CHAPTER 5

CONTEXT OF SEXUAL DISORDERS: ISSUES AND QUESTIONS IN THE PRESENT AND PAST

Of all the topics we consider, the content of sexual action and interaction has received the least scholarly attention. What people do sexually—alone or with others—and how they think about their sex lives are subjects that have rarely entered the mainstream of social scientific discourse. . .the level of an individual's sexual activity, however indexed over time, is perhaps the most lore ridden (topic) of all.

LAUMANN ET AL, 1994[1]

PROLOGUE

In the process of eliciting information about determinants of sexual dysfunctions, Kaplan incorporated a cross-sectional and a longitudinal view that included all aspects of biological, psychological, and social theorizing[2] (Box 5-2). She specifically described psychosocial contributing factors as "immediate" (Box 5-1) and "remote" (p. 118).

In scrutinizing the foundations of a sexual dysfunction, there is no necessary incompatibility between immediate and remote factors. They can, and often do, coexist. It is not necessary to theorize about an either/or issue. Uncovering immediate contributors requires an analysis of present sexual events. Other than the significant issue of personal comfort of the health professional, primary care clinicians can easily acquire immediate information within the time frame ordinarily spent with patients (although the process may involve more than one visit).

Other than the significant issue of personal comfort on the part of the health professional, primary care clinicians can easily acquire "immediate" information within the time-frame ordinarily spent with patients (although the process may involve more than one visit).

The process of discovering remote causes is considerably more complex and includes taking a developmental history (the "story" of the person from birth to the onset of present troubles). Acquiring this information involves more time than many primary care clinicians are regularly prepared to allow. In such instances, consulting a mental health professional who is comfortable with the subject of "sex" and skilled in talking to patients about sexual issues might be a reasonable alternative. Nevertheless, the section of this chapter on remote issues may be useful to the primary care health professional for reference purposes on a particular topic or to develop a better understanding of subjects covered if the patient was referred to a specialist.

PRESENT CONTEXT: IMMEDIATE ISSUES AND QUESTIONS

The most illuminating method for uncovering immediate contributors to a sexual dysfunction is through a detailed description of a recent sexual encounter. To be sure, this is not simple for the patient or the health professional. Describing the nature of,

Box 5-1 "Immediate" Psychosocial Causes of Sexual Dysfunction

1. Sexual ignorance
2. Fear of failure
3. Excess need to please a partner
4. Spectatoring[2]
5. Failure to communicate sexual preferences
6. Relationship problems

Adapted from Kaplan HS: *The new sex therapy: active treatment of sexual dysfunctions,* New York, 1974, Brunner/Mazel, Inc., pp. 121-136.

Box 5-2 "Remote" Psychosocial Causes of a Sexual Dysfunction

1. Internal conflict over sexual pleasure
2. Restrictive upbringing
3. Developmental sources of sexual conflict
4. Transference
5. Lack of trust
6. Traumatic early sexual experience

Adapted from Kaplan HS: *The new sex therapy: active treatment of sexual dysfunctions,* New York, 1974, Brunner/Mazel, Inc., pp.137-184.

for example, an erection problem is very different from telling the story of *"who does what to whom"* in bed (or anywhere else). The facts involved in the static and cross-sectional description of one's current sexual problem seem much easier to talk about than the dynamic and longitudinal view of a sexual encounter involving another person. Patients who spontaneously describe their sexual experiences run the risk of being seen as verbal exhibitionists, and health professionals who ask questions about these events might be viewed as voyeurs. Two factors could prevent either view:

- An attitude of the health professional that sexual function is a proper dimension of health and therefore a legitimate topic for discussion
- The ethical cloak of the health professional, which defines in whose interest questions are being asked (the patient's) and for what purpose (clarification)

Kaplan referred to the process of asking about the minutiae of a sexual encounter as the Sexual Status Examination[4] (pp. 77-84). Because of the great sensitivity involved in revealing specifics, it is best not to ask this at the beginning of an initial visit. Patients should have an opportunity to decide if they feel comfortable disclosing private and personal information to a particular health professional.

Questions can begin with the patient's (or couple, if both are seen together on a first visit) practices in being affectionate with a partner and how this is separated from what is regarded as "sexual."

The following are initial questions that might be asked of a heterosexual man (although they apply equally well to heterosexual women and same-sex partners):

Q. In what ways are you affectionate with your wife (husband, partner)?
Q. Is it possible for this to occur without thinking that some sexual event will automatically occur as a result?
Q. Do you sleep in the same bed together?
Q. What sort of bedclothes do you and your wife (husband, partner) wear?
Q. Do you snuggle together before going to sleep?
Q. Does this involve touching each other?
Q. What are your "geographical" limits to touching?
Q. What are your sexual "signals?"
Q. How do you separate affectionate and sexual signals?
Q. What are you thinking about when something sexual might occur?
Q. What sort of thoughts do you have at that time about the problem that brought you here today?

Much of the questioning revolves around touching, an aspect of human communication that is intimately related to sexual behavior[5] (pp. 204-236). Answers give the interviewer some idea of the level of sexual communication between the partners and also the extent of anticipatory worry about the sexual difficulty. The interviewer often hears that partners used to be affectionate with each other but that, since the onset of sexual troubles, sex and affection have diminished. This is often to the chagrin of both (see "Treatment of HSD" in Chapter 9).

The patient might then be asked to describe the last time that a sexual experience occurred. When a person is obviously uncomfortable with the request, the interviewer should quickly offer to ask specific questions. The focus in particular should be on what occurred just before attempts at intercourse, since the immediate precursors to sexual dysfunctions are often discovered with this kind of inquiry.

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Illustrative questions concerning sexual practices short of vaginal intercourse follow (asked, in this example, of a heterosexual man):

Q. Do you recall the last time a sexual experience occurred with your wife (partner)?
Q. Was the location usual for you?
Q. What occurred before attempt at vaginal entry?
Q. Do you usually touch your wife's (partner's) breasts before intercourse?
Q. As far as you know, how enjoyable is that for her?
Q. How does she let you know?
Q. Does she touch your penis?
Q. What are you thinking about when that happens?
Q. Are you clear with her about how you like your penis touched?
Q. Have you ever ejaculated when she rubbed your penis?
Q. How does she feel about the wetness of your semen?

Q. Do you touch your wife (partner) between her legs?
Q. What are you thinking about when that happens?
Q. How does she react to that?
Q. Are you aware of where her clitoris is?
Q. Do you stimulate her in this area?
Q. Has she told you how she likes to be touched?
Q. Does she come to orgasm when you're touching this area?
Q. Does oral stimulation of your penis take place?
Q. Do you stimulate her genital area orally?
Q. How do each of you feel about that?
Q. What are you thinking about when you're stimulating her orally?
Q. Are there other kinds of sexual experiences that you and your wife (partner) have together before you attempt vaginal entry?

These questions are explicit enough to uncover the following information:

1. Deficits in knowledge about body parts
2. The range of sexual activities engaged in by the patient and partner
3. Attitudes toward different sexual actions
4. The level of sexual communication between patient and partner
5. What occurs in the patient's mind as the experience evolves

These questions will reveal immediate problems such as:

- Sexual ignorance
- Fear of failure
- Excessive need to please the partner
- "Spectatoring"
- Insufficient communication

When these factors exist, they often can be quickly and effectively remedied.

Little objective information existed in the past about common sexual practices of heterosexual, gay, and lesbian couples. The knowledge that HIV/AIDS is usually transmitted sexually and is therefore potentially preventable has resulted in a need for more information about what people do sexually with one another. Laumann and colleagues discussed the occurrence and incidence of various sexual practices (Tables 5-1 and 5-2) used by opposite gender, gay, and lesbian partners[1] (pp. 96-109 and 317-320).

Almost 75% of men and women subjects in the Laumann et al. study reported that fellatio or cunnilingus was performed by an opposite-sex partner at some time in their lives.[1] Rates of experience over the previous year were similar to lifetime experience, yet only about 25% of the respondents experienced fellatio or cunnilingus during their last sexual event. The conclusion of the authors was that oral sex was familiar to many people and that, after experience with this practice, it was at least occasionally incorporated into a person's sexual activity for the remainder of their lives (p. 107). They added, however, that these two sexual activities did not become defining features of sexual activity between women and men—as was the case of vaginal intercourse, or perhaps, kissing (p. 101). Among gay men and lesbians, rates of activity increased as

Table 5-1 Sexual Practices of Men

	ANY SAME-GENDER PARTNERS IN PAST YEAR (%)	TOTAL POPULATION (%)
Masturbation (1x/wk or > {ly})	69	27
Active oral sex (sp)	89	77
Active oral sex (le)	—	27
Receptive oral sex (sp)	94	79
Receptive oral sex (le)	—	28
Active anal IC (sp)	79	26
Receptive anal IC (sp)	77	—
Anal IC (ly)	—	10
Anal IC (le)	—	2

Adapted from Laumann EO et al: *The social organization of sexuality: sexual practices in the United States,* Chicago, 1994, The University of Chicago Press.
sp, Since puberty; *ly,* last year; *le,* last event;
IC, intercourse.

Table 5-2 Sexual Practices Of Women

	ANY SAME-GENDER PARTNERS IN PAST YEAR (%)	TOTAL POPULATION (%)
Masturbation (1x/wk or >[1y])	—	8
Active oral sex (sp)	—	68
Active oral sex (le)	—	19
Receptive oral sex (sp)	—	73
Receptive oral sex (le)	—	20
Anal IC (ly)	—	9
Anal IC (le)	—	1

Adapted from Laumann EO et al: *The social organization of sexuality: sexual practices in the United States,* Chicago, 1994, The University of Chicago Press.
sp, Since puberty; *ly,* last year; *le,* last event.
IC, intercourse.

"homosexuality" was defined more narrowly (see below in this chapter for a discussion of homosexuality and problems with the definition).

The interviewer can continue with specific questions about vaginal intercourse (asked, in this example, of a heterosexual woman):

Q. How is a decision made about vaginal entry?
Q. What intercourse position(s) do you usually use?

Q. Is that something that the two of you talk about?
Q. What happens to your excitement level after he enters?
Q. Are you usually wet when he enters?
Q. Does he have any trouble entering because of the stiffness of his penis?
Q. What do you think about when he's inside?
Q. Does he usually tell you before he ejaculates?
Q. Does he usually ejaculate before you're ready?
Q. Do you tell him if you want him to delay ejaculation?
Q. Do you usually come to orgasm when he's inside?
Q. What do the two of you do after he ejaculates?
Q. How do you feel about the wetness of his semen?
Q. What do you think about when you're lying together?
Q. What is your experience with anal intercourse?

Laumann and colleagues had little to say about vaginal intercourse, since the lifetime experience of survey subjects with this sexual practice was virtually universal.[1] Much more was said about anal intercourse, which differed substantially in heterosexual men and women when compared to oral sexual activity (see Tables 5-1 and 5-2). The authors concluded that anal intercourse was "far less likely to become a common or even an occasional sexual practice once it has been experienced" (p. 107). The occurrence of anal intercourse among gay men is of particular interest because of its link to HIV/AIDS transmission. Of interest was the finding that 20% to 25% of the (narrowly defined) homosexual men reported that they have never experienced anal intercourse.

The questions outlined above provide details about the nature of the specific problem and, as well, can reveal information about immediate causes of a sexual dysfunction.

CONTEXT OF THE PAST: REMOTE ISSUES AND QUESTIONS

Some sex therapists say that in the process of assessing someone with a sexual complaint, one does not need to (indeed, *should* not) obtain detailed information about that person's life history unless obstacles arise[6] (p. 416). However, apart from clinical opinion, some research was conducted on the value of linking past and present. Heiman and colleagues studied couples defined as "clinical" (on a waiting list for a sex therapy clinic) and "nonclinical" (obtained from a newspaper ad).[7] She found that issues from "the more distant past" could be important for those with sexual dysfunctions, especially women. Clinical experience supports this point of view. Experience rather than research is the major tool guiding the clinician in clarifying when and under what circumstances detailed exploration of the past should or should not take place.

Circumstances in which an elaborate investigation of the past may *not* be necessary can often be defined in advance. These circumstances represent situations in which, for example, the focus of care is largely educational (as is often the case in lifelong and generalized orgasmic dysfunction in women [see Chapter 12]) or when the patient's status makes it predictable that the mainstay of treatment will be largely "medical" (for

example, instances of premature ejaculation in which the focus of care is on the use of medications rather than talk [see Chapter 10]). In the absence of research, two general concepts serve as a clinical rationale for reviewing the patient's past.

The first concept is that it is only *after* the fact that the interviewer knows the items in a patient's past history that may be of potential significance in relation to etiology or treatment. In other words, one does not know if a "smoking gun" is hidden in a particular field until that area is searched.

The second concept is the common sense notion that personality characteristics and facets of a relationship are not left outside the bedroom when people engage in sexual activities. Issues related to personality and the relationship are of as much concern in the bedroom as they are in the kitchen or living room. Elements that went into the formation of both partners need to be explored if one's concept of "sex" is such that the body and mind are inseparable. Only when genital function is the predominant sexual consideration, such as sexual activity between a prostitute and a client, may personality and relationship factors be less meaningful.

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SEXUAL-DEVELOPMENTAL HISTORY

As described here, the *sexual-developmental* history is a developmental history with a special focus on the individual's personal sexual evolution. Comprehensive texts on interviewing should be consulted in relation to nonsexual aspects of a developmental history[8] (pp. 65-82). The assumption in this book is that the special aspects of sexual development are "grafted" to the general aspects of a patient's personal and social history. As Gadpaille wrote, "Sexual development does not occur separately from all other aspects of human growth and maturation. To treat it separately is to some degree a distortion"[9] (p. 46).

In a sexual-developmental history, the list of sex-related questions that might be asked is exhaustive to the interviewer and exhausting for the patient. Inevitably, the interviewer is selective and inquires about issues that appear to have relevance to the present problem. The key word is "appear." Different areas appear to be pertinent to different clinicians. To some, all areas of inquiry are relevant. To others, there must be clear and prior justification for particular questions. In either instance, an interviewer should be able to explain the rationale for any question asked.

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The psychosocial connections between past and present in relation to sexual problems generally were subjects of speculation and data-oriented research. Intuitive concepts come from analytically oriented psychotherapists and theoreticians, including Freud and his disciples.[10] Data-oriented observations were derived from sources such as:

- Experimental research with primates[11]
- Gender problems in children[12]
- Intersex problems in children[13,14]

- Sex-related surveys[1,15-18]

There is an inclination to consider sexual dysfunctions as a group when, in fact, they are heterogeneous. Lumping them together is, to a large extent, unreasonable (hence the rationale for using the word "dysfunctions" in the plural). If the syndromes are, indeed, heterogeneous, it would not be surprising to find that the etiologies are heterogenous as well. Biopsychosocial issues that relate to girls and women are unlikely to be the same for boys and men. Sexual dysfunctions that are lifelong usually have different bases than those that are acquired.Desire disorders are grouped under the same heading in DSM-IV but their origins may well be different from other sexual dysfunctions.[19] These varied roots result in complex interpretation of information obtained in a sexual-developmental history. The connections between past and present may be obscure, may be a matter of speculation, or may be obvious. Without a diligent search it is not possible to determine which they might be.

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As an interviewer traverses the life span, areas of questioning can be defined for each part, as well as the specific questions to be asked and the rationale for the inquiry.

Childhood

Areas of Inquiry

Areas of inquiry include the following:

1. Family-of-origin practices in the exchange of affection (touching and talking)
2. Gender identity/role issues (feeling of maleness or femaleness as a child, favorite games, gender of friends)
3. Learning about intercourse from a reproductive point of view
4. Learning about body structure in the context of exploratory games ("playing doctor")
5. Reaction of adults to discovering one child investigating another
6. Childhood sexual experience with other children and adults

Suggested Questions

Q. Tell me about where you were born and grew up.
Q. Who was in your family at that time?
Q. Where are they now?
Q. What is the nature of your relationship with them now?
Q. Would family members hug or kiss one another when you were young?
Q. Were you happy with the idea of being a boy (girl) when you were small?
Q. Were your friends in primary school mostly other boys (girls) or mostly girls (boys)?
Q. What were your favorite games in your primary school years?
Q. Were you teased about anything?
Q. What about?
Q. How did you first learn about "how babies are made"?
Q. Did you play "doctor" games?

Q. Were you discovered by adults?
Q. How did they react?
Q. Do you recall having sexual thoughts, feelings, or experiences in your preschool years or before you were a teenager?
Q. Children sometimes have sexual experiences with other children or with adults. Was this part of your experience when you were a child?

Studies of Childhood Sexuality

Systematic research into childhood sexuality is limited, probably because parents and schools are circumspect in allowing children to be subjects of study. In spite of this, there is a substantial amount of accumulated information about childhood sexuality and preadolescent sexual behavior.[9,20-23] Martinson's review of relevant information from fetal life to the preadolescent years provides an understanding of the antecedents to adult sexual thoughts, feelings, and experiences.[22] He reflected on the following manifold developmental experiences of children:

- Sensory responsiveness and maternal attachment of the neonate
- Genital play, questions about sex, sex play among peers, and attitudes of parents toward touch in the young child
- Dating, masturbation, erection, orgasm, and heterosexual sex play in preadolescent years

Preadolescent Sexual Play

Kinsey et al. described the specifics of male preadolescent erotic arousal, sex play, and orgasm[15] (pp. 157-193). Their observations clearly established that the minds and bodies of boys were sexually simmering. They provided similar information in their later volume on females[16] (pp. 101-131) and, as well, commented on the significance of preadolescent sex play (pp. 114-116). They concluded the following:

1. First information about sex and body parts was often obtained in the context of play and was therefore of educational significance.
2. "Some of the preadolescent contacts provided emotional satisfactions that conditioned the female for the acceptance of later sexual activities."
3. Guilt reactions induced by adults discovering a child engaged in sex play in many instances "prevented the female from freely accepting sexual relations in her adult married relationships."
4. Male preadolescent sex activities were more commonly carried over into adolescent years than was preadolescent sex activities for females. This "discontinuity" in girls is more the result of culturally related restraints put on older children than "biological latency."

Cross-cultural studies of sexual behavior demonstrate that in sexually permissive societies, individuals in the middle childhood years are far from sexually disinterested, inactive, or "latent."[24] The concept of latency in these years seems more accurately applied to hetero*social* rather than hetero*sexual* relationships.

Touch in Childhood

Many of the studies on which Martinson's review was based were conducted in North America[22] (pp. 57-82). If one considers the variety of attitudes and practices toward sexual development in other cultures, it seems almost impossible to define universal preadolescent developmental norms. Montagu particularly emphasized the significance of touch in early childhood development and its relationship to adult sexual behavior and problems[5] (pp. 204-236). Touching was the subject of experimental investigation when the Harlows deprived primates of a warm and affectionate mother. It was demonstrated that primate offspring were so disturbed in their relational abilities that, among other things, they were unable to mate effectively.[11] While one must be cautious in comparing primates and humans, it is nevertheless interesting to consider the consequences of human childhood deprivation. Not surprisingly, studies of adults who were severely deprived in childhood suggest, among other things, substantial negative repercussions in the areas of relationships and sexual disorders.[25]

Roots of Atypical Sexual Behavior

The meaning of divergence from whatever norms exist in preadolescent years is often unclear in relation to adult sexual problems. These differences are particularly blurred when considering two groups of sexual disorders: sexual dysfunctions and paraphilias. In contrast, the childhood precursors of some atypical forms of adult sexual behavior such as same-sex interest and gender disorders have received a greater degree of attention and seem better defined.[26]

Gender problems in adult life frequently become apparent in childhood and hence it is important to ask about this in a sexual-developmental history. Long-term follow-up of boys with feminine characteristics shows that half or more are sexually atypical as adults.[27] Girls who behave in a boyish fashion (tomboys) usually develop as typical women; a small number emerge with a lesbian orientation (p. 155).

Sex Education

There is a certain ritual to the process of asking about "sex education" in a sexual-developmental history. In practice, the answers tend to be largely uniform. Many people say that sex was not discussed in their parental home and that what was learned as a child came from "the street." One has to distinguish between schooling and education in all matters. The importance of formal sex education courses in schools on adult sexual expression is difficult to assess. In the opinion of Masters, Johnson, and Kolodny[28] (p. 128), more information is learned by the informal process of a child watching his or her parents being affectionate with each other.

Child Sexual Abuse

In the Laumann et al. study, 12% of the men and 17% of the women respondents reported having been touched sexually before puberty or when they were 12 or 13 years old.[1] (Only 'hands-on' experiences [i.e., touching] were asked about to eliminate cases of exhibitionism.) Their data suggest the following:

1. That adult-child sexual contact was not occurring more often than in previous years
2. Girls were most likely to be touched by adult men
3. Boys were most likely to be touched by adolescent women
4. Genital touching was the most common sexual event
5. The most common age of the girls was 7 to 10
6. The common age of the boys was older
7. Experiences were most likely to occur with one adult (although one third had experiences with more than one person)
8. The adult was usually a relative or family friend

An evaluation of the effects of sexually abusive childhood experiences on adult life (a crucial clinical issue) revealed the following:

1. Women respondents answered questions on this topic more often than men
2. More women (70%) than men (48%) reported that the experience affected their lives
3. Nearly all respondents judged the effects to have been negative

The sexual sequelae of adult-child sexual activity include effects on sexual function and sexual practices[29]:

- More sexual partners
- More experience with anal intercourse with an opposite-gender partner
- More oral sexual experience among women
- A greater degree of thinking about sexual issues among men

Significant negative long-term consequences (sexual and nonsexual) to sexual experiences between an adult and female child have previously been reviewed.[30] Given this information about long-term sexual sequelae, there seems little doubt about the need to ask questions about this subject in a sexual-developmental history.

Puberty and Adolescence

Areas of Inquiry

Areas of inquiry include the following:

1. Body changes associated with puberty
   - Age of body growth
   - Pubic hair growth
   - Facial hair growth in boys
   - Breast development and onset of menstrual periods in girls
2. Changes in the size of genital organs
3. Feelings about the above changes in relation to peers
4. Changes in genital function associated with various sexual stimuli, including masturbation
   - Erection and ejaculation in men
   - Vaginal lubrication and orgasm in women

5. Sexual attraction to and sexual experiences with members of the opposite and the same sex
6. Reactions to these experiences
7. Repetitive thoughts about being attracted to same-sex individuals without desire or experience
8. Feelings about important love and sexual experiences through adolescence
9. Appearance of the present sexual problem in early sexual experiences
10. Atypical sexual thoughts, feelings, and experiences
11. Forced sexual experiences
12. Pregnancy
13. Abortion and birth control
14. Sexually transmitted diseases

Suggested Questions

Q. How old were you when you first noticed the development of body changes? (For example, men: becoming taller, voice changing, needing to shave; women: breast development, onset of menstrual periods)
Q. How did the timing of this compare to other kids in your class at school?
Q. How did this affect you?
Q. Did you know what to expect (and if so, how)?
Q. (men) Do you recall having erections before your teens?
Q. (men) Tell me about the first time you remember having an erection.
Q. (men) What do you recall about the first time you ejaculated?
Q. (men) Do you remember having "wet dreams"?
Q. Tell me about your experience with masturbation in your teens.
Q. (women) Did you usually come to orgasm?
Q. How did you feel about stimulating yourself?
Q. What did you think about when you masturbated?
Q. What is your experience with masturbation nowadays?
Q. What do you think about when you're masturbating nowadays?
Q. Boys (girls) often feel a surge of sexual feelings in their teens. What was it like for you in those years?
Q. Sometimes boys (girls) have sexual experiences with other boys (girls) during that time. Was that part of your experience?
Q. What about nowadays? Do you find yourself sexually attracted to other men (women)?
Q. Have you had sexual experiences with other men (women) since puberty?
Q. Boys in their teens who have trouble dating girls sometimes worry about being gay, even though they're not sexually attracted to other boys. Did that happen to you?
Q. Tell me about relationships that were important to you in your high school years?
Q. Was there a sexual component to those relationships apart from intercourse?
Q. What actually took place?
Q. Did intercourse take place?
Q. How did you feel about that?

Q. What were your intercourse experiences like?
Q. How did you feel about having intercourse at that time?
Q. Did the problem that you have now appear at that time?
Q. Did you have sexual thoughts or experiences in those years that you thought were unusual (e.g., being sexually involved with young children)?
Q. Did you have sexual experiences where force was used?
Q. (women) Did you become pregnant in your teens?
Q. (women) Did you ever have an abortion?
Q. Did you ever have a sexually transmitted diseases?

When a sense of unattractiveness is added to the surge of sexual feelings that typically occur at puberty, the result is often one of tremendous confusion about romance and "sex."

Physical Changes

The timing of the body changes of puberty and the accompanying feelings are usually well remembered. This is typically a time of magnified awareness of physical attributes and self-consciousness about every imperfection. Changes rarely occur in logical fashion. Instead, feet can become larger before legs become longer. Dissatisfaction is virtually universal. When this sense of unattractiveness is added to the surge of sexual feelings that typically occur at puberty, the result is often one of tremendous confusion about romance and "sex." Memories of this time remain vivid forever, and sometimes they have a major impact on later relationships.

Developmental deviance from age-mates is a potential source of embarrassment and bewilderment. The first girl in a class whose breasts are enlarging may simultaneously be an object of envy from other girls and teasing from boys. Conformity in dress and physical development is high on the list of adolescent aspirations. On an intuitive level, delay in physical development has a negative influence on adolescent sexual experimentation and, because of that, may have a negative effect on adult sexual behavior as well.

Adolescence is a time for relationship experimentation; biology influences when this begins and also its extent. Kinsey et al. found that later onset of puberty in boys (age 15 and over) was associated with a lower level of sexual activity among men in future years. Conversely, early onset of puberty (by age 11) was connected to a higher level of sexual activity throughout a man's life[15] (pp. 302-308).

That the hormonal surge of early adolescence has profound biological consequences is obvious. The onset of menstrual periods in girls can have meanings far beyond the flow of blood. The event presages the beginning of childbearing potential and, in the minds of parents, sexual capacity. Parental pride or dread can be transmitted to the adolescent. Cultural traditions in this area are fascinating. Among some groups in India, a public celebration occurs for an adolescent girl one week after the onset of her first menstrual period. Pride and publicity replaces the shame and secrecy that one sometimes still sees in North America. In more open cultures, the "whole world" knows that a "rite of passage" has taken place.

Erections in a male child occur regularly from infancy onward but awareness is often dated from puberty. Ejaculation must await the pubertal biological clock, although males may report orgasm in response to genital touch for years previously. Spontaneous nocturnal ejaculation (or "wet dreams") occur in over 80% of men at some time in their lives[15] (p. 274) but "are primarily a phenomenon of the teens and the twenties"(p.

243). For those who view nocturnal emissions as entirely a function of biology, it remains a challenge to explain Kinsey et al.'s finding (p. 277) that the frequency was higher for better-educated men. The fact that many women also experience orgasm during sleep is less well known. Over 35% of women contributing to the Kinsey et al. study experienced nocturnal orgasm by the age of 45[16] (p. 196).

Masturbation

The first experience with ejaculation is, for many men, through masturbation. This activity was so common among male adolescents in the Kinsey et al. study (88% for single men between ages 16 and 20) that they stopped asking whether it happened or not and, instead, simply asked at what age it began[15] (p. 238). Masturbation was less usual among females. By age 20, 33% of women had masturbated at least once in their lives to the point of orgasm[16] (p. 173). In a more recent survey, respondents were asked only about their experience in the last year[1] (pp. 80-86). In the age group 18 to 24, 41% of men and 64% of women reported that they didn't masturbate at all; 29% of men and 9% of women reported a frequency of once each week. By age 50, over 50% of the men and 70% of the women did not report masturbating.

Apart from frequency, the authors also studied the relationship between masturbation and *marital status*. In Laumann's opinion, Kinsey's view was that "sexual energy was channeled to autoerotic or coupled sexual outlets in a kind of zero-sum complementarity . . . [and thus] . . . the frequency of masturbation decreases in the context of a stable sexual relationship with an available partner." In a finding that was somewhat different from Kinsey and popular notions, Laumann and his co-authors[1] concluded that the two were disconnected in that:

- Rates of masturbation and coupled sexual activity were *both* high among young cohabiting individuals
- Masturbation had "no set quantitative relation to other partnered sexual activities"

Laumann et al. opinions about masturbation and *sexual drive* were also unconventional and instructive.[1] They described the popular belief that "rates of masturbation rise and fall with the availability of sex partners, suggesting that each individual has a given level of 'sex drive' that needs to be expressed in one way or another." However, in their view, "masturbation is driven primarily by . . . social factors . . . [that] can have complementary, supplementary, or independent status with reference to partnered sex." One implication of this view is that a health professional should exercise caution in interpreting the presence or absence of masturbation activity as an indicator of "sex drive."

The relationship between masturbation in adolescence or later and sexual dysfunctions is clearer in women than men. Kinsey et al. found that among women who masturbated to orgasm before marriage about 85% were described as "responsive" in the first year of marriage[16] (pp. 172-173). Of women who never masturbated before marriage or those who did not come to orgasm with masturbation, about one third did not

reach orgasm "in their coitus" in the first year of marriage, and the same situation existed for most by the fifth year (p. 172).

The absence of masturbation experience in men or women in the present means, obviously, the inability to use this information clinically. For example, when asking a man about his present erections under various circumstances, it would be pointless to include a question about masturbation erections if this was not part of his recent sexual experience. Negative attitudes toward self-stimulation can determine whether or not this kind of sexual activity occurs but, in addition, can also influence treatment suggestions. For example, it is ethically unreasonable (and from a practical viewpoint ineffective) to ask a woman who is nonorgasmic to stimulate herself if she regards masturbation as immoral.

Sexual Orientation

The hormonal surge of early adolescence is responsible for body changes and also strongly influences sexual attractions and actions that are typically aimed at the opposite sex, occasionally toward the same sex, and sometimes toward both. The evolution of "love" feelings and sexual experimentation needs to be explored. In a controversial finding, Kinsey et al. found that 37% of men "had at least some overt homosexual experience to the point of orgasm between adolescence and old age"[15] (p. 650). Newer data has resulted in more precise understanding of same-gender feelings and behavior (Table 5-3).

One of the objectives of the study by Laumann and his colleagues was to better understand this area and its relationship to HIV/AIDS transmission and vulnerability.[1] Nine percent of the men and 4% of the women respondents reported at least one sexual experience with a same-gender person since puberty (pp. 294-296). However, a critical distinction was made between same-gender sexual behavior before and after the age of 18. When this separation was made, almost half of the men (42%) who reported sexual experience with another man said that the experience occurred before the age of 18 and did not occur again at any time later in their lives (p. 296). The rates

Table 5-3 Homosexuality: Definitions And Frequencies

	MEN (%)	WOMEN (%)
Sexual experience with SGP in lifetime	9	4
Sexual experience with SGP since age 18	4.9	4.1
Sexual experience with SGP in past 5 years	4.1	2.2
Sexual experience with SGP in last year	2.7	1.3
Self-identification as homosexual or bisexual	2.8	1.4
Desire for SGP without activity or self-identification	5	5

Adapted from Laumann EO et al: *The social organization of sexuality: sexual practices in the United States,* Chicago, 1994, The University of Chicago Press.
SGP, Same gender partner

for men who engaged in sexual activity with another man were found to range between 2.7% in the past year and 4.9% with any male partner since age 18 (p. 294).

Any understanding of homosexuality must consider a person's behavior and how that individual thinks and feels. Interviewers in the Laumann et al. study inquired about sexual behavior toward others of the same gender and about how respondents think of themselves.[1] They referred to the latter as "identity" and found that "2.8% of the men and 1.4% of the women reported some level of homosexual (or bisexual) identity" (p. 293). In addition to behavior and identity, respondents were also asked about same-gender "desire." When all three factors were considered together, the authors found clinically important discrepancies. For example, they found that "about 5% of the men and women in our sample express some same-gender desire but no other indicators of adult activity or self-identification" (p. 301). The authors concluded that their "preliminary analysis provides unambiguous evidence that no single number can be used to provide an accurate characterization of the incidence and prevalence of homosexuality in the population at large" (p. 371).

After the subject of homosexuality is "on the table" in the process of asking about early adolescent sexual behavior, similar questions about adult attractions and experiences with same-sex individuals can be asked easily.

In the context of a clinical interview with a patient, after the subject of homosexuality is "on the table" in the process of asking about early adolescent sexual behavior, similar questions about adult attractions and experiences with same-sex individuals can be asked easily.

There are many reasons to ask such questions. Problems in adolescence among those emerging with a gay or lesbian identity are legion (see Chapter 7). In addition, worries about homosexuality in boys who are heterosexual but have trouble making contacts with girls are probably common.[31] Obviously, sexual interest in another person of the same sex may profoundly influence a person's sexual interest in, and function with, a heterosexual partner.

Initial Intercourse Experiences

In following the love and sexual experiences of a person throughout their teens and beyond, the interviewer must also be sensitive to what actually occurred and the development of sexual problems at those times. Laumann and colleagues wrote that "first intercourse, especially for women, has traditionally been a landmark event surrounded by a welter of moral strictures and normative concerns about the meaning of virginity, the loss of innocence, the transition to adulthood, and the responsibility for procreation and the next generation"[1] (pp. 322-324). Their opinion was that "much of the research on age at first intercourse during the mid- to late 1980s was motivated by an interest on contraceptive use and AIDS awareness among teenagers" and that several surveys (including their own) "overwhelmingly suggest that there has been a significant change in the early heterosexual life of young women in the United States."In their study, 19% of female respondents had vaginal intercourse by age 15, and 90% of males had intercourse by age 20 to 24 (pp. 326-327). The authors concluded the following from their own studies on first intercourse, as well as those of others:

1. First vaginal intercourse is occurring at younger ages

2. More people are engaging in premarital sexual activity with a partner earlier in their lives
3. Gender differences are evident in that "men start earlier, have more partners and are motivated by curiosity and self interest; women begin later, have sex with spouses or more serious lovers, and use birth control more than men"

Thompson provided a different perspective on first intercourse in young women.[32] On the basis of direct interviews of teenage girls, she detailed the elements determining the outcome of this experience. Girls with negative feelings and opinions described:

- An absence of former sexual awareness (including lack of preparatory experiences with petting, masturbation, sexual fantasy, desire, or contraception)
- Lack of control
- Vaginal pain
- Boredom
- Sexual pessimism

In contrast, girls with positive feelings and opinions:

- Approached intercourse with a sense of sexual desire, control, and knowledge
- Were contraceptively prepared
- Described mothers who were "open" about their own bodies, intimacies, and relationships

The positive group anticipated pleasurable intercourse within a mental and physical life-context that included sexual fantasy, masturbation, and petting. These were sexually optimistic young women who knew their own minds and bodies.

A study of "clinical" (on a waiting list for a "sex" clinic) and "nonclinical" (obtained through a newspaper ad) couples found that "sexual and emotional" responses to the first coitus appeared to be far more significant for women than for men.[7]

Sexual Function Difficulties

A study of over 1800 English teenagers concerning sexual issues (including problems), as well as a follow-up study of the same population when they were in their mid-20s, revealed that about one fourth "had a sex problem which they had never discussed with anyone."[33] These difficulties included anxiety over "performance," guilt feelings, change in sexual interest, and concern about masturbation. The extent to which concerns were carried over from adolescence to adulthood was not stated but the likelihood is that there were many.

In one study, "over 50% of the various categories of paraphilias developed their deviant sexual arousal pattern before age 18."[35]

Atypical Experiences

There is surprisingly little information about the epidemiology and childhood precursors of adolescent or adult paraphilias (previously known as perversions or sexual deviations (see "Nonparaphilic and Paraphilic Compulsive Sexual Behaviors: Sexual Issues

and Questions" in Chapter 8). An exception to this lack of information is the finding that those who have been sexually active with children were sometimes themselves the target of the same kind of sexual behavior when they were children.[34] When looking retrospectively, paraphilic behavior often begins in adolescence.[35] In one study, "over 50% of the various categories of paraphilias had developed their deviant sexual arousal pattern prior to age 18."[35] However, the extent to which paraphilic behavior can be an occasional and "benign" aspect of adolescent sexual development is unknown. Gender identity disorders are said to crystallize in this same period also.[36]

Sexual Assault

Laumann and his colleagues[1] (p. 333) asked respondents about "forced sex" rather than "rape" for two reasons:

- Rape was considered a legal rather than a descriptive term
- They wanted to "cast a wider net for coerced sexual events, recognizing that meeting the legal standards for rape does not exhaust the category of women being coerced to have sex"

A small number of men (1%) and a large number of women (22%) reported being sexually forced by a man (p. 335). In other words, "more than one in five women has experienced what she considers to be an incident in which she was forced to do something sexual that she did not want to do"(p. 335). The experience of women in this survey was described as being consistent with other surveys of sexual assault. The fact that forced sexual experiences can have profound effects on sexual function in women and men is well documented.[1,37,38] Diminished sexual desire appears to be one of the main consequences.

Pregnancy and Abortion

The effect of pregnancy and abortion on later sexual function depends on the circumstances. The results of various birth control approaches on sexual function have been reviewed[39] (pp. 404-410). The sexual impact of birth control pills in particular is subtle, in that sexual desire may be lessened in some individuals.[40]

Sexually Transmitted Diseases

The differentiation between Sexually Transmitted Infections and Sexually Transmitted Diseases (STIs and STDs) is explained by the fact that not everyone with an infection is symptomatic and therefore may not know they have a disease. Such disorders are not, of course, limited to puberty and adolescence; however, bacterial and viral infections occur most commonly in the 18 to 24 year old age group.[1] The frequency is thought to be related to a greater number of sexual partners, which "is the most succinct measure of the extent of exposure to infection" (pp. 385-386).

An interviewer may have to extrapolate the effect of sexually transmitted diseases on sexual function, since there is little information on this subject in the medical literature. One related exception is the modification of sexual practices in homosexual men in response to the AIDS epidemic. For example, changes are described in the use of condoms and the exclusion of anal intercourse in sexual activities[1] (pp.432-437).[41]

Adulthood

Areas of Inquiry

Areas of inquiry include the following:

1. Romantic relationships from quantitative and qualitative viewpoints
2. Sexual aspects of romantic relationships
3. Marriages and their sexual components
4. Reasons for the ending of important premarital and marital connections and the extent to which sexual problems were significant
5. Changes in sexual experiences before and after marriage
6. Covert or overt sexual experiences with other partners during marriage or committed relationships
7. The nature of a person's sexual response with (other) current and previous sexual partners
8. Reproductive issues

Suggested Questions

Q. Tell me about previous relationships that meant a lot to you.
Q. What were your sexual experiences like in those relationships?
Q. Why did those relationships end?
Q. Did you ever have the same kind of sexual problem that you have now?
Q. How long did you and your wife (husband, partner) know each other before living together?
Q. What was your sexual relationship like in those days?
Q. What were your living arrangements during that time?
Q. When your living circumstances changed, what effect did that have on your sexual relationship?
Q. Sometimes people who have a close relationship also have sexual experiences with other partners for various reasons; one reason is to test themselves to see if a particular sexual problem appears with someone else. Have sexual relationships with others for this or any other reason been part of your experience?
Q. How did you manage sexually on those occasions?
Q. To what extent is your wife (husband, partner) aware of those experiences?
Q. What was her (his) reaction?
Q. (If patient has children) Tell me about your sexual experiences when you were (your wife was) pregnant.
Q. (If patient has no children) Have you decided against having children or have you had some fertility difficulty?

RATIONALE FOR QUESTIONS

Relationships before marriage are interpersonal and sexual testing opportunities. Problem patterns may become evident as an interviewer explores the reasons for developing links with others and why they become disrupted, for example:

- Changes in living arrangements may imply alterations in expectations that, in turn, may have profound effects on a couple's sexual experiences
- Marriage may result in changes in a couple's sexual experiences
- Another area is the possible presence of other sexual partners

Kinsey et al. found that about 50% of married men reported having sexual intercourse with women other than their wives at some time in their married lives[15] (p. 585). Among women, about one fourth had similar experiences by age 40[16] (p. 416). Information on this subject provided in the Laumann et al. study was markedly different[1] (pp. 212-216). "Over 90 percent of the women and over 75 percent of the men in every cohort, report fidelity within their marriage, over its entirety" (p. 214).

Whatever the motivation for other relationships, it is useful to know whether or not the particular sexual problem that presently exists was present during those other occasions. When planning treatment, the health professional must also know if another current relationship is transient or committed. A productive treatment outcome could be difficult in the presence of an unseen third person with whom the patient has a substantial relationship.

Issues relating to reproduction can have profound effects on sexual experiences. Opposing ideas on the topic of having children can disrupt an otherwise harmonious couple. The process of trying to "make a baby" because of infertility problems results in sexual experiences that are structured, devoid of passion, and empty of feelings. It is hardly astonishing that problems might develop in such circumstances.

Most observers describe a constantly diminishing level of sexual interest in women through the period of pregnancy.[42] In contrast, Masters and Johnson described an increasing degree of sexual interest in pregnant women in the second trimester[43] (pp. 158-159).

The Older Years

Areas of Inquiry

Areas of inquiry include the following:

1. The nature of current relationships
2. How the past and present compare sexually
3. The frequency of sexual activities
4. The range of sexual experiences
5. The extent of understanding and expectation of alterations in sexual function in the aging process
6. Changes in sexual response
   - Extent and speed of vaginal lubrication (women)
   - Effective stimuli for erections, the rapidity and stiffness of erections, the length of time to obtain another erection after ejaculation, and the length of time required to come to orgasm (men)
7. Experience with the use of postmenopausal hormones (women)
8. Connections between health and sex

Suggested Questions

Q. What has your sexual relationship with your wife (husband, partner) in general been like in recent years?
Q. What were your sexual experiences as a couple like before the development of the problem you mentioned?
Q. How often does sexual activity occur now?
Q. What takes place now sexually when you and your wife (husband, partner) are together?
Q. What sort of sexual changes were you expecting as you became older?
Q. (women) Many women experience changes in the amount or speed of vaginal lubrication with menopause. What is your experience?
Q. (women) What is your experience with estrogens or other hormones after your menopause?
Q. (men) Have you noticed any change in the speed with which you get an erection compared to, say, five years ago?
Q. (men) Is there any change in the stiffness of your erections now compared to, say, five years ago?
Q. (men) Is there any change in how long it takes you to have another erection after you've ejaculated once compared to, say, five years ago?
Q. (men) Is there any change in how long it takes you to ejaculate or come to orgasm now compared to, say, five years ago?
Q. Have health problems influenced your sexual experiences?

Studies of Sexuality and Aging

The Kinsey surveys included very few older people and as a result others researched this gap in sex-related information.[15,16] Pfeiffer and his colleagues studied an elderly group at the Duke University Center for the Study of Aging and Human Development.[44] Their findings include the following:

- Sex has an important role in the lives of many elderly persons
- There is a tendency toward declining sexual activity with age

Of major consequence is the fact that they also saw exceptions in the form of patterns of stable, and even increasing, sexual activity.

In an effort to supplement the available information about sex and aging, Consumers Union (CU) undertook a survey of older readers of the magazine, *Consumer Reports*.[45] The result was the book, *"Love, Sex and Aging,"* based on written responses to a questionnaire completed by 4246 people over age 50 (of which 2456 were over the age of 60). The survey was obviously biased in that the sample:

- Was self-selected
- Consisted of people of higher than average income and education and better than average health and who had greater interest in the topic

Clinicians need to guage the overall quality of the relationship in the assessment of sexual difficulties.

However, the results are nevertheless significant because they describe what is sexually positive and possible in men and women as aging occurs.

The CU survey related 15 nonsexual factors (e.g., age, income, and the "empty-nest syndrome") to marital happiness. Only one was found to be "closely associated"—the quality of communication. When the quality was low, sexual activity suffered. This conclusion may have diagnostic implications and therapeutic ramifications. Clinicians need to gauge the overall quality of the relationship in the assessment of sexual difficulties. The nature of sexual activities a couple enjoys may represent vital information, depending on the problem presented.

In reading through Kinsey's surveys, it was also clearly evident that the acceptability of various sexual activities depended at least partly on the era in which a person was raised. For example, many older couples living in the 90s grew up in a time when it was considered improper for a woman to touch or stimulate a man's penis. Given this culture-based attitude, Masters and Johnson's observation, for example, of the older man's need for tactile stimulation to develop or maintain an erection may result in major sexual difficulties.[43]

Sexuality of Aging Men (Box 5-3)

In relation to men specifically, Kinsey et al. declared that of eleven factors that "are of primary importance in determining the frequency and sources of human sexual outlet," none seems more important than age.[15] "Having reached a peak in adolescence, sexual activity in the male drops steadily from then into old age." While this finding of diminished sexual activity in aging men has been confirmed by others, studies[46] also show the following:

1. A wide variation in individual rates of decline
2. Decreased sexual desire (although to a lesser extent than sexual activity)
3. Increased prevalence of erectile dysfunction
4. A general decrease in genital and extragenital reactions to sexual stimulation

Box 5-3 Summary of Sexual Function Changes in Aging Men[45-47]

- Quality of communication closely associated with marital happiness
- Sexual satisfaction—no difference
- Sexual desire generally decreased but wide variation
- Sexual activity generally decreased but wide variation
- Erection—some required longer time to become erect
- Erectile dysfunction—increased prevalence
- Erection following orgasm—some required increased time
- NPT testing—many aspects decreased
- Bio-available testosterone—decreased
- Luteinizing hormone—increased
- Ejaculation—often longer time from vaginal entry to orgasm

NPT, Nocturnal penile tumescence.

The Duke University study also examined the determinants of sexual behavior in middle age and old age and found that, among men, many factors influenced the extent of sexual behavior,[44] including:

- Past sexual experience
- Age
- Subjective and objective health
- Social class

In the CU Survey, four specific questions were asked of men about their erections.[45] Of the 2402 male respondents the following observations were noted:

- Their refractory period (the time it takes to have another erection after orgasm) was longer (65%)
- It took longer to get an erection (50%)
- Their penis was less stiff when fully erect (44%)
- They more frequently lost their erection during sexual activity (32%)

Ejaculation and orgasm changes in men were also described in the same survey. Ejaculation usually (not always) slowed so that there was a longer time from vaginal entry to orgasm. In addition, orgasms did not occur with every sexual experience.

More recent observations on male physiology have added important information to our knowledge about sexual changes in aging men. These changes seem to be mediated by hormonal, neural, and vascular mechanisms. Schiavi and his colleagues took physiological studies beyond others by examining the sexual function of *healthy* aging men.[46] Schiavi summarized from this study[47] as follows:

1. No reported difference in sexual or marital satisfaction in spite of age-related changes in the sexual desire and sexual activity of study subjects
2. A wide variation in levels of sexual desire, response, and activity among even the oldest of the subjects
3. A marked decrease on many aspects of Nocturnal Penile Tumescence (NPT) testing
4. A highly significant decrease in the amount of bio-available testosterone and an increase in circulating luteinizing hormone (confirming previous reports of an age-related decline in gonadal function, but he also noted that "the magnitude and extent of the hormonal–behavioral correlations observed . . . does not support the notion that hormonal factors are important determinants of individual differences")

In examining possible causes of changes in erection function specifically, another study looked at 39 healthy and sexually functional men ranging in age from 21 to 82 and related the observation of decreasing erectile capacity in aging men to decreasing sensory/neural and autonomic function rather than hormones.[48]

Schiavi concluded about sexuality in men that: "aging is associated with a decrease in sexual desire, arousal and activity even when the effects of illness, medication and psychopathology are minimized or eliminated . . . [and that] . . . a proportion of subjects in the oldest age group . . . remained sexually active and had regular intercourse in the presence of a marked decrement in erectile capacity . . . It would appear that in these individuals, the value that sexuality had in their lives, the fre-

quency and range of their past sexual behaviors, their motivation and ability to experiment and develop compensatory sexual strategies and the supportive attitude of their partners were instrumental in their continuing sexual activity, their sexual satisfaction and the self-perception of not being sexually dysfunctional."[47]

Sexuality of Aging Women

The Duke University study also drew conclusions that were specific to women.[44] The authors believe that the level of activity in women reflected "the availability of a socially sanctioned, sexually capable partner." Relatively few factors (compared to men) were determined to influence the level of sexual activity:

- Marital status
- Age
- Extent of enjoyment derived from sexual experiences in earlier years

In a general population survey of sexual desire in midlife, Hallstrom and Samuelsson interviewed 497 women living with a spouse, on two occasions, six years apart.[49] Ages of the women were 38, 46, 50, and 54 at the time of the first interview. The research strategy allowed the authors to study age and cohort effects. Their conclusions were that sexual desire showed considerable stability over time but that a substantial proportion of their subjects (27%) experienced a major change in sexual desire, mostly a decrease. Ten percent of their subjects demonstrated an increase. Decreased sexual desire was predicted by:

1. High sexual desire at the first interview
2. Lack of a confiding relationship

Table 5-4 Sexual Function In Aging Women

	AGE		
	50s (%)	60s (%)	70s (%)
Sexually active	91	91	79
Frequency/wk in married women	1.3	1.0	0.7
Vaginal lubrication, "right amount"	48	35	23
Orgasm frequency, almost every time	← 45 - 53 →		
Interest in sex—strong or moderate	75	67	59
Sexual relationship very or moderately important	83	73	63

Adapted from Brecher EM: *Love, sex and aging,* Boston, 1984, Little, Brown and Company.

3. Insufficient support from a spouse
4. Alcoholism in a spouse
5. Major depression

Increased sexual desire was predicted by:

1. A low level of desire in the first interview
2. Negative marital relations before the first interview
3. Mental disorder at the time of the first interview

The CU Survey (Table 5-4) included responses from 1844 women who were 50 years, or more, old[45] (pp. 311-346).

Brecher, the author of the CU report, commented on the apparent inconsistency between the decline in frequencies of sexual activities in men and women and the positive qualitative comments that accompanied the returned survey questionnaires.[45] "The enjoyment of sex can and sometimes does increase with age even as the frequency may decrease . . . [and in addition] . . . respondents . . . have found techniques for maintaining . . . their enjoyment of sex despite physiological changes . . . " (p. 346).

IMPACT OF HORMONAL CHANGES ON SEXUALITY IN AGING WOMEN

To understand the effects of aging on sexuality in women, some attention was given to the hormonal variations that occur in the peri- and postmenopausal years and the effects of those changes. Sherwin explained that there is a virtual cessation in the production of estradiol (the principal estrogen) by the ovary at the time of menopause (before menopause, 95% is derived from this source).[50] In addition, testosterone production from the ovary (a source of about 25% of testosterone in premenopausal years) becomes negligible at the same time in about 50% of women. Both hormones were described as having effects on the brain, as well as on peripheral tissues.

In the absence of estrogen, the vaginal epithelium becomes attenuated and pale due to diminished vascularity. The consequences of this can be atrophic changes, which in turn, can lead to inflammation or ulceration. All of this can result in diminished vaginal lubrication, which, in turn, might intuitively be expected to cause discomfort or pain with intercourse. Vaginal lubrication and pain with intercourse were investigated in the Laumann et al. study.[1] When women age 50 to 59 were asked if "trouble lubricating" had been a problem within the past year, 46% said "yes." However, a much smaller number (16%) of women respondents in this same age group reported "pain during sex." Clinically, postmenopausal women who use oral estrogens or estrogen vaginal cream generally find enhanced lubrication and the elimination of dyspareunia. It appears then that postmenopausal vaginal atrophy and diminished elimination of discomfort or pain with intercourse are not necessarily followed by dyspareunia but when postmenopausal dyspareunia does occur it is frequently accompanied by diminished vaginal lubrication.

While vaginal atrophy is a consistent finding in postmenopausal women, this is less so in women who regularly engage in intercourse. This observation may be even more prominent for those whose sexual activity involves masturbation.[51] The relationship between the thickness of the vaginal mucosa and vaginal lubrication is not entirely

clear. Although the two often are thought to be closely related, Masters and Johnson described three women who responded with considerable vaginal lubrication in spite of a thin and atrophic mucosa[43] (p. 234).

Studies of the absence of testosterone in women (which occurs suddenly when both ovaries are surgically removed) and its therapeutic use confirm that testosterone is associated with an enhancement of sexual desire, interest, and enjoyment of sex in some postmenopausal women.[52] Sherwin concluded elsewhere that "in women as well as in men, testosterone has its major effect on the cognitive, motivational, or libidinal aspects of sexual behavior such as desire and fantasies and not on physiological responses . . . [and that] . . . the likelihood . . . [is that] . . . the mechanisms impact directly on the brain."[50] From a therapeutic viewpoint, she also suggested treatment with testosterone in instances of surgically induced menopause, as well as in instances of natural menopause that is accompanied by a change (decrease) in sexual desire (see Chapter 9 for a more detailed discussion of the use of testosterone to treat sexual desire disorders in postmenopausal women).

SUMMARY

Investigation of a sexual problem begins with a description. However, understanding possible origins may entail the following:

- Detailed history-taking
- Physical examination (possibly)
- Laboratory studies (possibly)

Considering the etiology of a problem requires awareness of the context in which it exists. The interviewer needs a structure for obtaining this contextual information.

Kaplan's system for arranging explanatory information was to separate immediate and remote factors that might further understanding of the reasons for a sexual dysfunction.[2]

Immediate issues are best discovered during a patient's description of details of a sexual encounter as it takes place in the present. Describing the process of "who does what to whom" is considerably more disconcerting to health professional and patient than simply stating the fact that a problem exists and outlining what it is. Nevertheless, in the absence of objective measures, this process is a necessity, since the health professional depends entirely on the patient's words in attempting to understand the nature of a sexual dysfunction. However difficult talking about sexual details may appear, practice by the health professional makes this progressively easier.

Remote factors become apparent when reviewing a person's developmental history, particularly when the focus is on the evolution of his or her sexual development (hence the term *sexual-developmental history*). Although this process may not always seem necessary, the importance of past experiences may not be apparent until *after* the fact.

Primary care health professionals are able to acquire information about immediate factors within the time frame that they usually spend with patients (although the process may involve more than one visit). However, detailed inquiry into remote factors is more complex and time consuming and, as a result, may be more realistically undertaken by a health professional who has a special interest in sexual issues.

The sexual life cycle closely follows the unfolding of the individual. Through childhood, puberty and adolescence, adulthood and the older years, the interviewer traces the sexual thoughts, feelings, dreams, and events in the patient's life, all the while searching for anything that might help explain the reasons for a dysfunction in the present and for ways to correct it. Areas of inquiry arise for each period of time, as do questions. The rationale for the questions asked derive from the data: what is known about positive and negative happenings during each period.

When talking to an adult about "sex" during their childhood, the health professional is partly operating in a vacuum, since only a limited amount of knowledge is available. This lack of knowledge, for example, about sexual norms, probably results from the reluctance of parents and schools to allow children to be subjects of study. In contrast, much is known about adolescence—the multicolored picture of this period is a time of enormous sexual ferment, physically as well as in thought and behavior. Much can be learned about an adult by carefully detailing what took place in their mind and in their actions during their teenage years. Ways of thinking and behavior seem to crystallize at this time. The consolidation of adulthood often provides information about the appearance of sexual problems in, for example, the context of previous relationships.

Changes in the older years, including sexual alterations, are often a source of confusion. The virtual conspiracy of silence surrounding sexuality and aging relates partly to the great difficulty that many health professionals (especially students) find in talking about this subject to older patients and partly to the self-restraint displayed by those same patients.

When sexual dysfunctions occur, regardless of age, the health professional needs a structure within which to organize an assessment. This topic will be discussed in the next chapter.

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