=%22%2Bisexual+%2Bdesire%2). Judith Reichman

(1998) concludes that estrogen replacement makes sexual activity more comfortable and pleasurable, however it has no effect on sexual desire, whereas testosterone does. She further states that testosterone deficiency can result in diminished desire and arousability, insensitivity of the clitoris and nipples, and difficulty in reaching orgasm. However, “many women with low sexual desire have normal level of testosterone” (Retrieved from: Utxas.edu, 2000). Clearly, testosterone appears to play a significant role in the libido of both males and females, and is available as a treatment, both delivered orally or through a patch. DHEA may also be potential therapy because of its effects on testosterone production (Retrieved from: Utxas.edu, 2000).

Pharmacological therapy may play a role in sexual desire, in that side effects for treatment with medication for a condition unrelated to sexual desire may indirectly affect desire. Spark (2000) states that “even the newest antidepressants, those characterized as selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine (Prozac), paroxetine (Paxil) and sertraline (Zoloft) have been reported to inhibit sexual desire and potency” (p. 204). Reported side effects from the SSRIs include diminished libido, inability to acquire an erection, and delayed or absent orgasm (Spark, 2000). Therefore, it’s recommended that the physician identify and prescribe a medicine that has the minimal incidence of sexual side effects.

Nevertheless, options exist to offset the side effects of these antidepressant medications. Current options include adding yohimbine, or substituting another antidepressant, bupropion (Wellbutrin), have all been reported to provide relief from SSRI-induced sexual dysfunction. Dr. Alan Rothschild of MacLean Hospital in Massachusetts has achieved the same effect by giving his patients a “drug holiday”,

instructing his patients to discontinue their medication of Friday and Saturday and resume their normal dose Sunday at noon (Spark, 2000).

In treating Hypoactive Sexual Desire Disorder, it was found that sustained release bupropion (Wellbutrin SR) is a safe and effective treatment in non-depressed women. It increased sexual desire, arousal, fantasy, or satisfaction with sexual desire in twenty-nine percent of the women in a study funded by Gaxo Wellcome, Inc. (Retrieved from: findarticles.com).

A revolutionary new drug therapy has been identified for the treatment of sexual arousal that appears to have a positive effect on sexual desire, sildenafil (Viagra). Although Viagra is only approved for use in males, nationwide studies among urologists, gynecologists, psychologists, and sex therapists are currently being conducted to gain FDA approval for use in treatment of female arousal disorders (Berman and Berman, 2001). While this medication does not directly treat sexual desire disorders, it does address problems with sexual arousal, which may in turn, enable a client to enjoy sexual experiences to a greater extent, thereby indirectly improving his pre-existing sexual desire.

There are a number of other medications similar to Viagra that are currently being investigated for their effects on sexual response. Still other drugs under investigation may have an effect on activity of the sympathetic nervous system, which may play an essential role in the sexual response cycle (Retrieved from: Utxas.edu, 2002).

Therapeutic devices and treatment modalities that may assist in developing and enhancing of sexual arousal and desire include penile prostheses and injections, medicated urethral suppository system (MUSE), vacuum constrictor devices (VCD),

clitoral therapy devices (EROS-CTD) and various forms of vibrators. Regarding penile prostheses, Spark (2000) relates:

In 1989 U.S. surgeons implanted an estimated 27,500 penile prostheses. That number has declined only somewhat since the advent of penile injection and MUSE therapy. The fate of penile prosthesis surgery after Viagra remains to be determined. However, since about thirty to thirty-five percent of impotent men who try Viagra do not respond well enough to resume sexual intercourse, there will always be a sizable number of impotent men who will want to have penile prosthesis surgery or some other erection assistance to help them enjoy sex again. (p. 239)

Another treatment method, intrapenile injections, facilitate sexual arousal through the use of chemicals that stimulate release of nitric oxide and cyclic GMP, thereby increasing blood flow into the corpora cavernosae, resulting in erection. While the intrapenile injections successfully provide an erection, recommended usage is a maximum of two times per week. A need to increase the dose or switch medications is standard, thereby creating a tolerance condition. Other side effects may include sclerosis, and the possibility of priapism, requiring medical and surgical intervention. Alternatively, the MUSE device utilizes a chemical, alprostadil, which is administered into the penis by placing a plastic stem into the urethra, causing an erection that lasts seventy-nine minutes. This treatment is recommended for those patients who cannot tolerate Viagra (Spark, 2000).

The principle behind the VCD is to encourage blood flow into the penis to produce an erection capable of engaging in sexual intercourse. Devices resembling the VCD have been in existence for approximately seventy years. When blood flow is

accomplished in the penis, a ring or band is placed at the base to maintain an erection. Since blood supply is cut off, it is recommended that the device be left on only thirty minutes or less. Pain and discomfort are common experiences with this device, with evidence of black and blue marks occurring in most males. Males who have had nerve damage from prostate surgery, those having no response to Viagra and those unwilling or unable to use or to continue to use intrapenile injections and/or the MUSE system are candidates for the VCD (Spark, 2000).

Therapeutic devices to stimulate sexual arousal in females include the clitoral therapy device, known as EROS-CTD, and vibrators. Approved by the FDA in May 2000, the EROS-CTD is the first intervention female sexual dysfunction (Berman and Berman, 2001). The device creates a gentle suction over the clitoris and surrounding tissue, thus creating tumescence (engorgement due to increase blood flow), thereby increasing sexual arousal (Retrieved from: newshe.com, 2002). “The theory is that, over time, this will prevent fibrosis of the clitoral and labial arteries and the clitoral and labial erectile tissue that typically occurs with aging and menopause” (Berman and Berman, 2001, p. 12). Vibrators are also used to increase sexual arousal. There are many different types of vibrators; some directly stimulate the clitoris, while others are shaped for use inside the vagina. A penile shaped vibrator can also be inserted into the vagina while the clitoris is manually stimulated (Berman and Berman, 2001).

Chapter 8: Psychological Treatments for Sexual Desire Disorders

The treatment of a person's sexual desire disorder may be treated individually, however, most often, clinicians are presented with these disorders within the context of the coupleship. Common issues occurring in the context of a partnership, which may affect sexual desire, include communication problems, anger/resentment, expectations, fear of not being accepted/rejection, misconceptions concerning sexuality within the relationship. Further, according the DSM-IV (1994):

The clinician may need to access both partners when discrepancies in sexual desire prompt the call for professional attention...Apparent low desire in one partner may instead reflect an excessive need for sexual expression by the other partner. Alternatively, both partners may have levels of desire within the normal range, but at different ends of the continuum. (p. 497)

Based on the results of the diagnostic tool and the initial diagnostic interview, an appropriate treatment modality or referral can be made. With the use of the assessment tool and the clinical interview, the clinician can accurately identify and diagnose the patient's condition.

As the clinician compiles the sexual history and physical information and rules out physiological causes, a course of treatment can be identified and discussed with the patient. The DSM-IV (1994) refers to the clinician's expertise to factor in various social, cultural, interpersonal, and gender related influences to accurately assess the client's problem. Often, medical and psychological treatment can occur concurrently, such as a patient being treated with an antidepressant and also receiving psychological treatment. Important to mention is that psychological treatment for a sexual disorder should be

provided by a nationally certified clinical sexologist, who is also State licensed to provide mental health treatment.

Reichman (1998) describes Jack Anon's approach to treating sexual dysfunction, which has been recognized as an effective counseling method. This method consists of four stages including permission, limited information, specific suggestions and intensive therapy (PLISSIT).

Permission is the concept of allowing oneself (or partner) the freedom and acceptance of one's sexual self, identity and expression. Limited information is the educational aspect of therapy in which the patient is provided reference material, videos, pamphlets about sex toys, paraphernalia and erotic reading material, which opens the client to his/her own eroticism and provides accurate sex information.

Specific Suggestions consist of behavioral therapy techniques designed to address specific sexual desire disorders affecting the client individually, within the coupleship, and/or both. Such assignments are designed to facilitate an increased self-awareness and intimacy. Examples of these exercises include sensate focus, in which concentration is directed toward the physical senses (meditation and massage); reading erotica and viewing erotic videos; sensual touching/self- or partner-massage; and sexual stimulation. "The goal is to feel comfortable giving and receiving pleasure without having to perform or reach orgasm" (Reichman, 1998, 153). Further, the role of sexual fantasy has been effective in treating low sexual desire. Couples can be encouraged to explore and share safe, non-threatening romantic and sexual fantasies with each other (Green, 2002).

If the previous approaches do not produce results, intensive therapy may be required, as in the instances where underlying psychological conditions exist, such as

depression, anxiety, obsessive-compulsive disorder, bipolar disorder. Concurrently, at this point referral to a psychopharmacologist may be necessary. Other unresolved issues such as family dysfunction, trauma, sexual abuse, rape, as well as current relationship problems may warrant this more intensive psychotherapy approach.

It's important to understand that effective diagnosis and treatment for sexual desire disorders is an integrated approach that combines the mind and body (Berman and Berman, 2001). Understanding of a patient's cultural, familial, relational, and life-cycle influences, along with his or her medical history (if appropriate) provides an integrative approach in the treatment of sexual desire disorders.

Chapter 9: Discussion

Sexual desire is one of the most powerful forces on this planet. It includes instincts, thoughts, feelings, and urges. It is part of a biological nature and our physiological drive. It has a purpose of survival of the species and pleasure of our existence. Sexual desire can bring us to incredible heights and deplorable depths, physically, emotionally, and spiritually.

In creating this work, it is recognized that humankind has great difficulty in understanding sexual desire, and even greater difficulty attempting to control it. Evident throughout the research efforts, is humankind's fear of sexual desire, and the subsequent attempts to regulate and moralize it. It seems though, that most attempts at suppressing sexual desire result in emotional distress and pathology. It is almost as if various cultures feared that sexual desire was not controlled would cause chaos or mayhem. Could it be that persons in power of various cultures feared their own sexual urges and projected their need to control them on to the masses? Are we so animalistic in this area of existence that without regulation of sexual desire there would be sexual anarchy? Or would human beings find a balance of their sexual desire by themselves within the context of civilization?

As our knowledge and understanding of biology advances, we are able to identify imbalances within the chemistry of our bodies and therefore develop ways to treat them. It seems that the understanding of the psychology of sexual desire often leads us to the study of how an individual perceives his/her sexuality and how he/she is able to express it within his/her culture and relationships. Often, conflicts between society and self are the root causes for dysfunctions of sexual desire. The balance between a person's sexual

thoughts and feelings, and the culture in which he or she lives, is important to one's sexual health. Often this balance is difficult to achieve, resulting in conflicts and pathology. It seems that it is the individual's and society's responsibility to identify a balance between personal sexual desires and the prevailing culture. Some cultures have recognized the needs for personal freedom, sexually and otherwise, and are known as more permissive and tolerant cultures.

Perhaps religion is the culprit of repression of sexual desire. If it is, has it been shown to promote a more functional environment? One look at Middle Eastern society will tell you that religious/sexual repression has not produced a more functional society. Permission, tolerance, and freedom are essential in creating an environment where healthy sexual desire can exist. Is it unrealistic to propose a culture that respects an individual's sexuality will be an overall mentally healthier culture, therefore a more functional environment?

This work has stimulated as many questions as it has answers in regards to sexual desire. However, the importance of asking questions leads to answers in our quest for understanding sexual desire, and ultimately, in our quest for personal freedom.

Appendix A. Continuum of Sexual Desire

<i>Hyperactive Sexual Desire</i>	Intense, spontaneous sexual desire and fantasy.
(Sexual Addiction; Nymphomania; Don Juanism)	compulsive sexual behavior; high frequency; inadequate control of sexual impulses, distress.
<i>High-Normal Sexual Desire*</i>	Spontaneous sexual desire and fantasy; proactive sexual behavior; normal sexual functioning; high frequency.
<i>Low-Normal Sexual Desire*</i>	No spontaneous sexual desire or fantasy; reactive sexual behavior; normal sexual functioning; average or low frequency.
<i>Mild Hypoactive Sexual Desire</i>	No spontaneous sexual desire or fantasy; sexual avoidance; poor sexual functioning; low frequency, distress.
<i>Severe Hypoactive Sexual Desire</i>	No spontaneous sexual desire or fantasy; poor sexual functioning; sexual avoidance; very low frequency or celibacy, distress.

Sexual Aversion Disorder

Active aversion to and/or phobic avoidance
of sex;

(Sexual Phobia)

very low frequency or celibacy, distress.

*Normal levels of sexual desire

Appendix B. Questionnaire for the Diagnosis of Sexual Desire Disorders

1. Does the patient have a genuine desire disorder? What kind? (HSD)?
Sexual Aversion?
2. Is the desired problem lifelong or acquired?
3. How severe is the patient's desire disorder?
4. Is the patient experiencing distress because of his or her desire disorder? Is this damaging the relationship with the partner?
5. Is the disorder of sexual disorder primary or secondary to another pathological condition? (Psychiatric? Medical?)
6. What is the cause? (Organic? Psychogenic? Mixed?)
7. If the problem is psychogenic, what are: (A) the immediate causes of the patient's loss of desire or aversion? (B) the deeper causes?
8. Is the lack of desire or aversion generalized or specific to the partner?
(What, if any, are the contributions of the relationship? Does the patient have a pattern of losing his/her desire with familiar partner?)

Appendix C. Sexual Assessment and History Interview

Historical Information

I. Background and Early Childhood

The purpose here is to develop an understanding of the client's early affectionate and interpersonal experiences and his or her feelings about those experiences. Of special concern are early attitudes and feelings about affection, closeness, trust, male-female relationships, and sex that might have been fostered with the person grew up.

A. Family Background

1. Place of birth? Did your family travel around much during you childhood?
2. How old were your parents when you were born?
3. Do you have any brothers or sisters?
4. Are your parents still living?
 - a. Are they still married?
 - b. Had either a previous marriage?
5. What were your parents occupations?
6. Quality of relationships with family while growing up?
 - a. One or both parents emotionally distant, close, warm, binding, seductive?
 - b. More attached to one parent than another?
 - c. Closer to the same-sexed parent or opposite-sexed brother or sister?

B. Religious Influences

1. In what religion were you raised?
2. Were both of your parents of the same faith?
3. How religious were your parents?
4. Was religion an active factor in your early life (Sunday school, parochial school, etc.)?

C. Attitudes toward Sex in the Home

1. Were you allowed to ask questions about or discuss sexual topics?
 - a. How did your parents usually respond to questions?
 - b. Did you ever turn to siblings for information?
 - c. Can you remember any examples?
 - d. Did you get the feeling that one or both parents would be uncomfortable if you had tried to ask them questions about sex?
1. Was affection shown between your parents?
 - a. How were your parents affectionate with each other (was affection usually expressed verbally or physically)?
 - b. Did you get the feeling that your parents cared a lot about each other, whether or not they were visibly affectionate?
 - c. Was one parent more affectionate than the other?
2. Were your parents affectionate with you?

- a. Describe the kind of affection you received (verbal, physical) and who was more affectionate?
- b. Would you have liked more, less, or the same amount of affection from your parents?
3. What was the attitude toward nudity (or modesty) in your home?
4. What do you think your parents' attitudes toward sex were?
 - a. With each other?
 - b. Toward your own developing sexuality?
5. What kinds of sexual comments were made around the house by your parents either about other people, each other, or in terms of jokes?
6. What influence did your siblings or friends have on how you thought about sex at this time?
 - a. Did you ever discuss sex with friends or siblings?
 - b. Was sex the subject of jokes and embarrassment?
 - c. Did you consider sex dirty, frightening, curious, interesting?
7. Do you recall playing any games with sexual content as a child (i.e., "Doctor")?

D. Emerging Sexuality

1. At about what age do you recall first having pleasurable genital feelings?
 - a. Were these in connection with any particular thoughts, activities, or situations?
 - b. Did you define these activities as good or bad feelings at the time?

2. At what age did you first experiment with masturbation (or any other solitary activity that produced genital feelings of pleasure)?
 - a. Describe how and where you did this.
 - b. How often did you engage in this?
 - c. How did you feel about doing this?
 - d. Were you ever discovered at this?
3. Do you remember any petting experiences that occurred during childhood with regard to sex?

II. Puberty and Adolescence

A. Sexual Education

1. Toward which parent/sibling did you feel closest? To whom did you take your problems?
2. Did you have many friends, a few close friends, or were you a "loner"? Were they mostly the same sex or opposite sex? Have you had many, a few, or almost no close friends of the opposite sex?
3. When did you first learn about conception and reproduction?
 - a. How did you learn?
 - b. How did you react to this?

(females)

4. At what age did you start to menstruate?

- a. Had menstruation been explained to you in advance? How and by whom?
 - b. Was the subject discussed among your friends? What term(s) did you use to refer to it?
 - c. What were your feelings in anticipation of menstruation?
 - d. How did you feel after it had begun?
 - (1) Do you recall it influencing your life-style in any way?
 - (2) Did you feel any differently about yourself and your body?
 - e. Have you ever had any menstrual difficulties?
 - f. Have you ever had sex during your period? How do you feel about this idea?
5. Have you ever had sexual dreams where you felt you were aroused in your sleep? Have you ever had an orgasm during sleep?

(males)

6. How old were you when you had your first nocturnal emission (or "wet dream")?
 - a. Had you been told about these in advance? How and by whom?
 - b. How did you react?
7. How did you feel when you first heard about the fact that women menstruate?

A. Dating Behavior

1. At what age did you start to date?
 - a. In groups?

- b. On single dates?
2. Were most of your friends at this time male or female?
3. Did you date many different people or did you usually have a steady relationship with one person at a time?

B. Petting Behavior

1. What kinds of petting did you engage in?
2. Where did petting behavior usually occur? Under what circumstances?
3. What kind of emotional relationship did you have to have with someone before you would become involved in petting?
4. Was there any touching or manipulation of genitals involved?
5. How did you respond sexually to this behavior?
6. How did you feel about engaging in these behaviors?
7. How would your parents have responded if they knew? What were their attitudes about petting or other nongenital sexual contact?
8. Any negative petting experiences?

C. Coital Experiences

1. Did you ever engage in intercourse premaritally? If so, describe the first time.
2. Under what circumstances and how frequently did intercourse usually occur?
3. How did you respond sexually? (Were you orgasmic? Or were there any problems with erection or premature ejaculation?)

4. What were the emotional conditions that you needed to have intercourse with someone? For instance, was it important that you were in love with each other, emotionally involved in some way, committed to a long-term relationship, engaged, or married? Could you have sex with someone without being emotionally involved with them?
5. What feelings usually accompanied intercourse (satisfaction, guilt, pleasure, embarrassment, anxiety, etc.)?
6. Were you ever "walked in on" while you were having sex with someone?
7. Have you ever had any problems with VD? Pain during sex? Herpes?
8. What form of contraception did you use? Whose responsibility was this?
9. Did your parents ever discuss intercourse with you? Contraception?

D. Other Experiences

1. Did you read erotic material? Go to pornographic movies?
2. How frequently did you have sexual fantasies with masturbation, petting, or intercourse?
3. How often were you masturbating during these years?
4. Do you remember any sexual encounters with a member of the same sex? If so, how did you feel about this?
5. Do you remember ever seeing a person expose himself or masturbate in public?
6. Did you have any unpleasant experiences with undue physical intimacy by strangers or a family member or friend?
7. Any other unusual or unpleasant sexual experiences during these years?

(females)

8. Do you remember any discussions about homosexuals? Or the possibility of assault or rape? Describe?

(males)

9. What did you think of the women who would have intercourse with you? What about the women who refused?

E. Premarital Behavior and Feelings

1. Have you ever been in love before?
 - a. What does being in love mean to you?
 - b. Do you easily become emotionally involved with people? Do you easily fall in love?
2. Were you ever engaged, married, or seriously involved in another relationship(s) before meeting your spouse? If so, describe.
3. Describe the different sexual behaviors engaged in with spouse before marriage.
4. Describe the quality of these sexual experiences.
 - a. How did you respond sexually (orgasmic, etc.)?
 - b. How did you feel about this?

Current Information

I. Current Attitudes and Beliefs

A. The purpose of this section is to find out:

1. Current sexual values and behaviors
2. The degree of integration or segregation of sex from other aspects of the client's life
3. What areas might be particularly difficult for him/her to change

B. Current Attitudes toward Sex

1. What is your attitude toward sex in general? What specific activities are enjoyable? Do you ever feel dirty or guilty about any aspects of sex? Or thinking about sex?
2. Do you feel positive, negative, or neutral about:
 - a. Your genital area
 - b. Menstruation
 - c. Vaginal secretions and semen
 - d. Masturbation
 - e. Oral-genital contacts
 - f. Foreplay
 - g. Intercourse
 - h. Manual orgasms
 - i. Sexual fantasy
3. What do you think are your partner's perceptions of (1) and (2) above?

4. Do you feel that men and women should have distinct and different roles in nonsexual activities? In sexual activities? How does your current situation agree or disagree with views on sex-specific roles?
5. What sort of conflicts do you have between your own attitudes about sex and those of:
 - a. Peer groups
 - b. Religion
 - c. Your partner
6. How do you see the place of sex in marriage? Is it very important to you or not?

III. Current Behavior

A. Some of this is redundant. Pursue according to nature of problem and clarity of information already derived from other questions. Some repetition is useful to check reliability and to allow clients to share some information that they might not have recalled earlier.

B. Types of Noncoital Activity

1. What are the more pleasurable physical contacts between you and your partner that are not followed by intercourse? Do these activities occur frequently enough for you?

2. What are the more pleasurable contacts between you and your partner that do precede intercourse? How would you change them (duration, frequency, emphasis on manual or oral)?

C. Homosexuality

1. How would you describe your sexual identity? Are you comfortable with it?
2. Have you ever thought you would like to experience a sexual activity with someone of the same sex? How do you feel about this?

D. Extrarelationship Coitus

1. What kinds of social relationships do you have with people of the opposite sex (close friendships, frequent socializing, etc)?
2. During your marriage or current relationship, have you had any noncoital affectionate relationships with opposite-sexed friends? What sort of behaviors were involved? How intimate do you view the contacts? Was and is your partner aware of them?
3. Have you experienced coitus outside of your marriage relationship? How many times? Was it pleasurable? How did you feel about it? Were you orgasmic? Would you repeat the experience? Did/does your partner know?

E. Communication

1. Are you and your partner able to talk about most things? What are subjects that you avoid, find difficult, or often fight about?

2. Would you like to change the ways in which you communicate? How would you like to see your communication patterns change?
3. Is it difficult to tell your partner what you like about him/her? What don't you like?
4. Do you tell your partner what you do and do not like *during sex*? Do you feel comfortable expressing your preferences about what is going on when you are having sex? Do you feel comfortable sometimes being the initiator of sexual activity? How do you feel when your partner initiates sexual activity or refuses a sexual advance that you make?

F. Relationship

1. How do you feel about your relationship? Are you getting the things you want from it? What are some good things?
2. Do you feel satisfied with the amount and type of physical affection you have with your spouse? How often is he/she affectionate without necessarily expecting sex to follow? How about nonphysical affection—things that show consideration or caring?
3. What happens when you argue? What do you argue about? Have you ever separated or considered divorce?
4. How do you see your sexual difficulties affecting other aspects of your relationship?
5. What other areas in your marriage, in addition to sex, are currently causing trouble for you?

G. Life-Style

1. Are you working or unemployed? How do you feel about his? Any plans to go back to school or work, or to retire? How does your work (or your spouse's) affect your marital and sexual relationship? Do you feel you have enough time together? Are worries about work a problem? Is fatigue a problem?
2. If there are children: How do you feel your children affect your overall relationship with your spouse? Do you feel they affect your sexual relationship in any way? For example, do you feel concerned about a lack of privacy with the children around?

H. Nature of Sexual Difficulty

1. How would you describe the sexual problem(s) you've been experiencing?
2. How long has this been a problem? Do you recall the circumstances under which it first occurred or you became aware of the problem?
3. What are your ideas on how or why this problem developed? If dysfunction is present for both partners: Which do you recall as having developed first?
4. If dysfunction centers in one partner: In what way do you feel the problem affects your own or your partner's sexual functioning?
5. How have you both handled this difficulty in the past? What have you tried to remedy this problem (read books, tried different techniques, sought material or sexual counseling)?
6. Information on specific dysfunctions.

Below are some of the questions that should be asked in order to get a clear picture of the sexual problem. It is a good idea to inquire about all aspects of the sexual relationship since clients may not recognize all the problem areas. It is important to get the clients' feelings about the problem as well as the relevant facts. The spouse should also be asked for his/her perceptions of the problem in order to clarify any discrepancies and to evaluate the interactional factors that may be involved. Words such as *intromission* and *foreplay* should be defined for the client to ensure accuracy of information.

a. Premature ejaculation

- (1) How often do you have intercourse? How does this compare with your frequency in the past? Have you noticed any relationship between recency of intercourse and premature ejaculation?
- (2) When did you begin to notice this as a problem? After stimulation begins, how long does it usually take for you to have an orgasm? Does ejaculation occur inside of or outside of the vagina?
- (3) What kinds of stimulation do you usually receive during foreplay? Do you usually enjoy foreplay (too long, too short, too predictable)?
- (4) What do you do after ejaculation (manually stimulate wife, try for second erection, etc.)?
- (5) What about masturbation—how often do you masturbate? How quickly do you ejaculate?
- (6) Have you found anything that influences how quickly you ejaculate (alcohol, drugs, the use of a condom, etc.)?

- (7) What have you tried to delay ejaculation?
- (8) Have you ever seen a medical doctor for this? When? Any previous therapy experiences?
- (9) Are you on medication? Have you noticed any relationship between taking the medication and the problem of premature ejaculation?
- (10) Inquire about upsetting experiences that may relate—psychiatric problems, other medical problems.

b. Erectile problems

- (1) Has this ever been a problem for you? When did this problem start?
Under what circumstances does it usually occur? What influence does your relationship with your spouse have on this problem? What percentage of the time is this a problem?
- (2) When do you have a problem with erections—during foreplay? During intromission? During intercourse?
- (3) Have you ever experienced pain with intromission or ejaculation?
- (4) If you have a problem getting an erection, how do you as a couple handle this? What have you tried to remedy this problem? Any previous therapy?
- (5) Do you have a history of diabetes? Heart or circulatory problems?
Kidney or prostate problems?
- (6) Are you or have you ever been a heavy drinker?

- (7) Are you on any medication? For what? For how long? Have you noticed any relationship between the medication and the problem of erectile difficulties?
- (8) Do you have nocturnal emissions? Morning erections? Are you often fatigued when you begin sexual activities?
- (9) Have you seen a medical doctor about this problem? How recently?
- (10) How often do you masturbate? DO you have any erectile problems during masturbation?
- (11) Are there upsetting experiences that may relate? Psychiatric problems? Other medical problems?
- (12) What kinds of contraception do you use? Are you concerned about your spouse becoming pregnant?

c. Orgasmic dysfunction

- (1) Do you get aroused during foreplay? Intercourse?
- (2) Have you ever had an orgasm during foreplay? What percentage of time? During intercourse? What percentage of time? What kind of stimulation do you receive during foreplay? During intercourse? What positions do you use for intercourse?
- (3) When did you first start experiencing problems? What seems to influence your ability to become aroused? Are you often tired when you begin sexual activities?

- (4) Are you orgasmic during masturbation? What percentage of time? If female seems uncertain about whether she's orgasmic or not, or to find out if orgasm is pleasant to each female client: how would you describe your sensations during arousal? Orgasm?
- (5) What arouses you? Do you have sexual dreams or fantasies? How does your relationship with your spouse affect the problem?
- (6) How much time is spent in foreplay? In intercourse?
- (7) Do you ever experience any discomfort or pain? (If yes, get client to specify where, when.). Do you have problems with vaginal or bladder infections? How often?
- (8) Does sexual contact usually lead to intercourse? What percentage of time?
- (9) Do you take any medication? Any problems with alcohol, diabetes?
- (10) What kinds of contraception (if any) do you use? For how long? Any problems? Are you concerned about getting pregnant?
- (11) If age indicates, inquire about menopause.
- (12) Do you have any menstrual difficulties?
- (13) Have you seen a medical doctor about your sexual concerns?
- (14) What have you tried to do about this problem? Any previous therapy?
- (15) Are there any other upsetting experiences that may relate? Psychiatric problems? Other medical problems?

Questions about other sexual problems such as vaginismus, dyspareunia, or low sex drive should follow the same type of format: When did the problem start; what influences the occurrence of the problem; any relevant medical information and the couple's or individual's attempts to solve the problem. Usually a thorough medical exam is advised as a matter of course to rule out any physical causes of dysfunction.

IV. Summary Question

Is there anything else that you would like to tell me about your background that you feel bears on your sexual life?

V. Goals

A. Why would you decide to come for sex therapy at this time?

B. How would you like things to be different sexually and nonsexually after therapy? (Ask for specifics from both partners.)

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